

Canadian HIV/AIDS Legal Network

HIV/AIDS POLICY & LAW REVIEW

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Redoubling global efforts to support HIV/AIDS and human rights

The role that human rights can play in the global response to HIV/AIDS is crucial. People around the world continue to be placed at risk of HIV due to ongoing human rights violations. In this article — based on a public lecture he gave at “From Evidence and Principle to Policy and Action,” the 2nd Annual Symposium on HIV, Law and Human Rights, held on 10–12 June 2010 in Toronto, Canada — Michel Kazatchkine, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, discusses how the lack of support for programs that protect and promote human rights is one of the failures in the response to AIDS. He stresses that advocates must reinvigorate efforts for human rights and treatment and prevention for all, including for the most marginalized populations.

Introduction

Few moments in the history of the AIDS epidemic have been as pivotal as the plenary address by the Honourable Edwin Cameron, Justice of the South African Constitutional Court and one of the most eloquent and outspoken advocates for a rights-based

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Canadian
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Special Sections:

AIDS 2010

This issue of the *Review* includes a supplement containing a cross-section of presentations on legal, ethical and human rights issues from the XVIII International AIDS Conference, held in Vienna, in July. See page 35.



UNAIDS
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Symposium on HIV, Law and Human Rights

A summary of proceedings of “From Evidence and Principle to Policy and Practice,” the 2nd Annual Symposium on HIV, Law and Human Rights, which took place from 10–12 June in Toronto. See page 65.



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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.

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About the Canadian HIV/AIDS Legal Network

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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The Open Society Foundations work to build vibrant and tolerant democracies whose governments are accountable to their citizens. To achieve this mission, the foundations seek to shape public policies that assure greater fairness in political, legal, and economic systems and safeguard fundamental rights.

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The Levi Strauss Foundation advances the human rights and well-being of underserved people touched by its business by taking courageous risks, supporting innovative community partnerships and promoting the practice of good corporate citizenship.

Comments?

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

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CANADIAN DEVELOPMENTS

This section provides brief reports of developments in legislation, policy, and advocacy related to HIV/AIDS in Canada. (Cases before the courts or human rights tribunals in Canada are covered in the section on HIV in the Courts — Canada.) The coverage is based on information provided by Canadian correspondents or obtained through scans of Canadian media. Readers are invited to bring stories to the attention of Alison Symington (asymington@aidslaw.ca), senior policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. All articles for this issue were written by Cécile Kazatchkine, policy analyst with the Legal Network.

HIV prevalence in prison is 15 times greater than in the community as a whole

A report released in April 2010 by Correctional Service of Canada (CSC) on infectious diseases and risky behaviours reveals elevated HIV and hepatitis C (HCV) rates in federal prisons, and calls for the implementation of urgent comprehensive harm reduction measures.¹

The report indicated that 4.6 percent of prisoners are HIV-positive and that 31 percent are HCV-positive.² The HIV prevalence rate in federal prisons rivals those of many countries in sub-Saharan Africa and is greater

than those in all other regions of the world;³ and, at 4.6 percent, the rate is 15 times greater than that in the community as a whole in Canada. As for HCV in federal prisons, the 31 percent rate of infection is 39

times greater than the population as a whole.⁴

In both cases, incarcerated women, especially Aboriginal women, are disproportionately infected with HIV and HCV.⁵

The findings also revealed that 17 percent of men and 14 percent of women reported injecting drugs in prison, while 17 percent of men and 31 percent of women reported having engaged in oral, vaginal or anal sex. Among those surveyed, 55 percent of men and 41 percent of women used someone else's used needle, and 38 percent of men and 29 percent of women shared a needle with someone who had HIV, HCV or another infection.

Among those who had sex or injected drugs, risky sexual or injecting behaviour was associated with a greater demand for harm reduction services that, when accessible, were used as intended by those surveyed.⁶

The survey presented data that underscored inconsistent HIV care and treatment in prison. Sixty percent of HIV-positive prisoners reported past treatment interruptions at CSC.⁷ Greg Simmons, representative of prisoners and ex-prisoners for the Canadian Treatment Action Council, said that the lack of continuity that HIV-positive prisoners experience with their antiretroviral medications was troubling.

"Any interruption in their regimen could have serious implications on their health, and lead to them becoming resistant to medications. CSC must allow prisoners to retrieve their medication upon incarceration and change the way pharmacies in federal prisons monitor and order medications," Simmons commented.⁸

CSC also observed that 67 percent of HIV-positive prisoners were worried about discrimination in federal prisons and acknowledged that there were "opportunities to improve the care of HIV-positive inmates."⁹

There are also concerns that the current policy of the federal government, which includes crime bills authorizing mandatory minimum sentencing for drug-related offences, will only aggravate the health crisis in federal prisons by increasing the number of prisoners, especially prisoners at high risk of HIV and HCV.¹⁰

The survey not only illustrates the urgent need for comprehensive harm reduction programs in federal prisons, but also the need for the federal government to re-think its "tough on crime" agenda.¹¹

According to Seth Clarke, federal community development coordinator at the Prisoners' HIV/AIDS Support Action Network, "Given the dire conditions in federal prisons today, our federal government should respond with a sensible approach to drug policy based on solid scientific evidence, sound public-health principles and respect for human rights — both in and outside prisons. That means doing away with crime bills that incarcerate people with addictions and introducing needle and syringe programs in prisons to mitigate prisoners' risk of harm."¹²

The report presented the results of a survey conducted by CSC to optimize its strategy for preventing,

controlling and managing infectious diseases in federal prison. Conducted in 2007, the survey was a self-administered paper questionnaire completed by 3370 federal prisoners to collect information on their risk-behaviours, use of testing, treatment and programs, and knowledge of HIV and HCV.

¹ Correctional Service Canada, *2007 National Inmate Infectious Diseases and Risk Behaviours Survey*. April 2010, on-line: www.csc-scc.gc.ca.

² *Ibid.*

³ Canadian HIV/AIDS Legal Network, Prisoners' HIV/AIDS Support Action Network and the Canadian Treatment Action Council, "HIV and Hepatitis C Crisis in Federal prisons, according to new CSC report," news release, Toronto, 21 April 2010.

⁴ *Ibid.*

⁵ Correctional Service Canada (*supra*).

⁶ *Ibid.*

⁷ *Ibid.*

⁸ Canadian HIV/AIDS Legal Network (*supra*).

⁹ Correctional Service Canada (*supra*).

¹⁰ Canadian HIV/AIDS Legal Network (*supra*).

¹¹ Canadian HIV/AIDS Legal Network (*supra*); J. Tibbetts, "HIV rampant in federal prisons: report," *CanWest News Service*, 21 April 2010.

¹² Canadian HIV/AIDS Legal Network (*supra*).

New study puts forth HIV treatment as prevention

A new study from the BC Centre for Excellence in HIV/AIDS (BC-CfE) confirms that the benefits of Highly Active Antiretroviral Therapy (HAART) extend far beyond treatment and include dramatic secondary preventive benefits.¹

While new evidence from other settings had suggested that HAART could significantly decrease the risks of HIV transmission, the aim of the BC-CfE study was to analyze, at a population level, the potential association between expansion of HAART coverage, viral load and new HIV diagnoses per year in a Canadian province where access to HIV care is free.²

The study focused on British Columbia (B.C.). The team of researchers looked at three distinct periods based on antiretroviral use in the province. The first period was from 1996 to 1999, during the first rollout of HAART treatment; the second from 2000 to 2003; and the third from 2004 to 2009.

The study found that, between 1996 and 1999, there was a steep increase in HAART use and that, during the same period, the number of new HIV cases declined by 40 percent. From 2000 to 2003, HAART use increased only slightly, while the number of new HIV cases remained stable. Between 2004 and 2009, there was a steady increase in the number of people on HAART, but the number of new HIV cases per year decreased by 23 percent.

The results showed that, while the number of people actively receiving HAART in B.C. increased by 547 percent between 1996 and 2009, the number of HIV cases decreased by 52 percent over the same period.

There was a strong and significant association between increased HAART coverage, reduced community viral load and decreased number of new HIV diagnoses across the province, including in populations with a history of injection drug use.

The researchers concluded that the expansion of HAART can prove to be an important prevention tool that can complement community prevention efforts, including harm reduction programs.³ The results of the study also support the argument of global leaders in the fight against HIV to introduce treatment as soon as possible in order to prevent new HIV infections. As Michel Sidibé, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) pointed out, “Treatment not only saves lives, it can be one of the most compelling prevention tools we have.”⁴

Based on the concept of “treatment as prevention” and supported by the BC-CfE’s new findings, UNAIDS has developed an approach called “Treatment 2.0” that aims to scale up testing and treatment drastically. UNAIDS estimates that successful implementation of Treatment 2.0 could prevent 10 million deaths by 2025 and one million new HIV infections by the same time.⁵ As the authors of the BC-CfE’s study concluded, “[the] results should serve to re-energise the G8’s universal access pledge as a

means to curb the effect of AIDS and the growth of the HIV pandemic.”⁶

The government of B.C. recently launched a four-year, CAN\$48 million pilot program called “Seek and Treat” in order to improve access to treatment and care among hard-to-reach communities, including sex workers and injecting drug users.⁷ According to another recent study from the BC-CfE, treating more patients will also save almost CAN\$1 billion in health-care costs in B.C. over 30 years.⁸

BC-CfE director Dr. Juilo Montaner commented that “investing in universal access is not only the right thing to do; it’s the smart thing to do.”⁹

¹ J. Montaner et al., “Association of highly active antiretroviral therapy coverage, population viral load, and yearly new HIV diagnoses in British Columbia, Canada: a population-based study,” *The Lancet*, published on-line 18 July 2010: www.thelancet.com.

² Ibid.

³ Ibid; BC Centre for Excellence in HIV/AIDS, “Study shows HIV/AIDS Treatment Curbs Spread of Disease,” news release, Vancouver, 18 July 2010.

⁴ BC Centre for Excellence (supra).

⁵ “Global: A radical new UNAIDS Treatment strategy,” *PlusNews*, 16 July 2010, on-line: www.plusnews.org/Report.aspx?ReportId=89861; D. Black, “New hope to halt spread of HIV,” *The Toronto Star*, 19 July 2010.

⁶ J. Montaner et al. (supra).

⁷ C. Kazatchkine, “British Columbia project seeks to improve access to HIV treatment and care among hard-to-reach communities,” *HIV/AIDS Policy & Law Review*, 14 (3), June 2010.

⁸ K.M. Johnston et al., “Expanding access to HAART: a cost-effective approach for treating and preventing HIV,” *AIDS*, 24(12) (2010): pp. 1929–1935.

⁹ A. Picard, “No room for despair in quest to beat AIDS,” *The Globe and Mail*, 19 July 2010.

Keeping a common bawdy house becomes a “serious offence” under *Criminal Code*

New federal regulations targeting organized crime will make keeping a common bawdy house a “serious offence” under the *Criminal Code*. Sex work advocates reacted by calling the measure a serious step back that will undermine the protection of sex workers’ human rights, safety, dignity and health.

In July 2010, Minister of Justice Rob Nicholson, accompanied by Senator Pierre-Hugues Boisvenu, announced the enactment of new regulations “to strengthen the ability of law enforcement to fight organized crime”¹ and that will make eleven criminal acts “serious offences” for the purpose of Section 467.(1) of the *Criminal Code*.²

According to Section 467.(1), a “criminal organization” means a group, however organized, that is composed of three or more persons in or outside Canada that has as one of its main purposes or main activities the facilitation or commission of one or more serious offences that, if committed, would likely result in the direct or indirect receipt of a material benefit, including a financial benefit, by the group or by any of the persons who constitute the group.

Prosecutors and investigators will now be entitled to use various provisions of the *Criminal Code* to target organized crime, including the special procedures available in organized crime investigations and prosecutions in areas such as wiretaps, the granting of bails and parole eligibility.³

Sex work is directly targeted by these new regulations, as keeping a common bawdy house is one of the criminal offences that will become a “serious offence” and may consequently pose an additional

five years’ prison sentence in cases of participation in activities of criminal organization.⁴ This change in regulation could affect massage parlours, brothels, dungeons and bathhouses.⁵

Advocates have raised serious concerns about how these new regulations ignore both sex workers’ experience and research that shows that criminal laws contribute to unsafe working conditions for sex workers. According to Dr. Emily van der Meulen of the Centre for Research on Inner City Health at St. Michael’s Hospital in Toronto, “Research shows that working from indoor locations can be safer for sex workers. However, with changes to the law, sex workers will now be faced with much harsher penalties and more severe jail time if convicted.”⁶

The Toronto Sex Workers Action Project worries that “sex workers who work together out of concerns for safety risk being treated as organized criminals” and that may “deter [them] from working indoors and out of isolation.” It goes on to say that “many women protect their health and safety by negotiating services and safer sex when clients call to book appointments. Increased concern about wiretaps will interfere with the strategy and put workers at risk.”⁷

According to Stella, a sex workers organization in Montréal, the new regulations ignore the fact that the majority of people working in bawdy houses has deliberately chosen to work there. It says that these are workplaces where women can have more control over their work environment and charges that the new regulations violate sex workers’ right to freedom of association in order to protect their safety.⁸

Critics are worried about the direct link made between organized crime and sex work, which they say will create confusion between trafficking and consensual work.⁹ According to Maggie’s Toronto, linking organized crime and sex work will reinforce stigma against sex workers and contribute to additional, unjustified targeting of sex workers by law enforcement.¹⁰

The new regulations were enacted behind closed doors by the federal cabinet in the middle of the summer with no public debate or consultations with sex workers and advocacy groups.¹¹

¹ Department of Justice Canada, “Government of Canada Enacts New Regulations to Help Fight Organized Crime,”

news release, 4 August 2010, on-line: www.justice.gc.ca/eng/news-nouv/nr-cp/2010/doc_32531.html.

² Department of Justice Canada, "Backgrounder: new regulations to help fight organized crime," 4 August 2010, on-line: www.justice.gc.ca/eng/news-nouv/nr-cp/2010/doc_32532.html.

³ Ibid.

⁴ Ibid.

⁵ M. McCann, "Sex work activists condemn organized crime designation for bawdy-house keepers," *Xtra*, 4 August 2010, on-line: www.xtra.ca.

⁶ Maggie's Toronto, "The Toronto Sex Workers Action Project Objects to Recent Changes to Bawdy-House Sentencing Regulations," news release, Toronto, 12 August 2010.

⁷ Ibid.

⁸ Stella, "Harper ajoute un règlement au Code criminel :

tenir une maison de débauche devient une infraction grave," news release, Montréal, 5 August 2010.

⁹ Stella (supra); Maggie's Toronto (supra); M. McCann (supra).

¹⁰ Maggie's Toronto (supra).

¹¹ D. Smith, "NDP MP slams Tories over new organized crime regulations," *Xtra*, 4 August 2010; Maggie's Toronto (supra).

Vaccine initiative money reallocated; emphasis placed on research and mother-to-child transmission

When the federal government officially announced in February 2010 the cancellation of a CAN\$88 million project to establish a pilot-scale HIV vaccine manufacturing facility in Canada, it was unclear how the money would finally be used. However, in July the announcement came that the funds would be reallocated to research and to the prevention of mother-to-child transmission of HIV.¹

The original project was a centre-piece of the Canadian HIV Vaccine Initiative (CHVI), a five-year, \$139 million collaborative initiative between the Government of Canada and the Bill & Melinda Gates Foundation.²

During the XVIII International AIDS Conference in Vienna, the federal Minister of Health, Leona Aglukkaq, announced the change in strategy by saying that the government would create the CHVI Research and Development Alliance. She indicated that this would bring together researchers from the public and private sectors, both from

Canada and abroad, to develop innovative solutions to the challenges facing HIV vaccine development.

The Alliance would focus on scientific excellence and be supported by a number of significant investments to help researchers get potential HIV vaccines from the lab to internationally recognized clinical trials.³ The main feature of the Alliance is the allocation of \$102 million in funds toward vaccine research projects.⁴

The government also announced that \$30 million dollars would be allocated to the Canadian International Development Agency

to prevent mother-to-child transmission in developing countries. Even though this project appears to have nothing to do with vaccines, the decision did not come as a surprise, given that maternal and child health was a priority issue of the G8 summit that took place in Huntsville, Ontario in June.⁵

HIV/AIDS organizations, including the Canadian HIV/AIDS Legal Network, criticized the decision to reallocate the CHVI funds without first consulting either parliamentarians or community stakeholders.⁶ The Legal Network also deeply regretted that the Government of Canada

attended the International AIDS Conference to announce the reallocation of funds without also announcing a major contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria, which it said is key to a successful response to the global HIV epidemic.⁷

Canadian civil society organizations are calling on the Canadian government to commit to funding five percent of the US\$20 billion that the Global Fund will need over the next three years to turn the tide against HIV. That would represent \$1 billion over the next three years — about CAN\$10 per Canadian

per year.⁸ According to Dr. Julio Montaner, Executive Director of the BC Centre for Excellence in HIV/AIDS, the Canadian response to the global HIV epidemic is “insufficient and disappointing.”⁹

¹ “Lutte contre le VIH/sida – Le Canada et la fondation Bill Gates font front commun,” *Le Devoir*, 21 July 2010; E. Church, “Ottawa’s AIDS strategy target research, mother-child transmission,” *The Globe and Mail*, 20 July 2010.

² C. Kazatchkine, “Multi-million dollar AIDS vaccine project cancelled,” *HIV/AIDS Policy & Law Review*, 14(3) (2010): pp. 19–21.

³ Public Health Agency of Canada, “Government of Canada Announces Alliance to Spearhead Global Fight against HIV,” news release, Vienna, 20 July 2010.

⁴ M. Fitzpatrick, “Research network for HIV vaccine far too small; Ottawa failing to lead in the fight against HIV,” *Edmonton Journal*, 21 July 2010; D. Smith, “Critics track Canadian fallout from Vienna AIDS conference,” *Xtra*, 27 July 2010.

⁵ *Ibid.*

⁶ D. Smith (*supra*).

⁷ *Ibid.*

⁸ Canadian HIV/AIDS Legal Network et al., “Canadian and African activists call on G8/G20 leaders to take action on AIDS crisis at home and abroad,” news release, Toronto, 22 June 2010. Canada has committed CAN\$978 million to the Global Fund since its inception in 2001, including the latest pledge of \$450 million over three years (2008–2010).

⁹ M. Fitzpatrick (*supra*).

New legislation to improve Canada’s refugee system troubles advocates

Despite significant improvements, the new *Balanced Refugee Reform Act (the Act)* contains contentious provisions regarding Canada’s asylum system, according to refugee advocates.

The Act, which received Royal Assent on 29 June 2010, is intended to improve Canada’s asylum system, especially regarding proceedings delays.¹ One of the main aspects of the new legislation is to allow access to a new Refugee Appeal Division at the Immigration and Refugee Board (IRB), something that the Canadian Council for Refugees (CCR) has been advocating for more than twenty years.²

Bill C-11, which later became the Act, led to intense debate and controversies before the parliamen-

tary immigration committee finally agreed to important amendments that provide more protection for refugees. One of the most controversial provisions of the Bill empowered the Minister of Citizenship, Immigration and Multiculturalism to designate “safe” countries whose nationals would not have access to the refugee appeal process.³ The CCR indicated that such a provision would create an unfair “two-tier system, which denies some claimants access to the appeal based on nationality.”⁴ Critics also indicated that women making gender-

based claims and people claiming on the basis of sexual orientation or sexual identity would be particularly hurt by it.⁵

After opponents, including the Canadian gay and lesbian community, mobilized against the safe country provision, it was written out of the final version of the bill. Nevertheless, the new legislation still provides the authority for the government to designate countries of origin,⁶ but all refugees, including those from so-called “safe” countries, will be allowed access to the Refugee Appeal Division.

The delay to appeal first-instance decisions will be shorter for claimants coming from a “designated” country.⁷

A further contentious provision of the law relates to Humanitarian and Compassionate (H&C) refugee applicants. The Act bars the minister from considering H&C applications from anyone who has a protection claim pending and for a further one year from rejection of the claim. According to the Canadian Bar Association (CBA), “the H&C applications provide a vital safeguard to ensure that persons have a remedy in circumstances of rights violations that do not meet the stringent test for refugee claims.”⁸

At the very least, the CBA goes on to say, there is no reason to justify such a bar. According to the final text of the legislation, failed refugees will be allowed to make an H&C application within one year but the H&C decision-makers will no longer consider risks that are assessed within the refugee protection process.⁹

While there was no controversy around the need to speed up refugee claims, the new delays for a hearing and the introduction of an information-gathering interview at the begin-

ning of the process raised concerns.¹⁰ An information-gathering interview will occur no sooner than 15 days after a claim has been referred to the IRB. Under the current system, information is gathered through a Personal Information Form completed by asylum claimants.¹¹

Janet Dench of the CCR considers the interview “highly problematic, particularly for people who won’t be ready to talk in front of an official in terms of the real grounds of their claim, and that includes people who are claiming on the basis of sexual orientation and people who are not in a position really to talk about it openly.” She says that it is well established that people suffering from post-traumatic stress disorder often have difficulty providing coherent and consistent responses to questions about their experiences.¹²

Under the Act, hearings will take place within 90 days for most claimants and 60 days for those from “designated countries”¹³ According to Dench, that may also be problematic, “particularly for people who don’t have time to develop the confidence to testify, but also to collect information” in support of their claim.¹⁴

¹ Citizenship and Immigration Canada, *Moving ahead with refugee reform*, on-line: www.cic.gc.ca/english/refugees/reform.asp.

² Although the *Immigration and Refugee Protection Act* approved by Parliament in 2001, does contain a Refugee Appeal Division, its creation has been delayed indefinitely by the Ministry of Citizenship, Immigration and Multiculturalism Canada; Canadian Council for Refugees, *Protecting rights in a fair and efficient refugee determination system. Submissions on Bill C-11*, 5 May 2010, on-line: <http://ccrweb.ca/files/C11submissionmay2010.pdf>.

³ D. Smith, “Queers get props for winning refugee amendments,” *Xtra*, 11 June 2010; J. Ibbitson, “Tories, Liberals seek consensus on revamped refugee system,” *The Globe and Mail*, 1 June 2010.

⁴ Canadian Council for Refugees (supra).

⁵ Ibid.

⁶ According to Citizenship and Immigration Canada, designated countries of origin will include countries that do not normally produce refugees, have a robust human rights record and offer strong state protection. A country can be considered for designation only if the number of claims for refugee protection is equal to or greater than the number of claims specified in the regulations that will be developed later; and the rate of acceptance by the Refugee Protection Division is equal to or lower than the rate set out in regulations. In addition, the human rights record of the country and the availability in the country of mechanisms for seeking protection and redress will be taken into account.

⁷ Citizenship and Immigration Canada (supra).

⁸ Canadian Bar Association, *Submissions on the Balanced Refugee Reform Act- Executive summary*, May 2010, on-line: <http://ccrweb.ca/files/cbaexecsummary.pdf>.

⁹ Citizenship and Immigration Canada (supra).

¹⁰ D. Smith (supra).

¹¹ Citizenship and Immigration Canada, *Background: Bill C-11: The Balanced Refugee Reform Act*, on-line: www.cic.gc.ca.

¹² D. Smith (supra); Canadian Council for Refugees (supra).

¹³ Citizenship and Immigration Canada, *Moving ahead with refugee reform and Background* (supra).

¹⁴ D. Smith (supra).

In Brief

Saskatchewan: HIV infection rate double the national average

Saskatchewan has seen a marked increase in HIV cases in recent years and currently has the highest rates in

Canada — twice the national average at 20.3 infections per 100 000 people compared with 9.3 per 100 000 in the rest of the country.¹

According to provincial officials who attended the Canadian Association of HIV Research-

organized conference in Saskatoon in May 2010, 75 percent of new HIV cases can be linked to injection drug use.² First Nations and Métis women under age 30 account for a disproportionate number of those cases.³ The head of the Saskatoon Tribal Council

called the rising rates of HIV in the province a “crisis” facing his people.⁴

In response to the growing HIV epidemic in Saskatchewan, the Ministry of Health has developed an HIV strategy for 2010–2013 based on four pillars: surveillance; clinical management; prevention and harm reduction; and community engagement and education. The plan will establish prevention and well-being centres with increased access to needle exchange programs and other harm reduction measures; expanding addiction prevention and treatment; and incorporating mental health and addictions programming into a holistic approach.

However, provincial health officials have no plans to introduce supervised injection sites.⁵

Federal government’s Truth in Sentencing Act threatens to cost billions of dollars and increase prison population

The *Truth in Sentencing Act* (the Act), which came into force in February 2010, will cost taxpayers CAN\$1 billion to implement and billions more to maintain, according to Parliamentary Budget Officer Kevin Page in a report quantifying the implications of the legislation. He said that the construction of new correctional facilities alone would cost about \$1.8 billion over five years.⁶

The Act is expected to increase the number of inmates from 8618 in fiscal year 2007–2008 to 17 058, including 9021 in community supervision, the report said.⁷

The Act limits the credit judges can give prisoners for time served

before sentencing. Among other things, it eliminates the two-for-one credit for time spent in pre-sentencing custody.⁸ As a result, only the time actually served before sentencing can be deducted from the time a person must spend in prison after the sentence is handed down.

According to Justice Minister Rob Nicholson, “this will bring more truth in sentencing and give Canadians confidence that justice is being served.”⁹

HIV/AIDS and Tuberculosis Parliamentary Caucus forms in Ottawa

In June 2010, four members of Parliament (MPs) from all political parties represented in the House of Commons came together to create the HIV/AIDS and Tuberculosis (TB) Parliamentary Caucus.

The idea for the caucus came from Liberal MP Ruby Dhalla, who will co-chair with Lois Brown of the Conservative Party, Johanne Deschamps of the Bloc Québécois and Megan Leslie of the New Democrat Party.¹⁰

The goals of the non-partisan caucus are to increase awareness of the need for action on HIV/AIDS and TB, and to create a forum within Parliament for the exchange of ideas related to the needs of people living with or affected by HIV. The caucus will work both on international and domestic issues, and has already endeavoured to liaise with organizations, stakeholders, and individuals in order to raise awareness about HIV/AIDS and to promote policies and initiatives for the prevention and treatment of HIV/AIDS and TB.

The caucus launch, co-sponsored by the Canadian HIV/AIDS Legal Network, the Canadian Treatment Action Council and the Interagency Coalition on AIDS and Development, took place on 14 June 2010, a few days before the G8 and G20 meetings in Huntsville and Toronto, respectively.

¹ A. Picard, “A changing epidemic: Canada’s AIDS rate on the rise,” *The Globe and Mail*, 22 July 2010.

² “Saskatchewan first nations HIV rate double the national average,” *The Globe and Mail*, 7 May 2010.

³ Saskatchewan Ministry of Health, *HIV Strategy for Saskatchewan 2010-2010*, 6 May 2010, on-line: www.gov.sk.ca.

⁴ “Saskatchewan first nations HIV rate double the national average” (supra).

⁵ “Saskatchewan won’t get safe-injection sites,” CBC News, 16 May 2010.

⁶ “Sentencing act to cost billions: report,” CBC News, 22 June 2010.

⁷ Ibid.

⁸ G. Galloway, “The Truth in Sentencing bill becomes law,” *The Globe and Mail*, 23 February 2010.

⁹ Ibid.

¹⁰ Office of Ruby Dhalla, MP, “Four Female MPs Unite to Launch the HIV/AIDS and TB Parliamentary Caucus,” news release, Ottawa, 10 June 2010; D. Smith, “Parliament launches all-party HIV/AIDS & TB caucus,” *Xtra*, 16 June 2010.

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 Cécile Kazatchkine (ckazatchkine@aidslaw.ca), policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section.

Bills in Uganda would infringe upon rights of homosexuals and people living with HIV/AIDS

Two bills before the Uganda parliament have raised the ire of HIV and sexual equality advocates, who charge that the draft legislation will violate the basic rights of those affected.

Anti-Homosexuality Bill

The Anti-Homosexuality Bill, which member of Parliament (MP) David Bahati introduced in October 2009 as

a private member's bill, is stalled in the Ugandan Parliament's Committee on Legal and Parliamentary Affairs and reportedly unlikely to be passed in the current session.¹

Since it was presented in Parliament, the proposed legislation sparked an uproar both within Uganda and internationally. Rights advocates and leading political fig-

ures voiced their outrage with the bill — which aimed to outlaw homosexuality — and provisions within it that called for the death penalty in certain circumstances, including having same-sex relations while being HIV-positive and engaging in gay sex with a minor.² The bill also threatens long jail terms for those, including family members, who do not report homosexuals to the police.³

In the face of widespread international criticism, Ugandan President Yoweri Museveni publicly distanced himself from the proposed legislation. He later appointed a cabinet committee to review the bill, which recommended in May 2010 that it be withdrawn from Parliament.

The committee's report found that the bill had "technical defects in form and content" and that many of the clauses were either unconstitutional or redundant within existing laws. It recommended deflecting negative attention away from the bill by changing its title or combining it with Uganda's existing law, the Sexual Offences Act. Only Clause 13 of the Anti-Homosexuality Bill — which addresses the promotion of homosexuality — "was worthy of consideration," according to the report.⁴

Currently, homosexuality is illegal in Uganda, and offenders can be sentenced to up to 14 years in jail.

Homosexuals in Uganda have battled long for acceptance and equality in their country, but live in a hostile climate. Recent polls show that a majority of Ugandans are against homosexuality, with some saying that it is alien to the country's cultural practices as well as an affront to traditional values and belief systems.⁵

The Anti-Homosexuality Bill was introduced several months after a visit by several evangelicals from the

United States of America, who spoke at a conference called the "Seminar on Exposing the Homosexual Agenda."⁶

HIV Prevention and Control Bill

On 18 May 2010, the HIV Prevention and Control Bill was presented in Parliament. It was drafted by the parliamentary committee on HIV/AIDS and tabled by MP Beatrice Rwakimari.

Although the objective of the draft legislation is to curb the spread of the disease, critics charge that certain sections would discriminate against people living with HIV/AIDS (PHAs) and hinder efforts at HIV prevention. They point specifically to sections that call for the mandatory disclosure of one's HIV status, mandatory HIV testing and the criminalization of the intentional transmission of HIV.⁷

Human rights activists argued that criminalizing the spread of HIV would be counter-productive and may discourage people from testing for the disease.⁸ In an editorial, the Ugandan newspaper *The New Vision* stated that "there is no question that people who deliberately infect others with HIV should be punished, but how do you define the deliberateness? And how do you prove it?"⁹

A fellow at the Makerere University School of Public Health in the Ugandan capital of Kampala commented that the bill undermines HIV prevention efforts because people will choose not to know their HIV status, "as they will feel legally safer not to test. Otherwise, they would be proved guilty, hence 'ignorance of the status becomes a defence'."¹⁰ The writer goes on to recommend that an appropriate intervention would be to work toward reducing barriers to voluntary testing.

The bill has been controversial almost since its inception. During consultative meetings on the draft, several individuals and civil society organizations protested some of the clauses and demanded that they be deleted.

However, the Bill also fights discrimination, against both the employed and students. Among the highlights of the bill are:

- Ten years' imprisonment or 4.8 million Kenya shilling (approximately CAN\$ 62 030) fine for wilful HIV transmission;
- Ten years' imprisonment for health workers who unlawfully disclose information about one's HIV status;
- A five-year jail term for attempted HIV transmission;
- Mandatory HIV testing of pregnant women and their partners, as well as perpetrators and victims of sexual offences, prostitutes and drug users;
- No denial of employment for HIV-positive persons and no discrimination of HIV-positive students; and
- The right of a PHA to seek an elective or other public office.¹¹

The Bill also sets terms and conditions for HIV-related biomedical research, saying that such trials should not endanger the health of the participants and should be done with their written consent.

— David Cozac

David Cozac is managing editor of the *HIV/AIDS Policy & Law Review*.

¹ G. Branch, "Uganda: anti-gay bill stalls," *Global Post*, 6 August 2010, on-line: www.globalpost.com/dispatch/africa/100804/uganda-anti-gay-bill.

² Ibid.

³ G. Branch, "Is Uganda's anti-Homosexuality Bill Dead?" *Global Post*, 12 May 2010, on-line: www.globalpost.com/dispatch/africa/100510/uganda-anti-gay-bill.

⁴ Ibid.

⁵ P. Clotey, "Ugandan Activist Says Outside Pressure Has Slowed Anti-Gay Bill," *VOA News*, 20 July 2010, on-line: www1.voanews.com/english/news/africa/

Ugandan-Activist-Says-Outside-Pressure-Has-Slowed-Anti-Gay-Bill--98882249.html.

⁶ D. Harris, K. Hinman and A. Karamehmedovic, "Anti-Homosexual Bill in Uganda Causes Global Uproar," *ABC News*, 10 March 2010, on-line: <http://abcnews.go.com/Nightline/anti-homosexuality-bill-uganda-global-uproar/story?id=10045436>.

⁷ "HIV Bill Should Accommodate All Voices," *AllAfrica*, 8 July 2010, on-line: <http://allafrica.com/stories/201007090083.html>.

