Canadian HIV/AIDS Legal Network

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Legislative and policy analysis of HIV prevention, treatment and care for people who use drugs and incarcerated people in Central Asia and Azerbaijan

In January 2011, the Regional Office for Central Asia of the UN Office on Drugs and Crime (UNODC) and the Canadian HIV/AIDS Legal Network released an extensive report assessing the legislative and policy environment affecting the response to HIV in six countries of the Commonwealth of Independent States (CIS). The report, which draws in part upon the work of a national expert group in each country, puts forward dozens of recommendations for legislative and policy reform, including recommendations for specific reform tailored to the situation in each of the participating countries, with a particular focus on addressing the fast-growing HIV epidemic linked to injection drug use and in prisons.

The full text of the report — *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform* — is available on-line in both English and Russian via either www.unodc.org/centralasia or

cont'd on page 5

Inside

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

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

CONTENTS

cont'd

HIV/AIDS IN THE COURTS — INTERNATIONAL

Legislative and policy analysis of HIV prevention, treatment and care for people who use drugs and incarcerated people in Central Asia and Azerbaijan

cont'd from page 1

www.aidslaw.ca/centralasia. This article summarizing key findings and recommendations was prepared by David Cozac and Richard Elliott.[1]

Introduction

In recent years, the region of Eurasia has seen one of the world's fastest-growing HIV epidemics, with unsafe drug injecting practices being a major driver. During the past decade, the region comprising countries of the former Soviet Union has experienced the highest increase in prevalence of drug use worldwide.[1]

Although the six countries that form the basis of this legislative review and assessment — Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan — differ with regard to HIV prevalence and the extent of their responses to HIV, they have much in common. All of them face concentrated HIV epidemics driven predominantly by unsafe drug-injecting practices with significant potential for the further rapid spread of HIV.[2] HIV in prisons is another specific area of major concern and, given the extensive criminalization of people who use drugs, is linked heavily to injection drug use both inside and outside prisons. In addition, tuberculosis (TB) is a serious public health problem in the region and a major contributor to deaths among people with immune systems compromised by HIV. TB prevalence is particularly high among people injecting drugs and people in prison.[3]

While people who inject drugs and people in prison are heavily affected by HIV, they are poorly covered by HIV prevention and treatment services. According to UN agencies, "[i]n most countries of Eastern Europe and Central Asia, where injecting drug use accounts for more than 80% of all HIV infections, needle and syringe programs regularly reach only 10% of the estimated number of injecting drug users."[4] Interventions such as needle and syringe programs (NSPs) and opioid substitution therapy (OST) (e.g., medications such as methadone and buprenorphine) are widely recognized internationally as key elements of an effective response to HIV among people who inject drugs and in prisons. Yet overall access to such services remains exceedingly limited for these populations in the six participating countries, in part because of legal and social barriers.

The need for human-rights based legislative and policy reform

The assessment conducted by UNODC, the Legal Network and national experts showed that there are many common issues of concern in the legislation and policies of the project countries — and many ways in which reforms based on evidence and on human rights norms could significantly contribute to a more effective response to HIV.

As almost everywhere in the world, in the participating countries people who use illegal drugs and people in prisons are often among the most marginalized and stigmatized groups of society. Given administrative and criminal penalties for drug use and possession of even very small amounts of drugs for personal use, people who use drugs are at high risk of ending up in prison. They are vulnerable to abusive law enforcement practices, high rates of incarceration and the denial of health services (both outside and inside prisons).[5] Inside prisons, people are often at higher risk of HIV infection, because of sharing drug-injection and tattooing equipment, as well as unprotected sex, both consensual and

[1] All reasonable efforts were made by UNODC and the Canadian HIV/AIDS Legal Network to verify the accuracy of the information in the report (and summarized here) as of December 2009. Ongoing processes of legislative and policy reform, in part resulting from this project, mean some changes have since occurred; in some cases, those are noted here.

non-consensual. Conditions in prisons and pre-trial detention settings, including overcrowding, are poor and exacerbate damage to the health of individuals and to public health, such as contributing to high TB prevalence.

Outdated national laws often impede evidence-based approaches to HIV prevention among vulnerable groups such as people who use drugs and incarcerated people.

HIV prevention is not integrated into state health care systems (including health care services in prisons), meaning that health care professionals are often unfamiliar with effective, scientific methods of HIV prevention and treatment of HIV-infection and other concomitant health disorders for people at risk. Services for vulnerable populations are fragmented, uncoordinated and governed by vague rules and referral schemes. There are few or no official standards for providing harm reduction services. In addition, outdated national laws often impede evidence-based approaches to HIV prevention among vulnerable groups, in particular harm reduction measures, and complicate relationships between low-threshold HIV-related services and law enforcement bodies. The result of these structural, legal and social barriers is that hundreds of thousands of people who use drugs and people in prison have limited or no access to prevention and health care services.

However, if done correctly, with the objective of facilitating greater access to good-quality services, clear legislation and regulation could assist in scaling up evidence-based measures for HIV prevention and treatment.

It is widely recognized that responses to HIV and AIDS are much more effective if human rights, particularly of those most vulnerable to HIV infection, are protected.

International human rights treaties oblige ratifying states to *respect*, *protect* and *fulfill* a range of human rights, including in and through their national laws and policies. This includes the obligation to take positive measures to realize, over time, the right to the highest attainable standard of health for all [6] — and this includes people who use drugs and incarcerated people. The project countries have also committed to respecting and protecting numerous civil and political rights that are of great relevance to an effective response to HIV, including the rights to life, security of the person and privacy, to freedom of expression and association, and to receive and impart information.[7] Furthermore, underlying the entire body of international human rights law is the fundamental principle of non-discrimination, of particular relevance to people living with HIV and to those groups and individuals such as people who use drugs and people in prison, whose marginalization and exclusion, including through legally-sanctioned discrimination, contributes to their vulnerability to HIV and hinders their access to health and other services.

Summary overview of the project countries

Drug use and related risk behaviour

According to the UN, Central Asia as a region has experienced a dramatic rise in drug use, including injection of opioids.[8] A history of drug use is common among people imprisoned in the project countries, as is injection drug use in prisons. Sharing needles is a common practice: many prisoners reported lending, renting or selling their used needles to others for injecting.[9] Getting tattoos in prison is another common practice: among prisoners interviewed in three countries (Kyrgyzstan, Tajikistan and Uzbekistan), roughly 17% of the prison population in each country had received a tattoo while in prison, most of them with needles that had been used previously.[10]

HIV epidemic

Until 1994, there had been few registered cases of HIV infection in the countries of the region.[11] However, HIV is now spreading in the region more rapidly than in many other parts of the world. While there were only 50 HIV cases in 1996, 8,078 cases had been registered by 2004,[12] and there was a 1600% increase in HIV prevalence between 2002 and 2004.[13] All six of the participating countries are now experiencing HIV epidemics concentrated among people who inject drugs and their sexual partners, sex workers and to a lesser (but likely under-reported) degree, among men having sex with men.[14]

The single largest driver of the epidemic in the region is unsafe injecting practices widespread among people who use drugs.[15] According to data published by UNDP, levels of

awareness of the risk of HIV infection through sharing needles and other items is limited among both people who use drugs and the population in general. More than 60% of those in Uzbekistan living with HIV are people who inject drugs. In several regions in Azerbaijan, Kazakhstan, Kyrgyzstan and Uzbekistan, an estimated 30-40% of injection drug users have contracted HIV.[16]

Health care systems and services

In each country, the Constitution guarantees free health care services to some extent, but there is a significant gap between proclaimed legal guarantees and the reality.[17] Some of the national expert groups participating in this project have reported that persons seeking medical care often have to pay for such things as medical supplies, meals, linen or prompt admission to hospital.

All six of the countries are experiencing HIV epidemics concentrated among people who inject drugs.

Access to free health care is provided in district health care facilities on the basis of one's proof of residence (i.e., registration at a particular address). This system can present a potential problem for persons without such a certificate establishing a place of residence, most obviously homeless persons and migrants. In the absence of producing such a certificate, health services are provided on a fee-for-service basis only (with the exception of emergency care).

HIV prevention and treatment

All six countries have special AIDS centres responsible for HIV prevention and treatment, established in the early 1990s. While the approach seemed progressive at the time, doubts have since been raised about its efficacy — including that concern that singling out HIV from the broader system of public health care impedes the integration of HIV-related services with services for the prevention and treatment of TB, drug dependence and viral hepatitis.

Each country has public health legislation governing relationships in the sphere of health care, including the right to free health care services. These laws define such concepts as "diseases posing a threat to others" and "socially significant diseases." (The exception is Kyrgyzstan, which instead adopts annually a "Programme of State Guarantees" determining eligibility for certain free primary health care services). Both HIV infection and drug dependence are included in the scope of such coverage in all six countries, although in some circumstances certain treatment is only partially covered.

All six countries adopted specific statutes on HIV and AIDS in the mid-1990s, generally modelled on the Soviet Union's 1990 law. These laws regulate the rights and responsibilities of persons with regard to HIV infection and AIDS, and the mandate, obligations and privileges of health care workers and bodies working in the area of HIV. All of the laws contain anti-discrimination provisions and provisions on the confidentiality of medical information. However, there have been few cases of launching legal proceedings for breaches of such provisions, such as health care workers disclosing a patient's confidential HIV diagnosis.[18]

Although the countries have implemented voluntary HIV testing and counselling services, often these — and a clear requirement of informed consent to testing — are not formally reflected in or required by the law. In addition, with the exception of Kyrgyzstan, the participating countries' national laws on HIV and/or their subsidiary regulations contain very broad provisions on involuntary HIV testing for various categories of people.

Drug dependence treatment (narcological assistance)

In all six countries, treatment for drug dependence is provided in specialized "narcological" hospitals and in narcological offices in general hospitals. However, in accordance with the Soviet-era narcological system, treatment is generally based on detoxification with the limited use of rehabilitation and psychological methods. Other approaches have faced difficulty gaining acceptance even in the post-Soviet environment; this includes opioid substitution treatment using medications such as methadone and buprenorphine.[19]

At the time of publication of the UNODC/Legal Network report, despite solid evidence gathered over decades in other jurisdictions and endorsement by the UN's specialized technical agencies, opioid substitution therapy (OST) had been implemented only in three of six countries (Azerbaijan, Kyrgyzstan,

Kazakhstan), where the coverage of the services remains very limited. Kyrgyzstan was the first to implement opioid substitution treatment in 2002. In Tajikistan, government officials indicated that OST pilot projects were planned for the near future. In Uzbekistan, OST was available as of 2004, but in 2009 the government discontinued the projects. OST remains unavailable in Turkmenistan.

Harm reduction programs

Kyrgyzstan was the first country in the region to establish harm reduction programs when it launched needle exchange programs in Bishkek and Osh in 1999.[20] At this writing, needle and syringe programs exist in five of the six countries; Turkmenistan is the exception.

In none of the countries, however, have these interventions been entrenched in law. The breadth and depth of provisions on HIV prevention as it relates to drug use in the national anti-drug strategies of the project countries vary, but these documents do not define the legal status of HIV prevention programs for drug users. This often puts such programs as do exist in a precarious position, given the overwhelming emphasis on punitive and coercive approaches to drugs and those who use them (including as a result of drug dependence).

Correctional systems

Health care services in prisons are provided by health care departments within the relevant Ministry that has responsibility for the prison system, rather than being the responsibility of the Ministry of Health. According to the law in each country, prisoners with HIV are to receive antiretroviral treatment (ART). However, interviews conducted by the national expert groups demonstrated that health care services in prison are not equal to the services provided in the outside community

There were an estimated 135,000 people in prison in the project countries in 2008; a significant percentage of them were serving a sentence for drug-related offences.[21] In most of the project countries, prison authorities have recognized the reality of sexual activity and drug use in prisons and pre-trial detention facilities, and are now implementing HIV prevention interventions, albeit not comprehensive programs. (Official reports from Turkmenistan claim that there are no cases of HIV infection in its prisons and no drug use.)

According to the national expert groups, educational information on HIV prevention is distributed in prisons in all of the project countries. Condoms are distributed to prisoners in only three countries (Kazakhstan, Kyrgyzstan and Tajikistan). In other three countries condoms are available in the rooms for conjugal visits only.

In 2000, Kyrgyzstan was among the first countries in the Commonwealth of Independent States (CIS) to introduce NSPs in prisons — programs whose importance and efficacy is increasingly documented and recognized internationally by a growing number of countries as part of good, comprehensive practice in responding to HIV in prisons.[22] In three countries (Kazakhstan, Kyrgyzstan, Tajikistan), prisoners have access to disinfectants; while important, this is not considered a satisfactory substitute for access to sterile drug injection or tattooing needles.[23] (In February 2010, it was reported that Tajikistan would be piloting NSPs in prisons, and would start with educational sessions for staff and prisoners.[24])

Legislation in all of the countries also authorizes compulsory drug dependence treatment in prisons, but the implementation of such treatment varies. Meanwhile, voluntary treatment for drug dependence is not always accessible to patients in need. As of August 2008, pilot projects providing opioid substitution treatment (using methadone) were underway in prisons in Kyrgyzstan, but none of the other project countries had implemented access to OST in prisons.

Human rights situation: HIV, drug use and prisons

Drug laws and policies in all six countries are strict in punishing people who use drugs. A wealth of evidence has been amassed demonstrating that such policies contribute to the marginalization and stigmatization of people who use drugs, undermining HIV prevention services that seek to reach them and inhibiting their access to care, treatment and support for HIV infection, drug dependence and other health concerns. As such, these policies run counter to states' human rights obligations and to good public health policy.[25] For example, people who use drugs are easy targets for arrest in enforcing strict laws on drug use and possession: in a study in Kazakhstan, 80% of injection drug users interviewed by Human Rights Watch stated that they had received a prison sentence at some point in life, and many had their fourth or fifth sentence on charges of drug possession or robbery.[26] According to the same report, once apprehended, detainees are subject to extortion, threats and physical ill-treatment; many may succumb to pressure from law enforce-

ment agents to admit to false charges in response to coercive interrogation techniques or in exchange for drugs.

There are reports of systemic harassment and abuse of injecting drug users by police, and of torture of detainees. Based on interviews with drug users in Kazakhstan, Human Rights Watch reports cases of arbitrary arrest, verbal and physical mistreatment, physical abuse in some cases constituting torture, extortion, the planting of evidence on people who use drugs or are sex workers, forced sex and coerced confessions.[27] Upon incarceration, many opioid-dependent prisoners are forced to undergo abrupt opioid withdrawal, which can impair capacity to make informed legal decisions and heighten vulnerability to succumb to police pressure.[28] Furthermore, policing practices and the fear of arrest and prosecution contribute to high-risk drug injection practices and discourage people who use drugs from seeking harm reduction services and HIV information and treatment.[29]

Concerns have also been raised by government health officials and harm reduction workers that a lack of understanding on the part of law enforcement officers, insufficient training and education on HIV and AIDS for police, and entrenched repressive attitudes toward drug users result in harassment and discrimination by police against those providing harm reduction services. For example, according to one government official in Kazakhstan, police have targeted people who use needle exchange sites for surveillance and arrest.[30] The same research found cases of outreach workers being detained for carrying boxes of empty syringes; and, in two cities, several persons said that police conducted regular surveillance of pharmacies in order to identify drug users who buy disinfection material or syringes.[31] In the course of this project, national expert groups alluded to the concern that police practices could deter people who use drugs from seeking out health services. For example, the national expert group reported that, in many cities in Kazakhstan, people who use drugs are afraid to approach "trust points" (government-run facilities offering services including needle and syringe programs) because being identified as a drug user may result in further targeting by police.

Drug laws and policies in these countries are strict in punishing drug users.

The national expert groups from the six countries also consistently reported that the effectiveness of current drug dependence treatment is low. The majority of patients return to drug use almost immediately following the course of treatment, for which they often have to pay, despite the fact that, according to the law, it is supposed to be free.[32]

Prison conditions remain harsh and life-threatening. Prisons are generally overcrowded and unsanitary, and disease, particularly TB, is a serious problem. For example, government officials in Tajikistan reported that 36 prisoners died of tuberculosis or AIDS-related diseases in 2007.[33] According to the observations by the UN Committee Against Torture (CAT) on Tajikistan, there are numerous allegations concerning the widespread routine use of torture and ill-treatment by law enforcement and investigative personnel, particularly to extract confessions to be used in criminal proceedings.[34] There are reports of prisoners being denied or impeded in their access to legal counsel, family members and independent medical expertise. In Azerbaijan, Human Rights Watch has documented cases of torture, including through the use of electric shocks, severe beating and threats of rape, as well as other incidents of torture in police stations throughout the country, as well as in prisons.[35] Corruption is widespread and prisoners must pay prison guards for privileges and sometimes even for health care.[36]

Administrative and criminal law issues

In each of the six countries, the law and its implementation reflect a predominantly punitive approach towards people who use drugs, and the national response to drugs accords a predominant role to law enforcement agencies, rather than health agencies. This approach often ignores evidence-based methods of HIV prevention and treatment and international standards of drug dependence treatment, and often contradicts public health interests.

Each country maintains administrative and criminal law prohibitions on drugs. The countries vary in how they define various "small" or "large" (or even "extra large") quantities of drugs, and the administrative and criminal penalties associated with the possession of these different amounts. For example, at this writ-

ing, Uzbekistan and Kazakhstan have comparatively stricter definitions of quantities and harsher penalties, while Tajikistan takes a somewhat more liberal approach.[37] In all cases, however, the amounts for which possession triggers legal liability are quite small by any objective measure that considers realistic patterns of use by people with addictions — and in some cases, even minute amounts trigger serious legal consequences.

The countries' national laws generally make a distinction between people who use drugs and people who deal drugs, by adopting the concepts of possession "for sale" and "not for sale". Azerbaijan is the only country whose law explicitly reflects the notion of possession "for personal use".[38] Drug use *per se* is formally prohibited in several of the project countries, although it is not always penalized (e.g., accompanied by a specific penalty under the country's administrative or criminal code).[39]

Provisions for involuntary testing for illicit drugs by law enforcement authorities are common to all six countries. Frequently, the laws provide that law enforcement authorities need only have a suspicion of drug use in order to have legal authority to stop a person and send him or her for drug testing.[40] In some cases, it is also an administrative offence for someone to avoid medical examination, including drug testing, and treatment if there is "adequate data" to indicate drug use.[41]

In addition, other areas of criminal and administrative law may hinder an effective response to HIV among other vulnerable groups in addition to people who use drugs or are in prison. For example, both Uzbekistan and Turkmenistan still criminalize consensual sex between men.[42] All of the project countries except Kyrgyzstan maintain provisions imposing both administrative and criminal liability on sex workers. All six countries have HIV-specific provisions in their *Criminal Codes* regarding exposure or transmission. These kinds of legal provisions run contrary to international human rights standards and/or international policy recommendations.

The national response to drugs accords a predominant role to law enforcement, rather than health agencies.

Legislation related to health care systems and services

In each of the countries, health care is guaranteed by the state. As stated in the law, it is provided free-of-charge according to place of permanent residence based on a certificate of domicile. However, in all countries, people who use drugs have limited access to health care and HIV prevention. Harm reduction services are rare, marginalized and not integrated into legislation and governmental policies.

Compulsory drug dependence treatment in one form or another exists in all six countries, both in the community and in prison. The law generally allows for compulsory treatment of people with alcoholism and drug dependence who refuse to undergo "voluntary" treatment and whose behaviour disturbs public order or threatens the well-being of others. In all of the countries, narcological facilities under the purview of the Ministry of Health provide compulsory treatment for non-offending drug-dependent people. Turkmenistan also maintains a so-called treatment-labour camp *(лечебнотрудовой профилакторий)* run by the Ministry of Interior.

