Canadian HIV/AIDS Legal Network

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Treatment as prevention: assessing the human rights and ethical implications

When the results of the groundbreaking HIV Prevention Trials Network 052 study (HPTN 052) were made known in 2011 — which demonstrated that early antiretroviral therapy in the infected partner among stable, healthy sero-discordant couples led to a 96 percent reduction of sexual transmission of HIV — many who worked in the global response to HIV were quick to laud "treatment as prevention" as an essential tool in reducing the spread of the disease. At the same time, others spoke about the need to consider the privacy rights of people living with HIV, patient autonomy and consent to testing before treatment as prevention, which UNAIDS termed a "game-changer," could be adopted as part of global prevention strategies.

Following are three articles that feature various discussions of the human rights and ethical implications of treatment as prevention. Michaela Clayton, Lynette Mabote and Felicita Hikuam provide the global context, with examples from Africa, for implementation of such a policy, examining how discrimination and human rights violations can impede access to treatment for vulnerable populations. James B. Krellenstein and Sean Strub focus on the United States of America, where the health departments of New York City and San Francisco recommended immediate commencement of antiretroviral therapy for every person who tested HIV-positive, regardless of the state of his or her infection. Finally, Micheal Vonn looks to British Columbia, where the provincial government has provided funding for a large-scale "seek and treat" pilot project aimed at patients and health care providers.

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HIV and human rights in the United States

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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.

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

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Human rights in an era of treatment as prevention[1]

Respect for and protection of human rights have long been recognized as being essential to an effective response to HIV. Since the outset of the epidemic, fear, ignorance and prejudice have fuelled stigma and discrimination against people living with or perceived to be living with or at risk of HIV. The fear of discrimination associated with the disease has been a significant deterrent against accessing testing and treatment. Therefore, human rights protections for people living with HIV (PHAs) or at risk of HIV are critical, not only to protect their rights but also for the realization of universal access to testing, treatment and care.

International commitment to universal access has been evidenced by the adoption of the *Declaration of Commitment on HIV/AIDS* by United Nations member states in 2001 — goals that would provide HIV care, treatment and prevention services to all who need them.[2] The World Health Organization's (WHO) 3 by 5 Initiative[3] operationalized this goal, which was reaffirmed by the 2006[4] and 2011[5] *Political Declaration on HIV/AIDS*, and unanimously adopted by the member states. At the same time, the Declarations recognized that combating HIV/AIDS was a pre-condition to achieving many of the Millennium Development Goals (MDGs).[6]

To complement these political commitments, funding mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) were created. Much has been accomplished: since that first agreement in 2001, more than five million people have gained access to antiretroviral therapy (ART), AIDS-related deaths and hospitalizations have decreased and rates of new infections have been reduced in many countries.[7]

Despite these accomplishments, there is still an unacceptably large gap between the number of people on treatment and the number of those in need of it. With the revision by WHO of its guidelines on the initiation of ART, there are nine million people who should be on treatment, but who are not.[8] The likelihood of reducing this gap has been severely undermined by worrying signs that the donor commitment needed to sustain and increase the current momentum in the fight against HIV/AIDS is waning in the current climate of competing global priorities and a worldwide economic crisis.[9]

This situation has been exacerbated by the recent cancellation of the Global Fund's round 11 funding due to low funding levels, including from a number of unfulfilled pledges as well as lower-than-anticipated contributions. Instead, the Global Fund will provide for a "transitional funding mechanism," whereby countries known to be facing a disruption of programs for HIV, tuberculosis and malaria before 2013 will be offered a chance to apply for funding to cover their most essential needs.

For HIV, this funding can cover medicines for people already on treatment, but does not provide for HIV treatment initiation for new patients. This will have particularly devastating consequences for many of the countries in sub-Saharan Africa that are heavily reliant on donor funding for the provision of treatment.[10]

However, a lack of resources is not the only impediment to reaching universal access goals. Unacceptably high levels of stigma and discrimination and human rights violations against PHAs and key populations, as well as widespread criminalization of key populations and of HIV transmission have often acted as insurmountable barriers to accessing HIV prevention and treatment services. Although it has long been recognized that human rights abuses have an adverse impact on public health, particularly in the context of HIV, funding for interventions that promote a

human rights-based response to HIV and address stigma and discrimination and human rights violations against PLHIV and key populations remains limited.

As the benefits of treatment as prevention have been confirmed, funding for the global HIV response has diminished.

It is sadly paradoxical that dwindling financial support for the HIV response in general and, more specifically, for human rights-based programs is the reality at a time when the benefits of treatment as prevention have been confirmed by the HIV Prevention Trials Network (HPTN) 052 trial, which released its results in May 2011. HPTN 052 compared clinical outcomes and rates of transmission within predominantly heterosexual couples in which one partner is HIV-positive and the other is HIV-negative (i.e., sero-discordant couples). HIV-positive individuals with CD4 cell counts between 350 and 550 were randomly assigned to receive immediate ART or to delay initiation until clinical or laboratory guidelines (usually, CD4 cell count below 250) were met.

The randomized comparison between immediate and delayed ART initiation was stopped four years ahead of schedule due to evidence of overwhelming benefit. Specifically, the trial found that immediate initiation of ART in HIV-positive individuals with CD4 counts between 350 and 550 reduced the transmission risk to the HIV-negative partner by 96 percent.[11]

The significance of these results is illustrated by the modelling of the impact of a new strategic investment framework for the global HIV response that is based on existing evidence of what works in HIV prevention, treatment, care and support, and shows that meeting treatment targets based on current guidelines would avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020.[12]

Human rights concerns

Initial debate on this issue prior to the release of the HPTN 052 results, sparked by the publication in *The Lancet* of a mathematical model for universal voluntary HIV testing with immediate ART as a strategy for elimination of HIV transmission,[13] was punctuated by concerns raised by activists about the human rights implications of the operationalization of this model.

In addition to questions raised about several of the assumptions on which the model was based, concern was expressed about the failure of the strategy to consider the human rights aspects and implications of its implementation, particularly given that any universal testing and treatment model raises fears of coercion and other violations of individual human rights. In particular, there were concerns about the failure of the strategy to address the existing legal, social and economic barriers to uptake of testing and treatment, particularly among women and other vulnerable groups, or the range of human rights violations that fuel HIV vulnerability and impede access to treatment and testing in the first place.[14]

Any strategy for treatment as prevention has to be subject to the same concerns. In addition, some activists have questioned the value of any discussion regarding potential implementation of treatment as prevention strategies while governments, particularly in the global south, remain unable to meet current universal access targets, and in a climate where funding cuts are threatening their ability to initiate treatment for new patients who need it.[15]

Therefore, if HIV prevention and the use of ART as either prevention or treatment are to succeed, it is critical that we interrogate the human rights violations that act as barriers to accessing testing and treatment services as well as those that render people more vulnerable to HIV in the first place, and that we articulate the human rights elements of treatment and prevention interventions. Failure to do so will undermine the potential benefits of treatment as prevention and ensure that universal access targets are not met.

Since the outset of the epidemic, stigma and discrimination — on the basis of real or perceived HIV status, often fuelled by fear, ignorance and prejudice — have been pervasive and widespread. They take various forms and occur within different sectors of society. They include verbal and physical abuse of people infected and affected by HIV and AIDS, denial of employment to PHAs and denial of health care and social services to them.[16]

In a study conducted in 2009 in Namibia and Swaziland, respondents in both countries identified health care facilities as the place at which they most often experienced stigma

and discrimination.[17] It is frequently directed at those who already face inequality, prejudice and marginalization, such as those with limited power, people living in poverty and people engaging in criminalized behaviours.[18] PHAs continue to face high levels of stigma and discrimination and other human rights violations in their daily lives. Not only do they undermine the basic human rights and dignity of those affected, they also create barriers to access to HIV-related prevention, treatment, care and support services.

Failure to articulate the human rights elements of treatment interventions will undrermine the potential benefits of treatment as prevention.

People with limited ability to enforce their basic human rights are at higher risk of HIV exposure.[19] In Southern Africa, where women continue to face gender inequality entrenched in law and practice, as well as high levels of sexual assault and violence, evidence shows that women, particularly young women, are consistently more likely to be infected with HIV than men.[20]

The ability of PHAs and of key populations to enforce their human rights — and, more particularly, their right to health and to prevention and treatment services — is compromised both by stigma and discrimination faced at the hands of families, communities, employers, law enforcement officers and health care workers, as well as by legal and policy frameworks that fail to protect their human rights, criminalize their behaviour and, in many cases, actually violate their human rights.

Role of HIV-specific laws

In Africa, the response to HIV and AIDS has seen the proliferation of an epidemic of HIV-specific laws that have proved to be a double-edged sword. In an attempt to address stigma and discrimination on the basis of real or perceived HIV status, these laws contain provisions that outlaw discrimination. At the same time, however, they often provide for mandatory HIV-testing for members of key populations (e.g., sex workers), pregnant women or those wishing to marry. Additionally, a number of HIV laws provide for mandatory disclosure of a person's HIV status to others, such as a spouse or sexual partner.

Mandatory HIV testing and forced disclosure not only violate basic human rights, such as the rights to privacy and freedom and security of the person, but also have broader public health implications for the HIV response. They target and increase stigmatization against key populations at higher risk of HIV exposure and discourage people from accessing HIV-related prevention, treatment, care and support.

Many of these laws also criminalize HIV transmission and exposure. In several instances, the wording of these provisions is sufficiently broad to criminalize the transmission of HIV from mother to baby *in utero* even in instances where the mother has no access to prevention of mother-to-child-transmission services. There is limited evidence that criminalization of HIV helps to reduce the spread of HIV; evidence suggests it instead reinforces the concept of PHAs as potential "criminals" from whom society needs protection, increases stigma and fear, and deters people from accessing HIV-related health care.[21]

In addition to HIV-specific laws that deter access to testing and treatment, the majority of countries in sub-Saharan Africa have laws that criminalize key populations such as sex workers, men who have sex with men (MSM) and injection drug users (IDUs). The existence of such laws makes it increasingly difficult to reach these groups with HIV services. The legislation reflects and deepens their societal stigmatization and exposes them to discrimination, violence, harassment and abuse, including at the hands of law-enforcement officers.

Key populations express reluctance to use existing HIV-related health care services for fear of victimization and discrimination. This further increases their vulnerability to HIV. Criminal laws prohibiting sex between men create additional barriers to condom distribution in prisons, placing prisoners at higher risk of HIV exposure. Consequently, enabling legal environments need to be created to protect the rights of all populations and to support their access to HIV-related health care services.[22]

For their part, sex workers are often marginalized and face multiple barriers to accessing the health and social services they need, such as screening and treatment for sexually transmitted infections (STIs); HIV testing and

tailored counselling; post-exposure prophylaxis after rape; access to male and female condoms; ART; and mental health support and substance abuse treatment. Health care workers with negative or prejudiced attitudes towards sex workers further restrict access to services and drive them away from treatment and support. In Malawi, human rights non-governmental organizations (NGOs) are taking up a case against the police after 14 sex workers were arrested, forcibly tested for HIV and their HIV results reported in the media.[23]

Mandatory HIV testing increases stigmatization and discourages people from accessing HIV-related prevention and treatment.

In most sub-Saharan African countries, drug policy continues to focus on supply reduction and criminalization of users despite the fact that IDUs are at high risk of HIV infection. Since 2008, few additional countries have adopted key harm reduction interventions as part of their HIV response. Mauritius remains the only country with established needle and syringe programs (NSPs). Opioid substitution therapy (OST) is also available in Mauritius and, to a lesser extent, in South Africa, Senegal and Kenya.[24]

Although Mauritius sets an example in the region in terms of NSPs and OST, it has yet to amend its drug laws that make it an offence to possess drug-injecting paraphernalia, and the successful operation of the NSPs is often compromised by the presence of law-enforcement officers at or near needle exchange sites, which obviously deters uptake of these critical prevention services.[25]

The problem goes beyond laws that deter access to testing and, thus, to treatment. Mass testing campaigns that are likely to be a precursor to treatment as prevention strategies can also be problematic. Lesotho's "Know Your Status" campaign offered an HIV test to everyone above the age of 12 years. The testing was intended to be voluntary and confidential, and was offered by trained community counsellors in homes. A study of this model revealed flaws in the training of the community counsellors and, consequently, in their ability to deliver adequate pre-test counselling and to ensure that testing was conducted with informed consent and guarantees of confidentiality.[26]

Similar concerns have been expressed about the mass testing campaign in South Africa in 2011. The Treatment Action Campaign (TAC), an HIV lobby group in the country, has received anecdotal reports of coercive testing in KwaZulu–Natal and Eastern Cape.[27]

If universal access targets are to be met and the promise of treatment as prevention is to be realized, more focus must be placed on and more investment made in programs that place human rights at the centre of the response to HIV and promote the establishment and strengthening of an enabling legal, policy and social environment in which all people have access to prevention and treatment services without discrimination. It is not a question of human rights or public health. Although there may be specific human rights considerations that are of particular relevance to treatment as prevention strategies — such as concerns about the risks of compromised consent and confidentiality that accompany mass testing campaigns — the issues essentially remain the same.

The common agenda for all is earlier and successful uptake of HIV testing and counselling, and earlier, timely and successful access to HIV treatment as part of broader efforts to reach universal access to HIV prevention, treatment, care and support. This can only be achieved if human rights concerns are seriously addressed in national and international responses to HIV, including by funding and implementing a series of programs to reduce discrimination and other human rights abuses and increase access to justice in national HIV responses.

The fears of those who are disempowered and still afraid to take an HIV test or to initiate HIV treatment have to be addressed by investing in dignified health systems and protection from the harmful social and legal effects of one's health status being known. Indeed, the expanded value of ART only heightens the need to find successful approaches to improved HIV service delivery *and* human rights protection.