⁸ "Don't Pass HIV/AIDS Bill in a Hurry," *The New Vision*, 21 May 2010, on-line: www.newvision.co.ug/D/8/14/720269.

⁹ Ibid.

¹⁰ "HIV Bill Should Accommodate All Voices," (supra).

¹¹ M. Karugaba and M. Olupot, "HIV Bill Tabled in Parliament," *The New Vision*, 19 May 2010, on-line: www.newvision.co.ug/D/8/13/720055.

Malawi: President pardons convicted same-sex couple

A Malawian gay couple sentenced to 14 years' hard labour for holding a public engagement ceremony was pardoned by Presidential decree in May 2010 at a press conference alongside United Nations Secretary-General Ban Ki-moon.

"These boys committed a crime against our culture, our religion and our laws," said President Bingu Wa Mutharika. "However, as the head of state I hereby pardon them and therefore ask for their immediate release with no conditions."¹

The announcement came after the President met with Ban Ki-moon, UNAIDS Executive Director Michel Sidibé and Michel Kazatchkine, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The pardoned couple, Steven Monjeza, 26, and his partner Tiwonge Chimbalanga, 20, were arrested two days after their December 2009 ceremony and charged under Sections 153 ("unnatural offences") and 156 ("indecent practices between males") of the Malawian Penal Code. Denied bail, they were subjected to forced

medical examinations to determine "evidence" of homosexual behaviour.²

After a trial of several months, Judge Nyakwawa Usiwa-Usiwa sentenced the defendants on 20 May to the maximum penalty, in order that "the public be protected from people like you, so that we are not tempted to emulate this horrendous example."³

The arrest, trial and conviction of Monjeza and Chimbalanga provoked international outrage from governments and civil society alike. The United States of America state department had called the case "a step backwards in the protection of human rights in Malawi," and Human Rights Watch and Amnesty International both waged strenuous lobbying campaigns, the latter adopting the two men as "prisoners of conscience."⁴

However, domestic opinion ran strongly in favour of conviction, with the Malawi Council of Churches being one of many organizations that urged the government not to cave to international pressure.⁵

The use of international pressure, particularly when perceived to impact funding promises, is a sensitive issue in African countries, and Ban Ki-moon took care to emphasize that President Mutharika's pardon "is not because of foreign pressure but [because] he is exercising his presidential power."⁶

As part of his visit, Ban Ki-moon also addressed a session of Malawi's Parliament, in which he called for changes to legislation forbidding gay sex. "Any harassment or violation or discrimination against people based on sexual orientation is discriminatory," he said. "It's against international human rights law."⁷

Homosexuality remains illegal in Malawi, as it does in 37 out of 53 African nations. Despite President Mutharika's gesture and his role as Chairperson of the African Union, little doubt exists as to his position on the issue of lesbian, gay, bisexual and transgender rights. "I have done this on humanitarian grounds, but this does not mean that I support this," he said.⁸

— *Vajdon Sohaili*

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¹ "Gay couple in Malawi pardoned by president after outcry," *The Sunday Times* (U.K.), 29 May 2010, on-line: www.timesonline.co.uk/tol/news/world/africa/article7140000.ece.

² "Malawi: Drop Charges against Same-Sex Couple," Human Rights Watch, 12 January 2010, on-line: www.hrw.org/en/news/2010/01/12/malawi-drop-charges-against-same-sex-couple.

³ "Malawi gay couple get maximum sentence of 14 years," *BBC News*, 20 May 2010, on-line: www.bbc.co.uk/news/10130240.

⁴ "Malawi couple could face further harassment," Amnesty International, 2 June 2010, on-line: www.amnesty.org/en/news-and-updates/malawi-couple-could-face-further-harassment-2010-06-02.

⁵ "Malawi Gay Couple Found Guilty of Love," *AllAfrica*, 18 May 2010, on-line: www.allafrica.com/stories/201005180910.html.

⁶ "Gay couple in Malawi pardoned by president after outcry" (supra).

⁷ Ibid.

⁸ "Malawi President pardons jailed gay couple," *Nyasa Times*, 29 May 2010.

United States of America: Obama administration calls for an end to state criminalization of HIV transmission

The U.S. White House has issued a new strategy on HIV/AIDS that, among other things, calls for an end to state laws that make the transmission of HIV a crime.

Because "the continued existence and enforcement of these types of laws run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment,"¹ the government white paper specifically urges states to ensure that laws and policies support the current understanding of best public health practices for preventing and treating HIV.

Recommendation 3.3 of the *National HIV/AIDS Strategy for the United States* sets out the following:

Promote public health approaches to HIV prevention and care: State legislatures should consider reviewing HIV-specific criminal statutes to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to preventing and treating HIV.²

The document goes on to say:

A recent research study also found that HIV-specific laws do not influence the behavior of people living with HIV in those states where these laws exist. While we understand the

intent behind such laws, they may not have the desired effect and they may make people less willing to disclose their status by making people feel at even greater risk of discrimination.³

Thirty-two states have HIV-specific criminal laws on the books. Many of those laws date back to the late 1980s and early 1990s, when the death toll from HIV infection was mounting and no medications were readily available to treat the viral infection.⁴

Catherine Hanssens, executive Director of the HIV Law and Policy Center in New York City,

hailed the strategy as “the first truly meaningful official statement on the issue of criminalization and the role of civil rights in addressing the HIV epidemic.”⁵ For her part, Bebe Anderson, director of the Lambda Legal Defense and Education Fund’s HIV Project, echoed Hanssens, but cautioned about political realities on the state level, saying that some may struggle with addressing the laws.⁶

The Obama administration states that its overall goal is to make the

country “a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.”⁷

— David Cozac

¹ The White House, *National HIV/AIDS Strategy for the United States*, July 2010, on-line: www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

² Ibid.

³ Ibid. The study cited in this quote is K.J. Horvath et al., “An examination of attitudes among US men who have sex with men and the impact of state law,” *AIDS Care* (2010) (in press).

⁴ T. Heywood, “Obama administration calls for end to HIV-specific criminal laws,” *The Michigan Messenger*, 20 July 2010, on-line: <http://michiganmessenger.com/39807/obama-administration-calls-for-end-to-hiv-specific-criminal-laws>.

⁵ Ibid.

⁶ Ibid.

⁷ *National HIV/AIDS Strategy* (supra).

In brief

Kenya: government to draft policy on HIV and injecting drug use

The Kenyan government is drawing up plans for a new policy whose aim is to reduce HIV transmission among injecting drug users (IDUs) in the country.

“If we want to talk about HIV prevention, then we cannot afford to ignore any group,” Nicholas Muraguri, head of the National AIDS and Sexually Transmitted Infections Control Programme, said.¹ He added that the policy would treat drug addiction as a health issue rather than a matter of criminal justice.

Muraguri said his department was working on ways to ease access to treatment for HIV-positive IDUs.

“[We want to] learn from other countries where once [a person] is on [drug and HIV] treatment, they are provided with a card that will protect them from the police,” he explained. “This means the policy will only come out after wide consultations.”²

Muraguri pointed out that the policy would seek to include provisions for needle exchange and methadone substitution treatment.

In the meantime, the government is conducting research to find out where Kenya’s drug users are concentrated.

“Once we are ready to reach out to this group in a big way, it will be critical to estimate their numbers, know their networks and areas of concentration,” Muraguri said.

IDUs account for nearly four percent of new HIV infections nation-

ally and about six percent in Nairobi and Coast Provinces. However, the absence of good data makes it hard to calculate either the number of IDUs in Kenya or the percentage that may be HIV-positive.³

A study published in the medical journal *The Lancet* in July 2010 estimated that, if the Kenyan government adopted proper control measures immediately, it could reduce HIV prevalence among IDUs by 30 per cent in four years.⁴

The study estimated heroin users in Nairobi at about 24 500, with almost half using injections. Out of a hundred injectors, more than half were HIV-positive.

— David Cozac

Azerbaijan: new law on HIV includes harm reduction

A new law on HIV/AIDS, which came into force in Azerbaijan earlier this year, contains provisions that allow for harm reduction to be used in HIV prevention.⁵

The statute, which President Ilham Aliyev signed into law in June 2010, embraces harm reduction as one of the most effective measures for preventing HIV. Included in the legislation is mention of opioid substitution therapy, programs for syringe provision and harm reduction as a component of HIV prevention efforts in penal institutions.⁶

Human rights-based, the law focuses on the universal accessibility of HIV-related services. Its objective is to ensure the implementation of evidence-based, large-scale and comprehensive targeted HIV interventions, particularly among vulnerable groups, including drug users as well as inmates in custodial settings.⁷

The new law on HIV was developed because the previous one, adopted in 1996, was considered out of date. In particular, that law did not include evidence-based, HIV prevention measures such as harm reduction programs.⁸

To develop the new draft law, a special working group was created that included the input from representatives of civil society and international organizations.

Azerbaijan has been struggling with a dual epidemic of illicit drug use and HIV infection, the latter predominately driven by the former.

– David Cozac

Taiwan: government to introduce methadone treatment in prisons

In July 2010, Taiwan's Department of Health (DOH) announced plans to introduce methadone maintenance treatment (MMT) in prisons in the central and southern areas of the island nation, where most drug convicts are serving their time. The move is part of an effort to reduce recidivism among drug users and stem the spread of HIV/AIDS.

"In Taiwan, recidivism reaches 90 percent among drug convicts. Moreover, 33 percent of local HIV carriers are injecting drug users [IDU]. We believe it is necessary to introduce MMT into the prison system to help lower recidivism and prevent the spread of AIDS," said Lin Li-Jen, head of the fifth bureau at the Centers for Disease Control (CDC).⁹

Lin said that, based on his estimates, between 60 000 and 100 000 local IDUs are in and out of prisons repeatedly, with few prospects for quitting their addiction.

In the initial stage, MMT will mainly be offered to inmates whose prison terms will soon end.

As part of its nationwide HIV and AIDS prevention program, the CDC first introduced MMT and clean syringe supply services in four cities and counties in 2006 on an experimental basis. To date, 77 hospitals have been designated to offer MMT to addicts, with the DOH and prosecution authorities offering financial subsidies for the programs.

Statistics compiled by the Ministry of Justice showed that 60 000 of Taiwan's 400 000 documented drug addicts are IDUs. CDC statistics show that, as of the end of May 2010, 6372 of the country's approximately

19 000 HIV carriers are IDUs, making injecting the country's second-most common means of spreading HIV after homosexual intercourse.¹⁰

– David Cozac

Swaziland: prisoners to receive HIV testing and counselling

More than 20 000 people in Swaziland's prisons will be offered HIV testing and counselling in a joint initiative with South Africa's Departments of Health and Correctional Services.

The program, announced in June 2010, will run testing and counselling centres in each of the country's twelve prisons.¹¹ All HIV testing of Swazi prisoners had previously been carried out in local hospitals.

The program aims to collect thorough information on HIV prevalence in Swazi prisons, which has been severely lacking. Officials hope to gather enough data from the testing centres to be able to assess how many people come to prison already infected with HIV and how many become infected while incarcerated.

The HIV testing will be performed on a voluntary basis, as it is done in all programs and health-care centres across the country. Prison staff will encourage people to make use of the testing and counselling centres by training peer educators to share the importance of HIV testing and to help make appointments. Health-care providers hope that most prisoners will use the centres and learn their HIV status. Prison officials say that their goal is to test every prisoner in the system.¹²

The program will also strive to continue to monitor the status of inmates after they are released. Contacting inmates after their release is a difficult task, as the Swazi prison system often does not have accurate personal information about inmates, including real names and addresses.

The first of the twelve testing and counselling centres opened last year in the maximum security Matsapha Central Prison, with funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and technical support from the health organization Population Services International.¹³

HIV infection among sexually active adults in prison between the ages of 19 and 29 is at an elevated rate of 26 percent in Swaziland, according to the Ministry of Health.¹⁴ People incarcerated in Swazi prisons are considered to have at least as high a risk of HIV infection as the general population; however, the prison system has not maintained data on HIV prevalence and transmission rates.

— *Gilleen Witkowski*

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Uzbekistan: government criminalizes negligent HIV infection

A bill was recently passed in Uzbekistan that amended the country's criminal and administrative codes to hold medical personnel accountable in cases of HIV-related malpractice.

Signed by Uzbek President Islam Karimov on 24 May 2010, the legislation makes health practitioners criminally liable if their negligence or error results in the transmission of HIV. The penalty for infecting a patient with HIV through negligence is six months to five years in prison, while the sentence for knowingly putting someone at risk of infection is five to eight years.

While the Uzbek criminal code already included a provision that penalizes a person who infects another with HIV, proponents of the recent amendment said that the changes will make medical workers, in particular, more responsible for their actions.¹⁵ Instances of negligence can include failure to keep medical instruments sterile and failure to follow proper procedures for services like blood transfusions.

Some HIV infections in Uzbekistan have been the result of medical malpractice.¹⁶ Before the recent legal amendments were passed, there was a trial in the Namagan region in a case of 13 medical professionals accused of infecting 147 children with HIV through negligence. Prosecutors found that doctors and other medical workers had failed to sterilize equipment, re-used disposable syringes and needles for taking blood samples, and falsified sterilization records and later destroyed evidence. Twelve of the medical professionals were found guilty and given prison sentences of up to eight years.

More doctors were charged with infecting patients with HIV in a recent case in a different region of the country.¹⁷

— *Gilleen Witkowski*

China: hospital refuses to treat HIV-positive woman

A Chinese hospital refused to treat a migrant worker seriously injured in a wage dispute after doctors found out the woman was HIV-positive.

Li Na, 37, was beaten up and sent to hospital in July when she and fellow workers at a construction site in the Inner Mongolia region asked their company for their unpaid wages, said a co-worker, Wu Jibiao.

"She was badly hit five to six times and she was spitting blood, but when doctors did some tests and found out she was HIV-positive, they refused to treat her," he said.¹⁸

"They didn't give her a room either and our company said they would not pay us if she didn't leave [the hospital], so she eventually had to go."

Wu said doctors told Li's co-workers that she was HIV-positive.

"Now she doesn't want to live because her co-workers don't want to talk to her, they all look down on her now," he said.

HIV/AIDS remains a sensitive issue in China, where people living with the disease still face extensive discrimination.

Li contracted HIV more than 10 years ago when she gave blood in the central province of Henan, her home region. Henan was the scene of a major scandal in the 1990s when people were infected by HIV after repeatedly selling their blood to collection stations that pooled it into a tub and then injected it back into them after taking the plasma.

The scandal, which was initially covered up by local officials, saw entire villages in Henan devastated by HIV/AIDS.

China says that at least 740 000 people are living with HIV, but cam-

paigners say the actual figure could be far higher.¹⁹

— David Cozac

Gay marriage legalized in Mexico City and in Argentina

In December 2009, Mexico City's local city assembly passed a law giving gay and lesbian couples the same status as heterosexual couples, including full marital rights and the right to adopt children.²⁰ The law took effect in March 2010. While the law applied only to residents of Mexico City, a marriage performed there was recognized in the rest of the country.²¹

The federal government challenged the Mexico City law in the Supreme Court on constitutional grounds by arguing that it violated the charter's guarantees to protect the family (which they contended consist of a male and female parent), and that gay adoption would infringe upon the rights of children. In August 2010, the Court rejected the appeal by federal prosecutors and ruled that the legalization of gay marriage and adoption by gay couples is constitutional.²² The justices in the majority ruling stressed that, while Mexico's

constitution enshrines protection for families, it does not define what a "family" is.²³

The previous month, in July 2010, Argentina's senate passed a law, already approved by the lower house, legalizing same-sex marriage in the country.²⁴ Argentina became the first country in Latin America to confer all the legal rights, responsibilities and protections that heterosexual couples have in marriage to gay and lesbian couples, including the right to adopt children and inheritance rights.²⁵

— Sandra Ka Hon Chu

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

⁶ Ibid.

⁷ "New HIV law was adopted in Azerbaijan," United Nations Office on Drugs and Crime, on-line: www.unodc.org/centralasia/en/news/new-hiv-law-was-adopted-in-azerbaijan.html.

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¹⁸ "HIV+ patient denied treatment," *News24*, 16 July 2010, on-line: www.news24.com/World/News/HIV-patient-denied-treatment-20100716.

¹⁹ Ibid.

²⁰ "Gay marriage law comes into effect in Mexico City," *BBC News*, 4 March 2010.

²¹ "Same-sex marriages now OK in Mexico City," *CBC News*, 4 March 2010.

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¹ "Government changes tack on HIV prevention, treatment for drug users," *PlusNews*, 24 August 2010, on-line: www.plusnews.org/report.aspx?Reportid=90266.

² Ibid.

³ Kenya National AIDS Control Council, *Kenya HIV Prevention Response and Modes of Transmission Analysis*, March 2009.

⁴ G. Gathura, "Drug users to get free needles," *The Daily Nation*, 29 July 2010, on-line: www.nation.co.ke/News/Drug%20users%20to%20get%20free%20needles%20/-/11056/967318/-/sk6vwt/-/.

⁵ "Harm reduction included in Azerbaijani legislation," *Eurasian Harm Reduction Network*, 15 June 2010, on-line: www.harm-reduction.org/news/1845-harm-reduction-coincluded-in-azerbaijani-legislation.html.

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

HIV-positive Haitian man's application for immigration judicial review dismissed

On 28 April 2010, the Federal Court dismissed Joseph Frantz Nicolas's application for judicial review of an immigration officer's rejection of his pre-removal risk assessment (PRRA) application.¹

Nicolas, an HIV-positive citizen of Haiti, based his application on the cruel treatment suffered in Haiti by individuals deported from Canada for serious criminality; the risk to his life that would be created by the inhumane conditions of detention in Haiti and the fact that it is impossible

to obtain medical care in Haitian prisons; and the risk that he would suffer discrimination amounting to cruel and unusual treatment in Haiti.

Nicolas was sponsored by his then-wife and became a Canadian permanent resident in 1988. In 1998 and 2007, he was convicted of

offences relating to drug trafficking and was subsequently found inadmissible to Canada on grounds of serious criminality.

Nicolas submitted that the PRRA officer erred by basing her rejection of his PRRA application on a "vague" and "unreliable" statement by a

Canadian migratory integrity officer in the Haitian capital, Port-au-Prince, rather than on other documents submitted in evidence. The officer also erred by rejecting his argument that the detention of a criminal deported to Haiti may constitute torture, which the United States Court of Appeals found in a previous case of another Haitian man who was also HIV-positive and convicted of drug trafficking.²

Moreover, Nicolas submitted that the officer did not give reasons for her conclusion that his life would not be in danger in Haiti because she reviewed the documentary evidence on the situation in that country without also examining his personal situation.

Finally, Nicolas contended that the officer's conclusion that discrimination against him did not constitute cruel and unusual treatment was unreasonable. Among the evidence Nicolas cited was information that only 9.2 percent of HIV-positive peo-

ple in Haiti receive HIV medication and that "criminals" are precluded from receiving such medication.³

Justice Pinarud held that the PRRA officer did not err in assigning more weight to certain evidence, and her decision not to follow a previous U.S. case was not unreasonable. In his view, the officer was not bound by the U.S. decision, which could also be distinguished by that court's finding that the Haitian authorities would specifically target the applicant by subjecting him to inhumane conditions of detention, in which his illness would subject him to severe pain, suffering and even death.

Justice Pinarud also held that the immigration officer provided sufficient justification for her finding that Nicolas's life would not be endangered by his conditions of detention. While Nicolas's submission relating to alleged discrimination against "criminals" in access to HIV treatment was

serious, Justice Pinarud held that such discrimination did not constitute cruel and unusual treatment since it did not pose a risk to Nicolas's life.

Rather, it was Haiti's overall inadequacy of health care that affected Nicolas's health, and the *Immigration and Refugee Protection Act* precluded consideration of that risk. Justice Pinarud held that it was unlikely that Nicolas would have access to the HIV treatment he needs, even if there was no discrimination against him, simply because of the inability of the Haitian government to provide medical care for its population. As such, the immigration officer did not err in determining that the discrimination Nicolas might suffer in Haiti did not constitute cruel and unusual punishment.

¹ *Nicolas v. Canada (Minister of Citizenship and Immigration)*, 2010 FC 452 (Federal Court).

² *Ibid.* at paras. 12 and 20.

³ *Ibid.* at para. 29.

BREAKING: Ontario court strikes down prostitution-related provisions of *Criminal Code*

In an historic decision on 28 September 2010, Justice Susan Himel of the Ontario Superior Court of Justice held that three provisions of the *Criminal Code*, which deal with prostitution violated sex workers' liberty, security of the person and freedom of expres-

sion, were not in accordance with the principles of fundamental justice and must be struck down. The applicants — Terri Jean Bedford, Amy Lebovitch and Valerie Scott — challenged Sections 213(1)(c), 210 and 212(1)(j) of the *Criminal Code* that make it illegal, respec-

tively, communicate in public for the purposes of prostitution; keep a common bawdy house; and live off the avails of prostitution.

For further discussion and analysis of this decision, see the next issue of the *HIV/AIDS Policy & Law Review*.

Criminal law and HIV transmission or exposure

Low risk of HIV transmission key to acquittal in case involving unprotected anal sex

On 7 May 2010, the British Columbia Supreme Court acquitted J.A.T. of aggravated sexual assault and the lesser included offence of sexual assault of his ex-partner, with whom J.A.T. had unprotected sex without disclosing his HIV-positive status.¹ J.A.T.'s ex-partner did not contract HIV.

From 2003 to 2004, J.A.T. had a ten-month long sexual relationship with the complainant. At the time, J.A.T. knew he was HIV-positive, but told the complainant he had recently tested negative.

According to J.A.T., they had unprotected sex once during the course of their relationship, while they were both intoxicated. According to the complainant, they had protected anal sex 60 to 100 times and unprotected anal sex five times. J.A.T. was always the receptive partner on every occasion of anal intercourse. The complainant testified that, after the fifth time they had unprotected anal sex, J.A.T. indicated he had just discovered he was HIV-positive.

During the trial, Dr. Murphy, an expert in HIV treatment, testified that the vast majority of HIV-positive people live a normal lifespan with treatment. As Justice Laurie Ann Fenlon stated, "HIV is no longer synonymous with AIDS and premature death."²

Medical evidence showed J.A.T. had viral loads of between 12 000 and 30 000 particles of HIV per millilitre of plasma during the relevant period. Dr. Murphy also testified that unprotected anal sex posed a high risk of HIV transmission.

Taking into account J.A.T.'s viral load (which had not been suppressed by treatment because J.A.T.'s doctors had not yet deemed it necessary to prescribe antiretroviral drugs), the fact that the complainant was uncircumcised (which increases risk of transmission), and the fact that J.A.T. was the receptive HIV-positive partner and the complainant was the insertive HIV-negative partner, HIV expert Dr. Mathias testified that he estimated the risk of transmission of HIV to the complainant was 4 in 10 000 per incident of anal intercourse, a risk that is cumulative.³

Justice Fenlon held that there were some inconsistencies in J.A.T.'s evidence describing his sexual encounters with the complainant and she accepted the evidence of J.A.T.'s former roommate that the complainant had advised her that he and J.A.T. had unprotected sex more than once. Justice Fenlon estimated that J.A.T. and the complainant engaged in a total of three acts of unprotected intercourse.

In Justice Fenlon's view, the 0.12 percent risk that these incidents would have resulted in the transmission of HIV from J.A.T. to the complainant was too small to constitute endangerment for the purpose of an aggravated assault conviction.⁴

In relation to the lesser included offence of sexual assault, Justice Fenlon found that the complainant relied on J.A.T.'s representation he was HIV-negative in engaging in a relationship with him (which included unprotected sex) and would not have engaged in unprotected anal sex with J.A.T. if he were aware of his HIV-positive status. Nevertheless, the small risk of HIV transmission was not material enough to vitiate the complainant's consent to unprotected sex with J.A.T.

As Justice Fenlon concluded, "... not every immoral or reprehensible act engages the heavy hand of the criminal law. Aggravated sexual assault is a most serious offence — a person convicted of this charge is liable to imprisonment for life, the harshest penalty provided for in law. Only behaviour that puts a complainant at significant risk of serious bodily harm will suffice to turn what would otherwise be a consensual activity into an aggravated sexual assault. In my view, a risk of transmission of HIV of 0.12% falls short of that standard."⁵

Commentary

Justice Fenlon's judgment is unusual in that, in numerous other cases, people living with HIV have previously been convicted for unprotected vaginal or anal sex without disclosing their status. It would be unwise to assume that, because of this single ruling by a B.C. trial court, there is no need to disclose known HIV status when having unprotected sex.

Importantly, this decision reinforces the basic point that not every risk of transmission will be considered “significant,” and illustrates the importance of ensuring that courts carefully consider the scientific evidence before them in determining when there is a “significant risk” of harm, rather than simply criminalizing non-disclosure in all circumstances.

Ever since the Supreme Court of Canada ruled in 1998 in *R. v. Cuerrier*⁶ that there is a duty to disclose HIV-positive status before engaging in activity that poses a “significant risk” of transmission, there has been uncertainty about what this includes. There has been an inconsistent, and hence unfair, application of criminal charges aimed at defining this standard.

For example, in some cases, prosecutors and courts have agreed that unprotected oral sex, or vaginal or anal sex while using a condom, does not carry a significant enough risk to trigger criminal charges for not disclosing, yet there are other cases in which people have been charged and/or convicted for these very same activities. What this case illustrates is the need for greater clarity in the law.

Ontario court convicts man of aggravated sexual assault and sexual assault based on his unreliable evidence

On 14 July 2010, the Ontario Court of Justice convicted Lester Felix of five counts of aggravated sexual assault and one count of sexual assault for failing to disclose his HIV-

positive status to two women before having sex with them.⁷

The undisputed facts were that Felix was diagnosed with HIV on 15 September 2005 and was informed during a counselling session of his legal obligation to disclose his positive HIV status to all his sexual partners. After his diagnosis and counselling session, Felix had sex with the three complainants: N.S., M.F. and D.H.

As formulated by Justice Kelly Wright, the court was charged with deciding whether (1) Felix disclosed his positive HIV status to the complainants before having sex with them, and (2) the sex was unprotected, thereby creating a significant risk to the lives of the complainants.

N.S. testified that, in August 2009, she had consensual anal and oral sex with Felix, no condoms were used and Felix never disclosed his HIV status to her. Felix testified that N.S. had known about his HIV status since 2006, and that he was unsure about whether or not a condom had been used.

M.F. testified that, in 2009, she had sex with Felix five times, during which he wore a condom once. M.F. further testified that Felix never disclosed his HIV status to her. Felix testified that he did disclose his positive HIV status to M.F. before they had sex on the first occasion, and that he wore a condom every subsequent time they had sex.

D.H. testified that, between 13 August 2008 and July 2009, she had sex with Felix about 15 times a month and that they never used condoms. She also said that at no point did Felix ever disclose to her that he was HIV-positive. Felix disagreed with the frequency of the sexual activity alleged by D.H. and testified

that he did tell her that he was HIV-positive, right before the first time they had sex.

Justice Wright found Felix’s evidence inconsistent and unreliable. As she provided, “After a thorough review of all of Mr. Felix’s evidence, I was truly left with the impression that he was making it up as he went along with no regard for the truth. As a result, I do not accept his evidence nor I am left in a reasonable [doubt] by it.”⁸

In contrast, Justice Wright found the evidence of N.S. and M.F. credible and was prepared to rely on it. In light of D.H.’s criminal record and a number of factors concerning her testimony, Justice Wright was left in reasonable doubt by her evidence.

Accordingly, Justice Wright was convinced beyond a reasonable doubt that Felix did not disclose his HIV-positive status to N.S. or M.F. before he had unprotected sex with them, and found him guilty of one count of aggravated sexual assault on N.S. and four counts of aggravated sexual assault on M.F. Moreover, Justice Wright held that the lesser offence of sexual assault had been made in relation to the first occasion in which Felix may have had protected sex with M.F., since Felix’s lack of disclosure that he was HIV-positive vitiated any consent that was obtained on that occasion.

With respect to D.H., Justice Wright found the Crown had not proven the charges against Felix beyond a reasonable doubt and did not find him guilty of aggravated sexual assault in that case.

Commentary

According to the Supreme Court of Canada in *R. v. Cuerrier*, non-disclosure of HIV-positive status would

only amount to fraud vitiating consent when it has the effect of exposing someone to a “significant risk of serious bodily harm”.⁹

In relation to the first occasion in which Felix used a condom during sex with M.F., he was not convicted of aggravated sexual assault, as this would require an endangerment of M.F.’s life. Justice Wright correctly acknowledged that, if sex were protected, M.F.’s life could not have been endangered.

However, to the detriment of Felix, Justice Wright followed the Crown’s reasoning and decided that lack of disclosure vitiates consent to otherwise consensual sex. As a result, Felix was convicted of the lesser count of sexual assault despite the Crown not having proved beyond a reasonable doubt that he exposed M.F. to a significant risk of HIV transmission.

This decision raises concerns as it seemingly ignores the requirement in *Cuerrier* of a “significant risk” of HIV transmission to establish fraud vitiating consent to sex. Consequently, it unjustifiably extends the scope of the criminal law by making non-disclosure of HIV an assault, whatever the level of risk of transmission, including when a condom is used.

Criminal charges stayed for non-disclosure of HIV status involving oral sex

Criminal charges were stayed against Patrick Justus Zela, an HIV-positive man whose ex-partner alleged Zela had oral sex with him without disclosing that he had the virus.¹⁰ Zela’s ex-partner had not tested HIV-positive.

In February 2009, Zela was arrested in Nova Scotia where he had been studying and was brought to Hamilton to face charges. In a Hamilton court on 22 April 2010, Crown prosecutor Karen Shea stayed the charge of aggravated sexual assault against Zela because the Crown had no reasonable prospect of conviction.

Non-disclosure of HIV to a partner is only a criminal offence if there is a significant risk of bodily harm, which oral sex does not pose.

Non-disclosure of herpes condition results in assault conviction

On 21 June 2010, the Ontario Court of Appeal dismissed John Sherman’s appeal of an assault conviction for having unprotected sex with the complainant without disclosing the fact that he had Herpes II.¹¹ The conviction was entered by the Ontario Court of Justice in February 2009.

The Court of Appeal held that the trial judge found that Sherman knew he had herpes when he repeatedly had unprotected sex with the complainant without disclosing that fact, and acted in a manner that showed a marked and substantial departure from the way in which a reasonable person would have conducted himself.¹²

Sherman had received a total sentence of 12 months. While his counsel submitted that a conditional sentence should have been imposed, the Court of Appeal found no reversible error in the trial judge’s conclusion that a conditional sentence was inappropriate for a number of reasons, including the fact that Sherman

was on probation for domestic assault when he committed the offence.

Hepatitis C-positive Saint John man convicted of aggravated assault for spitting

Kristopher Ryan Wentworth pleaded guilty to aggravated assault in June 2010 after he spat on a sheriff’s deputy outside a provincial court in New Brunswick in March 2010. Wentworth, who has hepatitis C virus (HCV), was sentenced to 18 months in prison.¹³

According to provincial court Judge Mary Jane Richards, Wentworth knew he had HCV and should have known from the time he had spent in prison that it could be transmitted through bodily fluids.

HCV is spread through blood-to-blood contact and can be effectively treated.¹⁴ Despite hearing evidence that the risk of HCV transmission from saliva is low, Judge Richards decided Wentworth’s behaviour fit the definition for aggravated assault, which, in her words, is “a serious, life-threatening assault.”¹⁵

Alberta: Guilty plea for aggravated assault

In August 2010, John Duane Gilbertson pleaded guilty to aggravated assault for failing to disclose his HIV-positive status to a woman before they had sex.¹⁶ Gilbertson had been arrested two months earlier after his roommates called the police when they discovered him having sex with the complainant. He was charged with aggravated sexual assault, but

was allowed to plead guilty to the lesser offence of aggravated assault.

Gilbertson was sentenced to three years in prison, ordered to submit a DNA sample for the national DNA databank and prohibited for life from possessing weapons.

Dangerous offender designation and proceedings not a violation of Aziga's constitutional rights

On 24 June 2010, the Ontario Superior Court of Justice dismissed Johnson Aziga's application for (1) a declaration that a dangerous offender designation was a violation of his rights pursuant to the *Canadian Charter of Rights and Freedoms* (Charter) and (2) an order staying the dangerous offender proceedings on the grounds that the dangerous offender designation infringed upon his Charter rights.¹⁷

Aziga had been convicted in April 2009 of two counts of first-degree murder, 10 counts of aggravated sexual assault and one count of attempted aggravated sexual assault for failing to disclose his HIV-positive status to

women before having unprotected sex with them. The Ontario Ministry of the Attorney General subsequently obtained a psychological assessment of Aziga and, in April 2010, the Crown brought proceedings to have him declared a dangerous offender.¹⁸

Aziga argued that declaring him a dangerous offender would violate his Section 12 Charter right to be free from "cruel and unusual treatment or punishment" and Section 15 Charter right to equality before and under the law, and to the equal protection and equal benefit of the law without discrimination because he had been mistreated while in custody, was HIV-positive and was Afro-Canadian.¹⁹

In the Court's view, Aziga's conditions of detention were not so oppressive as to constitute "cruel and unusual punishment," and there was no evidence to support the allegation that the Crown sought a dangerous offender designation because Aziga is HIV-positive or Afro-Canadian.²⁰ Even if Aziga's allegations of mistreatment were sustained, they would not justify a stay of proceedings. As there was no reasonable prospect that the application could succeed, it was dismissed without further hearing or inquiry.²¹

¹ *R. v. J.A.T.*, 2010 BCSC 766 (British Columbia Supreme Court).

