Canadian HIV/AIDS Legal Network

HIV/AIDS POLICY & LAW REVIEW

VOLUME 14, NUMBER 3, JUNE 2010

Criminalizing HIV transmission or exposure: the context of francophone West and Central Africa

Nations throughout the world are increasingly criminalizing HIV transmission or exposure.[1] This trend, already very familiar to high-income countries such as Canada, the United States of America and some European nations, takes on a special meaning in Africa, where several national HIV/AIDS laws make HIV transmission or exposure a crime.

Introduction

Although there is, to date, no evidence that criminalization is an effective tool in combating the epidemic, and numerous expert bodies, including UNAIDS, have expressed their concerns about the impact of criminalization on the rights of people living with HIV (PLWHIV) and on prevention efforts, only one African country has amended its national legislation to impose stricter limits on the use of criminal law,[2] and several legislatures are still considering bills that criminalize HIV transmission or exposure.

Francophone West and Central Africa are no exception to this legislative onslaught. It appears that 13 countries have already enacted national HIV legislation criminalizing HIV transmission or

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Partial funding for this publication was provided by AIDES and by the Public Health Agency of Canada.

HIV/AIDS POLICY & LAW REVIEW

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Providing analysis and summaries of current developments in HIV/AIDS-related policy and law, the *HIV/AIDS Policy & Law Review* promotes education and the exchange of information, ideas, and experiences from an international perspective. The editors welcome the submission of articles, commentaries and news stories.

ISSN 1712-624X

Subscriptions
The *HIV/AIDS Policy & Law Review* is published three times per year. To subscribe, write to the address above.

Annual rate:
Within Canada: $CA 75.00
International: $US 125.00 (payment in US funds required)

Single or back issues:
Within Canada: $CA 12.00
International: $US 12.00 (payment in US funds required)

The *Review* has been published since 1994. Issues 1(1) to 5(2/3) were published under the title *Canadian HIV/AIDS Policy & Law Newsletter*. Issues 5(4) to 9(2) were published under the title *Canadian HIV/AIDS Policy & Law Review*.

Current and back issues of the *Review* are available via www.aidslaw.ca/review.

For membership information, write to the address above or visit www.aidslaw.ca/joinus.

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

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Established in 1984 and officially recognized as a non-profit organization in 1990, AIDES is the leading association in France in the fight against AIDS. Since its inception, its objective has been to bring together people either directly or indirectly affected by HIV/AIDS to have them join forces in the face of the epidemic. Its philosophy is that those living with or affected by HIV/AIDS should not stay on the sidelines, but instead initiate and take action, be active participants in health services, and inform significant public health decisions that affect them.

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exposure.[3] Côte d'Ivoire, Cameroon and the Republic of Congo are each considering legislation.

The issue of criminalization is particularly difficult in this region because the very legislation that criminalizes HIV transmission and/or exposure also makes some enormous strides in protecting PLWHIV rights. In fact, many of the bills were supported by HIV/AIDS organizations, and some were even championed by them.[4]

This article seeks to understand the objectives of the legislation and analyze its direct and indirect effects on the fight against the epidemic and on PLWHIV rights in the specific context of francophone West and Central Africa. It then provides an overview of international and national reaction to the spread of criminal legislation in the region. The analysis is guided by the comments of organizations that are combating AIDS in French-speaking Africa.

Legislating to protect the rights of HIV-positive and -negative individuals in the face of the epidemic

The willingness of francophone African countries to adopt national HIV/AIDS legislation primarily reflects their desire to take action on their international commitment to enact legislation favouring PLWHIV rights. This pledge was expressed in the *Declaration of Commitment on HIV/AIDS* by the United Nations General Assembly in 2001[5] and confirmed in the General Assembly's *Political Declaration on HIV/AIDS* in 2006.[6]

The N'Djamena model law contains troubling provisions on "wilful transmission" of HIV.

Against this backdrop, representatives from several West African countries assembled in September 2004 for a workshop organized in N'Djamena, Chad, by Action for West Africa Region — HIV/AIDS (AWARE-HIV/AIDS).[7] After three days of discussions, the participants adopted a model law on HIV/AIDS that sought to protect the rights of people infected by or exposed to HIV. It was hoped that this model law would facilitate the enactment of similar legislation, adapted to each country in the region.

In reality, many countries passed laws that closely track the wording of the model law. The model law contains positive measures to combat discrimination against PLWHIV and to address testing. However, it also contains troubling provisions,[8] which, among other things, prohibit the "wilful transmission of HIV"[9] and require people to disclose their HIV-positive status to their partners within six weeks.[10]

The national legislation, enacted in the wake of the workshop, seeks to achieve an additional, two-fold objective: to protect the rights of PLWHIV and those of people exposed to infection. The legislation is generally based on the principle that PLWHIV have duties as well as rights, including the duty not to transmit HIV to their partners.[11] The criminalization of HIV transmission is a product of this reasoning.

Some PLWHIV associations supported this approach. For example, Maggy Gouna, a former president of Espoir Vie Togo, an organization that pushed for the PLWHIV protection law, explained in a 2006 interview that Togo's "draft bill contained penalties for people who are knowingly HIV-positive and have unprotected sex" because "people living with HIV do not just have rights; they also have duties."[12]

Others, however, did not subscribe to this approach, since it might "insinuate that people living with HIV are careless" and therefore "reinforce their stigmatization," as noted by Jean-Marie Talom, president of REDS, an ethics, law and health network in Cameroon.[13] Indeed, the approach seems to disregard the fact that the vast majority of PLWHIV want to pro-

tect their partners from HIV regardless of what any law might say.[14]

The criminalization of HIV transmission or exposure in West and Central Africa is happening in a special context, and its underpinnings can only truly be understood if this context is taken into account. First of all, the region is experiencing a major HIV epidemic[15] in which the effects of prevention continue to be hampered by a shortage of resources, a lack of political will and cultural obstacles. Secondly, despite some progress in the last few years, access to treatment is still insufficient.[16] Consequently, many infected persons regard AIDS as a death sentence.

Lastly, the laws are being formulated at a time when violence against women has reached crisis levels, making them particularly vulnerable to HIV. Criminalization is seen as a way to remedy such violence, which is why many women's organizations in Africa continue to support the criminalization of HIV transmission.[17] Criminalizing HIV transmission or exposure is also a way for countries to give the impression that they are taking action against HIV when it is considerably more difficult to fight effectively against the discrimination suffered by the most vulnerable groups (including women, sex workers and men who have sex with men) and guarantee everyone access to prevention, treatment and care.

Existing provisions criminalizing HIV transmission or exposure

The N'Djamena model law

The criminal provisions in the national laws are based on the N'Djamena model, despite the fact that UNAIDS' *International Guidelines on HIV/AIDS and Human Rights* recommend against the creation of HIV-specific crimes.[18]

The model law prohibits the wilful transmission of HIV, which its French version defines as "any attempt against the life of a person by means of an inoculation of HIV-infected substances, however such substances were used or administered, and regardless of the results."[19] Both the French and English versions specify that inoculation can occur through sexual intercourse; blood transfusion or the sharing of an intravenous needle; skin-piercing instruments; or mother-to-child transmission.[20]

> Criminal law regarding HIV transmission or exposure is very broad and has serious flaws.

This definition is very broad and has severe weaknesses. First of all, the term "wilful" is not clearly defined. Based on a reading of the French version, the mere introduction of infected substances into the body could be sufficient to constitute an offence. Nothing suggests that there must be a deliberate attempt to infect another person with HIV or, at the very least, that the infectious substances be inoculated in the knowledge that it may result in HIV infection. There is nothing "wilful" about the offence.

In fact, the model law criminalizes HIV transmission without regard for (1) whether the person knew that he was infected by HIV or that there was a risk of transmission; (2) whether there was in fact a genuine risk of transmission; (3) whether the person disclosed his condition to his partner; (4) whether he took precautions to prevent infection; or (5) whether the PLWHIV had control over the degree of risk under the circumstances (e.g. the possibility of negotiating condom use).[21]

Moreover, the French phrase that might be translated as "however such substances were used or administered" is so vague that it could be applied to transmission from mother to child, *in utero* or during labour or delivery, without regard for the precautions taken to reduce the risk of transmission, or for the actual risk involved.[22]

Lastly, the very concept of "transmission" — from the phrase "wilful transmission" — is confusing because it could encompass mere exposure to HIV as well. Indeed, infected substances can be inoculated without causing contamination.

There is a significant difference between the French and English versions of the model law with respect to wilful transmission. The English version defines the phrase as "the transmission of HIV virus through any means by a person with full knowledge of his/her HIV/AIDS status to another person." Thus, by virtue of poor drafting alone, the French versions of the criminal provisions are considerably broader in scope. If the workshop participants' intent was to punish only those who deliberately infect their partners, they appear to be dangerously off the mark.

Domestic legislation

Regrettably, the hastily enacted national legislation contains the same

flaws. As Jean-Marie Talom notes, "African countries rushed to criminalize without first debating the ethical and legal implications. This haste was facilitated by the existence of model laws, which encouraged states to fill in the blanks without considering whether the provisions were appropriate."[23]

Most of the national laws punish both transmission of HIV (i.e. contamination) and mere exposure to the virus. Some of them expressly distinguish between HIV exposure and transmission. For example, Niger's legislation punishes "anyone who knowingly exposes a person to a risk of transmission."[24]

Most often, however, the fact that exposure is criminalized is deduced from the fact that the law prohibits PLWHIV from having unprotected or risky sexual relations, as is the case in Togo[25] and Benin[26] (where the person has not disclosed his HIV-positive status to his partner) or from the fact that the inoculation of infected substances is prohibited "regardless of the results," as is the case in Guinea[27] and Mali.[28] The latter wording is from the French version of the model law.

Like the N'Djamena model law, most of the national provisions punish wilful transmission, without requiring a deliberate intent to transmit the virus. In addition, most contain no limiting language and apply without distinction to PLWHIV who have taken certain precautions to protect their partner against HIV and/or have disclosed their status to their partner, to cite just two examples. Most are so vague that they could encompass mother-to-child transmission.[29]

It is clear, from reading these provisions, that the elements of foreseeability, intent, causation and consent are not clearly established, as recommended by the *International Guidelines*.[30] Consequently, the criminalization is quite sweeping and goes well beyond cases involving deliberate HIV transmission that actually causes infection.

The breadth of criminalization is particularly troubling when the statute, like the N'Djamena model law, says that an HIV-positive individual must disclose her status to her partner and that, if she does not, the medical staff must do so, without regard for the actual risks of transmission or for whether disclosure can be made without compromising her safety.

Despite the broad scope of criminal provisions, very little legal action has been initiated.

This is clearly an unwarranted violation of privacy that exposes PLWHIV to stigmatization, discrimination, violence and mistreatment.[31] It becomes untenable if she runs the risk of being prosecuted for HIV transmission or exposure without deliberate intent and if disclosure of her status to her partner is not a bar to prosecution. This kind of mandatory disclosure could discourage people from getting tested, out of fear of being prosecuted for HIV transmission or exposure. However, we still know little about the impact of criminalization on testing.

Certain national legislation reproduces the model law provisions imposing a general obligation on PLWHIV to disclose their status to their partner. If they do not disclose this status, the medical staff has the option or obligation to reveal the patient's condition, depending on the law in question. National legislation regarding breaches of confidentiality is often very broad and often provides little protection for the rights of people living with HIV.[32]

Legislation criminalizing HIV transmission or exposure: limited direct effects

There are currently no data demonstrating the impact of this legislation on the HIV epidemic in francophone West and Central Africa. Consequently, there is no way to tell whether it has reduced high-risk behaviours or prevented new HIV cases. Based on comments from several PLWHIV support associations in French-speaking Africa, the direct impact of this legislation will be limited at best, since the provisions are still largely unknown to the public in the countries concerned. It is therefore unlikely that the legislation will influence behaviour.[33]

It would appear that almost no PLWHIV have been prosecuted in francophone West or Central Africa for transmitting or merely exposing someone to HIV, even though the scope of the provisions is often very broad. Burkina Faso reports two cases involving its national HIV legislation. It is interesting to note that both cases involved women who were initially charged with wilfully attempting to transmit HIV, but who were

ultimately prosecuted and tried under non-HIV-specific provisions. Thus, the general penal code provisions proved sufficient to punish behaviour considered to constitute an offence or crime involving HIV.[34] Togo has apparently recorded four criminal prosecutions and two convictions.

As we have seen, another reason that prosecutions are rare is that the legislation is little known and it is not part of the culture to file criminal complaints.[35]

According to Brigitte Palenfo of the Burkinabe association REV+, another reason for the lack of criminal prosecution could be that most HIV-positive people do not want to make their status public. Furthermore, several associations have noted that PLWHIV continue to suffer police discrimination, which discourages them from filing a complaint.

Bintou Bamba, of ASFEGMASSI, an association of Guinean women fighting AIDS and other STDs, says that women are particularly frequent targets of discrimination and that they risk being disowned by their spouses and families if they file a police complaint. In addition, even PLWHIV support groups appear to be reticent to accompany a "victim" who wishes to file a complaint, since this would be tantamount to "turning against their own."[36] This combination of factors explains why a newly infected person is unlikely to seek redress from the justice system.

A Togolese association notes that there is an absence of political will to enforce the criminal provisions related to HIV transmission and exposure. The laws were drafted to give the impression that concrete measures had been taken to combat the epidemic, without any real intention to enforce them. In fact, the implementation of certain national HIV/AIDS laws, such as Togo's, has been delayed because the governments are slow to enact executive orders containing practical details regarding implementation.[37] The fact remains that criminal provisions are now part of the landscape. Thus, they can be enforced or used to pressure PLWHIV at any time.

Several associations argue that the legislation is out of step with the realities of local health care and justice, and is therefore often inapplicable. The fact that access to law and justice is limited has already been mentioned. The associations also note that it is a contradiction to criminalize HIV transmission and/or exposure when access to testing, treatment and prevention is far from assured.[38]

For example, while Burkina Faso has tried to make contraception, notably the female condom, more widely available, the cost remains highly prohibitive, and many people, especially women who have no income of their own, have no access to it at all.[39] Moreover, pre-natal screening may often be the only time that a person is tested for HIV,[40] and this means that men might be unlikely to get tested.

The obstacles are not just practical; they are also cultural. According to an Amnesty International report, opposition to contraception, including condom use, remains widespread in Burkina Faso because it is often rooted in traditional gender roles and to the fact that children are generally considered a source of wealth.[41]

Additional factors make these laws difficult to implement in practice. For example, the scope of the laws is both broad and vague. The fact that the laws are poorly drafted means that it is not always possible to identify clearly conduct that would warrant the police and justice systems investing time and resources in criminal prosecutions.

The legislation that criminalizes HIV transmission or exposure appears to have been drafted without taking these realities into account.

Provisions that criminalize HIV transmission or exposure could discourage people from getting tested.

In addition, it seems improbable that countries will have sufficient resources to prosecute HIV transmission cases. Indeed, it is particularly difficult, if not impossible, to prove with certainty that a person is responsible for his or her partner's infection (notably in cases where a person has more than one partner).[42] Consequently, convictions or acquittals are likely to turn solely on the credibility of the complainant or the accused.

The indirect consequences: troubling and very real

The fact that the provisions that criminalize HIV transmission or exposure appear to be difficult to implement and have been used infrequently does not mean that they have no impact on PLWHIV rights or prevention efforts.[43] For example, they could further discourage people from get-

ting tested, particularly where there is little access to treatment.

According to Jean-Marie Talom of REDS in Cameroon, "People who want to know their status will regard an HIV diagnosis as a weapon that can be used against them at any time."[44] The provisions might also dissuade HIV-positive people from disclosing their status to their partners, especially if such disclosure does not lessen the risk of prosecution. They are likely to undermine the trust between doctors and patients, because patients might fear that the information they reveal will be used against them later.

Lastly, due to their broad scope and poor drafting, some of the provisions directly contradict public health messages by punishing responsible behaviour. For example, in Mali, a PLWHIV can be prosecuted even though he has taken careful measures to reduce the risk of transmission by wearing a condom. In the realm of PLWHIV rights, there is a risk that HIV-specific criminal provisions will further stigmatize PLWHIV and encourage discrimination because they feed into stereotypes that PLWHIV are immoral and portray them as potential criminals.

Impact on women

Criminal laws could also have a disproportionate impact on women, thereby increasing their vulnerability. All the associations that were questioned expressed major worries about this. Women are generally the first, if not the only, members of a couple who find out about their status, since there has been a push to incorporate HIV testing in pre-natal screening as often as possible. As a result, women would face a greater risk of prosecution. In addition, women often do not have the means to protect themselves or their partners.

As we have noted, some women continue to experience considerable cultural pressure to have several children, particularly in rural areas.[45] This pressure makes it difficult for them to negotiate with their partners with respect to sexual relations and the use of contraception, including condoms. Some HIV-positive women also risk violence, abuse or abandonment if they reveal their status to their partner. Under such conditions, it is impossible for them to ask their partners to wear a condom.

Many women are also victims of domestic violence (including sexual violence), which is yet another way in which they are deprived of decision-making power over their sexuality.[46] These are just a few examples that show the extent to which criminal law can be turned against women instead of protecting them,[47] especially where the law, expressly or by implication, punishes mother-to-child transmission of HIV.[48]

Finally, the ability of medical staff to disclose a female patient's HIV-positive status to her spouse or partner must be examined having regard to the special situation of women. If there are not enough rules limiting the exercise of this option, it can be dangerous if the safety of HIV-positive women is not guaranteed.

International response

Countries are increasingly resorting to criminal law to deal with HIV transmission and exposure. Faced with this trend, UNAIDS, which had already recommended against HIV-specific offences in order to prevent the increased stigmatization of PLWHIV,[49] issued a policy brief on HIV criminalization. The document "urges governments to limit criminalization to cases of intentional transmission i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it."[50]

In relation to the N'Djamena model law in particular, and, by implication, national HIV statutes enacted in sub-Saharan Africa, UNAIDS has published a document proposing amendments to certain problematic articles of the model law. As far as the criminal sanctions are concerned, the proposed amendments acknowledge the fact that most legislators want to punish HIV transmission or exposure.