Programmatic interventions to create and strengthen an enabling legal, policy and social environment in which the human rights of PHAs and key populations are protected — and thereby in which access to and uptake of HIV prevention and treatment services is improved — must be funded and implemented. These interven-

tions take both a "top-down" and a "bottom-up" approach: working from the top in terms of addressing laws that act as barriers to accessing prevention and treatment as well as with law enforcers; and from the bottom within communities with a view to strengthening their capacity to access justice and claim their rights where they have been infringed.

The expanded value of ART only heightens the need to find successful approaches to improved human rights protection.

Community empowerment

Community empowerment and mobilization to know and claim one's rights is key to this effort. "Know your rights and laws" campaigns that empower those affected by HIV are essential in terms of gender equality; non-discrimination on basis of HIV and other social status; elimination of violence against women; protection of the rights of the child; and access to HIV prevention, treatment, care and support. PHAs and members of vulnerable and marginalized groups must be provided with services in the form of legal aid, community paralegals, dispute-resolution (including working with traditional leaders) and strategic litigation to enable them to enforce their rights where these have been denied or infringed.

Interventions aimed at community empowerment are of particular importance. Among the most significant advances that have been made regarding HIV are in countries where networks of PHAs and HIV legal and human rights groups have mobilized around "know your rights and laws" campaigns and undertaken legal advocacy, including strategic litigation. At the individual level, such mobilization results in individual empowerment in terms of being better able to negotiate safe sex, avoid violence, go through HIV testing and counselling and disclose status, and be treatment-literate and -compliant. This is particularly the case where mobilization and capacity-building include training on rights and laws for providers of key services (e.g., health care providers) concerning non-discrimination, informed consent and confidentiality, and sensitizing police on the rights of PHAs and members of key populations.

Strategies for treatment as prevention raise specific human rights considerations, including the potential for erosion of the rights to autonomy and privacy through the implementation of scaled-up testing and the administering of treatment as prevention for the "public good." In order to address these, it is suggested that the implementation of treatment as prevention strategies be guided by the following principles:

- Guidelines determining the optimal time to start ART must be based on what is best for the individual patient. PHAs should not be expected to begin therapy for the primary purpose of preventing HIV transmission. The primary purpose of treatment is treatment. Patients should not be compelled to risk earlier development of antiretroviral drug resistance or suffer drug-related side effects unless there is clear evidence that earlier use of ART can be beneficial for the patient in prolonging life and improving the quality of life.
- If resources are limited, decisions about who should receive ART must be based on the need to treat the sickest patients first and not based on perceived opportunities to prevent new infections. The best way to address this is to ensure that all those meeting current treatment guidelines have adequate access to ART and other health care services.
- The choice to use ART remains a personal one. Patients have the right to decide not to take ART.
- The availability of second- and third-line treatment combinations is essential to long-term use of ART. This will be especially important as earlier treatment is considered to maximize both treatment and prevention benefits of ART.[28]

Conclusion

An enabling legal, policy and social environment in which the rights of PHAs and key populations are protected and upheld has always been critical to achieving universal access to HIV treatment and prevention. The potential of treatment as prevention does not and should not alter the fact that everyone, regardless of their HIV status, sexual orientation or other status has the right to the highest attainable state of physical and mental health. For this to be realized, their rights to dignity, autonomy, privacy, information and to be free from

discrimination must be respected, protected and upheld.

However, the knowledge that attaining high coverage of ART can also reduce HIV transmission in a given population does highlight the need for dramatic scale-up of HIV testing as a step toward treatment. Nevertheless, if human rights protections are not a central and well-funded part of testing strategies, rapid scale-up of HIV testing can lead to widespread infringements of privacy rights, autonomy and the right to information without adequate diagnosis or linkage to HIV care for those who test positive. This will only drive people away from the very testing and prevention services that this strategy seeks to provide.

Paradoxically, funding is being flat-lined or reduced just as science, medicine and programs are providing the tools for success against HIV.[29] This threatens both the response to HIV and human rights imperatives in the response, and may result in countries having to choose between biomedical programs and programs to create enabling legal and social environments that serve to protect the human rights of those living with or vulnerable to HIV, when both are critical. It is therefore essential that programs to create such enabling environments, which serve to protect the human rights of those living with or vulnerable to HIV, be funded and implemented.

— Michaela Clayton, Lynette Mabote and Felicita Hikuam

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[1] The authors are grateful to David Barr for his advice in the preparation of this article.

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[13] R. Granich et al., "Universal Voluntary Testing with Immediate Antiretroviral Therapy as a Strategy for elimination of HIV Transmission: A Mathematical Model," *The Lancet* 373 (2009): pp. 48–57. Utilizing data from South Africa, this model explored the impact of testing all people of 15 years and older every year and immediately starting people who test HIV positive on ART (often referred to as the "test and treat" strategy); it found that this strategy could reduce HIV incidence and mortality to less than one case per 1000 people by 2016 or within 10 years of the full implementation of the strategy, and reduce the prevalence of HIV to less than 1 percent in 50 years.

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The ethical implications of "treatment as prevention" in the United States[1]

Since the first cases of what became known as HIV/AIDS were reported in 1981, various public health strategies have been proposed and developed to combat the HIV/AIDS epidemic. A relatively new development within this field is that of "Treatment as Prevention," or TasP, a policy that aims to reduce HIV transmission by greatly increasing HIV testing and then immediately initiating antiretroviral therapy (ART) for all patients who test positive.

It is important that we distinguish TasP, where ART is started regardless of the state of infection, from the commencement of ART when it is clinically indicated. High-quality evidence supports the individual — and public health — benefits of starting ART when an HIV infection reaches an advanced state[2] In this paper, we exclusively address the application of TasP that advocates the initiation of ART for patients with HIV *when it is not indicated by the current federal* [3] *and international*[4] *guidelines on ART*.

In 2009, Dr. Reuben Granich of the World Health Organization (WHO) and colleagues developed a compartmentalized stochastic mathematical epidemiological model, based on the South African HIV epidemic, to estimate the potential effectiveness of TasP. The results of this model were dramatic, predicting that with the universal implementation of TasP, annual new HIV infections would be reduced to less than one case per 1,000 persons within 10 years.[5]

In April 2010, the San Francisco Department of Public Health (DPH) endorsed a new policy that strongly recommended immediate commencement of ART for every person who tested HIV positive, regardless of the state of his or her infection. It is worth noting that the potential individual health benefits of starting ART immediately — not the potential public health benefits of ART as prevention — was cited as the main factor motivating this new policy.[6]

In December 2011, New York City's Department of Health and Mental Hygiene (DOHMH) adopted a similar policy, recommending the immediate start of ART for all persons who tested positive for HIV. DOHMH commissioner Dr. Thomas Farley noted in a letter to city health care professionals that the reasons for this new policy were two-fold: the individual health benefits and the public health rewards (i.e., a reduction in the HIV transmission rate).[7]

We support increasing access to both testing and clinical care, and initiating ART when it is clinically indicated. The scientific data on the relative benefits and risks of initiating ART before an HIV infection reaches an advanced state, however, are far from conclusive. Despite this lack of certainty, the enthusiastic adoption of early ART by two of the largest health departments in the United States of America represents a cause for concern. Indeed, advisory panels on HIV ART of both the WHO and the U.S. Department of Health and Human Services have consistently refused to recommend the initiation of ART before the infection reaches an advanced state, citing a lack of evidence of acceptable quality supporting the benefits of such a treatment.[8]

The implementation of this policy, based on public health guidelines promoted without high-quality supporting data demonstrating a benefit to the patient, represents a significant departure from the established procedures of evidence-based medicine. Establishing a potentially dangerous and unproven therapy as a standard of care, for a hypothesized public health benefit, represents a serious violation of three fundamental principles[9] of medical ethics: beneficence, non-malfeasance and patient autonomy.

Treatment as prevention's effect on public health

The correlation between a patient's viral load and their infectiousness is well documented within the literature. ART, when successfully implemented, reduces viral load, often to undetectable levels. Granich and his colleagues' work suggested that ART had the potential to slow down and effec-

tively halt an epidemic. However, the implicit limitations of their model must be remembered when seeking to apply it to a real-world situation. Important elements of the model that do not correspond to any known reality of the HIV epidemic include the assumption that all transmission of HIV is heterosexual;[10] that patients on ART are always fully adherent; that 100 percent of patients who tested positive would voluntarily consent to ART, regardless of the state of their infection; and that testing the whole population would not be encumbered by significant challenges.

Although this model stipulated that early intervention would be "voluntary," it is questionable how it is possible to get anything close to 100 percent of a large community to consent to testing and treatment without some form of coercion. Furthermore, the Granich model assumes that every person with HIV will take their medication exactly as prescribed with no limiting side effects, despite being prescribed medications when the person is not necessarily symptomatic.

Advocates of TasP often point to the 2011 randomized trial of HPTN 052 as empirical evidence of the epidemiological efficacy of TasP.[11] Although this trial showed that commencement of ART was effective in reducing the transmission rate within heterosexual serodiscordant couples, it did not analyze the effects of early ART outside of this small subset of the population. Importantly, patients with a CD4+ count of above 550 cells per μL were not enrolled in the study, unlike TasP as implemented in both San Francisco and New York City (where all HIV positive patients, regardless of the state infection, are urged to start ART). The HIV epidemic is an inherently complex system; empirical evidence that shows a reduction in one transmission category (i.e., heterosexual sero-discordant couples) does not necessarily imply that this would have a statistically significant effect on the transmission dynamics of the entire epidemic.[12]

Clearly, both the theoretical and empirical data on whether TasP, for patients for whom it is not clinically indicated is effective as a public health intervention are still evolving and not yet conclusive. Despite this, New York and San Francisco have implemented TasP as a public health policy.

Impact of treatment as prevention on individual health

It is one thing for individual clinicians to promote early ART to their patients based on a combination of scientific data and clinical experience. It is entirely different, however, for a public health agency to advocate a standard of care for public health purposes and claim that it is also for the benefit of the individual patient, despite the lack of high-quality data supporting that assertion. ART is far from a benign therapeutic intervention; patients taking antiretrovirals (ARVs) often experience serious long-term side effects and toxicities. In addition, as ART transitions from an acute therapy to a chronic one, more research is needed to determine the effects of chronic use of ARVs.

For patients who have advanced HIV disease — that is, a CD4+ count of ≤ 350 cells per μL and\or certain severe clinical symptoms of infection — high-quality evidence supports the relative benefits of treatment. That is to say, the net benefit of treatment outweighs the known side effects.[13] The WHO maintains that a CD4+ count of ≤ 350 cells per μL or severe symptoms of HIV infection indicate the need for ART.[14]

It is not clear, however, if starting ART before the patient reaches an advanced stage of infection (i.e., when the patient has >500 CD4+) is, on net, beneficial or deleterious. Indeed, data from a randomized, controlled clinical trial, the START (Strategic Timing of Antiretroviral Treatment) trial, will not be available until at least 2015.[15] There have been several observational cohort trials performed. While some have demonstrated a benefit from starting ART immediately,[16] one of the largest such studies failed to demonstrate any positive benefit from starting ART early.[17]

Scientific data on the benefits of initiating ART before an HIV infection reaches an advanced state are far from conclusive.

The lack of high-quality data available, coupled with the lack of consensus within the lower-quality data, demonstrates that significant questions remain as to whether starting ART early provides any positive benefit to the patients. This, along with the serious nature of ART and its side effects, makes it inappropriate for health agencies to establish or promote a standard of care that advocates for immediate

ART when it is not justified by sufficient high-quality evidence.

Ethical implications

Public health interventions have contributed to dramatic reductions in mortality and morbidity around the world. Vaccinations are perhaps the most obvious example. Their widespread use and, in many cases, the requirement to be immunized have led to a drastic decrease in the incidence and, in some cases, eradication of serious infectious diseases.

The current implementation of TasP, however, is an inherently different situation. Before clinicians routinely administer vaccines, high-quality evidence must demonstrate that the individual benefits of that vaccine — providing immunity against a disease — are greater than the possible adverse effects. Unfortunately, high-quality evidence has not yet been provided that demonstrates that immediately initiating ART, regardless of the state of a patient's infection, is beneficial to the individual patient.

The ethical concerns of implementing a policy of vastly increased HIV testing and immediate initiation of ART, regardless of infection state, have not been ignored by the literature.[18] Other papers, including those of Ron Bayer,[19] analyze the ethics of implementing TasP within the context of a policy that, as of now, shifts the benefit from the individual to the public good. We are aware of no scholarly articles that discuss the ethical concerns of these policies being implemented by major health departments in the U.S.

TasP, as implemented by both San Francisco and New York, advocates for physicians to encourage their individual patients to start ART, regardless of the state of their infections. TasP thus may be viewed as inherently infringing on the established standards and codes of clinical medical ethics.

Three fundamental *prima facie* principles of medical ethics are those of beneficence, *primum non nocere* ("first, do no harm") and patient autonomy.[20] A physician must ensure that his or her actions are first and foremost in the best interest of the patient being treated. A physician's responsibility to the individual patient is paramount, except in certain extreme circumstances.[21] The physician must also, to the best of his or her ability, ensure that treatment will not cause harm to the patient and that, if a treatment is prescribed, the possible benefits outweigh the possible risks. Every patient has a fundamental right to autonomy and to make informed decisions about their treatment free from coercion.

Inherent to the concept of patient autonomy is the right of a patient, or his or her authorized proxy, to be accurately and honestly informed of the risks and benefits of a treatment, and to be able to accept or refuse this treatment at his or her discretion without coercion or penalty.