The level of compulsory treatment of drug dependence for non-offenders varies in the countries. In Tajikistan, Azerbaijan and Kyrgyzstan, there is in practice little or no enforcement of such compulsory treatment, whereas in Kazakhstan, Turkmenistan and Uzbekistan, each year an estimated 6-13% of all persons undergoing drug dependence treatment are doing so under compulsion, according to the UNODC (UNODC, 2009, unpublished data). Compulsory drug dependence treatment for prisoners is used in all countries.[43]

In all of the countries, it is standard practice to *register* at narcological facilities the names and other information about people who use controlled substances and people with drug dependence. The existing legal provisions that regulate registration of people who use drugs at medical facilities allow for numerous negative consequences of registration, including exposing registered persons to legally-sanctioned discrimination in such areas as employment and/or education.

Many of the national HIV policies in the countries are out-dated, with unjustifiably broad provisions for mandatory or compulsory HIV

testing. Although national HIV laws may only explicitly mention mandatory or compulsory testing for HIV in some limited circumstances (e.g., blood donors, foreign nationals), they generally fail to prohibit explicitly the broader application of involuntary testing. It is often ministerial or departmental guidelines, orders or instructions that expand the categories of people who are subject to HIV testing that are not fully voluntary. There are also frequent breaches of confidentiality regarding HIV status of those tested.

The project countries should update existing or adopt new national laws and strategies in the areas of HIV and of drugs, so as to ensure that:

- the country's responses to the interconnected health problems of HIV and of drugs address the particular vulnerability of people who use drugs and people in prisons, including through guaranteeing easy access to effective services for preventing and treating drug dependence and reducing the harms associated with drug use;
- civil society and vulnerable groups are involved in the development, implementation and evaluation of these national policies and programs on HIV and on drugs; and
- health workers and law enforcement personnel have an informed understanding of HIV, drug dependence and harm reduction, as well of human rights, so that their work would contribute to an effective response.

In terms of the legislative basis for (1) drug dependence treatment, and (2) HIV prevention and treatment, with a particular focus on people who use drugs, it is recommended to amend national legislation, policies, regulations, guidelines and protocols to guarantee:

- the universal availability and accessibility of a variety of voluntary treatment options for drug dependence, including easy access to opioid substitution treatment (OST);

Many of the national HIV policies in the six countries are out-dated, with unjustifiably broad provisions for mandatory HIV testing.

- the application of compulsory drug dependence treatment only as a measure of last resort and, if applied, in full compliance with human rights principles and WHO-recommended clinical protocols;
- full confidentiality of patients' identity and health information, and the prohibition of using information from medical records of people who use and/or are dependent on drugs (i.e., from narcological registries) for reporting, without the explicit and documented informed consent of the patient.

As for HIV prevention and treatment, there is a need to develop legal, regulatory and policy provisions that will:

- ensure universal access to HIV testing, accompanied by quality pre- and post-test counselling, that is fully voluntary, informed and strictly confidential (and mandate access to truly anonymous HIV testing in at least some settings);
- explicitly prohibit mandatory and compulsory HIV testing (with the exception of mandating testing of donors of blood, organs, tissue or other bodily substances);
- guarantee full confidentiality of medical information, including HIV test results, and ensure that there are effective, accessible means of legal redress for persons whose right to confidentiality of medical information is violated;
- guarantee easy access to HIV-related care, including antiretroviral treatment (ARV) and especially for people who use drugs and people in prison who are HIV-positive; and
- guarantee easy access to TB services for drug dependent people and people living with HIV, including by integrating TB and HIV-related health care.

Addressing HIV and drug dependence in prisons

As noted above, in all the countries, people in prison are subject to compulsory drug dependence treatment. Courts commonly order compulsory treatment as part of sentencing, in addition to other criminal penalties — even though international drug control treaties explicitly allow for *alternatives* to conviction and incar-

ceration for drug offences, including providing treatment and rehabilitation services as alternatives, instead of imposing these *in addition to* criminal penalties.[44] According to national laws, voluntary drug dependence treatment in prisons is provided in almost all countries (with the exception of Turkmenistan). However, national experts note that, in reality, very few people in prison who need drug dependence treatment undergo it voluntarily.

In all of the countries, the law allows for compassionate release from prison of people with terminal illness; generally, this is thought to be available to at least some patients diagnosed with AIDS, although usually AIDS is not specifically mentioned. There are specific, discriminatory restrictions on the rights of prisoners with HIV and/or prisoners who have not completed compulsory drug dependence treatment, such as denying eligibility for transfer to prisons with less strict security regimes.

In order to strengthen the response to HIV in prisons, norms and regulations should be developed that will:

- include HIV prevention and treatment in prisons in national strategies and programs and specify clear funding sources for these measures;
- ensure the availability and accessibility of adequate health care services in prisons;
- make national health authorities responsible for prison health (as opposed to the Ministry of Justice or the Ministry of Interior), in order to make it easier to guarantee that people in prison are entitled to the same efforts to protect and promote health, and to the same health services, as people outside prisons;
- regulate the provision of information about HIV and AIDS and training for both prison staff and prisoners;
- ensure easy, confidential access to disinfectants such as bleach and to sterile injection and tattooing equipment;
- introduce easy access to voluntary drug dependence treatment (including OST) in prisons and limit the use of compulsory drug dependence treatment in prison settings;
- ensure access to antiretroviral treatment (ARV) in prison;
- ensure access to voluntary and confidential HIV testing, with counselling and informed consent, in prisons; and
- enable NGO contributions to HIV prevention and care in prisons, as well as supporting people in prisons to do peer HIV education and outreach to other prisoners.

Legislative discrimination and other restrictions of rights of people living with HIV or vulnerable to HIV

All six of the countries have general anti-discrimination provisions in their Constitutions and other legislation. However, there are no specific statutes to prohibit discrimination; rather, discriminatory acts towards certain groups may be prohibited in laws concerning these groups. Employment laws may also contain non-discrimination clauses, while health laws may contain non-discrimination clauses and/or the obligation on health care professionals to render medical care to everyone. In some countries, the violation of such non-discrimination (or equality) clauses is penalized by that country's *Criminal Code*. Similarly, in some of the countries, legislation establishes the possibility of criminal liability for a discriminatory refusal to provide medical services.

A number of the countries formally prohibit people who are living with HIV and people who use drugs from working in certain occupations or positions.

Nevertheless, contradicting such prohibitions, discrimination is often formally permitted by the law in areas such as employment and education, family life and some other areas. A number of the countries formally prohibit people who are living with HIV and people who use drugs from working in certain occupations or positions. In case of HIV infection, such prohibitions are often accompanied by — and made operational through — mandatory HIV testing for people working in, or applying to work in, certain positions. In some countries, people seeking to enrol in vocational training and higher education institutions are required to present a medical certificate, which includes a number of points (such as not being on the registry as a person who uses drugs or is dependent on drugs or alcohol,

and may in certain cases include HIV status). In countries where HIV testing is required in order to enrol in some types of educational institutions, such as a military academy, this provision infringes the right to education.

Many of the countries deport non-citizens living with HIV. This practice is sometimes associated with — and made operational through — mandatory HIV testing of foreigners and stateless persons. There are also restrictions on the right to found a family, such as when a government resolution lists the diseases that automatically prevent someone from adopting children (the list includes both HIV and drug dependence).

In order to counter such discrimination embedded in the law, it is necessary to include the development or elaboration of provisions that would strengthen existing legislative protections against HIV-based discrimination where there are gaps; introduce legal protection against discrimination based on drug dependence; recognize both HIV infection and drug dependence as disabilities for at least some legal purposes (e.g., protection against discrimination based on disability); and eliminate unjustified restriction or denial of rights of people who use drugs and people living with HIV such as unjustified discrimination in employment and educational institutions, immigration policies and in family relations.

Conclusion

There are issues common to all six countries in achieving universal access to HIV prevention and treatment. All countries have national laws that hinder the implementation of evidence-based approaches to preventing and treating HIV among vulnerable groups such as prisoners and people who use drugs. Current attitudes and policies sometime contribute to complicating interaction between HIV prevention services and law enforcement agencies. In general, the main issues that have been identified by the countries' expert teams and the international experts can be considered to fall into the following broad categories:

- punitive drug policies towards people who use drugs including their incarceration (sometimes for possession of very small amounts of drugs) and few or no alternatives to incarceration for people who use drugs in the case of non-violent offences;
- limitations of the rights of people living with HIV, people who use drugs, and prisoners with HIV and/or drug dependence, and no effectively enforceable anti-discrimination provisions;
- broad provisions for non-voluntary medical interventions such as coercive drug testing, compulsory treatment of drug dependence and mandatory HIV testing;
- absence of regulatory frameworks that clearly enable and support evidence-based HIV prevention interventions, including harm reduction services, that results in low access of people who use drugs and incarcerated persons to effective HIV prevention and treatment interventions;
- insufficient availability of effective_drug dependence treatment services, especially of opioid substitution treatment (i.e., no OST in some countries or low capacity pilot programs in a few others), and limited or no rehabilitation and overdose prevention programs in communities and in prisons; and
- limited meaningful participation of civil society, including groups of people living with HIV, people who use drugs and prisoners in the development, implementation and evaluation of the effectiveness of national strategies and laws on both HIV and on drugs.

National policy-makers and legislators should revisit laws and policies governing the accessibility of health care in general and of HIV-related services in particular — including those regulating drug dependence treatment and access to health care in custodial settings — and develop them in line with best, evidence-based practices and human rights principles. Amendments should be developed for health care laws (confidentiality, informed consent to medical procedures and treatment, limiting the use of coercive medical measures), HIV laws (HIV testing, repeal of discriminatory practices), social protection and family legislation (disability, child custody and adoption, deprivation of parental rights), and administrative and criminal laws (provisions on drug use/possession for personal use, alternatives to imprisonment, compulsory treatment of drug dependence).

Reforms should also be reflected in national programs on HIV, tuberculosis, drug control and criminal justice/penal reform. To make them operational, it will be necessary to align regulations and implementing practices with the amended laws. This will allow for the introduction and improvement of protocols and standards of services, improvements in reporting and accountability of

services, and improved professional education and vocational training. These reforms will contribute to the protection of people living with HIV, people who use drugs and prisoners from violations of their rights, including discrimination and punishment on the ground of their health status, while providing for universal access to evidence-based health interventions. The reforms will make national legislation and norms compliant with states' obligations to respect, protect and fulfil the human rights of these populations, including their right to health — and, therefore, ultimately will benefit the public health and society's well-being as a whole.

[1] *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan — Regional Study on Drug Use and HIV/AIDS, Regional Summary* (UNODC and World Bank, 2007), p. 16.

[2] UNODC (Regional Office for Central Asia), *Compendium of Drug-related Statistics 1997-2008* (June 2008), p. 32.

[3] *Towards Universal Access* (2008), pp. 36-38.

[4] Ibid, p. 63.

[5] See more in D. Barrett et al., *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy* (London: The Beckley Foundation Drug Policy Programme, 2008).

[6] *International Covenant on Economic, Social and Cultural Rights*, UN General Assembly, 993 UNTS 3 (1966) (entered into force 3 January 1976), Article 12; UN Committee on Economic, Social and Cultural Rights, *General Comment 14: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc. E/C.12/2000/4 (2000).

[7] *International Covenant on Civil and Political Rights*, UN General Assembly, 999 UNTS 171 (1966) (entered into force 3 January 1976), Articles 6, 17, 19, and 22.

[8] UNDP, Central Asia Human Development Report — "Bringing down barriers: Regional cooperation for human development and human security," *Central Asia Human Development Report* (2005), p. 122 [hereinafter "*Central Asia Human Development Report 2005*"].

[9] *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan — Regional Study on Drug Use and HIV/AIDS, Regional Summary* (UNODC and World Bank, 2007), p. 52.

[10] Ibid.

[11] UNDP, *Reversing the Epidemic: HIV/AIDS in Eastern Europe and the Commonwealth of Independent States* (UNDP Regional Office for Eastern Europe and the CIS, 2004), p. 11 [hereinafter "Reversing the Epidemic"].

[12] *Central Asia Human Development Report 2005*, p. 146.

[13] Ibid.

[14] UNAIDS, *Eastern Europe and Central Asia: AIDS Epidemic Update Regional Summary* (2007).

[15] *Central Asia Human Development Report 2005*, p. 123.

[16] Ibid.

[17] E.g., see: UNDP, *Reversing the Epidemic* (2004), *supra*; Human Rights Watch, *Fanning the Flames: How Human Rights Abuses are Fuelling the AIDS Epidemic in Kazakhstan* (2003).

[18] For one such report, see: L. Utyasheva, "First HIV legal precedent in Kyrgyzstan: breach of medical privacy," *HIV/AIDS Policy and Law Review* 2007; 12(2/3): 70, online via www.aidslaw.ca/review.

[19] E.g., see A. Latypov et al, *Opioid Substitution Therapy in Central Asia: Towards Diverse and Effective Treatment Options for Drug Dependence* (Eurasian Harm Reduction Network, 2010).

[20] D. Wolfe, *Pointing the Way: Harm Reduction in Kyrgyz Republic* (Harm Reduction Association of Kyrgyzstan, 2005).

[21] An estimated one-third of those in Tajikistan in prison had previously injected drugs and according to the national expert group, one-third were serving sentences for drug-related offences at the time of their review in 2007. 21.4% of people in prison were serving drug-related sentences in Uzbekistan.

[22] Wolfe, *Pointing the Way, supra*, p. 9; R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience* (2nd ed.), (Toronto: Canadian HIV/AIDS Legal Network, 2006), pp. 41ff, online via www.aidslaw.ca/prisons; R. Jürgens, *Interventions to address HIV in prisons: needle and syringe programmes and decontamination strategies*, Evidence for Action Technical Papers (Geneva: WHO, UNODC & UNAIDS, 2007).

[23] Jürgens, *Interventions to address HIV in prisons, supra*, p. 19–20.

[24] UNDP Tajikistan, "Needle and syringe exchange programmes for penitentiary facilities have started in Tajikistan," *UNDP Bulletin: Saving Lives*, Issue #11 (February 2010).

[25] For more discussion, see: J. Csete & J. Cohen, "Lethal Violation: Human Rights Abuses Faced by Injection Drug Users in the Era of HIV/AIDS," in Malinowska-Sempruch & Gallagher, *War on Drugs, HIV/AIDS and Human Rights, supra*, pp. 212-227; R. Elliott et al., "Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control," *Health and Human Rights* 2005; 8(2): 104-138; and *At What Cost?: HIV and Human Rights Consequences of the Global "War on Drugs" (New York: Open Society Institute, 2009)*.

[26] Human Rights Watch, *Fanning the Flames, supra*, p. 21.

[27] Ibid.

[28] R.D. Bruce & R. Schleifer, "Ethical and human rights imperatives to ensure medication-assisted treatment for opioid dependence in prisons and pre-trial detention," *International Journal of Drug Policy* 2008; 19(2): 17–23.

[29] Human Rights Watch, *Fanning the Flames, supra*, p. 18; see also J. Csete, *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs* (Toronto: Canadian HIV/AIDS Legal Network, 2007), online via www.aidslaw.ca/drugpolicy.

[30] Human Rights Watch, *Fanning the Flames*, pp. 32–33.

[31] Ibid, p. 33.

[32] M. Khidirov & M. An, in K. Malinowska-Sempruch, Sarah Gallagher (eds.), *War on Drugs, HIV/AIDS and Human Rights* (Russian edition) (IDEA, 2004), p. 190.

[33] U.S. Department of State (Bureau of Democracy, Human Rights, and Labour), *Country Reports on Human Rights Practices 2007: Tajikistan* (11 March 2008), online: www.state.gov/g/drl/rls/hrrpt/2007/100621.htm.

[34] UN Committee against Torture, *Tajikistan: Conclusions and recommendations of the Committee against Torture*, 37th Sess., 6-24 November 2006.

[35] Human Rights Watch, *Briefing Paper: Azerbaijan and the European Neighbourhood Policy* (15 June 2005), online: http://hrw.org/backgrounder/eca/azerbaijan0605.

[36] Ibid.

[37] For example, any quantity of heroin in Uzbekistan is classified as "large", while Kazakhstan's approach is effectively the same, defining any amount of heroin greater than 0.01 gram as "large".

[38] In other countries, the law on drugs does not reflect the concept of possession for "personal use" or permissible possession of a quantity that is based on an "average single dose".

[39] Legislation in Azerbaijan provides for administrative liability for drug use. In Tajikistan and Turkmenistan, drug use without a doctor's prescription is prohibited according to the laws on drugs, but there is no penalty defined in administrative or criminal codes. In Kazakhstan and Kyrgyzstan, drug use in public places leads to administrative penalty; possession of insignificant quantities of a narcotic substance in Kazakhstan may entail criminal charges. Uzbekistan does not have either administrative or criminal liability for drug use, nor does the law on drugs state any prohibition of it.

[40] E.g., Article 16 of Tajikistan's *Law "On narcotic drugs, psychotropic substances and precursors"* and Article 18 of Tajikistan's *Law "On Narcological assistance"*; Article 25 of Azerbaijan's *Law "On circulation of narcotic substances, psychotropic drugs and precursors"*; Articles 50–51 of Turkmenistan's *Law "On narcotics, psychotropic substances, precursors and measures to counter their illegal circulation"*.

[41] E.g., Article 326 of Kazakhstan's *Code of Administrative Offences*; Resolution of the Cabinet of Ministers of Azerbaijan, No. 135 (7 August 2000).

[42] Article 120 of the *Criminal Code* of Uzbekistan; Article 135 of the *Criminal Code* of Turkmenistan.

[43] Provisions for compulsory drug treatment are established by specific laws on compulsory treatment (e.g., in the case of Tajikistan, Turkmenistan and Uzbekistan), by special sections in the countries' *Criminal Codes* governing drug dependence treatment in prisons; and national laws on drugs.

[44] *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, Article 3(4).

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. Unless indicated otherwise, all articles for this issue were written by Ms. Symington.

Supervised injection sites in Quebec: one step closer to reality

Thanks to the efforts of community groups CACTUS Montréal and Point de repères, two supervised injection sites could soon be opening in Montréal and Québec City.

In November 2010, CACTUS Montréal announced that a supervised injection site (SIS) would open in Montréal in June 2011.[1] It is thought that as many as 30 000 people use injection drugs in Quebec and that 15 000 of those people live in Montréal.[2] According to CACTUS president Louis Letellier de St-Just, nearly 40 percent of users shoot up in the streets and many are reluctant to use health care services.[3]

As a result, 68 percent of injection drug users in Montréal suffer from hepatitis C and 19 percent are HIV-positive.[4] Therefore, CACTUS, which has been handing out sterile syringes since 1989, wants to take things a step further by setting up an SIS where users can benefit from preventive health measures.[5]

For now, Canada's lone SIS is in Vancouver. Numerous studies have shown that such sites are effective, both in Canada and abroad, in combating overdoses, lessening public nuisances, reducing risks associated

with injection drug use, stabilizing drug users' health and increasing access to drug addiction treatment.[6]

Nonetheless, for the past few years, Insite, the Vancouver facility, has been embroiled in a court battle between the federal government, which wants the site to close, and community organizations that back the drug users. The case is now before the Supreme Court of Canada, and CACTUS is part of an international coalition of harm reduction organizations that were recently granted intervener status.[7]

Despite the litigation, CACTUS has decided not to wait any longer to open an SIS in Montréal. In its view, the health of injection drug users requires an immediate response. Moreover, CACTUS cites a 2009 study by the INSPQ, Quebec's public health institute, which recommends that SIS be opened in Quebec on the basis that they are a pragmatic, humanistic and innovative response to certain problems that neither traditional approaches (such as prohibition and treatment) nor current harm reduction services have been able to solve.[8]

Although Yves Bolduc, Quebec's Minister of Health, does not support the initiative, another community group intends to follow the INSPQ's recommendation as well.[9] Point de repères has announced the opening of an SIS in Québec City in June.[10] Public consultations will be held in the spring by the St-Roch neighbourhood council. The aim of these consultations is to inform area residents about the project and get their views so that the neighbourhood council can issue an opinion as to whether it would be advisable to open an SIS in St-Roch.[11]

— Cécile Kazatchkine

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[1] "L'organisme Cactus annonce l'ouverture en juin d'un site d'injection supervisee," La Presse Canadienne, 29 November 2010.