Criminal laws could impact on women disproportionately and subject them to a greater risk of prosecution.

The intent of the document is to limit the negative effects of such provisions. For example, UNAIDS recommends amendments stating that cases involving protected sex, cases involving prior disclosure of HIV-positive status to the partner, cases where the HIV-positive individual is unable to disclose his or her status out of fear of abuse or violence, and cases of mother-to-child transmission are to be excluded from the ambit of criminal law.[51]

At the same time, UNAIDS supported workshops in several of the region's countries in order to encourage the implementation of its recommendations.

Also, considerable emphasis was placed on the debate regarding the criminalization of HIV transmission and exposure at the XVII International AIDS Conference held in Mexico City in 2008.

Domestic responses

The role of francophone West and Central African civil society in the debate regarding the criminalization of HIV transmission and exposure differs, depending on the country. The positions of PLWHIV support groups and organizations that combat HIV/AIDS vary as well. Some of these groups actually spearheaded legislative reforms seeking to criminalize HIV transmission and/or exposure, while others supported such reforms, hoping they would improve the status of women. Some opposed such reforms.

However, based on the comments obtained, it seems that the vast majority of associations that provide support to PLWHIV in the region were not really engaged in the debate regarding criminalization because their focus was mainly on more urgent requirements (such as anti-discrimination provisions) in national legislation. Moreover, it seems that the associations were not sufficiently informed or equipped to understand all the implications of criminalization, or to get involved in the legislative reform processes.[52] In addition, several associations said they found it difficult to achieve internal consensus on the issue of criminalization.[53]

However, some associations were heavily involved in HIV-related legal reforms, notably with respect to criminalization. For example, the Cameroonian organization REDS sought to stimulate a debate with other associations about the national HIV bill. This resulted in a 2008 draft bill, endorsed by Cameroonian civil society, in response to the draft bill proposed by the Ministry of Health.[54] Interestingly, this draft bill addresses HIV based on a human rights/responsibilities model. It also criminalizes HIV transmission and exposure. Thus, Cameroon's civil society, including PLWHIV, clearly expressed support for criminalization.[55]

Some francophone African countries are now moving to limit the reach of criminal law in HIV transmission or exposure cases.

However, the sentences that the civil society draft bill would impose are much less harsh than what the government would impose and the offence of wilful transmission requires a more demanding degree of intent.[56] In 2009, the draft bill was significantly improved by civil society with the support of REDS. It now incorporates the "alternative language" proposed by UNAIDS with regard to the criminalization of HIV transmission and the disclosure of HIV-positive status to spouses and partners by health care professionals.[57]

The bills drafted in countries that have not yet passed HIV legislation appear to have benefited from the international debate regarding the implications and challenges posed by the criminalization of HIV transmission and exposure, and from the increased participation of civil society. For example, the Association des jeunes positifs du Congo (AJPC), an HIV+ youth organization, was very much involved in the 2009 revision of the HIV bill through a broader national PLWHIV network called RENAPC.

With the support of UNAIDS, these organizations managed to convene a workshop yielding a new bill that contains significant improvements, notably with regard to HIV criminalization, which is now limited to the "intentional and deliberate" transmission of the virus. Moreover, and in accordance with UNAIDS' recommendations, the bill lists the circumstances in which criminal law cannot be applied,[58] just as Côte d'Ivoire's national bill has done.[59]

Thus, the debate regarding the criminalization of HIV transmission is not in vain, and progress is possible, as exemplified by Guinea, where the HIV law has been amended in order to limit the reach of criminal law in HIV transmission or exposure cases, as recommended by UNAIDS.[60]

Togo has also begun a review of its HIV legislation. Several amendments were endorsed at a workshop held in Kpalimé in August 2008 with the support of UNAIDS and the involvement of PLWHIV associations, PLWHIV support groups and physicians. The new bill adopted by the government contains signifi-

cant improvements. For example, it strictly limits the option of health providers to disclose their patients' status to their patients' partners. It also provides that a PLWHIV will not be prosecuted for wilful transmission if they have taken measures to reduce significantly the risks of transmission, notably by using a condom or by disclosing their status to their partner and obtaining free and informed consent to an act involving an actual risk of transmission.[61]

The progress is real, and it can be seen that certain UNAIDS recommendations have been taken into account. However, it is unfortunate that the new bill does not rule out prosecution for mother-to-child transmission.

Conclusion

Legislators and several associations that provide support to PLWHIV in francophone West and Central Africa continue to favour the use of criminal law to penalize HIV transmission, despite the fact that it is largely unsuited to local realities and that there is no evidence of its effectiveness in combating the epidemic.

HIV-related criminal provisions in force in the region are little known to the public and are infrequently used. However, given their broad scope, they could have a big impact. In addition, they could have extremely negative effects on PLWHIV rights (especially women's rights) and on prevention.

It is therefore essential to encourage national authorities and members of civil society to continue reviewing and discussing the merits of criminalizing HIV transmission. Additional research still needs to be done to identify the reasons behind the desire to criminalize, the needs of HIV-positive and HIV-negative people in the face of HIV, and the appropriate ways to respond to the epidemic without necessarily resorting to criminal law. At the same time, the review of existing or proposed legislation should continue so that the scope of HIV-related criminal law can be limited to the greatest extent possible and so that people infected or affected by the virus, especially women, who remain extremely vulnerable in the face of the epidemic, are afforded more protection.

– Cécile Kazatchkine

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[1] Criminalization can occur through the use of existing general provisions (as it has in Canada, France and the United Kingdom) or through the enactment of HIV-specific criminal provisions.

[2] Republic of Guinea, *Order No. 056/2009/PRG/SGG Respecting the Prevention, Care and Control of HIV/AIDS and Amending Law L/2005/025/AN of 22 November 2005 on the Prevention, Care and Control of HIV/AIDS* (26 October 2009).

[3] Burundi, Guinea, Togo, Benin, Mali, Djibouti, Equatorial Guinea, Niger, Chad, Democratic Republic of the Congo (DRC), Burkina Faso, and Senegal. At the time of writing, the Senegalese law had not yet been published. The Central African Republic has apparently also enacted a law criminalizing HIV transmission and exposure.

[4] In Togo, the *Law on the Protection of People Related to HIV/AIDS* was championed by a PLWHIV association called Espoir Vie Togo. See "Afrique : les séropositifs, des criminels potentiels ?" *Transversal* 29 (2006): pp. 16–21.

[5] *Declaration of Commitment on HIV/AIDS*, United Nations General Assembly, A/Res/S-26/227, June 2001.

[6] *Political Declaration on HIV/AIDS*, United Nations General Assembly, A/Res/60/262, 2 June 2006.

[7] AWARE –HIV/AIDS, *Regional workshop to adopt a model law for STI/HIV/AIDS for West and Central Africa: general report* (2004). AWARE-HIV/AIDS is based in Ghana but active throughout West Africa. The project receives funding from the United States Agency for International Development (USAID). It is implemented by Family Health International with additional funding from U.S.-based organizations such as Population Service International and the Constella Futures Group.

[8] Canadian HIV/AIDS Legal Network, *A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo.* September 2007.

[9] Article 36 of the *Model Legislation on HIV/AIDS* ("the N'Djamena model law"). French version available at http://rds.refer.sn/sites/rds.refer.sn/IMG/pdf/LOITYPESIDANDJAMENA.pdf

[10] The English version of Article 26 of the N'Djamena model law requires all PLWHIV to disclose their status to their "spouse or regular sexual partner" as soon as possible after the diagnosis, "provided that the period does not exceed six weeks." There is no penalty for contravening this provision.

[11] For example, see Section 1 of Cameroon's draft bill establishing the rights and obligations of persons living with HIV/AIDS (2002).

[12] "Afrique: les séropositifs, des criminels potentiels?" (supra). According to Espoir Vie Togo's current president, only the intentional transmission of HIV should be criminalized, since the vast majority of PLWHIV have no desire to transmit the virus.

[13] Ibid.

[14] The available data show that most PLWHIV who are aware of their status take the necessary measures to prevent transmitting HIV. See R. Bunnell et al, "Changes in sexual risk behaviour and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda," *Aids* 20 (2006): pp. 85-92.

[15] According to UNAIDS, in 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, and 72% of recorded deaths caused by AIDS. UNAIDS, *2009 AIDS Epidemic Update*.

[16] According to the most recent UNAIDS data, the coverage of anti-retroviral therapy in West Africa is 30%. Ibid.

[17] C. Sasman, "Michaela Clayton on the Criminalization Debate and Other Issues," *Openspace* 2(5) (October 2009); W. Brown et al, "Criminalizing HIV transmission: punishment without protection," *Reproductive Health Matters* 17(34) (2009): pp. 119-126. It is worth noting that the Rwandan provision permitting the punishment of HIV transmission is part of a law on gender-based sexual violence (Section 30).

[18] UNAIDS, *International Guidelines on HIV and Human Rights: 2006 Consolidated Version*, Guideline 4, paragraph 21(a), available at www.unaids.org.

[19] Articles 1 and 36 of the N'Djamena model law.

[20] Ibid.

[21] Canadian HIV/AIDS Legal Network (supra).

[22] Ibid.

[23] "Transmission du VIH : la pénalisation dans tous ses États," *Journal du sida* (August 2007).

[24] Article 39 of the *Law on the Prevention, Care and Control of the Human Immunodeficiency Virus (HIV) (No. 2008-08 of 30 April 2007).*

[25] Articles 13 and 53 of the *Law on the Protection of People with Respect to HIV/AIDS (No. 2005-12).*

[26] Article 27 of the *Law on the Prevention, Care and Control of HIV in the Republic of Benin (No. 2005-31 of 5 April 2006).*

[27] Articles 1 and 37 of *Order No. 056/2009/PRG/SGG.*

[28] Articles 1 and 37 of the *Law Establishing Rules Relating to the Prevention, Care and Control of HIV/AIDS (No. 06-028 of 29 June 2006).*

[29] This is the case in Burkina Faso, Burundi, Mali, Niger, the DRC, Republic of Congo, Chad and Togo, for example. However, the Guinean statute has been amended to preclude prosecution for mother-to-child transmission (section 37 of *Order No. 056/2009/PRG/SGG).*

[30] *International Guidelines on HIV and Human Rights* (supra), Guideline 4, paragraph 21(a).

[31] R. Pearshouse, "Legislation contagion: the spread of problematic new HIV laws in Western Africa," *HIV/AIDS Law and Policy Review* 12(2/3) (2007): pp. 1, 5-11.

[32] Canadian HIV/AIDS Legal Network (supra); R. Pearshouse, "Legislation contagion: building resistance," *HIV/AIDS Law and Policy Review* 13(2/3) (2009): pp. 1, 5-10.

[33] On the contrary, existing general data show that the criminalization of HIV has no influence on behaviour. See S. Burris, "Do Criminal Laws Affect HIV Risk Behaviour? An Empirical Trial," *Arizona State L.J.* 39 (2007): pp. 467-517.

[34] Neither case involved HIV transmission or exposure through sexual contact. For more information, see P. Sanon et al, "Advocating prevention over punishment: the risks of HIV criminalization in Burkina Faso," *Reproductive Health Matters* 17(34) (2009): pp. 146-153.

[35] Information obtained from K. Eugène Novon of Aide Médicale et Charité, an association based in Togo.

[36] Comments by Brigitte Palenfo of REV+, an association in Burkina Faso.

[37] "Togo : Protéger les personnes vivant avec le VIH, une obligation légale," 5 September 2006, on-line: http://osi.bouake.free.fr.

[38] Information obtained from Bintou Bamba of ASFEGMASSI, a Guinean association.

[39] Amnesty International, *Giving Life, Risking Death: Maternal Mortality in Burkina Faso,* May 2009.

[40] Information obtained from Bintou Bamba of the Guinean association ASFEGMASSI.

[41] *Giving Life, Risking Death: Maternal Mortality in Burkina Faso* (supra), p. 33.

[42] E. Bernard et al, "The use of phylogenetic analysis as evidence in criminal investigation of HIV transmission" (2007), on-line: www.aidsmap.com.

[43] R. Jurgens et al, "Ten reasons to oppose the criminalization of HIV exposure or transmission," *Reproductive Health Matters* 17(34) (2009): pp. 163-172; UNAIDS/United Nations Development Programme, *Policy Brief: Criminalization of HIV Transmission.* August 2008, on-line: http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf.

[44] "Afrique : les séropositifs, des criminels potentiels ?" (supra).

[45] *Giving Life, Risking Death: Maternal Mortality in Burkina Faso* (supra).

[46] Information obtained from Brigitte Palenfo of REV+ in Burkina Faso.

[47] J. Kehler et al, "Ten reasons why criminalization of HIV exposure or transmission harms women" (2009), on-line: www.athenanetwork.org.

[48] J. Csete et al, "Vertical HIV transmission should be excluded from criminal prosecution", *Reproductive Health Matters* 17(34) (2009): pp. 154-162.

[49] *International Guidelines on HIV and Human Rights* (supra); UNAIDS, *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper* (2002).

[50] *Policy Brief: Criminalization of HIV Transmission* (supra).

[51] UNAIDS, *Recommendations for alternative language to some problematic articles in the N'Djamena model legislation on HIV (2004)* (2008), on-line: http://data.unaids.org/pub/Manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf.

[52] Information obtained from Tété Koffi Wilson of the Ivoirian association RAP+AO and from other sources.

[53] Information obtained from Brigitte Palenfo of REV+, an association in Burkina Faso. In addition, see the comments of Mohamed Toure of Kénédougou Solidarité in Mali, *Transversal* (supra).

[54] REDS, *Sida : droits de l'homme et santé publique,* Bulletin d'information du projet no 3 (June 2008)

[55] Information obtained from Jean-Marie Talom of REDS.

[56] Article 20 of the bill; see *Global Criminalization Scan*, on-line: www.gnpplus.net/criminalisation.

[57] Information obtained from Jean-Marie Talom of REDS. In November 2009, REDS met with parliamentarians to present to them the last version of the Cameroonian civil society draft bill.

[58] Sections 44 and 45 of the Draft bill to protect people living with HIV/AIDS. We are unaware whether there has been any progress on adopting such a bill.

[59] See *Global Criminalization Scan.* The draft bill was discussed at a workshop held by the Ministry of Justice and Human Rights, with support from UNAIDS, at the Cocody headquarters of Transparency, an NGO, in February 2009. "Côte d'Ivoire : Bientôt une loi pour protéger les séropositifs," 18 February 2009, on-line: www.allAfrica.com. At the time of writing, the bill had not yet been tabled in the Ivoirian parliament.

[60] Articles 1 and 37 of *Order No. 056/2009/PRG/SGG.*

[61] Article 61 of a bill to amend the *Law (2005-012) on the Protection of People in Relation to HIV/AIDS.* At the time of writing, the bill had apparently not yet been passed.

MSM law in francophone Africa and the fight against AIDS: the hypocrisy of certain countries

In addition to being the targets of frequent discrimination and violence, African men who have sex with men (MSM) are being hit hard by the HIV/AIDS epidemic. Although there is still insufficient research regarding the methods of HIV transmission in sub-Saharan Africa, several studies show that the prevalence of HIV infection among MSM is more than ten times higher than among the general population.

Moreover, in a socio-cultural context characterized by a denial of homosexuality or even by homophobia, and reinforced in several African states by laws criminalizing sex between men, MSM are highly stigmatized.

This stigmatization of MSM dramatically hampers their access to HIV/AIDS, hepatitis and sexually transmitted infection (STI) prevention and care. Paradoxically, and likely under pressure from international donors, almost all African countries recognize a specific right to public health and have agreed to include actions and/or priorities geared toward MSM constituencies in their national AIDS strategies and in their proposals to The Global Fund to Fight AIDS, Tuberculosis and Malaria.

Hypocritically, some countries have pledged to fight discrimination while continuing to support legislation that criminalizes homosexuality.

Drawing on the testimony of local MSM organizations, this analysis of criminal legislation concerning MSM and priorities related to MSM in four francophone sub-Saharan African countries (Cameroon, Côte d'Ivoire, Mali and Senegal) seeks to show the disconnect of government health strategies directed toward MSM in countries where homosexuality is illegal.

The aim is to help develop an advocacy strategy that highlights the incoherence of criminal laws against homosexuality and to fight more effectively against them, especially in countries that receive foreign aid. We will also consider the relationship between religion, homosexuality and criminalization, since these appear to be key factors in understanding the policies of countries that criminalize homosexuality.

Some countries have pledged to fight discrimination while continuing to support legislation that criminalizes homosexuality.

We have chosen to consider four francophone African countries with ties to the French association AIDES.[1] This choice was made not only because of their existing partnerships, but also because the countries have different political and legal positions on homosexuality: two of them (Cameroon and Senegal) prohibit homosexuality and two (Côte d'Ivoire and Mali) do not.

The testimony quoted in this article was obtained from semi-directive interviews (approximately ten per country) with MSM. The individuals were approached in various ways: via associations based on identity, the fight against AIDS or human rights; through social connections (using the "snowball effect"); or over the Internet. The information from concerned actors is not held out to be representative of all MSM who live in these countries. The use of various outreach methods helped yield the greatest possible diversity of interviewee profiles. The men in question are 18–45 years old. Half of them are single. Most of the others are in a relationship with a man, and a small number are married or in a relationship with a woman. Most participants are not activists with an association, but many are, and this might explain why quite a few of our respondents self-identify as "gay" or "homosexual", unlike most MSM in

Africa. Hence, this article will go beyond an analysis of current legislation and will consider the individual experiences of African MSM.

Existing laws on homosexuality and "real life" under those laws

In Cameroon and Senegal, legislation prohibiting non-heterosexual relations has been on the books for a long time. In the former country, Article 347 bis of the Penal Code (*Law No. 65-LF-24 of 12 November 1965* and *Law No. 67-LF-1 of 12 June 1967*) states that "any person who has sexual relations with a person of the same gender is liable to imprisonment for a term of six months to five years and to a fine of 20 000 to 200 000 CFA francs [approximately CAN$40 to $407]." In Senegal, Article 319:3 of the Penal Code (*Law No. 66-16 of 12 February 1966*) says that "any act considered to be against nature, including a sexual act between persons of the same gender, is liable to imprisonment for a term of one to five years and to a fine of 100 000 to 1.5 million CFA francs [approximately CAN$204 to $3,057]. If the act is committed with a minor 21 years of age or younger, the maximum sentence shall be mandatory."