The New York City DOHMH and the San Francisco DPH are advising physicians to commence ART immediately, regardless of the stage of infection, and claim that ART will provide a net benefit to those patients. Yet, the scientific data are far from conclusive to support such an assertion. Clinicians heeding the advice of the public health authorities are promoting a treatment that is not known to provide a net benefit to their patients whose HIV has not reached an advanced state of infection. Therefore, a patient is not given the right to make an informed decision about his or her care. This deception represents an *ipso facto* violation of the principles of patient autonomy.

Every patient has a fundamental right to autonomy and to make informed decisions about their treatment free from coercion.

The formulation of formal standards of care for public health purposes must meet a higher standard of evidence than what is required of a clinician, who, correctly, uses the best externally-provided evidence, combined with his own clinical experience and judgment.

In the absence of high-quality evidence demonstrating the individual health benefits, it is unethical for public health authorities to, in pursuit of their public health goals, recommend TasP to clinicians as an appropriate standard of care. Recommendations from public health authorities, who often control or influence funding and other resources, can have an inhibiting effect on a clinician's ability to determine whether a treatment is consistent with the principles of beneficence and non-malfeasance.

The goal of reducing HIV transmission is an admirable one. We cannot support, however, a policy, which as of now violates fundamen-

tal principles of medical ethics. If conclusive, high quality data demonstrate that starting ART immediately, regardless of the state of the patient's infection, is in the net interest of the individual patient, we see no reason why this approach should not be supported. This has not yet been demonstrated, and may never be.

— James B. Krellenstein and Sean Strub

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[1] The authors gratefully acknowledge critical and insightful comments of L. Sprague, J.A. Sonnabend, M.D. and D.J. Krellenstein, M.D. Ph.D., during the preparation of this article.

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[3] Department of Health and Human Services, "Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents," 10 January 2011.

[4] World Health Organization, *supra*, note 2.

[5] R. M. Granich et al., "Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model," *The Lancet* 373, 9657 (2009): pp. 48–57.

[6] S. Russell, "City Endorses New Policy for Treatment of H.I.V.," *The New York Times*, 3 April 2010.

[7] T. Farley, "Health Department Releases New HIV Treatment Recommendations," New York City Department of Health and Mental Hygiene, 1 December 2011.

[8] World Health Organization and Department of Health and Human Services, *supra*, notes 2 and 3.

[9] R. Gillon, "Medical ethics: four principles plus attention to scope," *BMJ* 309, 6948 (1994): p. 184.

[10] In the United States, over 50 percent of transmission is through homosexual contact. See H. I. Hall et al., "Estimation of HIV Incidence in the United States," *Journal of the American Medical Association* 300, no. 5 (2008): pp. 520–529.

[11] M. S. Cohen et al., "Prevention of HIV-1 Infection with Early Antiretroviral Therapy," *New England Journal of Medicine* 365, no. 6 (2011): pp. 493-505.

[12] Importantly, HIV-positive patients with a CD4+ count of above 550 cells per µL were not enrolled in the HPTN 052 study. This is in direct contrast to the TasP policy, as implemented by San Francisco and New York, in which all patients, regardless of CD4+ count or other clinical indicators are urged to start ART.

[13] See P.G. Yeni et al., "Antiretroviral Treatment for Adult HIV Infection in 2002," *Journal of the American Medical Association* 288, no. 2 (2002): pp. 222–235; P.G. Yeni et al., "Treatment for Adult HIV Infection," *Journal of the American Medical Association* 292, no. 2 (2004): pp. 251–265; and S.M. Hammer et al., "Antiretroviral Treatment of Adult HIV Infection," *Journal of the American Medical Association* 300, no. 5 (2008): pp. 555–570.

[14] World Health Organization, *supra*, note 2.

[15] "Strategic Timing of Antiretroviral Treatment," ClinicalTrials.gov. On-line: http://clinicaltrials.gov/ct2/show/NCT00867048.

[16] M. M. Kitahata et al., "Effect of Early versus Deferred Antiretroviral Therapy for HIV on Survival," *New England Journal of Medicine* 360, no. 18 (2009): pp. 1815–1826; C. M. Hogan et al., "The Setpoint Study (ACTG A5217): Effect of Immediate Versus Deferred Antiretroviral Therapy on Virologic Set Point in Recently HIV-1–Infected Individuals," *Journal of Infectious Diseases* 205(1) (2012): pp. 87-96.

[17] Writing Committee for the CASCADE Collaboration, "Timing of HAART Initiation and Clinical Outcomes in Human Immunodeficiency Virus Type 1 Seroconverters," *Archives of Internal Medicine* 171(17) (2011): pp. 1560–1569.

[18] Indeed, the 3 January 2009 issue of *The Lancet* contained two letters discussing the possible ethical implications of implementing a policy similar to the one modeled in Granich et al. See K. M. De Cock et al., "Can antiretroviral therapy eliminate HIV transmission?" and G. P. Garnett and R. F. Baggaley, "Treating our way out of the HIV pandemic: could we, would we, should we?" *The Lancet* 373, no. 9657: pp. 7–11.

[19] R. Bayer, "Mass Testing and Mass Treatment for Epidemic HIV: The Ethics of Medical Research is No Guide," *Public Health Ethics*, vol. 3, no. 3 (2010): pp. 301–302.

[20] R. Gillon, *supra*, note 9.

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British Columbia's "seek and treat" strategy: a cautionary tale on privacy rights and informed consent for HIV testing

The British Columbia Centre for Excellence in HIV/AIDS (BC-CfE) is credited with pioneering the "treatment as prevention" strategy. While Dr. Julio Montaner, the Director of the Centre, has expressed frustration over the government of Canada's "lack of support for the program,"[1] it is clear that the government of British Columbia strongly supports the "seek and treat" approach. Currently, a large-scale seek-and-treat pilot project — the STOP HIV/AIDS Project — is underway in B.C.

The provincial government has pledged CAN$48 million for the four-year initiative, said to be the first of its kind in the world.[2] The pharmaceutical company Merck has reportedly committed CAN$1.5 million to help evaluate it.[3] Pilot programs operate in the cities of Vancouver and Prince George, and include a focus on Aboriginal populations. The project has extensive partnerships with regional health authorities, health care facilities and non-governmental organizations.[4]

The STOP HIV/AIDS Project includes education campaigns aimed at patients and health care providers that expressly juxtapose an old, purportedly out-of-date approach to HIV with a new, supposedly optimal approach. Hence, the main social marketing slogan is "It's different now."[5] However, this new scenario, as it is being introduced in B.C., is decidedly contrapuntal: as the treatments are advancing, the approaches to patient rights and provider ethics are regressing. In particular, legal and ethical concerns are arising with respect to informed consent for testing and privacy rights.

The push for "routine," opt-out testing

The success of the STOP HIV/AIDS Project is highly dependent on greatly increased levels of HIV testing. While the literature of the BC-CfE cites "voluntary, confidential testing for HIV" to identify people needing treatment through a program to "normalize HIV testing,"[6] documents from Vancouver Coastal Health (VCH), a project collaborator, spell out what "normalization" means in this context. The medical health officers of the health authority have called on physicians to implement "routine," annual, opt-out testing of all sexually active patients.[7] In the view of VCH, this routine testing does not require detailed pre-test counselling, but merely a handout as needed and answering questions if they arise.[8]

STOP HIV/AIDS partners and proponents often express the view that pre-testing counselling is a barrier to testing and a simplified approach is claimed to be beneficial to patients.[9] This is mirrored in terms of the new post-test practices, which move away from the norm of only giving HIV test results in person and instead endorse giving HIV negative test results over the phone.[10] That this is tantamount to giving all test results over the phone — for, if one cannot get his or her results on the phone, by process of elimination the person will know that the result is positive — has either not been considered or is considered acceptable.

Notably, none of the handouts that are meant to serve in lieu of pre-test counselling appear to mention the criminal jeopardy of people living with HIV (PHAs) who are accused of not disclosing to sexual partners.

VCH has also decided to actively discourage non-nominal testing.[11] It takes the position that nominal testing is "standard" and, while noting that patients should be informed of the option to test non-nominally, it suggests that health care providers discourage non-nominal testing and inform patients that non-nominal testing "offers little additional privacy and can make any follow-up care you might need more complicated."[12] There is no anonymous HIV testing available in B.C., so the best privacy protection available is through a non-nominal test. This option, however,

will presumably become more difficult to access in an environment where it is actively discouraged by providers.

In addition, routine testing is not limited to family practice: VCH has committed to implementing routine testing in primary and acute care. The STOP HIV/AIDS Project is piloting routine testing in three Vancouver hospitals.[13] Posters have been printed to be placed in these hospitals. The text of the posters reads: "You will be asked to have an HIV test." The hospital setting further heightens the informed consent concerns of a shift to routine testing. It is likely that a significant portion of patients will simply fail to understand or appreciate that they can decline a blood test that appears to be folded into the "blood work" that is needed for their care in the hospital.

As HIV treatments are advancing, the approaches to patient rights and provider ethics are regressing.

Not long after the pilot for routine testing in hospitals was launched, there were anecdotal reports of patients who said they had been tested without their knowledge. The STOP HIV/AIDS Project has also partnered with at least one women's health clinic that provides abortion services. Abortion services are clearly a context in which shifts to minimal pre-test counselling and "routine" HIV testing should be resisted on the grounds of safeguarding informed consent.

Failure to provide proper information about medical privacy

PHAs in B.C. are among Canada's most active and effective grassroots advocates for patient privacy rights in the context of electronic health records, and their efforts helped to secure a provision in the province's e-health legislation that allows for a limited ability for patients to mask records in the provincial system. Since the start of the STOP HIV/AIDS Project, the only component of the provincial e-health system that has been operational is the Patient Laboratory Information System (PLIS), the data repository for laboratory tests.[14] As a consequence, almost all HIV tests since the project began are held and distributed within this new system.

While point-of-care (rapid) HIV test results are not processed through a laboratory, confirmatory blood tests are done by the British Columbia Centre of Disease Control laboratories, which now use PLIS. In fact, an amendment to the privacy provisions of the Health Act Communicable Disease Regulation was quietly passed in order to ensure that reportable diseases like HIV could flow in the provincial repositories without patient consent.[15]

It is also notable that, as for patients tested "routinely" in the pilot hospitals, the data system used in those facilities has recently been heavily criticized by the provincial Office of the Information and Privacy Commissioner for providing vastly over-broad access to patients' personal health information and failure to provide patients with a mechanism for limiting disclosure.[16] This created a perfect storm of privacy concerns in relation to HIV testing: more people being tested through "routine" testing and special testing initiatives, as well as less privacy protection for those test results, because of newly instituted data-sharing systems providing broad access to personal health information along with legal reforms that allow for that broad access.

Under the provincial e-health legislation, patients may implement a "disclosure directive" that locks down their health record to most system users, while allowing access to providers to whom the patient gives their personal identification number. This is the only control that a patient can exercise in relation to his or her personal health information held in the B.C. e-health system — and it is no protection at all if patients do not know about it.

Community-based AIDS organizations were key advocates in the campaign to secure some patient controls over access to personal health information held in the e-health system. However, a subsequent campaign to convince the Ministry of Health to inform patients of their option to protect their health information has been unsuccessful to date. While the STOP HIV/AIDS Project did not create the medical privacy problems of the e-health system, the e-health backdrop presents a pointed ethical challenge for the initiative.

The newly revised privacy policy of the Canadian Medical Association states that physicians have an obligation to inform patients that, when the patient's information flows into an electronic health record, the physi-

cian cannot control access or guarantee confidentiality.[17] While the CMA admitting that e-health undermines medical confidentiality is highly significant, it is merely a statement of the obvious: without an ability to control access, there can be no ability to guarantee confidentiality.

Many in the B.C. AIDS community feel that the STOP HIV/AIDS Project is therefore misleading patients with the language of "confidential testing" and "confidential computer systems," and that the project and its partners should instead be proactively explaining to all patients the changes that have occurred in medical privacy in B.C., and actively assisting in the process of securing disclosure directives for patients who wish to limit access to their records. The advocates have managed, in some places, to get mention of disclosure directives into some of the written materials on HIV testing. At best, however, messages are mixed and there appears to be a general reluctance on the part of STOP HIV/AIDS Project proponents to provide explicit information for fear of scaring people away from HIV testing.

Incentivizing HIV testing

Another troubling aspect of the STOP approach is incentivized testing. The Downtown Eastside (DTES) of Vancouver is a particular focus of the STOP HIV/AIDS Project. That part of the city has extremely high rates of HIV infection, is often cited as "the poorest postal code in Canada"[18] and is home to Vancouver's supervised injection facility, Insite. The STOP HIV/AIDS Project, in collaboration with partners in the DTES, has been holding HIV testing fairs, which are essentially large street parties, with streets closed to vehicular traffic and which include day-long music and entertainment as well as incentivized HIV testing.

The poster[19] for the testing fairs held on 9 and 10 July 2010 at Victory Square in the DTES announced that those getting an HIV test at the fair "get a $5 Gift Card to Army & Navy and a free meal." The testing fairs have been well attended and popular enough that notices were posted advising that the campaign limits HIV testing to once every three months, although those who had already tested within the previous three months were welcome to attend at the event.

> The STOP HIV/AIDS Project misleads patients with the language of "confidential testing."

DTES community partners who help sponsor the HIV testing fairs have said that they participate because increased "access" to testing is urgently needed. However, it is entirely unclear why HIV testing needs to be incentivized for people who purportedly have an urgent need for access. The notion that there is limited access to HIV testing in the DTES is extremely odd, given that there are well-used and -respected health care facilities right in the DTES that provide ready access to HIV testing, such as the Vancouver Native Health Clinic and Downtown Community Health Centre. Rather than an urgent need for access to HIV testing, a more likely explanation for the popularity of the HIV testing fairs is that people have an urgent need for gift certificates and free food.