[2] Ibid.

[3] Ibid.

[4] M. White, "Community groups want to open safe-injection sites in Quebec," Postmedia News, 30 November 2010.

[5] "L'organisme Cactus annonce l'ouverture en juin d'un site d'injection supervisée" (supra).

[6] See, for example, the findings of the Institut national de santé publique du Québec (INSPQ) in *Avis sur la pertinence des services d'injection supervisée : une analyse critique de la littérature* (December 2009) and K. Dooling and M. Rachlis, "Vancouver's supervised injection facility challenges Canada's drug laws," *CMAJ*, 182(13) (2010): pp.1440-1444.

[7] The coalition is made up of the International Harm Reduction Association (IHRA), the Canadian HIV/AIDS Legal Network and CACTUS Montréal. See Canadian HIV/AIDS Legal Network et al., "Une coalition internationale interviendra pour sauver le lieu d'injection supervisée de Vancouver," 17 February 2011. On-line: http://aidslaw.ca/publications/interfaces/downloadFile.php?ref=1818.

[8] C. Kazatchkine, "The National Institute of Public Health of Quebec voices support for supervised injection sites," *HIV/AIDS Policy & Law Review* 14(3) (2010): pp.23-24.

[9] L.-M. Rioux Soucy, "Québec et Montréal lanceront leur site d'injection supervisé, avec ou sans Bolduc," *Le Devoir*, 30 November 2010. On-line: www.ledevoir.com.

[10] Ibid.

[11] M. Boivin, "Centre d'injection supervisé : la santé publique appuie Point de Repères." *Le Soleil*, 13 November 2010; "Centre d'injection spécialisé : vers une consultation publique à St-Roch," *Le Soleil*, 28 January 2011.

Correctional Investigator highlights pending adverse impacts of the government's "tough on crime" agenda

Released in November 2010, the 2009–2010 annual report of the Correctional Investigator — the ombudsman for federal prisoners — presents a bleak picture of over-crowded prisons lacking in rehabilitative programming and increasingly populated by mentally ill and substance-dependant inmates in need of services.[1]

The investigator, Howard Sapers, notes the unusually high degree of legislative activity in the area of criminal law and sentencing reform, predicting that the "cumulative impact

of recent legislation and pending initiatives will be significant on the rate, cost, duration and distribution of incarceration in this country. As the legislative and policy agendas take full and combined effect, there will almost certainly be disproportionate impacts on Canada's more distressed and vulnerable populations."[2]

Sapers further expresses concern that the underlying principles guiding correctional practice and operations since the enactment of the *Corrections and Conditional Release Act* (1992) — the notion of the "least restrictive" measure, the recognition that prisoners have retained rights, the idea that the correctional authority has a duty to act fairly or that supervised and gradual community release is safer than release at warrant expiry — no longer "hold the same currency as they once did."[3]

With respect to infectious diseases, the report notes that HIV rates are seven to ten times higher among inmates than among the general population, and estimated Hepatitis C prevalence is 30–40 times higher.[4] Noting that a limited range of harm reduction measures are made available in prisons (i.e., condoms, dental dams and bleach), the report emphasizes that there is room for improvement in terms of what harm reduction measures are available and how they are dispensed.

"Denying prisoners access to the same harm reduction measures available in the community that do not present an unmanageable security risk raises human rights concerns," the report states.[5]

Specifically, the report notes that the scientific and medical literature on prison needle and syringe programs suggests that these initiatives reduce risk behaviour and the spread of infectious blood-borne diseases that arise through needle-sharing, do not increase drug consumption or injecting, and do not endanger staff or institutional safety and security. Further, the safer tattooing initiative, cancelled in December 2006, had a largely positive evaluation.[6] The report therefore recommends that a full and comprehensive range of harm reduction measures be made available to federal inmates.[7]

The report includes 24 concrete recommendations. In addition to the recommendation on harm reduction measures, others include:

- enhancing the recruitment of mental health professionals to work in prisons;
- prohibiting prolonged segregation of prisoners at risk of suicide or self-injury;
- conducting a review of all prisoners released directly into the community from medium-security facilities to determine why they were not first transferred to minimum-security facilities;
- making public the long-term capital, accommodation and operational plan, including offender population forecasts, planned capital expenditures for new construction and ongoing maintenance costs;
- conducting a review of all inmates in segregation-like units to ensure they are provided the same legislated protections and access to programs afforded to the general inmate population; and
- reviewing the eligibility restrictions on the Mother–Child Program with a view to maximizing safe participation.

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[1] The Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator 2009–2010*. 2010. On-line: www.oci-bec.gc.ca.

[2] Ibid., p. 4.

[3] Ibid., p. 5.

[4] Ibid., p. 22.

[5] Ibid.

[6] Ibid., pp. 22–23.

[7] Ibid., p. 23.

In brief

Ottawa police change policy on releasing photographs of suspects in HIV non-disclosure cases

Following controversy over a press release issued in May 2010, Ottawa Police Services announced a change in its policy with respect to the release of personal information and photographs of persons accused of not disclosing their HIV-positive status to sexual partners. In future cases of HIV non-disclosure, the chief of police will decide whether to release personal information and photographs of the accused.[1] The information may include the suspect's name, photo and date of birth. In some circumstances, police may consult with Ottawa Public Health or other stakeholders in the community.[2]

In July 2010, the Ottawa Police Services Board had indicated that it would not review the policy on how it released information about suspects.[3] Representatives of the LGBT community in Ottawa had petitioned the Board to conduct such a review and develop guidelines around the handling of HIV non-disclosure cases.[4]

Leaving the final decision in the hands of the chief does not necessarily mean that, in practice, anything will be done differently. Ottawa Police Chief Vern White reportedly stated in early 2011 that, given circumstances similar to those surrounding the case that incited this debate, he would again release the name and photo.[5]

Prison expansions to accommodate anticipated inmate population surge

Through a series of funding announcements, the Government of Canada has revealed that, in order to accommodate the expanding prison population in coming years, current prisons will be expanded. Correctional Services Canada (CSC) estimates an increase of 3400 prisoners, requiring 2700 new prison cells.[6] The majority of this increase will result from the *Truth in Sentencing Act*, which came into force in February 2010 and ended the practice of giving inmates double credit for time served in jail before sentencing.

Other proposed legislation that imposes mandatory minimum sentences, eliminates conditional sentencing for some types of offences and ends early parole could also result in more inmates spending more time behind bars.[7]

The precise cost of the required prison expansion is contentious. The minister of Public Safety has indicated that the *Truth in Sentencing Act* is expected to cost CAN$2 billion over five years.[8] Parliamentary Budget Officer Kevin Page has reportedly estimated that the increase in prisoners will be 4200 at a cost of $1.8 billion for facility construction and an additional $3 billion a year for operations and maintenance.[9] He further suggests that, by 2015–2016, annual prison expenditure will have increased to $9.3 billion from the current $4.3 billion.[10]

According to a CBC News analysis of data from CSC, spending on capital items such as new prison cells is increasing at double the rate of spending on programming for inmates.[11]

Three Canadian cities endorse the Vienna Declaration

As previously reported in the *HIV/AIDS Policy & Law Review*,[12] the Vienna Declaration, launched at the XVIII International AIDS Conference in Vienna in July 2010, is a statement seeking to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies.[13]

In 2010, three Canadian cities endorsed the document, adding to the over 19 500 scientists, researchers, legal professionals, members of law enforcement and the judiciary, current and former heads of state, and a wide range of academics, organizations and individuals from around the world[14] who have added their names to the list. Toronto was the first municipality to endorse the declaration, with a City Council vote on 26 August. The following month, Victoria City Councillors followed suit. Finally, in November, the City of Vancouver also endorsed the Declaration.

The Vienna Declaration was drafted by an international committee of experts in HIV/AIDS and drug policy from around the world. It asserts that prohibitionist policies have failed to

eradicate harmful drug use but have fuelled HIV epidemics.

British Columbia moves to a "routine offer" model of HIV testing

In December 2010, revised HIV testing guidelines were announced to health-care providers and community members in British Columbia as part of the STOP HIV/AIDS (Seek and Treat for Optimal Prevention of HIV/AIDS) project.

Under the new guidelines, health-care providers are encouraged to offer an HIV test routinely to individuals presenting to acute or community care who meet any of the following criteria: anyone who has ever been sexually active and has not had an HIV test in the past year; individuals with a past history of sexually transmitted infection (STI); and anyone tested for or diagnosed with Hepatitis C, any STI or tuberculosis. These additional criteria supplement previous guidelines that recommend that HIV tests be offered based on the presence of HIV symptoms and provider-awareness of a patient's HIV risk factors.[15]

Dr. Patricia Daly of Vancouver Coastal Health is quoted in local media as saying that offering HIV tests to people outside of high-risk groups will help to remove stigma and identify people who are unaware that they are affected with HIV, thereby getting them into treatment sooner and reducing the risk they will infect others.[16] According to Vancouver Coastal Health, an estimated 25 per cent of the approximately 13 000 British Columbians living with HIV are unaware of their infection.[17]

STOP HIV/AIDS is a four-year, CAN$48 million program funded by the British Columbia Ministry of Health Services to improve access to HIV testing, treatment and support services in Vancouver's Downtown Eastside and the city of Prince George.[18]

Public Health Agency of Canada releases HIV status report on Aboriginal peoples

The Public Health Agency of Canada (PHAC) has issued a population-specific HIV/AIDS status report on Aboriginal peoples. It is the second of eight reports summarizing current evidence about HIV/AIDS within key populations in Canada.[19]

As the report details, Aboriginal peoples are over-represented among HIV and AIDS cases in Canada. It is estimated that they make up 8 percent of all those living with HIV in Canada (2008 data), but only 3.8 percent of the Canadian population (2006 data).[20] Moreover, HIV infections among Aboriginal peoples are diagnosed at a younger age and affect a higher proportion of women when compared to the non-Aboriginal population. Injection drug use is the main category of exposure to HIV for both Aboriginal males and females.[21]

The report discusses various factors that impact Aboriginal peoples' resiliency and vulnerability to HIV, including culture; social environments and support networks; income, education and employment; physical environments; personal health practices and coping skills; child development; health services; gender; and the legacy of residential schools.[22] For example, the report notes that prevention approaches must be tailored to the historical, cultural, spiritual and linguistic realities and needs of Aboriginal peoples, and identifies cultural reconnection as an important source of strength and resilience for Aboriginal peoples living with HIV (APHAs).[23]

APHAs experience increased mortality, reduced access to medical treatment, increased food insecurity and increased experiences of discrimination in accessing housing than non-Aboriginal PHAs.[24] The report highlights how many Aboriginal peoples face unique barriers to good health as a result of geographic isolation.[25] It also discusses the over-representation of Aboriginal peoples within the prison population and the risks of HIV infection within prisons.[26]

The final chapters of the report provide an overview of current research on and responses to HIV among Aboriginal peoples, including the many innovative strategies, coalitions, networks and organizations dedicated to addressing this element of the epidemic within Canada.[27]

Canadian Medical Association releases new policy on privacy

The Canadian Medical Association (CMA) has issued a new policy, *Principles for the Protection of Patients' Personal Health Information*, to "highlight ethical and practical ways to protect patients' personal health information, including situations where legislation grants physicians discretion to collect, use and disclose personal health informa-

tion without consent."[28] The policy contains 14 principles to guide physicians and medical students.

The document acknowledges that privacy, confidentiality and trust are cornerstones of the patient–doctor relationship and that patients have a general right to control the use and further disclosure of their personal health information.[29] It notes that physicians may rely on a patient's implied informed consent to share personal health information for purposes directly relevant to patient care and treatment. However, the patient's express consent is generally required to disclose any of the patient's personal health information in response to a third-party request (e.g., insurance company or lawyer) that is not directly related to the patient's health care or treatment.[30]

The policy asserts that patient information should be disclosed within the patient's health-care team on a need-to-know basis only.[31] It also notes that physicians may use or disclose personal health information without consent when it is required by law, such as to fulfill mandatory reporting requirements or in accordance with a warrant, subpoena, court order or summons.[32]

With respect to electronic health records, the policy states that "[p]atients should be informed that the treating physician cannot control access and guarantee confidentiality for an electronic health record (EHR) system."[33] Further, patients should be informed if the transfer of patient health information to an interoperable (i.e., provincial or regional) EHR system is legislatively required, and that options for protecting information in an EHR system, such as opt-out, disclosure directives, masking or lock-boxes, should be available and disclosed to patients.[34]

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[1] N. Fagan, "Ottawa Police chief will decide whether info is released in future HIV cases," *Xtra*, 18 November 2010. On-line: www.xtra.ca/public/Ottawa/Ottawa_Police_chief_will_decide_whether_info_is_released_in_future_HIV_cases-9448.aspx.

[2] Ibid.

[3] "Ottawa police won't review HIV disclosure policy," CBC News , 27 July 2010. On-line: www.cbc.ca/canada/ottawa/story/2010/07/27/ottawa-disclosure-police.html.

[4] N. Fagan (supra).

[5] Ibid.

[6] J. Ivison, "We don't need bigger prisons," *The National Post*, 11 January 2011, p. A6.

[7] D. McKie, "Inmate programs fall short of capital spending," CBC News (on-line), 14 January 2011; G. Galloway, "Government faces hard sell for thousands of new jail cells," *The Globe and Mail*, 10 January 2011.

[8] Correctional Service of Canada Media Lines, 13 May 2010 (obtained through the Access to Information Act by the CBC).

[9] J. Ivison (supra).

[10] Ibid.

[11] D. McKie (supra).

[12] M. Montaner, "The Vienna Declaration: a call for drug policy reform," *HIV/AIDS Policy & Law Review* 15(1) (2010): pp. 36-37.

[13] The Vienna Declaration is accessible on-line at: www.viennadeclaration.com/the-declaration/.

[14] The list of endorsements is available via: www.viennadeclaration.com/.

[15] Vancouver Coastal Health, "Expanded HIV testing guidelines will improve early diagnosis," news release, Vancouver, 3 December 2010.

[16] S. Lazaruk, "Blanket HIV testing in B.C. to help 'remove stigma'," *The Province*, 5 December 2010, p. A2.

[17] Vancouver Coastal Health (supra).

[18] Ibid.

[19] Public Health Agency of Canada, *Population-Specific HIV/AIDS Status Report: Aboriginal Peoples*. 2010. On-line www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/index-eng.php.

[20] Ibid.

[21] Ibid.

[22] Ibid., pp. 33–66.

[23] Ibid., pp. 33–4.

[24] Ibid., p. 35.

[25] Ibid., p. 38.

[26] Ibid., p. 40.

[27] Ibid., pp 67–90.

[28] Canadian Medical Association, *CMA Policy: Principles for the Protection of Patients' Personal Health Information*. 2011.

[29] Ibid., pp. 1–2.

[30] Ibid., p. 3.

[31] Ibid.

[32] Ibid.

[33] Ibid., p. 4.

[34] Ibid., pp. 4–5.

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. Unless indicated otherwise, all articles for this issue were written by Ms. Kazatchkine.

Phylogenetic analysis alone cannot prove source of HIV infection: experts

According to a recent report from the United States of America published in the *Proceedings of the National Academy of Sciences*, scientists could prove with certainty which person was the source of an HIV infection.[1] However, international experts have disputed the claim.

The report details the phylogenetic analysis methodology used in two criminal cases related to HIV transmission in the states of Washington (2004) and Texas (2009).[2] Both of the accused were convicted.

Phylogenetic analysis examines small differences in HIV's genes using computational methods to calculate the genetic distance between strains. It is a complex scientific process undertaken by HIV virologists. It can only determine the degree of relatedness of two samples of HIV; it cannot create a definitive "match." This is because HIV, unlike human DNA samples or fingerprints, is not unique to an individual.[3]

Although the report was presented by co-author Michael Metzker of the Baylor College of Medicine in Texas as the first one "to establish the direction of transmission,"[4] several international experts who have acted as forensic advisors in criminal courts say that it "draws unwarranted conclusions."[5] They all agreed that phylogenetic analysis remained an informed, but sometime imperfect, estimate of the relationship between the viruses. According to them, although there are a variety of methods by which it is possible to increase the confidence that the samples are very closely related in comparison with other samples, there could never be complete confidence that the defendant infected the complainant(s) based on phylogenetic analysis alone.[6]

Anne-Mieke Vandamme of Leuven Catholic University and Rega Institute in Belgium said that "there is still the possibility that there is a missing link, a consecutive transmission with an intermediate missing link."[7] She says she would "only use such paraphyletic clustering to exclude a direction of transmission. The elimination of all other possible contacts is something to be done outside the phylogenetic analysis." She concludes that the only safe use of phylogenetic analysis in criminal prosecutions is to exonerate the accused.[8]

In a recent article published in *The Lancet Infectious Diseases*, several experts in phylogenetics, including Professor Vandamme, cautioned that the technique had the potential to be misused and that, by itself, it could not prove transmission of HIV.[9] The authors list several guidelines for scientific experts to follow in order to prevent the misuse of phylogenetic evidence in criminal cases for HIV transmission, stating that "scientists should be aware of the limitations of this analysis, and should emphasise that courts must use other evidence to achieve a conviction."[10]

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[1] J. L. Santini, "Lab detectives use science to nab HIV criminals: study," Agence France-Presse, 15 November 2010.

[2] E. J. Bernard, "Claims that phylogenetic analysis can prove direction of transmission are unfounded, say experts," Aidsmap News, 24 November 2010. On-line: www.aidsmap.com/Claims-that-phylogenetic-analysis-can-prove-direction-of-transmission-are-unfounded-say-experts/page/1556716/.

[3] NAM and the National AIDS Trust, *The use of phylogenetic analysis as evidence in criminal investigation of HIV transmission*. February 2007.

[4] J. L. Santini (supra).

[5] E. J. Bernard (supra). Experts interviewed by Aidsmap include Anne-Mieke Vandamme, a professor at Leuven Catholic University and Rega Institute in Belgium; Jan Albert, a professor at the Karolinska Institute and Karolinska University Hospital in Sweden; and Thomas Leitner, staff scientist at Los Alamos National Laboratory in the United States.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] A. B. Abecasis et al, "Science in court: the myth of HIV fingerprinting," *The Lancet Infectious Diseases* 11(2) (2011): pp. 78–79.

[10] Ibid.

Proposed EU–India free trade agreement could impede manufacture of generic HIV drugs

Medical experts are warning that an international trade agreement being brokered between the European Union (EU) and India could greatly restrict the access of people living with HIV in the developing world to life-saving antiretroviral medication.[1]

According to Médecins sans Frontières (MSF), hidden clauses in the free trade agreement under negotiation will prevent the manufacture and distribution of crucial generic medicines produced in India, a concern that has been echoed by the World Health Organization (WHO).[2]

Currently, generic manufacturers rely on the results of original clinical trials carried out by drug developers that prove the effectiveness and safe-

ty of medicines in order to get their cheaper versions of drugs registered. Campaigners claim that a "data exclusivity" provision in the free trade agreement would effectively copyright information gathered in the clinical trials.[3] Unless they conduct their own clinical trials, Indian companies would be left without the data they need to register their drugs.