² *Ibid.* at para. 22.

³ *Ibid.* at paras. 29 and 31.

⁴ *Ibid.* at para. 58.

⁵ *Ibid.* at para. 89.

⁶ [1998] 2 S.C.R. 371 (Supreme Court of Canada).

⁷ *R. v. Felix*, 2010 ONCJ 322 (Ontario Court of Justice).

⁸ *Ibid.* at para. 38.

⁹ *R. v. Cuerrier*, [1998] 2 S.C.R. 371 (Supreme Court of Canada).

¹⁰ "Sexual assault charges stayed against HIV-positive man in Hamilton Court," *The Canadian Press*, 22 April 2010.

¹¹ *R. v. Sherman*, 2010 ONCA 462 (Ontario Court of Appeal).

¹² *Ibid.* at para. 1.

¹³ B. Bartlett, "Man who spat on sheriff's deputy sent to prison," *Telegraph-Journal*, 21 June 2010.

¹⁴ Health Canada, *It's Your Health: Hepatitis C*, May 2009. Available on-line: www.hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/hepc-eng.php.

¹⁵ B. Bartlett (supra).

¹⁶ T. Blais, "HIV-risky sex earns man three years in slammer," *The Edmonton Sun*, 14 August 2010, p. 5. The case is unreported and it is not clear from media reports whether the sex was unprotected.

¹⁷ *R. v. Aziga*, [2010] O.J. No. 2763 (Ontario Superior Court of Justice) (QL).

¹⁸ B. Brown, "Lawyer fights to have Aziga not declared dangerous offender," *The Hamilton Spectator*, 30 April 2010, p. A3.

¹⁹ *Aziga*, at para. 4.

²⁰ *Ibid.* at para. 7.

²¹ *Ibid.* at para. 13.

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 Mikhail Golichenko (mgolichenko@aidslaw.ca), senior policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Except where otherwise noted, the articles in this section were written by Patricia Allard, Deputy Director of the Canadian HIV/AIDS Legal Network.

Michigan judge rules that HIV-positive man not a bioterrorist

On 2 June 2010, the trial court in Macomb County, Michigan, dismissed charges against an HIV-positive man brought under the state's "bioterrorism" statute. David Allen was charged in November under a provision of the statute that prohibits the manufacture, delivery, possession, use or release of a harmful biological substance.¹

The charges stemmed from an altercation between Allen and his neighbour, Winfred Fernandis Jr., which took place in 2009. During the altercation, which Allen says

was the result of many years of anti-gay harassment by Fernandis and his family, it is alleged that Allen bit Fernandis on the lip. Allen was initially charged with assault with

the intent to maim, but after revealing during a television interview that he was HIV-positive, Allen found himself facing additional charges for bioterrorism and assault with the

intent to do great bodily harm less than murder.²

Judge Peter J. Maceroni of Macomb County Circuit Court upheld the motion to quash the bioterrorism charges, noting that “[t]he fact that the defendant is HIV-positive, alone, cannot demonstrate he manufactured or possessed his HIV infected blood for an unlawful purpose. In addition, the defendant’s alleged action of biting the complaining witness, without the presence of blood, is not a documented manner in which HIV can be transmitted.”³

Ultimately, the case turned on the fact that there was no evidence of the transmission of blood during the altercation. The court did not comment on whether the statute would be applicable in future situations involving exposure to HIV-infected blood.⁴

Lambda Legal,⁵ along with several other community-based organizations, filed an amicus brief in the matter, urging the court to drop the bioterrorism charge. The brief explained that the facts of HIV transmission did not support the allegation that biting constitutes a use of a harmful biological substance, and argued that the charge reflected a misunderstanding of how HIV is transmitted, contributed to stigmatizing people living with HIV and undermined prevention and treatment efforts.⁶

Although the first known case of HIV-related charges under the bioterrorism law, Michigan has prosecuted HIV-positive individuals for aggravated assault and assault with a deadly weapon or dangerous instrument for allegedly exposing others to the virus. In 2007, a state Court of Appeal ruling set a precedent when it affirmed the conviction of an HIV-positive inmate accused of spitting blood at a corrections officer.⁷

While HIV-infected blood has been classified by the courts as a harmful biological substance, there was no evidence that any blood was shed by either individual in the Allen case. Allen and his advocates say the charges are indicative of ignorance regarding HIV transmission and an unwarranted fear of HIV-positive individuals.⁸

The state’s bioterrorism statute was crafted in 1998 in the wake of the Oklahoma City bombings and a Michigan anthrax scare.⁹ Lawmakers have expressed concern about how the statute was applied in Allen’s case and have commenced discussions intended to clarify the purpose and effect of the law.

The author of the statute, Congressman Gary Peters, said that the law was drafted in response to the absence in Michigan of a mechanism for law enforcement agencies to deal with terrorist threats involving biological or chemical weapons. While Peters would not comment specifically on Allen’s case, state Representative Rick Jones stated, “I don’t think the intent of the terrorism law has been applied correctly in this case That’s unfortunate.”¹⁰

Jay Kaplan, staff attorney for the American Civil Liberties Union (ACLU) of Michigan’s LGBT Project, commented that the order represented “a victory for all people living with HIV who risked facing similar outrageous and misguided criminal charges based solely on their HIV status,” noting that the order “made it clear that one does not become a bioterrorist because he has HIV.”¹¹

Kaplan indicated that the ACLU was not aware of any other individuals facing similar charges, and expressed hope that this would be the last time.¹²

Of the ruling, Allen said that he hoped the decision would help HIV-positive people everywhere. “It gives the opportunity for people to get tested and not be afraid to get tested and accused of being a terrorist.”¹³

Allen still faces the two assault charges. Both are felony charges and, if convicted, Allen could face up to ten years in prison for each charge.¹⁴

— Kelly Sinclair

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¹ *People of the State of Michigan v. Daniel Allen*, Case No. 2009-4960-FH (Circuit Court for the County of Macomb).

² T. Heywood, “HIV-as-terrorism charges dismissed by Macomb county Judge,” *The Michigan Messenger*, 2 June 2010.

³ *People of the State of Michigan* (supra).

⁴ *People of the State of Michigan* (supra).

⁵ Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

⁶ *Amicus Curiae Brief of Lambda Legal Defence and Education Fund, Inc., Community AIDS Resource and Education Services, Michigan Positive Action Coalition, and Michigan Protection and Advocacy Service, Inc.* in Case No. 09-004960-FH.

⁷ C. Ferretti, “HIV-positive man faces charge of bioterrorism,” *The Detroit News*, 8 May 2010.

⁸ J. Cook, “Judge dismisses bio-terrorism charge against HIV-positive man,” *The Macomb Daily*, 3 June 2010.

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ J. Cook (supra).

¹² J. Cook (supra).

¹³ J. Cook (supra).

¹⁴ T. Heywood (supra).

Gay asylum seekers win right to stay in United Kingdom

The Supreme Court has unanimously ruled that gay men facing persecution in their home countries have the right to asylum in the United Kingdom. This decision comes as a response to an appeal by two gay men who had their applications for asylum rejected on the basis that they could choose to keep their personal lives to themselves.

In denying the applications, the Court of Appeal adopted the policy of the Home Office, which had been refusing asylum claims by gay men on the grounds that they could hide their sexuality — and therefore avoid persecution — by behaving discreetly.¹

In a test case before the Supreme Court, the applicants argued that the policy of the Home Office was contrary to the United Nations Convention Relating to the Status of Refugees, to which Britain is a party. The Convention provides that members of a particular social group, which includes groups with a common sexual orientation, are entitled to asylum in states that are parties to the Convention if they can establish that they would face a well-founded fear of persecution if returned to their home country.²

The applicants — who fled from Cameroon and Iran respectively — had been told that they should be “more discreet” in future and that they could be “reasonably expected to tolerate” conditions in their home countries.³ These “conditions” include punishment for homosexual acts ranging from public flogging to execution in Iran, and in Cameroon, to jail sentences ranging from six months to five years.

The applicant from Cameroon fled after being attacked by an angry mob

who witnessed him kissing his partner. The other disputed application was from an Iranian man who was attacked and expelled from school when his homosexuality was discovered.⁴ The Court of Appeal found that neither individual had a “well-founded fear” of persecution which entitled them to protection.⁵

A panel of five Supreme Court justices, who heard the case over three days in May 2010, unanimously held that the test applied by the Court of Appeal was contrary to the Convention and should not be followed in the future.

Lord Hope, who read the judgment on behalf of the court, said, “To compel a homosexual person to pretend that his sexuality does not exist or to suppress the behaviour by which to manifest it is to deny his fundamental right to be who he is.” He went on to note that “homosexuals are as much entitled to freedom of association with others who are of the same sexual orientation as people who are straight.”⁶

The government, which had already promised to review its treatment of homosexual asylum seekers, has apparently welcomed the ruling. In a response to the decision, Home Secretary Theresa May commented, “We have already promised to stop the removal of asylum seekers who

have had to leave particular countries because their sexual orientation or general identification puts them at proven risk of imprisonment, torture or execution I do not believe it is acceptable to send people home and expect them to hide their sexuality to avoid persecution.”⁷

May promised that, in future, asylum decisions would be considered under the rules established by the Supreme Court, noting that the judgment gives “an immediate legal basis for us to reframe our guidance for assessing claims based on sexuality, taking into account relevant country guidance and the merits of individual cases.”⁸

Ben Summerskill, the chief executive of gay lobby group Stonewall, said that the group was delighted with the decision and offered to help the government respond to future claims. Stonewall’s recent report, *No Going Back*, estimated that, between 2005 and 2009, the Home Office had initially refused 98 percent of all gay or lesbian asylum claims.

On the former policy of the Home Office, Summerskill noted that “[d]emanding that lesbian or gay people return home to conceal their sexuality bears no resemblance to the reality of gay life in many countries.”

The Supreme Court said it would pass detailed guidance to the lower

courts about how to treat such cases in the future. In the meantime, the cases of the applicants in question will be sent back for reconsideration in light of the Supreme Court's decision.⁹

Commentary

This stigmatization of homosexual men and women dramatically hampers access to HIV/AIDS, hepatitis and sexually transmitted infection prevention and care. The direction by the Court of Appeal to live “discreetly” thus undermines attempts to

ensure that at-risk individuals have access to counselling and testing, information about prevention, and access to treatment where needed.

— *Kelly Sinclair*

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¹ “Supreme Court Judge says homosexual asylum seekers should be allowed to stay because ‘gays must be free to enjoy Kylie concerts and cocktails,’” *Mail Online*, 8 July

2010, on-line: www.dailymail.co.uk/news/article-1292715/Gay-asylum-seekers-win-legal-battle-stay-Britain.html.

² “Gay asylum seekers win right to stay in Britain,” *The Telegraph*, 6 July 2010, on-line: www.telegraph.co.uk/news/uknews/immigration/7876634/Gay-asylum-seekers-win-right-to-stay-in-Britain.html.

³ “Gay asylum seekers from Iran and Cameroon win appeal,” *BBC News (UK)*, 7 July 2010.

⁴ *Ibid.*

⁵ “Gay asylum seekers win right to stay in Britain” (*supra*).

⁶ “Gay asylum seekers from Iran and Cameroon win appeal” (*supra*).

⁷ “Supreme Court Judge says homosexual asylum seekers should be allowed to stay because ‘gays must be free to enjoy Kylie concerts and cocktails’” (*supra*).

⁸ “Gay asylum seekers from Iran and Cameroon win appeal” (*supra*).

⁹ “Gay asylum seekers win right to stay in Britain” (*supra*).

Criminal law and cases of HIV transmission or exposure

United Kingdom: appellate court cuts HIV-positive man's sentence

On 29 June 2010, the Court of Criminal Appeal in Edinburgh determined that the original sentence of ten years' imprisonment against Mark Devereaux for recklessly having unprotected sex with four women was excessive and reduced it to eight years, “a tariff which includes a discount of one-third for an early admission of guilt.”¹

Last February, the High Court in Dumbarton sentenced Devereaux for failing to disclose his HIV-positive sta-

tus to the women, with whom he had sexual relations from 2003 to 2008. One woman, who accidentally discovered Devereaux's HIV status, tested positive for the virus and decided to terminate her pregnancy of twins she was expecting by the accused. The other three women tested negative.

United States: HIV-positive man gets five-year sentence for spitting on police officer

On 26 July 2010, a Circuit Court jury in Washington County, Maryland

found Jeffrey Lynn Black guilty of second-degree assault and sentenced him to prison for five years for having spat on police officer Richard Cook.

In February, officers were responding to a report of vandalism involving Black. Upon arresting him, Black — who was intoxicated at the time — spat at Cook's face. Cook has been undergoing regular HIV tests every three months since the incident.

During the trial, Black's wife testified that “her husband often spits unintentionally because he has no teeth.”² At sentencing, Black apologized to Officer Cook, saying that he did not intend to spit on him.

Australia: first gay criminalization case in New South Wales

In August, a 55-year-old from New South Wales was the first gay man to face the charge of wilfully spreading HIV to another person.

The criminal charges in this case follow a civil suit in which the man was ordered to pay his former partner AUS\$757 487 (approximately CAN\$711 000) “for causing pain and suffering, loss of income and loss of life expectancy.”³ The court apportioned AUS\$50 000 (approximately

CAN\$47 000) in exemplary damages, demonstrating its “disapproval of disgraceful conduct.”⁴

Rob Lake, CEO of the Australian organization Positive Life, said that greater public health intervention should be employed in non-disclosure cases.

“The [New South Wales Health] Department has a range of measures it can use for both the victim and the alleged perpetrator, and where it is considered appropriate, they can refer [a matter] to police.”⁵

Stanislas Kanengele-Yondjo, a heterosexual Congolese man, was the

first individual in New South Wales to be convicted of transmitting HIV. He was sentenced to 12 years in prison in 2005.

¹ “Dundee HIV man’s jail sentence cut by judges,” *The Courier*, 30 June 2010, on-line: www.thecourier.co.uk.

² “Man with HIV who spit on police officer sentenced to five years,” *The Herald-Mail*, 26 July 2010, on-line: www.herald-mail.com.

³ A. Potts, “First Gay HIV Criminal Charge,” *Sydney Star Observer*, 28 July 2010, on-line: www.starobserver.com.au.

⁴ *Ibid.*

⁵ *Ibid.*

In brief

Zambia: court awards damages to two former military officers in mandatory HIV screening case

On 27 May 2010, the Livingstone High Court held that the Zambian Air Force’s decision to subject Stanley Kingaibe and Charles Chookole to a mandatory HIV test violated their rights to privacy and to be free from inhuman and degrading treatment under the Zambian Constitution.¹

The court awarded each man damages of 10 million Kwacha (approx-

mately CAN\$2120) for the violation of their constitutional rights.

Chookole and Kingaibe were employed by the Zambian Air Force in non-combat positions for almost two decades. In 2001, they were tested for HIV without their consent and dismissed from employment in 2002. They launched a suit against the Zambian Air Force, arguing that the treatment violated their rights under the Zambian Constitution, including the rights to privacy and be free from cruel, inhuman and degrading treatment.

The two men also argued that they were dismissed due to their HIV status. This was rejected by the court, which found that the decision for dismissal was made based solely on their medical health and not their HIV status. The court did not reach the ques-

tion of whether dismissal solely on HIV status would be unconstitutional.²

In reaching its decision that mandatory HIV testing violated the Zambian Constitution, the court referenced Zambia’s obligations under international and regional treaties, including the *African Charter on Human and People’s Rights*.

United States of America: HIV-positive man wins \$1.25 million in a privacy case

An Indiana court awarded US\$1.25 million (CAN\$1.35 million) in damages to an HIV-positive man whose privacy was violated by a medical institution.

Internal Medicine Associates (IMA) disclosed his HIV status to its collection lawyers when it provided them with information for a debt collection of US\$326 (CAN\$345) for a past-due bill.³ Because the information became publicly available once the collections case was filed, anyone could have seen the filing and known the man's status.

The plaintiff testified in court that IMA had disclosed his status to more people than he had. For its part, IMA argued that it had no obligation to compensate the plaintiff for disclosing his status to a non-relevant party, since he had told at least one other person who was neither a sexual partner nor family member. Its counsel also demanded to know how many sexual partners the man had had so that IMA would know how many people he had told before having sex.⁴

As he no longer felt comfortable living in the town of Bloomington, the plaintiff asked the jury to give him enough money to relocate.

Egypt: new pricing system threatens the availability of generic drugs

On 27 April 2010, the Court of Administrative Justice issued a ruling that suspended work under a new drug-pricing system that tied drug prices in Egypt with global prices.

Citing Article 16(2) of the *African Charter on Human and Peoples' Rights*, the court found that the new system would lead to "inevitable repercussions ... principally increased prices of pharmaceutical drugs and the consequences this will have for citizens' health and their right to obtain affordable medicine."⁵

The Egyptian Initiative for Personal Rights (EIPR) had filed a lawsuit on 22 October 2009 asking the court to suspend Health Minister Decree 373/2009, which would have entailed substantial price hikes for many kinds of drugs. The EIPR warned that the decree would lead to higher prices for generic drugs in particular, which Egyptians rely on heavily due to their low cost.⁶

Dina Iskander, a researcher with the EIPR's Right to Health Program, noted, "The new pricing system has several flaws that make it impossible to implement on the ground. It contains loopholes that allow pharmaceutical companies to circumvent the rules and obtain the highest possible price for their products regardless of their true cost."⁷

Prior to the introduction of the new pricing system, "the price of generic drugs was determined on the basis of the actual production cost, plus profit mark-ups."⁸ Under the contested system, the price of a brand-name drug would be set 10 percent lower than the cheapest consumer price of the drug in the countries in which it is currently available and the price of a generic drug would be set at a fixed percentage of the brand-name version — thereby linking the prices with global markets.

The case is significant as it is the first one to contest the national drug pricing system and question the accessibility and affordability of medicines in Egypt under that system. It is also the first case to argue for a rights-based approach to implementing such a policy.

The Ministry of Health has appealed the lower court's decision to the Supreme Court of Administrative Justice.

Kenya: court considers issue of access to affordable medicines

The Kenyan Constitutional Court will hear an application against the *Anti-Counterfeit Act* of 2008, of which clauses pertaining to medicines have been suspended pending the court's decision on whether the law violates the right to health and life.

The move follows a case in which three people living with HIV applied in July 2008 for the Act to be suspended, as it threatened the importation or manufacturing of affordable and life-saving generic antiretroviral medication, against their constitutional right to health and life.⁹

In April 2010, Constitutional Court Justice Roselyn Wendo acknowledged that the petitioners would suffer irreparable damage if their plight were not addressed. In her ruling, Justice Wendo issued a conservatory order on the application of the law to medicines until a verdict is delivered in the case.

Jacinta Nyachae, executive director of the Aids Law Project, said that the law contravenes sections of the *Industrial Property Act* of 2001, including Section 58 (2) providing for parallel importation and Section 80 on government use.¹⁰

Parallel importation is when a product that is not counterfeit is imported from another country without the patent holder's consent. Section 58 (2) waives patent rights pertaining to some products on the market in Kenya or in any other country or imported into Kenya. Section 80 on government use allows the government or its agents to exploit a patent in the public interest.

Health rights activists argue that developed countries are trying to force Trade-Related Aspects of Intellectual Property (TRIPs)-plus agendas (i.e., intellectual property or IP rights protection that goes beyond TRIPs) regarding medicines on developing countries in favour of IP rights holders, of which the majority are multinational companies from the Global North. They also say that the *Anti-Counterfeit Act* fails to acknowledge and, specifically, to exempt generic medicines from the definition of counterfeits.

TRIPs identifies IP rights as “territorial rights.” IP on medicines would only be protected in the territory where it is registered. However, the *Anti-Counterfeit Act* upholds IP rights registered in countries outside Kenya.¹¹

“This automatically makes generic drugs imported into or transiting through Kenya illegal if a patent exists anywhere in the world,” noted Christa Cepuch, programme director at Health Action International (HAI) Africa.¹²

“We hope the court will provide clear direction on how to protect public health and ensure access to medicines for all Kenyans vis-à-vis the widely acknowledged risks that this act poses,” Cepuch added.

Namibia: HIV-positive women sue the government over forced sterilization

Three Namibian women are suing the government for being allegedly sterilized without their informed consent after testing positive for HIV. The

women say the doctors and nurses should have informed them properly about what was happening.¹³

They are seeking one million Namibian dollars (approximately CAN\$143 500) in compensation from the health ministry.

The Legal Assistance Centre (LAC), the rights organization representing the women, says the High Court has granted that their identities should not be revealed in order to prevent “further discrimination and stigmatisation because of their HIV status.”¹⁴

Gladys Kamboo, a spokesperson for the health ministry, said she could not comment on the case while it was being heard in court, but insisted that the ministry had not done the women any intentional harm.

“We want a health system based on human rights which promotes equality for all,” said Amon Ngavetene of the LAC.¹⁵

He explained that, when HIV-positive women go to hospital, they are sometimes, at the discretion of the doctors, advised to undergo a sterilization operation. However, Ngavetene said that these women are not always given a clear idea of what the procedure involves and dangerous pre-existing conditions are not always taken into account. There may also be a language barrier in a country where there are 11 indigenous languages, he added.

The LAC reports that there have been at least 15 documented cases of alleged forced sterilization in public hospitals in Namibia since 2008.¹⁶

Namibian advocates state that this type of bias and abuse in public hospitals “could deter women from trusting services providers and drive them away from hospital settings — making

it increasingly difficult to ... provide them with the care that they need.”¹⁷

Kenya: two tuberculosis patients sentenced to prison

In August 2010, a Kapsabet court magistrate ordered the imprisonment for eight months of two patients who declined to take tuberculosis (TB) drugs. The sentence was intended to enable them to take the drugs as prescribed by doctors in order to curb the spread of the disease while in confinement because they had refused to swallow them voluntarily.¹⁸

Justice John Njoroge noted that the court had a duty to protect lives of Kenyans. He directed that the two patients serve their sentence in isolation until their term ends. He further ordered that they be placed under the supervision of a public health officer to ensure that they complete the prescribed doses.

The accused men, Daniel Ng’etich, 35, and Patrick Kirui, 40, were charged on 12 June 2009, after they had stopped taking drugs prescribed to them by doctors in Kapsabet District Hospital.

Ng’etich and Kirui, who were not represented, pleaded guilty and asked the court to treat them with leniency.

“Safeguarding public health supersedes an individual’s right to comfort and these two not only had an infectious disease but were also failing to take their drugs as prescribed,” said Joseph Sitienei, head of the National Leprosy and TB Control Programme. “They were not only endangering their lives but also those of other people.”¹⁹

He added that the law was very clear on what a public health officer should do in such cases. The *Public Health Act* authorizes public health officers to take whatever action they deem necessary — including detaining infectious patients — to prevent the spread of diseases.²⁰

Kenya ranks 13th on the World Health Organization's list of high-burden TB countries. An estimated 40 percent of HIV-positive Kenyans are also infected with TB.²¹

— David Cozac

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¹ Southern Africa Litigation Centre, "Zambian High Court Finds Mandatory HIV Testing by Military Unconstitutional," news release, Johannesburg, 27 May 2010.

² Ibid.

³ B. Browning, "Indiana man wins \$1.25 M after doc discloses he's HIV+," The BILERICO Project, 5 July 2010, on-line: www.bilerico.com/2010/07/indiana_man_wins_125m_after_doc_discloses_hes_hiv.php.

⁴ Ibid.

⁵ "Pharmaceutical Companies Intervene in Support of the Government in the Drug Pricing Case," Egyptian Initiative for Personal Rights, 10 June 2010, on-line: <http://eipr.org/en/pressrelease/2010/06/09/911>.

⁶ "Court of Administrative Justice Suspends New Drug-Pricing System," Egyptian Initiative for Personal Rights, 27 April 2010, on-line: <http://eipr.org/en/pressrelease/2010/04/27/811>.

⁷ Ibid.

⁸ ESCR-Justice, "Egyptian Court Strikes Down New Market-based Medicine Pricing System as Undermining 'Health Security,'" *Monthly Caselaw Update*, July 2010.

⁹ S. Mbatiah, "Kenyans' Right to Affordable Drugs in Hands

of Court," Inter Press Service, 22 July 2010, on-line: <http://ipsnews.net/news.asp?idnews=52236>.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

¹³ "Namibia HIV women sue over forced sterilization," BBC News, 1 June 2010.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ A. Ahmed, "Sterilized: against our will," Open Democracy, 3 June 2010, on-line: www.opendemocracy.net/5050/aziza-ahmed/sterilized-against-our-will.

¹⁸ "Two jailed for failing to take TB drugs," *The Daily Nation*, 24 August 2010, on-line: www.nation.co.ke/News/regional/-/1070/995776/-/9c1kl8/-/.

¹⁹ "TB patients held in police cells for defaulting on treatment," PlusNews, 24 August 2010, on-line: www.plusnews.org/report.aspx?Reportid=90270.

²⁰ Ibid.

²¹ Ibid.



AIDS 2010: LAW, ETHICS AND HUMAN RIGHTS

In this special section of the *HIV/AIDS Policy & Law Review* — made possible by funding received from the Open Society Foundations’ Public Health Program, the Levis Strauss Foundation and UNAIDS — we reproduce some of the most relevant presentations on legal, ethical and human rights issues related to HIV/AIDS featured at the XVIII International AIDS Conference (AIDS 2010) in Vienna, Austria in July 2010. We did the same for the conferences held in Geneva in 1998, in Durban in 2000, in Barcelona in 2002, in Bangkok in 2004, in Toronto in 2006 and in Mexico City in 2008. The goal of this supplement is to increase access to materials on human rights, legal and ethical issues related to HIV/AIDS for individuals and organizations worldwide; to facilitate networking among individuals and groups active in the area; and to promote policy and legal responses to HIV/AIDS that respect human rights.

The theme of AIDS 2010 was “Rights Here, Rights Now” and marked the first time that human rights took centre stage at an International AIDS Conference. As a result, there were countless presentations focusing on an issue of HIV and human rights. In this section, we present a sampling of some of the most interesting, timely and innovative topics discussed in Vienna, including a summary of a pre-conference satellite on the criminalization of HIV transmission or exposure, organized by the Canadian HIV/AIDS Legal Network, the Global Network of People Living with HIV (GNP+) and NAM.

The Vienna Declaration: a call for drug policy reform

The Vienna Declaration was launched as the official declaration of AIDS 2010. It was drafted by a team of international experts and initiated by the International AIDS Society, the International Centre for Science in Drug Policy (ICS DP) and the BC Centre for Excellence in HIV/AIDS. In this article, Michaela Montaner describes how the declaration seeks to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies.

The Vienna Declaration, the official declaration of the XVIII International AIDS Conference in Vienna, was released to the public on 26 June 2010; three weeks later, it emerged at the AIDS 2010 opening ceremony with over 10 000 endorsements. It is a scientific statement seeking to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies.¹

The Vienna Declaration calls upon policy-makers to implement evidence-based prevention, treatment and harm reduction programs; recognizes the link between illicit drug policies and HIV transmission; and calls for the decriminalization of drug users. It is modeled after the Durban Declaration, which was issued at the XIII International AIDS Conference in South Africa in 2000.²

Like its predecessor, the Vienna Declaration aims to shed light on a similarly simple fact. Outside of sub-Saharan Africa, 1 in 3 new HIV cases occur in intravenous drug users,³ with areas in Eastern Europe and Central Asia reporting estimates of HIV prevalence as high as 70 percent.⁴

Illicit drug and law enforcement policies that prohibit access to services such as sterile needles and opioid substitution therapy have been proven

to result in behaviours that lead to avoidable HIV and hepatitis C virus transmission.⁵ In order to reduce effectively the harms associated with illicit drug use, these policies must change.

At AIDS 2010, Sandra Roelofs, First Lady of Georgia; George Tsereteli, Georgia's Deputy Chairman of Parliament; and Irakli Giorgobiani, Georgia's Deputy Minister of Labour, Health and Social Affairs, signed the Vienna Declaration. At the time, Ms. Roelofs, the wife of Mikheil Saakashvili, President of Georgia, stated, "Georgia supports evidence-based policy in our efforts to protect community health and safety. Our signatures on the Vienna Declaration reinforce our recognition that harm reduction can provide numerous benefits and highlights the need to design policies that align with emerging science."⁶

This announcement came in the wake of the Canadian government's dismissal of the Vienna Declaration. In a widely-circulated e-mail from Charlene Wiles of the Public Health Agency of Canada to The Canadian Press news agency, she stated that the federal government would not endorse the declaration because it conflicted with existing policies of the current Conservative government:

Given that some of the recommendations outlined in the Vienna Declaration are inconsistent with Canada's National Anti-Drug Strategy and current federal drug policy, Canada will not support the document. ... The government of Canada believes that the best way to address the public health consequences of injection drug use is to prevent people from using illicit drugs in the first place. Treatment services are essential in helping those addicted to drugs to stop.⁷

The Vienna Declaration provides a brief list of evidence-based policy directions that governments must follow should they wish to reduce drug-related harms. The Canadian government's position is therefore worrisome, given that it has chosen to reject science-based approaches in favour of law-and-order measures that have little evidence of effectiveness. For example, the government is proposing mandatory minimum sentences for drug law violations. This policy lacks scientific credibility, particularly when taken alongside existing literature proving that drug law enforcement has the adverse effect of increasing HIV risk behaviours and drug-related violence,⁸ in addition to other social and economic costs.⁹

The Vienna Declaration is intended to facilitate open dialogue

pertaining to evidence-based drug policy reform. A rights-based, public health approach to illicit drug policy is the way forward. As international and interdisciplinary support for the Vienna Declaration continues to grow so too does the demand for policy-makers willing to lead in this regard.

— Michaela Montaner

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¹ The Vienna Declaration is available on-line at: www.viennadeclaration.com. Among the endorsers are world leaders in politics, medicine, science and economics, along with citizens worldwide.

² There, a group of 5000 doctors and scientists endorsed the Durban Declaration, which stated that HIV was the cause of AIDS.

³ D. Wolfe and K. Malinowska-Sempruch, *Illicit drug policies and the global HIV epidemic: Effects of UN and national government approaches*, Open Society Institute, 2004; P. Lurie and E. Drucker, "An opportunity lost: HIV infections associated with lack of a national needle-exchange programme in the USA," *The Lancet* 349, 9052 (1997): pp. 604–608.

⁴ B.M. Mathers et al., "Global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review," *The Lancet* 372, 9651 (2008): pp. 1733–1745.

⁵ UNAIDS, *2008 Report on the global AIDS epidemic*. 2008; T. Rhodes et al. "Explosive spread and high prevalence of HIV infection among injecting drug users in

Togliatti City, Russia," *AIDS* 16, 13 (2002): F25–F31.

⁶ "Three Georgian Leaders Sign Vienna Declaration, Strengthen Call for Science-Based Drug Policy," 22 July 2010, on-line: www.viennadeclaration.com/july-22---georgian-leaders-sign-the-vienna-declaration.html.

⁷ "'War on drugs' fuels HIV epidemic: conference," *The Canadian Press*, 19 July 2010.

⁸ E. Wood et al., "The war on drugs: a devastating public-policy disaster," *The Lancet* 373, 9668 (2009): pp. 989–990; D. Werb et al., *Effect of drug law enforcement on drug related violence: Evidence from a scientific review*, The International Centre for Science in Drug Policy, 2010.

⁹ C. Suddath, "A brief history of the War on Drugs," *Time*, 25 March 2009, on-line: www.time.com/time/world/article/0,8599,1887488,00.html; The United States Office of National Drug Control Policy, *FY 2011 Budget Summary*, 2010, on-line: www.whitehousedrugpolicy.gov/publications/policy/11budget/index.html; United Nations Office on Drugs and Crime, *World Drug Report 2005*, 2005.

HIV/AIDS and drug policy: a new approach for law enforcement

While law enforcement often plays a deleterious role in furthering the spread of HIV/AIDS, there are also opportunities for it to promote health and reduce risky behaviour. The following article by Tom Lloyd summarizes an AIDS 2010 panel discussion, which he moderated, on the steps that law enforcement leadership could take in that regard.

In some parts of the world, law enforcement activity contributes extensively to the spread of HIV/AIDS. For example, officials may harass drug users at treatment clinics and needle exchange points. At the same time, it has become increasingly clear that law enforcement has a crucial role to play in reducing risky behaviour and promoting health.

As concerns about the unintended consequences¹ of the illegal drugs

market have grown, the dominant focus of the reform movement appears to have been on respecting the human rights of drug users and in working to improve their health. Yet, insufficient attention has been paid to engaging positively with law enforcement agents as opposed simply to criticizing and accusing at a distance.