Incentivizing is a difficult arena in medical research ethics, but it does not appear that the testing fairs are considered part of research and have not been subject to ethics review. This is another confounding aspect of the STOP HIV/AIDS Project, because it is clearly research (which Merck is helping to evaluate), and yet it is entwined with the local health authorities and their new "policies" in such a way that it becomes extremely difficult to sort out the research components from the program components, as well as when the patient is simply a patient and when the patient is (also) a research subject.

On the subject of access to testing, there is an apparent irony that, as the STOP HIV/AIDS Project proceeds, B.C. is simultaneously closing five sexual health clinics, leaving huge areas of the province without any sexual health services.[20] It remains to be seen if this is, in fact, indicative of how a treatment-as-prevention approach, as it is evolving under the STOP HIV/AIDS Project with routine HIV testing imported into primary and acute care, is going to be seen — that is to say, not as an enhancement, but as an alternative to comprehensive, specialized sexual health services.

Certainly the question of the allocation of resources, particularly the perceived funnelling of resources away from community-based services, is a contentious aspect of the STOP HIV/AIDS Project. It has provided funding to a number of community-based partners and, while

that is obviously welcome in terms of making resources available to community-based groups, it also means that there has been reticence among community partners and members to bring forward concerns about the project.

Its advertising campaigns and the media portrayals paint a picture of a seemingly unassailable win–win scenario: people become healthier and transmission rates decline. Nevertheless, this is a very partial vantage point. Obviously, everyone is in favour of increased access to testing and treatment. The questions posited by the B.C. experience of treatment as prevention go far deeper, and those questions have to do with where human rights will be situated in health care.

The question of rights

As noted, there are various patient-rights concerns that have arisen with respect to the STOP HIV/AIDS Project. These concerns are focused on the issue of informed consent and the shifts in norms that are eroding patient autonomy by minimizing the amount of information provided to people who are considering whether or not to have an HIV test (little or no pre-test counselling; pre-test counselling perceived as "barrier" to testing); mischaracterizations and failure-to-disclose risks ("confidential tests" and failing to mention criminal law regarding non-disclosure); limiting the ability of patients to protect privacy and confidentiality (dissuading patients from non-nominal testing); capitalizing on the inherent vulnerability of patients (opt-out, "routine" testing); and incentivizing testing.

None of these shifts in approach is required to improve access to HIV testing and treatment. Rather, they suggest that the true aim of the program is solely one of increasing testing and treatment, and in which patient rights, like pre-test counselling, are perceived as a "barrier." Stated broadly, the concern is that the justification of the purported "greater good" of the new paradigm is very quickly eroding the foundation of the human rights approach to health care that has informed the approach to HIV testing and treatment.

— Micheal Vonn

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[2] British Columbia Centre for Excellence in HIV/AIDS, "Forecast: Journal of the BC Centre for Excellence in HIV/AIDS," February 2010. On-line: www.cfenet.ubc.ca/news/forecast.

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[4] Ibid.

[5] See www.itsdifferentnow.org/.

[6] British Columbia Centre for Excellence in HIV/AIDS, "Forecast: Journal of the BC Centre for Excellence in HIV/AIDS," December 2011.

[7] R. Gustafson, "Memorandum to Vancouver Coastal Health Affiliated Physicians, Nurse Practitioners and Registered Nurses," 30 June 2011.

[8] Ibid.

[9] Vancouver Coastal Health, "Routine HIV Testing in Primary Care Frequently Asked Questions." Internal document made available to and on file with the author.

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[11] Vancouver Coastal Health, *supra*, note 9.

[12] R. Gustafson, *supra*, note 7.

[13] Vancouver Coastal Health, "BC hospitals begin routine testing for HIV to help curb global epidemic," news release, Vancouver, 23 September 2011.

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[15] Province of British Columbia, Order of the Lieutenant Governor in Council, Order No. 726, 18 November 2010.

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[18] R. Matas and I. Peritz, "Canada's poorest postal code in for an Olympic clean-up?" *The Globe and Mail*, 15 August 2008.

[19] On-line: http://ahamedia.ca/2011/07/09/hiv-status-testing-event-at-victory-square-in-vancouver-downtown-eastside-on-sat-july-9-sun-july-10-2011/.

[20] C. Takeuchi, "Closure of B.C. Interior sexual health clinics concerns nurses," *The Georgia Straight,* 19 December 2011.

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.

Federal government's omnibus crime legislation becomes law

In March 2012, the *Safe Streets and Communities Act*[1] (the Act) received royal assent and officially became law. Bill C-10 introduced amendments to thirteen existing statutes and created a new one: the *Justice for Victims of Terrorism Act*. The legislation introduces several mandatory minimum prison sentences; alters the way that pardons are granted and criminal records managed; imposes changes to immigration laws; and places priority on punishment and denunciation as an objective of the criminal law, as opposed to rehabilitation.

For marginalized people, the legislation alters the discretion of judges to grant sentences for criminal offences that reflect the individual circumstances of the crime and the offender, taking into account that the person might have committed an offence because of addiction, that the person is homeless or oth-

erwise impoverished, or that the offender is Aboriginal. The Act does this through the imposition of new mandatory minimum sentences for a variety of offences, including several drug offences in the *Controlled Drugs and Substances Act*.

For Aboriginal offenders in particular, mandatory minimum sentences preclude principles stated in the *Criminal Code* that recognize the over-representation of Aboriginal people in the justice system and require judges to consider alternatives to imprisonment, such as conditional sentencing where the offender may serve part of their time in their community under supervision.[2]

Mandatory prison sentences of one year will be required for offences of trafficking or possession for the purposes of trafficking if one or more of the set of these "aggravated factors" is present: the behaviour was related to organized crime, violence was threatened, a weapon was used or the person had been convicted of a designated substance offence within the last ten years. A mandatory sentence of two years will be imposed if one of another set of aggravating factors is met, including that the offence was committed near a school or a public place frequented by minors.

The Act also imposes mandatory minimum prison sentences for drug production for the purpose of trafficking, including a mandatory sentence of six months in prison for the production of as few as six marijuana plants. If any aggravating factors are present, the term of mandatory imprisonment will increase by 50 percent. Included in these aggravating factors are that the property used belonged to a third party. The mandatory minimum prison sentences under this section increase up to three years if over 500 plants are produced and one of the aggravating factors is met.

The new legislation leaves a "safety valve" whereby a judge can order a person to a drug treatment court program in lieu of a mandatory minimum sentence.[3]

Commentary

The *Safe Streets and Communities Act* heralds a new and disturbing direction for criminal justice policy in Canada. At a time when there is a growing awareness internationally of the devastating unintended consequences of the criminalization of drugs and those who use them,[4] the federal government is charting a course that will have significant human and fiscals costs as the legislation is implemented.

Several areas of the legislation sound alarm bells for those concerned with the welfare and fair treatment of marginalized people, including HIV-positive people who use drugs or those at risk of contracting HIV. There is concern that the provision of mandatory prison sentences of one year for offences of trafficking or possession for the purposes of trafficking will criminalize the common behaviour of addicted people who use drugs who traffic in small amounts to fund their own purchase of drugs; and that these provisions may be challenged on *Canadian Charter of Rights and Freedoms* ("Charter") grounds of an infringement of liberty, discrimination and that they are overbroad, since a "public place usually frequented by persons under the age of 18 years" might be almost anywhere. They also may raise Charter challenges on the grounds that the sentences are cruel and unusual punishment given the disproportionate impact of a prison sentence to a relatively minor offence.

With regard to the sections of the Act that relate to drug policy, the legislation will do little to impact illegal drug markets or reduce drug use or low-level drug dealing, if the experience of the United States of America with mandatory minimums bears out in Canada.[5] What it will succeed in doing is to expose increased numbers of low-level drug offenders to the risk environments within the prison system.[6]

It is well documented that rates of HIV infection in prison are 10–15 times higher than in the community. For hepatitis C, this number is a staggering 30 times higher.[7] Increased contact with prison environments will inevitably lead to increased risks for low-level offenders coming into contact with HIV and other communicable infections.

Initiation into injection drug use by non-injection drug users in Canadian prisons is also a concern. Low-level offenders who may not have used "harder" drugs in the community will be subjected to an environment where more easily concealed drugs like heroin, cocaine and methamphetamine are accessible and harm reduction equipment (clean syringes, cookers and filters) is scarce.[8]

Perhaps the most troubling part of the legislation is that the government is attempting to address complex social issues through the blunt instrument of the criminal law, which may lead to the over-incarceration of segments of the population and have long-term impacts on social integration and the career trajectories of those impacted by mandatory minimum sentences.

The *Safe Streets and Communities Act* is a very complex piece of leg-

islation with many troubling aspects that will be subject of much analysis over the coming years. If this legislation leads to increased overcrowding, health and human rights concerns focusing on standards of care within the Canadian corrections system will, no doubt, come to the forefront of the discussion of the impacts of this legislation over the next few years.

The implementation of this legislation will exacerbate an already serious situation in Canadian prisons with regard to HIV, hepatitis C and other health conditions. It will also target those more vulnerable populations experiencing addictions and often low-level involvement in some aspect of the drug trade, without having a discernible impact on the drug market itself or a deterrent effect on those who use drugs. This legislation further commits Canada to a punitive and discredited "war on drugs" approach to addressing drug problems, one that is increasingly out of step with the movement in other jurisdictions to embrace policies informed by evidence and based on principles of public health, human rights and social development.

— Scott Bernstein and Donald MacPherson

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[1] Safe Streets and Communities Act, S.C. 2012, c. 1, 2012. On-line: http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2012_1/page-1.html#s-1.

[2] In the 1999 decision of *R. v. Gladue*, the Supreme Court of Canada stressed the importance of this provision for addressing the imbalance in the justice system, and the newly imposed mandatory minimums will mean that judges' hands are tied and more Aboriginal offenders will end up imprisoned. These sentences, however, may be the subject of Charter challenges on the grounds that they are discriminatory and unjustified.

[3] However, these programs are only in a few urban centres in Canada, they receive minimal funding and their record of success is mixed.

[4] See Global Commission on Drug Policy, *War on Drugs: Report of the Global Commission on Drug Policy*. 2011. On-line: www.globalcommissionondrugs.org.

[5] T. Gabor and N. Crutcher, *Mandatory Minimum Penalties: Their Effects on Crime, Sentencing Disparities, and Justice System Expenditures,* Department of Justice Canada, 2002.

[6] Ibid.

[7] Correctional Service of Canada, *Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*, 2010

[8] See E. Wood et al., "Initiation of opiate addiction in a Canadian prison: a case report," *Harm Reduction Journal*, doi: 10.1186/1477-7517-3-11 (2006) and A. Boys et al., "Drug use and initiation in prison: results from a national prison survey in England and Wales," *Addiction,* 97 (12) (2002): pp. 1551–1560.

Alberta orders end to distribution of crack pipes in Calgary

Last summer, Alberta Health Services (AHS) put an end to the free distribution in Calgary of safer equipment for smoking crack cocaine, raising fears of a rise in the transmission of infectious diseases, including HIV. The decision came while similar programs currently operate in other jurisdictions in Canada.

In August 2011, AHS announced that its mobile van-based harm reduction program, Safeworks, would no longer hand out clean crack pipes to people who use drugs. Safeworks staff received an internal memo from the agency stating that "we have been instructed by the deputy minister of health to discontinue crack pipe distribution until further notice due to legal implications. Crack pipes are to be removed from the van immediately."[1]

Since 2008, the outreach program had been quietly providing smoking kits — comprised of a pipe, mouthpiece, screens and cleaning rod — to users, along with health care and education services. However, when

Vancouver health officials announced a similar pilot initiative early last summer, the ensuing coverage in the Calgary media also shone a spotlight on Safeworks, generating criticism from opponents in Alberta's largest city.[2] It appears that AHS responded to the outcry by shuttering the crack pipe distribution program.[3]

Concern from Calgary police — which consulted with federal officials for advice on whether the program could fall under a criminal statute for distributing drug paraphernalia — may also have influenced the AHS decision regarding Safeworks.

Although AHS indicated in January 2012 that it had no plans to re-visit its decision, a lone organization in the province continues to distribute crack cocaine smoking materials. The Central Alberta AIDS Network Society (CAANS) said that the CAN$20 000 that it receives annually from AHS is allocated to clean needles, not smoking-related materials, which means that the health authority is unable to govern the practice.[4]

"It's about the prevention of HIV and hepatitis C in people who would smoke crack. We stand for the drug users in our community," CAANS executive director Jennifer Vanderschaeghe said.[5]

Elsewhere, there is concern in Winnipeg that, if the provincial Conservative party wins the fall 2012 election, a seven-year-old crack-smoking kit distribution program could end. Candidate Ian Rabb said that his party would need more hard data about the success of the Winnipeg Regional Health Authority (WRHA) program before agreeing to "subsidize addiction."[6]

WRHA medical officer of health Pierre Ploude said that he was very pleased with the results of the program, which hands out roughly 2000 crack-smoking kits per month.

"It's hard to attribute cause and effect, but we certainly are not seeing any major harms and probably seeing significant benefits."[7]

For its part, the city of Vancouver launched an eight-month pilot project in December 2011 to distribute free crack-smoking materials, including shatter-proof glass pipes. The intention is to provide kits that should reduce injury to users' lips and mouths that could make them more susceptible to infectious diseases.[8]

The initiative has proven so popular that two partner agencies reported that user demand was outstripping supply.[9]

Commentary

In Canada, the rates of HIV and hepatitis C virus (HCV) infection among people who use drugs are much higher than in the population as a whole. While the sharing of equipment to inject drugs represents a major public health concern, other ways of consuming drugs also carry health risks — including the smoking of crack cocaine, which has been identified as a possible risk factor for transmission of HIV and HCV. Harm reduction programs represent a pragmatic public health response for people who are unable or unwilling to stop using drugs immediately.