The EU insists that, while data exclusivity clauses are included in the free trade agreement, they will not affect India's ability to produce generic medicines.[4] According to its spokesperson, the EU explicitly recognizes India's right to issue compulsory licences for life-saving medicines.[5] However, WHO has contended that, until a draft of the agreement is released, concerns over its contents and their impact on public health will persist.[6]

Correspondingly, health experts are becoming increasingly concerned about a separate treaty aimed at tackling the international counterfeiting trade that could potentially have a significant impact on generic drug production. The Anti-Counterfeiting Trade Agreement is intended to deter the production of fake medicines, but activists say that counterfeit medicines are being deliberately conflated with generic medicines to interfere with their production and distribution.[7]

In India, the absence of patent protection for drugs from 1972 to 2005 allowed drug companies to manufacture generic drugs at costs that were among the lowest in the world. In 2005, India reintroduced patent protections for drugs to comply with its obligations under the agreement on Trade-Related aspects of Intellectual Property Rights (TRIPS). However, TRIPS allows countries flexibilities toward protecting public health.[8]

In particular, India's unique laws governing medicine production allow the manufacture of generic medicines deemed essential by authorities. This has enabled India to continue to provide affordable medicines to its population as well as to people in the developing world. More than 80 percent of all donor-funded antiretroviral drugs used in developing countries are Indian generics, and the availability of cheap medication has enabled more than five million people around the world to access essential HIV treatment.[9]

Given the global impact of the proposed agreements, a number of activists have rallied against them, including the Global Network of People Living with HIV. Kenyan activists have, for example, written to the EU and the Kenyan government to protest both agreements on the basis that they would undermine the fight against HIV/AIDS.[10] The Delhi Network of Positive People also staged a mass demonstration in October 2010 and sent a letter to the Indian Prime Minister urging him to reject the free trade agreement.[11]

– Sandra Ka Hon Chu

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[1] A. Wander, "EU deal threatens HIV drug supplies," Al Jazeera, 4 November 2010.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] "Africa: EU-India deal could threaten access to essential HIV drugs," IRIN PlusNews, 9 November 2010.

[6] A. Wander (supra).

[7] Ibid.

[8] A. Grover and B. Citro, "India: access to affordable drugs and the right to health," *The Lancet*, 12 January 2011.

[9] "Africa: EU-India deal could threaten access to essential HIV drugs," IRIN PlusNews, 9 November 2010.

[10] J. Oywa, "Kenya joins drive to block new EU policy on ARVs," *The Standard*, 5 February 2011.

[11] "Activists decry India-EU IPR talks," *The Times of India*, 6 October 2010.

Ukraine: HIV policy advances overshadowed by police crackdown on drug therapy clinics

In October 2010, the government of Ukraine made progressive revisions to a law aimed at reducing the spread of HIV/AIDS and supporting the rights of people living with HIV/AIDS (PHAs). However, policing methods continue to constrain access to harm reduction services.

Among the changes to the *Law on Prevention of AIDS Cases and Social Protection (1991)*, a clause was abolished that had required visitors staying in the country more than 90 days to provide a certificate of absence of HIV/AIDS.[1] Consequently, PHAs will no longer have restrictions on the duration of their stay in the country and can even apply for residency without having to disclose their status.[2] Other changes to the 1991 law are especially beneficial to non-governmental organizations (NGOs) that provide HIV treatment, care and prevention services by making it possible for them to apply for state contracts.[3]

Of particular note, however, is that the revised legislation enshrines the provision of harm reduction services for HIV-positive injection drug users (IDUs) and other IDUs. In Ukraine, new cases of HIV are mostly reported among IDUs.[4] It is estimated that 350 000 people in the country live with HIV, one of the highest infection rates in Europe.[5]

In spite of these changes to the law, local NGOs that provide harm reduction services were recently subject to police harassment. Clinics and offices run by the International HIV/AIDS Alliance and the All Ukrainian Network of People Living with HIV/AIDS were visited by law enforcement officers. Clients and patients of the clinics were forced to provide personal and health-related information under threat of arrest,[6] while staff were also compelled to provide information on the programs. Documents were reportedly confiscated and harm reduction services outside the capital, Kiev, shut down.[7] The two organizations said that they had been providing substitution therapy to IDUs for many years.

The crackdown was ordered by the head of the Department to Fight Drug Trafficking of the Ministry of Interior. Order #40/2/1-106 instructed police around the country to collect the personal data of patients using substitution treatment. The order came with a list of questions for patients and the relatives of patients, including questions about drug history and HIV status.[8]

It is thought that the purpose of the crackdown was to shut down drug trafficking rings that pose as substitution therapy clinics. Nevertheless, instead of conducting a more thorough investigation, police targeted all clinics providing substitution therapy, violating their own laws in the process. The crackdown also came in advance of a meeting between the head of the Department to Fight Drug Trafficking and the Ukraine President Viktor Yanukovych to address the social rehabilitation of drug addicts and any problems surrounding substitution therapy in Ukraine.

Because of the police harassment, NGO staff are now concerned that they will not be able to reach out and provide assistance to those who need and access their services. It is also feared that doctors who traditionally provide harm reduction services will no longer feel secure in providing this form of treatment.

— Eli Arkin

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[1] International AIDS Society, "IAS Applauds the Revision of Ukraine's Legislation," news release, Geneva, 29 October 2010. On-line: www.iasociety.org/Default.aspx?pageId=489.

[2] Ibid.

[3] Ibid.

[4] International HIV/AIDS Alliance, "HIV Prevention under Threat in Ukraine". February 2011. On-line: www.aidsalliance.org/NewsDetails.aspx?Id=836.

[5] UNAIDS, *Ukraine Fact Sheet: Country Situation*. July 2008. On-line: http://data.unaids.org/pub/FactSheet/2008/sa08_ukr_en.pdf.

[6] International HIV/AIDS Alliance, "Ukraine: Crackdown on Drug Substitution". 1 February 2011. On-line: www.aidsalliance.org/newsdetails.aspx?id=810.

[7] Ibid.

[8] Chief of Department to Fight Drug Trafficking: Ukraine Ministry of Interior, "Order #40/2/1-106," 18 January 2011. (A copy of the document in the original Ukrainian was made available to the Canadian HIV/AIDS Legal Network.)

Africa: sexual minorities at risk

Violence against homosexuality is growing in Africa, where most of the countries on the continent continue to criminalize same-sex relations, fostering a climate of hate that, in some cases, is abetted by politicians.

On 26 January 2011, a young gay rights activist in Uganda, David Kato, was beaten to death in his own home.[1] The murder occurred several months after the Ugandan newspaper *Rolling Stone* published his picture, alongside others claimed to be gay. The headline of the article read "Hang them". Following the publication of the photos, Kato and two other activists obtained a permanent injunction to prevent the newspaper from publishing any more such images. Subsequently, Kato told friends that he began to receive threats.[2]

His death is the latest example of difficulties faced by gay Ugandans in their country. An anti-homosexuality bill was introduced in Parliament in October 2009; and, although homosexuality is already illegal in Uganda (offenders can be sentenced to up 14 years in jail), the proposed legislation calls for even harsher sanctions, including the death penalty in certain circumstances, such as engaging in same-sex relations while HIV-positive or with a minor.[3] However, after widespread international pressure and criticism, a cabinet committee called upon to review the bill by President Yoweri Museveni recommended in May 2010 that it be withdrawn from Parliament.[4]

Uganda is not alone in its attitude toward gay rights. In Cameroon, Alice Nkom, a lawyer who defends the rights of sexual minorities, recently received death threats after the European Union (EU) had agreed to fund a project to promote their rights in the country.[5] Nkom is to play a key role in the implementation of this project through the Cameroonian Association for the Defence of Homosexuality, of which she is president. Cameroon's government has also spoken out against the project: foreign affairs minister Henri Eyebe Ayissi told the EU that the government of Cameroon disapproved of it.[6] Same-sex relations are currently criminalized in Cameroon and can result in five years' imprisonment.[7]

In December 2010, the Parliament of Malawi passed a bill to amend the Penal Code to criminalize sexual relations between women. Previously, only "indecent practices between males" had been against the law. Under Section 137A of the Penal Code, any female person committing, whether in public or private, "any act of gross indecency with another female" will be guilty of an offence and liable to a prison term of five years.[8] Six months prior to the amendment, Tionge Chimbalanga and Steven Monjeza, a male couple, had been sentenced to 14 years' imprisonment before receiving a presidential pardon on humanitarian grounds following international pressure.[9]

In the Democratic Republic of Congo — where same-sex relations are currently legal — a bill criminalizing homosexuality was introduced in Parliament in October 2010 by member of Parliament and Pentecostal bishop Ejiba Yamapia.[10] The bill states that same-sex relations could result in five years' imprisonment and a fine. Associations that support gays and lesbians would also be banned, impeding the fight against HIV in the country.[11] The bill was passed by the lower house (*Chambre basse*) of Parliament and sent to the social and cultural commission for further examination. According to Jean Bedel Kaniki, president of the LGBT association Groupe Hirondelles-Bukavu, the bill was to come to a vote in the spring of 2011.[12]

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[1] G. Jeffrey, "Ugandan who spoke up for gays is beaten to death," *The New York Times*, 27 January 2011; "David Kato: man arrested over murder of Ugandan gay activist," *The Guardian*, 3 February 2011.

[2] Ibid.

[3] D. Cozac, "Bills in Uganda would infringe upon rights of homosexuals and people living with HIV/AIDS," *HIV/AIDS Law and Policy Review,* 15(1) (2010): pp.13–14.

[4] Ibid. As of this writing, the future of the bill remains uncertain.

[5] AIDES, "Croisades anti-gay au Cameroun : l'Etat français doit réagir!" news release, Paris, 13 January 2011.

[6] "Homosexualité : tension entre le Cameroun et l'Union européenne ," Afrik.com, 18 January 2011.

[7] Human Rights Watch, *Criminalizing Identities. Rights Abuses in Cameroon based on Sexual Orientation and Gender Identity*. 2010.

[8] International Commission of Jurists, "Sex between women now a crime in Malawi: New law violates human rights obligations of Malawi", press release, 8 February 2011.

[9] V. Sohaili, "Malawi: President pardons convicted same-sex couple," *HIV/AIDS Law and Policy Review*, 15(1) (2010): pp.15–16.

[10] "RDC, un projet de loi pour punir les gays," *Le Figaro*, 25 October 2011.

[11] H. Bangré, "Sur la voie de la criminalisation de l'homosexualité?" Jeune Afrique, 22 October 2010.

[12] "Pénalisation de l'homosexualité?", Afriquinfos, 5 November 2011.

In brief

Denmark: HIV-specific criminal law suspended

On 16 February 2011, Denmark's justice minister, Lars Barfoed, announced that all legal proceedings falling under Article 252 of the country's *Criminal Code* — which criminalizes HIV transmission or exposure — would be temporarily suspended until the legislation is reviewed by a government working group in charge of examining whether the article in question should be amended or abolished.[1]

Barfoed said that the reason for the decision was the evolution of the epidemic. When treated on time, HIV is no longer a fatal disease. Moreover, effective antiretroviral therapy greatly reduces the risk of HIV transmission. The current law — which casts HIV as a life-threatening condition and criminalizes unprotected sex by a person living with HIV — therefore appears to be obsolete and should be reviewed.[2]

According to Article 252, "any person who in a reckless manner exposes another person to the dangers of being infected with a fatal and incurable disease" shall be liable to imprisonment for any term not exceeding eight years. In 2001, the law was amended to specify that HIV be covered.[3] As a result, Denmark became the only country in Western Europe to have an HIV-specific criminal law.[4]

It is estimated that 5600 persons are living with HIV in Denmark. Since 1994, 18 people have been prosecuted for either exposing another person to HIV or transmitting the virus. Of these, 11 people have been convicted.[5] Similar to other countries in Europe, men of African descent are over-represented as defendants in cases related to HIV.[6]

Australia: supervised injection centre becomes permanent

In May 2001, Australia opened its first medically supervised injection centre (MSIC) in Sydney's Kings Cross area, where drug overdose deaths are concentrated. After operating on a trial basis for more than nine years, the centre will finally become a regular health service, according to the New South Wales government.[7]

Since its inception, more than 12 000 individuals have benefited from the MSIC, which currently supervises an average of 200 injections a day. About 3500 drug overdoses have been successfully managed on site without a single fatality, and there have been 8500 referrals made to other health and social welfare agencies in and around the local area. Approximately half of these referrals have been for drug treatment.[8]

Recent evaluations of the centre have also demonstrated a reduction in street-based injections and in the number of discarded needles in the vicinity. Clients have reported an increase in knowledge of the risk of spreading blood-borne viruses and have described behavioural changes that reflect safer injection practices to minimize this risk. More generally, findings indicate that the site provides a service that reduces the impact of overdose-related events and other health-related consequences of injec-

tion drug use for the site's clients, and provides access to drug treatment with a high degree of uptake of referrals.[9]

Cambodia: first methadone clinic opens

Introduced by the World Health Organization (WHO) and administered by the Cambodian Ministry of Health, the country's first methadone clinic opened in September 2010 as a year-long pilot program.[10] Aimed at tackling Cambodia's drug problem, the new clinic is a departure from state-run rehabilitation programs that have become infamous due to their harsh conditions and unconventional methods of detoxification.

As of November 2010, 61 people were enrolled in the methadone clinic, which is staffed with trained counsellors and professionals. Local non-governmental organizations (NGOs) that work with injection drug users (IDUs) refer patients to the clinic, where they may access services on a voluntary basis. Included in the therapy are support groups and individual one-on-one sessions with a counsellor.[11]

This is in stark contrast to typical rehabilitation methods in Cambodia. Rights groups have reported IDUs being arrested and forced into drug rehabilitation centres, which are staffed chiefly with law enforcement officials or administrators, without knowledge of or access to proper treatment, which is critical to rehabilitation.[12] Instead of receiving treatment in these centres, patients are made to exercise and perform hard labour as a form of rehabilitation. These methods violate Cambodia's constitution, which prohibits the coercion, ill-treatment or any other mistreatment that causes additional punishment on any person who is already a prisoner or detainee.[13]

While local NGOs working with IDUs welcomed the new methadone clinic as a sign of progress, they point to the recent opening of another state-run rehabilitation centre in the boot-camp model as evidence that the government's rehabilitation protocol remains "mixed".[14]

By government estimates, a quarter of Cambodia's IDUs are HIV-positive.[15] These numbers have grown due to a lack of availability of clean, sterilized needles as well as obstacles in accessing education on the spread of HIV amongst IDUs.

— Eli Arkin

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Portugal: study demonstrates positive impact of drug decriminalization

A study published in November 2010 concluded that, contrary to predictions, Portugal's decriminalization of the use and possession of all illicit drugs in July 2001 did not lead to major increases in drug use.[16] Under the country's decriminalization policy, drug users are not arrested but referred by the police to a "dissuasion" commission for counselling. The committees are also empowered to impose warnings or administrative penalties, including fines, restrictions on driving and referrals to treatment.[17]

Drawing upon independent evaluations and interviews conducted with key stakeholders in 2007 and 2009, the researchers analyzed the criminal justice and health impacts of decriminalization against trends from neighbouring Spain and Italy. They concluded that decriminalization resulted in reductions in problematic drug use, drug-related harms and criminal justice overcrowding.[18]

Moreover, decriminalization also resulted in less drug use among teenagers, less use of drugs by injection, fewer HIV infections and more drugs seized by law enforcement. While adult drug use slightly increased, this increase was not greater than that seen in nearby countries that did not change their drug policies.[19]

According to Alex Stevens, who co-authored the study, "The most important direct effect was a reduction in the use of criminal justice resources targeted at vulnerable drug users."[20] This likely enabled the expansion of treatment, which is in turn linked to the decline in rates of HIV and opioid-related deaths.

– Sandra Ka Hon Chu

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South Africa prepares to bring HIV testing into classrooms

The South African government has been holding nation-wide consultations with members of the education, children's rights and HIV sectors to develop a national policy, including guidelines and recommendations, for

HIV testing in high schools.[21] The initiative is part of the government's national voluntary HIV testing and counselling campaign, which seeks to test 15 million South Africans by April 2011.

Advocates for school-based testing claim it would enable children living with HIV to access care sooner. Moreover, widespread testing would reduce the stigma of being tested, encourage repeat testing and underscore safer-sex messages.[22]

However, a number of student and teacher unions are opposed to school-based testing on the basis that children may not be psychologically or emotionally prepared to deal with a positive diagnosis.[23] Other main concerns are the need to ensure consent of the students to be tested for HIV and confidentiality. In particular, it is important to ensure that students not be able to identify who tests positive for HIV.

Additionally, students should be linked to follow-up care that includes sufficient psycho-social support. In the context of the HIV testing initiative, South African Health Minister Aaron Motsoaledi stated that, eventually, every school would have access to nurses, psychologists, social workers and trained counsellors dedicated to looking after its pupils.[24]

– Sandra Ka Hon Chu

Global commission on HIV and the law

The Global Commission on HIV and the Law was launched in June 2010 to develop actionable, evidence-informed and human rights-based recommendations for effective HIV responses that promote and protect the human rights of people living with and most vulnerable to HIV.[25] It focuses on some of the most challenging legal and human rights issues in the context of HIV.

The initiative is led by the United Nations Development Programme (UNDP), on behalf of UNAIDS, working in close collaboration with a range of partners that include governments, foundations, academic bodies, other UN agencies and civil society, including key population groups and networks.

The mandate of the Global Commission on HIV and the Law is to analyze the legal and human rights dimensions of the global response to HIV.[26] It will also make recommendations to policy-makers to provide suitable, rights-based responses to HIV.

The structure of the Commission is comprised of three components. First is a high-level body of 14 members, who are eminent leaders in their field. Among the commissioners are former President Fernando Henrique Cardoso of Brazil and co-Chair of AIDS-Free World, Stephen Lewis. Second is a Technical Advisory Group of 22 individuals with expertise in HIV and the law who will help generate and build consensus around the evidence base.

A series of Regional Dialogues constitute the third component. The objective of these meetings is to inform the deliberations of the Commission and to ensure the participation of regions most affected by HIV/AIDS.[27] It is hoped that the regional dialogues will create policy discussion of issues relating to human rights and the law in a regional context. Two of the seven regional dialogues have already taken place (in Latin America and Asia).

A final report will be issued in early 2012 that will include findings from the regional dialogues and research done over the course of the Commission's mandate.

— Eli Arkin

Pope's comments signal possible shift in condom messaging

In a book interview, Pope Benedict XVI suggested that for some people — such as male prostitutes — condom use could be morally justified to prevent HIV transmission. The comments attracted much approval from AIDS activists, particularly in Africa, since a shift in the stance of the Catholic Church with respect to condom use could make a dramatic impact in terms of HIV prevention.[28]

A flurry of confusion followed the remarks, with disagreement about whether the pope was justifying condom us in a stark departure from church doctrine opposing contraception. Senior Vatican officials have advocated monogamous marriages and abstinence from sex outside of marriage as key weapons in the fight against HIV. However, many see Benedict's remarks as a signal that the Vatican is softening its stance on condom use, at least for the purposes of preventing HIV infection.[29]

— Alison Symington

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[1] E. J. Bernard, "Denmark: Justice Minister suspends HIV-specific criminal law, sets up working group," 17 February 2011. On-line: http://criminalhivtransmission.blogspot.com/2011/02/denmark-justice-minister-suspends-hiv.html; AIDS-Fondet, "Ministry of Justice stands by AIDS-Fondet: HIV law is suspended", news release, Copenhagen, 17 February 2011.

[2] Ibid.

[3] Global Network of People Living with HIV, *Global Criminalisation Scan*. On-line: www.gnpplus.net/criminalisation/index.php?option=com_content&task=view&id=90&Itemid=42.

[4] Global Network of People Living with HIV, *2010 Global Criminalisation Scan Report*. July 2010, On-line: www.gnpplus.net/programmes/human-rights/global-criminalisation-scan/1648-2010-global-criminalisation-scan-report.