To be sure, there has been progress in this area. The three panel-

lists in the session² identified the development of joint objectives and productive partnerships between law enforcement and harm reduction, education of the police, and the use of discretion in enforcement as key areas for action. They also identified opportunities for change in prison services and urged improvements in monitoring and accountability in order to encourage good practice and reduce harm.

There is a real tension between the demands of the public and governments for police to crack down on drug users and the evidence that shows this is an ineffective, costly and counter-productive approach. Many current enforcement policies are ineffective, even in their own terms, with performance indicators focused on inappropriate process measures such as numbers of arrests and quantities seized. Geoffrey Monaghan mentioned good examples in Australia, the United Kingdom (institutionalized in the multi-disciplinary Drug and Alcohol Action Teams (DAATs)) and various cities in the United States of America and Canada where police activity supports rather than thwarts public health ambitions, while also maintaining public support.

Many police forces around the world hold deeply entrenched views that drug users are enemies of the state, families and themselves, and should be severely punished for their own and others' own good. Aleksandr Zelichenko's work in Kyrgyzstan and elsewhere shows that integrating harm reduction as a compulsory and tested element of officers' training, with non-governmental organizations and users directly involved, is having a positive impact on attitudes and behaviour.

When Datuk Zaman was head of the Malaysian prison service, he saw the reality close at hand and quickly

realized that, as well as being very expensive, many practices were ineffective and wholly inappropriate. Prisoners living with, and at risk of, HIV need education, care and treatment. A prisoner loses their freedom but should not lose their human rights or dignity.

Even though there is still harassment from the police and the anti-drugs agency in Malaysia, law enforcement is beginning to realize that it can play an important role in ensuring that users receive treatment and care, particularly those living with HIV. Indeed, police behaviour in relation to needle exchange and methadone treatment appears to have improved after a drug policy seminar for senior police officers delivered by the Malaysian AIDS Council and the International Drug Policy Consortium in December 2009.

The United Nations Office on Drugs and Crime is encouraging collaborative programmes and publishing relevant guidance, and can make a great contribution in understanding, challenging and exploiting local legal systems in seeking to change behaviour. Using discretion within current systems is also quite possible, as there is very rarely an obligation on police to make arrests, and police forces always have to make choices in managing scarce resources. Law enforcement's role is to serve and protect, not to oppress and abuse.

The story so far has been of a costly and counter-productive failure. There are many police officers who want to do better; this is a great opportunity to work together and tell a better story.

— Tom Lloyd

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¹ Antonio Maria Costa, Executive Director, United Nations Office on Drugs and Crime, address to the 51st Session of the Commission on Narcotic Drugs, Vienna, 10 March 2008, on-line www.unodc.org/unodc/en/about-unodc/speeches/2008-03-10.html.

² "Law Enforcement Leaders for Public Health and Rights." The panellists included: Datuk Zaman, President of the Malaysian AIDS Council and former police chief and head of the country's prison service; Aleksandr Zelichenko, a police colonel from Kyrgyzstan; and Geoffrey Monaghan, a former police officer from the United Kingdom and an HIV/AIDS expert with the United Nations Office on Drugs and Crime.

Policy advocacy for female injecting drug users in Eastern and Central Europe

A key reason for hosting AIDS 2010 in Vienna was to highlight the spread of HIV through injecting drug use, something that has reached crisis proportions in many parts of Eastern Europe and the former Soviet Union. In this article, based on a presentation at the conference, Anna Zakowicz discusses the options for promoting policy advocacy for female injecting drug users (IDUs) in Central and Eastern Europe.

The 1990s marked the beginning of a heroin epidemic in Central and Eastern Europe, which saw a dramatic increase in HIV cases among drug users. Injecting drug use is still the primary cause of new HIV infections in the region, with women comprising between 15 and 30 percent of IDUs.¹ In nine European countries, the average HIV prevalence among IDUs was more than 50 percent higher among women than men.² Injecting is the main route for administering opioid substances,³ and among female drug users with HIV, those facing multiple stigma are sex workers, transgender, prisoners and migrants. What should also be noted is the failure of existing prevention and treatment interventions.⁴

There is relatively little data about female drug use in the region, for reasons that might include obstacles to accessing the services that female drug users need; gender-specific barriers such as housework and child-care responsibilities that impede access to harm reduction and drug treatment services; domestic violence and police abuse;⁵ or even the relatively little focus on female drug users in research. It is hoped that the recent *Asking the Right Questions: Advancing an HIV Research Agenda for Women and Children* consensus statement on a comprehensive

research agenda will enhance clinical and operations research for female drug users in Europe.⁶

What the European Union (EU) aimed to do with its 2005–2012 drug strategy was to base the initiative on the EU's founding values: respect for human dignity, liberty, equality and human rights. The policy also sought to protect and improve the well-being of society and of the individual; to protect public health; to offer a high level of security for the general public; and to take a balanced, integrated approach to the drugs problem.⁷

The EU's 2009–2012 action plan⁸ to implement the strategy is based more on the overarching protection of public health than on the individual and individual choices. The plan focuses on halting initial drug use, preventing experimental use from becoming regular, and early interventions; however, it does not focus on the right of the individual or informed choices for drug users either to stop, enrol into maintenance therapy, or learn how to inject safely. Nevertheless, the focus in the plan is treatment, which is based on programs and rehabilitation. It is also worth noting that the stress is placed on reintegration into society and a reduction of social damage.

At AIDS 2010, the drug user community was hoping for a con-

structive discussion on drug use, HIV prevention and treatment. The Vienna Declaration⁹ was to be one of the tools to foster this dialogue. The document, which stresses the need for policy reorientation on illicit drugs and the criminalization of illicit drug users, was unfortunately not taken up by the EU leaders. Moreover, the member states in Central and Eastern Europe tend toward an approach that often prioritizes criminalizing drugs and the people who use them instead of protecting and promoting health.¹⁰

In terms of proper health care for women, it is necessary to make explicit how their physical, psychosocial and social health should be addressed at every stage of their lives. Generally speaking, health care must be more sensitive to women's specific needs.¹¹

Female drug users are part of the community of women. In order to increase their access to health care, there must be a change in punitive policies and legislation, as well as increased tolerance and less discrimination by police, health-care providers and society as a whole. Socio-economic drivers such as poverty exclusion and sexual violence must be targeted at national and international levels. Finally, there needs to be improved access to female-oriented health services with sound

prevention, screening, treatment and care, and access to motherhood for women who used to have a history of drug use. Political action and political commitment to implement the above is imperative to ensure the protection of the fundamental rights of female drug users.

— Anna Zakowicz

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¹ UNAIDS, *AIDS Epidemic Update*. November 2009, on-line: http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf.

² European Monitoring Centre for Drugs and Drug Addiction, *Annual report 2006: the state of the drugs problem in Europe, 2006*, on-line: <http://ar2006.emcdda.europa.eu/en/home-en.html>.

³ European Monitoring Centre for Drugs and Drug Addiction, *Trends in Injecting Drug Use in Europe, 2010*.

⁴ Ibid.

⁵ Open Society Institute, *Women, Harm Reduction, and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine*. October 2009, on-line: www.aidslex.org/site_documents/DR-0147E.pdf.

⁶ International AIDS Society, *Asking the Right Questions: Advancing an HIV Research Agenda for Women and Children*. March 2010, on-line: www.iasociety.org/Web/Content/File/Consensus_Statement_Asking_the_Right_Question_March_2010.pdf.

⁷ Council of the European Union, *EU Drugs Strategy (2005–2012)*, November 2004, on-line: http://europa.eu/legislation_summaries/justice_freedom_security/combating_drugs/c22569_en.htm.

⁸ Council of the European Union, *EU Drugs Action Plan for 2009–2012*, 2008, on-line: www.emcdda.europa.eu/html.cfm/index66221EN.html.

⁹ On-line: www.viennadeclaration.com/. See also, "The Vienna Declaration: a call for drug policy reform," on page 36.

¹⁰ Eurasian Harm Reduction Network, *Drug Policy Position Paper, 2010*, on-line: www.harm-reduction.org/images/stories/library/drugpolicy_position.pdf.

¹¹ European Communities, *Data and Information on Women's Health in the European Union, 2009*, on-line: http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf.

Criminalization of HIV transmission or exposure: global extent, impact and the way forward

In the following article, Edwin J. Bernard provides a summary of a satellite meeting¹ co-organized by the Canadian HIV/AIDS Legal Network, the Global Network of People Living with HIV (GNP+) and NAM, held just prior to AIDS 2010, in which advocates working to end the criminalization of HIV non-disclosure, exposure and non-intentional transmission shared experiences of national and international advocacy responses to help inform future strategies.

Co-chairs Michaela Clayton of the AIDS and Rights Alliance for Southern Africa (ARASA) and Richard Elliott of the Canadian HIV/AIDS Legal Network introduced the session and the speakers, contextualizing the issue as one that is great cause for concern for HIV and human rights advocates, but one where consensus regarding the risks and benefits of unintended impacts for public health and human rights has not yet

been reached within broader civil society.

In a global overview of criminal laws and prosecutions based on data from the *2010 Global Criminalisation Scan Report*,² Moono Nyambe of GNP+ highlighted that more than 300 of the 600 or more known convictions in over 50 countries took place in the United States, with Canada (63), Sweden (38), Austria (30) and Switzerland (30)

following in terms of conviction numbers. Per capita, Sweden and Norway have convicted the most individuals with HIV using strictly enforced public health-focused legal frameworks.

Although most prosecutions take place under non-specific legislation, 45 countries have introduced HIV-specific criminal laws, including more than 20 African countries, over the past ten years. Johanna Kehler

of the AIDS Legal Network in South Africa argued that advocacy against such laws requires wider civil society awareness of the potential harms of criminalization for women³ in order to build broad anti-criminalization alliances across human rights, women's and HIV/AIDS organizations.

Clayton had previously noted that, although few prosecutions have been reported in Africa, the majority of defendants had been women. When ARASA and the Open Society Initiative for Southern Africa brought civil society together to discuss the issue in greater detail in Johannesburg in 2007,⁴ some supporters of criminalization had what Clayton characterized as a “light-bulb moment” — reversing their positions — once the potential for unintended impacts were explained.

Susan Timberlake, Senior Human Rights and Law Adviser for UNAIDS, highlighted that the organization's anti-criminalization strategy focused on three equally important areas: law reform, law enforcement and access to justice. She noted that working with legislative bodies to remove laws is extremely complex and time-consuming, and requires sophisticated political know-how. Nevertheless, there has been some limited success, notably in Guinea and Sierra Leone, in removing overly broad criminalization clauses from existing legislation as well as at draft stage.

Timberlake noted that a more effective short-term approach would be through engaging with the major actors within the criminal justice system — police, lawyers and judges — to enhance the capacity of the judiciary to limit the overly broad application of the law. She added that no country with laws or prosecu-

tions should be without prosecutorial guidelines and that advocates needed to begin targeting those countries that do not have them.

Lisa Power of Terrence Higgins Trust described the pragmatic response to the use of general assault laws to prosecute HIV transmission in England and Wales, including the creation of prosecutorial⁵ and police⁶ guidance with input from the HIV sector. This has not only clarified the exact circumstances regarding when prosecutions might be warranted and reduced the flow of cases reaching court, but also led to closer relationships between the HIV sector and the criminal justice system, fostering improved advocacy and mutual understanding.

Power suggested a number of steps that advocates could replicate in their own countries, such as monitoring and carefully documenting cases, including abandoned ones; working with academic and criminal lawyers; challenging inaccurate or stigmatizing media coverage; and HIV sector collaboration. One particularly successful example of the latter was when experts in HIV science worked with civil society to highlight the necessity for, and limitations of, scientific evidence⁷ now reflected in prosecutorial guidelines.

Glenn Betteridge of the Ontario Working Group on Criminal Law and HIV Exposure argued that further national and international HIV-sector collaborations were necessary to improve the criminal justice system's engagement with HIV science and reduce potential miscarriages of justice. Specifically, broad consensus on the impact of HIV on quality of life and life expectancy is required in order to contextualize accurately the

“harm” of HIV compared with other sexually transmitted infections or physical assaults.

In addition, a clear consensus regarding the relative risks of HIV transmission, which he said are often “overestimated and poorly understood” in the legal context, would have a positive impact on criminal charges and convictions in cases where the risk was very low or negligible. Such consensus could then be incorporated into science-informed guidelines for police and prosecutors.

The meeting was also an opportunity to debate whether a focus on the negative public health or human rights impact of laws and prosecutions was the way forward. Several speakers highlighted the importance of continued monitoring of the application of criminal laws and to build an evidence base of “injustices” due to poor handling by law enforcement and prosecutors of individual cases.

However, Timberlake stressed that, since this evidence remains largely anecdotal, it is often insufficient to convince public health officials or legislators. She said that they want to see a population-level negative impact on these laws, but that kind of evidence was unavailable. It poses a real problem for advocacy in this area, she concluded.

During the discussion, several audience members debated the focus of research that might best persuade public health officials or legislators to abandon current prosecution policies, and suggested that UNAIDS provide guidance, including information on sources of funding. Further guidance may follow at the conclusion of the ongoing Global Commission on HIV and the Law, convened by United Nations Development Programme

and UNAIDS, which is expected to deliver its report in late 2011.

The author of this article ended the meeting by suggesting a framework for the way forward that would include:

- evidence of laws, prosecutions and their impact;
- engagement of key stakeholders;
- education of those working in and with the criminal justice system;
- empowerment of people living with HIV to protect themselves from the impact of the law, and others from HIV exposure; and

- a concerted international group effort in the form of networking to share advocacy experiences.

— Edwin J. Bernard

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¹ The entire meeting is available to watch on-line at: www.aidslaw.ca/aids2010/#satellite.

² S. Cameron and L. Reynolds, 2010 *Global Criminalisation Scan Report*, GNP+, 2010, on-line: www.gnpplus.net.

³ J. Kehler, M. Clayton, T. Crone, *10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women*. ATHENA Network, 2009, on-line: www.athenanetwork.org.

⁴ AIDS and Rights Alliance of Southern Africa and the Open Society Initiative for Southern Africa. *Report on the ARASA/OSISA Civil Society Consultative Meeting on the Criminalization of the Willful Transmission of HIV*, 2007, on-line: www.aidslex.org/site_documents/CR-0108E.pdf.

⁵ Y. Azad, "Developing guidance for HIV prosecutions: an example of harm reduction?," *HIV/AIDS Policy & Law Review* 13(1) 2008: pp. 13–19.

⁶ Further information, including detailed guidance, is available on-line: www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Police-investigations.aspx.

⁷ E. Bernard et al., *HIV Forensics: the use of phylogenetic analysis as evidence in criminal investigation of HIV transmission*, NAM/NAT, 2007, on-line: www.aidslex.org/site_documents/CR-0037E.pdf.

Criminalization of HIV transmission or exposure in eight Latin American countries

While the prosecution of HIV transmission or exposure has been widely documented in Western Europe and North America, Latin America has not figured in this trend. In this article, based on an oral abstract presentation at AIDS 2010, Tamil Kendall reviews HIV-specific legislation and instances of prosecution in eight countries in the region, and discusses how civil society might respond.

HIV-specific legislation criminalizing HIV transmission or exposure in African countries and the increasing criminal prosecution of people living with HIV/AIDS (PHAs) for transmission or exposure using existing criminal codes in Western Europe and North America generate increasing concern for HIV and human rights advocates.¹ Latin America, however, has been notably

absent from these discussions and debates.

As part of a larger study on prevention of parent-to-child HIV transmission and the sexual and reproductive health needs and rights of female PHAs,² a content analysis of the criminalization of HIV transmission or exposure in national HIV plans, criminal codes and HIV-specific laws or regulations was

undertaken in eight Latin American countries: Bolivia, Colombia, Guatemala, Honduras, Mexico, Nicaragua, Paraguay and Peru.

All the countries have provisions in the criminal code to prosecute transmission of infectious disease, and all except Guatemala and Peru criminalize exposure. Legislation generally specifies that, to be considered criminal, transmission or

exposure must occur with knowledge of disease status and, in most cases, must be intentional (*doloso*). In several instances, presence of a sexually transmitted infection (STI) aggravates sexual assault and increases minimum sentencing.

With the exception of the Mexican state of Guerrero, the criminal codes do not refer specifically to HIV.³ Rather, national HIV laws criminalize HIV by referring to the relevant articles on exposure to or transmission of infectious disease. None of the countries mention mother-to-child HIV transmission; the statutes are sufficiently broad that women could be prosecuted, yet no cases were identified.

As of July 2010, the Global Network of People Living with HIV/AIDS (GNP+) Global Criminalisation Scan did not identify any prosecutions of PHAs in the countries studied,⁴ and the interviews identified only a handful of cases. The fact that those who had been charged, detained pending trial or sentenced were either women or gay men suggests that the selective and discriminatory application of laws that criminalize HIV transmission to socially vulnerable and marginalized groups, documented in Asia and Africa, is also operating in Latin America.⁵

Perhaps because there have been few prosecutions in the region, criminalization was not seen as a high priority by the civil society informants and advocacy has been reactive rather than proactive. One informant, a Mexican PHA, commented: "I am not really sure that [criminalization] is on the agenda. But when we find out there is a proposal, then civil society mobilizes to make sure it doesn't pass."

Reacting has not always been successful. For example, despite significant local and national civil society mobilization, modifications to the criminal code of Chiapas, Mexico — which criminalize exposure to or transmission of "curable" and "incurable" STIs — were passed in September 2009.⁶

Internal civil society divisions exist about how to respond to HIV-specific legislation and regulations criminalizing HIV transmission or exposure. Frequently, national HIV laws bundle crucial rights — e.g., access to antiretroviral treatment and protection from health-care provider discrimination — with criminalization of transmission or exposure, creating ambivalence among activists about advocacy strategies. Further, PHAs and the activist community are struggling to resolve tensions between mutual responsibility for the practice of safer sex and the right to confidentiality of the HIV diagnosis, and the perceived responsibility of PHAs to disclose their HIV status to sexual partners and to practise safer sex.

A significant number of respondents supported criminalization. This consensus from government and civil society was particularly notable in Nicaragua, where the HIV law was under review at the time of research. One female PHA stated, "I believe the law should be reformed [to criminalize transmission] because, if we are demanding rights, we also have to know our responsibilities. My right is to protect myself, and when I have HIV, a condiloma, an STI, my responsibility is also to protect the other person." Another argument made in favour of criminalizing HIV transmission was the putative protection it gives women in cultures marked by gender inequality.

Globally, legislators and, in some instances, the broader women's movement have promoted and justified criminalization of HIV to protect women.⁷ In contrast, female PHAs and feminist HIV activists argue that women are disproportionately harmed by criminalization of HIV transmission or exposure.⁸

In order to limit the application of existing criminal codes to HIV transmission or exposure, respond to worrying trends in obligatory HIV testing of pregnant women, and move towards removing articles that criminalize HIV from existing laws in Latin America, proactive education with legislators and members of the judiciary is necessary before such statutes and cases make their way into the bureaucratic machinery. To do this, regional civil society requires greater awareness of existing legislation and the discriminatory ways it has been applied. Given arguments about HIV criminalization "protecting" women, female leaders with HIV can be particularly effective advocates and should be prioritized for training opportunities.

— Tamil Kendall

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¹ E.J. Bernard, "Where HIV is a crime, not just a virus: a global ranking of prosecutions for HIV non-disclosure, exposure and transmission," paper presented at the XVIII International AIDS Conference, 2010, Vienna, Austria (abstract no. THAF0201); E. Cameron et al., "HIV is a virus, not a crime," *HIV/AIDS Policy & Law Review* 13(2/3) (2008): pp. 64–68; R. Pearshouse, "Legislation contagion: the spread of problematic new HIV laws in Western Africa," *HIV/AIDS Policy & Law Review* 12(2/3) (2007): pp. 1–11; R. Pearshouse, "Legislation contagion: building resistance" *HIV/AIDS Policy & Law Review* 13(2/3) (2008): pp. 1, 3–10.

²The author thanks Eugenia Lopez-Urbe and Gabriela García Patiño for assistance with data collection and content analysis.

³Ricardo Hernández Forcada, "Algunas consideraciones desde los derechos humanos sobre la penalización del peligro de contagio en el marco jurídico vigente," paper

presented at the XI National Conference on HIV/AIDS and other STIs, 2009, Tuxtla Gutiérrez, Chiapas, Mexico.

⁴ www.gnpplus.net/criminalisation

⁵ "HIV is a virus, not a crime" (supra).

⁶ Código Penal para el Estado de Chiapas, Decree 139,

September 23, 2009, Article 444.

⁷ "HIV is a virus, not a crime" (supra).

⁸ ATHENA Network, *10 Reasons Why Criminalization of HIV Transmission or Exposure Harms Women*. 2009, on-line: www.athenanetwork.org/10_reasons.html.

The impact of a state criminal HIV exposure law on residents living with HIV in the USA

The United States of America has, by far, the highest number of cases of and convictions for HIV transmission or exposure in the world. Little is known, however, about the impact of this phenomenon on people living with HIV/AIDS (PHAs). In this article, based on an oral abstract presentation at AIDS 2010, Carol Galletly provides information on research into the impact on PHAs of the HIV exposure law of the state of Michigan.

The criminalization of HIV exposure through consensual sex has long been contested.¹ Application of criminal laws to the consensual sexual activities of PHAs subjects them to state regulation of their most private behaviours. HIV exposure laws offend our sense of fairness; the privacy of PHAs is burdened without a commensurate benefit to society, such as a reduction in new HIV infections. Serious concerns also exist about the inadvertent negative effects of criminalizing HIV exposure, both on PHAs and on HIV prevention efforts.²

Because little empirical research has been conducted to assess the impact of criminalization on PHAs, an empirical study was undertaken

of a HIV exposure law's impact on a state-wide sample of HIV-positive residents of Michigan. The law requires PHAs to disclose their seropositive status to prospective partners prior to engaging in virtually any sexual activity.³

The aim was to examine the most basic questions about the impact of the law. First, were PHAs in Michigan aware of the law? Any effect, positive or negative, would require awareness of the law. Second, did the law appear to be effective in reducing new infections? Did persons who were aware of the law more often report prior seropositive status disclosure to all of their sex partners or sexual abstinence than those who were unaware of the law?

Third, the study explored whether the law had any negative effect on PHAs and whether persons who were aware of the law experienced more HIV-related stigma, perceived more discrimination against PHAs or were more reluctant to disclose their positive serostatus or be known as a PHA than those who were not aware of the law. PHA attitudes toward the law and their perceptions of its effectiveness were also investigated.

A majority of the 384 HIV-positive study participants were aware of Michigan's HIV exposure law. Most had heard about the law from a variety of sources. Many reported learning about the law when they were first diagnosed, as state policy requires.⁴ Persons aware of the law

were not more likely to have disclosed to all of their sex partners or to report being sexually abstinent for the previous 12 months than those who were unaware.

There were, however, findings suggestive of an effect of the law. Persons who believed the law prompted PHAs to disclose were more likely to report they had disclosed to all of their partners. Persons who disclosed to all of their partners were more likely to report the law played an important role in their decision to disclose.

There was no association between participants' awareness of their state's HIV exposure law and perceived discrimination against PHAs, nor were participants who were aware of the law less comfortable with seropositive status disclosure or being known as someone who has HIV. There was, however, an inverse association between awareness of their state law and HIV-related stigma. Persons who were aware of the law experienced significantly less stigma than persons who were not aware of the law.

Virtually all participants agreed that lying about one's positive serostatus or engaging in sexual activity with the intent of infecting a partner should be criminalized. Many participants believed it should be unlawful for a PHA to have unprotected sex with an uninformed partner. Just over half believed hav-

ing protected sex with an uninformed partner should be criminalized, and nearly two thirds believed oral sex with an uninformed partner should be proscribed by law.

Support for criminalization was significantly associated with demographic characteristics of marginalized groups in society such as being female, being an ethnic minority, having less education and having a lower income.

The burden of Michigan's HIV exposure law on PHAs appears not to be balanced by a commensurate benefit to society or to the public's health. Still, more study is needed to understand statistical trends suggestive of an indirect or more limited effect of the law.

The association between heightened HIV-related stigma and ignorance of the law may be indicative of the social isolation of some PHAs. HIV-positive persons who are uninformed about the law may have less contact with other PHAs and their allies, and thus may be less prepared to reject negative beliefs about persons who have HIV.

The criminal law should be a last resort in addressing HIV infection. Prosecuting persons for not disclosing their positive serostatus is costly, time-consuming, achieves little in the way of preventing future infections and does nothing to address the infection of the complaining

witness. Many participants endorsed criminalization in only the most egregious circumstances. However, the much broader endorsement of the use of the criminal law that was seen among participants likely to be most marginalized is very concerning. Recourse through the criminal law after the fact is not a substitute for primary prevention.

— Carol Galletly

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¹ S. Burris et al., "Do criminal laws influence HIV risk behavior? An empirical trial," *Arizona State Law Journal* 39 (2007): pp. 467–519.

² C.L. Galletly and S.D. Pinkerton, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts of control the spread of HIV," *AIDS and Behavior* 10 (2006): pp 451–461.

³ Mich. Comp. Law Serv. § 333.5210.

⁴ C.L. Galletly et al., "HIV-positive persons' awareness and understanding of their state's criminal HIV disclosure law," *AIDS and Behavior*, 13(6) (2009): p. 1262.

Switzerland: exclusion of a healthcare professional because he was HIV-positive

People who live with HIV routinely encounter barriers to occupations in the health care sector. In this article, which is based on a workshop presentation, Caroline Suter discusses a Swiss case in which a young man was denied access to training as an operating room technician (ORT) because he was HIV-positive.

A young man decided to train as an ORT. He applied to the school and passed the admission exam without difficulty. The school sent him a signed training contract and a health questionnaire. The young man was HIV-positive, but in excellent health and, as agreed upon with his doctor, was not yet taking medication. He answered the health questionnaire honestly, stating that he was HIV-positive. In its reply letter, the school terminated the training contract on the basis of the young man's medical condition. The man applied for a judicial review of this decision.

In his judicial review application, the man argued that the training contract was terminated solely because he was HIV-positive and that this reason alone was not sufficient to bar him from the school. He noted that his admission tests showed that he was completely qualified to enter the occupation in question. He also tendered a medical certificate stating that he was in good health and fully capable of working. Lastly, he noted that the risk of HIV transmission from an ORT to a patient had been greatly exaggerated.

The court held that the man had suffered discrimination based on his HIV-positive status. It allowed the man's application based on the federal constitution and on the statute concerning the equality of disabled persons.

In order to facilitate its adjudication, the court ordered an expert opinion about the risk of transmitting HIV as an ORT. The expert essentially found that the residual risk of HIV transmission to a patient is practically zero. The only recorded cases involving doctor-patient transmission involved a dentist in the United States of America and an orthopaedic surgeon in France. These professionals are frequently in close contact with their patients, whereas ORTs are only in indirect contact with patients. ORTs pick up instruments with sterile gloves and give them to surgeons. In theory, an ORT could injure his own hand; however, even if this happened, it is highly unlikely that a patient would be infected as a result, because the injury would be noticed immediately, the instrument replaced and the gloves changed.

Based on the expert's report, the court held that the immediate termination of the contract had no rational basis and was therefore void. Consequently, the young man was able to proceed with his training.

The court properly weighed the tiny residual risk of HIV transmission against the irrational fears of HIV. In its opinion, the young man's exclusion from this occupational training was a serious violation of individual freedom.

Discrimination in the legal sense occurs when a person is treated differently without a reason. This principle is articulated in section 8(2) of the Swiss Constitution. The principle of equality before the law does not require absolute equality of treatment. Rather, it demands that people be treated the same way to the extent that they are the same, and differently to the extent that they are different. In this particular case, the young man was treated unequally because he was just as qualified for his occupation as the other students.

The young man's fitness for work was also comparable to that of the other students because his HIV infection had no effect on his health. Nonetheless, the school excluded him because it did not want to take the risk of a patient getting infected with the virus. And since the residual risk of transmission was close to zero, this ground of exclusion was not admissible. Moreover, the young man's exclusion was disproportionate to the residual risk of HIV transmission, so the school's decision was clearly discriminatory.

This case was an instance in which the disability equality statute was helpful. The statute seeks to prevent, reduce or eliminate the unequal treatment of disabled persons. It establishes minimum standards and protects not only people who are

disabled, but also people who have a socially “imputed” disability and are marginalized on that basis.

People living with HIV regularly confront this “imputed disability” because of the taboo associated with the virus. In this particular

example, the school imputed the disability: it decided that the young man’s HIV posed an unacceptable risk to the hospital before it even examined the actual risk of transmission in such an instance. The young man succeeded

in defending himself against this instance of discrimination.

— *Caroline Suter*

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Using the courts to secure positive law reform for women in Malawi

Women’s inheritance and property rights are essential to an effective response to HIV/AIDS. For women living with HIV, denial of these rights can lead to loss of shelter and livelihood, result in dislocation from their social safety nets and, because of stigma and gender-based discrimination, jeopardize their access to testing, treatment, care and support. In this article, based on a symposium presentation at AIDS 2010, Seodi White discusses efforts in Malawi to challenge the country’s current approach to marital property.

How the property of couples is administered, owned and distributed at the end of a marriage has considerable relevance in the context of HIV/AIDS, especially in Malawi, where women represent almost 60 percent of those over the age of 15 who are infected.¹ Women and Law in Southern Africa Research Trust — Malawi (WLSA-Malawi) is challenging Malawi’s current approach to marital property law before the Constitutional Court of Malawi because this approach discriminates against women.

The legal challenge² is based on Malawi’s Constitution, which prohibits discrimination on the

basis of sex and mandates women’s right to property, specifically upon the end of the marriage. As such, WLSA-Malawi is requesting that the Constitutional Court of Malawi declare Section 17 of the *Married Women’s Property Act*³ invalid or declare that Section 17 be interpreted in a manner that recognizes women’s contributions to marital property and guarantees women receive half the marital assets upon the end of a marriage.

Section 24(1)(b)(i) of the Constitution provides that women are entitled to “a fair disposition of property that is held jointly with a husband” upon the dissolution of

marriage. However, the current interpretation of Section 17 of the *Married Women Property Act* only considers property to be held “jointly” if a direct, financial contribution has been made to its acquisition.

Case law has shown that courts in Malawi do not recognize household and caregiving work that women often perform during marriage as an economic activity that contributes to the acquisition or maintenance of family assets. Consequently, many women retain virtually nothing upon the end of the marriage. This is because property is rarely registered in their name or they cannot prove a

direct, economic contribution to its acquisition or maintenance. The fact of marriage is irrelevant when courts are deciding a spouse's entitlement to property, so husbands can more often claim ownership of the assets that they personally purchased.

The presumption in court is that "an inference of joint ownership of property is not to be made from a mere fact of marriage."⁴ The courts insist on strict proof of ownership for a spouse to be allocated a piece of property. They have relied on Section 17 of the *Married Women's Property Act*, as stated above.⁵ Any spouse wishing to claim a share in an object of property that is not in her or his name must prove that he or she contributed.⁶ The courts have held that the contributions must be financial and that those made toward the maintenance of property items, housekeeping and child-care by spouses are not accepted as sufficient for any proprietary rights,⁷ which disadvantages as well as causes hardship on women, whose contributions in the household are not primarily monetary.⁸

Unequal marital property rights can affect women's economic autonomy, security, dignity and health by reinforcing their dependence on

their husbands. For example, given the linkages between property and a woman's physical security and her capacity to provide for herself, a right to marital property is directly linked to the right to health, which includes the right of every person to control one's health and body. Women with access to resources — including land and property — are better able to negotiate condom-use in their sexual relationships, to provide for their own and their children's needs, and to leave abusive partners.⁹

It is the hope of WLSA-Malawi and its partners that the Constitutional Court will rise to the occasion and use this opportunity to clarify the guarantees that the Constitution of Malawi has in place to protect women's marital property rights. The court can do this by recognizing the household and caregiving work that women often perform during marriage as an important and valuable activity that contributes to the acquisition or maintenance of family assets. Therefore, unless a couple contracts out of this approach, marital property shall be deemed to be owned and controlled equally by parties to the marriage. In short, marital property shall be deemed to be owned equally by the spouses and

that, upon marriage dissolution, each spouse shall receive half its value.

— Seodi White

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¹ Canadian HIV/AIDS Legal Network and WLSA-Malawi, *Malawi's Marital Property Law: Questions & Answers*. May 2010, on-line: www.aidslex.org/site_documents/WG-0138E.pdf.

² Organizations such as the Malawi Human Rights Commission, the Southern African Litigation Centre and the Canadian HIV/AIDS Legal Network are supporting WLSA-Malawi's efforts by outlining the national, regional and international human rights arguments for changing Malawi's current approach to marital property.

³ A statute of the United Kingdom that is still in general application in Malawi. On-line: www.opsi.gov.uk/acts/acts1882/pdf/ukpga_18820075_en.pdf.

⁴ *Nyangulu v. Nyangulu*, 10 Malawi Law Reports 435 per Villiera J.

⁵ *Malenga v. Malenga*, MC no 13 of 2001.

⁶ *Malinki v. Malinki*, 9 MLR 441; *Mtegha v. Mtegha*, MC No. 9 of 1994.