Government support for the distribution of safer crack use kits is consistent with Canada's obligations under international human rights. The *International Covenant on Economic, Social and Cultural Rights* recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." In order to ensure realization of this standard, Canada is required to take all necessary steps for "the prevention, treatment, and control of epidemic … diseases." This obligation includes "the establishment of prevention and education programs for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS," as well as making "available relevant technologies … and other strategies of infectious disease control."[10]

— David Cozac

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[1] J. Wilt, "Safeworks banned from handing out crack pipes," *Fast Forward Weekly*, 15 August 2011.

[2] "Calgary addicts no longer given crack pipes," CBC News, 19 August 2011.

[3] J. Wilt (supra).

[4] J. Wilt, "Central Alberta charity stands alone with clean crack pipe program," Open File, 16 January 2012.

[5] D. Singleton, "Red Deer group continues to distribute free crack pipes," *The Calgary Herald*, 25 August 2011.

[6] P. Turene, "Tories not keen on 'subsidizing addiction'," *The Winnipeg Sun*, 2 August 2011.

[7] Ibid.

[8] M. Hager, "Thousands of free crack pipes to be handed out to Vancouver drug addicts," *The Vancouver Sun*, 30 December 2011.

[9] M. Mui, "Crackpipe distribution falls short," *24 Hours*, 2 January 2012.

[10] For further information on safer crack use kits, see *Distributing safer crack use kits in Canada: Questions and Answers* (Canadian HIV/AIDS Legal Network, 2008), available via www.aidslaw.ca/drugpolicy.

New research demonstrates negative public health impact of criminalizing HIV non-disclosure

Two Canadian studies provide an empirically informed examination of HIV criminal non-disclosure laws from a public health perspective. Until recently, the majority of the research on the topic has focused on legal and ethical issues.

In *The problem of significant risk: exploring the public health impact of criminalizing non-disclosure*,[1] sociology professor Eric Mykhalovskiy demonstrates that the criminalization of HIV non-disclosure has unfavourable outcomes for both people living with HIV (PHAs) and for HIV prevention counselling. Specifically, the ambiguity surrounding the legal concept of "significant risk" generates a host of uncertainties, often immobilizing or limiting patient care.

According to this qualitative study, uncertainty over legal repercussions has hindered communication about risk behaviour between PHAs and counsellors, and produced "anxiety, confusion and contradictory HIV counselling advice."[2] Generally, fear of criminalization has aggravated open communication in counselling relationships. Compounded with imprecise legal obligations, counselling and health records may be used as evidence in criminal proceedings for alleged non-disclosure. As a result, key informants from public health reported that they often counsel with an "eye to the law."[3]

Similarly, front-line staff from AIDS service organizations and family physicians reported that the criminal law had created "a chill" in their counselling relationships.[4] Mykhalovskiy also expresses concern that some counsellors are telling PHAs that they should ensure all sexual partners are informed of their HIV status, regardless of risk level, an approach with the potential to influence judicial decision-making in ways that increase criminal liability.[5]

In conclusion, Mikhalovskiy notes that the lack of clarity around the significant risk test burdens HIV prevention work:

> In a perverse fashion, rather than promoting openness, criminalization has made it more difficult to provide meaningful HIV prevention counselling and support about HIV non-disclosure. While the use of the criminal law may be warranted in some circumstances, the expansive use of a vague legal concept of significant risk does little good either for preventing HIV transmission or for the credibility of the criminal justice system.[6]

Nursing professor Patrick O'Byrne supplements Mykhalovskiy's critique of HIV criminalization with his statistical study, *Criminal law and public health practice: Are the Canadian HIV disclosure laws an effective HIV prevention strategy?*[7]

O'Byrne interrogates the ways that existing criminal laws regarding HIV non-disclosure impact on public health HIV prevention efforts. While the legal obligation might prevent transmission in a few cases, overall it is unlikely to influence overall population-level rates of HIV transmission. O'Byrne's analysis suggests that the most profound prevention effects would occur if highly efficacious interventions were implemented with high uptake among individuals who are most responsible for transmission. He demonstrates that serostatus disclosure is not an efficacious HIV prevention strategy.[8]

Two key shortcomings he identifies are: a) the existing law focuses on PHAs who are likely involved in the minority of HIV transmission in Canada, and b) the potential prevention effects are likely limited because these rulings do not induce behaviour that decreases HIV transmission.[9]

Similar to Mykhalovskiy, O'Byrne's analysis suggests that criminalizing HIV non-disclosure is unhelpful to public health objectives.

— Samya Kullab

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[1] E. Mykhalovskiy, "The Problem of 'Significant Risk': Exploring the Public Health Impact of Criminalizing HIV Non-Disclosure." 73 *Social Science & Medicine* (2011): pp. 670–677.

[2] Ibid., at p. 676.

[3] Ibid., at p. 674.

[4] Ibid.

[5] Ibid., at p. 676.

[6] Ibid.

[7] P. O'Byrne, "Criminal Law and Public Health Practice: Are the Canadian HIV Disclosure Laws an Effective HIV Prevention Strategy?" *Sexuality Research and Social Policy* 9 (2012): pp. 70–79

[8] Ibid., at pp. 74–5.

[9] Ibid., at p. 76.

Painkiller medication OxyContin removed from shelves

In an attempt to stem widespread abuse of OxyContin, several Canadian provinces have opted to restrict the availability of the painkiller medication under their respective health care coverage plans.[1]

Prince Edward Island, Nova Scotia, Ontario, Manitoba, Saskatchewan and British Columbia have either delisted entirely or limited access to OxyContin. For its part, the federal government announced in February 2012 that it would no longer pay for OxyContin for patients under the Non-Insured Health Benefits Program (NIHB).[2]

Purdue Pharma Canada, the company that makes the narcotic painkiller, will replace it with a new version, called OxyNEO, which the company says was designed to help "discourage misuse and abuse" of the medication.[3]

Some members of the Canadian medical community and law enforcement agencies have welcomed the move. However, Health Canada says that there is no proof to suggest OxyNEO was "less abusable."[4] Several provinces have also announced OxyNEO will not be covered by public funds and will have restricted access.

OxyContin abuse is rampant in Canada. In the five years after it was introduced into the market in 2000, painkiller-related deaths rose 41 percent — with over 300 deaths a year in the province of Ontario alone, according to a 2009 study by physicians at St. Michael's Hospital in Toronto.[5]

The problem is particularly widespread in First Nations communities. Benedikt Fischer of Simon Fraser University said that more than 50 percent of adults on some Canadian reserves are addicted to OxyContin, and he believes residents may turn to harder drugs once it is no longer available.[6]

Leaders in the pain community say that delisting OxyContin could lead to unforeseen fallout beyond just in Aboriginal communities, such as a run on emergency services for people going into withdrawal[7] or wider prescription of less-controlled but potentially more harmful opioids.[8]

Individuals addicted to OxyContin and not provided with a proper safety net for withdrawal may turn to other, equally powerful narcotics such as heroin, which is injected intravenously, thereby heightening the threat of transmission, through needle-sharing, of HIV and hepatitis C.

— David Cozac

[1] "Placing new restriction on OxyContin is not enough," *The Globe and Mail*, 1 March 2012.

[2] "Health Canada takes oxy off drug coverage plans," Wawatay News Online, 17 February 2012.

[3] K. Kirkup, "OxyContin removed from Canadian market," *The Toronto Sun*, 29 February 2012.

[4] Ibid.

[5] B. Poynter, "Canada uneasy about OxyContin phase-out," MinnPost.com, 6 March 2012.

[6] Kirkup (supra).

[7] Public health officials in Ontario have already warned that their treatment programs are overwhelmed. See "Ontario must boost addiction services and treatment programs to help OxyContin addicts," *The Toronto Star*, 2 April 2012.

[8] S. Kirkey, "OxyContin's removal could cause whole new set of problems," *The Gazette* (Montréal), 1 March 2012.

In Brief

Report recommends supervised drug injection sites in Toronto and Ottawa

A joint report by a team of investigators from St. Michael's Hospital and the Dalla Lana School of Public Health, University of Toronto, recommends the creation of supervised drug injection facilities in Toronto and Ottawa, modelled after Insite, the facility in Vancouver. The report advises three such sites in Toronto and two in Ottawa.[1]

Four years in the making, the *Toronto and Ottawa Supervised Consumption Assessment Study* (TOSCA) estimates that opening safe injection facilities would reduce new HIV and hepatitis C (HCV) infections. Mathematical models suggest each site in Toronto would prevent 2 to 3 HIV infections and 15 to 20 new HCV infections annually. The report anticipates the effect will be greater in Ottawa — which has the highest rate of new HIV infections among injection drug users in Ontario — by averting 6 new HIV infections and 20 to 35 HCV infections per year.[2]

Although the authors of the report admit the numbers are not substantial, they point out the health care costs that would be saved through the establishment of such facilities. It is estimated that one HIV infection costs the health care system CAN$500,000 over the lifetime of a single HIV-positive individual.[3]

Co-principal investigator Dr. Ahmed Bayoumi said that he was unsure how the recommendations contained in the report could be translated into policy. He explains that, in order to open a facility, one would need to apply to the federal government for an exemption from section 56 of the *Controlled Drug and Substances Act*.[4]

However, the current federal government has repeatedly expressed its objection to the existence of safe injection facilities for people who use drugs and fought to shut down Insite until the Supreme Court of Canada ruled in 2011 that the site had a legal right to operate.[5] In that ruling, the court said that the government could not deny an exemption if there were a demonstrated need for the service.

— Samya Kullab

New Brunswick to scale back methadone program

In December 2011, New Brunswick's Department of Social Development launched a new methadone maintenance benefit program that will impose an 18-month limit on how long methadone patients can receive travel subsidies — usually bus passes or reimbursements for gas and taxis — to get to the pharmacy.[6] Benefits have also been capped at CAN$200 per month. The new policy comes after the government had asked every department to reassess operations and find internal cost savings.[7]

According to department spokesperson Mark Barbour, cutbacks were appropriate because the program was unsustainable. In 2011, 1 328 people used the subsidy compared to 181 people in 2004.[8] Eighteen months was reasoned to be the amount of time required for a patient to recover. Barbour added that the program was not designed to help patients pick up their daily prescriptions. He also indicated that, after 18 months, individual cases could be reviewed to assess whether travel subsidies ought to continue.

Julie Dingwell, executive director of AIDS Saint John, argued that, based on studies, the optimum recovery time was a minimum of two years.[9]

The number of people who use drugs relying on provincial help to travel to and from methadone clinics accounts for a third of the government's medical transportation budget.[10]

Because intravenous drug use is a risk behaviour that might result in HIV infection, methadone treatment for substance abuse is believed to be an important prevention tool. Critics fear that missing daily doses might cause patients to relapse into risky behaviour habits, especially if they are already on income assistance.

— Samya Kullab

Alberta: cases of sexually transmitted infections decline

According to the province's Annual Report on Notifiable Sexually Transmitted Infections, overall new cases of sexually transmitted infections (STIs) fell in Alberta in 2010.[11]

The rates are the lowest the province has seen in six years and are said to be the result of a robust public awareness campaign initiated by the provincial government.

There were 16 298 newly diagnosed cases of STIs in 2010, down five percent from the peak of 17 217 cases the previous year. Of this number, 192 newly diagnosed cases of HIV were recorded in 2010, down from 219 in 2009. The number of new AIDS cases — 30 — is the lowest since 1987.

Alberta has been criticized in the past for producing the highest STI and HIV rates in Canada. After public health doctors warned of a syphilis crisis in 2007, the government initiated a five-year plan in May 2011, endowing four million dollars annually for three years with the aim of reducing infection rates.

According to health minister Fred Horne, the "more aggressive" campaign focused on public education to raise awareness. The use of Internet and TV ads and social media tools aimed to raise awareness in the highest risk group: people aged 15 to 24.[12] Horne said that the best possible goal was zero new cases.

For his part, Dr. Andre Corriveau, a medical officer of Alberta Health and Wellness, cautioned that more work needed to be done to reach high risk groups, including people aged 15 to 24, men who have sex with men and Aboriginal populations. In the latter group, the HIV rate was 22.2 out of 100 000 compared to 4.5 out of 100 000 in non-Aboriginal populations.[13]

— Samya Kullab

[1] A.M. Bayoumi et al., *Report of the Toronto and Ottawa Supervised Consumption Assessment Study, 2012,* St. Michael's Hospital and the Dalla Lana School of Public Health, 2012. On-line: www.toscastudy.ca/TOSCA_Report.html.

[2] Ibid.

[3] "Safe injection sites report: Toronto, Ottawa would benefit from facilities," The Huffington Post, 11 April 2012.

[4] Ibid.

[5] See S. Chu, "Supreme Court of Canada orders Minister of Health to exempt supervised injection site from criminal prohibition on drug possession" on page 42.

[6] K. Donkin, "Methadone benefits to be cut," *Saint John Telegraph-Journal*, 22 December 2011.

[7] "Budget cuts target bus passes for methadone patients," CBC News, 21 December 2011.

[8] K. Donkin (supra).

[9] Ibid.

[10] "Methadone program cuts defended," CBC News, 22 December 2011.

[11] "Alberta's sexually transmitted infection rate falls: report," *The Edmonton Journal*, 31 January 2012.

[12] "Alberta's sexually transmitted infection rate falls in 2010: report," The Huffington Post, 19 March 2012.

[13] Ibid.