[5] *Global Criminalisation Scan* (supra).

[6] *2010 Global Criminalisation Scan Report* (supra).

[7] M. Sweet, "Australia's supervised injecting centre has a more certain future," *BMJ*, 341 (2010): p. 629.

[8] Sydney Medically Supervised Injecting Center (MSIC), *Factsheet*. Updated September 2010. On-line: www.sydneymsic.com.

[9] NSW Health, *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007–2011): Final Report*. September 2010.

[10] "Cambodia: Government opens first methadone clinic," IRIN Asia, 17 September 2010. On-line: www.irinnews.org/Report.aspx?ReportId=90507.

[11] World Health Organization, *Cambodia Methadone Maintenance Program: Newsletter: Number 1, Quarter 1*. November 2010

[12] World Health Organization, *Assessment of Compulsory Treatment for People Who Use Drugs in Cambodia, China, Malaysia, and Viet Nam*. 2009.

[13] Ibid.

[14] "Cambodia: Government opens first methadone clinic" (supra).

[15] Ibid.

[16] C. Hughes and A. Stevens, "What Can We Learn from the Portuguese Decriminalization of Illicit Drugs?" *British Journal of Criminology* 50 (6) (2010): pp. 999–1022.

[17] P. Smith, "Portuguese Drug Reformers Look Beyond Decriminalization," StoptheDrugWar.org, 1 December 2010. On-line: http://stopthedrugwar.com/chronicle/2010/dec/01/portuguese_drug_reformers_look_b.

[18] C. Hughes and A. Stevens (supra).

[19] M. Szalavitz, "Portugal's Drug Experience: New Study Confirms Decriminalization Was a Success," *Time*, 23 November 2010.

[20] Ibid.

[21] "South Africa: HIV testing in schools is a minefield," IRIN PlusNews, 7 February 2011.

[22] Ibid.

[23] Ibid.

[24] H. Prince and H. McLea, "Health minister intensifies fight against AIDS," *The Times*, 14 February 2011.

[25] The Global Commission on HIV and the Law. On-line: www.hivlawcommission.org.

[26] Ibid.

[27] Ibid.

[28] J. Straziuso and J. Gross, "Africa, where 20M people have HIV and which is more Catholic, welcomes pope's condoms message," The Canadian Press, 23 November 2010; V. Simpson, "Vatican says pope's condom remarks not 'revolutionary,' but many others see historic change," *The Washington Examiner*, 22 November 2010; and N. Winfield, "Vatican to host international AIDS conference," *The Globe and Mail*, 3 February 2011.

[29] Ibid.

HIV/AIDS IN THE COURTS — CANADA

This section presents a summary of Canadian court cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on criminal and civil cases. The coverage aims to be as complete as possible, and is based on searches of Canadian electronic legal databases and on reports in Canadian media. Readers are invited to bring cases to the attention of Sandra Ka Hon Chu (schu@aidslaw.ca), senior policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Unless otherwise indicated, all articles in this section were written by Ms. Chu.

Ontario: prostitution-related provisions of *Criminal Code* struck down

In September 2010, the Ontario Superior Court of Justice held that three provisions of the *Criminal Code* dealing with prostitution violated sex workers' constitutional rights, were not in accordance with the principles of fundamental justice and must be struck down.[1]

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

They submitted that these provisions deprived sex workers of their right to liberty under Section 7 of the *Canadian Charter of Rights and Freedoms* (*Charter*) by exposing them to the risk of imprisonment and their right to security by creating legal prohibitions on the necessary conditions required for sex work to be conducted in a safe and secure setting, thus exposing sex workers to an increased risk of physical or psychological harm. With respect to Section 213(1)(c) (communication), the applicants submitted that the provision deprived sex workers of their freedom of expression.

To support these submissions, 21 witnesses tendered evidence on behalf of the applicants, describing the nature and frequency of physical and psychological violence experienced by sex workers in various cities and towns across Canada. All 21 witnesses testified that the current legal regime significantly contributes to the risk of violence experienced by sex workers.

A variety of experts also testified on the detrimental impact of the impugned provisions on the overall health and safety of sex workers, including on how the enforcement of Section 213(1)(c) of the *Criminal Code* posed an obstacle for sex workers to negotiate condom use.[2] Moreover, the criminalization of prostitution hindered sex workers' access to health services, including access to HIV testing, education, prevention, care, treatment and support.[3] Sex workers who did access health services were often further marginalized by the discriminatory attitudes of health-care staff.[4]

Justice Himel of the Ontario Superior Court of Justice held that the applicants had proven that the impugned provisions infringed their *Charter* rights to liberty, security of the person and freedom of expression, and that the infringement of those rights were not justified under Section 1 of the *Charter*.

In particular, she accepted that there are ways of conducting prostitution that may reduce the risk of violence towards sex workers, and that the impugned provisions made many of these "safety-enhancing" methods or techniques illegal. Therefore, the law played a sufficient contributory role in preventing sex workers from taking steps that could reduce the risk of violence.

Accordingly, Justice Himel struck down the impugned provisions. While the Attorney General of Canada argued that striking down the provisions without enacting something in their place would pose a danger to the public, Justice Himel was not persuaded by this and found that the danger faced by sex workers greatly outweighed any harm that may be faced by the public.

However, Justice Himel temporarily stayed her decision to enable the parties to make fuller submissions on the matter.

Soon after the historic decision, the federal government announced its intention to appeal and the Attorney General of Canada sought leave to extend the stay of the decision of the Ontario Superior Court of Justice.

On 22 November 2010, Justice Rosenberg of the Ontario Court of Appeal held that it was in the public interest that the judgment be stayed until 29 April 2011 to permit appellate review of the decision.[5]

The appeal is scheduled to be heard in June 2011.

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[1] *Bedford v. Canada*, 2010 ONSC 4264 (Ontario Superior Court of Justice).

[2] Affidavit of Eleanor Maticka-Tyndale, paragraph 12: Joint Application Record, Volume 12, Tab 45 at p. 3094.

[3] See, for example, House of Commons Subcommittee on Solicitation Laws Evidence 2005-03-30, testimony of Mandip Kharod (Volunteer Coordinator, Asian Society for the Intervention of AIDS): Joint Application Record, Volume 84, Tab 164V, at p. 25578 and House of Commons Subcommittee on Solicitation Laws Evidence 2005-03-30, testimony of Evan Smith (Coordinator, University of Toronto Genderqueer Group): Joint Application Record, Volume 83, Tab 164P, at p. 25361.

[4] See, for example, "Living in Community: Balancing Perspectives on Vancouver's Sex Industry" (Draft): Joint Application Record, Volume 5, Tab 22B at p. 1079 and "Voices for Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws": Joint Application Record, Volume 24, Tab 55M at p. 7150.

[5] *Bedford v. Canada (Attorney General)*, 2010 ONCA 814.

British Columbia: sex workers granted standing to challenge Criminal Code

On 12 October 2010, a majority of the Court of Appeal of British Columbia allowed the appeal of Shari Kiselbach and the Downtown Eastside Sex Workers United against Violence Society (SWUAV) regarding their standing to challenge provisions of the *Criminal Code* concerning prostitution.[1]

Kiselbach, a former sex worker, and SWUAV, a non-profit society striving to improve working conditions for sex workers and comprised of women who recently were or currently are engaged in sex work, sought to challenge the constitutional validity of *Criminal Code* Sections 210 (keeping and being within a common bawdy house); 211 (transporting a person to a common bawdy house); 212 except 212(1)(g) and (i) (procuring and living on the avails of prostitution); and 213 (soliciting in a public place).

Kiselbach and SWUAV argued that those sections violated their constitutional rights pursuant to Sections 2(b) (freedom of expression), 2(d) (freedom of association), 7 (liberty and security of the person) and 15 (equality) of the *Canadian Charter of Rights and Freedoms* (*Charter*).

The Attorney General of Canada applied to the B.C. Supreme Court to dismiss the action, contending that SWUAV was not directly affected by the law, nor was Kiselbach, who was no longer a sex worker. It argued that neither met the test for standing to bring the challenge. The court agreed and dismissed the action.[2]

Kiselbach and SWUAV appealed the order dismissing the action, submitting that the B.C. Supreme Court erred in finding that Kiselbach does not have private interest standing and in finding that neither she nor SWUAV have public interest standing. In particular, they argued that sex workers charged under the *Criminal Code* do not have the resources to bring a constitutional challenge nor mount a personal defence.

Therefore, a collective representing sex workers was best-placed to mount a challenge to the law, because the highly public nature of the court process prohibits active sex workers from coming forward individually to support a *Charter* challenge due to fears of police arrest and retaliation, as well as social stigma.

While the B.C. Court of Appeal agreed that Kiselbach did not have private interest standing in the case since she did not have a sufficiently "direct, personal interest in the litigation,"[3] it held that the lower court judgment did not fully reflect the "systemic and comprehensive nature of the challenge advanced."[4] In its view, an opportunity to mount a constitutional challenge to a section of the *Criminal Code* could not arise only in the presentation of a defence to a criminal charge.

The Court of Appeal held that the trial judge failed to "give sufficient weight to the breadth of the constitutional challenge and the comprehensive and systemic nature of the plaintiffs' theory."[5] Accordingly, it ruled that SWUAV and Kiselbach had public interest standing to bring the challenge, allowed the appeal and set aside the order dismissing the action.

[1] *Downtown Eastside Sex Workers United Against Violence Society v. Canada (Attorney General)*, 2010 BCCA 439.

[2] *Downtown Eastside Sex Workers United Against Violence Society v. Canada (Attorney General)*, 2008 BCSC 1726.

[3] *Downtown Eastside Sex Workers United Against Violence Society v. Canada (Attorney General)*, 2010 BCCA 439 at para. 30.

[4] Ibid at para. 62.

[5] Ibid at para. 66.

Swazi man's refugee claim rejected: PHAs not a "particular social group"

On 14 July 2009, the Refugee Protection Division of the Immigration and Refugee Board (IRB) rejected the claim for refugee protection of B.L.H., an HIV-positive man from Swaziland.[1] B.L.H. made a Convention refugee claim on the basis of his membership in a particular social group, claiming a fear of persecution based on his HIV-positive status.[2] B.L.H. also claimed that he was in need of protection in accordance with Section 97 of the *Immigration and Refugee Protection Act* (IRPA).

B.L.H. was diagnosed with HIV in 2003 while in Swaziland and received medical and other assistance from the Swaziland AIDS Support Organization (SASO). In 2006, B.L.H. arrived in Canada and requested refugee protection.

In his claim, B.L.H. identified his family, tribe and Swazi society more generally as people who persecuted him on the basis of his HIV status. Upon being diagnosed with HIV, B.L.H. testified that he did not tell anyone of his illness because of the stigma surrounding HIV, having observed people with HIV shunned in Swaziland. In particular, he feared rejection from his family.

The IRB panel referred to evidence that some members of Swazi society continue to stigmatize HIV-positive people but noted that this behaviour was not government-sanctioned. It then concluded that B.L.H.'s HIV-positive status did not render him a member of a particular social group, pursuant to the Supreme Court of Canada's reasoning in *Canada (Attorney General) v. Ward*.[3]

In its view, B.L.H. was not a member of a particular social group because he did not have an "innate or unchangeable characteristic", since HIV was something that he suffered "later in life"; he did not "voluntarily associate" with other HIV-positive people, since people living with HIV did not comprise a voluntary group; and he was not part of a group association based on *former* voluntary status, unalterable due to its historical permanence.[4]

Based on a balance of probabilities, the panel thus found that B.L.H. had not established a well-founded fear of persecution, as he was not a member of a particular social group, and rejected his Convention refugee claim.

With respect to whether B.L.H. was a person in need of protection, the panel noted that B.L.H. obtained free medical treatment from SASO upon diagnosis, although it had negative side-effects that he did not experience from the HIV medication that he was prescribed in Canada. The IRB further noted that there was no general right to health care for all citizens of Swaziland and that just over one quarter of people needing HIV treatment in Swaziland received it.

While the panel acknowledged that the level of health care available to B.L.H. in Swaziland would not be the equivalent to that he would receive in Canada, it ruled that the evidence did not suggest that the state denies access to treatment for HIV based on discriminatory grounds.

Therefore, the IRB found that the risk B.L.H. faced was based on Swaziland's inability to provide adequate health or medical care and he did not qualify for protection in accordance with Section 97 of the *IRPA*.

B.L.H. successfully applied to have his case judicially reviewed before the Federal Court, which returned the claim to the Refugee Protection Division for a re-hearing. At the time of writing, a decision based on the re-hearing of the matter before the Refugee Protection Division had yet to be rendered.[5]

Commentary

While the panel seemed ultimately to conclude that Swaziland did not persecute people living with HIV, its application of the test in *Ward* was a clear legal error that is not expected to be repeated in the re-hearing of B.L.H.'s case before the Refugee Protection Division.

The panel held that, because B.L.H. was diagnosed with HIV "later in life", he was not defined by an "innate or unchangeable characteristic". This view is a misunderstanding not only of the life-long, "unchangeable" nature of the illness, but also of how it is experienced by those who are living with HIV and perceived by others.

HIV-positive people are often defined by the virus, which is viewed as an "innate and unchangeable" characteristic that is reflective of traits that are usually deemed negative (e.g., promiscuity). This, in turn, gives rise to considerable stigma and discrimination against, and marginalization of, HIV-positive people.

Moreover, to suggest that an "innate or unchangeable characteristic" is limited to one that people are born with arbitrarily divides people living with HIV, some who may have very well been born with the virus although may experience persecution no differently from those infected after birth. Correspondingly, individuals may acquire a religious identity, nationality or political opinion "later in life", yet all of these are explicitly recognized in the IPRA as grounds for persecution.

By failing to recognize the long history of stigma, discrimination and persecution associated with HIV, as well as the reality that HIV infection is an unchangeable condition, the Refugee Protection Division erred in holding that HIV-positive people could not be a particular social group that might be subject to persecution. This finding reflects ongoing misconceptions about the virus and a need for greater HIV education among the judiciary and the public at large.

[1] *B.L.H. (Re)*, [2009] R.P.D.D. No. 67.

[2] *Immigration and Refugee Protection Act*, S.C. 2001, c. 27, s. 96.

[3] *Canada (Attorney General) v. Ward*, [1993] 2 S.C.R. 689.

[4] *B.L.H. (Re)* (supra at para. 13).

[5] Personal communication with the law office of El-Farouk Khaki, counsel for B.L.H. in the 2009 matter before the Refugee Protection Division.

Federal Court allows application for judicial review of HIV-positive woman from Jamaica

On 26 January 2011, the Federal Court allowed an application for judicial review by Ferona Elaine Mings-Edwards, who based her application for permanent residence on humanitarian and compassionate grounds, including the hardship that she claimed that she would face in Jamaica from her former domestic partner and because of her HIV-positive status.[1]

In her submission for humanitarian and compassionate relief, Mings-Edwards described the stigma and discrimination that she would face in Jamaica as an HIV-positive woman and provided significant information regarding the treatment of HIV-positive people there, including the lack of legal protection against discrimination.

In particular, HIV-positive women are stigmatized in Jamaican society, as they are regarded either as promiscuous or sex workers, thus exposing them to violence and negatively impacting their ability to access health care and other services.

While the Pre-Removal Risk Assessment (PRRA) officer recognized the persistence of stigma and discrimination against, and lack of legal protection for, people living with HIV in Jamaica, the officer nevertheless found that state protection existed in Jamaica and that it would not be a hardship for Mings-Edwards to access that protection, if required. The officer thus rejected her application on the basis that she had not established that she would face

unusual, undeserved or disproportionate hardship if she were required to return to Jamaica in order to apply for permanent residence.

Justice MacTavish of the Federal Court held that this decision was unreasonable because the PRRA officer did not fully consider or evaluate the hardship that Mings-Edwards would face in returning to a society where she would be exposed to pervasive discrimination and stigma as a result of her status as an HIV-positive woman.

Therefore, the PRRA officer failed to evaluate properly the hardship that Mings-Edwards would face. Accordingly, Justice MacTavish allowed the application for judicial review and remitted the matter to a different PRRA officer for re-determination.

[1] *Mings-Edwards v. Canada (Minister of Citizenship and Immigration)*, [2011] F.C.J. No. 109.

Quebec: employer who disclosed employee's HIV-positive status violated rights to dignity and freedom from discrimination

The Quebec human rights tribunal held that an employer who disclosed the HIV-positive status of an employee to his staff violated the employee's right to the safeguard of his dignity, without distinction or exclusion based on disability, contrary to Sections 4 and 10 of the *Charter of Human Rights and Freedoms* (the Quebec *Charter*).

In 2007, Mr. L. responded to a classified advertisement for a cook's helper position at a mobile french-fry canteen. He went to the canteen to meet the owner, who described the position's duties. The main duty was to peel potatoes. A few days into the job, the employer asked Mr. L. to mow the lawn at his personal residence. This is when Mr. L. told the employer that he was HIV-positive.

The following day, Mr. L. found that his duties at the canteen had been changed. He was now responsible for maintenance. Moreover, all the staff members had been told that Mr. L. was HIV-positive. Mr. L. complained to the employer, who allegedly responded that if he allowed Mr. L. into the kitchen, he risked losing his customers. Ultimately, Mr. L. was dismissed by his employer.

Based on these events, the Quebec human rights and youth rights commission commenced proceedings in the Quebec human rights tribunal, alleging that, by dismissing Mr. L. from his position as customer service clerk and cook's helper, the employer violated Mr. L.'s rights to full equality without distinction based on disability, contrary to Sections 10 and 16 of the Quebec *Charter*.[1] The Commission also alleged that, by dismissing Mr. L., the employer violated his right to the safeguard of his dignity without discrimination based on disability, contrary to Sections 4 and 10 of the Quebec *Charter*.

The employer said that, in view of Mr. L.'s lack of experience, he would never have agreed to hire him as a cook's helper but that, since he wanted to help Mr. L., he gave him other duties. He said that it was only when Mr. L. asked to be paid $10 an hour — a request he deemed excessive — that he terminated the employment contract.

After finding that HIV-positive status is a disability within the mean-

ing of the provisions prohibiting discrimination, the Tribunal held that Mr. L. did not prove that he was dismissed because he had HIV. Based on the evidence, Mr. L. did not have enough fast-food industry experience, as required by the job advertisement.

However, the Tribunal found that, by disseminating the fact that Mr. L. had HIV, even merely to his staff, the employer caused Mr. L. to be excluded from the premises, and stigmatized him. Having found that prejudice regarding HIV/AIDS persists and is extremely widespread, the Tribunal held that the employer's conduct was unacceptable. The Tribunal allowed the employee's complaint on the basis that Mr. L.'s dignity had been violated, and it ordered the employer to pay him CAN$1,000 in moral damages.

— Cécile Kazatchkine

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[1] *Commission des droits de la personne et des droits de la jeunesse v. Poisson,* 2010 QCTDP 15.

Court of Appeal reaffirms long-term income support for alcohol and drug dependence

On 16 September 2010, the Ontario Court of Appeal upheld a decision of the Social Benefits Tribunal that found discriminatory the exclusion from long-term income support of people suffering from alcohol or drug dependency.[1]

In 1999, Robert Tranchemontagne and Norman Werbeski applied for long-term income support under the *Ontario Disability Support Program Act* (ODSPA). At the time, they were receiving financial support under the Ontario Works Program, which provides lower financial assistance and requires its recipients to pursue employment.

Their applications for support were rejected by the director of ODSPA because they were suffering from alcohol and drug dependence. Section 5(2) of the ODSPA establishes that those whose disability and "only substantial restriction in activities of daily living" is due to dependence on drug and alcohol (members of the "sole impairment group") should not be given assistance under ODSPA.