It is worth clarifying that all of these laws punish the practice of homosexuality; that is to say, sexual relations with a person of the same gender. However, in reality, men and women are not arrested and convicted on this ground, because they are not generally caught in the act, as "S" explains: "Even though it is the act that is punished by article 347 bis, arrests for homosexuality in Cameroon are arbitrary. You can wind up in prison based on false evidence or false statements from neighbours or others." (S., 23 and single, Cameroon).

In addition, most Cameroonians and Senegalese say that filing a complaint is impossible and that an exclusion process kicks in when homosexuality becomes a factor in the justice system:

> "You can file a complaint for theft or assault, but as soon as the word 'homosexual' is heard, you become the accused." (D., 29, in a relationship with a man, Senegal).

> "I do everything to make sure nobody knows, and the legislation is also the reason for this." (S., 25, single parent, Cameroon).

> "I must always avoid doing certain things in public." (G., 29, single, Cameroon).

> "Since my release from jail, everything has changed. People don't look at me the same way." (A., 29, in a relationship with a man, Senegal).

Côte d'Ivoire does not directly prohibit homosexuality, but the Penal Code refers to it in defining the crime of "public indecency". According to Article 360 (Penal Code of 31 August 1981):

> Any person who commits public indecency is liable to imprisonment for a term of three months to two years and a fine of 50 000 to 500 000 CFA francs [approximately CAN$102 to $1020].
>
> If the public indecency is an indecent act or act against nature with an individual of the same gender, the term of imprisonment shall be six months to two years and the amount of the fine shall be 50 000 to 300 000 CFA francs [approximately CAN$102 to $610].

Public indecency is punishable regardless of whether it involves violence, according to Articles 355 to 357 of the Penal Code, but there is a provision specifically punishing indecent acts involving a minor of the same gender as the perpetrator.

In Cameroon and Senegal, legislation prohibiting non-heterosexual relations has been on the books for a long time.

According to Article 358 (Penal Code of 31 August 1981), "A person who commits an indecent act or an act against nature with a minor of the same gender who is 16 or 17 years of age is liable to imprisonment for a term of six months to two years and to a fine of 10 000 to 100 000 CFA francs [approximately CAN$20 to C$202]. Although there is no formal prohibition of homosexuality in Côte d'Ivoire, the fact that certain provisions refer to homosexuality could cause law enforcement to apply them in a way that they do not specifically contemplate: "The absence of a law enables us to live freely, but we can be prosecuted on other grounds, such as public indecency and the like." (B., 27, in a relationship with a man, Côte d'Ivoire).

Mali does not have any specific legislation prohibiting or authorizing homosexuality, nor are there aggravated sentences for offences involving a person of the same gen-

der. However, the Malian Penal Code contains "classical" provisions against sexual offences (indecency, immorality, etc.) that are regularly cited in the event of flagrant offences or simply where homosexuality is suspected. Two Malians declared:

> "I had a problem with my friend, and I had to pay some money to avoid going to jail." (N., 23, in a relationship with a man and with a woman, Mali).

> "If they find two guys together having sex, it's straight to the lockup." (C., 27, single, Mali).

The role of religion

Religion is another key to understanding the challenges and stakes associated with laws that criminalize homosexuality or bills that propose to do so. On 22 March 2010, a summit was held in Amsterdam. Approximately 40 Buddhist, Christian, Hindu, Muslim, Jewish and Sikh leaders gathered there, along with Michel Sidibé, Executive Director of UNAIDS. The theme was religious leadership in the response to HIV/AIDS. In his speech, Sidibé felt it important to note that there are concerns beyond social inequality:

> As I travel the world, I see increasing evidence of social injustice. Growing economic disparities, inequality and social injustice stalk the earth. The greatest impact is felt by the poorest segments of society, on women and girls and on the marginalized. Social injustice only serves to increase the vulnerability of the vulnerable and push them farther out of reach of HIV services.

Sidibé noted that the hatred toward constituencies that are already "vulnerable" compounds exclusion and hampers the fight against HIV/AIDS:

> Those who work on the front lines of this global epidemic have been forced to witness not only the ravages of this dreadful disease and its capacity to destroy human lives, but also the seemingly endless capacity for human cruelty and hate. Whether it means turning someone away from a clinic — and life-saving treatment and care — because he or she is a transgendered person or a mob that violently attacks a gay man or woman because they disapprove of whom he or she chooses to love, it is still meanness and hate. And these can kill just as surely as any disease… . People most at risk of HIV infection include men who have sex with men, sex workers and people who use drugs. Incidence is higher among people marginalized and stigmatized in society. This makes it more difficult to reach them with services and compounds their vulnerability.

In the four countries selected for this paper, the most common religions are Islam, Christianity and indigenous beliefs. Schematically, the distribution of religions is as follows: in Mali and Senegal, Islam is largely dominant. (It is practised by more than 90 percent of the population). Côte d'Ivoire and Cameroon are each characterized by a coexistence of two main groups: Muslims and Christians in Côte d'Ivoire, and Christians and practitioners of indigenous religions in Cameroon.[2] However, certain other sects are gaining influence in Cameroon.

There does not appear to be any correlation between the prohibition of homosexuality and the comparative size of any particular religious group within any of the countries studied. Islam is practised by more than 90 percent of the population in Mali and Senegal, yet Mali has no law against homosexuality, while Senegal does have such a law. However, there are certain similarities between Mali and Senegal with regard to religiously inspired discrimination against MSM. In both countries, religious groups, essentially those that practise radical Islam, call for discrimination against MSM.

These groups try, notably during election periods, to secure guarantees from the government that it will fight homosexuality. Homosexuality is portrayed as a typical example of societal decadence attributable to a lack of proper action by the state. Thus, the social homophobia is not directly correlated with religion (since there have been periods of relative tranquility even though religion has always been important and its presence has always been felt). Rather, the homophobia is more closely attributable to the exploitation of religion in political manoeuvring. Governments appear to be more sensitive to such political pressures these days.

MSM and health policy

Overall, studies regarding this population in Africa prior to the late 1990s are extremely rare. The first article describing the homosexual population of a sub-Saharan African country was published in 1984 in *Les Cahiers internationaux de sociologie*.[3] This was followed by historical studies published in 2004[4] and 2006,[5] and by investigations of AIDS-related behaviour in 2003[6] and 2006.[7]

The first epidemiologic data regarding MSM in French-speaking Africa were only published in 2002. They were obtained from an investigation in Senegal, funded by a major non-governmental organiza-

tion.[8] This was followed in 2005[9] by an article in the journal *AIDS* about a 2004 investigation in Senegal. Currently, we have epidemiologic data regarding ten African countries.[10]

The data were often obtained from studies of the general population, but later research focussed on MSM, notably in Cameroon and Senegal.[11] Most published research about MSM in Africa, regardless of the country, comes to the same conclusion: unprotected sex between men is very frequent[12] and the prevalence of HIV among a given country's MSM is almost systematically higher than that of its general population.[13]

> Homosexuality is portrayed as a typical example of societal decadence attributable to a lack of proper action by the state.

The responses proposed by the Global Fund countries show that projects involving sexual "minorities" are underrepresented in applications for funding, but that there has been a notable increase in the last two calls for proposals (Rounds 8 and 9). However, with regard to these last two rounds, the Global Fund report notes that 57 percent of countries that submit projects do not make any express reference to projects geared toward MSM, transgender persons or sex workers.

In March 2010, the Global Fund, as part of its Third Replenishment (2010–2013), published policy guidelines entitled *The Global Fund, HIV and Sexual Orientation / Gender Identities*.[14] The document clearly refers to the prioritized constituencies: "Sex workers, men who have sex with men, transgender people and other sexual minorities are among the groups and communities most affected by HIV and AIDS around the world."

It also notes the funding priorities: "In recent years, the Board and Secretariat have recognized the need to strengthen efforts to ensure that most-affected populations, including sex workers, men who have sex with men, transgender people and other sexual minorities be given appropriate priority in Global Fund policies, processes and funding."

These elements refer to the Global Fund's May 2009 "Sexual Orientation and Gender Identities" strategy, which "seeks to ensure an environment that is supportive of strengthened programming targeting sex workers, men who have sex with men, transgender people and/or other sexual minorities."

The example of Senegal

Senegal is a particularly significant example of how funding mechanisms can be used to press for changes to laws and public health policies because it recognizes MSM as a population vulnerable to HIV and as a priority in its 2007–2011 AIDS strategy. This means that actors in the fight against AIDS have the benefit of national support that can "facilitate" action geared toward MSM.

Senegal and Mali are the only countries that have included an MSM component in their proposal to The Global Fund.[15] Côte d'Ivoire recently proposed such a component, but it has still not been formally approved.

The Senegalese authorities' approach is particularly telling. It shows the contradictions that the country is experiencing and is a remarkable example of existing leverage for advocacy because:

- Senegal criminalizes homosexuality;
- Senegal includes actions specifically directed toward MSM in its proposal to the Global Fund and in its national AIDS plan; and
- Senegal's proposal to the Global Fund[16] includes a paragraph on the fight against stigmatization and discrimination. The paragraph states that the actions being taken "help the struggle against the exclusion and discrimination experienced by people suffering from HIV/AIDS" and that "the decision-makers who have an influence on the rights of this population group will foster the emergence of more positive attitudes that are more respectful of the principles of fairness and equality."

Although this discusses HIV-positive people and does not specifically mention MSM, the elements outlined above show that the Senegal is strongly ambivalent or, at the very least, that there is a contradiction between its laws and what it claims to be its public health policy.

The best leverage for advocacy?

The inclusion of MSM in public health policies is a decisive advantage in advocacy, in helping people and in fighting discrimination. The Global

Fund's priorities are an essential asset in this regard. However, explicit language regarding the fight against anti-gay discrimination, in particular the criminalization of homosexuality, has still not been included.

International organizations now unanimously agree that human rights are a necessary dimension of health strategy. The task ahead is to convince the most conservative elements of society (who are sometimes the majority and might be influenced by religious radicals and the populist politicians) that human rights are an essential element.

– Alain Legrand (alegrand@aides.org), Yves Yomb, Michel Bourrelly and Nicolas Lorente of AIDES, under the direction of Alice NKom, a Cameroonian lawyer who defends the rights of LGBT in her country.

[1] AIDES provides coordination and support for two major networks in Africa: Afrique 2000 and Africagay contre le sida.

[2] Central Intelligence Agency, *The World Factbook 2009*, on-line: https://www.cia.gov/library/publications/the-world-factbook/index.com.

[3] M. Le Pape and C. Vidal, "Libéralisme et vécus sexuels à Abidjan," *Cahiers internationaux de sociologie* 76 (1984): pp. 111-118.

[4] M. Epprecht, *Hungochani: The History of a Dissident Sexuality in Southern Africa* (Montréal: McGill-Queen's University Press, 2004).

[5] M. Epprecht, *Heterosexual Africa? The History of an Idea from the Age of Exploration to the Age of AIDS.* (Athens: Ohio University Press, 2006).

[6] C.I. Niang et al, "It's raining stones: stigma, violence and HIV vulnerability among men who have sex with men in Dakar, Senegal," *Culture, Health and Sexuality* 5(6) (2003): pp. 499-512.

[7] R. Lorway, "Dispelling heterosexual African AIDS in Namibia: Same-sex sexuality in the Township of Katutura," *Culture, Health and Sexuality* 8(5) (2006): pp. 435-449; B. Luirink, *Moffies: Gay Life in Southern Africa* (Cape Town: Ink Inc., 2000).

[8] C.I. Niang et al., *Satisfaire aux besoins de santé des hommes qui ont des rapports sexuels avec d'autres hommes au Sénégal,* The Population Council, 2002.

[9] A.S. Wade et al., "HIV infection and sexually transmitted infections among men having sex with men in Senegal," *AIDS* 19 (2005): pp. 2133-40.

[10] A. Smith et al., "Men who have sex with men and HIV/AIDS in sub-Saharan Africa," *The Lancet* 374 (2009): pp. 416-422.

[11] Larmarange J., "Homosexuels masculins : une épidémie sous estimée" *Transcriptases* 138 (2008): pp. 61-62.

[12] Cáceres, C. et al, "Epidemiology of male same sex behaviour and associated health indicators in low- and middle-income countries: 2003-2007 estimates," *Sexually Transmitted Infections* 84 (2008): pp. 149-156.

[13] Wilson, D, "Overview of MSM epidemiology in the Global South," The invisible Men: Gay Men and Other MSM in the Global HIV/AIDS Epidemic, MSM pre-conference to AIDS 2008, on-line: www.msmandhiv.org/documents/Wilson.pdf.

[14] On-line: www.theglobalfund.org/documents/replenishment/2010/The%20Global%20FUND%20SOGI%20Sttrategy%20Update.pdf.

[15] The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Proposal Form, Round 8: Republic of Mali.* August 2008. On-line: www.theglobalfund.org/grantdocuments/8MALH_1714_0_full.pdf; The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Senegal Proposal: Global Fund Round 9*. June 2009. On-line: www.theglobalfund.org/grantdocuments/9SNGH_1911_0_full.pdf.

[16] The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Proposal Form, Round 6: Republic of Senegal.* August 2006. On-line: www.theglobalfund.org/grantdocuments/6SNGH_1411_0_full.pdf.

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.

British Columbia project seeks to improve access to HIV treatment and care among hard-to-reach populations

A four-year, $48 million pilot program called "Seek and Treat" was recently launched by the government of British Columbia to improve access to treatment and care among hard-to-reach communities, including sex workers, injecting drug users and aboriginal people.[1] The project will operate in Prince George and in Vancouver's Downtown Eastside.

"Seek and Treat," the first program of its kind in Canada and thought to be the first internationally, will provide Highly Active Antiretroviral Therapy (HAART), which was pioneered in the early 1990s by Dr. Julio Montaner, Director of the British Columbia Centre for Excellence in HIV/AIDS (BC-CfE).

All HIV-positive residents in the province have free access to HAART through the BC-CfE. The number of people using HAART has doubled to more than 5000 since 2004. However, a large portion of the at-risk populations, where HIV prevalence is high, does not benefit from treatment because it remains disconnected

from the health system. Moreover, it is estimated that approximately 27 percent of the 12 000 people infected with HIV in the province remain undiagnosed.[2]

Under the pilot program, health workers will be deployed on the streets of marginalized communities in order to diagnose, support and provide treatment to those who are medically eligible. As indicated by Dr Montaner, the program is "over and above throwing pills to people" and more "about outreach and support."[3]

According to the Health Services Minister Kevin Falcon, "Seek and Treat" promises to decrease HIV- and AIDS-related suffering and further prevent the spread of HIV. Mathematical modelling suggests that the pilot project in Prince George and Vancouver's Downtown Eastside could avert as many as 173 HIV infections in the first five years, which would represent about $65 million in avoided lifetime HIV treatment costs alone.[4]

The pilot program was launched after a recently published study found evidence suggesting that HAART is becoming increasingly effective at the population level in British Columbia.[5] As stated by Dr Montaner, "the findings of this study…show that the current HIV management strategies, supported by the B.C. government, are working."[6] He said that it also provided further rationale to expand the number of people on therapies, for their own benefit and for the benefit of the community as a whole.

[1] Ministry of Health Services, Ministry of Health Living and Sport and the British Columbia Centre for Excellence in HIV/AIDS, "B.C. to seek and treat most vulnerable HIV patients," news release, Vancouver, 4 February 2010; N. Hall, "B.C. will take AIDS treatment to sex workers, drug users," CanWest News Service, 5 February 2010.

[2] Ministry of Health Services (supra).

[3] W. Stueck, "B.C.'s street-smart strategy to treat HIV — no matter who has it", *The Globe and Mail*, 4 February 2010.

[4] Ministry of Health Services (supra).

[5] V.S. Gill et al., "Improved virological outcomes in British Columbia concomitant with decreasing incidence of HIV type 1drug resistance infection," *Clinical Infectious Diseases*, 50(1) (2010): pp. 98-105; D. Ryan, "Drug-resistant infections drop dramatically as HIV treatments improve; transmission rates should decrease, says author of study that involved 5,500 patients over a decade", *Vancouver Sun*, 11 January 2010.

[6] D. Ryan (supra).

Multi-million dollar AIDS vaccine project cancelled

Two years after calling for applications, the Government of Canada and the Bill & Melinda Gates Foundation decided not to proceed with a planned $88 million project to build an HIV vaccine plant[1], raising questions about what was behind the move.

The cancelled project was a centrepiece of the Canadian HIV Vaccine Initiative (CHVI), a five-year, $139 million collaborative initiative between the Government of Canada and the Gates Foundation. The CHVI was established in 2007 to help accelerate global efforts to develop a safe, effective, affordable and globally accessible HIV vaccine.[2]

The project was intended to address the lack of pilot-scale manufacturing to produce HIV vaccines for clinical trials in North America, as identified in 2005 by the Scientific Strategic Plan (SSP) of the Global HIV Vaccine Entreprise. As a result, the CHVI committed to dedicate $88 million to the establishment of a pilot-scale manufacturing facility in Canada.[3]

In April 2008, the Government of Canada invited applications from not-for-profit corporations to implement

the project,[4] but in January 2010, the finalists — the University of Western Ontario in London, Winnipeg's International Centre for Infectious Disease, Laval University in Québec City and the International Consortium on Anti-Virals at Trent University in Peterborough — were told that their bids had been rejected.[5]

The Public Health Agency of Canada published a note on its website indicating that the pilot vaccine plant was no longer needed as there were already enough manufacturers for test vaccines. The notice was removed shortly after publication with claims it was an administrative error.[6] After several weeks of silence, the federal government officially announced the cancellation of the project.