INTERNATIONAL DEVELOPMENTS

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

Global Fund cuts threaten harm reduction efforts in Eastern Europe and Central Asia[1]

In early 2012, the Global Fund to fight AIDS, Tuberculosis and Malaria (the "Global Fund") marked its tenth anniversary amid a worldwide economic crisis as well as the organization's own internal struggles.[2] This followed decisions made by the board of the Global Fund in November 2011 that affected the countries of Eastern Europe and Central Asia — namely, the cancellation of Round 11 of grant-making (but establishing transition measures for ensuring that basic services would continue to be funded) and stipulating that 55 percent of all financing through various mechanisms would go to low-income countries, while the remainder would be made available to middle-income countries.[3]

For most countries in Eastern Europe and Central Asia, the Global Fund is not only the largest donor to HIV-related activities, but often the sole funder of politically sensitive services that target the most at-risk populations in the region — specifically, people who inject drugs. The Global Fund managed to facilitate changes in

"legalizing" some key services, such as opioid substitution therapy (OST) in Ukraine and Kazakhstan, and scaling up low threshold harm reduction services across the region.

With its support, national investment in HIV responses has greatly increased across the region, with middle-income countries now providing support for HIV treatment from their national budgets. National investment in harm reduction, however, is extremely limited: most of it comes in the form of in-kind support for government-run medical services of OST, but not for low-threshold services run by non-governmental organizations (NGOs).

Evidence for the impact of the Global Fund crisis is already visible. In Albania, funding for needle exchange services and drop-in centres ended on 31 March with no alternative donor identified.[4] In Armenia, the sub-recipients of Global Fund-supported projects were abruptly informed by principal recipients about the cuts of funding for several programs, most significantly: almost 500,000 Euros (CAN$657,000) for programs for people who inject drugs; nearly 100,000 Euros (CAN$131,000) for treatment and care; and another 500,000 Euros (CAN$649,000) for building the capacity of civil society over the next three years. Elsewhere, Belarus is planning to reduce its responses and eliminate the programs targeted at the general population and youth in rural areas while its epidemic moves beyond the key populations.

Round 11 was expected to support HIV prevention among key populations in Lithuania, which is in the midst of an economic crisis and where, until 2011, external donors had helped to develop services and policies for harm reduction in the NGO sector. Now, however, the country has to scale down efforts. Ukraine's funding request was lowered during the preparation of its proposal to the Global Fund; given that it received insufficient funding, the country plans to reduce harm reduction programs and reduce work on both capacity-building and strengthening communities of people who use drugs that could support harm reduction.

In Kyrgyzstan, harm reduction programs were interrupted, but have continued to operate irregularly since September 2011, after Global Fund auditors identified "potential irregularities" in 2010.

In order to prevent interruptions of previously supported services, the Global Fund established the Transition Funding Mechanism. However, only Russia will use this option for HIV responses. Most of the other countries in Eastern Europe and Central Asia are not eligible or chose not to apply until they secured other ongoing grants for HIV programs. Failing this, they would need to limit their responses to a very basic level and separate them from advocacy, human rights work and capacity-building, which had been foreseen under the previous grants. Only two Russian NGOs have applied to this transition mechanism for harm reduction services, in an attempt to fill in a major funding gap for the country, which has strong political opposition to harm reduction.

More developments are expected this year and in 2013, when a set of grants are to undergo renewal for future phases. Most of them for Eastern Europe and Central Asia are expected to be reduced by at least 25 percent.[5] This major reduction is set for higher-income countries, encompassing most of the countries of the region and which is a result of the new 55 percent rule.[6]

The crisis at the Global Fund has sparked international advocacy at mobilizing new resources. However, as of this writing, few donors have stepped forward. Earlier this year, Japan made its highest contribution of US$340 million (CAN$341 million), while new contributions were received from Saudi Arabia and the Bill & Melinda Gates Foundation. The U.S. government proposed a 26.9 percent increase in its annual contribution beginning in 2013 in order to meet its initial pledge of US$4 billion (CAN$4.01 billion) over three years.[7]

The Russian Federation has both the ambition and resources to lead the HIV response in Eastern Europe and Central Asia. Its preparedness and leadership have been on display on multiple occasions, most recently at a high-level forum dedicated to the Millennium Development Goals (MDG 6) in the region.[8]

Commentary

In an effort to support the HIV response in Eastern Europe and Central Asia, the Global Fund should urgently abolish the "55 percent rule" because it ignores the fact that middle-income countries are home to the largest number people with HIV and tuberculosis (TB). (Two thirds of all people with HIV and in need of treatment, and most people with TB, are located in middle-income countries.)[9] This would ensure that increased resources are made available to middle-income countries, including in Eastern Europe and Central Asia, where access to HIV treatment is one

of the lowest in the world and which continues to experience a rise in the epidemic, unlike in other middle-income regions.

The Global Fund and other actors should also invest in policy dialogue and country-specific strategies in order to assist governments to, in turn, invest in harm reduction so that mechanisms and best practices are established.

However, the support of Russia in funding efforts may lead to unintended adverse consequences for HIV prevention and care in key populations, such as people who inject drugs. The country's repressive drug policy, based on zero tolerance for drug use and its rejection of harm reduction, hinders HIV prevention, given that sharing contaminated injecting equipment by people who inject drugs is the main driver of the epidemic in the region, including in Russia.

International experience shows that the HIV epidemic among people who inject drugs can be stopped and reversed only if health- and human rights-oriented programs are in place, including harm reduction programs such as needle and syringe programs and OST. As such, there are reasonable concerns that, apart from its approach to HIV treatment, Russia may go one step further and promote its own HIV prevention policy.

— Raminta Stiukyte and Ivan Varentsov

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[1] Adapted from a report by the Eurasian Harm Reduction Network on the impact of the Global Fund crisis on harm reduction services in Eastern Europe and Central Asia. On-line: www.harm-reduction.org/news/2287-quitting-while-not-ahead-the-global-funds-retrenchment-and-the-looming-crisis-for-harm-reduction-in-eastern-europe-and-central-asia.html.

[2] See, for example, A. Kelly, "What does the second decade hold for the Global Fund?" *The Guardian* (U.K.), 2 February 2012.

[3] The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Transitional Funding Mechanism Decision Point GF/B25/DP16*, 2011. On-line: www.theglobalfund.org/documents/board/25/BM25_DecisionPoints_Report_en/.

[4] However, two organizations on the ground have volunteered to continue needle exchange programs.

[5] The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Forecast of Uncommitted Assets Available for Grants Approvals GF/B25/9*, 2011. On-line: www.theglobalfund.org/documents/board/25/BM25_09ForecastOfAssets_Annexes_en.

[6] In July 2011 the World Bank classified only two countries in Eastern Europe and Central Asia as low-income: Kyrgyzstan and Tajikistan. The remaining countries were middle-income, with the exception of Croatia and Estonia, which were previously eligible for funding. The list of middle-income countries includes Albania, Armenia, Azerbaijan, Belarus, Bosnia & Herzegovina, Bulgaria, Georgia, Kazakhstan, Kosovo, Macedonia, Moldova, Montenegro, Latvia, Lithuania, Romania, the Russian Federation, Serbia, Turkey, Turkmenistan, Ukraine, and Uzbekistan.

[7] C. Lubinski, "PEPFAR raided to meet Global Fund pledge in President Obama's fiscal year 2012 budget," Sciencespeaksblog.org, 13 February 2012.

[8] MDG6 aims to stop and reverse HIV/AIDS, TB and malaria epidemics by 2015. See www.who.int/topics/millennium_development_goals/diseases/en/index.html.

[9] A. Glassman et al., *Global Health and the New Bottom Billion: What Do Shifts in Global Poverty and the Global Disease Burden Mean for GAVI and the Global Fund?*, Center for Global Development, Working Paper 270, October 2011.

UN releases report on discriminatory practices against individuals based on sexual orientation and gender identity

Following a recent Human Rights Council resolution,[1] the United Nations High Commissioner for Human Rights released an historic report highlighting "critical human rights concerns that States have an obligation to address" in relation to discriminatory laws and acts of violence against individuals based on their sexual orientation.[2] It also describes how international human rights law can be used to end violence and related human rights violations by identifying applicable international standards and obligations.[3]

The report reveals that, "in all regions, people experience violence and discrimination because of their sexual orientation or gender identity. In many cases, even the perception of homosexuality or transgender identity puts people at risk. Violations include — but are not limited to — killing,

rape and physical attacks, torture, arbitrary detention, the denial of rights to assembly, expression and information, and discrimination in employment, health and education."[4]

According to the UN report, 76 countries have laws criminalizing same-sex sexual relations or other laws used to criminalize individuals because of their sexual orientation or gender identity. In at least five countries — Iran, Mauritania, Saudi Arabia, Sudan and Yemen — the death penalty prevails. Such laws, including so-called "sodomy laws," are often colonial-era legislation. The report says that these constitute a breach of international human rights law, which also contributes to homophobic hate crimes, police abuse, torture, and family and community violence against lesbian, gay, bisexual and transgender (LGBT) persons, as well as legitimizing homophobia in society at large.[5]

Discriminatory practices based on sexual orientation and gender identity have been observed in every region of the word and include discrimination in employment, education and health care, reinforced in some countries by discriminatory laws criminalizing same-sex sexual relations. As noted by the High Commissioner, "the criminalization of homosexuality may deter individuals from seeking health services for fear of revealing criminal conduct, and results in services, national health plans and policies not reflecting the specific needs of LGBT persons."[6]

Even in countries where homosexuality is not criminalized, "homophobic, sexist and transphobic practices and attitudes on the part of health-care institutions and personnel may nonetheless deter LGBT persons from seeking services, which in turn has a negative impact on efforts to tackle HIV/AIDS and other health concerns."[7]

Moreover, the report documents how LGBT people are often targets of oppression within families and communities. This manifests in different ways, including through individuals being excluded from family homes, disinherited, prevented from going to school, sent to psychiatric institutions, forced to marry, forced to relinquish children, punished for activist work and subject to attacks on personal reputation. LGBT people are also among the "victims of so-called 'honour' killings, carried out against those seen by family or community members to have brought shame or dishonour on a family, often transgressing gender norms or for sexual behaviour, including actual or assumed same-sex sexual activity."[8]

The report provides examples of initiatives developed by states and others entities to address these acts of violence and human rights violations. For instance, some states have made it easier for transgender and intersex people to obtain legal recognition of a change of gender or to indicate a gender other than male or female.

The High Commissioner has formulated several recommendations to Member States and to the Human Rights Council. These recommendations, among others, include:

- Investigate promptly all reported killings and other serious incidents of violence perpetrated against individuals because of their actual or perceived sexual orientation or gender identity, whether carried out in public or in private by State or non-State actors, and hold perpetrators accountable, and establish systems for the recording and reporting of such incidents.
- Ensure that no one fleeing persecution on grounds of sexual orientation or gender identity is returned to a territory where his or her life or freedom would be threatened, and that asylum laws and policies recognize that persecution on account of one's sexual orientation or gender identity may be a valid basis for an asylum claim.
- Repeal laws used to criminalize individuals on grounds of homosexuality for engaging in consensual same-sex sexual conduct, and harmonize the age of consent for heterosexual and homosexual conduct; ensure that other criminal laws are not used to harass or detain people based on their sexuality or gender identity and expression; and abolish the death penalty for offences involving consensual sexual relations.

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[1] E. Arkin, "United Nations passes historic resolution to protect LGBT rights," *HIV/AIDS Law and Policy Review*, 15(3), October 2011: p. 40.

[2] "UN issues first report on human rights of gay and lesbian people," UN News Centre, 15 December 2011.

[3] United Nations Human Rights Council, *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientations and gender identity: Report of the United Nations High Commissioner for Human Rights*, A/HRC/19/4, 17 November 2011.

[4] "UN issues first report on human rights of gay and lesbian people" (supra).

[5] Since 2000, several countries have repealed laws criminalizing homosexual acts between consenting adults, including the United States of America, India and Azerbaijan.

[6] United Nations Human Rights Council (supra).

[7] Ibid.

[8] Ibid.

United States: legislation introduced to end HIV criminalization

In September 2011, Democratic Congresswoman Barbara Lee introduced legislation that seeks to end discrimination against people living with HIV (PHAs) and would require federal and state officials to review federal and state laws and policies that involve criminal cases against them.[1]

The *Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act* (the "REPEAL Act") is the first federal U.S. legislation to address discrimination in the use of criminal and civil statutes against those who test positive for HIV. It reflects current consensus on the failure of HIV-specific criminal laws to influence positively the risk behaviours of persons living with or at risk of HIV.

The REPEAL Act calls for a review of federal and state laws, policies, regulations, and criminal and related civil commitment cases involving PHAs to examine whether they demonstrate a public health-oriented, evidence-based and medically accurate understanding of the epidemic. The review is also intended to determine whether laws and policies place unique or additional burdens on PHAs solely based on their HIV status. It proposes the provision of technical assistance and other incentives to encourage states to reform existing laws and policies that unfairly target and discriminate against the HIV/AIDS community.

As of the date of the introduction of the legislation, 34 states and two territories had criminal statutes based on perceived exposure to HIV, and prosecutions for alleged exposure to HIV had occurred in at least 39 states. Many prosecutions stem from a defendant's alleged failure to disclose her or his HIV status to a partner before engaging in sexual activity. Others result from a defendant's behaviour — biting, spitting, scratching, sharing of needles during intravenous drug use or unprotected and protected sexual activity, etc. — and there is typically little or no consideration of the relative HIV transmission risks associated with that behaviour.