They both appealed the director's decision to the Social Benefits Tribunal (SBT) and argued that Section 5(2) discriminated against them on the basis of their disability and was contrary to Section 1 of Ontario's *Human Rights Code* (*Code*).[2] While the SBT initially held that it did not have jurisdiction to apply the *Code* to the ODSPA, the Supreme Court of Canada determined that it did have such jurisdiction.

In November 2006, the SBT determined that Section 5(2) was discriminatory and was thus inconsistent with the *Code*. The director of ODPSA appealed the SBT's decision to Ontario's Divisional Court, which ultimately dismissed the appeal.[3] The case was further appealed to the Ontario Court of Appeal.

While the Ontario Court of Appeal did not adopt the test for discrimination suggested by the Divisional Court for establishing a violation of the *Code*, it nevertheless found that the SBT's ruling on discrimination concerning Section 5(2) of the ODSPA was in line with the test adopted by the Supreme Court of Canada.[4]

It also did not accept that the SBT and Ontario's Divisional Court

had erred in their approach to the evidence presented by the director. As there were no other grounds presented, the Court of Appeal dismissed the director's appeal and reaffirmed that Section 5(2) of the ODSPA is discriminatory and inconsistent with the *Code*.

— David Bernstein

David Bernstein (dw.bernstein@utoronto.ca) is a law student at the University of Toronto.

[1] *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593.

[2] Section 1 of Ontario's *Human Rights Code* R.S.O. 1990, CHAPTER H.19, provides, "Every person has the right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability."

[3] *Ontario Disability Support Program v. Tranchemontagne*, 2009 CanLII 18295 (ON S.C.D.C.). For more information regarding the Divisional Court's decision and the SBT's ruling and more history surrounding the SBT's jurisdiction to apply the *Human Rights Code* to law, please see S. Chu, "Court decision extends long-term income support to those dependent on alcohol or drugs," *HIV/AIDS Policy & Law Review* 14(2) (2009): pp.38–39.

[4] *R v. Kapp*, 2008 SCC 41.

Federal Court: incarcerated man did not have right to choice of doctor

In December 2010, the Federal Court rejected a former prisoner's request for judicial review of a decision of the Correctional Service of Canada (CSC) regarding his choice of physician while incarcerated.[1]

Richard Harnois, who is infected with HIV and hepatitis C virus (HCV), was incarcerated at La Macaza Institution, a federal penitentiary in the province of Quebec, until August 2008. At that time, Harnois was granted statutory release to serve the final third of his sentence in the community under supervision and under conditions of release. At La Macaza Institution, his physician was Dr. Jean Robert, who continued to treat Harnois during his statutory release.

In April 2009, Harnois's statutory release was suspended by CSC after he violated conditions of his release and he was re-incarcerated at Leclerc Institution, another federal penitentiary in Quebec. At the time of his re-incarceration, Harnois was being treated for HCV.

Although the institutional physician at Leclerc Institution was Dr. Michel Breton, Harnois requested that he continue to be treated by Dr. Robert. In June 2009, CSC rejected the request. Therefore, one of the issues before the Federal Court was whether Harnois had a right to be treated by the physician of his choice during his incarceration.

The Federal Court underlined that CSC's decision was made in context of the prison and that the decision-maker has expertise with respect to the management of penitentiaries. Accordingly, the applicable standard of judicial review was reasonableness.

However, CSC was required to conform to the law, including its obligation to ensure prisoners receive "essential health care" and reasonable access to non-essential mental health care that will contribute to their rehabilitation and successful reintegration into the community, pursuant to Sections 85 and 86 of the *Corrections and Conditional Release Act* (CCRA).[2] The Federal Court also referred to Section 4(e) of the CCRA, stipulating that prisoners "retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence."[3]

To provide health care to prisoners, CSC employs both doctors who are engaged contractually as consulting physicians and institutional physicians. Under the terms of a Commissioner's Directive, an institutional physician is responsible for prescribing treatment and medication for prisoners, while a consulting physician can make recommendations to an institutional physician.

Upon Harnois's admission to Leclerc Institution, Dr. Breton substituted his patient's previous HCV medication with treatment in accordance with CSC's drug formulary, in part because the previous dosage prescribed to Harnois did not fall within CSC guidelines for HCV treatment, which the Federal Court found was in conformity with recognized Canadian standards in this area.

Thus, Harnois argued that his HCV treatment was discontinued by Dr. Breton. The Federal Court held, however, that Dr. Breton did not contravene professional standards and that there was no indication that his medical opinion was inaccurate, unreasonable or not within standards recognized by the medical profession.

Harnois further contended that CSC refused to allow Dr. Robert to treat him, but the Federal Court found that CSC did not object to Dr. Robert temporarily providing care to Harnois while communicating with Dr. Breton. In the Court's view, this satisfied CSC's responsibilities under the CCRA and the Commissioner's Directive.

Ultimately, the Federal Court held that a prisoner does not have the right to access a physician of his or her choice. While there exists a universal right to health, this right is not an absolute one for the population as a whole or for prisoners. As such, the Court concluded that CSC's decision to have Harnois treated by the institutional physician of Leclerc Institution was reasonable, and it rejected his application for judicial review.

[1] *Harnois c. Canada (Procureur général)*, [2010] A.C.F. no 1613.

[2] *Corrections and Conditional Release Act*, RSC 1992, c.20.

[3] Ibid.

Blood donor ban upheld

On 8 September 2010, the Ontario Superior Court rejected a claim that Canadian Blood Services (CBS) is violating Section 15 of the *Canadian Charter of Rights and Freedoms (Charter)* by refusing blood donations from men who have had sex with other men (MSM) since 1977.[1] The case arose because CBS sued Kyle Freeman, a gay man, for lying about his sexuality on the screening questionnaire in order to give blood.

He counter-sued, claiming discrimination on the basis of sexual orientation in violation of the *Charter*.[2] The judge ruled that he had committed negligent misrepresentation and awarded $10,000 in damages to CBS.[3]

The counter-claim with respect to discrimination failed because the judge ruled that the *Charter* did not apply to CBS's policies and operations because it is not a government entity.[4] In this respect, she noted that it was a conscious decision on the part of federal, provincial and territorial governments to hand over complete management discretion with respect to all operational blood-supply system decisions, including matters of health and safety of the blood supply.[5] However, the judge did suggest that CBS's lifetime ban on blood donations from MSM may be excessive.[6]

At trial, the court heard legal arguments from six groups: CBS, the Government of Canada, counsel for

Freeman, the Canadian Haemophilia Society, EGALE Canada and the Canadian AIDS Society (CAS). Lawyer Doug Elliott, who represented CAS, was quoted as saying that the judgment set a dangerous precedent, allowing governments to set up arm's length agencies in order to avoid *Charter* protections.[7]

— *Alison Symington*

Alison Symington (asymington@aidslaw.ca) is a senior policy analyst with the Canadian HIV/AIDS Legal Network.[8]

[1] *Canadian Blood Services v. Freeman*, [2010] O.J. No. 3811.

[2] N. McKinnon, "Gay blood donor advocates await Kyle Freeman decision," *Xtra*, 2 July 2010.

[3] *Canadian Blood Services v. Freemen*, paras. 217–223.

[4] Ibid., para. 367.

[5] Ibid., para. 367.

[6] Ibid., para. 608.

[7] D. Butler, "Charter fears arise from court blood ruling; Decision means governments can quash rights by making agencies independent: lawyer," *The Ottawa Citizen*, 10 September 2010, p. A1; and K. Makin, "Ruling on gay blood donors stirs fears of 'Charter-free zone'," *The Globe and Mail*, 9 September 2010.

Saskatchewan Court of Appeal: marriage commissioners cannot discriminate

The Saskatchewan Court of Appeal has ruled that proposed legislation allowing marriage commissioners to refuse to solemnize same-sex marriages based on religious objections would violate the equality rights of gays and lesbians under the *Canadian Charter of Rights and Freedoms (Charter)*.[1] The Court expressed its opinion in a Reference involving proposed amendments to the *Marriage Act*.

In Saskatchewan, couples can choose to marry in a religious or civil ceremony. Religious officials may refuse to perform any marriage on religious grounds. Couples who want a non-religious ceremony must rely on civil marriage commissioners appointed by the province. Practically speaking, since many religions do not approve of same-sex marriages, most gays and lesbians can only be married by those commissioners.

The first proposed amendment would have amended the *Act* to allow a commissioner appointed on or before 5 November 2004 to decline to solemnize a marriage based on his or her religious beliefs. An alternative proposed amendment would grant the same right of refusal to every commissioner, regardless of date of appointment. The significance of 5 November 2004 is that this was the date on which the Court of Queen's Bench struck down the prohibition against same-sex marriage in Saskatchewan.[2]

The Court of Appeal ruled that neither amendment would be constitutional. Justice Richards authored the majority judgment (on behalf of three judges). He found that the purpose of the amendments was to accommodate the religious views of commissioners, which was a valid objective. However, he held that the effect of the amendments would be to deny gays and lesbians equal treatment, contrary to Section 15(1) of the *Charter*, and that this was not justifiable under Section 1 of the *Charter*.

He concluded that there were less restrictive means available to protect commissioners. He also concluded that the deleterious effects of the amendments would far outweigh any benefits. Allowing commissioners to deny services to gay and lesbian couples would undermine the principle that the state serves everyone equally. Requiring marriage commissioners to perform same-sex marriages did not in any way impair the freedom of

commissioners to hold the religious beliefs they choose or to worship as they wish.

Justice Smith authored a concurring opinion (on behalf of two judges). She questioned whether freedom of religion was actually engaged, since commissioners solemnize civil ceremonies, specifically designed as an alternative to religious marriages. Freedom of religion does not include the right to act on one's beliefs (as opposed to the right to hold such beliefs), when to do so would infringe the rights of others.

Furthermore, freedom of religion includes freedom from others' religious beliefs. A dangerous precedent would be established by accommodating the religious objections of commissioners, since those who sell marriage licences, rent halls for wedding ceremonies or provide rental accommodations to married couples could also argue they should be permitted to deny services to lesbians and gays based on religious grounds. Considering the doubtful and limited value of the legislative objective, as compared to its discriminatory effects, Justice Smith concluded that the proposed amendments could not be justified under Section 1 of the *Charter*.

— Cynthia Petersen and Christine Davies

Cynthia Petersen (cpetersen@sgmlaw.com) and Christine Davies (cdavies@sgmlaw.com) represented Egale Canada Inc. as an intervener in this case.

[1] *Marriage Commissioners Appointed Under* The Marriage Act *(Re)*, 2011 SKCA 3.

[2] *N.W. v. Canada (Attorney General)*, 246 D.L.R. (4th) 345.

Criminal law and HIV transmission or exposure

Manitoba Court of Appeal sets precedent for evaluating risk of HIV non-disclosure

On 13 October 2010, the Manitoba Court of Appeal, in a unanimous decision, acquitted Clato Lual Mabior on four counts of aggravated sexual assault, granting him a new sentencing hearing.[1] Mabior had appealed his conviction on six counts of aggravated sexual assault, one count of invitation to sexual touching and one count of sexual interference. These convictions resulted from relationships with six women between February 2004 and December 2005. All of these women have so far tested HIV-negative.

Mabior was diagnosed as HIV-positive in January 2004. At the time, he was counselled on the various aspects of living with HIV and was told to use protection during sexual activities. Mabior began antiretroviral therapy in April 2004 and subsequently had his viral load checked every three to four months. His viral load was low until October 2004, when it was undetectable. It remained that way until December 2004.

At trial, the judge held that the significant risk of bodily harm necessary, in the context of HIV non-disclosure, to constitute fraud that vitiates consent to sexual relations existed even if the intercourse was protected. She found that the level of risk would only fall below significant when viral load was undetectable and condoms were used.

On appeal, the Canadian HIV/AIDS Legal Network was granted status as an intervenor, and argued, along with the defence, that the trial judge made two errors with respect to assessing the risk of harm. First, due to the nature of the potential harm, the trial judge required that there be no risk of transmission at all. Second, she misconstrued the evidence about the risk of transmission in situations of protected sexual inter-

course and this mistake was central to her reasoning.

The Crown submitted that condom use or low viral load does not address the fundamental issue of consent. Individuals are entitled to bodily integrity, which includes information that may affect their decision to have sexual relations or the manner in which they do so. Alternately, they submitted that there was insufficient evidence of the factors necessary to reduce transmission. They also argued that, given the severity of the consequences, even a small risk of harm is significant.

The appeal court held that the relevant legal standard in HIV non-disclosure cases is not the elimination of risk. Rather, what constitutes a significant risk is a matter of fact that must be determined in each case. The standard of significant risk of serious bodily harm will change depending on developments in medicine in relation to the treatment of HIV/AIDS.

Regarding the effect of condom use on the level of risk, the court found, on the basis of scientific evidence, that the use of condoms reduces the risk of transmission below a significant level, although it does not completely eliminate the risk. The court held that whether or not condoms were used carefully and consistently is a matter to be determined in each case.

The court further held that viral load should be considered in an evaluation of the level of risk. However, since viral load is measured at a particular moment in time, the court could not make a comprehensive statement about its impact. Rather, it held that its relevance will depend on the particular facts of a case, the available medical evidence and the way in which viral load evidence is presented in the case.

In terms of the specific facts of Mabior's case, the court found risk that was insufficient to constitute serious bodily harm in several of the counts. In one case, a condom was used and there was no evidence of its failure or human error, so the court found no significant risk of serious bodily harm and acquitted Mabior on that count. In three other cases, Mabior's viral load was very low, such that he was highly likely not infectious. In these cases, the court acquitted Mabior, despite evidence of only inconsistent condom use.

The case has been appealed to the Supreme Court of Canada, where a decision on leave to appeal is pending.

Commentary

This case contains several important developments in the appropriate evaluation of a significant risk of serious bodily harm, particularly with respect to recognizing medical advances in the understanding and treatment of HIV/AIDS.

First, the Manitoba Court of Appeal indicated that complete elimination of risk is not necessary in order to constitute less than a significant risk of serious bodily harm. The judges held that either careful and consistent use of condoms or an undetectable viral load can reduce the level of risk below the significant level. It specifically rejected the trial court's finding that both condoms and an undetectable viral load are necessary to achieve this result. This is an important development because it provides defences to those accused of HIV non-disclosure. Further, since either a defence of condom use or undetectable viral load is possible, it may be easier for an accused to raise a defence than if he or she had to show both.

Yet, these defences are limited. The court did not make an unequivocal statement on the effect of condom use or viral load on the level of risk. Rather, the judges cautioned that the impact of both must be assessed on the basis of the particular facts of each case. Specifically, condom use must be careful and consistent, and evidence on viral load will be evaluated with regard to the manner in which such evidence is presented, as well as current medical evidence. Additionally, the court held that, if a condom breaks, the person living with HIV is obliged to inform his or her sexual partner so that that person can take prophylactic measures.

Second, at the end of their decision, the judges questioned whether exposing someone to a significant risk of contracting HIV continues to constitute an endangerment of life, given advancements in the treatment of HIV/AIDS. This is significant since it is endangerment of life that raises assault to aggravated assault, making harsher penalties available.

Indeed, the judges suggested that it might be time for the Supreme Court of Canada to revisit its 1998 decision *Cuerrier,* where the significant risk of serious bodily harm test was first developed in relation to HIV non-disclosure.[2] However, although this indicates recognition of the changing medical reality of HIV/AIDS, the judges were not asked to decide on this issue and so these comments are not binding on lower courts.

Thus, this decision indicates positive, though cautious, developments for individuals charged with HIV non-disclosure.

— Elizabeth Bingham

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Quebec Court of Appeal acquits woman based on undetectable viral load

On 13 December 2010, the Quebec Court of Appeal reversed a decision of the Court of Quebec convicting a woman of sexual assault and aggravated assault for failing to disclose her HIV-positive status to her partner prior to having a single instance of unprotected sex with him.[3] Because the woman's viral load was undetectable, the appellate court held that the sexual encounter in question did not expose the complainant to a significant risk of HIV transmission.

The woman, D.C., was diagnosed with HIV in 1991. From 2000 to 2004, she was in a relationship with the complainant. After their relationship ended, D.C. laid charges of domestic violence against the complainant, for which he was convicted.

The complainant subsequently filed a complaint against D.C., alleging that, at the onset of their relationship, he had on several occasions had unprotected sex with her before she disclosed her HIV-positive status to him. The complainant did not contract HIV.

D.C. contended that they had sex only once before she disclosed her HIV status to him, and that they had used a condom then. Moreover, D.C. had an undetectable viral load at the relevant time.

The Court of Quebec found that the couple had unprotected sex one time before D.C. disclosed her HIV status to the complainant. Because it did not take into account the fact that D.C. had an undetectable viral load, the Court held that this singular act exposed the complainant to a significant risk of serious bodily harm and convicted her of sexual assault and aggravated assault. D.C. was given a 12-month sentence to be served in the community.

At the appeal, the Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-SIDA) and the Canadian HIV/AIDS Legal Network intervened and argued that a person living with HIV should not be convicted for non-disclosure if a condom was used during sex or if his/her viral load was undetectable at the relevant time.

The Quebec Court of Appeal declined to make a decision on the question of whether protected sex poses a significant risk of HIV transmission because it confirmed the lower court's finding that D.C. had had *unprotected* sex with the complainant before she disclosed her HIV status to him.

Therefore, the central issue was whether this instance of unprotected sex exposed the complainant to a significant risk of HIV transmission. While the trial court did not take into account D.C.'s undetectable viral load, this factor was crucial in the Court of Appeal's decision to acquit her. The Court confirmed that a duty to disclose exists only where the evidence shows that there is a "significant risk" of HIV transmission and rejected the Crown's argument that, in view of the seriousness of HIV, *any* risk of transmission is a significant risk.

In this case, the medical experts assessed the risk of transmission as 1 in 10 000 where the viral load is undetectable and characterized this risk as "truly minimal" and "very, very low."[4] In light of this evidence and the fact that the couple only had unprotected sex once before D.C. disclosed her status to the complainant, the Court of Appeal held that the complainant was not exposed to a "significant risk of serious bodily harm" and acquitted D.C.

At the time of this writing, the Crown had filed a motion for leave to appeal the case to the Supreme Court of Canada.

Commentary

This decision of the Quebec Court of Appeal is a significant step forward in recognizing that an undetectable viral load alone does not necessarily carry a significant risk of HIV transmission and therefore does not always give rise to an obligation to disclose. This is in line with a trend in Canadian criminal law whereby viral load must be taken into account in assessing the risk of HIV transmission from a legal point of view.[5]

However, the Court was careful not to establish a general rule that an undetectable viral load removes the duty to disclose one's HIV-positive status. Therefore, analysis of risk will continue to be done on a case-by-case basis, having regard to the facts and medical evidence of each particular case.

On the issue of condom use, because the appellate court found the one instance of sex prior to disclosure was unprotected, this decision does not address the possibility that a condom can reduce the risk of transmission to a level below the "significant risk" threshold.

Conviction for aggravated sexual assault highlights factors for courts evaluating risk of HIV non-disclosure

On 23 August 2010, the British Columbia Supreme Court found Adrian Sylver Nduwayo guilty of five counts of aggravated sexual assault.[6] Nduwayo had been charged with seven counts of aggravated sexual assault resulting from his failure to disclose his HIV-positive status in his relationships with seven different women between 1997 and 2003. Four of these women later tested HIV-positive.

Nduwayo was diagnosed as HIV-positive in 1996. At that time, his doctors informed him that he should use protection during sexual intercourse and should disclose his HIV status to any potential sexual partners. Nduwayo was a participant in a medical study from 1996 to 1998, during which time he received treatment for HIV. However, in 1999, he stopped taking medication due to negative side effects.