According to the government, an evidence-based review of all applications had revealed that none of the applicants had successfully met the pre-established criteria. Moreover, a study commissioned by the Gates foundation had recently concluded that there was currently sufficient vaccine manufacturing capacity in North America and Europe to meet research needs. On the basis of such evidence, the Government of Canada and the Gates Foundation had decided not to proceed with the pilot-scale vaccine manufacturing facility.[7]

The unsuccessful applicants were extremely surprised by the decision and remain dissatisfied with the government's response.

According to Ted Hewitt, vice-president of research at the University of Western Ontario, the proposal was to build a non-profit facility that would have made it easier for researchers to develop vaccines. Since no such non-profit facility currently exists in Canada, he said that the decision to cancel the project did not make sense.[8] Dr Bill Cameron, president of the Canadian Association of HIV Research, said that a public facility was needed because private-sector trials were constrained by intellectual property and market considerations.[9]

In the House of Commons, opposition parties also expressed dissatisfaction with the government's decision. The New Democratic Party speculated that major pharmaceutical companies may have played a role in the decision to cancel the project, while the Liberal Party called for an independent third-party investigation.

It remains unclear how the $88 million dollars allocated for the manufacturing facility will now be used. In March 2010, several Canadian organizations that fight HIV/AIDS, including the Canadian HIV/AIDS Legal Network, circulated an open letter to Prime Minster Stephen Harper and Bill Gates calling on them to return a portion of the funds to the Federal Initiative to Address HIV/AIDS and to use the money to strengthen support for new HIV prevention technologies.[10]

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[1] E. Church, "Ottawa scraps $88-million AIDS-vaccine project," *The Globe and Mail*, 19 February 2010.

[2] Government of Canada, "An update on the HIV Vaccine Manufacturing Facility," 19 February 2010, on-line: www.chvi-icvv.gc.ca/index-eng.html.

[3] Ibid.

[4] Ibid.

[5] E. Church (supra).

[6] E. Payne, "When good ideas go bad," *The Ottawa Citizen*, 25 February 2010.

[7] Government of Canada (supra).

[8] "We want your bids…now we don't," *North Bay Nugget*, 22 February 2010.

[9] M. Rabson, "Researchers' group slams decision to cancel HIV-vaccination facility," Canwest News Service, 23 February 2010.

[10] "Canada's HIV Vaccine Initiative: An open letter from Canadian organizations fighting HIV/AIDS," March 2010, on-line: www.aidslaw.ca/publications/publicationsdocEN.php?ref=1027.

Surveys in Quebec reveal workplace discrimination against people living with HIV/AIDS

Two recent surveys reveal that people living with HIV/AIDS (PLWHIV) continue to suffer discrimination in the workplace from both colleagues and employers. Findings from the surveys, which were commissioned by the Coalition des organismes communautaires Québecois de lutte contre le sida (COCQ-SIDA), were released in November 2009.[1]

COCQ-SIDA said that the findings revealed that prejudices against PLWHIV remained strong in Quebec, which could seriously impede PLWHIV's access to employment or impair their occupational life.[2]

The first survey[3] focused on people's behaviour toward PLWHIV coworkers as well as their knowledge of HIV. It included 1054 respondents. The second survey[4] focused on employers and how they dealt with potential or current PLWHIV employees.

First survey

Over 42 percent of the respondents in the first survey declared that they would be worried if they learned that one of their colleagues was HIV-positive. Thirteen percent would avoid playing sports with that person and 16 percent would tell other colleagues about that person's HIV-positive status. Also, 43.6 percent of the respondents considered that knowing their colleague's HIV status was very important.[5]

About 51.5 percent of the respondents who had worked with a PLWHIV believed that this person had been rejected by her or his colleagues and/or that he or she had been subject to rumours and gossip (47.7 percent). Thirty percent of the respondents believed that a PLWHIV colleague had been the victim of harassment.[6]

Regarding people's knowledge of HIV, although over three quarters of the respondents stated that they were able to define HIV and AIDS, only over half of them were able to identify the best expression to define them. Moreover, 58.1 percent of the respondents believed that the life expectancy of a PLWHIV ranged from between 10 and 20 years.[7]

Many prospective employees were asked to provide health information during the hiring process. According to the survey of employees, 23.7 percent of the respondents who had looked for a job during the previous five years declared being questioned orally or in writing about their health status,[8] even if such a question is illegal. Indeed, under the *Canadian Charter of Rights and Freedoms*, employers are not entitled to ask candidates for such information except in very limited circumstances when required by a specific position. Also, in most circumstances, requiring that a person disclose his or her HIV status, or to have tested negative, as a condition of employment would amount to unjustifiable discrimination (based on disability), contrary to the *Canadian Human Rights Act*.

Second survey

The second survey, which focused on employers, also suggested that PLWHIV continue to be victims of prejudice. Thirty-eight percent of the respondents declared that they would avoid hiring a PLWHIV, if possible, while 35.9 percent believed that they would have a negative reaction (eg., disappointment, anger or feeling of betrayal) if they learned that one of their employee was HIV-positive but had not disclosed his or her status when responding to a questionnaire during the hiring process. Most of the employers responded that they were afraid that their employee would be less productive and less efficient, and would frequently need to stay away from work if he or she were HIV-positive.[9]

The survey also revealed a strong link between employers' reluctance to hire PLWHIV and collective insurance. Employers who work in companies where employees benefit from collective insurance worried about contribution costs. One third of the respondents declared experiencing a situation where premiums had dramatically increased because of one employee's health situation. Sixty percent declared having been informed by insurers of the reasons why their contributions

to collective insurance would have increased; 45 percent declared having been informed of some of the claims made by their employees; 24 percent mentioned that they knew the names of people in their teams under medication.[10] Those results indicated that the confidentiality of employees' health information is not well respected.

COCQ-SIDA said that the surveys revealed a need to raise awareness among employers and employees and work with them in order to improve PLWHIV access to employment and fight against their discrimination. To that end, since 2006, COCQ-SIDA and its partner organizations have been working on a multi-sectoral working committee on access to employment for people living with chronic and sporadic disease. A first meeting was recently organized with the support of the Institut national de santé publique du Québec.[11]

[1] COCQ-SIDA, "Remise d'un rapport d'enquête sur le VIH/sida en milieu de travail. La méconnaissance et la désinformation font des ravages," news release, Montréal, 25 November 2009.

[2] Ibid.

[3] COCQ-SIDA, *Rapport d'enquête, sondage téléphonique sur les attitudes et comportements au travail à l'endroit des personnes vivant avec le VIH (PVVIH) ou vivant avec une autre maladie chronique et épisodique (PVMCE)*, 2 July 2009.

[4] COCQ-SIDA, *Rapport quantitatif, embauche et attitudes des employeurs,* 11 November 2009.

[5] COCQ-SIDA, *Rapport d'enquête* (supra).

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] COCQ-SIDA, *Rapport quantitatif* (supra).

[10] Ibid.

[11] COCQ-SIDA, "Remise d'un rapport…" (supra).

Historic trauma contributes to high rates of hepatitis C among Aboriginal youth: study

A recent study conducted of Aboriginal youth in British Columbia suggests that trauma associated with the residential schools system increases the risk of hepatitis C virus (HCV) infection among those who inject drugs. The study also warns of a larger epidemic of HCV in the northern area of the province.[1]

Part of the Cedar project, a long-term research initiative funded by the Canadian Institutes of Health Research on HIV and HCV among Aboriginal youth who use drugs in British Columbia,[2] the study's main objective was to estimate the prevalence and incidence of HCV infection among Aboriginal youth who use drugs and to identify risk factors associated with HCV in this population.[3]

Of 512 young Aboriginal people aged 14 to 30 living in Vancouver and the northern town of Prince George, more than half (286) reported injection drug use, 59 percent of whom were infected with HCV. The study also revealed that the prevalence of HCV infection among Aboriginal youth was similar in Vancouver and Prince George.[4] Previously, the former was considered the main provincial and national epicentre for HIV and HCV; however, according to co-author Patricia Spittal, these new findings may reveal an impending larger epidemic in northern B.C.[5]

The study also found that factors significantly associated with HCV infection among young Aboriginals who used injection drugs included the daily injection of opiates; reuse of syringes; having at least one parent who attended residential school;

being female; and duration of injection drug use (per year).[6]

According to Chief Wayne Christian of the Splatsin Secwepemc First Nation, the findings confirm the necessity of acknowledging the role of historic trauma in the health of aboriginal people.[7] Aboriginal scholars have long suggested that discussion on addictions and vulnerability to infectious diseases needed to be framed within the context of Aboriginal history, including the residential school system that removed more than 100 000 children from their families between 1874 and 1986.[8] Some earlier research had shown that children who attended residential school suffered higher rates of sexual abuse or drug use. This particular study shows a link between residential schools trauma and increased risk of infectious disease.[9]

Spittal and her co-authors call for culturally based prevention, treatment and harm-reduction programs for Aboriginal youth. Chief Christian says that community-based programs are also necessary to help survivors and their children, especially women, cope with historic trauma associated with residential schools systems.[10]

The Public Health Agency of Canada estimates that the prevalence of HCV infection is 0.8 percent in the general population of Canada and seven-fold higher among Aboriginal people. However, these data only represent Aboriginal people living in urban areas and may not be applicable to the entire Aboriginal population.

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[1] K. J. P. Craib et al., "Prevalence and incidence of hepatitis C virus infection among Aboriginal young people who use drugs: results from the Cedar Project," *Open Medicine*, Vol. 3, No. 4 (2009).

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] A. Picard, "One-third of young native drug users have hepatitis C, study finds," *The Globe and Mail*, 11 February 2010.

[6] Ibid.

[7] "Historic trauma in aboriginals boosts hepatitis C risk," CBC News, on-line: www.cbc.ca.

[8] K. J. P. Craib et al. (supra).

[9] Ibid.

[10] Ibid., A. Picard (supra).

In Brief

The National Institute of Public Health of Quebec voices support for supervised injection sites

In December 2009, the National Institute of Public Health of Quebec released an opinion recommending the implementation of supervised injection sites (SIS) in the province. The opinion is based on a critical analysis of scientific research into the impact of SIS as well as literature reviews concerning the legal, ethical and social aspects of the sites.[1]

According to the government-run organization, SIS represents a pragmatic, humane and innovative response to problems that either traditional approaches (e.g. prohibition and treatment) or other harm reduction programs have not been able to solve. In addition, none of the available scientific research has reported any negative effects of SIS.[2]

The Institute said that some of the identified benefits of SIS included improvement in outreach to marginalized populations; no deaths by overdose; reduction of health risks related to injection drug use; no increase, and possible reduction of, nuisances in public places; stabilization of the health of people who inject drugs; and increased referrals to drug treatment programs.[3]

It further pointed out that SIS were an efficient and effective use of public health resources, as confirmed by a recent study based on Vancouver's supervised injection facility, Insite.[4]

In addition to the National Institute of Public Health of Quebec, a number of organizations, including the Canadian Medical Association and the World Health Organization, have supported SIS. The British Columbia Court of Appeal also recently ruled in favour of Insite.[5]

Injection drug use has critical consequences for public health in Quebec. According to the Association québécoise pour la défense des droits et l'inclusion des personnes qui consomment des drogues, an organization that defends the rights of drug users, 17 percent

of people who use drugs in Quebec are HIV-positive and 68 percent of the Association's clients suffer from hepatitis C.[6]

Nevertheless, in spite of the Institute's recent opinion and the fact that SIS have officially been included in Quebec's Public Health National Program since 2008, Quebec Minister of Health Yves Bolduc has not expressed any interest in establishing SIS in the province.[7]

Prorogation of Parliament impedes progress of drug legislation

On 30 December 2009, Canada's Prime Minister requested that the Governor-General prorogue Parliament until 3 March 2010. The move brought an end to two pieces of drug-focused legislation, while a third bill survived to advance to the new session of Parliament.

Prorogation, which brings to a halt all Parliamentary work and legislative initiatives, meant that Bill C-15, *An Act to Amend the Controlled Drugs and Substances Act and to Make Related and Consequential Amendments to Other Acts*, "died" on the Order Paper because it had not received royal assent.

Bill C-15 was passed by the House of Commons and by the Senate but with amendments made by the latter. The Bill was therefore sent back to the House of Commons on 14 December 2009, in order to obtain the House's concurrence with the Senate's amendments.

This legislation proposed establishing minimum prison terms for a variety of drug offences, such as trafficking, possession for the purpose of trafficking, importing or exporting, and producing, and for any quantity of controlled substances such as heroin, cocaine and amphetamines. The Canadian HIV/AIDS Legal Network prepared a written testimony in which it stated that, while enhancing public safety and security was laudable, the means proposed in Bill C-15 were ill-advised on fiscal, public health and human rights grounds.

It is expected that the ruling Conservative Party will re-introduce Bill C-15 later this year.

Prior to prorogation, there were also two legislative initiatives to reform Canada's Access to Medicines Regime (CAMR). The Senate's Bill S-232 and Private Member's Bill C-393 both proposed streamlining the system with the goal of getting more affordable, generic medicines to patients in the developing world. Since CAMR was adopted in May 2004, only a single shipment of medicines has been sent to one country: Rwanda. The Legal Network considers CAMR flawed, notably because the current process is too cumbersome. The proposed reforms would largely address this concern.

Prorogation, however, signalled the end of the road for the Senate's Bill S-232. It was being considered by the Standing Committee on Banking, Trade and Commerce. The Committee had held hearings in the fall and heard testimonials from various experts and groups, including the Legal Network.

Bill C-393, an almost identical legislative initiative to reform CAMR, was given second reading in the House of Commons on 2 December 2009. However, as a Private Member's Bill, it survived prorogation and is automatically reinstated at the committee stage. This means Bill C-393 will be debated by the House's Standing Committee on Industry, Science and Technology now that Parliament has resumed.

– Gilles Marchildon

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Québec City by-law on drug paraphernalia could hinder the work of harm reduction programs

A municipal by-law in Québec City could bode ill for harm reduction efforts in the city, as community workers and injecting drug users may both find themselves targeted.

Under Article 4 of the By-law on Peace and Orderly Conduct (*Règlement sur la paix et le bon ordre*), "it is forbidden, in a public place or a street, to possess any object, material, equipment used for or facilitating drugs consumption… including…any hash pipes…syringes and any other objects related to drug use." According to Article 21, anyone who contravenes or allows one to contravene this law would be fined between CAN$150 and $1000, in the case of an individual, and between $300 and $2000 in the case of a legal entity ("*personne morale*").[8]

The consequences for harm reduction programs in Québec City could be serious. Participants may be reluctant to carry syringes for fear of being caught and fined by police. Instead, they may prefer to leave used syringes in the streets rather

than returning them to the program. They may also be tempted to reduce the number of syringes they use, thereby increasing the risk of HIV, hepatitis C and other disease transmission.[9] Community workers could also run afoul of the municipal law, as they may be fined for distributing clean syringes.

There have been at least five police reports filed under the by-law. The organization Point de repères, which has been appointed by the municipality to collect used syringes across the city and which is funded by the Direction de la santé publique de la Capitale-nationale to distribute clean syringes to drug users, reports that at least one individuals has been fined.[10]

Point de repères has called for the by-law to be amended so that it would not apply to equipment distributed or obtained for the prevention of blood-borne infection. As of early April 2010, more than 564 individuals signed a petition backing changes to the law, while 23 organizations in Quebec expressed their support. Meetings have also been organized with the Québec City chief of police and a municipal councillor to convince them of the need to change the by-law.[11]

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[1] Institut national de santé publique Québec, *Avis sur la pertinence des services d'injection supervisée : une analyse critique de la littérature*, 4 December 2009, on-line : www.inspq.qc.ca/pdf/publications/962_PertinenceInjecSupervisee.pdf; "Superviser pour éviter les maladies," Radio Canada, 6 December 2009, on-line: www.radio-canada.ca/nouvelles/Science-Sante/2009/12/05/001-toxico-sites-supervises.shtml.

[2] Institut national de santé publique Québec (supra).

[3] Ibid.

[4] Ibid., M. A. Andresen and N. Boyd, "A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility", *International Journal of Drug Policy* 21 (2010): pp. 70–76. Vancouver is the only city in Canada to have a supervised injection site.

[5] See S. Chu, "B.C. Court of Appeal upholds supervised injection site's right to operate," *HIV/AIDS Policy & Law Review* 14(3) (2010): pp. 31-33.

[6] "Superviser pour éviter les maladies" (supra).

[7] M. Marchal, "Le ministre Bolduc est évasif à propos des sites d'injection supervisée ," *Métro*, 8 December 2009.

[8] Ville de Québec, *Règlement R.V.Q. 1091, Règlement sur la paix et le bon ordre*, 16 March 2009.

[9] M. Lalancette, "Interdiction de posséder des seringues: les travailleurs de rue piqués au vif," *Le Soleil*, 7 November 2009.

[10] Information provided by Point de repères.

[11] Ibid.