⁷ *Nyangulu v. Nyangulu* (supra).

⁸ S. White et al., *Beyond Inequalities 2005: Women in Malawi*, Southern African Research and Documentation Centre, 2005.

⁹ Canadian HIV/AIDS Legal Network and WLSA-Malawi (supra).

South Africa: Durban's ante-natal clinic environment and its impact on a woman's choice to test for HIV during pregnancy

Informed consent, counselling and confidentiality are key tenets of a human rights approach to HIV testing. In this article, based on an oral poster presentation at AIDS 2010, Allison K. Groves and Cynthia Eyakuze discuss the results of a study on HIV testing of women in ante-natal clinics in Durban, South Africa and how communication about testing may undermine the practice of obtaining informed consent.

In 2007, the United Nations issued new guidance on provider-initiated testing for HIV.¹ A key component of the guidelines is that testing should be conducted within an enabling environment and respect informed consent, counselling and confidentiality. While recognizing the importance of increasing access to testing, human rights advocates have raised concerns that the revised guidelines could disproportionately target women and affect individual autonomy to test.²

As pregnant women are a key target for HIV testing, the Public Health Program of the Open Society Foundations funded a review of testing policies during pregnancy in 2008.³ The following year, it supported case-study research in South Africa, Kenya and Ukraine to learn how such policies were being implemented.

South Africa has a detailed policy on HIV testing of pregnant women,⁴ which was revised after the 2007 UN guidance. The South African policy — one of routine testing — calls for a human rights approach and clearly outlines its commitment to counselling, confidentiality and consent. The policy states consent should be both verbal and written, and obtained fol-

lowing pre-test counselling. This paper describes how communication about HIV testing in ante-natal clinics (ANC) affects a woman's ability to consent to an HIV test

Qualitative research was conducted at two public ANC in Durban by doing 32 semi-structured in-depth interviews with pregnant women who had tested for HIV within the previous three months. Twelve HIV-positive and four HIV-negative women were interviewed at each clinic after obtaining informed consent. The mean age of the participants was 24 years, and it was the first pregnancy for slightly more than half of them.

All of the women were tested for HIV at their very first ANC visit, and two thirds of them recalled hearing during group education at the clinics that they had to be tested for HIV during pregnancy. A 21-year-old HIV-negative woman said, "[The nurse] said that, 'Seeing as you are all sitting here, you are going to get tested. You are going to have your blood drawn from you and tested for HIV.' She'd ask if it's your first time testing or not and you'd have to answer appropriately."

While women later recounted hearing that they did have the right

to refuse testing, the flow of procedures at both clinics made refusal difficult. For example, in one of the clinics, nurses ensured that women went to the group education after ANC by holding on to all maternal health cards and giving them to the HIV counsellors. Since women need this card to navigate the health-care system, they were effectively forced to attend these sessions.

A majority of the women described how the pressure from clinic staff and the messages they heard from them were a major factor in their decision to test. However, almost half of the participants who heard this same message also felt that they had more power in the decision to test for HIV and described testing as a decision they made to protect the health of their unborn babies.

Women who refused to get tested for HIV during pregnancy were not interviewed. When participants were asked if they thought a woman could refuse to get tested during pregnancy, the majority felt that a woman could refuse and that she would not face negative repercussions. In addition, most said they had not heard of negative repercussions for not testing.⁵ However, only one participant actually knew of a woman who refused

to be tested: a neighbour who had stopped attending ANC because she did not know how to refuse to be tested for HIV.

The way in which HIV testing is presented to pregnant women at these two clinics undermines the practice of obtaining informed consent. Although all of the women interviewed described either providing written or verbal consent to test, the clinics were structured such that refusal was difficult, if not impossible. This is reflected in the fact that all women were tested the very first day they sought ANC, the fact that many of them described different ways in which the staff pressured them to test, and the fact that only one woman had ever heard of someone who had refused to test for HIV during pregnancy.

In settings where provider-initiated or routine testing in ANC is standard

practice, there appears to be a need for additional guidance on ways to protect autonomy beyond the consent form to ensure that women have the option to refuse — or defer — testing. Ensuring consent and patient autonomy may positively affect future health-care-seeking behaviour.

— Allison K. Groves and
Cynthia Eyakuze

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Nkosi and Dhayendre Moodley (Nelson Mandela School of Medicine, University of KwaZulu-Natal, Department of Obstetrics and Gynaecology).

¹ UNAIDS/World Health Organization, *Guidance on provider-initiated HIV testing and counselling in health facilities*, 2007.

² J. Csete et al., "'Opt-out' testing for HIV in Africa: A caution," *The Lancet* 363(9407) (2004): pp. 493–494; I. Stuart Rennie, F. Behets, "Desperately seeking targets: The ethics of routine HIV testing in low-income countries," *Bulletin of the World Health Organization* 84(1) (2006): pp. 52–57; S.A. Gruskin, L. Ferguson, "Provider-initiated HIV testing and counselling in health facilities — what does this mean for the health and human rights of pregnant women?," *Developing World Bioethics* 8(1) (2008): pp. 23–32.

³ S. Maman, A. Groves, E. King, M. Pierce, S. Wyckoff, *HIV testing during pregnancy: a literature and policy review*, Open Society Institute, 2008.

⁴ South African National Department of Health, *Protocol for providing a comprehensive package of care for the prevention of mother to child transmission of HIV (PMTCT) in South Africa*, 2008.

⁵ Several stories of negative repercussions were described by women in a separate narrative collection exercise undertaken by women's groups in three regions in South Africa to complement the case studies.

Namibia: litigating the cases of sterilization without informed consent of HIV-positive women

Reports of the forced sterilization of pregnant HIV-positive women first surfaced in 2008. In this article, which is based on an oral abstract presentation at AIDS 2010, Linda Dumba outlines the litigation work that her organization, the Legal Assistance Centre, has done on behalf of 16 HIV-positive women sterilized without their informed consent.

In February 2008, media reports¹ in Namibia indicated that HIV-positive women who had been seeking assistance with the delivery of their babies

were sterilized without their informed consent at state health facilities. The extent of this human rights issue is yet to be discovered.

The Legal Assistance Centre (LAC) is presently litigating against the Namibian government on behalf of 16 HIV-positive women who

were sterilized without informed consent. This is a violation of their rights to found a family and to equality and non-discrimination, which are guaranteed under the Namibian Constitution² and existing regional agreements such as the Protocol to the *African Charter on Human and People's Rights* on the Rights of Women in Africa³ and international human rights instruments such as the Convention on the Elimination of All Forms of Discrimination against Women,⁴ which Namibia has ratified.

The women claim that they were sterilized without their informed consent and discriminated against due to their HIV-positive status. Each is seeking 1.2 million Namibian dollars (approximately CAN\$174 280) in damages as compensation from the government. For its part, the government counters that the women requested the sterilizations and consented thereto in writing, and that, therefore, their claims should be dismissed with costs.

In order to ensure that the violations to the rights of these women were properly redressed, the LAC initiated litigation

- because there is a reasonable chance of success of implementation any decision that the court will make;
- to hold the Namibian government accountable for its actions;
- to put an end to the sterilization of HIV-positive women without their informed consent; and

- to compensate the women for the wrongs that they suffered.

Three of the 16 cases were heard from 1 to 3 June 2010, and continued in early September 2010. In June, two of the three women testified that they were forced to sign consents for sterilization due to their HIV status. In September, the third woman testified that she had been asked to sign a consent form without any explanation as to the nature of both the caesarean section and the sterilization that she underwent. The LAC called an expert gynaecologist to the stand to provide evidence on the nature of consent required for surgical procedures such as sterilization and whether sterilizations are reversible. Subsequently, the government was to lead with its evidence.

Despite these efforts, litigation as an advocacy tool must be accompanied by other methods for it to bring about any social change. Therefore, the LAC intends to provide input on the reproductive health policy⁵ currently being reviewed by the government; lobby the government to reform the current sterilization law;⁶ undertake a research project to document the extent of the issue in Namibia; and conduct legal education workshops to raise awareness on the outcome of the court's eventual decision in order to empower women on their rights and on how to assert them.

Irrespective of whether or not the women's claims are successful, the

court is expected to rule on the rights implicated in these cases. A very important precedent will be established on the principle and standard of informed consent, and what it means to give informed consent for a medical procedure in Namibia. This will be a crucial contribution to the emerging constitutional and human rights jurisprudence in the country.

— Linda Dumba

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¹ W.Tjaronda, "Forcible sterilisation rouses interest," *New Era*, 20 February 2008, on-line: www.newera.com.na/article.php?db=oldarchive&articleid=19535.

² Articles 10 and 14 of the *Constitution of the Republic of Namibia*, on-line: www.orusovo.com/namcon/.

³ Specifically, Article 14 on Health and Reproductive Rights, on-line: www.africa-union.org/root/au/Documents/Treaties/Text/Protocol%20on%20the%20Rights%20of%20Women.pdf.

⁴ Article 12(1), on-line: www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12.

⁵ *National Policy for Reproductive Health*, 2001, on-line: www.youth-policy.com/Policies/Namibia%20National%20Policy%20for%20Reproductive%20Health.pdf.

⁶ *The Abortion and Sterilization Act*, 1975, on-line: www.namchild.gov.na/library.php?po=427.

Integrating sexual and reproductive health and rights and HIV/AIDS in South Africa

The topic of integrating sexual and reproductive health and rights (SRHR) and HIV/AIDS received substantial attention at AIDS 2010. Establishing linkages between the two plays a crucial role in efforts to achieve universal access to HIV prevention, treatment, care and support. In this article, based on a presentation at AIDS 2010, Marieta de Vos discusses what has been done to bring together SRHR and HIV/AIDS in South Africa.

In South Africa, as in most countries where HIV/AIDS has been a huge health crisis over the last decades and where it has been addressed vertically, the need for integration of HIV/AIDS services with related services is finally becoming part of policy discussions. The process of integrating SRHR and HIV/AIDS in South Africa is slow and complicated because integration efforts are not only a health function but also fall under the realms of social services, justice, human rights and education, among other jurisdictions. Departments tend to focus on their line functions and generally find it difficult to link SRHR and HIV/AIDS with their own programs.

In 2007, the Mosaic Training, Service and Healing Centre for Women initiated an UNGASS¹ Forum with the aim of contributing to South Africa's bi-annual UNGASS reports. The gathering, consisting of over 40 women's organizations, focused on the linkages between and integration of SRHR and HIV/AIDS at policy-making and service-delivery levels. Meeting a number of times over the past three years, the forum made recommendations to address the gaps and challenges of integration efforts in South Africa. This initiative formed part of a collaborative effort of 16 non-governmental organiza-

tions (NGOs) from 12 countries led by Gestos in Brazil that intended to nurture community-based research and advocacy for monitoring public policies on women's SRHR and HIV/AIDS.

In 2009 and 2010, the forum gathered information on the issues, resulting in a civil society report that tracked the progress made towards achieving the UNGASS HIV/AIDS indicators that relate to the SRHR of women and girls. It focused on three main elements: sexuality education, including information, education and communication programs; sexual and reproductive health and rights services; and violence against women. The report gives qualitative accounts of the experiences of women and girls, and goes beyond official statistics provided in the government report.

The executive summary of the report, which was submitted to the South African National AIDS Council (SANAC) under the banner of the Women's Sector, was annexed to South Africa's 2010 UNGASS Report,² giving credence to the importance of integration between SRHR and HIV/AIDS. Below are some of the key policy recommendations of the report for South Africa:

- Develop an overarching SRHR policy that integrates HIV/AIDS

into SRHR programs and, conversely, SRHR into HIV/AIDS programs.

- The Domestic Violence Act, No. 116 of 1998 needs to address adequately issues of HIV/AIDS and SRHR of women experiencing intimate partner violence, and an overarching policy framework with implementation guidelines for this Act is needed.
- Update contraception and termination of pregnancy policies with a view to providing comprehensive SRHR services and choice to women living with HIV/AIDS.
- Finalize the integration of cervical cancer into the HIV policy and make the human papillomavirus (HPV) vaccine available to women and girls in the public sector.
- Finalize the delayed National Policy Framework of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, No 32 of 2007 in order to ensure adequate protection for victims of sexual violence.
- Decriminalize sex work in order to protect the health of sex workers and of the public that uses their services.
- Update antiretroviral therapy guidelines to cover relevant

SRHR issues beyond treatment specifications.

At the structural level, the UNGASS Forum recommended the development of a unified monitoring and evaluation framework that is informed by human rights; that takes SRHR and quality-of-care issues into consideration more effectively; and that allows for collection of disaggregated data on SRHR and HIV/AIDS at national, provincial and local levels. The scaling-up of technical skills in government departments and NGOs to implement the Maputo Plan of Action, which aims to provide universal access to SRHR for all citizens, is paramount. Linked to this is the training of nursing, medical and community health workers to integrate SRHR and HIV/AIDS care, as well as screening, counselling and referral of women experiencing domestic and sexual violence. Other

recommendations regarding services included:

- improved access to services for under-serviced vulnerable groups such as lesbian, gay, bisexual, transgender, and intersex (LGBTI) people, sex workers, and women with disabilities;
- funding research on the epidemic among women who have sex with women, LGBTI groups and other minority groups, such as refugee women;
- development of a large-scale program that works with traditional leaders and communities to interrogate resolutely cultural norms and traditional practices in as far as they increase the vulnerability of women and girls to HIV and other SRHR abuses; and
- to make the female condom available on a large scale throughout South Africa.

The process of gathering information for the report was a difficult but rewarding one. Four advocacy alerts have been circulated since then and more joint advocacy work is envisaged. There is much work to be done to bring the SRHR and HIV/AIDS organizations in South Africa closer together, but it is essential to continue the pressure for integration at policy, structural and implementation levels.

— Marieta de Vos

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Health consequences of pre-trial detention in Zambian prisons

High rates of pre-trial detention and extreme prison overcrowding are closely linked to poor health — and particularly to HIV and tuberculosis transmission and treatment — in prisons in sub-Saharan Africa. In this article, based on a presentation made at an AIDS 2010 satellite, Katherine Todrys describes the intersection of pre-trial detention and health in Zambian prisons.

Research in sub-Saharan African prisons on transmission and treatment of HIV and tuberculosis (TB)

has been minimal, despite the high prevalence of both diseases and overcrowded conditions conducive

to their spread. To assess medical care available to prisoners, and human rights abuses that contribute

to poor health, the Prisons Care and Counselling Association, the AIDS and Rights Alliance for Southern Africa and Human Rights Watch visited six prisons in the central corridor of Zambia between September 2009 and February 2010. Researchers interviewed 246 current prisoners, 30 prison officers and 46 non-governmental organization (NGO), donor and government representatives. More detailed results are published elsewhere.¹

Overcrowding and extended pre-trial detention

Built to accommodate 5500 prisoners, Zambia's prisons housed 15 300 in 2009. Overcrowding is so severe that inmates at some facilities are forced to sleep seated, or in shifts, in cells with little ventilation. Convicted and pre-trial ("remanded") detainees are routinely mixed. Such overcrowded conditions exacerbate inadequate sanitation, nutrition and health care, and contribute to the spread of infectious disease. They also violate international standards.²

Extended pre-trial detention in violation of Zambia's international human rights obligations³ is a major contributing factor in the overcrowding. Pre-trial detainees constitute over one third of the total prison population. Despite a Zambian law requirement that inmates be brought before a judge or magistrate within 24 hours of arrest,⁴ one inmate reported being detained for over three years before an initial appearance before a judge. Even after an initial appearance, remandees are routinely held for years before trial. Another prisoner, now convicted, reported being held 10 years in pre-trial detention.

There is insufficient use of non-custodial pre-trial alternatives. Inmates reported being unaware of the right to request bail. Even when bail had been offered, inmates frequently reported being unable to afford its terms. Inmates had low levels of knowledge of their right to a lawyer and low levels of representation.

Health consequences

In October 2009, the Zambia Prisons Service employed only 14 health staff — including one physician — to serve 15 300 prisoners. Of Zambia's 86 prisons, only 15 had a health clinic, many with little capacity beyond distributing paracetamol.

For prisoners at those prisons without a clinic — and for prisoners with more serious medical conditions at those with a clinic — access to care is controlled by medically unqualified and untrained prison officers who decide who is, and who is not, allowed medical attention. This presents particular problems for remandees because of a dispute between the Prisons and Police Services over responsibility for remandee medical care. As a result, pre-trial detainees frequently are not allowed to leave the prison confines to seek medical care, and may wait weeks or months after falling ill before being allowed to access care.

HIV prevalence in Zambian prisons was last measured at 27 percent.⁵ In recent years, the prisons have begun to expand HIV testing with the assistance of an NGO. However, access is uneven: convicted prisoners at all prisons visited were more likely than remandees to have been tested. Sixty-five percent of convicts interviewed at all six prisons had been tested for HIV, compared with 46 percent of remandees.

TB is also a major threat. The Zambia Prisons Service has reported a case infection rate for TB of 5185 cases per 100 000 inmates per year.⁶ However, as with HIV, remandees are less likely than their convicted counterparts to be tested for TB: 28 percent of convicted prisoners interviewed at all six prisons had been tested for TB, compared with 12 percent of remandees. Lower rates of HIV and TB testing among pre-trial detainees may be attributed, at least in part, to the heightened barriers faced by remandees in accessing medical care outside of the prison confines.

Conclusion

Prisoner overcrowding — and its health consequences — are inextricably linked to failings in the criminal justice system that engage the responsibility of the Zambian judiciary, police, immigration and prison authorities. Immediately scaling up prison-based health services and ensuring linkages to existing care in the general population are crucial to improving health. However, attention to human rights and improvement in the conditions that lead to overcrowding through criminal justice system reforms are also essential to public health objectives.

— Katherine Todrys

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² *United Nations Standard Minimum Rules for the Treatment of Prisoners*, adopted by the First United Nations

Congress on the Prevention of Crime and the Treatment of Offenders, Geneva, 1955, paras. 9–19.

³ *International Covenant on Civil and Political Rights*, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), arts. 9, 14.

⁴ *Criminal Procedure Code Act*, Laws of Zambia 7, 1996, c.

88, para. 33(1).

⁵ O.O. Simooya et al., "Behind walls: a study of HIV risk behaviors and seroprevalence in prisons in Zambia," *AIDS* 15 (2001): pp. 1741–1744.

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Emerging human rights issues in China's response to HIV/AIDS

There was a visible presence for China during AIDS 2010, which included a delegation of non-governmental organizations (NGOs) from the country. Chinese officials also presented on the government's work on HIV/AIDS, which elicited critical feedback from activists. In this article, conference attendees Sara L. M. Davis and Li Dan outline the main human rights issues in China's response to HIV/AIDS.

On 5 July 2010, less than two weeks prior to AIDS 2010, China convened the Red Ribbon Forum, a meeting of government officials, NGOs and experts to discuss HIV/AIDS and human rights. The gathering was the first in China to bring NGOs and officials together to discuss human rights.¹ The key issues addressed during the meeting are varied and form the basis of any discussion on the human rights challenges related to HIV/AIDS in the country.

The HIV blood disaster

In the 1990s, hundreds of thousands of farmers in central provinces such as Henan were infected with HIV through an unsafe blood collection program and subsequent hospital transfusions of contaminated blood.² The disaster attracted international

attention.³ Because hospitals never informed those who received contaminated transfusions of the risk of HIV transmission, some received inappropriate treatment for opportunistic infections and died as a result. China has yet to create any system to compensate victims or to hold health officials accountable. Local courts refuse to accept HIV-related lawsuits and local activists have been detained.

In December 2009, China's leading AIDS whistle-blower, Dr. Gao Yaojie, relocated to the United States of America, expressing concerns for her safety. She was followed in May 2010 by well-known HIV activist Wan Yanhai.⁴ In August 2010, just weeks after the Red Ribbon Forum, activist Tian Xi was detained after continuing protests on behalf of him-

self and others infected with contaminated blood.⁵

Discrimination

A 2009 UNAIDS report found that 42 percent of Chinese people living with HIV/AIDS (PHAs) experience stigma.⁶ While Chinese policies discourage discrimination, there is no national law that either clearly defines the term or prohibits discrimination. Chinese NGOs have reported that PHAs who require surgery may be tested without their consent and then refused care.⁷ PHAs also report that schools refuse to accept children whose parents are living with HIV/AIDS.⁸ In August 2010, an Anhui man sued the Education Bureau in the country's first AIDS-related occupational discrimination suit.⁹

Criminalization

China has made impressive strides in providing methadone and needle exchange for drug users in a growing number of regions. However, both sex work and drug use are criminalized in China. Drug users may be stopped by police and forced to undergo urine-testing at any time, and can be imprisoned for up to six years in abusive forced detoxification centres.¹⁰ Identity card records identify former detoxification centre detainees, affecting their ability to find employment and housing. Sex workers can be sent to similar facilities during periodic “Strike Hard” anti-crime sweeps and may have their occupations exposed to the public through media coverage during such sweeps.

Testing

The government and international donors have actively promoted HIV testing among vulnerable communities. Yet, while China provides free AIDS treatment, many people are reluctant to take the test. AIDS activists say that testing centres fail to protect patient confidentiality. As a result, a positive test can be profoundly destructive to a person’s ability to live with her family, work, rent an apartment or educate her children.¹¹ PHAs also report hospitals testing people without their consent. Forced detoxification centres also test detainees without consent and without informing them of their status.¹² These issues surrounding confidenci-

ality, consent and discrimination must be addressed if more people are to come forward to be tested.

International funding

Grassroots groups of PHAs and affected communities have also reported barriers to fundraising. Some NGOs allege that funds from the Global Fund are distributed through local government agencies that skim off a large percentage for themselves, or register “fake” NGOs to access funds.¹³ New restrictions on foreign wire transfers make it harder for independent NGOs to raise funds overseas.¹⁴

These issues are serious, but the rapid evolution of China’s AIDS policies in the past ten years gives some hope. In his opening speech at the Red Ribbon Forum, Mark Heywood, chair of the UNAIDS Theme Group on HIV/AIDS and Human Rights, called on authorities to work closely with civil society.¹⁵ Through collaboration, government and NGOs can find workable solutions.

— Sara L.M. Davis and Li Dan

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Europe: securing legal protection against expulsion for HIV-positive migrants

International human rights and refugee law prohibits deportations to a state where the deportee would be at risk of being subjected to torture or other cruel, inhuman, or degrading treatment or punishment. In the case of Europe, case law is inconsistent in regard to HIV-positive migrants. In this article, based on a presentation at AIDS 2010, Caroline Izambert discusses recent case law from the European Court of Human Rights (ECHR) concerning migrants affected by HIV and how legal protection against the deportation of others can be ensured.

Article 3 of the European Convention on Human Rights prohibits “inhuman or degrading treatment or punishment.” On 27 May 2008, the ECHR held that it was not a violation of Article 3 for the United Kingdom to expel a 34 year-old HIV-positive woman to Uganda. The judgment sets a precedent with respect to the removal of people with HIV and, more broadly, with respect to foreign nationals with serious illnesses in the Convention’s 42 signatory states.

AIDS advocacy groups have argued that HIV-positive migrants should not be removed to countries that do not ensure access to treatment, because this would turn an administrative measure into a death sentence. The court’s decision conflicts with that position. However, it must be put in perspective, because it is largely based on a misunderstanding of migrants’ motivations.

What was the court’s reasoning? It is clear that the court declined to endorse a principle that foreign nationals are entitled to remain in a country to obtain medical services. Yet, the court previously held that there are “very exceptional circumstances” in which the removal of a sick person would have to be stayed

under Article 3. Indeed, in 1997, the court held that the expulsion, from the U.K. to St. Kitts, of Mr. D, who was suffering from an advanced stage of AIDS, constituted “inhuman or degrading treatment.”

Why were Ms. N’s circumstances not found to be exceptional as well? Did the court find that, unlike Mr. D, Ms. N would have access to treatment upon returning to her country? The answer is no. Based on data from UNAIDS, the court admitted that Ms. N would most likely not get access to treatment in Uganda and that, without such treatment, she would suffer an early death. So, the court seems to have reversed its previous stance based on financial considerations. In the judges’ opinion, deciding in Ms. N’s favour would “place too great a burden on Contracting States” because too many people with HIV would then come to Europe for treatment, at a cost that would destabilize European countries’ social security regimes.

This assertion is based on the idea that many people would wish to migrate to northern states for treatment if they could. But there is a wealth of statistics showing that medical immigration is a marginal

phenomenon, at least among people of modest means.

According to a 2008 Doctors of the World survey of more than 1,000 undocumented migrants in Europe, only 6 percent cited health as a reason for migrating.¹ A 2002 study, conducted in 22 hospitals,² found that only 9 percent of people with HIV had been tested in their country of origin. In 2007, the Comité médical pour les exilés, which provides care to nearly 5000 patients in France each year, estimated that 6 to 9 percent of patients with HIV or Hepatitis B or C had been tested in their country of origin.³ It is difficult to see how medical treatment can motivate a person to migrate when the person is unaware of his condition.

France’s experience shows that the ECHR judges are wrong when they assert that host countries’ health-care systems and finances are destabilized when foreigners with medical conditions are protected against administrative expulsion and given access to care. Since 1998, persons with serious illnesses, who cannot obtain treatment in their country of origin, have been exempt from expulsion and entitled to French residency.⁴

The legislation that made this possible was obtained through the

advocacy of a coalition of patients' and immigrants' associations called the Observatoire du droit à la santé des étrangers.⁵ According to the latest statistics (2005) from France's interior ministry, 18 600 foreigners — less than 0.6 percent of the 3.5 million aliens living in France — had residency on medical grounds.

The ECHR lays down minimum standards, but each state can implement legislation that provides greater protection, and the French experience proves that legislation that respects human rights does not spur massive migrations of the sick. Consequently,

the ECHR's decision should not be an obstacle in the fight to secure the right to reside in countries where access to treatment is assured.

— Caroline Izambert

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New ILO standard on HIV rejects discrimination against HIV-positive workers

2010 saw a significant development in advocating for enhanced rights protection of HIV-positive workers: the adoption of an International Labour Organisation (ILO) recommendation on HIV/AIDS in the employment sphere. In this article, based on a presentation made at AIDS 2010, Ronald Brands outlines the key components of the document and how it seeks to protect employees and job-seekers from discrimination on the grounds of real or perceived HIV status.

In June 2010, governments, employers and workers adopted the ILO's *Recommendation concerning HIV and AIDS and the World of Work* at the 99th International Labour Conference in Geneva.¹ It is the first international human rights instrument to focus specifically on the HIV pandemic as a workplace

issue and marks a new milestone in the international response to the pandemic. It calls on the world of work to play a significant role in preventing HIV transmission, protecting human rights and mitigating the impact of the disease at work, on local communities and in national economies.

Among its provisions, the new ILO instrument stresses that measures to address HIV and AIDS in the workplace should be part of national development policies and programs.² In adopting the HIV and AIDS recommendation by an overwhelming majority vote, all governments as well as employers'

and workers' organizations around the globe have committed themselves to greater collaboration in scaling up and harmonizing the global HIV response, and have given the international community an invaluable tool to assist them in achieving this goal.

The recommendation provides guidance on actions to be taken at the global, regional and national levels, as well as in the private sector, and paves the way for innovative partnerships and synergies, including among, crucially, representatives of networks of people living with HIV/AIDS (PHAs). The ILO standard states that workers, their families and their dependents should enjoy protection of their right to privacy, including confidentiality related to HIV/AIDS, and that no worker should be required to undertake an HIV test or disclose his or her HIV status. The workplace is expected to facilitate access by workers, their families and dependents to prevention, treatment, care and support. In addition, the standard rejects discrimination against all workers and accords fundamental priority to preventing all modes of HIV transmission.

The recommendation calls for member states to develop national HIV workplace policies and programs through an inclusive dialogue process involving governments, organizations of employers and workers, as well as organizations representing PHAs. These policies can be implemented

at individual workplaces as part of a national workplace plan or strategy and are of critical importance to engaging with all workplaces actors.

In addition to the development of national HIV workplace policies and programs of action, the provisions may also be implemented through national laws and regulations, collective agreements and sectoral strategies, particularly in places where persons are considered to be at most risk, such as in the sex work industry.

Under the ILO Constitution, all member states are required to report within one year to the ILO on the steps taken to implement the recommendation. The ILO governing body may then decide to request regular follow-up reports from member states at a later date.

In support of the new standard, the ILO's annual conference adopted a resolution³ inviting the agency's governing body to allocate greater resources to promoting it. It also asked that a global plan of action be established to achieve widespread implementation of the standard, including regular reporting from ILO member states on their actions.

The Recommendation concerning HIV and AIDS and the World of Work will greatly improve the position of PHAs during job selection procedures as well as with employment contracts. The new ILO working conditions are a milestone in the world of work and HIV. It is hoped that networks representing PHAs around

the world will be active in their home countries and hold their national governments as well as employers' and workers' organizations accountable for their actions in the world of work and HIV/AIDS.

— Ronald Brands

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¹ On-line: www.ilo.org/aids/lang--en/docName--WCMS_142706/index.htm.

² Although an ILO Recommendation, unlike a Convention, does not require ratification, it must be communicated to national parliaments for discussion of how it might be implemented through domestic policies and legislation.

³ *Resolution concerning the promotion and the implementation of the Recommendation on HIV and AIDS and the world of work, 2010*, on-line: www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_143164.pdf#page=1.

Zambian court issues groundbreaking decision concerning HIV testing without informed consent

HIV testing is a critical component in the response to HIV. Human rights law requires that it include informed consent, pre- and post-test counselling, and guaranteed confidentiality of test results. In this article, based on her presentation at AIDS 2010, Priti Patel discusses a precedent-setting case in Zambia in which two former members of the Zambian Air Force were subjected to HIV testing without their consent.

In 2007, Stanley Kingaipe and Charles Chookole, two former employees of the Zambian Air Force (ZAF), instituted suit in the Livingstone High Court for being subjected to HIV testing without their consent, placed on antiretroviral drugs without their knowledge and being dismissed due solely to their HIV status. Kingaipe and Chookole alleged violations to their rights under the Zambian Constitution to liberty and security of person; to be free from inhuman and degrading treatment; to equal protection of the law; and to be free from discrimination. They were represented by the Legal Resources Foundation — Zambia.

According to Kingaipe and Chookole, they went for their annual medical exam in 2001. For the first time they were asked to give a blood sample. They were not informed for what purpose their blood was being taken. Following the medical exam, they were called back to the medical office where they were given a set of medication, the nature of which was not disclosed to them. They were dismissed in October 2002, ostensibly on medical grounds, despite not having taken any sick leave during the previous year and, in the case of

Chookole, having received a promotion. Both were in non-combatant positions at the time of dismissal. At the trial, an independent medical expert who had examined the two men testified to their current good health.

In their submissions, ZAF denied having tested Kingaipe and Chookole for HIV. It further denied being aware of their HIV status when dismissing them from employment. However, at trial, the ZAF medical doctor conceded that he did indeed subject all “ill employees” to a mandatory HIV test, but claimed that they all received pre- and post-test counselling as well as counselling regarding antiretroviral treatment.

This was the first case in Zambia to raise a constitutional challenge to mandatory HIV testing and dismissal due to HIV status. The Livingstone High Court issued its decision in May 2010, holding that Kingaipe and Chookole were subjected to HIV testing without their consent in violation of their rights to privacy and to be free from cruel, inhuman and degrading treatment, under the Zambian Constitution.¹

In reaching its decision, the High Court relied on comparative case law from, among others, South Africa and

New Zealand, as well as Zambia’s regional and international treaty obligations. The High Court also held that there was insufficient evidence to prove the two former employees were dismissed solely due to their HIV status and thus failed to reach the legal issue of whether a dismissal due solely to an employee’s HIV status would violate the Constitution. Neither party has appealed the decision.

Given the groundbreaking nature of the case, a number of civil society organizations — including Zambian People Living with HIV (NZP+), Zambia AIDS Law Research and Advocacy Network (ZARAN) and the Southern Africa Litigation Centre (SALC) — supported Kingaipe and Chookole’s legal efforts by organizing marches, conducting media advocacy, blogging updates from the trial, ensuring supporters were present at the trial (including representatives from the Law Association of Zambia), and generally increasing awareness among the broader public of the issues raised in the case. These advocacy strategies — aimed at both the court and the public — were successful in making the High Court aware of the unprecedented nature of the case and in raising the issue of

HIV discrimination and mandatory HIV testing among the broader Zambian public.

However, the organized marches and the broad media campaign were met with disapproval by the High Court, which went as far as stopping the marches and calling on activists to appear in non-slogan t-shirts to trial. Despite the High Court's disapproval, the marches raised awareness of the case and increased solidarity among activists.

The High Court's decision is expected to have far-reaching implications. The latest Zambian Military

HIV policy issued in 2008 prohibits the dismissal of any employee on the basis of the individual's HIV status.

However, the policy does provide for mandatory HIV testing for all prospective employees and denies employment to anyone found to be HIV-positive.²

Despite efforts by a coalition of partners including ZARAN, SALC and the Treatment Action Literacy Campaign, the pre-employment testing policy remains in place. In light of the High Court ruling in *Kingaipe v Attorney General* regarding mandatory HIV testing in the military, it

may be possible to challenge the constitutionality of this policy.