In 2005, Nduwayo was tried for the first time as a result of his failure to disclose his HIV-positive status. He was convicted of five counts of aggravated sexual assault and one count of attempted aggravated sexual assault, and was sentenced to fifteen years' imprisonment. This decision was overturned by the British Columbia Court of Appeal in 2008 on the grounds that the judge had not sufficiently warned the jury against using evidence from one complainant when considering guilt on another count. A new trial was ordered.

At the 2010 trial, the complainants testified that Nduwayo was reluctant to use condoms. They all alleged that he had, at some time and in some way, denied being HIV-positive.

During this trial, the defence argued that the main issue was whether the Crown had proven that there was a significant risk of bodily harm in Nduwayo's sexual encounters with the complainants. In the context of HIV non-disclosure, this risk provides proof of fraud, which in turn vitiates consent to sexual relations. The defence submitted that factors other than condom use, such as viral load, the type of sexual activity, whether there was ejaculation and whether any sores or lesions were present should bear on the court's determination of whether or not there was a significant risk of serious bodily harm.

The judge accepted that whether or not Nduwayo's failure to disclose resulted in a significant risk of serious bodily harm was the central issue in his determination of guilt or innocence. He found that two issues must be considered in an assessment of whether actions constitute a serious risk of bodily harm.

First, the amount of risk in terms of the potential for transmission must be determined. Many variables should be taken into account in this part of the analysis, including condom use, the accused's viral load at the relevant time and the type of activity. Overall, the degree of risk necessary must be greater than "minor or insignificant," but does not have to be "high or very likely." Regarding condom use, the judge indicated that the careful use of a condom might be found to reduce the risk of harm such that it can no longer be considered significant.

Second, the seriousness of the possible harm must be considered. The judge found that the consequences of contracting HIV are a serious threat to the health and general well-being of an individual.

Ultimately, the judge found Nduwayo guilty of five of seven counts. In one count, Nduwayo was acquitted since, in his one sexual encounter with the complainant, there was doubt as to whether a condom was used or not. Nduwayo was entitled to the benefit of this doubt, so the judge considered this one incident of protected intercourse. He found that this did not constitute a significant risk of bodily harm.

In the second count where Nduwayo was acquitted, the judge found that, according to the evidence, there was only one unprotected sexual encounter. Taking into account that the complainant was not infected, the judge considered that one unprotected act did not constitute a significant risk of serious bodily harm.

Commentary

This case illustrates the different factors a court can take into account when applying the legal test of a "significant risk of bodily harm."

First, the court delineated the degree of risk sufficient to find that there was a significant risk of serious bodily harm. In particular, the judge indicated that the harm must be greater than "minor or insignificant," but that it does not have to be "high or very likely." Although this may not be a precise guideline, it does indicate that some level of risk is acceptable.

Second, the judge considered condom use to be a key factor. When a condom was carefully used — or potentially used — and no infection occurred, the offence of aggravated

sexual assault was not proven beyond a reasonable doubt.

Third, the frequency of sexual intercourse was also considered a key factor in this decision. One act of unprotected intercourse along with no evidence of HIV transmission was not a significant risk of bodily harm. This is especially noteworthy since no obvious means of reducing risk (i.e., condom use or an undetectable viral load) was present.

Finally, in only one count was there evidence of Nduwayo's viral load. The judge took this element into account, but decided that there was a significant risk of serious bodily harm. It is possible that this decision was made because Nduwayo's viral load was not sufficiently low at the relevant time.

— Elizabeth Bingham

Quebec man acquitted in case of HIV non-disclosure

M.P. was charged with aggravated sexual assault for failing to disclose his HIV-positive status prior to having sexual relations with his neighbour Ms. E. at various times from 1 August to 28 October 2008. She testified that they engaged in sexual touching ("*attouchements*") and at least ten instances of unprotected full intercourse without his revealing his HIV-positive status.

The accused claimed that they had only engaged in sexual touching and two instances of protected full intercourse, and that he had disclosed his status.[7]

According to the judge, the parties agreed that the only true issue is whether the accused "dishonestly failed to disclose his HIV-positive status" to his neighbour. He specified that, "if so, Ms. E.'s consent to sexual relations with M.P. [was] vitiated by fraud." The court acquitted M.P. on the basis that his testimony, and that of Ms. E., raised a reasonable doubt as to M.P's guilt. Among other things, the judge took into consideration the fact that Ms. E. brought her complaint in the context of a dispute that had nothing to do with M.P.'s HIV-positive status.

Commentary

This decision illustrates the fundamental importance of the parties' credibility in HIV non-disclosure cases. It also raises concerns about the way the parties and the judge defined the terms.

The decision's wording suggests that mere non-disclosure of HIV-positive status prior to having "sexual relations" is sufficient to vitiate consent by fraud, and that there is no need to inquire about the level of HIV transmission risk associated with the sexual relations in question. This is surprising, because the Supreme Court of Canada has clearly established that consent is only vitiated by fraud if the non-disclosure exposed the sexual partner to a "significant risk" of transmission.[8]

Here, the parties' contradictory testimony did not clearly establish that the couple had unprotected sex that posed a significant risk of transmission. The issue of transmission risk should have been addressed.

— Cécile Kazatchkine

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Two years in jail for non-disclosure of HIV-positive status

R.M. pleaded guilty to charges of aggravated sexual assault in relation to three instances of unprotected oral sex and six instances of unprotected vaginal sex without first disclosing that he was HIV-positive. His partner was not infected.

R.M. was sentenced to two years less one day of imprisonment, and to three years' probation, which included "therapy to help him accept and better understand his disease."[9]

Commentary

This decision is unsettling. First of all, the accused pleaded guilty to unprotected oral sex, even though there was no significant risk of transmission. Secondly, it is questionable whether the guilty plea for the unprotected vaginal sex was appropriate.

The pre-sentencing report said that R.M. did not believe he had exposed the victim to a significant risk of HIV transmission, because his viral load was undetectable and he did not ejaculate inside her.

Moreover, although the sentencing judge admitted that these statements appeared to "qualify essential elements of the offence admitted to in the plea," he chose to use them against R.M. in finding a risk of reoffending that justified an order that R.M. undergo psychotherapy even though he was now married.

The judge found that R.M. had "engaged in magical thinking" about the risks of transmission and was "avoiding a sense of responsibility through his self-indulgent beliefs." These "beliefs" were inconsistent with his doctor's recommendation in 1993 that he be abstinent, and, since then, he had apparently failed to find out more about the risks of transmission.

Such reasoning underscores the urgent need to ensure that professionals within the justice system are better informed of the evolution of HIV since the 1990s, and of the complexity of the concept of transmission risk.

— Cécile Kazatchkine

Ontario: HIV+ man acquitted of aggravated sexual assault

On 17 December 2010, the Ontario Superior Court of Justice acquitted Patrick Pottelberg of aggravated sexual assault because it had a reasonable doubt as to whether the complainant would not have consented to unprotected sex had he known Pottelberg's HIV-positive status.[10]

Pottelberg was diagnosed with HIV in 2006 by his doctor and friend Rice.[11] In December 2007, the complainant, N.B., visited Rice's residence, where Pottelberg was also staying. There, the complainant and Pottelberg engaged in unprotected sexual activity; sexual relations between the two occurred over a period of eight months without Pottelberg ever having disclosed the fact that he was HIV-positive. When N.B. subsequently tested positive for HIV, he spoke with Pottelberg, who then revealed his HIV status to N.B.

The Ontario Superior Court found that Pottelberg had not informed N.B. of his HIV-positive status prior to their having sex, and that N.B.'s consent to sex was thus vitiated by this non-disclosure. However, N.B. had participated in unprotected sexual activity both prior and subsequent to his contact with Pottelberg. As there was a possibility that N.B. had contracted HIV through a third party, the Crown could not prove that Pottelberg had endangered N.B.'s life.

Following the Supreme Court of Canada's decision in *R. v. Williams*,[12] which established the test for attempted assault offences, the Crown argued that Pottelberg was guilty of attempted aggravated assault. In order to prove this, the Crown had to prove that Pottelberg had the intent to commit the offence of aggravated assault, and it was irrelevant that it was impossible under the circumstances to have committed the full offence of aggravated sexual assault (since N.B. might have already contracted HIV).

The defence argued that Pottelberg had a mistaken belief that there had been consent, having believed that Rice had informed N.B. of his HIV status prior to their having sex. The defence further argued that the Crown had not proven that N.B. would not have consented to unprotected sex had he been aware of Pottelberg's status. As stated by the Supreme Court of Canada in *R. v. Cuerrier*, the Crown is required to prove that a complainant would not have consented, had he or she been informed of the accused's status.[13]

N.B. had testified at trial that he would not have consented to sex with Pottelberg had he known his HIV status, but the court found inconsistencies between N.B.'s testimony at the preliminary hearing and at trial. As N.B. was familiar with how HIV is transmitted from his time volunteering at an AIDS clinic and Pottelberg showed visible signs of his illness when they first had sex, the court had reasonable doubt that N.B. would not have consented to unprotected sex with Pottelberg had the latter informed him of his status. The court thus acquitted Pottelberg on this ground.

— David Bernstein

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Edmonton man sentenced to three years in prison for failing to inform woman he had HIV prior to sex

John Duane Gilbertson was originally charged with aggravated sexual assault for failing to inform a woman with whom he had sex that he was HIV-positive. Although Gilbertson told Judge Marilena Carminati of the Provincial Court of Alberta that he was on HIV medication and that his viral load was "barely detectable," he pleaded guilty in August 2010 to the lesser offence of aggravated assault after he admitted he failed to inform the complainant of his HIV status before they had sex.[14]

Gilbertson was arrested on 3 June 2010 after his roommates, who were aware of his HIV status, reportedly

called police after coming home and finding him having sex with a woman. It is not clear from media reports whether the sex was unprotected, although the complainant was reportedly drunk and had trouble providing details to the police of what had happened.[15]

Gilbertson was sentenced to three years in prison and ordered to submit a DNA sample for the national DNA database and prohibited from possessing weapons for life.[16]

Man acquitted of aggravated sexual assault for alleged HIV non-disclosure

On 21 January 2011, the Alberta Court of Queen's Bench acquitted Patient Simpenzwe of aggravated sexual assault for allegedly having had unprotected sex with a woman without first disclosing his HIV-positive status.[17]

According to the complainant, Simpenzwe had forced her twice to have unprotected sex with him at his Edmonton home, after which he told her he was HIV-positive. However, evidence was introduced at trial that condoms had been seized from Simpenzwe's home, of which at least two had the complainant's DNA on them. Simpenzwe's lawyer argued that his client was candid about his HIV status and had used a condom during consensual sex.[18]

After two hours of deliberation, the jury found Simpenzwe not guilty of aggravated sexual assault.[19]

Deported HIV-positive man faces outstanding warrant for aggravated sexual assault

In May 2010, Vinroy Spencer was deported from Canada to an unnamed Caribbean country after having been convicted of assault and aggravated assault. After his deportation, the Hamilton Police Service issued an arrest warrant against Spencer in July for the offence of aggravated sexual assault for allegedly failing to disclose his HIV-positive status to his girlfriend during their five-year relationship.[20] The complainant was reported to have learned of Spencer's HIV status from his deportation appeal document. She subsequently tested positive for HIV.

Despite notice from Hamilton police of pending charges, Canada Border Services Agency deported Spencer because he was deemed a "high priority" in light of his previous convictions.[21] The warrant against Spencer is still outstanding.

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[1] *R. v. Mabior,* [2010] 2010 MBCA 93 (Manitoba Court of Appeal).

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

[3] *R. c. D.C.,* 2010 QCCA 2289.

[4] COCQ-SIDA, *R. c. D.C.: Summary of the decision of the Court of Appeal of Quebec.* 2010.

[5] Ibid.

[6] *R. v. Nduwayo,* [2010] 2010 BCSC 1467 (B.C. Supreme Court).

[7] *R. v. Parenteau*, 2010 ONSC 1500. All quotes in this article are translations from French.

[8] *R. v. Cuerrier*, [1998] 2 S.C.R. 371.

[9] *R. v. Mercier,* 2011 QCCQ 198. All quotes in this article are translated from French.

[10] *R v. Pottelberg*, 2010 ONSC 5756.

[11] No first name noted in decision.

[12] *R v. Williams*, 2003 SCC 41.

[13] *R v. Cuerrier,* (1998) 127 C.C.C. (3d) 1.

[14] T. Blais, "HIV-risky sex earns man three years in slammer," *The Edmonton Sun*, 14 August 2010, p. 5.

[15] Ibid.

[16] Ibid.

[17] T. Blais, "HIV man cleared in sex assault charge," *The Edmonton Sun,* 22 January 2011, p. 4.

[18] T. Blais, "Woman knew accused was HIV positive: Defence," *The Toronto Sun*, 21 January 2011.

[19] "HIV man cleared in sex assault charge" (supra).

[20] N. O'Reilly, "Woman hurt that 'lover' won't face charges," *The Hamilton Spectator*, 25 September 2011.

[21] Ibid.

HIV/AIDS IN THE COURTS — INTERNATIONAL

This section presents a summary of important international cases relating to HIV/AIDS or of significance to people living with HIV/AIDS. It reports on civil and criminal cases. Coverage is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the *Review*. Coverage of U.S. cases is very selective, as reports of U.S. cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of Mikhail Golichenko (mgolichenko@aidslaw.ca), senior policy analyst at the Canadian HIV/AIDS Legal Network and editor of this section. Except where otherwise noted, the articles in this section were written by Mr. Golichenko.

China: court rules school board did not discriminate against prospective HIV-positive employee

On 11 November 2010, the Anqing Yinjiang District Court ruled that a local education board did not unlawfully discriminate against an HIV-positive college graduate when it decided not to employ him upon discovering his HIV status.[1]

The judge agreed with the board's contention that regulations barring HIV-infected civil servants superseded a four-year-old law that protects people living with the virus from employer discrimination. That measure, passed by the State Council, the chief administrative body in China, states that "no institution or individual shall discriminate against people living with HIV, AIDS patients and their relatives."[2]

After graduating from a college in Anqing and passing several interviews, the plaintiff — who used the alias Xiao Wu in legal documents to conceal his identity — learned of his application status when the municipal education board decided not to employ him because he had failed the physical examination. He said he did not know he was HIV-positive before the examination and that he has no idea how he contracted the disease.[3]

The case had been a bright spot for AIDS activists, who for years had seen a series of job-discrimination lawsuits rejected by Chinese courts before going to trial. Domestic media coverage of the case was sympathetic and, given the central government's laws against discrimination, legal advocates hoped a positive outcome would set a precedent. Now advocates worry that the ruling will have the opposite effect, providing legal cover for employers who do not want to hire people with HIV.[4]

"The case highlights the public's poor awareness of how the disease is transmitted. The discrimination resulted from ignorance and panic," Zhang Beichuan, a renowned Chinese AIDS expert, said.[5]

The plaintiff has already lodged an appeal of the ruling.

"I was not the first to be discriminated against for being HIV-positive and I certainly will not be the last. But I will continue to strive for the rights of China's over 740 000 HIV-positive people," Wu said.[6]

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[1] A. Jacobs, "H.I.V. Discrimination Law Fails in Chinese Court," *The New York Times*, 12 November 2010. On-line: www.nytimes.com/2010/11/13/world/asia/13china.html?_r=1.

[2] Ibid.

[3] "College graduate appeals to higher court after losing China's 1st HIV-related job bias suit," People's Daily Online, 29 November 2010. On-line: http://english.peopledaily.com cn/90001/90776/90882/7215108.html.

[4] A. Jacobs (supra).

[5] "College graduate appeals to higher court after losing China's 1st HIV-related job bias suit" (supra).

[6] Ibid.

South Africa: HIV-positive man wins wrongful dismissal suit

An award-winning horse-riding instructor and stable manager dismissed by his former employer in 2008 for being HIV-positive won his case in a Johannesburg court in February 2011. The employer was ordered to pay the man a year's salary and cover his legal costs.[1]

Gary Allpass was fired from Mooikloof Estates in Pretoria after his boss had asked him to fill in a form disclosing if he was on long-term medication. Allpass, who has been living with HIV for more than 20 years, revealed on the form that he was taking antiretroviral drugs. The following week, he was dismissed from his position and forcibly removed from staff lodgings.[2]

In a formal dismissal note, the employer stated the reason for the action as "fraudulent misrepresentations." Mooikloof Estates said in court that it had fired Allpass because of a breakdown in trust, as he was "dishonest about his illness."[3]

In her ruling, Judge Urmila Bhoola noted that the dismissal of employees because of their HIV status was widely acknowledged as discrimination unless the employer could show that being free of HIV was an inherent requirement of the job.

"It is trite law that the applicant was under no legal obligation to disclose his HIV status to his prospective employer and that the expectation that he should have so disclosed violates his right to dignity and privacy," Judge Bhoola noted. "It was this expectation, moreover, that informed the primary reason for his dismissal."[4]

The judge also said that there was no medical or physical reason why Allpass could not do his job, adding that the notion that HIV and AIDS are synonymous with serious illness is common, but that this stereotype results in a loss of dignity.[5]

"We get many cases like this and this says there is still a problem with some employers, especially the smaller ones," said Mark Heywood from Section 27, a human rights group that provided Allpass with legal assistance. "We hope the message [from this victory] will be heard by thousands of people and also that people with HIV know the law is there to protect them."[6]

[1] "Estate to pay HIV+ man," iafrica.com, 16 February 2011. On-line: http://news.iafrica.com/sa/706722.html.

[2] A.D. Smith, "SA court condemns HIV sacking," Radio France International, 18 February 2011. On-line: www.english.rfi.fr/africa/20110218-sa-court-condemns-hiv-sacking.

[3] "Estate to pay HIV+ man" (supra).

[4] Ibid.

[5] A. D. Smith (supra).

[6] "Estate to pay HIV+ man" (supra).

City of Moscow decision to forbid gay pride marches violates European Convention on Human Rights

On 21 October 2010, the European Court of Human Rights ruled that the office of then-mayor of Moscow Yuri Luzhkov violated the rights to freedom of assembly and from discrimination of Russians who had sought to organize and participate in gay pride marches in the Russian capital of Moscow.[1]

The applicant in the case before the court, Nikolay Alekseyev, was one of the organizers of several planned marches in 2006, 2007 and 2008 that were aimed at drawing public attention to the discrimination against the gay and lesbian community in Russia and promoting tolerance and respect for human rights.

The organizers submitted notices to the office of the mayor on several different occasions announcing their intention to hold marches. They also undertook to cooperate with law-enforcement authorities in ensuring safety and respect for public order and to comply with the regulations on restriction of noise levels when using loud speakers and sound equipment.

Nevertheless, the office turned down the organizers' requests, citing the need to protect public order, health, morals and the rights and freedoms of others, as well as to prevent riots. Luzhkov and his staff were also quoted in the Russian media saying that "the government of Moscow would not even consider the organization of gay marches" and that no gay parade would be allowed in Moscow under any circumstances "as long as the city mayor held his post."[2]

In his case before the European Court, Alekseyev argued that the repeated ban on holding the gay pride marches was discriminatory because of the participants' sexual orientation.

Article 11 of the European Convention on Human Rights guarantees freedom of peaceful assembly and of association, and the Court noted that it protected non-violent demonstrations that might annoy or offend people who did not share the ideas promoted by the demonstrators. It also stressed that people had to be able to hold demonstrations without fearing that they would be physically harassed by their opponents. The mere risk of a demonstration creating a disturbance was not sufficient to justify its ban.

The Court stated that Moscow authorities should have made arrangements to ensure that marches proceeded peacefully and lawfully, thus allowing both sides to express their views without a violent clash. Instead, by banning the gay pride marches, the authorities had effectively approved of and supported groups who had called for the dis-

ruption of the peaceful marches, in breach of law and public order.