INTERNATIONAL DEVELOPMENTS

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

Kenyan government to establish special tribunal for HIV-related issues

On 21 January 2010, Kenyan government officials formally announced the creation of the first-ever tribunal dedicated to hearing legal issues related to HIV/AIDS. Among other things, the Tribunal will handle issues relating to the transmission of HIV; confidentiality of medical information and records; testing; access to health-care services; discriminatory acts and policies; and HIV-related research.[1]

The Tribunal was established under the *HIV and AIDS Prevention and Control Act* (HAPCA),[2] signed by President Mwai Kibaki in 2006. HAPCA states as its purpose the extension "to every person suspected or known to be infected with HIV/AIDS full protection of his human rights and civil liberties."[3] It also prohibits discrimination based on HIV status and makes breaches of its provisions an offence punishable by fines or imprisonment.[4]

While it does not have jurisdiction over criminal matters, HAPCA empowers the Tribunal to make any order it considers appropriate in response to a breach of its provisions, including the payment of damages for financial loss, the impairment of dignity or pain and suffering, as well as directing that steps be taken to ensure that the discriminatory practice is stopped.[5]

The Tribunal will operate under the office of the Attorney General, with the legal standing and powers of a subordinate court, including the right to summon witnesses and take evidence.[6] Pursuant to HAPCA, the Tribunal is to be composed of a chairman with a minimum of seven years' experience as an advocate of the High Court, two High Court advocates with a minimum five years' standing, two medical practitioners and two members with specialized skill or knowledge appropriate to the Tribunal.[7] With respect to the latter category, one of the appointed members is reported to be an AIDS activist who has been living with HIV/AIDS for more than twenty years.[8]

Ambrose Rachier, chairperson of the Tribunal, confirmed the important role of the Tribunal, indicating that "nobody can pretend that there haven't been cases of violations and abuse of people living with HIV. When an HIV-positive woman is chased from her home, either by in-laws or the husband, you have a serious case of human rights abuse." Rachier explained that the duty of the Tribunal will be to look at HIV-related human rights complaints within the confines of HAPCA, and to act as expeditiously as possible, emphasizing that "human rights do not take leave because one is living with HIV."[9]

Networks of people living with HIV have welcomed the formation of the new court and, along with groups of activists, were already compiling lists of complaints when the Tribunal was announced in January. According to the *East African Standard*, cases planned for presentation at the Tribunal include claims of discrimination at work, school, foreign embassies and at home. Sources to the *Standard* have reported claims of testing without consent and illegal research, denial of travel visas, loss of employment, divorce, eviction and expulsion from schools based on HIV status.[10]

To date, Kenya has lost more than 1.5 million people to HIV/AIDS and it is estimated that more than 2 million others are living with the virus at present.[11]

- Kelly Sinclair

Kelly Sinclair
(ksinclair@millerthomson.com) is a lawyer practising at Miller Thomson in Toronto.

[1] "Kenya: Special Tribunal for HIV-related issues," *PlusNews*, 21 January 2010.

[2] Act No. 14 of 2006 – *HIV and AIDS Prevention and Control Act*.

[3] Ibid, s. 3(b).

[4] Ibid.

[5] Ibid, s.27(7)(c).

[6] D. Manes, "Kenya forming special tribunal to hear HIV-related legal issues," *The JURIST*, 22 January 2010.

[7] *HIV and AIDS Prevention and Control Act* (supra).

[8] J. Oywa, "Can of Worms Awaits HIV and AIDS Tribunal," *East African Standard*, 14 January 2010.

[9] "Kenya: Special Tribunal for HIV-related issues" (supra).

[10] D. Manes (supra).

[11] National Empowerment Network of People Living with HIV/AIDS in Kenya, "HIV in Kenya", on-line: www.nephak.org.

South Africa: new policy means more opportunities for HIV-positive soldiers

In late 2009, the South African government announced that it had approved a new HIV/AIDS policy for the South African National Defence Force (SANDF). The move means that HIV-positive soldiers will be allowed to serve in foreign deployments and be promoted.[1]

A November 2009 statement by the SANDF noted that the new policy made provision for the "recruitment and selective deployment of HIV-

positive members" of the military and complied with a High Court ruling in May 2008, which found unconstitutional the previous policy of excluding HIV-positive people from recruitment and foreign deployment.[2]

The South African Security Forces Union (SASFU), assisted by the AIDS Law Project (ALP), had brought a case to the High Court on behalf of two SASFU members who were denied employment and deployment opportunities because of their HIV-positive status.

SANDF surgeon general Lt-Gen Vejaynand Ramlakan said the military had been in the process of reviewing its HV/AIDS policy long before. He noted, however, that the particulars of the new framework remained classified, although parts of it were "in the public domain" and already being implemented.[3]

"The reason [the new policy] has taken so long is that we're dealing with the stigma and fears that surround HIV and AIDS," Ramlakan said. "Military people share all the misunderstandings of wider society. We needed to consult very widely with all military commanders and to convince them of the need to change the existing policy, and to prevent any misunderstanding about whether combat readiness would be affected."[4]

Ramlakan said that the policy did not mean that all HIV-positive soldiers would be deployed. "If you are HIV and sick, clearly you will not be in the front line. If you are physically fit and you're just HIV positive, then your HIV positive status would be minimized…."[5]

ALP attorney S'khumbuzo Maphumalo, who brought the test case, said that "it means that people who are HIV positive in our military — who for instance, are on treatment and have stabilized on treatment — they meet minimum requirements, they will now qualify to be recruited and deployed and promoted which was not the case in the past."[6]

A draft of the new policy, obtained by the ALP, draws on a system of classifying soldiers according to their health status and needs.

An HIV-positive soldier who is stable and asymptomatic can now be classified as a "G2K1," meaning they have a chronic but treatable disease and can be deployed "anywhere at any time." However, if HIV-positive soldiers are to be deployed abroad they must have a CD4 cell count higher than 350 and an undetectable viral load. The ALP pointed out that this excluded anyone not on treatment, as only ARVs could reduce the viral load to undetectable levels.[7]

An HIV-positive recruit is also required to be on ARVs for three to six months before being considered for deployment. Failure to adhere to treatment is grounds for being declared "temporarily unfit for deployment and military courses."[8]

Ramlakan confirmed that a soldier would have to be on ARVs to qualify for foreign deployment, but declined to discuss the rationale for such a provision. He also noted that personnel with higher health classifications would be given preference for foreign deployment.

Ramlakan said that a campaign to inform unit commanders and health workers about the new policy was underway.

Past studies have found that between 25 and 30 percent of South African soldiers are infected with HIV and that most of them acquire the disease while on deployment.[9]

– David Cozac

[1] "New AIDS policy for South African military," *Public Radio International*, 19 December 2009.

[2] "South Africa: Military gets new HIV policy," *PlusNews*, 26 January 2010.

[3] Ibid.

[4] Ibid.

[5] "New AIDS policy for South African military" (supra).

[6] Ibid.

[7] "South Africa: Military gets new HIV policy" (supra).

[8] Ibid.

[9] "New AIDS policy for South African military" (supra).

In brief

South Korea's lifting of HIV travel ban is misleading

Both UNAIDS Executive Director Michel Sidibé and U.N. Secretary-General Ban Ki-moon applauded South Korea's apparent elimination of travel restrictions based on HIV status, which took effect on 1 January 2010.[1] However, while provisions of its *Immigration Control Act* ostensibly provide the legal basis for travel restrictions and deportation based on HIV-positive status, South Korea never previously required short-term visitors to submit to HIV testing, so the country's "travel ban" was seldom, if ever, enforced.[2]

In fact, no new laws or policies were created in conjunction with the announced lifting of HIV-related travel restrictions, and the announcement did not appear to affect rules related to mandatory HIV testing of certain "long-term sojourners," or foreigners who seek to work in the country for longer than three months.[3] According to Article 8(3) of South Korea's *AIDS Prevention Act*, individuals applying for an E-6 employment visa (e.g. those who wish to work in the field of entertainment or sports in South Korea for more than three months) are required to submit to HIV testing. If they are found to be HIV-positive, the government is still able to invoke Article 46(1) of the *Immigration Control Act* to deport them.[4] Similarly, individuals applying for an E-2 visa (e.g. foreign language instructors) are also required to undergo an HIV test within 90 days of entry, although this requirement is currently being challenged on constitutional grounds.[5]

As reported by human rights organization Asia Catalyst, it appears "too early to determine what impact, if any, the recent announcement will have on the momentum of Bill 3356 [mandatory HIV testing bill for all foreigners applying for work visas], currently pending before the National Assembly."[6] While people living with HIV will not necessarily be prevented from entering South Korea, those hoping to live and work there may still be required to submit to mandatory HIV testing and be subject to deportation because of their HIV status.

– Sandra Ka Hon Chu

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

Zimbabwe's constitutional reform process presents opportunity to protect rights of HIV-positive people

A constitutional reform process is underway in Zimbabwe, and AIDS activists have launched a major drive to ensure that Zimbabwe's constitution — which currently does not include an explicit right to health or reference to HIV — enshrines the rights of people living with HIV. The constitutional reform process was sanctioned by an agreement signed in September 2008 by the three main political parties in Zimbabwe, mandating a 19-month constitution-making process through which a new constitution is to be established.[7]

The Southern Africa AIDS Information Dissemination Service (SAfAIDS), a regional non-profit AIDS organization, and the Zimbabwe National Network of People Living with HIV and AIDS (ZNNP+) have called for a bill of rights that would feature provisions on non-discrimination and equal protection before the law to ensure better access to health services. According to the ZNNP+, the two million people living with HIV and AIDS in Zimbabwe continue to face grave challenges in accessing treatment, social services, basic health care and education.

The activists have also urged policymakers to include a clause that would commit the government to spending a minimum of 10 to 15 percent of the national budget on health care.[8]

SAfAIDS and ZNNP+ have planned policy dialogues throughout Zimbabwe to collect the views of people living with HIV to be included in a document to be presented to members of the Parliamentary Select Committee for inclusion in the draft constitution.

– Sandra Ka Hon Chu

Australia's HIV policies regarding refugees criticized as discriminatory

In January 2010, the United Nations High Commissioner for Refugees (UNHCR) urged Australia to discon-

tinue its present policy of screening refugee applicants for HIV and effectively barring the immigration of those who test positive. In a submission to the Joint Standing Committee on Migration — a parliamentary inquiry into Australia's treatment of migrants with disabilities — the regional office of the U.N. agency criticized the policy and described it as endangering a number of human rights norms, including those found in international treaties to which Australia is a signatory.[9]

Currently, a prospective immigrant or refugee with a disability or illness must be assessed to estimate the treatment costs they are likely to incur. In order to be considered for an immigration visa, their estimated lifetime treatment costs must be no more than AUS$21 000 (approximately CAN$19 670). Australia's Immigration Department estimates the lifetime treatment cost of an HIV-positive person is AUS$240 000 to $250 000 (approximately CAN$224 776 to $234 158).[10] While the Immigration Department has some leeway to waive this requirement in the case of skilled immigrants or people who are partners of Australian citizens, refugee applicants have no access to such a waiver unless they have an Australian sponsor.[11] As the UNHCR contended, "Although the waiver is theoretically available, UNHCR's experience in practice suggests that it is very rarely granted."[12]

A number of Australian HIV/AIDS organizations also lobbied for the reform of rules affecting refugees and immigrants with HIV. Included in their submissions to the Joint Standing Committee on Migration were calls for Australia's *Migration Act* no longer to be exempt from the *Disability Discrimination Act* and for compulsory HIV testing of refugees and immigrants to cease; for refugees and immigrants to be assessed by specialists in their condition; and for refugees and immigrants to be allowed to contribute to the health and welfare system differentially to defray costs associated with their migration. A recommendation specific to refugees was a call for HIV testing of refugees to occur after arrival in Australia so refugee applicants could be referred to appropriate and culturally tailored support and health services.[13]

The Committee, which was formed to study the failure of Australia's current migration policies to take into account the potential economic and social contributions an immigrant or refugee with a disability may make, is expected to issue a report later this year.

– Sandra Ka Hon Chu

Tajikistan piloting prison-based needle and syringe programs

In November 2009, in response to the risk of HIV and hepatitis C virus transmission among incarcerated people who inject drugs, Tajikistan's Department of Correction Affairs, supported by United Nations Development Programme's HIV/AIDS, Tuberculosis and Malaria Control Programme, initiated a rapid assessment of several prisons in Tajikistan to identify an institution for a pilot prison-based needle and syringe program (PNSP). In January 2010, the Department of Correction Affairs signed a decree to pilot such programs in prisons in Tajikistan.[14]

The first stage of implementation included training of staff and prisoners in the pilot institution on the urgency and specifics of PNSP implementation. This was followed by training on HIV/AIDS prevention, focusing on harm reduction, for 20 staff in the pilot institution. A number of education sessions for prisoners have also been scheduled.

Tajikistan will be the second country in the region of Central Asia to implement PNSPs, after Kyrgyzstan.

– Sandra Ka Hon Chu

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[1] "UN Secretary-General applauds the removal of entry restrictions based on HIV status by United States of America and Republic of Korea," 4 January 2010, on-line: www.unaids.org.

[2] K. Oh, "A Second Look at Korea's "Lifting" of its HIV Travel Ban," 26 January 2010, on-line: www.asiacatalyst.org.

[3] Korea HIV/AIDS Prevention and Support Center, *FAQs: Korean Policy on HIV/AIDS*, undated, on-line: www.khap.org/Eng_Html/Counsel_022.php.

[4] K. Oh, supra.

[5] Ibid.

[6] Ibid.

[7] SAfAIDS, *Making HIV Prevention, Care, Treatment and Support a Constitutional Issue in Zimbabwe: Amplifying voices of PLHIV*, undated.

[8] "HIV-positive people want constitutional rights," *PlusNews*, 4 February 2010.

[9] N. Bita, "United Nations blasts HIV tests on asylum-seekers," *The Australian*, 29 January 2010.

[10] C. Hart, "PM blasted over HIV comments," *The Australian*, 14 April 2007.

[11] G. Brown, "Why can't Australia accept migrants with HIV?" *The Punch*, 3 February 2010.

[12] N. Bita, supra.

[13] A. Potts, "HIV+ migrant inquiry," *Sydney Star Observer*, 9 March 2010.

[14] *UNDP Tajikistan Bulletin*, Issue #11, February 2010.

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.

B.C. Court of Appeal upholds supervised injection site's right to operate

On 15 January 2010, the British Columbia Court of Appeal held that Insite, North America's first supervised injection site, was a provincial undertaking that did not undermine the federal goals of protecting health or eliminating the market that drives drug-related offences. As such, the Court held, the drug possession and trafficking provisions of the *Controlled Drugs and Substances Act* (CDSA) did not apply to it.[1]

In September 2003, the Vancouver Coastal Health Authority, in partnership with PHS Community Services Society, opened Insite and operated it under the purview of exemptions from prosecution for possession and trafficking of a controlled substance contrary to Sections 4(1) and 5(1) of the CDSA, based on necessity for a scientific purpose.

The exemption was originally granted by the federal Minister of Health in 2003 and subsequently extended to June 2008. When no further extensions appeared to be

forthcoming, two separate actions were commenced before the B.C. Supreme Court, one by PHS and two of its clients, and the other by the Vancouver Area Network of Drug Users (VANDU).

In its action, PHS claimed that Insite is a health care undertaking, authority for the operation of which lies with the province, and that the federal constitutional power to legislate with respect to criminal law cannot interfere with the provincial constitutional power with respect to health care because of the doctrine of inter-jurisdictional immunity.

The B.C. Supreme Court rejected this argument, but accepted PHS's alternative claim, which was that Sections 4(1) and 5(1) of the *CDSA* are unconstitutional and should be struck down because they deprive persons addicted to one or more controlled substances of access to health care at Insite — and, therefore, violate the right conferred by Section 7 of the *Canadian Charter of Rights and Freedoms* (*Charter*) 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.[2]

Consequently, the B.C. Supreme Court declared those sections of the *CDSA* inconsistent with the *Charter* and of no force and effect, and granted Insite an ongoing, constitutional exemption to permit its continued operation without fear of criminal prosecution of its users or staff. The federal government was granted a one-year suspension of the effect of the declaration of constitutional invalidity so it could rewrite its laws to allow for the medical use of illegal drugs if they are part of a health care program.

The Attorney General of Canada (Canada) appealed this order and PHS cross-appealed the dismissal of its application for a declaration that Sections 4(1) and 5(1) of the *CDSA* did not apply to Insite because of the doctrine of inter-jurisdictional immunity.

In its decision, the B.C. Court of Appeal held that the effect of the application of the doctrine of inter-jurisdictional immunity was to limit the federal enforcement power sufficiently to protect the exercise of an exclusive provincial power — namely, the provision of a health care service.

As Justice Huddart, writing for the majority, held,

> Insite is a provincial undertaking. It is a health care facility created under and regulated by provincial legislation within the province's exclusive power.… *It would be difficult to envisage anything more at the core of a hospital's purpose, than the determination of the nature of the services it provides to the community it serves*. Indeed, it would be difficult to envisage anything more at the core of the province's general jurisdiction over health care than decisions about the nature of the services it will provide.[3] [emphasis in original]

In Justice Huddart's view, a supervised drug injection service did not undermine the federal goals of protecting health or eliminating the market that drove the more serious drug-related offences of import, production and trafficking. Rather, "[t]o the extent that the criminal law treats possession for personal use as an offence because of its role in creating an illegal 'supply and demand' market, that role has already run its course when an addict enters Insite or a comparable facility."[4]

Justice Huddart said that the restricted application of inter-jurisdictional immunity to protect a provincial undertaking where two *intra vires* exercises of authority collide precluded a pre-emptive, automatic and non-contextual determination in favour of federal power. Accordingly, the B.C. Court of Appeal dismissed Canada's appeal and allowed the cross-appeal of PHS, holding that Sections 4(1) and 5(1) of the *CDSA* were inapplicable to Insite. Given its findings in this regard, Justice Huddart decided that consideration of PHS's alternative claim under Section 7 of the *Charter* was unnecessary.

Nevertheless, Justice Rowles held, in *obiter*, that she agreed with the lower court ruling that Sections 4(1) and 5(1) of the *CDSA* engaged the rights to life, liberty and security of the person with respect to users of Insite and that those provisions violated Section 7 of the *Charter* in a manner that was not in accordance with the principles of fundamental justice. In her view, "[t]he effect of the application of the *CDSA* provisions to Insite would deny persons with a very serious and chronic illness access to necessary health care and would come without any ameliorating benefit to those persons or to society at large."[5]

Moreover, in her decision, Justice Huddart said that she had had the opportunity to review the reasons of Justice Rowles, and that she was in "general agreement with them."[6] As such, a majority of the B.C. Court of Appeal agreed with the *Charter* arguments advanced by PHS in support of Insite.

In February 2010, federal Justice Minister Rob Nicholson announced

Canada's intention to appeal the ruling to the Supreme Court of Canada.[7]

[1] *PHS Community Services Society v. Canada (Attorney General),* 2010 BCCA 15 (B.C. Court of Appeal).

[2] *PHS Community Services Society v. Attorney General of Canada*, 2008 BCSC 661 (B.C. Supreme Court).

[3] *PHS Community Services Society v. Canada* (supra), at para. 157.