— Priti Patel

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¹ *Kingaipe et al v Attorney General* (27 May 2010), Livingstone 2009/HL/86 (Livingstone High Court), online: www.southernafricalitigationcentre.org/library/item/kingaipe_et_al_v_attorney_general.

² Section 6.1(d) of the Zambia Defence Force, HIV and AIDS Policy (January 2008) (on file with author).

Vulnerabilities and rights of migrant sex workers in Europe

In recent years, Europe has witnessed a rise in the number of migrant sex workers, in part because of increased mobility for citizens of European Union member states. However, migrant sex workers find themselves in a highly vulnerable position in regard to having their rights respected and accessing HIV prevention services. In this article, based on a presentation at AIDS 2010, Licia Brussa and Veronica Munk outline the current situation of migrant sex workers in Europe and the steps that need to be taken to ensure that their rights are respected.

Legislation, policies and practices regarding sex work are increasingly more repressive and punitive across Europe. Instead of laws that empower, support the independence and autonomy of sex workers, and improve their working and living conditions, measures are being implemented that undermine their dignity

and self-determination, and violate their human rights.

For migrant sex workers, the situation is even worse. A dominant discourse conflating sex work and trafficking is being used to justify restrictive regulations on migration and prostitution. Within this context, migrant sex workers are seen as vic-

tims without agency and find their rights constantly violated.

Statistics bear out an increase in migrant sex work in Europe. The European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers (TAMPEP) has documented that approximately 70 percent of those

working in the West European sex industry are migrants, with 65 different countries of origin, and that about 65 percent are non-European Union citizens.¹ Clients have also become more mobile, as there has been an increase in sex work venues in the border areas of new EU countries.

Against this backdrop, migrant sex workers find themselves highly vulnerable. They experience a disproportionate level of violence and abuse, which can be distinguished by institutional pressures (e.g., the police), as well as those related to exploitative and unsafe working conditions (e.g., pimps and clients). Struggling in a dependent working situation exacerbates this situation, as those who are able to work for themselves are more likely to be able to insist on condom use or refuse abusive clients. For many, their inability to communicate well in the local language furthers their isolation and exposure to abuse.

The weak legal position of migrant sex workers increases this vulnerability. Repressive policy and law enforcement continue to make their situation more uncertain. Consequently, the level of fear among migrant sex workers has risen and they have increasingly become the victims of exploitation by managers and of crimes of theft, extortion and violence as the perpetrators correctly assume that they will not report such abuses to the authorities. Many migrant sex workers also lack confidence that those authorities would treat them fairly.

Efforts to provide effective HIV prevention services for migrant sex workers face serious obstacles in light of these realities. Indeed, the trend in Europe toward criminalizing clients of sex workers has also negatively affected the safety of sex

workers because it drives sex work underground. Health authorities have been shifting funds from health promotion and harm reduction to programs that encourage the eradication of the sex industry. This means that sex workers have had less access to information, prevention and care.

Another result of this trend, which has been directed mainly at street-based sex workers, is that there has seen a tremendous shift from outdoor to indoor forms of prostitution. Currently, about two thirds are indoor-based. This fact has made it much more difficult for service providers to establish contact with sex workers. TAMPEP estimates that only about 30 percent are covered by prevention activities.

One of the biggest barriers in recent years is the lack of political commitment and governmental responses focused on reducing sex workers' vulnerability to HIV and the absence of adequate public health approaches that are appropriate for this highly marginalized population.

In order to be effective, HIV prevention for sex workers requires comprehensive service provision that:

- responds to the diverse health and social care needs of sex workers;
- is psychologically and physically accessible to both indoor and street-based sex workers;
- includes low-threshold harm reduction services in relation to both sex work and drug use; and
- operates within accepted good practice guidelines and protocols.

In addition, successful HIV prevention needs to reach the majority of sex workers within each country. Therefore, it is essential to ensure both geographic and temporal cover-

age of all sex work settings operating within the country. Access to both health and social care services as well as strengthening the capacity of multi-sectorial services are imperative for reducing the vulnerabilities of sex workers.

A human rights-based approach to program implementation has been the core principle of sex work projects for many years. National and regional programming policies and interventions for sex workers should fall in line with a human rights framework if they are to be effective in reducing vulnerability to HIV/AIDS and enhancing the health and well-being of all sex workers.²

— *Licia Brussa and Veronica Munk*

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¹ TAMPEP. *Sex Work in Europe: a mapping of the prostitution scene in 25 European countries*. 2009. On-line: <http://tampep.eu/documents/TAMPEP%202009%20European%20Mapping%20Report.pdf>.

² In addition, TAMPEP has developed a series of recommendations to enhance the rights of migrant sex workers in Europe, which include calling for the development of a non-repressive policy regarding sex work and migration in Europe, in order to support the ability of sex workers to implement strategies of self-protection and self-determination; and for the support and empowerment of sex workers, recognizing their right to migrate and to make their own choices.

Implications of PEPFAR's anti-prostitution pledge for HIV prevention among organizations working with sex workers

Even though the United States President's Emergency Plan for AIDS Relief (PEPFAR) has facilitated access to treatment for people living with HIV/AIDS across the planet, sex workers are not as fortunate. In this article, based on an oral abstract presentation at AIDS 2010, Melissa Ditmore and Dan Allman present a case-story analysis of the implementation of PEPFAR's anti-prostitution pledge.

Since its introduction as policy in 2003, PEPFAR has enabled access to treatment for hundreds of thousands of people living with HIV/AIDS in places where they would not otherwise have received antiretroviral medicines.

However, beginning in 2004 and continuing until today, this U.S. government funding initiative has been subject to an anti-prostitution clause forbidding the "promotion of prostitution" by grant recipients. The consequences of this clause have been severe, far-reaching and detrimental.

This article utilizes a "case story" approach to build a composite narrative of defining features of organizations in receipt of PEPFAR funding. To do this, multiple cases are compiled within a single narrative. Data for this case story have been collected since 2003 from 25 organizations and projects in 14 nations in Africa, the Asia-Pacific region, the Americas and Europe. Data come from published accounts and directly from sex workers, non-governmental organization (NGO) staff and United States Agency for International Development (USAID) representatives.

The case story

The fictional West Lannadesh is a poor country with limited manufactur-

ing and a growing population. Sex work is carried out in a wide variety of venues, including streets, bars, hotels and brothels. HIV prevalence is around 1 percent, with a concentrated epidemic of HIV among sex workers and drug users of around 15 percent.

Prior to PEPFAR, only people who can afford to pay for HIV treatment receive it. PEPFAR has made it possible for approximately one quarter of the people who need HIV medications to receive them.

HQ, a fictional agency, provides direct services in West Lannadesh. HQ is affiliated with a large international NGO in the U.S. HQ works in partnership with smaller organizations. Although the organization does not condone prostitution, it does not condemn the individuals involved in it.

Assured by USAID that drop-in centres for sex workers are definitely not permitted under the PEPFAR restriction, HQ's Director consults with the agency board and staff. Rather than police who can and cannot use the HQ drop-in centres, the result is simply to close them and to inform any clinic attendees who are known or suspected to be involved in prostitution that they will no longer be provided services.

In response to the PEPFAR anti-prostitution pledge, sex workers from West Lannadesh organize a meeting with the staff of an international human rights organization to try to exert pressure on HQ. Under the increased pressure from sex workers, local communities and human rights organizations, the board of HQ decides to stop seeking HIV funding and instead concentrate on school-based sex education.

At an International AIDS Conference, others share the same sentiments:

"I understand the decision not to report the provision of these services. My organization has adopted a similar policy. I only wish we could do more."

As the case story reflects, guidance on the implementation of the anti-prostitution pledge has been unclear and enforcement has been unpredictable. PEPFAR'S chilling effect on HIV prevention to sex workers is noted both socially and structurally. There has been an elimination or decline of services; drop-in centres have closed; sex workers have reduced access to places to bathe and use a toilet; sex workers have been denied clinic-based care; and sex

workers have less access to condoms and other necessary commodities for safer sex. Within some organizations, peer education for sex workers about safer sex techniques has ended. In other instances, campaigns addressing violence against sex workers, who are subject to some of the highest rates of abuse among any population, have been dropped.

To counter this, many organizations have interpreted the restriction on their own, with varying results. While some have chosen to decline to work with sex workers altogether for fear of losing important USAID contracts, others cautioned that, to do so, would be to discriminate against and deny critical HIV prevention and health services to sex workers. The consensus reached by a number of organizations has been to modify the terminology used to describe programs in order to offer services to sex workers without compromising U.S. funding.

Importantly, the anti-prostitution restriction embedded within PEPFAR has come to be applied to many other programs beyond USAID, and so the restriction has reached well beyond only those programs directly funded by PEPFAR. One consequence of the restriction's wide scope is an inhibition in the sharing of information in the form of reports, papers, presentations and other media. The lack of information-sharing is a direct result of the chilling effect of the restriction. Furthermore, the lack of information-sharing prevents the development, implementation and replication of effective programming for sex workers.

In 2010, United Nations Secretary-General Ban Ki-moon emphasized that best practices for HIV prevention need to address the combat of stigma and discrimination and the involvement of target populations in designing programming for effectiveness. Sex workers' descriptions of the

adverse effects of this restriction have been repeatedly ignored by multiple U.S. administrations. This is counter to best HIV-prevention practices and should be rectified.

— *Melissa Ditmore and Dan Allman*

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FROM EVIDENCE AND PRINCIPLE TO POLICY AND PRACTICE:

PROCEEDINGS FROM THE 2ND ANNUAL SYMPOSIUM ON HIV, LAW AND HUMAN RIGHTS

Introduction

From 10–12 June 2010, the 2nd Symposium on HIV, Law and Human Rights took place in Toronto and drew close to 200 participants from Canada and some international guests. The event built on the success of the inaugural Symposium in 2009, bringing together researchers, community-based organizations and members, lawyers, policy-makers, students in various disciplines and others in pursuit of evidence- and human rights-based public policies relating to HIV prevention and treatment.

The primary objective of the Symposium and related activities was to inform and educate the participants on a range of key HIV-related legal issues.

On 10 June, the Canadian HIV/AIDS Legal Network organized a day-long skills-building workshop for a number of representatives of AIDS service organizations (ASOs)

and other community-based organizations from across Canada that focused on the criminalization of HIV transmission or exposure. Over 50 people learned and shared information about

community responses to cases where charges have been laid; discussed the elements of emerging efforts to pursue the adoption of guidelines for prosecutors to avoid the misuse of the criminal law; and participated in a role-playing exercise on handling media inquiries regarding cases of HIV transmission or exposure.

At the end of the day, participants also enthusiastically endorsed the formation of a national network of organizations that would commit themselves to taking action to defend and promote the human rights of people living with and vulnerable to HIV. They asked the Legal Network to take a lead role in creating and

sustaining this network in the coming months, and a number of participants have already volunteered to be on a temporary coordinating committee and several working groups to move things along.

The following day, Symposium participants attended three panel discussions focused on several critical areas of HIV and human rights. The topics were:

- criminalization of HIV non-disclosure: new developments and community responses;
- current research and legal issues in Canadian immigration policy for people living with HIV; and

- a more comprehensive understanding of maternal health and HIV.

This special section of the *Review* contains a summary of the proceedings of presentations made at these three panels.

On the evening on 11 June, a public lecture featured Dr. Michel Kazatchkine, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, who spoke of the role of human rights advocacy in overcoming the global AIDS crisis. His adapted remarks serve as the feature article in this issue of the *Review*.

Redoubling global efforts to support HIV/AIDS and human rights

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response to AIDS, which he gave at the International AIDS Conference in Durban, South Africa in 2000. It was titled “The deafening silence of AIDS.”¹ Following on the heels of a march of thousands through the streets of Durban, Cameron’s speech helped bring the world’s attention to the moral outrage of the failure to provide life-saving antiretroviral treatment in much of the developing world, where it was desperately needed. Building on and supporting the concerted advocacy efforts of other South African activists, the speech laid the foundation for one of the greatest human rights victories in the fight against AIDS: the global rollout of antiretroviral treatment.

Cameron appealed to the conscience of a world that was letting poor people die, and declared that governments, including his own, could not be allowed to shirk their responsibility to act. The speech crystallized sentiment in favour of providing antiretroviral treatment to those who needed it in developing countries, rather than only in high-income countries where treatment had been available for years. The broader global health and human rights movement to which the speech by Cameron belongs has led to a variety of actions, from price cuts on medicines to former UN Secretary General Kofi Annan’s call to action on AIDS and, ultimately, the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

At the time of this speech, ten years ago, many were sceptical that treatment could or should be provided

in the developing world, and had a long list of arguments against providing it. They said that making treatment available would be too expensive; that patients would not be able to adhere to treatment, leading to drug resistance; that the necessary infrastructure was lacking and could not be built; and that providing treatment would not be cost-effective. In other words: it could not be done and would not be worth it.

**Advocates must
reinvigorate efforts
for human rights and
treatment and prevention
for all.**

Ultimately, all of these claims were proven wrong. Ten years later, five million people in low- and middle-income countries are on antiretroviral treatment. At least another five million people are in urgent need of treatment, but we have made huge progress compared to where we were a decade ago, or even five years ago.

Establishing targets for HIV treatment

The world took action by establishing ambitious targets, such as provid-

ing treatment to three million people in developing countries by the end of 2005 and, subsequently, the goal of providing “universal access” to prevention, treatment, care and support by the end of 2010, the goal first articulated by the G8 countries and then adopted by the UN General Assembly.

The Global Fund was created to respond to the crisis and make action possible. Importantly, it took some risks and did not follow the conventional wisdom. However, I would argue that, if we want to win the fight against pandemic diseases such as AIDS, tuberculosis and malaria, we must be bold and make strategic bets — as long as we are vigilant about the outcomes and adjust our course of action as necessary.

By way of example, when the first needle and syringe programs were opened in the 1980s, often illegally or in a legal grey zone in many countries, we knew that rates of HIV were exploding among people who inject drugs. We also knew that they were often subject to abuse by law enforcement officers and even by health-care providers. At the time, we did not have extensive scientific evidence that the spread of HIV could be significantly slowed, without increasing drug use, by making sterile injecting equipment easily accessible to people who use drugs.

Nevertheless, it stood to reason that providing easy access to sterile equipment, combined with effective education about the need to avoid sharing used equipment, could

help people avoid a behaviour that carries a high risk of transmitting HIV and other blood-borne viruses, among other harms. We took action, acknowledging that people who use drugs can be agents of change and should be treated with dignity. We monitored the results and evaluated the programs thoroughly, and today it can no longer be disputed that harm reduction measures such as needle and syringe programs are essential health services and are key to realizing the human right of all persons to enjoy the highest attainable standard of health.

In Canada and elsewhere, the story has been the same with supervised injection sites, which science has shown, time and again, are important services protecting and promoting the health of some of those who are most marginalized and at risk of HIV and other harms.²

Similarly, despite the doubts expressed by many, we started making antiretroviral HIV treatment available in developing countries and then vastly scaled up treatment access, while continuing to monitor results. Today, even in the most fragile states and in the most difficult settings, people are benefiting from treatment. Adherence is good and there is no alarming evidence of widespread drug resistance. There is a substantial body of clinical evidence to show that the drugs work well, regardless of the setting. Lives are being saved on an unprecedented scale — not only in Toronto, but in Durban, Dushanbe, Port au Prince, Dar-es-Salaam and Vientiane.

The progress we have achieved represents not only a tremendous public health success, but also a major human rights victory. At the same time, advocates must be per-

sistent and reinvigorate efforts for human rights and treatment and prevention for all. Instead of building upon the results we have achieved and continuing to move forward resolutely, what I am hearing too often these days is the voices of the doubters and sceptics, as in the year 2000, when many people argued against providing treatment in developing countries.

A troubling backlash against HIV treatment

Today, we have proven that we can provide treatment to everyone in need. Yet, some vocal people are saying that this is not sustainable, that perhaps “we should do less, but better,” that AIDS has received too much attention compared to other diseases, and that there is treatment just because AIDS activists have been louder than advocates for other health problems.

Some people are talking about a “treatment mortgage” that donors will have to pay in the long term — a very negative and inappropriate term when what we have done is saved lives and given new hope to millions of people and should be celebrating the treatment successes. This backlash against treatment is a backlash against human rights that we must resist. Instead of turning people away from treatment centres or putting them on waiting lists — something that is already happening in too many places, every day³ — we should continue scaling up.

To be sure, many countries are facing difficult economic times. However, what some may not realize is that poor countries are among the hardest hit and that, in times of crisis, their needs are greatest. We should not allow this crisis to increase inequities again. Unless we act now, we

risk undoing the progress we have achieved since Cameron’s speech in Durban, and since the Global Fund was created eight years ago and become the world’s most powerful vehicle to reduce inequities in health — and hence a powerful vehicle for the realization of human rights.

A recent report by the World Bank and the International Monetary Fund examines the impact of the global economic recession on poverty and human development outcomes in developing countries.⁴ It concludes that the progress in poverty reduction made before the economic crisis will likely slow, particularly in low-income countries in Africa.

No household in developing countries is immune. By the end of 2010, an additional 64 million people will fall into extreme poverty due to the crisis. Even households above the poverty line are coping by, among other things, buying cheaper food and reducing visits to doctors.

While international financial institutions and the international community have responded forcefully and quickly to the crisis with unprecedented millions to support the financial sector and other industries, efforts are now needed to regain momentum toward achieving all of the Millennium Development Goals (MDGs) in every region. One of those goals, to be achieved by 2015, is to have halted and begun reversing the spread of HIV. The year 2010 will be decisive. This is the year in which we decide if we will win the fight against AIDS and more broadly, meet the health-related MDGs.

The outcome of various important meetings in 2010 — such as the G8 and G20 meetings in Toronto, the International AIDS Conference in Vienna, the African Union Head

of State Summit in Kampala, the Millennium Development Goals Summit at the United Nations in New York and the Global Fund replenishment meeting — will determine whether we will be able to continue scaling up programs and ultimately win the fight or whether we will waver in our commitment and let the progress falter, allowing AIDS, tuberculosis and malaria to gain force again.

Action on maternal and child health

There are four main priorities and challenges in the months and years ahead. The first is action for maternal and child health. Canada has been pushing the G8 for a wide focus on both child and maternal health. Several other meetings, including the “Women Deliver” Conference in Washington in June 2010, have focused on maternal and child health.

There has recently been some good news. Studies published in *The Lancet* have shown that significant progress has been achieved in the last decades, both on maternal⁵ and on child health.⁶ In many ways, the Global Fund has made key contributions to this progress, among other things by protecting millions of children and mothers against malaria infection, preventing mother-to-child transmission of HIV and providing treatment to women with HIV and tuberculosis.⁷ The Global Fund has also adopted a progressive strategy on gender equality. Under this strategy, we support a range of structural interventions to enhance gender equity, increase women’s participation in decision-making and protect women against gender-based violence.

At the same time, nobody disputes that a lot more can and must be done.

However, it remains unclear whether bold action will follow all the talk. This would require significant additional resources for maternal and child health, and not a redistribution of resources from other under-funded areas of health and development to maternal and child health. It would also require a comprehensive approach, including funding for family planning and safe abortions, rather than an approach that fails to include these key aspects of sexual and reproductive health and rights.

Action for maternal and child health needs to include championing of the rights of women.

The HIV struggle has highlighted for the world the direct ways in which subordination of women and politicized denial of comprehensive reproductive services and information to women directly undermine health and rights of women. Action for maternal and child health needs to include a real championing of the rights of women, including their sexual and reproductive rights.

The Global Fund is ready and committed to continue playing an important role in maternal and child health. If indeed additional resources become available, we could take on added responsibilities, such as

hosting a new facility, focused on maternal and child health, at the Fund.

The second priority and challenge is to stop pitching HIV treatment against HIV prevention. We need to continue scaling up both. In remarks that I delivered at the International AIDS Conference in Mexico City in 2008, I celebrated the progress on access to treatment, and am pleased to report that we have made more progress since. At that time, three million people in developing countries were accessing treatment. Two years later, it is five million. With adequate resources, we can continue scaling up and ultimately provide access to everyone in need.

I also noted in Mexico City that, while the need to drastically scale up HIV prevention efforts had dominated the AIDS conference, we had finally “moved on from the fruitless debate between prevention and treatment that has plagued us in the past”.

An integrated approach to HIV prevention and treatment

Sadly, it seems that assessment was premature. This is clearly an area in which we have gone backwards. Indeed, some have recently argued that the Global Fund and other funders are investing too much in HIV treatment, to the detriment of HIV prevention. They are wrong. At the Global Fund, we support programs developed at the country level that pursue an integrated and balanced approach covering both HIV prevention and treatment, and broader elements of comprehensive care.

Furthermore, there are strong public health arguments for investing in treatment. We cannot successfully prevent the further spread of HIV

unless we scale up both prevention and treatment. We know that people are less likely to come forward for HIV testing if they cannot access treatment. Now we have evidence that antiretroviral treatment plays a key role in decreasing HIV transmission.⁸ We must move on from this fruitless debate and scale up both prevention and treatment. The supposed dichotomy between the two is a false one, and one that is too easily used as a justification for flat-lining or reducing funding commitments to the global AIDS response.

The third priority is to take serious action on HIV and human rights. In countries all over the world, people living with and communities affected by AIDS are still too often being denied their rights. This is despite evidence that the protection of human rights is central to an effective response to AIDS. Early on, people such as Jonathan Mann powerfully articulated that public health interventions can only be effective if affected people are empowered, informed and participate in decisions that concern their health.⁹ He worked tirelessly to bring to the world's attention the basic notion that improved health cannot be achieved without basic human rights, and that these rights are meaningless without adequate health.

Human rights violations continue to happen despite the fact that governments — indeed, all UN Member States — have committed themselves, including in the General Assembly's 2006 *Political Declaration on HIV/AIDS*, to intensifying “efforts ... to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups”.¹⁰

There has been progress in some areas in recent years. Most notably, the United States of America and, more recently, China have repealed, or are in the process of repealing, restrictions on entry of people living with HIV, which are unjustified. We should celebrate this.

In other areas of human rights, however, we have made little, if any, progress. This must change. There are many examples; let me highlight just a few. In May 2010, I was in Malawi, with UNAIDS Executive Director Michel Sidibé, just days after two men were sentenced to 14 years in prison with hard labour for “indecent practices between males” and “unnatural offences.” We discussed the case with President Bingu wa Mutharika, who said that case was opening the debate in Malawi around the health, societal, cultural and human rights ramifications of laws criminalizing homosexuality. The President since granted a presidential pardon to the jailed couple. This is, of course, great news and we applaud this decision.

People living with and communities affected by AIDS are still too often being denied their rights.

In many other countries in Africa, however, gay men and other men who have sex with men are increas-

ingly the target of a campaign of hate and have been arrested, detained and sentenced simply for having sex with another man or even for being suspected of having sex. This is not only unacceptable under international human rights law, but also counterproductive from the point of view of public health. It drives these men underground and away from the services they need. We cannot speak out enough about the worrisome trend we are seeing, and I call on legislators to change outdated penal codes that contain prohibitions against same-sex sexual activity.

Human rights abuses of illegal drug users

People who use illegal drugs also continue to suffer widespread human rights abuses. They continue being denied harm reduction services, have poor and inequitable access to antiretroviral therapy, suffer abuse and sometimes torture at the hand of law enforcement officials, and are often incarcerated, for long periods of time, simply for using or possessing drugs.¹¹

These abuses are reported from all regions of the world. They are abhorrent in themselves and we must fight them for this reason alone. They also increase people's vulnerability to HIV and negatively affect the delivery of HIV programs.

Much more needs to happen to fight these abuses. One of the priorities is to stop wasting resources on the failed so-called “war against drugs” that has turned into a war against people and communities — as has been highlighted time and again in report after report. Instead, these resources should be devoted to providing, to everyone who needs them, evidence-based and human rights-based interventions that prevent problematic drug

use, treat drug dependence and ensure harm reduction services for people who use drugs.

In the two years since the last International AIDS Conference, several reports have drawn attention to the fact that, in a number of countries, people who use drugs are detained, without due process, in compulsory drug detention centres. In these centres, they face what is called “treatment” and “rehabilitation.” In reality, these are coercion, forced labour and human rights abuses, including torture.¹² In many of these centres, the services provided are of poor quality and do not accord with either human rights or evidence. Not surprisingly, relapse rates are very high.¹³

Global Fund grants finance some services in a number of these centres. We have undertaken an initial analysis of our grant portfolio, which indicates that our grants support a range of HIV prevention and treatment services, as well as some training in providing such services, in some of these centres. Even providing such services in centres where serious human rights violations occur poses ethical dilemmas.

All compulsory drug treatment centres should be closed and replaced by drug treatment facilities that work and that conform to ethical standards and human rights norms. At the same time, as long as such centres exist, I strongly believe that detainees should at least be provided with access to effective HIV prevention and treatment, provided in an ethical manner and respectful of their rights and dignity.

The human rights of women and girls

Another area in which progress lags far behind, with disastrous conse-

quences including fuelling the HIV epidemic, is the human rights of women and girls. In too many countries, women and girls continue to be subject to violence, denied sexual and reproductive health services, property and inheritance rights, and the basic means to protect themselves from HIV.

The lack of support for programs that protect human rights is one of the failures in the response to AIDS.

In Namibia, there have been many positive developments in recent years in the fight against AIDS. Nevertheless, recently advocacy groups have documented the stories of dozens of women living with HIV who were sterilized against their will in public maternity hospitals. One of the Global Fund’s grants included support for expansion of HIV testing and counselling and vertical transmission services in all of Namibia’s public maternity hospitals. I take the issue very seriously and we are examining its implications.

Cases such as these speak to what Joanne Csete, professor at the Mailman School of Public Health at Columbia University in New York, has called the “heart of the Global Fund’s human rights dilemma: espousing human rights principles while also being committed to allow-

ing HIV responses to be driven by countries.” Indeed, the Fund is firmly committed to both: to human rights-based programming and to the principle that responses must be driven and owned by countries, rather than imposed by donors. Countries must be in the driver seat and develop proposals. Independent technical experts then review all proposals and make decisions independently of the Global Fund.

Admittedly, our dual commitment to human rights and to country ownership sometimes poses challenges, particularly when countries fail to implement rights-based policies and programs or have policies that undermine human rights. One thing is clear, however: we do not support interventions that are not evidence-based or that infringe upon human rights.

The lack of support for programs that protect and promote human rights is one of the failures in the response to AIDS. Rights-based programming puts the needs of women and of the most marginalized populations at the centre, and addresses not only their most immediate health needs but recognizes, for example, that providing legal assistance may be as important to a person who injects drugs as a needle or a condom.

The Global Fund actively encourages rights-based programming, including through our gender equality and sexual orientation and gender identities strategies. Similarly, we have recently adopted an initiative to increase access to prevention and treatment for people who inject drugs, including in prisons and pre-trial detention settings, which we hope will contribute to vastly increased access to services for people who inject drugs.

Analysis of recent Global Fund applications shows that still relatively few countries include human rights programs in their proposals, such as long-term campaigns against stigma and discrimination, programs to combat violence against women, or legal services and law reform programs. This is slowly changing, and we look forward to working with partners in encouraging further advances on this front. We need a new, strong and united call for human rights and for continued, ambitious scale-up of treatment and prevention programs — now more than ever.

Need for an ambitious replenishment of the Global Fund

Finally, the fourth priority and challenge: we need a robust, ambitious replenishment of the Global Fund. Without it, we will not be able to move resolutely forward, at the speed required, on any of the other three priorities I just mentioned. Since its inception, the Global Fund has become the main multilateral contributor to achievement of the health-related MDGs.

Today, the Global Fund provides approximately two thirds of international funding for malaria and TB and about one fifth of international funding for the response to HIV. Proposals totalling more than US\$19 billion have been approved for programs in over 140 countries. We fund antiretroviral therapy for 50 percent of the people living with HIV who currently access this lifesaving treatment in Africa, and for 75 percent in Asia. We are also the major multilateral source of external funding for harm reduction programs and other HIV prevention interventions,

such as prevention of mother-to-child transmission of HIV.

The results achieved by the Global Fund, together with its partners, are extraordinary. The programs we support have saved more than five million lives in the last six years. Every day, an additional 3600 lives are saved and thousands of new infections are prevented.

Canada could make a significant difference for maternal and child health.

We had a first replenishment meeting in March 2010, where we outlined the health impacts that could be achieved with resources of US\$13 billion, US\$17 billion and US\$20 billion, respectively, over the three years from 2011–2013. With US\$13 billion, we would be able to continue funding the successful programs countries are implementing, but we would not be able to continue scaling up programs at the same level as in recent years. Efforts to fight AIDS, TB and malaria would slow down.

In contrast, if we had sufficient resources to enable countries to continue scaling up programs rapidly, we could come close to, reach or even exceed the health-related MDGs. By 2015, we could

- eliminate malaria as a public health problem in most countries where it is endemic;
- prevent millions of new HIV infections;
- dramatically reduce deaths from AIDS;
- virtually eliminate transmission of HIV from mother to child;
- substantially reduce child mortality and improve maternal health;
- achieve significant declines in TB prevalence and mortality; and
- continue strengthening health systems.

The final decisions about how much each country, including Canada, will contribute to the Global Fund for 2011–2013 are to be announced at our replenishment conference in New York in October 2010.

Canada has a big role to play, in each of the priorities and challenges I have set out. As an example, I very much welcome the initiative for maternal and child health Canada has been promoting. As the host of the 2010 G8 and G20, Canada could make a significant difference for maternal and child health if its initiative leads to bold, coordinated, well-funded and comprehensive action, necessarily including women's sexual and reproductive health and rights.

On access to treatment, Canada can complement a major contribution to the Global Fund by also making Canada's Access to Medicines Regime (CAMR) — which was supposed to enable licensing of pharmaceuticals under patent in Canada for the limited purpose of exporting lower-cost, generic versions of those medicines to eligible importing countries — workable. This would facilitate access by developing countries

to medicines, including fixed-dose combinations and paediatric formulations. As recognized by the World Health Organization and the Global Fund, fixed-dose combinations of antiretrovirals — that is, multiple medicines in one tablet — are critical to achieving universal access to HIV treatment, as is the more efficient use of funds by procuring needed medicines at the lowest price possible.

In 2004, Canada provided international leadership by enacting CAMR. Yet, this regime has delivered only one medicine once, under one licence, to one country: Rwanda — surely not what Canada sought to achieve with its much-lauded initiative. In the face of the ongoing need for sustainable sources of affordable medicines, CAMR can and should be reformed so that it can deliver on the promise.

As Jonathan Mann taught us, the fight against AIDS is a fight for human rights, and the fight for human rights is an essential component of the fight against AIDS. The efforts that advocates undertake for health and human rights is changing history and bringing hope to people around the world. Together, we must continue and keep up the fight.

— Michel Kazatchkine

Dr. Michel Kazatchkine is Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

¹ E. Cameron, "The deafening silence of AIDS," *HIV/AIDS Policy & Law Review* 5(4) (2000): pp. 79–86, on-line: www.aidslaw.ca/publications/publicationsdocEN.php?ref=238.

² See, e.g.: E. Wood et al., "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility," *Canadian Medical Association Journal* 175(11) (2006): pp. 1399–1404; A. M. Bayoumi and G. S. Zaric, "The cost-effectiveness of Vancouver's supervised injection facility," *Canadian Medical Association Journal*, 179(11) (2008): pp. 1143–1151.

³ Médecins sans Frontières, *No time to quit: HIV/AIDS treatment gap widening in Africa*, May 2010, on-line: www.msf.org/source/countries/africa/southafrica/2010/no_time_to_quit/HIV_Report_No_Time_To_Quit.pdf.

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⁵ M. Hogan et al., "Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5," *The Lancet* 355(9726): 1609–1623, on-line: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60518-1/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60518-1/abstract).

⁶ J. Knoll Rajaratnam, "Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970–2010: a systematic analysis of progress towards Millennium Development Goal 4," *The Lancet*, early publication online, 24 May 2010: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60703-9/fulltext#](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60703-9/fulltext#).

⁷ The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Investments in the health of women and children: Global Fund support of millennium development goals 4 and 5*, 2010, on-line: www.theglobalfund.org/documents/replenishment/2010/Investment%20in%20Health%20of%20Women%20and%20Children_GF%20Support%20to%20MDG%204%20and%205.pdf.

⁸ D. Donnell et al., "Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis," *The Lancet*, early publication, on-line: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60705-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60705-2/abstract).

⁹ See, e.g., J. Mann et al. (eds.), *Health and human rights: a reader* (London: Routledge, 1999).

¹⁰ United Nations General Assembly, *Political declaration on HIV/AIDS*, 60th session, 2 June 2006.

¹¹ R. Jürgens et al., "People who use drugs, HIV, and human rights," *The Lancet*, in press.