The Court further noted that the considerations of safety had been of secondary importance for the authorities who had been mainly guided by the prevailing moral values of the majority. Luzhkov had, on previous occasions, expressed his determination to prevent gay parades, as he found them inappropriate. The Russian Government also stated in its submissions to the Court that such events had to be banned as a matter of principle because gay propaganda was incompatible with religious doctrines and public morals, and could harm children and adults who were exposed to it.

The Court stressed that, if the exercise of the right to peaceful assembly and association by a minority group were conditional on its acceptance by the majority, it would be incompatible with the values of the Convention. The purpose of the gay pride marches had been to promote respect for human rights and tolerance towards sexual minorities; they were not intended to include nudity or obscenity or to criticize public morals or religious views.

In addition, ample case law has shown the existence of a long-standing European consensus on questions such as the abolition of criminal liability for homosexual relations between adults, on homosexuals' access to service in the armed forces, to the granting of parental rights, to equality in tax matters and the right to succeed to the deceased partner's tenancy. The Court indicated that it was also clear that other Convention member states recognized the right of people to identify themselves openly as gay and to promote their rights and freedoms, in particular by peacefully and publicly gathering together. It emphasized that it was only through fair and public debate that society could address such complex issues as gay rights, which in turn would benefit social cohesion, as all views would be heard.

Finally, the Court observed that the main reason for the bans on the gay marches had been the authorities' disapproval of demonstrations, which, they considered, promoted homosexuality. In particular, the Court could not disregard the strong personal opinions publicly expressed by Luzhkov and the undeniable link between those statements and the bans. Consequently, the Court found that, as the Government had not justified their bans in a way compatible with the Convention requirements, the applicant had suffered discrimination because of his sexual orientation, in violation of Article 14 of the Convention.

[1] European Court of Human Rights, "Repeated unjustified Ban on Gay-Rights Marches in Moscow," news release, 21 October 2010.

[2] Ibid.

Romania: European Court of Human Rights rules degrading treatment for man who contracted TB in prison

In December 2010, the European Court of Human Rights ruled that a Romanian man who contracted tuberculosis (TB) while in prison had his rights violated pursuant to Article 3 of the European Convention on Human Rights, which prohibits torture and degrading treatment.

In April 2003, the applicant was sentenced to four and a half years in prison for robbery. He had been in pre-trial detention in a prison in Ploieşti since October 2002. In July 2003, he was transferred to a prison in Jilava.[1]

A medical report dated 11 July 2003 by doctors with the Jilava prison hospital noted that the applicant had arrived with "suspected" pulmonary TB. On 31 July, as he was to be returned to the prison, the doctors confirmed that the man had the "after-effects" ("*séquelles*") of

TB. A subsequent medical report declared him "fit" ("*apte*") and indicated that he be examined in another two months.

During the second hospitalization of the applicant, from 11 September to 27 November 2003, further confirmation of the presence of TB was noted and doctors prescribed specific treatment for him, which began on 18 September. A third hospitalization occurred from 2 December 2003 to 29 January 2004, while he was again sent for care a fourth time on 3 February, which lasted until the end of May. In January 2005, doctors concluded that his condition had stabilized. On October of that year, the applicant was released after serving two thirds of his sentence.

The applicant alleged before the Court that a lack of appropriate medical treatment while incarcerated, and his contracting TB, contravened Article 3 of the Convention, which states that "[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment." He claimed that staff were negligent in separating prisoners in poor health from those in good health. The man also said that the prisons were unhygienic and over-crowded, indicating that, between October 2002 and June 2003, he was placed in a cell with more than 60 other prisoners. He noted that conditions in Jilava were "worse than those in the Ploieşti prison."

The government of Romania argued that the absence of specific treatment for TB until September 2003 was due to the lack of medical confirmation of active TB, as doctors had only noted its "after-effects." The government pointed out that, from November 2002 to July 2003, there was no other case of TB in the Ploieşti prison and that any prisoner with a contagious disease was placed in the infirmary, isolated from fellow prisoners and kept under medical supervision.

The Court noted that, at the time of his detention in October 2002, the prison doctor had examined him and concluded that he was "clinically in good health." Along with the man not having shown any prior symptoms of TB, the Court reasoned that it could not be concluded that he was threatened with TB prior to his detention.

The Court went on to say that "any possible diagnostic failure when the applicant was under the responsibility of the State cannot be attributable to the applicant." In addition, "aside from the obligation to maintain the health and well-being of a prisoner, notably through the administration of necessary medical care, the Court considers that Article 3 of the Convention obliges the State to implement effective prevention and testing measures for contagious diseases in a prison setting." It said that "the obligation [is] on the State to carry out early testing of those detained, at the moment of their incarceration, in order to identify the carriers of the germ or of a contagious illness, to isolate them and to care for them effectively."

As for the medical care given to the applicant while in prison, the Court noted that treatment for TB appeared to have been adequate in stabilizing the disease. Nevertheless, after having suspected the presence of pulmonary TB, Jilava prison authorities placed him in "conditions of detention likely to worsen his health." Consequently, the Court concluded that "the applicant developed TB while under State responsibility, between the date of his initial detention and that of the testing for the illness, because of prison conditions and contrary to Article 3 of the Convention."

While the Court acknowledged that there was no deliberate intent on the part of the State to humiliate or demean the applicant, it said that "the conditions of detention for over eight months, combined with the TB that the applicant developed, constitute degrading treatment. Accordingly, there has been a violation of Article 3 of the Convention."

— David Cozac

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[1] *Dobri. c. Roumanie*, European Court of Human Rights, 14 December 2010. On-line: http://cmiskp.echr.coe.int/tkp197/view.asp?item=1&portal=hbkm&action=html&highlight=dobri%20|%2025153/04&sessionid=67240497&skin=hudoc-en. French only. All quoted references to the case were translated by the author.

Criminal law and cases of HIV transmission or exposure

Republic of Congo: man sentenced to 15 years for "poisoning" wife with HIV

On 24 February 2011, an appeals court in Pointe-Noire sentenced Eustache Mbouayemou to 15 years in prison and ordered him to pay 100 million CFA (CAN$206,000) in damages for having infected his wife with HIV.[1]

This case marked the first time that the issue of deliberate HIV transmission was brought before the courts in the Republic of Congo.

According to the woman's lawyer, Raymond Nzondo, her husband had been receiving treatment for HIV since 2000, but said nothing to his wife, who developed the virus in 2005.

The judge in the case used the offence of "poisoning"[2] in rendering the verdict because, to date, there is no specific law in the country criminalizing HIV transmission.

"There are no restrictions on the use of poisoning in our law," Nzondo stated. "It can be the administration or introduction ["*inoculation*"] of a substance into the body causing harm or death."

Reacting to the verdict, Irénée Malonga, lawyer for the accused, called the motion illegal. "This offence does not exist in our legislation," she said, indicating that an appeal would be launched.

Nzondo countered by saying that "the man knew he was sick and took medication behind his wife's back. [The transmission of HIV to her] was intentional and criminal."

"This is a very delicate case," said Germain Céphas Ewangui of Thomas Sankara Pan-African Foundation in Brazzaville, which works on HIV and human rights issues. "Even in countries where HIV laws have been adopted, their applicability poses problems."

USA: Air Force veteran sentenced to military prison for unprotected sex with multiple partners

On 19 January 2011, Air Force sergeant David Gutiérrez was sentenced to eight years in military prison and was to be dishonourably discharged. A court martial judge found him guilty of aggravated assault and violating his commander's order to notify sexual partners of his HIV status and to use condoms.[3]

Lt. Col. William Muldoon delivered the sentence after a brief hearing. Gutiérrez had begged a judge not to discharge him so that he could keep his military medical benefits.

Prosecutors, who had sought 18 years' imprisonment, argued that Gutiérrez played Russian roulette with his sexual partners' lives.

"The accused was not thinking about how his victims would pay for their medications," Capt. Sam Kidd said.[4]

Several people who participated in swinger and partner-swapping events with Gutiérrez and his wife testified that they never would have had sex with him had he told them he was HIV-positive.[5]

USA: HIV-positive man receives probation for biting neighbour

On 8 December 2010, a Michigan man received an 11-month probation sentence after pleading no contest to an aggravated assault charge.[6] Daniel Allen was also ordered to stay out of contact with Winfred Fernandis, Jr., the man who claims Allen bit his lip during an altercation in 2009.[7]

Allen originally faced a bioterrorism charge under Michigan law for allegedly using HIV as a weapon.

Allen, who is openly gay, maintained his innocence throughout the case, suggesting his neighbour attacked him over his sexual orientation.

"This was nothing more than gay-bashing," attorney James L. Galen, Jr. said. "The only reason my client took a plea deal was because of his health, and one of the witnesses didn't show up for the defense."[8]

Germany: HIV-positive pop star convicted of grievous bodily harm, avoids jail

A German pop singer who confessed to knowingly exposing two men to the risk of HIV was convicted of assault on 26 August 2010.[9]

Nadja Benaissa of girl-band No Angels was convicted of causing grievous bodily harm in one instance for infecting a 34-year-old talent agent, and attempted grievous bodily

harm for a separate occasion when she had unprotected sex with another man between 2000 and 2004. She was given a two-year suspended sentence and required to perform 300 hours of community service and submit to regular counselling sessions.

Benaissa was facing up to ten years in jail. However, prosecutors sought a lenient sentence because she had confessed and expressed remorse.[10]

AIDS awareness group Deutsche AIDS-Hilfe (DAH), which had hoped for an acquittal, was unhappy with the decision, arguing that people infected with HIV now risked further stigma and would not be encouraged to come clean about the virus.

"I think this is the wrong verdict. This will do serious damage to HIV prevention," DAH spokesman Carsten Schatz said.[11]

Finland: Kenyan-born woman sentenced to 4½ years in prison

In December 2010, a district court in the Finnish city of Tampere handed down a four-year, six-month prison sentence to a 28-year-old woman for endangerment and attempted aggravated assault, after having unprotected sex with several partners, even though she knew she was HIV-positive. The woman was also ordered by the court to pay almost 20,000 Euros (CAN$27,000) in damages and 24,000 Euros in court costs.[12]

The Kenyan-born woman, who reportedly worked as an erotic dancer to support herself after her marriage to her Finnish husband ended, had unprotected sex with 16 men from 2005 to 2010.[13]

She was arrested prior to February 2010. Before the police went public that month, seven men, of whom one claimed to have tested HIV-positive, came forward to claim that they had unprotected sex with her without being informed that she was HIV-positive. The woman apparently consented to having her picture released in hopes that her other possible sex partners might have themselves tested for HIV.[14]

This is the 14th case of an HIV-related prosecution in Finland since 1989, when such proceedings began.[15]

France: HIV-positive man sentenced to prison for infecting partner

On 10 November 2010, a court in Besançon sentenced a 36-year-old man to two years in prison for knowingly transmitting HIV to his then-partner. He had been charged with the "administration of a harmful substance causing mutilation or permanent disability" after lying about his HIV-positive status and then engaging in unprotected sex with him.[16]

The accused said during a hearing on 21 October that he had been "in denial" about his serostatus and apologized to his former partner.[17] In 2005, the partners had HIV tests for the purpose of determining their ability to have unsafe sex together; however, the accused allegedly lied to his partner, telling him his test results were negative. The former partner, who later tested positive in 2006, launched the suit after discovering a letter from the HIV testing centre confirming the accused's HIV-positive status.[18]

Australia: man pleads guilty to infecting partner with HIV

A Melbourne man pleaded guilty to reckless sexual activity that led to his sexual partner being infected with the virus. On 9 February 2011, Paul Spiekman admitted causing serious injury to a partner and the indecent assault of another woman on the same night in April 2007.[19]

He pleaded guilty to one charge of reckless conduct endangering serious injury and one of indecent assault. Two other charges of intentionally infecting with a very serious disease and negligently causing serious injury were withdrawn.

One of the victims ended up contracting HIV.

All articles in this section were written by David Cozac (dcozac@aidslaw.ca), managing editor of the *HIV/AIDS Policy & Law Review*.

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In brief

Russia: Supreme Court rules HIV-positive pilots can operate planes

On 16 February 2011, the Supreme Court of the Russian Federation ruled that an HIV-positive status is no longer cause for dismissal of civil aviation pilots. The ruling came from proceedings launched by an HIV-positive pilot who was barred from operating planes in 2005 when his serostatus became known.[1]

The legal grounds for the dismissal were based on health-related criteria of the Federal Aviation Rules, which states that having HIV disqualifies anyone from working as a pilot.

The ministries of Transport and Justice, as well as the Medical Commission for Civil Aviation, had sought to reject the plaintiff's action. They argued that the "presence of HIV in the body [of a pilot] could put passengers in danger as the health condition of a pilot might deteriorate quickly." They added that the presence of HIV in the body should be considered an unconditional ground to ban pilots from operating aircraft.[2]

For his part, the pilot claimed that his health was good and he suffered from no opportunistic infections. "I have met all of the required health criteria and there is no need to infringe my rights just because I am HIV-positive," he stated.[3]

The representative of the General Prosecutor's Office supported the arguments of the plaintiff as being in line with Russia's *Law on the Prevention of HIV Infection*. The legislation prohibits termination of employment based solely on a diagnosis of HIV. The Office noted that such a dismissal would also contradict the Convention on International Civil Aviation.

Ireland: former surgeon successfully sues state for exposure to HIV

An Irish man successfully sued his former hospital, the Health Service Executive (HSE) and the Irish state after contracting HIV through occupational exposure, which ended his career as a surgeon.[4]

He said he contracted HIV as a result of needle-stick injuries sustained while operating on patients. After becoming unwell with a flu-like illness, he received the HIV diagnosis in May 1997. Then a senior surgical registrar, he had to give up his duties, just as he was on the verge of securing an appointment as a consultant surgeon. He said the virus had caused him and his wife a great deal of distress and altered their plans for the future.[5] The combination triple therapy also substantially altered his lifestyle and caused nausea, upset and trauma.[6]

In his suit, the plaintiff claimed that the lack of a mandatory screen-

ing of patients for HIV exposed him to a risk of harm. He alleged that the defendants had a duty to take all reasonable precautions for his safety while he was engaged in his work. They had a duty not to expose him to a risk of injury or damage of which they knew or ought to have known, and to provide a safe system of working and safe place of work, he said.[7]

For its part, the defence said it did not implement the test as it was "uneconomical" and that patients suspected of being infected were asked if they were infected.[8] Contributory negligence on the part of the doctor for allegedly failing to have adequate regard for the risk of infection from HIV while carrying out invasive surgical procedures was also pleaded.[9]

The legal action was initiated in 1999 and had been adjourned a number of times prior to both parties reaching the settlement.

— David Cozac

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USA: Justice Dept. directs Puerto Rico vocational school to admit HIV-positive applicant

The Department of Justice forced a hairstyling school in Puerto Rico to offer enrolment to an HIV-positive applicant, pay that person US$8,000 in damages and pay a US$5,000 penalty to the United States as part of the settlement reached in the case.[10]

The case centred on a complaint filed under the *Americans with Disabilities Act* (ADA) against the Modern Hairstyling Institute, Inc., in Bayamon, Puerto Rico by a female applicant.

Under the terms of the settlement agreement, Modern Hairstyling Institute, Inc. will also cease to request information about HIV status from future applicants and will provide training to all employees about discrimination on the basis of disability.[11]

"It is critical that we continue to work to eradicate discriminatory and stigmatizing treatment towards individuals with HIV," said Thomas E. Perez, Assistant Attorney General for the Civil Rights Division. "The ADA clearly protects individuals with HIV and other disabilities from this kind of exclusion or marginalization."[12]

Title III of the ADA prohibits public accommodations, such as Modern Hairstyling Institute, Inc., from excluding people with disabilities, including people with HIV, from enjoying the services, goods and facilities provided.[13]

— David Cozac

India: court rules transport company discriminated against HIV-positive applicants

On 4 January 2011, the Madras High Court ordered the Tamil Nadu State Transport Corporation to hire two men who had been denied employment because of their HIV-positive status.[14]

In late 2009, an employment agency had sponsored the two candidates — identified as "Mr. X." and "Mr. Y." — for driver posts for the company. They were then sent to a panel of doctors to receive a medical fitness certificate. After their blood samples revealed both men to be HIV-positive, the doctors said in their report that they were "unfit" to be hired. Management at the company used this report to deny the jobs to the men.[15]

The blood test was conducted without the consent of the candidates. Moreover, no pre-test or post-test counselling was provided by the laboratory.[16]

In his decision, Justice K. Chandru criticized the transport company for its "pedestrian understanding of AIDS and HIV." He went on to say that "[t]he action of the state-owned transport corporations in driving the candidates to test for HIV itself was totally repugnant" to India's national policy on HIV/AIDS,[17] the guiding principle of which is non-discrimination.[18]

The judge directed management at the company to employ Mr. X. and Mr. Y. within a period of eight weeks, given that there was no other disqualification against them.[19]

— David Cozac

Russia: court frees men who had forcibly confined and treated drug users

On 3 November 2010, the regional court of Sverdlovsk province, under intense public pressure, ruled in favour of the defence and reduced the punishment for three members of the City without Drugs foundation. All of them received a conditional sentence and avoided prison-time.[20]

Earlier in the year, a subordinate district court in the city of Nizhny Tagil had sentenced the three young men to different terms of imprisonment for kidnapping. Egor Bychkov, the head of City without Drugs, was sentenced to three-and-a-half years' imprisonment. The other two received lighter sentences.

The three had been accused of kidnapping and mistreating seven drug users. According to the prosecutor, drug users were forcibly confined for several weeks with no heat and no access to food except bread, onion, garlic and water.[21]

The district court had dismissed the charge of ill-treatment based on the testimonies of medical practitioners who stated during the proceedings that a rigorous diet of bread, onion, garlic and water facilitated quick detoxification, reasoning that the drug users could not have suffered severe pain and suffering as a consequence of the their withdrawal program.[22]

During the trial at the district court, all but one of the drug users withdrew their charges, saying that they had been confined based on the will of their parents or their own choosing.

The City without Drugs case triggered a widespread public debate over drug treatment practices in Russia. Many senior politicians and public figures sympathized with the accused and spoke in favour of compulsory treatment of people addicted to drugs. Well-known Russian singer Vladimir Shakhrin personally brought the information about the case to the attention of the President Dmitry Medvedev, who subsequently tasked the General Prosecutor's Office to "take the case under control."[23]

Given such public pressure, the regional court reconsidered the case and freed the accused immediately after its ruling.

Ireland: High Court rules HIV drugs can be administered to baby despite mother's protests

In November 2010, the High Court of Ireland ruled that doctors could administer antiretroviral (ARV) drugs to a child then due to be born from an HIV-positive woman.[24]

The country's Health Service Executive had sought a court order requiring that certain drugs be administered from birth to the child, asserting that ARV medication, if administered from birth for a four-week period, would reduce the risk of transmission.[25]

The pregnant woman opposed the drugs being administered because she believed they represented a serious risk to her child. She also raised issues about whether her HIV-positive diagnosis was accurate, but accepted that diagnosis for the purpose of the court proceedings.[26]

Medical experts were unanimous in their view that these drugs should be administered because the risk of a child being born with an incurable illness had been shown to present greater dangers.[27]

In addressing the risk of mother-to-child transmission of HIV, the medical team outlined four general guidelines: the mother should take ARV medication during pregnancy; she should have an elective Caesarean section; she should refrain from breastfeeding after birth; and the newborn should receive from birth a four-week course of ARV medication.

Three of those these elements were not at issue; at issue was whether the court should intervene to direct three ARV drugs be administered to the child — Nevirapine, Zidovudine and Lamivudine — immediately after birth and for four weeks. The mother was opposed to the child receiving this medication.[28]

The judge said he had no doubt the best interests of the child would be served by administration of the medication. However, he added that the issue was not that straightforward because this was not a case of the state or the court knowing best.

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