[4] Ibid., para. 169.

[5] *PHS Community Services Society v. Canada* (supra) at para. 76.

[6] Ibid., para. 199.

[7] "Ottawa to appeal injection site ruling," *CBC News*, 9 February 2010.

Ontario court justice dismisses class action suit of persons notified of exposure to tuberculosis

A recent decision of the Ontario Superior Court of Justice to dismiss a class action suit by individuals who had been notified of possible exposure to tuberculosis and who later required testing has important implications for the public health practice of mounting public notification campaigns to encourage testing to reduce the spread of communicable diseases such as tuberculosis (TB) and HIV.[1]

Healey v. Lakeridge Health Corporation ("*Healey"*) arose out of a notification campaign carried out by public health officials following the identification of two active TB cases. Lakeridge Health Corporation, a public hospital, had reported the active TB cases to public health authorities, as required by Ontario's *Health Protection and Promotion Act*.[2]

Public health responded with notification activities in compliance with guidelines established by the provincial Ministry of Health and Long-Term Care, including press releases and more targeted calls based upon the classes of patients most likely to have been exposed to the risk of transmission in a waiting room or physician's office. The public health objective of these activities was to encourage those who may have been exposed to the risk of TB transmission to seek TB testing that would enable them to receive related care and counselling to reduce the risk of further transmission.

About 3500 people were tested for TB as a result of these public health notification campaigns. Approximately 3000 tested negative and 500 tested positive (although some of the positive test results may have reflected pre-existing conditions rather than new infections).

The plaintiffs commenced a class proceeding against the hospital and two physicians who had cared for the TB patients reported to public health. They sought damages for all persons notified and tested for TB, including those who tested both positive and negative, together with family members entitled to advance related claims under Ontario's *Family Law Act*. The action was certified by the Court to proceed as a class proceeding.[3]

The plaintiffs' claim on behalf of members of the Uninfected Class was for damages for psychological injury as a result of being notified of their exposure to TB and undergoing related testing, on the basis that they had suffered severe emotional stress and psychological trauma, nervous shock, fear for their health and loss of enjoyment of life and incurred out-of-pocket expenses.

Following certification, Lakeridge brought a motion for summary judgment in which it argued that Lakeridge had no duty of care to the class of "Uninfected Persons." Justice

Perell agreed and dismissed these claims. His reasons for the decision are of interest from the point of view of broader public health practice because of the policy-based arguments that were advanced by the Hospital and ultimately accepted by the Court.

Justice Perell analyzed whether the hospital owed a duty of care to the Uninfected Persons using the current "*Cooper-Anns*" test, which requires:

> (1) ***foreseeability***, in the sense that the defendant ought to have contemplated that the plaintiff would be affected by the defendant's conduct; (2) ***sufficient proximity***, in the sense that the relationship between the plaintiff and the defendant is sufficient to give rise to a duty of care; and (3) ***the absence of overriding policy considerations*** that would negate any prima facie duty established by foreseeability and proximity. Under this formulation not all reasonably foreseeable harm is subject to a duty of care: *Cooper v. Hobart*, [2001] 3 S.C.R. 537 at para. 21. Whether a relationship entails a duty of care depends on foreseeability of a harm, moderated by policy concerns: *Anns v. Merton London Borough Council*, [1978] A.C. 728 (H.L.); *Mustapha v. Culligan of Canada Ltd*., [2008] 2 S.C.R 114 at para. 4.[4]

Justice Perell concluded that, while the forseeability requirement was satisfied, "there [was] not a proximate relationship between the Uninfected Persons and Lakeridge upon which to base a duty of care and, … if there was a *prima facie* duty of care, there [were] public policy reasons to negate that duty of care."[5]

With respect to proximity, he found that "an Uninfected Person could not reasonably expect Lakeridge to be an insurer against all harm that might happen as a result of a hospital visit."[6]

Most importantly, Justice Perell was persuaded that the following policy reasons argued against imposing a duty of care on Lakeridge to the Uninfected Persons for psychological injuries:

- to do so would produce the prospect of indeterminate liability;
- in a context in which hospital resources are limited, to do so would increase expenses and reduce the funds available for patient care including to members of the Uninfected Class and their family members;
- it would be of "doubtful social utility" to recognize a duty of care since any recovery would be modest and, in any event, under Ontario's public health system all members of the class would have access to needed health care without the need to prove the existence of recognizable psychological injury or fault on the part of Lakeridge; and
- contrary to the public health imperative of expanding notification programs as widely as possible to reach all those who might require testing and related care, it would have the negative effect of encouraging public health authorities and hospitals to reduce the scope of such programs out of concern for the legal and financial consequences of giving notice to persons unaffected apart from the emotional harms presented by receiving the notice.[7]

Justice Perell's ruling on this motion for summary judgment in *Healey* is under appeal.

Commentary

Healey merits careful consideration in relation to "fear of AIDS" litigation, in which plaintiffs seek damages for exposure to a risk of HIV transmission that has not resulted in infection.[8]

It may be argued that such cases, especially if successful, foster a continued social climate that stigmatizes HIV infection and those living with HIV.

– Lori Stoltz

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[1] *Healey v. Lakeridge Health Corporation,* [2010] O.J. No. 417 (Superior Court of Justice).

[2] *Health Protection and Promotion Act,* R.S.O. 1990, c.H.7, as amended.

[3] *Healey v. Lakeridge Health Corporation,* [2006] O.J. No. 4277 (Superior Court of Justice).

[4] *Healey* [2010] (supra), para. 196; emphasis added.

[5] Ibid., para. 209. Note that at para. 213 of his Reasons, Justice Perell was careful to limit his conclusion to the class of Uninfected Persons and specifically noted that Lakeridge might well be found to owe a duty of care to a patient infected with TB not to have exposed the patient to this risk of transmission.

[6] Ibid., paras. 215-217.

[7] Ibid., paras. 219-229.

[8] See, for example *Farkas v. Sunnybrook and Women's College Health Sciences Centre,* [2009] O.J. No. 3533 (Superior Court of. Justice), paras. 1, 9, 19 and 25.

Coroner's jury recommends improved care for HIV-positive prisoners

Following an inquest into the 2007 death of a young man in his twenties who had died from AIDS-related causes while serving a sentence in an Ontario correctional facility, a jury issued a number of recommendations to improve the treatment and care of HIV-positive individuals in prison.

At the inquest, which took place in the fall of 2008, the HIV&AIDS Legal Clinic (Ontario) (HALCO) represented the young man's family and Cynthia Fromstein, senior criminal defence counsel, represented the Prisoners' HIV/AIDS Support Action Network (PASAN).

HALCO and PASAN presented evidence demonstrating problems with the treatment of prisoners with chronic and life-threatening illnesses, including difficulties with access to outside organizations like PASAN. Representatives from the prison system presented evidence about new policies and practices being developed to treat prisoners with chronic and life-threatening illnesses better.

The jury recommended that the process of implementing the new policies and practices be sped up; that access to prisons by support organizations be improved (including making access to PASAN's newsletter, *Cell Count*, available); that a brochure on prisoner health — which is already being developed — be made available as soon as possible and that an electronic health records database be developed, also as soon as possible.

The law at the time of the man's death stated that, whenever a person died in custody, an inquest must be held.[1] Inquests, which are hearings held before a jury, inquire into five questions:

- Who was the deceased?
- Where did the death occur?
- When did the death occur?
- How did the death occur? (eg, medical cause)
- By what means did the death occur? ("By what means" must be one of the following categories: natural causes, accident, homicide, suicide or undetermined.)

At the end of the inquest, the jury makes recommendations. The recommendations are not orders and there are no consequences for not following them. However, such recommendations are important in ongoing attempts to effect positive change regarding the prison system.

If implemented, the jury's nine recommendations to the Ontario Ministry of Community Safety and Correctional Services could go a long way to improving the treatment and the health of prisoners living with HIV, hepatitis C and other serious illnesses that require continuous monitoring.

– Renée Lang

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[1] In 2009, the *Coroners Act* was amended so that inquests into deaths in correctional institutions are no longer mandatory. Inquests will only be held when a coroner is of the opinion that the person may not have died of natural causes. HALCO opposed this amendment.

Ontario court strikes civil suit against Toronto and Ontario for failing to protect plaintiff from contracting HIV

On 10 March 2010, the Ontario Superior Court of Justice struck in its entirety Percy Whiteman's statement of claim against Ontario and Toronto for negligently failing to protect him from contracting HIV from his spouse, holding that it disclosed no reasonable cause of action. Whiteman's claim that Canada was vicariously liable for the acts of immigration agents and employees was allowed to proceed, as it was not plain and obvious that no private law duty of care could be found to exist between Whiteman and Canada.[1]

In March 2008, Whiteman commenced an action against nine defendants, including his spouse Suwalee Iamkhong, the province of Ontario, the city of Toronto and Canada, in which he alleged that all three levels of government were negligent in failing to protect him from contracting HIV from Iamkhong, an immigrant to Canada from Thailand.

Whiteman claimed that Iamkhong intentionally failed to disclose her HIV-positive status to him in order to secure sponsorship into Canada via marriage. In 1999, when Iamkhong applied for permanent residence in Canada with Whiteman acting as her sponsor, Whiteman alleged that the examining physician, Dr. Taylor, failed or neglected to test Iamkhong for HIV. Had he done so, Whiteman alleged, it is unlikely that Iamkhong would have been admitted to Canada as a landed immigrant.

In March 2001, Iamkhong was granted landed immigrant status. In February 2004, Iamkhong was admitted to hospital in the advanced stages of AIDS. The following month, Whiteman was informed that he was HIV-positive. In May 2004, Iamkhong was charged with criminal negligence and aggravated assault against Whiteman, for which offence she was ultimately convicted three years later.

Ontario, Toronto and Canada moved to dismiss Whiteman's claim on various bases, among them that the pleadings disclosed no reasonable cause of action. With respect to the defendants Ontario and Toronto, the Ontario Superior Court of Justice agreed and held that Whiteman's claims against them had no chance of success. There was no basis in the facts pleaded, or in law, to support Whiteman's assertion that Dr. Taylor was a servant, agent or employee of Ontario or Toronto such that the province or city was therefore vicariously liable for the doctor's acts.

Alternatively, Whiteman claimed that, if Dr. Taylor did test Iamkhong for HIV and reported her status to the appropriate health officials, Ontario failed to take appropriate steps to prevent "the spread of disease," as required pursuant to the *Health Protection and Promotion Act* (HPPA). The Court rejected this argument and held there was nothing in the HPPA to indicate that Ontario or Toronto was vicariously liable for the negligence of a local board of health in relation to an individual case. In the Court's view, Whiteman was driven to make broad systemic claims against Toronto and Ontario because there never was any close or proximate relationship between him and these defendants.

However, the Court said, because Whiteman had pleaded the essential facts relating to his sponsorship of Iamkhong and his dealings with the federal government and its agents in the course of Iamkhong's sponsorship application, the onus was on Canada to establish that it was plain and obvious that no private law duty of care could be found to exist between Whiteman and Canada.

Because Canada failed to raise or address whether it was plain and obvious or beyond doubt that Dr. Taylor, in carrying out his statutory duties, was not a servant of the Crown for whom the Crown was vicariously liable, the Court said, it was at least arguable on the facts that the relationship between Whiteman and Canada was sufficiently close to give rise to a duty of care. As such, Whiteman's negligence action against Canada was allowed to proceed.

[1] *Whiteman v. Iamkhong*, [2010] O.J. No. 966 (Ontario Superior Court of Justice).

HIV-positive Zimbabwean couple's refugee claim accepted on the basis of their political affiliation

On 23 November 2009, the Refugee Protection Division of the Immigration and Refugee Board (IRB) found two citizens of Zimbabwe to be Convention refugees based on their political affiliation with Zimbabwe's opposition party and the impact this had on their access to antiretroviral treatment in Zimbabwe. The refugee claims of their children, who were not infected with the virus, were rejected.[1]

The claimants, whose identities were protected by a publication ban, had claimed refugee protection pursuant to sections 96 and 97(1) of the *Immigration and Refugee Protection Act* (IRPA), which require a claimant to demonstrate a well-founded fear of persecution or a foundation for establishing a personal risk to life, or cruel and unusual treatment or punishment, or danger of torture. Prior to leaving Zimbabwe, the principal claimant (the husband) and the associated claimant (his wife) were supporters of the opposition Movement for Democratic Change (MDC) party and had been harassed by government officials and threatened by mobs for their support of the MDC. In 2002, the female claimant and her daughter were sexually assaulted by three men in their home.

In 2002, the claimants left Zimbabwe for the United States of America with two of their children. There, they made an unsuccessful claim for asylum. In 2008, the principal claimant came to Canada and made a refugee claim, followed that same year by his wife and their younger son. In 2009, the claimants' adult son arrived in Canada and made a refugee claim. Since coming to North America, the principal claimant and his wife learned that they were HIV-positive and began taking antiretroviral treatment.

The IRB found the claimants credible in their testimony. Based on the documentary evidence, it also found the situation in Zimbabwe dire for those living with HIV, as many HIV-positive people died as a result of an insufficient supply of antiretroviral treatment and chronic malnutrition.

With regard to the provision of medical services, the IRB noted that the inability of a country to provide adequate health or medical care should be distinguished from those situations where adequate health or medical care is provided to some individuals but not to others. According to the IRB, individuals who are denied treatment may be able to establish a claim under the IRPA because, in their case, their risks arise from the country's unwillingness to provide them with adequate care.

The IRB held that Zimbabwe restricted antiretroviral treatment to its citizens based on the Convention ground of political opinion. The female claimant had indicated that, when they were in Zimbabwe, the supply of antiretroviral treatment was secure only for those who were involved with the government, whereas other people in Zimbabwe had a sporadic or uncertain supply. This was confirmed by documentary evidence from various sources.

The IRB said that because of the couple's affiliation with the MDC, their access to life-saving medication would be limited by their political opinion. On this basis, the IRB accepted their claim for refugee protection.

With respect to the claims of the couple's two sons, who were not HIV-positive, the IRB did not find that they faced persecution based either on stigmatization because of their parents' HIV-positive status or based on their family members being MDC supporters. In the IRB's view, the social stigmatization the sons may face because of their parents' health situation would not reach the level of persecution. Moreover, given the passage of time, the IRB did not find a continued risk of government agents targeting family members. Therefore, their claims for refugee protection were rejected.

[1] *A.A.W. (Re)*, [2009] R.P.D.D. No. 37 (Immigration and Refugee Board of Canada).

Federal Court dismisses appeal in permanent residence case, says personal commitments to pay for HIV treatment are unenforceable

On 16 February 2010, the Federal Court dismissed the judicial review application of Al-Karim Ebrahim Rashid on the basis that personal commitments to pay for required health services such as HIV treatment are non-enforceable.[1]

In January 2004, Rashid, who is HIV-positive, had applied for a permanent resident visa under the Federal Skilled Worker Program at the Canadian High Commission in Nairobi, Kenya. While the High Commission found that Rashid had met the requirements of the Program, he was deemed inadmissible pursuant to Section 38(1) of the *Immigration and Refugee Protection Act* (IRPA) because a medical officer had determined that the costs of HIV treatment would likely exceed the amount spent on the average Canadian.

In reply to the medical officer's findings, Rashid submitted additional statements of his financial resources, a letter of support and financial documents from his sister who agreed to support him for his first five years in Canada, letters from two Canadian doctors who also agreed to contribute to his support, and a medical report from the Aga Khan Hospital in Nairobi. In September 2008, a medical officer reviewed the additional documents and concluded that the information did not alter the opinion that Rashid's admission to Canada might reasonably be expected to cause an excessive demand on health services.

In his judicial review application, Rashid relied on the Supreme Court of Canada's decision in *Hilewitz v. Canada (Minister of Citizenship and Immigration); De Jong v. Canada (Minister of Citizenship and Immigration)* ("*Hilewitz*") to argue that, as in the case of social services, a personalized assessment should be conducted to determine whether he had a viable plan to cover the costs of his anti-retroviral medication.[2]

Justice Mosley also considered another Federal Court decision, *Companioni v. Canada (Minister of Citizenship and Immigration)* ("*Companioni*"), in which that Court held that *Hilewitz* was equally applicable to any consideration as to whether the cost of out-patient drugs would constitute an excessive demand on health services.[3] However, Justice Mosley held that the facts of Rashid's case were distinguishable from those in *Companioni* because, in that case, one of the two applicants had a personal insurance policy that covered prescription drug costs and the second was covered by an employer-based group policy, either or both of which might have continued to apply if the applicants relocated to Canada.

Rashid, on the other hand, was relying on the personal commitments of his sister and two others. Justice Mosley emphasized that it was not possible to enforce a personal undertaking to pay for health services that may be required after a person has been admitted to Canada as a permanent resident if the services are available without payment.

In Justice Mosley's view, the visa officer's findings were to be given significant deference. He was not satisfied that Rashid had met the burden of demonstrating that the visa officer, through the medical officer's assessment, made an erroneous finding. Because the plan that Rashid put forward was based upon personal commitments to pay for the required health services and because those commitments are non-enforceable, Justice Mosley held that Rashid would pose an excessive demand on health services.

The Court concluded by certifying a question posed by the Minister of Citizenship and Immigration on the basis that the question would be dispositive of an appeal and transcended the particular context in which it arose:

> When a medical officer has determined that an applicant will be in need of prescription drugs, the cost of which would place the applicant over the threshold of "excessive demand" as set out in the *Immigration and*

Refugee Protection Regulations, must a visa officer assess the applicant's ability to pay for the prescription drugs privately when those same drugs are covered by a government program for which the applicant would be eligible in the province/territory of intended residence?

[1] *Rashid v. Canada (Minister of Citizenship and Immigration)*, [2010] F.C.J. No. 183 (Federal Court) (QL).

[2] 2005 SCC 57 (Supreme Court of Canada).

[3] 2009 FC 1315 (Federal Court) at para. 10.