The REPEAL Act builds on a base of national and international statements about the need to reassess HIV criminalization. There have been recent statements by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the National Alliance of States and Territorial AIDS Directors (NASTAD) and President Barack Obama's National HIV/AIDS Strategy (NHAS) questioning the efficacy of these laws.

Commentary

The REPEAL Act recognizes the need for consultation with legal advocates and HIV/AIDS services organizations and, perhaps more importantly, with PHAs who are affected by HIV-specific laws and policies. Laws that place an additional burden on HIV-positive persons solely based on their HIV status, that treat a positive HIV test as evidence of a crime and that single out PHAs for severe punishment in the absence of actual wrongdoing are contrary to the values of fair treatment under the law, including equitable treatment for and other disabilities.

As Catherine Hanssens, executive director of the Center for HIV Law and Policy pointed out, the U.S. finally has a proposal related to criminalization that "relies on science and public health, rather than punishment, as the lead response to HIV exposure and transmission incidents. It embodies the courage and leadership needed to replace expensive, pointless, and punitive reactions to the complex challenge of HIV with approaches that can truly reduce transmission and stigma."[2]

— Adrián Guzmán

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[1] Office of Congresswoman Barbara Lee, "Congresswoman Call for Repeal of Unfair Criminal and Civil Laws," news release, Washington, 23 September 2011. The *REPEAL HIV Discrimination Act* is available online at www.hivlawandpolicy.org/resources/view/650.

[2] "Rep. Lee introduces groundbreaking anti-HIV criminalization bill," Housingworks.org, 26 September 2011.

UN joint statement calls for closure of compulsory drug detention and rehabilitation centres

In March 2012, twelve United Nations agencies issued a joint statement calling for the closure of compulsory drug detention and rehabilitation centres.[1] They call on member states to implement voluntary, evidence-informed and rights-based health and social services in the community.

According to the statement, these centres "raise human rights issues and threaten the health of detainees, including through increased vulnerability to HIV and tuberculosis (TB) infection," and detention often occurs without sufficient due process, legal safeguards or judicial review.[2]

The agencies affirm that there is no evidence that drug detention and rehabilitation centres "represent a favourable or effective environment for the treatment of drug dependence," for the "rehabilitation" of those who have engaged in sex work or for children who have been victims of sexual exploitation, abuse or the lack of adequate care and protection.[3]

The statement calls on states that operate these centres to close them immediately and to release the individuals detained. Upon release, "appropriate health care services should be provided to those in need of such services, on a voluntary basis, at community level."[4] It asserts that these services should include evidence-informed drug dependence treatment as well as HIV and TB prevention, treatment, prevention and care.

Commentary

Although the joint statement is a welcome advance in terms of international drug policy, it provides an incomplete perspective on the incarceration of people who use drugs. It does not address the situation of people — and not necessarily those who suffer from drug dependence — who are imprisoned for possession of drugs for personal use, nor does it comment on the detention of those who commit minor offences, such as petty theft (e.g., shoplifting), chiefly to finance their dependence.

Around the world, provisions of the UN drug conventions[5] that are reflected in national legislation make it a crime to possess illicit drugs in amounts that are often less than a single dose. Many states go even further than required by the conventions, making drug use a criminal offence often punishable by incarceration.[6] One must consider whether there is much difference between keeping people in drug detention centres in the name of "treatment" or "rehabilitation" and incarcerating people for possession of very small amounts of drugs.

The joint statement suggests that the centres, as a means of treating dependence, fail to achieve the aim of treatment. Therefore, the incarceration or punishment of people who use drugs for possession or for committing non-violent offences to finance their dependence represents a dubious tool for achieving the aim of drug control as stipulated by the drug conventions — specifically, health and welfare, prevention of drug addiction, protection of legitimate economies, stability, security and state sovereignty.[7]

The increasing arrest and incarceration of people who use drugs does not have any discernible effect on the level of drug use among the population[8] nor do these measures reduce access to illegal narcotic drugs. Moreover, the availability of and access to narcotic drugs is unaffected by the extensive use of punishment.[9] Fear of arrest and sanctions is not a major factor in an individual's decision whether to use or deal drugs.

Beyond merely condemning drug detention centres, the UN should also address the wider problem of incarceration of people who use drugs for victimless drug offences or non-violent offences where the underlying cause is drug dependence. Using the same reasoning and human rights basis, the agencies that endorsed the joint statement might have gone further to address the disproportionate and irrational punishment of people who use drugs for actions that are much better addressed through public

health interventions rather than criminal justice sanctions.

— Mikhail Golichenko and David Cozac

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[1] The entities comprise the following: International Labour Organisation; Office of the High Commissioner for Human Rights; United Nations Development Programme; United Nations Educational, Scientific and Cultural Organisation; United Nations Population Fund; United Nations High Commissioner for Refugees; United Nations Children's Fund; United Nations Office on Drugs and Crime; United Nations Entity for Gender Equality and the Empowerment of Women; World Food Programme; World Health Organisation; and Joint United Nations Programme on HIV/AIDS. The joint statement is available on-line at: www.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Single Convention on narcotic drugs, 1961, as amended by the 1972 Protocol; Convention on psychotropic substances, 1971; UN Convention against illicit traffic in narcotic drugs and psychotropic substances of 1988.

[6] European Monitoring Centre for Drugs and Drug Addiction, *Illicit Drug Use in the EU: Legislative Approaches*, 2005, p. 13.

[7] As found in the preambles to the UN Drug Conventions.

[8] S. Friedman et al., "Drug Arrests and Injecting Drug Deterrence," *American Journal of Public Health* (2011) 101: pp. 344–349; D. Werb et al., "Effect of drug law enforcement on drug-related violence: evidence from scientific review," *Journal of Epidemiology and Community Health* (2010); L. Degenhardt et al., "Toward a global view of alcohol, tobacco, cannabis, and cocaine use: Findings from the WHO World Mental Health Surveys," *PLOS Medicine* 5 (2008): pp. 1053–67; UK Drug Policy Commission, "Consultation paper on sentencing for drug offences," July 2009.

[9] Office of the National Drug Control Policy of The Executive Office of the President of the USA, *The Price and Purity of Illicit Drugs: 1981 through the Second Quarter of 2003*, November 2004; P. Reuter, "Ten years after the United Nations General Assembly Special Session (UNGASS): assessing drug problems, policies and reform proposals," *Addiction* 104 (2009): pp. 510–7.; European Commission, *A report on Global Illicit Drugs Markets 1998–2007*, 2009.

China: provinces to introduce real-name HIV testing

In February 2012, Guangxi and Hunan provinces announced plans to require use of real names for all HIV tests in their proposed regulations on HIV/AIDS.[1] This announcement has triggered widespread public discussion over real-name testing and the protection of privacy.

The Guangxi ministry of health subsequently commented that real-name testing would only be implemented in the second confirmatory test,[2] not in the initial screening test.

China's ministry of health has expressed support for the proposed regulations. Wang Yu, director of the national Centre for Disease Control (CDC), stressed in media interviews that he believes real-name testing is conducive to HIV prevention and treatment because it enables the government to keep track of people living with HIV (PHAs) and ensure that they receive treatment.[3]

According to national law, doctors are supposed to inform the patient first of a positive test. In practice, however, regional CDCs often inform the patient's family, local health authorities and even their workplace before informing the patient.[4] Inappropriate forms of follow-up, such as driving a car bearing a CDC logo to the home of a patient, can also result in violations of privacy.

The ministry of health has yet to announce any measures to improve protection of privacy once real-name testing is instituted.

Commentary

China has an estimated 780 000 PHAs, but more than half of them

cannot be located, because many people go underground after taking an initial test and do not return to receive their test results.[5] Since discrimination against PHAs is widespread in the country, protection of privacy is a cause for concern. PHAs may be rejected by schools, find it difficult to find jobs or earn promotions, and are even refused care by health care workers.

Although China has been continually improving its HIV testing system, many weaknesses remain. Many testing sites do not offer pre- and post-test counselling. Some doctors have said that they cannot provide counselling to everyone who takes a test because hospitals are overcrowded and underfunded, and doctors overworked. Where there is counselling, a lack of social workers and minimal involvement of community-based organizations may mean that it is not provided by trained professionals, but rather by health care workers who could discriminate against PHAs.

An important part of post-test counselling is the provision of psychological support in order to reduce the emotional impact on the patients, and this element is sorely lacking in China.

HIV testing should follow the "3 Cs" principles of informed consent, counselling and confidentiality. A policy that does not address the concerns raised by Chinese AIDS non-governmental organizations and that does not make people at risk of HIV feel safe will only drive people away from testing and increase the risk of HIV infection.

— Shen Tingting

Shen Tingting (tshen@asiacatalyst.org) is the director of advocacy at Korekata AIDS Law Center in Beijing.

[1] Cao Baoyin, "HIV Real Name Testing: Confidentiality is Important," *Xinjing News*, 20 March 2012.

[2] Chen Xianling, "Guangxi HIV Real Name Testing, Authority Stated It is Conducted in Confirmatory Testing," *Southern City News*, 5 April 2012.

[3] Wu Jie, "Officials of Ministry of Health: HIV Real Name Testing benefits HIV Prevention and Control," *Southern Weekly*, 20 March 2012.

[4] Feng Lifei, "People Living with HIV/AIDS: Real Name Testing Drives Us to a Corner," *Wangyi News*, 20 March 2012.

[5] Lv Nuo, "Minister of Health Talked About Response to HIV/AIDS in China," *Xinhua News*, 2 April 2012.

Russia orders NGO website shut down over harm reduction information

On 3 February 2012, the website of the non-governmental organization Andrey Rylkov Foundation for Health and Social Justice (ARF) was closed on the order of the Federal Drug Control Service (FDCS) for propaganda relating to narcotic drugs, which is an administrative offence in Russia.[1]

An FDCS representative later reported to journalists that the website was blocked because it contained "propaganda on substitution therapy, which is prohibited in the Russian Federation," adding that this constituted a violation of the *Law "On narcotic means and psychotropic substances"* as well as the state Anti-drug Policy. For these reasons, the representative said, the closure of the website did not constitute a violation of the right to freedom of expression.[2]

The ARF, supported by Russian lawyers, disagreed and launched legal

proceedings against the FDCS action in the domestic court. ARF and its supporters in the international community approached several United Nations Special Rapporteurs as well as UNESCO, arguing that the website closure was a violation of the interrelated rights to freedom of expression, to the highest attainable standards of physical and mental health, and to enjoying the benefits of scientific progress and its applications.[3]

For Russia and countries where Russian is understood, websites in the ".ru" domain are the premier source of information about harm reduction services, including opioid substitution therapy (OST). The ARF website was the only one that brought together objective scientific and human rights information about OST, including a consolidated library of publications of UN agencies, international human rights bodies, scientific reports, country experience and interviews with people who use drugs.

Commentary

With the exception of Russia, Turkmenistan and Uzbekistan, OST programs have been implemented all over Eastern Europe and Central Asia, often as part of pilot projects financed by international donors.[4] Despite the fact that there is ample evidence of the effectiveness of OST for treatment of opioid dependence and thereby of HIV prevention among people who inject drugs,[5] debates have occurred in these countries, with calls for the immediate termination of the programs because of their alleged ineffectiveness and perpetuation of drug use by substituting one narcotic drug with another.[6]

Opponents of OST refer to the position of the Russian Federation, quoting Russian drug treatment doctors, officials from the ministry of health and the FDCS. Providing false information about OST has become routine for senior public health and drug control officials in Russia.

It is important to note that, in Russia, federal law prohibits freedom of information if it concerns the medical use of narcotic drugs.[7] Since 2009, law enforcement agencies in Russia are mandated by the Security Council,[8] the President and the State Anti Drug Committee[9] to limit activities of civil society organizations that promote alternative methods of drug treatment, including OST.[10]

Consequently, senior state officials regularly make false statement about OST, which are posted on the official websites of the state agencies. At the same time, the state prohibits correct information about OST being made available to the public.

In the case of the ARF, the closure of its website results in inaccurate and false information about OST promoted by Russian state agencies to remain unchallenged, which could postpone the introduction of OST in Russia and obstruct OST development in Russian-speaking countries. With no fully fledged OST programs supported by Russian authorities, there is little to no chance that the HIV epidemic in Eastern Europe and Central Asia will be stopped and reversed by 2015 as stipulated by the UN Millennium Declaration.[11]

— Mikhail Golichenko

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[1] Order of the Moscow Department of the Federal Drug Control Service, No. 1/15-344 of 25 January 2012.

[2] I. Chevtaeva, "Experts on the Russian Drug Policy and the Ban on its Discussion," Svobodanews.ru, 10 February 2012. (In Russian; title trans. by author.)

[3] See Andrey Rylkov Foundation, *Information note regarding retaliation of the Government of the Russian Federation against the Andrey Rylkov Foundation for Health and Social Justice*, February 2012; and Canadian HIV/AIDS Legal Network and Andrey Rylkov Foundation, *When Science is Just a Decoration: Russian Drug Policy & the Right to Scientific Progress*, March 2012.

[4] A. Latypov et al., *Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality,* International Drug Policy Consortium, 2012.

[5] See the World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, 2009.

[6] See E. Kozmets, "Are we hooked up on narcotics?" Caravan.kz, 4 March 2011; and A. Makenov. "Ernest Abdysaparov: Methadone in Kyrgystan is illegal," Knews.kg, 7 December 2011. (In Russian, titles trans. by author.)

[7] See Article 40.2 of the federal Law # 3-FZ of 8 January 1998 "On narcotic drugs and psychotropic substances."

[8] The Security Council facilitates the decisions of the President regarding state security.

[9] The State Anti-Drug Committee was created in 2007 to coordinate the activities of state agencies to counteract drug trafficking. It is headed by the Director of the FDCS and includes heads of federal ministries and services, such as the ministry of health, the ministry of the interior and the Federal Security Service.