¹² See, e.g., R. Pearshouse, "Patients, not criminals? An assessment of Thailand's compulsory drug dependence treatment system," *HIV/AIDS Policy & Law Review* 14(1) (2000): pp. 11–17; World Health Organization Western Pacific Region, *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles*, 2009; Open Society Institute, *At What Cost? HIV and Human Rights Consequences of the Global "War on Drugs"*, 2009; D. Wolfe, "Paradoxes in antiretroviral treatment for injecting drug users: Access, adherence and structural barriers in Asia and the former Soviet Union," *International Journal of Drug Policy* 18(4) (2007): pp. 246–54; Su J., "Analysis of 272 cases swallowing foreign body in compulsory detoxification," *Chinese Journal of Drug Dependence* 13(3) (2004): pp. 221–3; Human Rights Watch, "Skin on the Cable": *The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia*, 2010; Human Rights Watch, *An Unbreakable Cycle: Drug Dependency Treatment, Mandatory Confinement, and HIV/AIDS in China's Guangxi Province*, 2008; Human Rights Watch, *Where Darkness Knows No Limits: Incarceration, Ill-Treatment and Forced Labor as Drug Rehabilitation in China*, 2010.

¹³ *Ibid.*

Panel — Criminalization of HIV non-disclosure: new developments and community responses

This article provides summaries of the six presentations made during the panel. **Stéphanie Claviaz-Loranger** gives an overview of the recent developments in Canadian law since *R v. Cuerrier*. **Barry Adam** discusses views of people living with HIV/AIDS (PHAs) with respect to the criminalization of HIV transmission and exposure. **Shannon Thomas Ryan** discusses the racialized nature of criminalization. **Eric Mykhalovskiy** explains the available policy options for Ontario concerning criminalization, and calls on the **Ministry of the Attorney General** to establish a consultation process to inform the development of policy and practice memoranda. **Glenn Betteridge** discusses the development and work of the **Ontario Prosecutorial Guidelines Campaign**. Finally, **Lisa Power** presents the experience of England and Wales with regard to HIV criminalization.

Criminal prosecutions for HIV non-disclosure in Canada: legal developments

Stéphanie Claviaz-Loranger, lawyer, Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-SIDA)

In Canada, PHAs can be prosecuted for not disclosing their HIV-positive status before engaging in an activity that represents a “significant risk” of HIV transmission. Most of these cases have involved sexual activity, and exposure to HIV is a sufficient condition for prosecution. In terms of numbers, more than 100 criminal prosecutions for HIV transmission and exposure have occurred from 1989 to 31 December 2009. There has been a significant increase in the number of prosecutions since 2003, at an average of ten per year; 45 percent of these charges have been laid in Ontario. Eighty-eight percent of the individuals who are known to have been convicted have been incarcerated.

In 1998, the Supreme Court of Canada (SCC) handed down its first ruling on criminalization of HIV exposure: *R. v. Cuerrier*.¹ In that decision, the court ruled that PHAs have a legal duty to disclose their HIV status before engaging in an activity involving a “significant risk” of transmission of HIV. If PHAs do not meet this standard, they can face legal charges, including aggravated sexual assault, since the law holds that a failure to disclose is equivalent to vitiated consent during sexual intercourse. The courts have determined that unprotected vaginal and anal intercourse involve a “significant risk” of HIV transmission. However, it still remains unclear which other sexual activities carry a “significant risk” of HIV transmission.

New developments since *Cuerrier*

The law is still developing with respect to condom use. Lower courts have generally held that there is no duty to disclose when condoms are used, but this is not always the case.

Appellate level courts have held that condom use is one factor to be taken into account in evaluating whether there was an exposure to a “significant risk” of transmission of HIV.² In another case, a crown prosecutor agreed that there was no duty to disclose when a condom was used.³

Viral load is a new issue before the courts, and the law is still developing. Thus far, no Canadian court has accepted an undetectable viral load as a defence to charges based on HIV non-disclosure and unprotected intercourse. In a trial court decision that is being contested on appeal, the judge held that there is no duty to disclose only when there is an undetectable viral load and condom use.⁴ In another decision, which is also being contested in appeal, the accused’s undetectable viral load was not even taken into account.⁵

The 2009 British Columbia appellate court decision, *R. v. Wright*, suggests, however, that the accused’s viral load is “very relevant”⁶ to the determination of criminal liability. Upcoming cases will determine how,

and to what extent, courts will use viral load as a means of assessing risk.

Since *Cuerrier*, with respect to oral sex and criminal liability, a PHA was acquitted for charges based on oral sex because proof was not made that unprotected oral sex presented a “significant risk” of HIV transmission.⁷ In another case, a judge agreed with the Crown prosecutor that unprotected oral sex was “low risk” and could not constitute aggravated assault.⁸ However, there has not been confirmation of this standard at the appellate court level.

Recent developments at the trial court level have been contradictory with respect to the criminal liability that may be incurred with oral sex. For example, a PHA was convicted of aggravated sexual assault for unprotected oral sex.⁹ In another case, the Crown prosecutor stayed criminal charges of aggravated sexual assault against a man concerning unprotected oral sex.¹⁰

In a recent case in Vancouver, a man in British Columbia was acquitted where there was unprotected anal sex.¹¹ The key findings included:

- the accused did not disclose his status;
- the couple had unprotected anal sex three times;
- the accused was the receptive partner; and
- according to the Crown’s expert evidence, there was not any significant risk of HIV transmission in the particular circumstances of the case.

In that case, Justice Lauri Ann Fenlon stated, “Not every unethical act invokes the heavy hand of the criminal law.”

It is necessary to stress that community involvement plays an important role. Every time that the developments move in a positive direction, it has been a result of community efforts.

Viral load is a new issue before the courts, and the law is still developing.

Drawing the line: views of HIV-positive people on the criminalization of HIV transmission in Canada

Barry D. Adam, Professor of Sociology, University of Windsor

My comments are based on a research study that we have been working on the past two years, titled *Impacts of Criminal Prosecutions for HIV exposure and transmission on people living with HIV*. Data are drawn from two sources. One is survey questions posed to the *Positive Spaces Healthy Places* cohort with 438 respondents, a study focused primarily on housing, into which some legal questions were inserted. The second source is interviews with 122 PHAs, drawn from three Toronto and one Ottawa sites, in both English and French. Data is also currently being collected from an Ontario HIV

Treatment Network (OHTN) cohort study with 500 respondents.

The responses from the two different samples are slightly different because of the variance in demographics. The *Positive Spaces Healthy Places* cohort’s demographic characteristics are: 74 percent male and 26 percent female; 59 percent gay, lesbian or bisexual; 13 percent aboriginal; 12 percent African or Caribbean; 22 percent employed; 74 percent earning less than \$1500/month; 39 percent with a history of homelessness; and 56 percent living in the Greater Toronto Area.

We asked this group whether they had heard that Canadian law requires them to tell their sexual partners about their HIV-positive status, at least in some circumstances. There was near universal awareness, as 96 percent of the group responded yes to that question, while 3 percent said no and 1 percent did not know. The leading source of this information was the media, as 244 individuals, or 56 percent, had heard about it this way. The media appear to be influential in shaping the views of PHAs, at least from this sample.

The next most influential source was AIDS service organizations at a 54 percent response rate. Thirty-one percent heard from another PHA, 21 percent from an HIV clinic; 18 percent from friends or family; 17 percent from a physician who was treating them; 12 percent from a nurse or health-care provider; and 12 percent from a social service agency.

HIV status disclosure

We also asked the respondents from this cohort about HIV status disclosure. Specifically, we asked them about HIV-negative partners and those whose HIV status they did not know,

with whom they had anal or vaginal sex in the last six months. Forty-five percent disclosed; 32 percent did not have an HIV-negative partner or partner(s) whose HIV status they did not know; and 9 percent did not feel it was necessary to disclose to their partner(s) because they had protected sex. Nine percent of this group told some of their partners and not others, while 6 percent were too afraid to disclose and 5 percent did not disclose at all. Another 5 percent stated that they dropped hints that they could be HIV-positive, while 5 percent said that they felt it was unnecessary to disclose because their partners should presume everyone is positive. Four percent did not feel it was necessary to tell their partners because it was their responsibility to use a condom if they wanted to and 3 percent did not feel it was necessary to tell their partners because they were willing to have unprotected sex.

It is also important to note that these statistics are not mutually exclusive and the respondents could answer one or more of these questions. Further data analysis will be pursued to see how PHA attitudes may vary by demographic characteristics.

The next set of questions dealt with PHAs' answers to some of the legal questions on grey areas such as balancing the demand for disclosure and determining significant risk. The respondents were asked whether they felt that they should have to disclose their HIV status to their sexual partners if their viral load is undetectable. There is strong agreement among this sample that is in favour of disclosure regardless of viral load.

Concerning whether respondents think someone with HIV should be

charged with a crime, and perhaps sent to prison for having unprotected vaginal or anal sex without telling sexual partners he or she has HIV before having sex, there is still quite a strong endorsement of disclosure. However, there is still a minority that disagrees.

The respondents were also asked, if a condom were used for vaginal or anal sex would they think that someone with HIV should be charged with a crime and perhaps sent to prison for not telling their sexual partner that he or she has HIV before having sex? Here, the majority of opinions indicated that, if individuals were having protected sex, disclosure would not be necessary. This speaks to the significant risk issue, and most PHAs believe that it should not be necessary if one is taking due precautions.

Some PHAs believe that disclosure is unnecessary if safe sex is practised.

Respondents were also asked, if oral sex were being given to a person with HIV without a condom, would they think that the HIV-positive person should be charged with a crime, and perhaps sent to prison, for not telling sexual partners that they have HIV? Again, most believed that disclosure was not necessary and only a minority believed otherwise.

Respondents believed that low-risk activity was unlikely to transmit HIV to a partner, and this indicates their perceptions about significant risk.

In the interview cohort, the responses are similar but vary slightly from the survey sample. The demographics of the interview group include majority white respondents, almost 20 percent Afro-Caribbean, some Aboriginals and 8 percent from other ethnic categories. The income levels in this group are low, but on average slightly higher than the housing study group. It is also a well-educated group.

The responsibility to disclose

The interview questions started by acknowledging that considerable debate exists about the responsibility to disclose, specifically whether respondents think that there are circumstances under which PHAs should be charged. The questions asked whether they thought that individuals who had unprotected sex with an undetectable viral load should be charged and perhaps sent to prison, and whether individuals having unprotected vaginal or anal sex without disclosing he or she has HIV beforehand. For both questions there seems to be an endorsement of the duty to disclose, but there is clear division in the responses.

Another question asked about sero-status disclosure when a condom was used during vaginal, anal and oral sex. Not many respondents believe that legal sanction is appropriate in this context.

Some of the interview cohort does not feel broadly affected by the legal implications of the duty to disclose sero-status, since they consistently disclose their HIV-positive status to

sexual partners, openly engage in sero-sorting, feel morally obligated to disclose regardless of the law, are in monogamous relationships or are not engaging in sexual activities. One respondent stated a common sentiment that they “had to come up with a code of ethics for myself, and that has not changed.”

Other respondents take a more situational or conditional strategy, believing that disclosure is unnecessary if safe sex is practised, assess how safe they would feel if they did disclose or assess if the relationship has the potential to be more than casual. The largest number, however, believe that criminalization unfairly shifts the burden of proof such that PHAs are held to be guilty until proven innocent. This causes unease among respondents because they believe that it may give former disgruntled partners a legal weapon to wield against them, or that the onus falls on women, despite men’s power to ignore the issues.

Many respondents feel fear and vulnerability, but other respondents also feel that the climate of acceptance is better than the early days of the epidemic, despite criminalization. Moreover, they feel that the high-profile prosecution cases are giving other PHAs a bad name.

The racialization of the criminalization of HIV transmission or exposure

*Shannon Thomas Ryan,
Executive Director, Black
Coalition for AIDS Prevention*

This presentation is focused mainly on the issue of racialization and the

ways in which Ontario’s African, Caribbean and black communities are responding to criminalization. The racialization of criminalization reflects a disproportionate application of the criminal justice system against members of these highly vulnerable communities and is an especially troubling trend that needs to be addressed more closely.

While academics and lawyers thus far have excellently led the discussion, we are at a time when we need to ensure that community members and racialized PHAs are central to the issue of criminalization and its impacts; their inclusion is integral. Thus, it is necessary to create and lead a coordinated, balanced and informed response that is inclusive of all the realities, including racialized PHAs.

The stakes are incredibly high. The more that criminalization occurs, the more likely the impact of AIDS service organizations (ASOs) diminishes. The African and Caribbean communities are especially vulnerable to criminalization and are highly over-represented. It places members of already high-stigma, high-prevalence and high-risk communities at additional risk.

As organizations, both the Black Coalition for AIDS Prevention (Black CAP) and the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) believe that criminalization is not an effective response and that the broad use of the criminal justice system is done to the detriment of ASOs, effective programming and effective public health policy and practice. Moreover, use of the criminal justice system in this context lacks the appropriate evidentiary basis.

The effects of stigma

There are parallels of stigma between PHAs and members of groups that face systemic discrimination as a result of systemic racism. PHAs are experiencing a form of systematized and institutionalized HIV stigma that is very similar to the systemic racism that is encountered elsewhere. The response of the criminal justice system is an indication of how systems and institutions faithfully reproduce some of the class, gender and race inequities that they are meant to remedy in the first place.

African and Caribbean communities are especially vulnerable to criminalization and are highly over-represented.

Indeed, there is an incredible amount of fear among community members. In 2009, in efforts to educate the public, Black CAP held a forum to address the racialized nature of criminalization. While it thought that it had done a good job of educating the community, the session ended with a PHA stating: “You are scaring the hell out of me. Think about how you are communicating this message. Every time you communicate this message, you are not encouraging me to disclose my status; you are actually pushing me underground.”

As a community, this raises a number of issues for us and exposes some important realities. First, black straight men are disproportionately charged in criminalization cases. The numbers suggest that, between 2004 and 2009, 50 percent of the straight men who were charged were black men. This statistic is troubling and needs to be explored. Second, the broader issue of race and criminalization needs to be studied. The overrepresentation of black men in these charges represents another form of criminalization of a community that experiences the criminalization of our bodies, families, youth and so on.

For instance, the framing of social assistance and social welfare systems as a system that is abused by members of racialized communities — or the especially high incarceration rates of black youth within the criminal justice system — are indications of how our communities are engaged with these systems due to racism at the structural levels. An important question to ask is whether Crown attorneys are pursuing charges more vigorously against members of racialized communities compared to others.

Media representation

A third reality is the ways in which black PHAs are being represented in the media. How the dialogue has been framed in the media is also a salient issue. I recently ran a Google News search of the *Aziga*¹² case and found that articles from *The Toronto Star*, the Canadian Broadcasting Corporation, CTV, *Maclean's* and Wikipedia all reviewed the core elements of the case. With the exception of one of the articles, all framed *Aziga* as a black, Ugandan newcomer, descriptions that are seemingly irrelevant to the charges.

We need to ask why people are being framed in this way and why the media reinforce stereotypes and assumptions about black men in this manner. Moreover, we need to question the framing of this public conversation and how it changes both public and personal perceptions about black men living with HIV.

Fourth is the issue of HIV stigma. Is there a connection between stigma and the challenges related to disclosure? Simply put, I come from a community where HIV stigma is very high and the likelihood of disclosure is very low.

There are multiple issues that need to be explored and, importantly, there are a lot of issues about which we do not have enough knowledge. What is clear, however, is that there are a lot of questions. For example, why is race a significant factor and stigma unique among black PHAs? How do blackness and being a PHA intersect? What is the outcome of this intersectionality?

We need to explore the issue of proportionality and why black straight men represent half of the charges in HIV criminalization, and what the impacts of the criminal justice system are on those communities.

HIV non-disclosure and criminal law: establishing policy options for Ontario

Eric Mykhalovskiy, Associate Professor of Sociology and CIHR New Investigator, York University

A project team of university and community-based researchers funded primarily by the OHTN had as its central purpose to develop policy options for Ontario and to engage the

Ministry of the Attorney General in dialogue on that front.

In Canada, criminal law is used to regulate the risk of the sexual transmission of HIV by requiring PHAs to disclose their HIV-positive status to others before engaging in activities that pose a “significant risk” of HIV transmission. This has raised a number of concerns among PHAs, ASOs, lawyers, academics and others. The key concern is the Supreme Court of Canada and lower courts’ failure to clearly define what constitutes a significant risk, which has resulted in PHAs’ inability to know with certainty their obligation to disclose under the criminal law.

Importantly, some police and Crown counsel have interpreted the significant risk test in overly-broad terms, such that charges are being laid and proceeded with in circumstances where there is little risk of transmission. As a whole, the criminal justice system has not approached criminal charges related to HIV non-disclosure in ways that are adequately informed by current scientific research. Moreover, the criminalization of HIV non-disclosure hinders established community-based and public health approaches to preventing HIV transmission and supporting PHAs.

Despite the complexity of these and other concerns, the use of the criminal law to address HIV non-disclosure in Canada has not been informed by a sustained, evidence-based policy discussion.

The team’s response was to create a policy analysis¹³ that provides new research evidence, reviews existing scientific research and frames policy options for responding to the problems posed by the criminalization of HIV non-disclosure.

The creation of new research evidence was conducted in three ways. First, team members created what is, to their knowledge, the first comprehensive database on criminal charges related to HIV non-disclosure in Canada and produced an analysis of temporal trends, demographic patterns — including the gender, race and sexual orientation of defendants — and the disposition of the cases. Here, it was found that:

- Ontario accounts for 47 percent of Canadian cases and that 89 percent of individuals charged in Ontario have been men;
- In Ontario, 84 percent of criminal cases for which the year of charge is known have occurred since 2004;
- In Ontario, 50 percent of heterosexual men who have been charged since 2004 have been black;
- 68 percent of criminal cases in Ontario result in convictions;
- In 34 percent of cases resulting in convictions in Ontario, HIV transmission did not occur; and
- 68 percent of convicted cases in Ontario result in prison terms.

While the data indicate that criminal charges for HIV non-disclosure arise primarily out of heterosexual relations, they also suggest that charges may be increasing among men who have sex with men (MSM). For example, in Ontario, 10 out of 42 men have faced criminal charges for failing to disclose their seropositive status in sexual relations with men, and nine of those charges were laid within the last four years. This number represents 41 percent of the men charged in Ontario between 2006 and 2009.

Second, the team analyzed the application of the significant risk test by examining how criminal courts in Ontario and Canada have interpreted and applied the test in their decisions. The analysis revealed that there are three main types of inconsistency in the law: inconsistencies in evidence used to establish whether the sexual relation involved a significant risk in HIV transmission, inconsistencies in how courts have interpreted the legal test of significant risk and inconsistencies in actual decisions in cases with similar facts.

The uncertainty of the significant risk concept has led to mixed messages in HIV prevention.

Third, the team conducted interview research that, for the first time in Canada, explores the impact of the criminalization of HIV non-disclosure on PHAs as well as on those who work with them, including physicians, public health nurses and front-line ASO staff. Research consisted of individual and focus group interviews with 28 PHAs, of whom 11 were women, 17 white, six black, two Aboriginal, one bi-racial, one Asian and one South Asian. Individual interviews were also conducted with physicians, health-care and social service providers, ASO

staff, public health nurses and officials, totalling 25 individuals.

Vagueness of “significant risk”

Highlights of the social science research were that the vagueness of the significant risk concept produces fear and anxiety among PHAs, and confusion among health-care and service providers. For example:

What’s significant risk? That’s what I never understand. Like it’s significant risk but what necessarily is significant risk? ... The whole haziness of the law around HIV I find it, it kind of makes you a little bit angry, especially being an HIV-positive person. (HIV-positive man, Interview 25)

Working on the front line there is a lack of clarity and you can write three million ASO policies but they’re still not going to be clear because the law’s not clear. So it makes my work sometimes and the things I can say or can’t say unclear. (ASO case manager, Interview 21)

The uncertainty of the significant risk concept has led to mixed messages in HIV prevention and resulted in providers counselling PHAs to disclose regardless of the risk of the sexual activities involved:

I would say we’re generally a fairly conservative health department and our information is that, as an HIV-infected person, you’re obligated to disclose your status before entering into any sexual contact or needle sharing where there would be a risk of transmissions. And we talk about the fact that there is sort of a grey area with the law around significant risk and therefore you’re not required to use condoms, where I think our approach is more conservative in saying your best approach would be to disclose and use condoms all the time,

and that way in terms of how the law would see you they would see that as being sort of the most proactive approach to managing that. (Public health nurse, Interview 17)

The criminalization of HIV non-disclosure prevents vulnerable PHAs from seeking the support they need regarding HIV disclosure issues. Many PHAs are concerned that disclosure of their HIV-positive status to sexual partners does not protect them from criminal charges. PHAs and providers are also concerned about the extent to which court decisions in HIV non-disclosure criminal cases have been adequately informed by scientific research.

PHAs and providers have numerous suggestions for responding to the problems posed by the criminalization of HIV non-disclosure, including: clarifying the significant risk test; exploring possibilities for coordination between the public health and criminal justice systems; and implementing prosecutorial guidelines.

Policy options

To encourage practical solutions that can respond to the uncertainty and related problems posed by the criminal law related to HIV non-disclosure, the team identified and explored three policy options: case-by-case interpretation and application of the law; amendment to the Criminal Code; and the development of Crown policy and a practice memorandum.

The first and second options both face significant barriers regarding outcomes and the potentially lengthy period of time to bring about changes in the law. Therefore, the research team recommends the third option. The Ontario Ministry of the

Attorney General should establish a consultation process to inform the development of policy and a practice memorandum regarding cases involving allegations of non-disclosure of sexually transmitted infections (STIs), including HIV.

The team's recommendations address the range of stakeholders who should be involved in the consultations and the issues that should be addressed in the consultation process.

An outline of the Ontario Prosecutorial Guidelines Campaign

Glenn Betteridge, legal and policy consultant, Toronto

The Ontario Working Group on Criminal Law and HIV Exposure (CLHE) came together in 2007 and is comprised of PHAs and representatives from over 20 community-based ASOs from across the province. CLHE opposes the expansive use of the criminal law and advocates for sound policy responses to HIV based on the best available evidence, grounded in proven HIV prevention, care, treatment and support programs, and respectful of the human rights of people living with and vulnerable to HIV. CLHE calls on the Ontario Ministry of the Attorney General to undertake immediately a process to develop prosecutorial guidelines for cases involving allegations of HIV non-disclosure.

The initiative is necessary because of the lack of clarity in the criminal law test for when PHAs must disclose their HIV status to sex partners, which is based on the "significant

risk" of HIV transmission. This uncertainty has led to an expansive use of the criminal law. The criminalization of HIV non-disclosure was firmly entrenched in Canadian law by the Supreme Court of Canada in the *Cuerrier* decision,¹⁴ which established the significant risk test for HIV disclosure based on the *Criminal Code* offence of "aggravated assault." Courts are struggling to articulate the meaning of significant risk and this lack of clarity has led to the expansive use of the criminal law. For example, there have been over 100 prosecutions across Canada, including murder convictions, attempted murder charges, and oral sex convictions and charges.

The CLHE considered several options to limit the expansive interpretation and application of the criminal law. Parliamentary legislative amendment of the *Criminal Code* was ruled out as a strategy, since the legislative process is lengthy as well as politically and strategically fraught. The CLHE also considered the potential for court decisions to restrict the current application of law, but recognized that, despite the fact that lawyers and the Canadian HIV/AIDS Legal Network are working in this vein, working to change the law on a case-by-case basis can be lengthy and the outcomes uncertain.

Guidelines as a tool for advocacy

Prosecutorial guidelines offer a viable, realistic avenue for advocacy and activism that can lead to positive change in the short-term. The CLHE's Prosecutorial Guidelines Campaign is a grassroots community campaign, involving significant

community knowledge and capacity-building.

We based the campaign goal — and our Call for Prosecutorial Guidelines — on an understanding of the criminal justice system in Ontario and the central role played by Crown counsel in that system. Police are employed by municipal corporations (or the Ontario Provincial Police), and receive complaints of alleged HIV non-disclosure, at which point they investigate those complaints. This may lead them to interview people, take statements, obtain search warrants and subsequently search for and seize medical and other records, and issue media releases. The police often have sole discretion to decide both whether to lay charges under the *Criminal Code* and what charges to lay. These can include common nuisance, aggravated assault, aggravated sexual assault and attempted murder charges.

Prosecutorial guidelines offer a viable, realistic avenue for advocacy.

Crown counsel are employed by the Ministry of the Attorney General. While they are independent from the police, Crown counsel depend on the police to investigate the complaint and gather evidence. They have a duty to ensure that the criminal jus-

tice system is fair to all, including the accused, the victims of crime and the public. After police lay criminal charges, Crown counsel review the charges in a process known as charge screening to decide whether to go forward with prosecution. Charge screening involves a two-part test: Crown counsel will only proceed with prosecutions where there is a reasonable prospect of conviction and where the prosecution is in the public interest, and Crown counsel are solely responsible for deciding whether and how to proceed with prosecutions.¹⁵

While police, Crown counsel and courts are all independent of each other, each possessing their own decision-making power, the CLHE believes that prosecutorial guidelines can influence police decisions and court cases. Decisions by Crown counsel can affect whether police bring charges and in what circumstances, what cases get to court and the way a case is presented in court.

The Crown Policy Manual

While the role of Crown counsel is largely discretionary, this power is not completely unfettered. Crown Counsel must abide by the law and owe a duty to the court. They also must consider the overall direction of the Ontario Attorney General as published in the Crown Policy Manual. The Manual is intended to assist its counsel in making decisions, as a means of structuring prosecutorial discretion and to promote high standards and consistency in how Crown Counsel conduct criminal prosecutions.

The Manual is comprised of two types of documents, the first being very general policy statements and

the second being practice memoranda that provide detailed guidance. The manual covers a range of “foundational” case management, victim, fairness and procedural issues, and provides guidance for specific types of prosecutions. Some examples of Ontario guidance for specific types of prosecutions include hate crimes and discrimination, impaired driving and road safety offences, sexual offences, and spouse or partner offences. There is currently no prosecutorial guidance about HIV non-disclosure or other STIs.

British Columbia is the only province with a policy that addresses prosecutions involving allegations of HIV exposure or transmission. The B.C. Sexually Transmitted Diseases guideline came into effect in 2007.¹⁶ The guideline applies to HIV/AIDS and other STIs, and provides guidance in relation to two basic topics: reporting of HIV/STIs by Crown counsel to the medical health office and the review by and reporting to Crown counsel superiors to proceed with a charge involving the possible transmission of a STI.

Prosecutorial guidelines in Ontario can measurably and concretely help PHAs and ASOs. Guidelines would help clarify the public policy that should guide prosecutions. Potentially, policy could place more emphasis on HIV prevention, deterrence and public health, as opposed to the current emphasis on criminal justice, and prosecution would only occur in cases where it serves the public interest. Guidelines would also help ensure that decisions to investigate and prosecute allegations are informed by a complete and accurate understanding of current medical

and scientific research about HIV, and take into account the social contexts of PHAs. This would help ensure that PHAs would not be prosecuted where there had been no significant risk of HIV transmission during the sexual acts.

Guidelines would help ensure that police and Crown counsel handle HIV-related criminal complaints in a fair and non-discriminatory manner. Guidelines could give senior Crown counsel and other officials in the Ministry of the Attorney General an important role in supervising, approving and monitoring prosecutions, and present an opportunity to provide ongoing professional development for Crown counsel, defence lawyers and judges. Finally, guidelines would also clarify that the law applies to all STIs, so that PHAs will not continue to be singled out and stigmatized.

Prosecutions for HIV transmission: the practical experience of England and Wales

Lisa Power, Head of Policy, Terrence Higgins Trust, United Kingdom

In England and Wales, Victorian assault law is used to criminalize HIV/AIDS. It is non-specific and broad. Unlike in Canada, only transmission can be prosecuted. While individuals can lay charges for attempted intentional transmission, these charges have been dropped fairly early. The first case was in 2003, and less than 20 have been in court. However, there have been many more allegations and investigations.

These cases have important and damaging impacts on PHAs, clinicians, support workers and researchers. For instance, the latter are not as willing to work on sexual issues because of the complications that arise from these investigations.

Some of the work that the Terrence Higgins Trust and the National AIDS Trust have been doing is to document cases carefully; engage in individual advocacy; provide information support and sector development; work with lawyers (both academic and criminal); challenge media coverage; liaise with police; engage in joint cooperative work; liaise with the Crown Prosecution Service (CPS); and collaborate on research projects.

The outcomes of the work have included clarification of the circumstances of prosecution, CPS and Association of Chief Police Officers (ACPO) guidance and closer relations to these groups, which have led to improved advocacy, improved understanding by the sector and by PHAs, and a reduced flow of the cases that went to court.

Crown Prosecution Service guidelines

The CPS process involved accepting high levels of confusion. The existing CPS prosecution guidance is in socially sensitive areas, invoking equalities and human rights issues. The working group associated with developing it included clinicians and community members, as well as full public consultation. Additionally, the published guidance was periodically reviewed with civil society input.

The content of the CPS guidance applies to all serious STIs. As the guidelines are not specific to HIV, it

is necessary to consult with hepatitis- and herpes-focused groups to ensure that they are aware of their inclusion. The CPS vets all cases centrally before anyone is prosecuted.

While the content of the guidance is still somewhat vague, there is some clarity in the realm of the necessity and limitations of scientific evidence. For example, one cannot be charged with recklessness in the absence of transmission. In other instances, proof of understanding infectiousness and risk of transmission may be difficult since, in the British system, testing is not required and the person need only have a reasonable expectation that he or she has HIV. Also, reasonable safeguards and consent are defences in the British system. The process involved simultaneous processes with the police and the creation of allies with the police force through identified shared commitments to justice and equality.

The key issues that emerged from the British experience include the combination of practical experience with human rights theory and a pragmatic approach to collaboration with authorities. Sector development was also hugely important in order to make and keep allies, and to find knowledgeable defence solicitors. The British experience additionally found that having personal champions within organizations was also key.

¹ *R. v. Cuerrier*, [1998] 2 S.C.R. 371.

² *R. v. Wright*, 2009 BCCA 514 (British Columbia Court of Appeal); *R. v. J.T.*, 2008 BCCA. 463.

³ *R. c. D.C.*, Cour du Québec, District de Longueuil.

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Chambre criminelle, 505-01-058007-051, 14 février 2008. The Crown agreed on this point in its memorandum to the Court of Appeal. The hearing was scheduled for late 2010.

⁴ *R v. Mabior*, 2008 MBQB 201 (Manitoba Queen's Bench).

⁵ *R. c. D.C.* (supra).

⁶ *R. v. Wright* (supra).

⁷ *R. c. Charron*, Cour du Québec, District de Longueuil,

Chambre criminelle, 706-01-010423-024, 1^{er} mai 2008.

⁸ *R. v. Edwards*, 2001 NSSC 80 (Nova Scotia Supreme Court).

⁹ *R. v. Aziga*, (4 April 2009), Hamilton CR-08-1735.

¹⁰ See Canadian HIV/AIDS Legal Network, "AIDS Organization Welcomes Crown Decision to Stay Criminal Charges in Hamilton HIV Case," news release, Toronto, 22 April 2010, on-line: www.aidslaw.ca/media.

¹¹ *R. v. J.A.T.*, 2010 BCSC 766.

¹² *R. v. Aziga* (supra).

¹³ E. Mykhalovskiy, G. Betteridge and D. McLay, *HIV Non-disclosure and the criminal law: Establishing policy options for Ontario*, 2010. (Funded by the Ontario HIV Treatment Network.)

¹⁴ *R. v. Cuerrier* (supra).

¹⁵ See Canadian HIV/AIDS Legal Network (supra).

¹⁶ Available online: www.ag.gov.bc.ca/prosecution-service/policy-man.

Panel — Overcoming exclusion: current research and legal issues in Canadian immigration policy for people living with HIV

This article provides summaries of presentations made during the panel. Laura Bisailon presents findings on the activities, actions and practices newcomers undertake as a result of being tested positive for HIV during Canadian immigration medical screening. Michael Battista discusses how to challenge the “excessive demand” barrier for HIV-positive newcomers through case law and advocacy.

Examining bodies: putting the HIV testing policy to the test

Laura M. Bisailon, Ph.D. candidate, Institute for Population Health, University of Ottawa

The purpose of this study — for which field work commenced in Fall 2009 — is to explain how Canada’s mandatory HIV testing policy of immigrants organizes how things happen to newcomers who are managing HIV; that is to say, what activities, actions and practices they undertake as a result of being tested positive for HIV during Canadian immigration medical screening.¹ This is the first work of its kind because the mandatory policy has not been reviewed since its introduction in January 2002.

The motivation for this sociological investigation stemmed from gaps between official reports on the functioning and purpose of the policy,² and anecdotal experiences with immigration HIV screening as recounted to the author in her work with persons living with HIV/AIDS (PHAs). Immigrant persons reported certain tensions and contradictions that were not reflected

in official reports. Preliminary findings presented here are from the standpoint of persons tested for HIV during immigration medical testing.³

At the start of 2002, blanket serological screening was introduced as one of the three conditions (along with tuberculosis and syphilis) for which all applicants to Canada are mandatorily tested. According to official reports, immigrants consent to the testing, receive pre- and post-test counselling, and are linked with services following an HIV-positive diagnosis. Canadian testing policy is “unique” because its purpose is health promotion and prevention, and not exclusion of HIV-positive applicants.⁴ However, these latter points remain unconfirmed in the regulating texts governing the testing policy.⁵

Citizen and Immigration Canada (CIC) contracts physicians called designated medical practitioners (DMPs) to carry out HIV testing on the federal government’s behalf. This procedure is done in medical offices in both in Canada and abroad.⁶

Enigma of admissibility determination

To date, four findings have emerged from the study. The first is that the

process of determining admissibility into Canada is an enigma to all informants. This is true regardless of how the person entered Canada, what motivated his or her application to remain in Canada and other factors such as level of education, gender or country of citizenship.