Federal Court orders review of prospective immigrants' plan to obtain private insurance for HIV medication

On 31 December 2009, the Federal Court allowed the judicial review application of Ricardo Companioni and his common-law partner on the basis that the ability and willingness of the applicants to defray the cost of their out-patient prescription drug medications is a relevant consideration in assessing whether the demands presented by an applicant's health condition constitute an "excessive demand."[1]

Companioni and his partner Andrew Grover, both of whom are HIV-positive, applied to immigrate to Canada as members of the skilled worker class. In view of the projected cost of their HIV medication, totalling $33 500 per year, a visa officer determined they would pose an "excessive demand" on Canadian health and social services and deemed the couple inadmissible pursuant to Section 38(1) of the *Immigration and Refugee Protection Act* (IRPA).

At the time of the application, Companioni had a personal insurance policy that covered prescription drugs and Grover had an employer-based group policy that did the same. Although they both undertook to obtain medical insurance coverage for their prescription drugs once they were in Canada, there was no evidence to substantiate this claim.

Companioni and the intervener, the HIV & AIDS Legal Clinic (Ontario), argued that the principles in *Hilewitz v. Canada (Minister of Citizenship and Immigration); De Jong v. Canada (Minister of Citizenship and Immigration)* ("*Hilewitz*") — in which the Court held that assessments of "excessive demands" on social services must be individualized and take into account not merely eligibility for services but also likely demand, as well as an applicant's ability and intention to pay[2] — were equally applicable to determinations as to whether the cost of drugs would create an excessive demand on Canadian health services.

While Justice Harrington agreed, he noted a fundamental distinction, at least in Ontario, between social services, which as a matter of law the province was entitled to recover most, if not all, of those costs from those who could afford it, and prescription drugs, the cost of which were mostly borne by the province.

In Justice Harrington's view, the visa officer should have called upon Companioni to provide a viable plan to obtain medical insurance coverage for their prescription drugs in Canada. Accordingly, he ordered that the matter be returned to a different visa officer for a fresh determination limited to medical admissibility.

The Court concluded by certifying a question submitted by counsel for Companioni:

> "Is the ability and willingness of applicants to defray the cost of their out-patient prescription drug medication (in keeping with the provincial/territorial regulations regulating the government payment of prescription drugs) a relevant consideration in assessing whether the demands presented by an applicant's health condition constitute an excessive demand?"

Commentary

Justice Harrington's decision is important because it extends the *Hilewitz* principles from social services to prescription drug costs. This will have particular significance for prospective immigrants who are HIV-positive and either living in Canada and employed in situations where their prescription medication is covered or have medical insurance plans that are transferable to Canada.

Prior to this decision, the willingness and capacity of HIV-positive people to finance their prescription medication coverage through private plans was not considered by Citizenship and Immigration Canada.

[1] *Companioni v. Canada (Minister of Citizenship and Immigration)*, [2009] F.C.J. No. 1688 (Federal Court) (QL).

[2] 2005 SCC 57 (Supreme Court of Canada).

Criminal law and cases of HIV transmission or exposure

Court considers viral load evidence in convicting man for HIV exposure

On 19 November 2009, the British Columbia Court of Appeal dismissed an appeal by Michael Wright of his conviction for two counts of aggravated sexual assault for failing to disclose his HIV status to two sexual partners in 2005 and 2006.[1]

Wright tested positive for HIV in 1998 and immediately began antiretroviral treatment. However, he stopped taking his medication during the time that he had vaginal intercourse with the complainants. One complainant, P.S., mainly received oral sex from Wright but also had unprotected vaginal intercourse. Another complainant, D.C., had vaginal intercourse with the accused one time; whether or not a condom was used was disputed. At the time of the trial, neither complainant had tested positive for HIV.

At the conclusion of the Crown's case, Wright applied for a directed verdict of acquittal, citing that no evidence had been adduced concerning his viral load. The trial judge rejected the directed verdict application. Wright was later convicted by a jury and sentenced to 45 months in prison.

In his appeal, Wright submitted that the trial judge had erred in rejecting his application for a directed verdict. He argued that an undetectable viral load makes the risk of transmission less than significant; and that since the Crown had not adduced evidence on his viral load, it had not met its burden of showing that Wright posed a significant risk of harm to the complainants when he engaged in sexual intercourse with them. Therefore, Wright said, the trial judge erred in rejecting the directed verdict because there was insufficient evidence for a jury to convict.

The B.C. Court of Appeal held that the trial judge had not erred in rejecting the directed verdict. The Court stated that, in the absence of evidence concerning the accused's viral load, the Crown could introduce evidence of an average risk of transmission based on average viral loads. However, if there was evidence concerning the accused's actual or estimated viral load at the

time of the sexual relations, it would be open to the accused to introduce such evidence. According to the Court, it would "be very relevant to determining whether there was a significant risk of serious bodily harm."[2]

The Crown introduced evidence that the average risk of HIV transmission from an infected man to an uninfected woman during vaginal intercourse was 0.5 percent. In the Court's view, that evidence was sufficient for a jury to conclude that there was a significant risk of HIV transmission and to convict Wright.

Wright also submitted that there was a reasonable doubt that he had not used a condom with D.C., and therefore a reasonable doubt that he exposed her to a significant risk of serious bodily harm. He referred to a statement made by Justice Cory in the Supreme Court of Canada decision *R. v. Cuerrier* that the use of a condom might make the risk of harm less than significant.[3]

The appellate court held that the *Cuerrier* statement was not conclusive on whether a condom was sufficient to make the risk of harm less than significant. It is a question of fact for the jury to determine whether the use of a condom, during a particular sexual encounter, sufficiently reduced that risk of harm. The trial judge therefore did not err in leaving it to the jury to determine whether the possible use of a condom during sexual intercourse raised a reasonable doubt as to whether there had been a significant risk of HIV transmission.

Commentary

This case raises substantial concerns about viral load evidence and the use of condoms during sexual intercourse. According to the B.C. Court of Appeal, the Crown does not need to provide evidence concerning an accused's viral load to prove that there was a significant risk of HIV transmission. In the absence of specific information about the accused's viral load, evidence based on *average* viral loads can be sufficient for a conviction even if it is possible that the accused's viral load was undetectable.

However, the Court conceded that if, at the relevant time, viral load evidence was known and the risk of harm could be estimated, it would be relevant to the determination of whether the conduct posed a significant risk of serious harm. Therefore, this decision may allow a "viral load defence" when an accused can prove that his or her viral load was undetectable during sex and that, consequently, the risks of transmission were dramatically reduced.

The case also raises significant uncertainty about whether the use of a condom removes the requirement to disclose. While the Supreme Court of Canada suggested in *Cuerrier* that the use of a condom might sufficiently reduce the risk of serious bodily harm, the B.C. Court of Appeal ruled that it is actually a question of fact. The appellate court said that in each case, it must be determined whether the use of a condom has reduced the risk of HIV transmission below the "significant risk" threshold.

The decision to make the use of a condom a matter of fact leaves considerable uncertainty in the law for HIV-positive persons and may lead to great unfairness in the application of the law. While one person may be convicted for failing to disclose prior to protected sex, another may be found not guilty.

– Caroline Brett

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Ontario man convicted of two counts of aggravated sexual assault despite condom use

First conviction

On 14 September 2009, the Ontario Court of Justice convicted Yonatan Mekonnen of aggravated sexual assault for failing to disclose his HIV-positive status to the complainant L.L. prior to having sex with her from the period November 2007 to January 2008.[4]

According to the complainant, she met Mekonnen at a motel three times between December 2007 and January 2008 to have sex. Each time they had sex they used a condom, though with respect to one occasion of oral sex she did not recall if he wore a condom. Mekonnen testified that he only had a platonic relationship with the complainant, which he broke off in January 2008 because he made an agreement with his girlfriend not to have other women call him.

In June or July 2008, two of the complainant's friends contacted the complainant to alert her to Mekonnen's HIV-positive status, which they had learned from newspaper articles about another criminal charge of HIV non-disclosure against

him. After learning of Mekonnen's status, the complainant went for HIV testing and tested negative.

A short time after she was tested for HIV, the police contacted her about her relationship with Mekonnen. At trial, the complainant indicated that she did not wish to testify against Mekonnen because he had not infected her with HIV and because she had forgiven him.

Since Mekonnen and the complainant had differing versions of their relationship, Justice Bovard held that the credibility of the parties was crucial to the resolution of the case. Justice Bovard rejected Mekonnen's assertion that he did not have a sexual or romantic interest in the complainant when they first met and accepted, without a reasonable doubt, that Mekonnen had sex with the complainant in a motel.

Judge Bovard convicted Mekonnen of aggravated sexual assault, in spite of the fact that there was no dispute about whether a condom was used during sex. Mekonnen received a 12-month sentence and three years of probation.

Second conviction

On 26 January 2010, the Ontario Court of Justice convicted Mekonnen of another count of aggravated sexual assault for failing to disclose his HIV status to the complainant K.S. prior to having sex with her.[5] Mekonnen was charged with two counts of aggravated sexual assault in relation to sex he had with the complainant in January 2008 and in February 2008. According to the complainant, she and Mekonnen first had unprotected oral and vaginal sex in January 2008. They continued to have unprotected sex until 6 March 2008, when Mekonnen disclosed his HIV-positive status to the complainant. The complainant tested negative for HIV in March 2008 and the two continued having sex while using condoms. In April 2008, the relationship ended.

Mekonnen testified he first had sex with the complainant in February 2008. He further testified that he had always used a condom with the complainant and confirmed that he disclosed his HIV status to her on 6 March 2008. While he had tested HIV-positive in November 2007, he did not believe or accept that diagnosis and was tested four or five more times before he was convinced of his HIV status.

In Justice Keaney's view, "It is not necessary to find that there was condom usage…. Condom use is not absolutely safe ... [Mekonnen's] failure to disclose his status on the first sexual encounter, when he knew his status, endangered the life of the complainant."[6] Justice Keaney rejected Mekonnen's argument that the fact the complainant continued to have protected sex with Mekonnen after she learned of his HIV-positive status was evidence that she would have likely engaged in sex with him prior to that.

In Justice Keaney's view, "The complainant's assertion was clear. If he had told her at the outset he was HIV positive she would not then have engaged in any sexual activity, and it would not have made a difference if he had offered to use a condom."[7]

Justice Keaney convicted Mekonnen of one count of aggravated sexual assault for sex he had with the complainant in February 2008, and held that there was insufficient evidence to prove he had sex with the complainant in January 2008. On 31 March 2010, Mekonnen was sentenced to nine months' imprisonment followed by three years of probation. In addition, a DNA database order was granted against Mekonnen and he was ordered to comply with the *Sex Offender Information Registration Act*.

Thirty-month sentence for man who failed to disclose his HIV-positive status

On 23 February 2010, the Ontario Court of Justice sentenced Justin Bruneau to 30 months' incarceration for failing to disclose his HIV-positive status to his ex-girlfriend prior to having unprotected sex with her.[8] Bruneau, who pleaded guilty to aggravated assault, assault and uttering threats, did not infect the woman with the virus.[9]

According to the Crown, the couple engaged in unprotected sex approximately 80 times in the course of their four-month relationship.[10] At the time, Bruneau had been HIV-positive for more than 10 years. The relationship ended following a domestic dispute in which Bruneau physically assaulted the complainant and threatened to kill her teenage son, to which the charges of assault and uttering threats pertain. After their relationship ended, the complainant learned of Bruneau's HIV-positive status from one of his previous girlfriends.[11]

Bruneau's lawyer had sought a sentence of one year to 18 months in light of his Aboriginal background and life experiences, which included being born to alcoholic parents, living

in foster homes, and struggles with gender identity and alcohol and drug addiction, while the Crown sought a three-year sentence.[12] Justice Hugh Fraser rejected the defence argument and held that Bruneau's failure to disclose his HIV status had little to do with his life experiences.[13]

Ontario man receives eighteen-month sentence for aggravated sexual assault

William Andre Boisvert, 53, pleaded guilty to one count of aggravated sexual assault and was sentenced to 18 months' in prison. The charge had been laid against Boisvert in December 2008 for failing to disclose his HIV-positive status to his partner. According to the police, Boisvert tested positive for HIV in 2005, and the complainant learned of Boisvert's HIV status from another source.[14]

At the time of his arrest, Niagara region police issued an alert asking anyone who had been in sexual contact with Boisvert to seek medical attention.[15] Although police indicated they were not anticipating further complainants, they nevertheless released a photo of Boisvert.

Toronto woman receives two-year conditional sentence for failing to disclose HIV-positive status

On 20 November 2009, following her guilty plea to one count of aggravated sexual assault, Robin St. Clair was given a two-year conditional sentence and three years' probation for failing to disclose her HIV-positive status to a man prior to having sex with him.[16] As a result of the convictions, St. Clair will also be registered for life as a sex offender.

St. Clair met the complainant in March 2007 and they had sex twice with a condom.[17] On the second occasion, the condom ripped, at which point St. Clair disclosed her HIV status to the complainant. The complainant was not infected with HIV.

Man convicted of sexual assault for failing to disclose his hepatitis B condition

On 3 March 2010, Darral James O'Regan was sentenced to one year imprisonment and three years' probation for failing to disclose his hepatitis B condition before having unprotected sex with two women in Prince Edward Island.[18] O'Regan, who had pleaded guilty to sexual assault and sexual assault causing bodily harm, will also have his name recorded on Canada's sex offender registry for 20 years.

O'Regan contracted hepatitis B in the 1970s. He had sex with the two women between 2003 and 2006, one of whom later contracted hepatitis B.

According to police, they began an investigation into O'Regan's activities in 2007 after being contacted by one of the complainants. A second complainant was identified in the course of their investigation. O'Regan was arrested in August 2008 in Hamilton, Ontario.[19]

Hamilton man convicted of aggravated sexual assault dies before sentencing

Daniel Edgar Chin, who had pleaded guilty in October 2009 to four counts of aggravated sexual assault for failing to disclose his HIV-positive status to four sexual partners, died in his home on 16 November 2009.[20] Chin was to be sentenced in January 2010.[21]

Chin, who had no prior criminal record, had been permitted to reside with his parents on strict terms of bail until his sentencing.[22]

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[1] *R. v. Wright,* [2009] 2009 BCCA 514 (B.C. Court of Appeal).

[2] ibid,, para 32.

[3] *R. v. Cuerrier,* [1998] 2 S.C.R. 371 (Supreme Court of Canada) at para. 129.

[4] *R. v. Mekonnen,* [2009] O.J. No. 5766.

[5] *R. v. Mekonnen* (26 January 2010), Brampton File #08-7087.

[6] Ibid., paras. 44–45.

[7] Ibid., para. 57.

[8] M. Gillis, "Prison term for hiding HIV status," *The Ottawa Sun*, 24 February 2010, p. 17.

[9] M. Gillis, "Man convicted for exposing woman to HIV," *The Ottawa Sun*, 19 February 2010, p. 8.

[10] A. Seymour, "Jail HIV-positive man for 3 years: Crown; Woman 'traumatized' after transgendered sex partner exposed her to potentially fatal virus '80 times,'" *The Ottawa Citizen*, 19 February 2010, p. B1.

[11] Ibid.

[12] Ibid.

[13] M. Gillis, "Prison term for hiding HIV status" (supra).

[14] R. De Lazzer, "HIV-infected St. Kitts man faces sex charge," *The Hamilton Spectator*, 30 December 2008.

[15] "Police warn public about St. Catharines man charged in HIV-assault," *The Canadian Press*, 29 December 2008.

[16] "Toronto woman gets house arrest for failing to disclose HIV status to man," The Canadian Press, 20 November 2009.

[17] Ibid.

[18] "Man with Hepatitis B Jailed for Sexual Assault," CBC News, 4 March 2010.

[19] "Hamilton man brought to P.E.I. to face sex charges," CBC News, 18 August 2008.

[20] B. Brown, "Man pleads guilty to HIV assaults; Chin didn't tell partners," *Hamilton Spectator*, 6 October 2009, p. A3.

[21] "Man convicted of HIV sex assault dies before sentencing," *Hamilton Spectator*, 24 November 2009, p. A4.

[22] Ibid.

HIV/AIDS IN THE COURTS — INTERNATIONAL

This section presents a summary of important international cases relating to HIV/AIDS or of significance to people living with HIV/AIDS. It reports on civil and criminal cases. Coverage is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the *Review*. Coverage of U.S. cases is very selective, as reports of U.S. cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of 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.

South Africa: ANC Youth League President found guilty of hate speech

On 15 March 2010, the Johannesburg Equality Court found African National Congress (ANC) Youth League President Julius Malema guilty of hate speech and harassment for his comments regarding rape survivors.

The Sonke Gender Justice Network (Sonke) brought the hate speech and harassment charges against Malema following a speech that he had made to students at Cape Peninsula University of Technology in January 2009. Regarding the woman who accused then-Deputy ANC President Jacob Zuma of rape, Malema told the students, "When a woman didn't enjoy it, she leaves early in the morning. Those who had a nice time will wait until the sun comes out, request breakfast and ask for taxi money."[1]

Malema admitted to making the remark, but claimed that he intended it only as a comment on the judgment that acquitted Zuma. Malema's

lawyer, Tumi Mokwena, explained that Malema's comments referred to the fact that the judge, in acquitting Zuma, had said the woman had not screamed and that she had gone to the kitchen for food the next morning.[2]

Sonke claimed that the comments perpetuated myths and stereotypes about rape, and argued that the perpetuation of such rape myths may lead perpetrators to believe they can act with impunity and may dissuade rape survivors from seeking health care or justice. Sonke spokesperson Mbuyiselo Botha argued that "instead of perpetuating rape myths, public figures should make it clear that rape can happen anywhere, and that the rapist could be anyone."[3]

Botha emphasized that there are no rules governing how a rape victim may behave, and that it is essential to "make sure that women who have been raped are not stigmatized and are not made to feel like the crimes against them were their fault."[4]

The Equality Court agreed with Sonke's position and found that the comments made by Malema amounted to hate speech and harassment as contemplated by South Africa's *Promotion of Equality and Prevention of Unfair Discrimination Act* (also known as the Equality Act). Magistrate Colleen Collis ordered Malema to make an unconditional public apology and to make a payment of 50 000 rand (approximately CAN$6 900) to a centre for abused women.

In response to the ruling, Botha said that "Magistrate Collis has shown that we have a solid and strong justice system in South Africa which upholds the values of the Constitution, and this ruling demonstrates that the court system can protect the rights of rape survivors."[5]

The press statement issued by Sonke the day of the ruling stated that "it is not sufficient [...] for leaders to refrain from making irresponsible comments; we need proactive leadership to mobilize men and boys to take action against gender-based violence." The statement called upon men in public positions to be "clear and consistent in their explicit support of gender equality and to condemn openly and unequivocally all forms of gender-based violence."[6]

Malema's lawyers have announced their intention to appeal the ruling.

Commentary

Gender-based violence is one of the worst manifestations of inequality and has a devastating impact on the lives, health and general well-being of women worldwide. Given the now well-established link between gender-based violence and HIV,[7] the existence of such violence has also become a major public health concern. Inequality against women increases their risk of HIV infection, which in turn elevates the risk that they will face further violence.

According to UNAIDS, at the end of 2008, it was estimated that out of the 31.3 million adults living with HIV and AIDS worldwide, approximately half were women,[8] whose biology and social status continue to put them at increased risk of HIV transmission. Biologically, women are twice as likely as men to become infected with HIV through unprotected heterosexual intercourse.

In societies like South Africa, where power imbalances and gender-based violence are common, a woman is less able to negotiate condom use and monitor her spouse's extra-marital activities and more likely to be subjected to non-consensual sex.[9] A South African study conducted in 2004 concluded that women who were beaten or dominated by their partners were much more likely to become infected with HIV than those who were not. A 2009 study of 20 425 couples in India confirmed the link between HIV transmission and abuse, and also found that abusive husbands were more likely to be infected with HIV than non-abusive husbands.[10]

Although the post-Apartheid years have been marked by increasing state intervention into the problem of violence against women, Malema's comments provide an important reminder that law and policy alone is inadequate without the proactive leadership called for by Sonke.

– Kelly Sinclair

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[1] "Equality Court to rule on Malema hate speech complaint," *The Citizen* (on-line edition), 15 March 2010.

[2] "Malema back in Equality Court over rape remarks," *Mail and Guardian Online*, 27 August 2009.

[3] Sonke Gender Justice Network, "Julius Malema's Comments Amount to Hate Speech and Harassment," news release, 15 March 2010, on-line: www.genderjustice.org.za/press-releases/sonke-press-statement-on-the-equality-courts-ruling-on-the-julius-malema-case.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Canadian HIV/AIDS Legal Network, *Respect, Protect and Fulfill: Legislating for Women's Rights in the Context of HIV/AIDS, Volume 1*, 2009.

[8] UNAIDS, *Report on the global AIDS epidemic*, 2009, on-line: www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp.

[9] AVERT, "Women, HIV and AIDS", 10 March 2010, on-line: www.avert.org/women-hiv-aids.htm.

[10] Ibid.

High Court in India decides property dispute in favour of HIV-positive widow

On December 22, 2009 the Calcutta High Court settled a property dispute in favour of an HIV-positive widow. This decision has been described as setting "a new bench mark," both because of the outcome of the case and the speed with which a settlement was achieved.[1]

The widow, Pampi Das (whose name was changed for media purposes), lost her husband to AIDS in 2006. He had run a transport business with his brothers; however, upon discovering that Pampi was also HIV-positive, the brothers denied her husband's share of the business.

Pampi spent years attempting to regain her share from her brothers-in-law, but was unsuccessful until being introduced to an organization known as Solidarity and Action Against the HIV Infection in India (SAATHII), which advocates on behalf of government, U.N. agencies and civil society members for universal access to HIV/AIDS prevention, care, support and treatment services; health and legal policy reforms; and reduced stigma and discrimination for people living with or vulnerable to HIV/AIDS.[2]

When Pampi presented her case to SAATHII, the organization promptly filed a petition in the High Court on her behalf. After three hearings, Justice Shankar Prasad Mitra passed an order entitling Pampi to her husband's share of the company.

Daily News and Analysis (DNA) India described the judgment as coming "to the rescue of the Indian judiciary, which had become synonymous with inordinate delays," and as revealing "the humane side of the judiciary" as it "spared the ailing Pampi Das ... the ordeal of doing the rounds of court and spending her savings fighting the case."[3]

SAATHII documentation officer Soma Roy Karmarker shared a similar view of the judgment, stating that "in most cases, victims have to wait years to get justice. But Pampi's case has given us new hope."[4]

Commentary

In the case discussed above, HIV-positive status resulted in discrimination, which negatively impacted on a woman's property rights. However, the denial of inheritances and other such rights to property ownership may also increase a woman's vulnerability to transmission of the virus. A lack of, or inability to own, property may result in instability and economic dependency. This, in turn, puts women at increased risk of sexual exploitation and violence, as they may be forced to tolerate abusive relationships or resort to sex work in order to support themselves.[5]

– Kelly Sinclair

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[1] S. R. Chadhuri, "Positive Calcutta HC settles HIV patient's case in 3 days," DNA India, 24 December 2009.

[2] www.sathii.org

[3] S.R Chadhuri (supra).

[4] Ibid.

[5] "Women, HIV and AIDS," AVERT, last updated 10 March 2010, on-line: www.avert.org/women-hiv-aids.htm.

HIV-positive worker in Ecuador takes his employer to court for discrimination

The Ecuadorian Constitutional Court is currently considering the case of a person living with HIV/AIDS who claims that, contrary to federal and international laws, he was dismissed from his employment in the fall of 2009 because of his HIV status.

According to the Ecuadorian Coalition for People Living with HIV/AIDS (CEPVVS), Carlos (name altered to protect the individual's privacy), who had worked for the Ecuadorian division of Baxter Laboratories for six years, was fired in October 2009, two months after disclosing, in writing, his HIV-positive status to his immediate supervisor and the director of the division.[1]

In August 2009, Baxter's company physician offered Carlos a hepatitis B vaccination that is routinely offered to all employees. However, Carlos informed the company physician that his primary care doctor had advised him to not take such vaccination as it would affect his low CD4 count.[2]

Baxter's physician accepted the explanation, but asked that Carlos inform the Director of Baxter Laboratories Ecuadorian division and his immediate supervisor in writing. In August 2009, Carlos sent an e-mail letter to the Director of the company and his supervisor informing them of his HIV status, but he never received a reply from either of them acknowledging receipt of the e-mail.[3]

Following his disclosure to management, Carlos began to experience a certain level of ostracism and harassment on the job. Starting in early fall, Carlos's spot in the company's parking lot was revoked; and, after six years of employment, during which time he was never required to punch a time clock, he was suddenly compelled to record his hours. In addition, the colleagues he had eaten with at the same table for many years now refused to eat with him.[4]

On 21 October 2009, Carlos was summoned by the company's lawyer, who informed him, without further explanation, that he was being terminated. He asked him to sign a resignation letter and offered CAN$8000 as a "bonus." Carlos refused either to sign the letter or to take the "bonus."[5]

The employer's dismissal was immediately appealed with the Ecuadorian Labour Ministry. Dr. Gabriela Garcia, the Labour Ministry inspector charged with reviewing the case, found that Baxter violated Carlos's rights not only under Clause 81 of the articles of the International Labour Organization (ILO), but also under Article 11 of the Ecuadorian Constitution and Article 398 of the regulations of the Ecuadorian Law Ministry.

Article 11 (2) of Ecuador's Constitution stipulates: "All people are equal and are entitled to the same rights, obligations and opportunities. No one can be discriminated against for their ethnicity, birth place, age, sex, religion, sexual orientation … health status, HIV/AIDS status, physical handicap…. The law will provide consequences for any form of discrimination."[6]

Based on domestic and international law, the Labour Ministry ordered Baxter to reinstate Carlos immediately, which it did — at least initially. However, on 17 November, Carlos was fired once again. It is the company's position that Carlos's contract was terminated based on legitimately objective and non-discriminatory reasons.

On 20 November 2009, Judge Susana Vallejo found in favour of Carlos and "issued a restraining order against Baxter, mandating that he not be dismissed." By 27 November, the same judge had reversed her order, offering a limited explanation for her reasoning.

The Ecuadorian newspaper *El Telégrafo* reported that Hernan Barrios, a lawyer for the Baxter company, stated, "Baxter asserts that the dismissal of Carlos was due to motives related to his job performance while with the company."[7] Barrios is quoted as saying that, "once Baxter became aware that Carlos had HIV, the company had to analyze if his job, which was related to providing technical support to maintain dialysis equipment, would affect the patients who received this treatment."[8]

According to Carlos, during his last six years with the company he received stellar evaluations. *El Telégrafo* also interviewed Illmer Coello, an ex-Baxter employee and

one of Carlos's former supervisors. Coello indicated that Baxter's contention that Carlos had been fired for poor performances is absolutely false. According to Coello, "the company has very rigorous evaluation procedures."[9] Coello believed that, should Carlos's performance records become public, it would show that Carlos never had a negative performance evaluation.

According to Santiago Jaramillo, Director of CEPVVS, many companies routinely request their employees to take an HIV test, resulting in many cases where people are fired because of their HIV-positive status. Jaramillo explained that most people do not challenge these discriminatory practices in court because of their distrust for the judicial system. According to Jaramillo, Carlos's case is the first one that CEPVVS has been able to take through the judicial system.[10]

[1] Ecuadorian Coalition for People Living with HIV/AIDS, "Press release," 2 February 2010, on-line: www.kimirina.org/component/content/article/20-noticias-recientes/44-denunciacoalicion.

[2] R. Stern, "Baxter Laboratories Accused of Discrimination against PLWA," The Agua Buena Human Rights Association, February 2010, on-line: www.kimirina.org/component/content/article/20-noticias-recientes/44-denunciacoalicion.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Constitution of the Republic of Ecuador, 2008, Título II, , Art. 11 (2).

[7] F. Cárdenas, "Personas con HIV callan el discrimen laboral," *El Telégrafo*, 2 January 2010.

[8] Ibid.

[9] Ibid.

[10] R. Stern (supra).

Criminal law and cases of HIV transmission or exposure

United Kingdom: fugitive jailed for infecting partner with HIV

A man in the United Kingdom was jailed after evading police for more than three years. Mark James had disappeared just prior to being sentenced for causing grievous bodily harm for infecting his former boyfriend with HIV. At the time of his sentence, he was believed to be the first person to be jailed for the reckless spread of HIV in the U.K.

James tested positive for HIV and syphilis in 2004, but continued to have unprotected sex with his boyfriend without revealing his illness. He was arrested after his partner became extremely ill and had to be rushed to the hospital, where he was diagnosed as HIV-positive.

After being convicted of grievous bodily harm for "recklessly" spreading the virus, James disappeared just days before he was sentenced to three years and four months for the offences. He fled to Narbonne, in south-west France, where he resided until early this year. He returned to England in January 2010 in order to receive medical treatment for lymphoma, and was arrested by police on 10 February.

In addition to his original sentence, James was given a further 10-month sentence for breaching his bail.[1]

New Zealand: court hears case of man who infected wife with HIV through needle attack

A HIV-positive New Zealand man faces up to 14 years in prison after admitting to infecting his sleeping wife with the virus using a tainted needle.

The man discovered that he had contracted the virus in 2004, although his wife and children tested negative. After his diagnosis, the couple

quickly began to experience marital problems because the wife was concerned that she would contract the disease and refused to have sexual intercourse with her husband.

His wife tested positive shortly after two incidents in which she awoke to stinging feelings in her legs. When the wife later confronted her husband with her diagnosis, he admitted to pricking her with a sewing needle that had been dipped in his blood. He stated that he had intended to infect her so that she would not leave him.[2]

Popular German singer charged with causing bodily harm

Nadja Benaissa, a popular German singer of the girl group No Angels, was charged with causing serious bodily harm for failing to disclose that she is HIV-positive to three sexual partners. It was alleged that Benaissa had sex with the three men between 2006 and 2008. One of those partners has since tested positive for the disease.[3]

The singer was originally arrested in 2009 for the same offences on the "urgent suspicion" that she had exposed the three men to the HIV virus. She was in custody for several days after a judge ruled that there was a danger that she would re-offend.[4] She was later released due to lack of evidence.

Scottish man convicted for non-disclosure despite no transmission

A Scottish man has been sentenced to ten years in prison for four counts of reckless and culpable conduct for infecting one woman and engaging in unprotected sexual intercourse with three others without disclosing his HIV status. This is the first time that someone has been convicted for failure to disclose their HIV status when the virus has not been transmitted.[5]

Mark Devereaux engaged in unprotected sexual intercourse with the four women between 2003 and 2008. One woman discovered her infection upon becoming pregnant and subsequently terminated the pregnancy. The other three women did not become infected after having sex with the HIV-positive man.[6]

Devereaux has appealed the length of his sentence, one of the longest ever imposed for this type of offence.[7]

[1] J. Thomas, "Fugitive who infected partner with HIV is jailed," *Hounslow Chronicle*, 16 February 2010.

[2] B. Malkin, "HIV-positive man infects sleeping wife with virus in needle attack," *The Daily Telegraph*, 7 December 2009.

[3] "German girl band star charged in HIV case," BBC News, 12 February 2010.

[4] F. Yeoman, "Singer with most popular German band faces jail for 'injecting man with HIV'," *The Times Online*, 14 April 2009.

[5] M. Carter, "Ten-year sentence in Scottish HIV prosecution," Aidsmap News, 26 February 2010.

[6] "Man guilty of 'reckless' HIV sex," BBC News, 19 January 2010.

In brief

Malawi: country's first same-sex wedding ceremony results in criminal charges

On 29 December 2009, Tiwonge Chimbalanga and Steven Monjeza were arrested after getting married in the first known same-sex wedding ceremony in Malawi. The two men were charged with unnatural acts and gross indecency, and face up to 14 years' imprisonment if convicted.[1]

The men appealed to Malawi's Constitutional Court, arguing that that the criminal charges violated their rights to privacy, belief and self-expression. Their application was denied, with Chief Justice Lovemore Munlo stating that the case was a

simple criminal proceeding that did not concern "the interpretation or application of the constitution."[2]

The case will proceed at a lower court level.

India: Supreme Court justices advise legalizing prostitution

In December, two Justices of the Supreme Court of India recommended to India's Solicitor-General that prostitution be legalized. Justices Dalveer Bhandari and A.K. Patnaik made their remarks during a public interest litigation case on trafficking raised by Bachpan Bachao Aandolan, an NGO working to combat child trafficking.[3]

The Justices commented that prostitution is the world's oldest profession, that it has never been curbed through criminalization, and that it would be better controlled if legalized. They suggested that this would allow the government to effectively "monitor the trade, rehabilitate and provide medical aid to those involved."[4]

Regulation would also provide more controls to prevent abuses that are suffered in the sex-trade, such as woman- and child-trafficking. Solicitor-General Gopal Subramaniam, who represented the government at the proceedings, agreed to consider their recommendations.

Prostitution is on the rise in India. A recent study suggested that the number of sex workers in the country had risen from two million in 1997 to three million in 2003–2004.[5]

It is believed that the trade plays a big role in the number of people living with HIV/AIDS in India, now estimated to be between 2 and 3.1 million.[6]

Bombay: High Court asks government to consider conjugal visits

In January 2010, the High Court of Bombay heard a public interest case focused on the lack of adequate medical assistance to HIV-positive people in prison. In response to the rising HIV infection rates among incarcerated persons in Bombay institutions, Justices Majumdar and Ketkar asked the Maharashtra government to consider permitting those serving sentences of two years or more to have private monthly visits with their wives.

The Judges' request was based on the view that permitting conjugal visits might decrease high risk behaviour and HIV transmission within prisons. Advocate Anand Grover, appointed amicus curiae, told the court "Whether we like it or not, there is sex in jails. It is an issue which everyone wants to sweep under the carpet."[7]

Justice Majumbar observed that the government is spending crores of rupees[8] to curb the spread of the virus in prisons and suggested that addressing the physical needs of prisoners would be a wise preventative step.

Although Grover also promoted condom use in prisons, Advocate-General Ravi Kadam dismissed this as an option, arguing that providing condoms would further encourage sex among inmates.[9]

The court also directed the government to fill vacant medical officer posts for all prisons in Maharashtra by February 2010 and to set up HIV-testing laboratories in the Nashik, Thane, Pune and Nagpur central prisons by 20 January.

Chinese teacher sentenced to three years in jail for jabbing students with syringe

In March 2010, a kindergarten teacher was sentenced to three years behind bars after pleading guilty to charges of "jeopardising public safety."[10]

Sun Qiqi had been accused of stabbing over 60 children in her care with an empty syringe. It is reported that Qiqi did so in an effort to discipline the students for their disobedient behaviour.

The Xinhua news agency reported that Qiqi, who worked at a privately run kindergarten in Yunnan province, was overwhelmed by the sheer number of children in her care.

The parents of the children — aged from three to five — filed claims against the teacher for compensation in the amount of 1.8 million yuan (CAN$264 000). Although the court found that the assaults created panic among the kindergarten students and their parents, it rejected the claims.[11]

All the pre-schoolers who had been victims of the attacks tested negative for HIV and hepatitis B and C.

[1] D. Smith, "Malawi launches operation against high-profile gay and lesbian people", *The Guardian*, 16 February 2010.

[2] "Constitutional Court rejects gay appeal," Afrol News, 24 February 2010.

[3] "Legalize prostitution if you can't curb it: SC to Govt," *The Times of India*, 10 December 2009.

[4] "India court raises questions of legalising prostitution," BBC News, 10 December 2009.

[5] Ibid.

[6] "India's Supreme Court suggests legal prostitution: report", Agence France-Presse, 10 December 2009.

[7] "Why can't prisoners have sex in jails, court asks Maharashtra govt," *The Times of India*, 14 January 2010.

[8] One crore is equal to approximately CAD$222 266.

[9] "Give inmates gyan, not condoms: Bombay High Court," DNA India, 9 March 2010.

[10] "China teacher jailed for jabbing kids with syringe," Agence France-Presse, 24 March 2010.

[11] Ibid.