Shortly after their arrival, PHA newcomers are exposed to the socio-legal environment in Canada and the jurisdiction in which they settle. Persons quickly become familiar with terms such as “excessive demand” and “medical inadmissibility,” legal terminology found in the *Immigration and Refugee Protection Act (IRPA)* and its regulations. Although they gain awareness through numerous means of the theoretical background and context of the laws and policies that affect them, immigrant PHAs are ill-positioned to know how their application is making its way through government channels during the years it may take to acquire permanent residency.

Indeed, the application process is structured such that the actual knowing is unknowable. A cast of many intermediaries collects information, speaks, sets dates and represents them on their behalf. Contact with

CIC is minimal, as is access to specific details of their file. As one informant said, “It was very, very hard to actually speak to someone on the phone because there were answering machines instead of people.” As a result, the applicant resident in Canada follows the file through the CIC website or a toll-free phone line, with varying levels of understanding of the information provided.

The actual importance accorded to an immigrant’s HIV status within government decision-making about them remains unknown and is a source of mystery and tension well after migration to Canada. Informants are similarly unaware of how their health information actually circulates, and they question the nature of information flows more broadly. An informant said, “I had to give the DMP five photos, so there is a relationship between my face and the positive status. Everyone at CIC in Ottawa knows that I am positive.”

Questionable pre- and post-test counselling

The second finding to emerge from this study is that there is a dramatic difference between DMPs and applicants with respect to the meaning, quality and content of pre- and post-test counselling for HIV. Many informants tested for HIV in Canada and overseas reported that counselling did not happen at all during the immigration medical examination. For their part, DMPs interviewed for the study reported having provided information on condoms, blood donation and protecting others as per population and health concerns.

On the other hand, upon being called back to receive a positive diagnosis by the DMP, the majority of informants in Montréal reported that

the post-diagnosis encounter consisted of the DMP providing them with a referral slip on which there was contact information and directions to a hospital with HIV expertise.

Aside from the varying quality and quantity of counselling made available to them, informants in Toronto and Montréal reported being put on the defensive when DMPs asked if they actually knew their status before undergoing the HIV test.

The importance accorded to an immigrant’s HIV status within government decision-making about them is unknown.

Most informants reported surprise and dismay at the absence of post-test counselling. One person said, “I prompted them [medical personnel] several times, giving them the chance to do pre-test counselling. That was my goal: to receive details about this. That did not happen. At least they are supposed to explain something about the HIV test.”

Still, most or many informants rationalized the absence of pre- and post-test counselling for reasons that are not limited to, but include the following:

- that doctors are presumed to be busy looking at their watch or clock during consultation, which gives the informant the impression that he or she is imposing on the doctor’s time;

- that medical encounters are brief because the doctors work on both time and money;
- that the informant was aware of his or her serostatus and, as a result, may have sabotaged the doctor’s intent to counsel;
- that immigration doctors are not HIV specialists and therefore less trained to provide the service, explaining why there was referral to specialized facilities in lieu of counselling; and
- that Canada cannot influence what happens in a DMP office other than in Canada.

An informant said, “Maybe there was intended counselling that I very quickly aborted. Probably he was going to give me that talk. I read through his paper; I agreed with everything it said. I signed it.”

A 2001 report commissioned by the Canadian HIV/AIDS Legal Network recommended that counselling related to immigration HIV testing observe Canadian and international guidelines, and “that testing without providing adequate pre- and post-test counselling can constitute cruel, inhuman or degrading treatment.”⁷⁷ In fact, CIC accords importance to pre- and post-test counselling under DMP application criteria. Forms and specific instructions are listed in the reference manual that DMPs are asked to use in carrying out their work.⁸ Yet, findings from this study discovered that DMPs mobilize their general practitioner knowledge when delivering key messages about HIV to PHA applicants rather than referring to the manual.

Procedural gaps in HIV testing

A third finding is that there is a procedural gap, at worst, or inconsisten-

cy, at best, between what is set out in the DMP manual and what reportedly happens at the immigration medical encounter from the perspective of the person being tested and who tests positive for HIV. After delivering counselling, the doctor is supposed to have the PHA applicant sign a form saying that counselling occurred. However, only one informant in the study signed this form. Two others recalled having put their signature to what they called an “informed consent” to be tested for HIV (noting that there was actually no choice other than to be tested).

There is often an absence of post-HIV test counselling for immigrant PHAs.

One informant reported that “the DMP gave me a piece of paper that I had to sign that stated that I tested HIV-positive, that I am aware that I am HIV-positive and that I have been educated about the means of transmission. I had not been educated through him.” A government advisor said that this form is part of the DMP manual “to at least have a control record that positives are actually receiving post-test counselling.”

The following informant account highlights inconsistencies between the counselling protocol listed in the DMP manual and what occurred at her immigration medical examination:

My exam took ten minutes from start to finish. That physician was on a good rate. She did approximately ten exams per hour. It was an assembly line. That was my \$260.00 up in smoke. At no point was there ever any counselling or signing, whatsoever. Just “there is your requisition. Go and get it done.” Unless you work for Public Health or are part of the system, you would not know that they are looking for HIV.

Under the Interim Federal Health program, which is health coverage for refugee applicants, the DMP can bill \$120 for having delivered post-test counselling, which is more than the scheduled cost for the examination itself.

“Lawyering” work

A fourth finding from the study is that the lawyer is a central and influential actor in the immigration of most informants interviewed. The amount of time that applicants who use publicly subsidized legal services for their immigration spend with their legal representative in preparing for immigration interviews or hearings is limited. Coupled with this is the perception on the part of many informants that their lawyers are actually doing little on their behalf; the work that occurs is invisible to them, intuitive or negotiated beyond their knowing.

Consequently, newcomer PHA applicants engage in and retain a significant amount of “lawyering” work in their effort to gain and acquire permanent residency, including but not limited to:

- spending time to secure a lawyer;
- crafting their Personal Information Form (i.e., their refugee story);

- arranging legal aid certificates;
- setting up appointment to see a lawyer;
- knowing the time delays associated with submitting documents; and
- conducting Internet searches at their lawyer’s request.

One informant said, “Lawyers wait until you give them documentation on yourself. If my lawyer had Googled me, he would have found a lot there on me. He was surprised, at the hearing, that the judge had a large file on me.”

Informants in Toronto and Montréal reported that they actively shop for, switch and rate their lawyers as per his or her expertise and experience with HIV and immigration issues. Sometimes this is measured in the number of victories that the lawyer has had at the Immigration and Refugee Board, for example.

The last finding invites inquiry about the relational positions, ordering, social alignment and differential “power resources”⁹ of legal professionals, government decision-makers and HIV-positive newcomers to the country as they all work to navigate the immigration and health systems in Canada.

Challenging the “excessive demand” barrier for HIV-positive newcomers

Michael Battista, partner at Jordan Battista LLP, Toronto

Perhaps the most significant obstacle that potential immigrants with a physical disability face is the “excessive demand” clause of IRPA. This

provision denies admission to people whom the government believes will place excessive demands on Canadian health or social services as a result of their health condition.

Immigration officers conduct an inquiry of an applicant who is faced with a health condition. They tabulate the costs, determine which medications are required for the newcomer and come up with a figure. If the total exceeds the excessive demand threshold — which currently sits at \$5143¹⁰ — even by one dollar, the application is rejected. No consideration is given to the ability of the applicant to pay.

The barrier is an understandable hardship on people's lives. Their applications for admission into Canada can drag on for years, leaving them uncertain of their fate and of support for their health condition. For many, the resulting decision will be denial of entry as an immigrant or refugee because their expected health costs are too expensive for Canada to support.

However, the situation has changed, such that newcomer PHAs now have hope in challenging the excessive demand barrier. In order to do so and work toward having the standards applied fairly, advocates have two options. The first is through case law and litigation. Some principal cases that have been used to advance the cause of PHA applicants ensure that the threshold is not applied too harshly or broadly.

The Hilewitz decision

Much of this case law is based on a 2005 Supreme Court of Canada (SCC) decision called *Hilewitz*.¹¹ It has been the most effective tool for advocacy and marked the first time that the court dealt with the exces-

sive demand barrier. The ruling was based on Canada's previous legislation, the *Immigration Act*, which had a provision on excessive demand that IRPA has today. The SCC made it clear that the principles outlined in *Hilewitz* applied to the current legislation.

This case involved two families: Hilewitz and De Jong. They came to Canada through the business class as an investor and an entrepreneur. They were wealthy and well-established, and each family had a child with developmental disabilities. As part of their application to immigrate to Canada, they acknowledged the need for social services for those children. Although they made this admission, the families also indicated that they were prepared to pay for them due to their personal wealth. Indeed, they had a history of paying for them in their native countries.

The “excessive demand” barrier is a hardship on immigrant PHAs' lives.

The question that arose was this: could their ability and willingness to pay for the social services be considered by the immigration officer or does the officer just consider the health condition of the children? The officer refused both applications, saying the costs were too much. The

applicants' wealth was not taken into consideration. Consequently, the case led to the SCC to decide if this was the right approach.

Hilewitz was a ground-breaking decision. In it, the SCC made a number of important findings. First, it said that the excessive demand threshold required individualized assessment; that is to say, one could not take a “cookie-cutter” formula and apply it to a particular health condition. For example, CIC came up with a policy for newcomer PHAs. It said that applicants who had a CD4 count of less than 500 and a viral load of more than 55 000 were eligible for antiretroviral (ARV) treatment — and were consequently denied because the cost of treatment exceeded the excessive demand threshold. This was a formula that focused on the disease or disability and not the person.

The SCC ruled that this process was the incorrect approach. It said that it was necessary to take an individualized formulation, taking into account all of the evidence that the applicant submitted. One must assess the likely demands on health and social services, not just the possibility of demands, the court ruled.

Another significant finding to emerge from *Hilewitz* was that one must consider medical and non-medical factors such as the willingness and the ability of the person to defray the costs of their health condition. As a result, a huge body of case law was overturned that had said otherwise.

Hilewitz concerned social services in Ontario, which was the destination of the applicant families. The province's social services legislation considers the fact that people can contribute to the social services that they require. The SCC relied on that point to say, in this particular instance, that

one had to consider their ability and willingness to contribute.

However, some questions still remained following the SCC decision. Because *Hilewitz* concerned applicants coming to Canada in the business category, did it apply to people coming on humanitarian or compassionate grounds for permanent residence, for example? A second question — and this was an important one for PHA applicants — was: did the decision apply to health services as well? The position of the federal government was that *Hilewitz* was confined only to social services.

Following *Hilewitz*, the government became pro-active and came up with a set of policies called *Operational Bulletin 63*. This was its response to the 2005 decision of the SCC. It said that applicants could now come up with declarations of ability and intent if they were at risk of being determined medically inadmissible. It would give them the opportunity to explain to an immigration officer that they had the resources to offset the potential costs of their health condition. A sample declaration was attached to this policy. However, this policy only applied to social services.

With respect to the first question arising from *Hilewitz* — the scope of the applicants — the Federal Court of Canada answered this by ruling that it applied to everyone seeking to come to Canada.¹² With respect to the question of health services, the government position was that health care in Canada is universal. There was no mechanism for people to contribute, nor was there one for the government to recover the costs.

The *Companiononi* decision

The next legal development concerned *Companiononi*.¹³ It involved a

same-sex couple on ARV medication that had applied to come to Canada as skilled workers from the United States of America. There, they had private insurance to cover the costs of their medication: one had employment-based insurance, while the other had private insurance.

Companiononi opened the door to HIV-positive applicants to say that they had some way to pay for their ARVs.

When they applied to come to Canada, they acknowledged needing ARVs, but also promised two things. The couple submitted a declaration of ability and intent in which they promised to obtain private coverage through an employer and to cover the costs themselves if, at any time, they were not employed and did not enjoy such benefits. They were well resourced and could economically cover the costs themselves.

However, the immigration officer refused the application by saying that they had not submitted a credible plan of how they were going to cover the medication costs. The officer was under the impression that their pre-existing condition would exclude them from any private insurance in Canada and said that they did not, in fact, have sufficient funds to cover their medications here.

The case went to the Federal Court of Canada and succeeded in 2009 at the Trial Division. The important conclusion drawn from the ruling was that, for the first time, the Federal Court determined that the *Hilewitz* principles applied to health services — at least, to certain ones (in this case, ARV medication). This was a significant finding, because it opened the door to HIV-positive applicants to say that they had some way to pay for their ARVs.

A second conclusion from *Companiononi* concerned the credibility of the couple's plan. The Federal Court said that, given the confusion of the immigration officer about the automatic exclusion for pre-existing health conditions in the private insurance plans, and given the evidence that their counsel submitted — namely, that, in most employment-based group plans, there are no pre-existing exclusions — the officer ought to have gone back to the couple and told them to produce a plan and explain in further detail about how they would offset those costs.

The Federal Court overturned the decision of the immigration officer and sent it back the Canadian Consulate in the U.S. However, it did say that the mere undertaking by the couple to cover the costs of their medication through their own private funds was not sufficient. The court made it clear that a person could not come to Canada and claim that he had enough money to pay for his medication, because there was no means for the government to enforce that.

Nevertheless, a window for PHA applicants had been opened up. *Companiononi* allowed PHA applicants to say that they did have sufficient funds to cover the costs of their

health services. They could no longer face automatic exclusion.

The federal government filed a notice of appeal; however, it was not clear what it was unhappy with in the ruling by the Federal Court.

The Rashid decision

Meanwhile, another Federal Court decision¹⁴ concerned a person with HIV. The individual, Rashid, was a PHA coming to Canada who needed ARV medication. He had submitted a plan that outlined payment for the ARVs solely through private means: his siblings would pay for it. He did not indicate anything about obtaining private or employer-based insurance.

The Federal Court agreed with the *Companioni* principles, in that PHA applicants were entitled to put forward these plans and demonstrate that they would not be in excessive demand. On the other hand, the court said that the mere undertaking to pay out of one's own funds was not enough. This point refers back to the fact that the government cannot enforce such undertakings. In other words, a plan by the applicant has to be something more than a promise to pay.

Rashid lost his case, but it is currently under appeal. (Meanwhile, the federal government dropped its appeal in *Companioni*, so that decision stands as good law.)

Under the current law, PHAs are admissible to Canada. They can overcome the excessive demand threshold as long as they can show a credible plan to offset the cost of their ARV medication. The question is: what is that credible plan? At this point, the answer remains unknown. It will be developed as cases come through the courts. However, the legal community is of the impression that pre-arranged employment with

employment benefits will constitute a credible plan.

Beyond this case law, there remain other options to challenge the excessive demand threshold. One would be for the applicant to request a waiver of medical inadmissibility based on humanitarian or compassionate grounds. Another possibility is a Charter challenge. One could seek to have the entire excessive demand provision removed by saying that it runs contrary to the *Canadian Charter of Rights and Freedoms*. Nevertheless, the better things develop for PHA applicants by virtue of the *Hilewitz* decision, the more difficult it will be to launch a challenge, because such a move is usually only successful when the law is very rigid and unfair. The more flexible the excessive demand threshold is, the harder it will be to have it removed.

Lobbying for change

A second strategy to challenge the excessive demand barrier is through lobbying. This can entail meeting with members of Parliament, appearing before Parliamentary standing committees or undertaking good, quality research.

By way of example, the Ontario HIV Treatment Network funded a study¹⁵ that looked at the question of the reliability of the current approach to excessive demand, which involves the government taking the overall cost of health care and dividing it by the number of Canadians. The figure, as mentioned, comes to \$5143.

The authors of the study attempted to devise a formula that was more reasonable and responsive to the excessive demand threshold. They came up with a statistical model that looked at an alternate way of distributing the costs in Canada per capita.

Under this model, the new threshold would be approximately \$14 000. A second part of the study also established a way of assessing people's contributions to Canada and presented a chart of profiles that would assess their anticipated contributions.

The study was sent to the CIC Parliamentary standing committee; however, no response has been received. Nevertheless, this is the type of research that can be presented that demonstrates the urgency of the issue and serves as useful tool in order to break down the excessive demand barrier.

¹ L.M. Bisailon, "Implications of mandatory HIV screening as pre-condition for immigration to Canada," paper presented at the Ontario HIV Treatment Network Annual Research Conference, 2009, Toronto; L.M. Bisailon, "Cordon sanitaire ou politique saine? La politique de dépistage obligatoire pour le VIH/sida et les nouvelles arrivantes au Canada," paper presented at the Femmes, corps et santé panel of the Annual Association francophone pour le savoir Conference, 2009, Ottawa.

² M. Zencovich et al., "Immigration medical screening and HIV infection in Canada," *International Journal of STD and AIDS* 17 (2006): pp. 813–816.

³ Preliminary findings are based on data from interviews and focus groups with PHAs in Toronto and Montréal. Informants were citizens of 21 different countries, having arrived in Canada from 2002 onward. Informants entered Canada under various categories: skilled worker, spouse/common law, refugee, refugee applicant, and humanitarian and compassionate grounds. Most inform-

ants were living with HIV and some were born with HIV. Despite best efforts to locate PHAs outside of Canada whose applications had been refused, this population was unfortunately not part of the study. Second-level data were gathered through the review of official and informant documents, forms and other publicly available texts, as well as bilingual (French and English) interviews in Toronto and Montréal with the following: lawyers; designated medical practitioners; social workers; nurses; AIDS service organization case workers; Canadian Border Services Agency employees; government advisors and officials; and HIV physicians.

⁴ M. Zencovich (supra).

⁵ *Immigration and Refugee Protection Act, c. 27; Canadian Immigration and Refugee Protection Regulations (SOR/2002-227)*; Citizenship and Immigration Canada, *Operational processing instruction 2002-004. Medical assessment of HIV positive applicants* (2002).

⁶ For a historical account and critical review of Canada's practices related to immigration medical screening, see S. Wiebe, "Producing bodies and borders: a review of immigrant medical examinations in Canada," *Surveillance & Society*, 6 (2009): pp. 128–141.

⁷ A. Klein, *HIV/AIDS and Immigration: Final Report*, Canadian HIV/AIDS Legal Network, 2001. See also B. Hoffmaster and T. Schrecker, *An ethical analysis of the mandatory exclusion of refugees and immigrants who test HIV-positive*, The Names Project, 2000, for the companion piece of advocacy research that was commissioned by the Canadian HIV/AIDS Legal Network before the testing policy was introduced in 2002.

⁸ Public Works and Government Services Canada, *Handbook for designated medical practitioners*, 2009.

⁹ R.V. Ericson and P.M. Baranek, *The ordering of justice: a study of accused persons as dependants in the criminal pro-*

cess. (Toronto: University of Toronto Press, 1982).

¹⁰ This figure is calculated by the total cost of health care in Canada divided by the number of citizens in the country.

¹¹ *Hilewitz v. Canada (Minister of Citizenship and Immigration)*; *De Jong v. Canada (Minister of Citizenship and Immigration)*, [2005] 2 S.C.R. 706.

¹² *Colaco v. Canada (Minister of Citizenship and Immigration)* 2007 FCA 282.

¹³ *Companiononi v. Canada (Minister of Citizenship and Immigration)*, [2009] F.C.J. No. 1688 (QL).

¹⁴ *Rashid v. Canada (Minister of Citizenship and Immigration)*, [2010] F.C.J. No. 183 (QL).

¹⁵ P.C. Coyte and M. Battista, *The economic burden of immigrants with HIV/AIDS: When to say no?* Ontario HIV/AIDS Treatment Network, 2009.

Panel — Our bodies, our health: a more comprehensive understanding of maternal health and HIV

This article provides summaries of presentations made during the panel. Shari Margolese outlines the work of the Canadian HIV Fertility Program on behalf of HIV-positive women and men looking to conceive. Khatundi Masinde presents research on the impact of gender, race and stigma on the housing experiences of African and Caribbean mothers living with HIV in Canada. Suzannah Phillips discusses the violations of reproductive rights of HIV-positive women, including forced or coercive sterilization.

Fertility, desires and intentions of HIV-positive women and men

Shari Margolese, Community Consultant, Women's College Research Institute

The majority of HIV-positive women and men in Canada are of child-bearing age.¹ A 2009 survey in Ontario found that 69 percent of HIV-positive women desired to give birth, while another 57 percent intended to give birth in the future.²

Nevertheless, challenges remain for those who wish to become parents. Sperm-washing fertility treatments and fertility investigation for people living with HIV (PHAs) who wish to conceive is not readily accessible across Canada. Some PHAs who wish to conceive must travel far distances for weeks at a time and incur the financial costs of doing so in order to undergo fertility treatment to prevent HIV transmission between partners or between mother and child. In some instances, fertility clinics will agree to see PHA patients who are looking to conceive and do testing to see if this is possible, but will not assist the patients in the actual conception.

For this reason, fertility assistance for this cohort is a pressing matter. The Canadian HIV Fertility Program at Women's College in Toronto is a community-based project that aims to develop a collaborative program, based on research, to form a set of guidelines in order to assist all PHAs in Canada with their fertility desires and pregnancy planning in a holistic, ethical, supportive and medically sound manner.

Pregnancy planning guidelines

The program aims to compile a list of fertility care providers for each province and contact each one to determine how many of them would be willing and able to provide fertility investigation and treatment for PHAs. This list would be made readily available to communities of HIV-positive individuals. From this list, a dynamic team of experts would be chosen to form development teams focused on producing national HIV pregnancy planning guidelines to help fertility care providers and clinicians nationwide understand the important options that are available for their HIV-positive patients who wish to conceive.

The development team will include PHAs, community service organiza-

tions, health-care providers, academics as well as other researchers, relevant governing bodies and policy-makers. The purpose of employing such a group is to ensure that the guidelines reflect a collaborative approach to best practices at the community, clinical and government levels.

Programming to achieve

The Canadian HIV Fertility Program expects that some members of the guideline development team will take it upon themselves to spread their knowledge and newly formed framework within their communities, in the hopes of building provincial and national capacity to improve access to reproductive options for PHAs. The team will do this by developing and disseminating resources and programs, which will include educational pamphlets, fact sheets, workshops and websites discussing the national pregnancy planning guidelines. There will also be focus groups, train-the-trainer sessions and community capacity-building workshops to disseminate the information directly to PHAs. All programming and literature will be developed and implemented alongside HIV-positive individuals in order to maintain the relevancy of the work.

At its very core, the Canadian HIV Fertility Program aims to support HIV-positive individuals who wish to have children. Through its programming and literature, it also hopes to build the capacity of PHAs to become informed about their opportunities to conceive. Furthermore, the program wants to bring about increased access to fertility services for HIV-positive communities through improved policies and guidelines that require this.

The Canadian HIV Fertility Program is focused on producing national HIV pregnancy planning guidelines.

Underpinning the program is a reaffirmation of the fundamental human right to a healthy pregnancy free from discrimination. For PHAs, this means easy access to fertility services that will allow them this right. Services such as assisted reproductive technologies should therefore be covered by health care, while confidentiality and privacy of HIV-positive patients must be respected.

Continuing research

The Canadian Institute of Health Research (CIHR) has recently funded research to be conducted by the Canadian HIV Fertility Program. The work will examine

the risk of HIV transmission from a PHA to an HIV-negative individual in a sero-discordant couple where the HIV-positive partner has full plasma viral suppression while taking antiretroviral medications and where the HIV-positive partner is a heterosexual woman, a heterosexual man or a homosexual man. Using this research, the program hopes to enlighten counselling approaches on the risk and prevention of HIV transmission in the discordant couple, while also informing provincial and national policy on the topic.

The CIHR has also funded a study by the Canadian HIV Fertility Program that will look at HIV-positive individuals and couples living in Ontario who are actively getting pregnant in order to determine the proportion of successful pregnancies, the health system experience required to achieve them, the means utilized to prevent horizontal transmission and the rates of horizontal and vertical transmission. The study will also evaluate the patient education tools used and determine the degree of risk of horizontal HIV transmission that PHAs and their partners living in Ontario are willing to accept in order to get pregnant.

The impact of gender, race and stigma on the housing experiences of African and Caribbean mothers living with HIV

Khatundi Masinde, Research Assistant, Fife House

A community-based study exploring the impact of gender, race and stigma on the housing experiences of African and Caribbean mothers living with

HIV in Canada was conducted by McMaster University in Hamilton, Fife House and other agencies who work with or could potentially work with PHA parents. This research followed them and their experiences with housing, health and social services in their community in order to identify positive practices as well as areas in need of improvement. Researchers took into account gender, poverty, racism and immigration status in order to understand the social inequalities that can affect a woman's health.

Semi-structured and in-depth interviews were conducted with PHA parents living with their child or children. The interviews focused on the parents' experiences accessing housing, housing providers and systems of support. Their experiences transitioning in and out of shelters and abusive environments, as well as the impact of disclosing their HIV status on their access to housing applications, were common themes in many of the parents' stories.

The parents, mainly women, recounted their experiences in the shelter system and their reasons for living in them. Out of the 30 people interviewed, only one had a positive experience. The others spoke of over-crowding and a constant concern for their children's well-being while in the shelters. One of the respondents said the following:

We were in a shelter for two months, yes. So, we were housed in a shelter And even in the shelter we were not well housed. We were in one room, four of us in one room. We shared the same room with the kids for two months ... it was really a transitory solution. And as soon as we got the social assistance we decided to leave and find our own means.

The research revealed that the applicants for housing services were forced into disclosing their HIV status through humiliating interviews where they were expected to divulge their life stories, including their sero-status, to multiple people and service organizations. This process left them feeling vulnerable and emotionally drained. It also led many applicants to remain in shared and sometimes unsanitary living conditions, at the risk of their own health, rather than continue with the interview process.

Housing-influenced stigma

Some women opted to live in shared housing rather than applying to housing services because they were worried that, if housing services placed their families in houses “marked” for PHAs, their children would be teased at school and grow up in a depressing environment. Other women found comfort in living in such housing, because they knew their neighbours would not discriminate or stigmatize them or their children. Common among all of the women interviewed was the concern for the well-being of their children over their own health.

Applicants for housing services were forced into disclosing their HIV status.

Another common theme among the parents interviewed was that of abuse. Some women reported that

their partners shouted negative slurs in regard to their HIV status. Others feared abuse from strangers living in the shelters with them or violent and intoxicated neighbours within the subsidized housing community. These women felt that, as long as their housing situation was unstable, they would not feel safe, healthy or free to carry on with their lives.

Other women, who were not in abusive relationships, observed that housing services did not treat their housing needs urgently, even though they had children and were also sometimes supporting extended family members. These women shed light on the fact that the government would only consider children as dependants when deciding which housing cases were priorities, even though it is common among the Afro-Caribbean community financially to support extended family members.

It is suggested that the shelter sector and AIDS service organizations’ housing services should undergo targeted training and education on and about the unique issues that face HIV-positive mothers, particularly those who are experiencing issues related to immigration, sponsorship and racism, and how to support this community better. PHAs will be meaningfully engaged in this training process, from design to implementation, in order to ensure that this community is served in a way that best suits their needs. These training sessions will integrate members from different service sectors related to immigration, mental health, child and family services, education, housing and HIV, and will, it is hoped, create a foundation for better communication between these groups in the future in order to encourage more appropriate services.

Violations of reproductive rights of HIV-positive women

Suzannah Phillips, International Legal Fellow, Center for Reproductive Rights

Reproductive rights include the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so free from discrimination, coercion and violence. This basic right is based on numerous human rights protected in national laws and binding international and regional human rights agreements.

In spite of these legal standards, the stigma surrounding HIV and motherhood in some countries can lead to discriminatory treatment of women living with HIV who are pregnant or wish to become so. Often these women are not able to make free and informed decisions to become pregnant. For instance, they may be denied information about how to conceive safely or denied access to birth control under the assumption that they should not be having sex in the first place.

Sometimes, women who are HIV-positive are even refused standard pre-natal, delivery and post-natal care, resulting in haemorrhaging, miscarriages and even death. HIV-positive women may also be victims of coercive or forced sterilization, denying them their right to make informed decisions about their continued fertility and future pregnancies.

Domestic legal systems perpetuate rights violations through various means. By criminalizing HIV transmission, including mother-to-child

transmission (MTCT), some national laws essentially codify discrimination against PHAs. In addition, regulations and guidelines on informed consent, confidentiality and other standards of care may not be adequately disseminated or implemented. Even where domestic laws uphold women's reproductive rights, they are often inadequately enforced.

Laws that uphold women's reproductive rights are often inadequately enforced.

Violations of the reproductive rights of HIV-positive women, gathered from studies carried out in Latin America and Africa, can include being discouraged from becoming pregnant or given misinformation about HIV and pregnancy; being denied information on how to conceive safely (e.g., sero-discordant couples); mandatory HIV screening and/or testing without informed consent; lack of confidentiality in testing and treatment; inadequate counselling on prevention of MTCT or post-partum family planning; and coercive or forced sterilization.

Coercive and forced sterilization of women

Forced sterilization is when a sterilization procedure is carried out without the patient's knowledge or consent. Coercive sterilization occurs when a patient has not given

informed voluntary consent for the procedure. The sterilization of a woman can have grave physical and psychological impacts on her well-being. She may also face severe discrimination from her community and abandonment by her husband.

In order to give informed consent, a woman would have to receive and understand adequate information about the risks and benefits of sterilization and counselling from a trained professional. Informed consent must be given without threat, inducement, fraud or coercion. For example, medical providers have been known to threaten to withhold antiretroviral medication from women who are HIV-positive unless they consent to sterilization. These doctors may think that they are doing what is right for their patient, but consent under such circumstances is not informed or voluntary, and such practices directly violate women's reproductive rights.

Over the past several years, reports of coercive and forced sterilizations of HIV-positive women have increased around the world. In one case — *F.S. v. Chile*³ — an HIV-positive woman was sterilized without her knowledge or consent while under anaesthesia for a caesarean section to give birth to her child. During routine prenatal screenings, the 20-year-old agricultural worker from rural Chile learned that she was HIV-positive. Throughout her pregnancy, she took the necessary precautions to reduce the risk of MTCT.

In November 2002, F.S. checked into the hospital for a programmed caesarean delivery. She went into labour the night before her scheduled operation and was administered anaesthesia shortly after midnight. She slept during the operation, awaking only briefly to learn that she had

given birth to a baby boy. Several hours later, F.S. awoke in the recovery room, where the nurse on duty informed her that her son was born healthy and HIV-negative, but that it would be her only child: the surgeon had sterilized her during the procedure.

Under Chilean law, discrimination against HIV-positive people in the health-care setting is prohibited. The law also requires written authorization for surgical sterilization and criminalizes any harm that leaves the victim impotent. Although these rights exist in policy, the systemic nature of coercive sterilization of HIV-positive women in Chile demonstrates that they are not always respected in practice.

Coercive and forced sterilizations of HIV-positive women have increased around the world.

At the time of the sterilization, F.S. was not aware that the actions of the surgeon were in violation of her rights according to Chilean law. Eventually, she learned of her rights through her association with a Chilean advocacy organization called Vivo Positivo. In 2007, F.S. filed a criminal complaint against the surgeon who had sterilized her, wanting to ensure that other women did not have to endure what she went through.

The investigation into the claims by F.S. against the surgeon was marked by irregularities and bias. The prosecutor chose to ignore the lack of written consent as required by law, as well as discrepancies between the testimonies of the attending medical team, and advised the court to dismiss the case. The court followed the recommendations of the prosecution and, in August 2008, the appellate court upheld this dismissal.

In February 2009, the Center for Reproductive Rights and Vivo Positivo jointly filed a petition to the Inter-American Commission on Human Rights on behalf of F.S. The petition alleged that the Chilean

state violated her rights to physical and mental integrity and humane treatment; freedom from gender-based violence; personal liberty and security; privacy; family life; health; non-discrimination and equality before the law; and judicial remedies. In addition to seeking redress for the harm that F.S. suffered, the organizations are seeking normative and policy changes to address the systemic nature of such coercive practices, with the hope that the case will have a broader ameliorative effect. By bringing a claim before a regional human rights body, the organizations also aim to raise awareness about coercive and forced

sterilizations of HIV-positive women, shape public discourse around the issue and strengthen international norms on the reproductive rights of HIV-positive women.

¹ Public Health Agency of Canada, *HIV and AIDS in Canada: Surveillance Report to December 31, 2008*. 2009.

² M. R. Loutfy et al., "Fertility Desires and Intentions of HIV-Positive Women of Reproductive Age in Ontario, Canada: A Cross-Sectional Study," *PLoS* 4(12) (2009): e7925. doi:10.1371/journal.pone.0007925.

³ Inter-American Commission on Human Rights. Petition presented on 3 February 2009, pending admissibility decision.