[10] Such a mandate is stipulated by the Decree of the President of the RF No. 690, dated 9.06.2010," On the approval of the State Anti-Drug Policy Strategy of the Russian Federation until 2020;" the Plan for the Implementation of the State Anti-Drug Policy Strategy of the Russian Federation until 2020 and the Protocol of the Security Council's meeting on 8 September 2009.

[11] United Nations General Assembly, *United Nations Millennium Declaration A/RES/55/2*, 18 September 2000.

High burden of HIV disproportionally among female sex workers in low- and middle-income countries

A systematic review and meta-analysis from the Johns Hopkins School of Public Health shows that female sex workers have been reported to be at high risk of HIV across the world.[1] The analysis included 102 selected articles and surveillance reports, representing 99 878 female sex workers in 50 countries.

In low- and middle-income countries, the risk of contracting HIV was almost 14 times higher for female sex workers than for women in the general population. The worst region in terms of infection risk for female sex workers was Asia. For example, data from the past five years in India revealed that female sex workers are fifty times more likely to contract HIV, despite the existence of progressive HIV prevention programs in the country.

Elsewhere, HIV prevalence had limited magnitude among sex workers in Latin America and the Caribbean, where the high risk of HIV within this demographic has been subjected to early recognition and intervention. The study cites the example of Brazil, which declined United States Agency for International Development funding that would have limited the country's ability to do comprehensive surveillance and service provision for sex workers. Instead, it decided to continue to invest in HIV prevention for sex workers throughout the country.

Data on female sex workers in Eastern Europe, the Middle East and North Africa were lacking, but available studies showed that the prevalence of HIV was concentrated among female sex workers.

Overall, sex workers from countries with very low or low HIV prevalence had higher odds of infection than did sex workers from countries with medium or high HIV prevalence among all women, even though in a generalized epidemic as in sub-Saharan Africa, female sex workers were still 12 times more likely to live with HIV compared to other women.

Approximately two thirds of low-and-middle income countries have no data on HIV on female sex workers. According to the study, "Possible explanations for these gaps include social stigma, criminalization of sex work, and the 'Prostitution Pledge' which conflated the issue of sex work with human trafficking and substantially reduced research funding and investigator interest in this area."[2]

Such factors also contribute to increasing the risk of HIV infection by limiting access to prevention and pushing sex workers underground. This is why "considerations of the legal and policy environments in which sex workers operate, and the important role of stigma, discrimination and violence targeting female sex workers globally will be required to reduce the disproportionate disease burden among these women."[3]

The disproportionate risk for HIV infection among female sex workers documented in this study calls for urgently scaling up "comprehensive initiatives simultaneously targeting HIV prevention, antiretroviral therapy access and care among female sex workers, especially in view of the established role of treatment as prevention," according to Julio Montaner and Kate Shannon in a published comment on the study.[4]

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[1] S. Baral et al, "Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis," *The Lancet Infectious Disease*, DOI: 10.1016/S1473-3099(12)70066-X, 15 March 2012.

[2] Ibid.

[3] Ibid.

[4] K. Shannon and J. Montaner, "The politics and policies of HIV prevention in sex work," *The Lancet Infectious Disease*, DOI: 10.1016/S1473-3099(12)70066-X, 15 March 2012.

Possible link between contraceptives and HIV transmission spurs international consultation

A study published in *Lancet Infectious Diseases* in October 2011 reported that the use of hormonal contraceptives was associated with a two-fold increase in the rate of HIV-1 acquisition by women and HIV-1 transmission from women to men.[1] The authors concluded that women should be counselled about the potential for increased HIV-1 risk with hormonal contraceptive use and the importance of dual protection with condoms to decrease that risk.[2]

Although this was not the first study to demonstrate a link between increased risk of HIV transmission and hormonal contraceptives, these noteworthy results spurred the World Health Organization (WHO) to convene a technical consultation on this issue. A WHO media statement from 16 February 2012 indicated that "WHO has concluded, on the advice of its Guidelines Review Committee, that women living with HIV or at high risk of HIV can safely continue to use hormonal contraceptives to prevent pregnancy."[3]

The accompanying technical statement explained that women living with or at high risk of HIV infection can use all existing contraceptive methods without restriction, but that women at high risk of HIV infection and using progesterone-only injectable contraception should be strongly advised always to use condoms. For women living with HIV, it notes that consistent and correct use of condoms is critical for HIV prevention. The technical statement also recommends further research on this issue.[4]

Criticism of WHO's statement focuses around the need to communicate this critical research to women. Lillian Mworeko, the sole African civil society representative invited to participate in the consultation, is quoted as stating, "We are at a point where we need to move very fast…. As a woman who sat in on that meeting, I feel we are moving very slowly [to communicate this] and this is unacceptable."[5]

Commentary

Women have the right to make fully informed sexual and reproductive health decisions. They therefore need to be informed that using hormonal contraceptives may carry some risk, and how to protect themselves and their partners from that risk. In order to ensure that women are able to make informed decisions about their health and give informed consent to hormonal contraceptive treatments, health care providers and counsellors need to explain this important research to women — both what is known and what is not yet known about the effects of different types of hormonal contraceptives.

In line with the UN commitment to women's rights, both WHO and UNAIDS should take a leadership role in providing balanced and accurate information and ensuring that a full range of contraceptives and HIV prevention technologies be made available to women.

— Alison Symington

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

[1] R. Heffron et al., "Use of hormonal contraception and risk of HIV-1 transmission: a prospective cohort study," *The Lancet Infectious Diseases* 12 (2012): pp. 19–26. Note that the most common form of hormonal contraception used by the study group was injectables. The results are insufficient for drawing definitive conclusions about oral contraceptive use and HIV risk.

[2] Ibid., at p. 25.

[3] World Health Organization, "WHO upholds guidance on hormonal contraceptive use and HIV," news release, Geneva, 17 February 2012.

[4] World Health Organization, "Hormonal contraception and HIV: Technical Statement," 16 February 2012, at p. 4.

[5] "Hormonal contraception advice not reaching women," SafAIDS, 6 March 2012.

Report urges Chinese government to compensate HIV blood disaster victims

A new report says that victims of China's HIV blood disaster, which resulted in thousands of people being infected with HIV through tainted blood, have been unable to get fair compensation through the legal system and calls for a national compensation fund.

The report, *China's Blood Disaster: The Way Forward*,[1] is jointly published by the U.S.-based Asia Catalyst and the Korekata AIDS Law Center in Beijing. To collect information, Korekata researchers traveled to remote villages in China where they interviewed more than 30 victims of tainted blood, and drew on the legal aid centre's dossiers of another 30 victims, to make policy recommendations.

In the 1990s, state-sponsored for-profit blood-collection centres used unsafe practices to collect blood from poor farmers, which resulted in the spread of HIV to thousands of people in Henan and other central provinces. After the virus entered hospital blood supplies, it was spread further through hospital blood transfusions, and again through sexual transmission and vertical transmission (i.e., mother-to-child transmission).

When non-governmental organizations and journalists exposed the disaster, the Chinese government worked to bring the situation under control by banning the sale of blood. However, most victims were never compensated for the harm they suffered. The government estimates there are 65 100 victims, but AIDS activists believe the number to be higher.

The report documents victims' efforts to seek compensation in the courts and the failure of the judicial system to deliver compensation. Many courts have refused to accept lawsuits relating to HIV transmission through tainted blood. Even in rare cases where a lawsuit was accepted, it encountered numerous procedural obstacles:

- Courts may take years to issue a final judgment, if cases are not suspended due to political pressure.
- Lawyers have found it difficult to provide evidence of the causal relationship between blood transfusion and HIV transmission, especially in cases where hospital records have been lost or destroyed.
- In the rare cases where plaintiffs won, some have found it difficult, if not impossible, to implement judgments.

Through active protest, some victims have been able to pressure hospitals or local government authorities to settle for small sums of compensation out of court. However, in the absence of a policy, payouts have been uneven, ranging from 40,000 to 440,000 CNY (CAN$6,274 to $62,740).

The report draws on international legal standards and the response of other countries to similar blood disasters to make detailed recommendations for a comprehensive national compensation policy, including:

- a full and independent investigation to establish a reliable estimate of the number of victims, including people who sold blood to state-run facilities, recipients of contaminated hospital blood transfusions, and children and partners infected through secondary transmission;
- detailed recommendations on the establishment and operation of the fund, including eligibility of applicants, compensation amounts and civil society participation; and
- an official government apology to the victims.

Proposals for a compensation fund for people who have been infected with HIV through tainted blood have been submitted to the National Committee of the Chinese People's Political Consultative Conference where it is currently being reviewed by legislators.

— Sara L.M. Davis and Shen Tingting

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[1] Asia Catalyst and Korekata AIDS Law Center, *China's Blood Disaster: The Way Forward*, March 2012. On-line: http://asiacatalyst.org/blog/2012/03/china-compensate-hiv-blood-disaster-victims.html.

In Brief

Criminalization of HIV: international civil society releases Oslo Declaration

In February 2012, twenty individuals and organizations from international civil society — including people living with HIV (PHAs) and advocates with expertise in medical, social, ethical, political, human rights and judicial issues relating to HIV and the criminal law — released the Oslo Declaration on HIV Criminalisation. The document opposes the overly broad use of the criminal law against PHAs, stating that "a growing body of evidence suggests that the criminalisation of HIV non-disclosure, potential exposure and non-intentional transmission is doing more harm than good in terms of its impact on public health and human rights."[1]

The Declaration calls for existing HIV-specific criminal laws to be repealed, in accordance with UNAIDS recommendations. If a jurisdiction undertakes a "thorough evidence-informed national review" of its HIV-related criminal laws and determines they are still necessary, it must ensure that any prosecutions are "based on principles of proportionality, foreseeability, intent, causality and non-discrimination; informed by the most-up-to-date HIV-related science and medical information; harm-based, rather than risk-of-harm based; and be consistent with both public health goals and international human rights obligations."[2]

Where the general law can be, or is being, used for HIV-related prosecutions, prosecutorial and police guidelines should be developed in consultation with key stakeholders to ensure clarity in the law and that police investigations are appropriate.

Many countries across the world criminalize HIV exposure, transmission or non-disclosure. In some, existing criminal laws have been adapted and applied to HIV cases, while many others have enacted HIV-specific laws. Although prosecutions and new specific laws have been increasing in recent years, several countries are now questioning the criminalization of HIV based on the evolutions in the science and treatment of the virus.[3]

The Oslo Declaration was released in Norway where a High Level Policy Consultation on the Science and Law of the Criminalisation of HIV Non-disclosure, Exposure and Transmission was convened by the Government of Norway and UNAIDS. The objective of the meeting was to provide a global forum in which policy-makers and other concerned players could consider their current laws and policies regarding HIV criminalization in light of the most recent and relevant scientific, medical, public health and legal data that should inform the application of the criminal law to HIV.[4]

As of this writing, more than 1300 individuals and organizations across the world have endorsed the Declaration.

United Kingdom no longer to charge undocumented migrants for HIV treatment

Earlier this year, and in response to years of lobbying by HIV organizations and the imminent threat of an amendment to their Health & Social Care Bill in the House of Lords (drafted by the National AIDS Trust and proposed by Lord Fowler[5]), the British government announced that charging for HIV treatment would end for all persons living in England from October 2012, including undocumented migrants.[6]

While the amendment would have given people free treatment after six months' residency (whether legal or not), the government response

goes further by removing the time restriction. The government view appears to be that, since HIV treatment can render someone less infectious, this should be done as soon as possible in order to reduce transmission and associated further costs to the health service from anyone living in the United Kingdom, whatever their formal immigration status. Guidance is currently being drawn up to prevent people abusing this new system by flying in for free treatment.

It has also been announced that all other National Health Service (NHS) regulations concerning charges to migrants will shortly be subject to a full review.

The concept of treatment as prevention was instrumental in changing the government's response; however, evidence that differing on-the-ground practices in neighbouring Wales and Scotland had not increased uptake of services there also played a part, as did ongoing advocacy.

For many years, the NHS, free to most at the point of use, has had a policy of charging some categories of people, notably undocumented migrants and people refused asylum but not removed from the U.K., for vital health services. Some conditions, including tuberculosis and all sexually transmitted infections other than HIV, have always been excluded from this charging policy because of public health considerations. Until now, HIV had been explicitly excluded from these public health exemptions by regulations enacted in 1989, before HIV treatment was available.

— Lisa Power

Lisa Power (lisa.power@tht.org.uk) is head of policy for the Terrence Higgins Trust in London.

Malawi: new inheritance legislation includes rights-protecting provisions

The Deceased Estates (Wills, Inheritance and Protection) Act, 2011[7] (replacing the former *Wills and Inheritance Act*) sets out a new framework for handling the devolution of property under wills and of persons dying without valid wills in Malawi. Provisions of the new law are gender-neutral, ending discrimination against women in terms of their share of an inheritance and the administration of estates.

The law includes several provisions that are protective of the rights of women with respect to inheritance. For example, under section 15, when a testator has inadvertently or otherwise omitted to make reasonable provision in his or her will for an immediate family members (e.g., a spouse or child) a court may order that "such part of the value of the testator's estate after payment of the testator's debts and funeral and administration expenses of the estate, be applied for the maintenance of the member," helping to minimize the disruption caused by a death in the family and protecting surviving family members from poverty.

Moreover, section 17 protects the spouse's and children's share in an estate. A number of considerations are outlined with respect to how the shares will be divided, but in the absence of special circumstances, the spouses and children shall be entitled to equal shares. Finally, sections 74, 84 and 88 make wrongful deprivation of property an offence, punishable by fee or imprisonment. These provisions provide important protection against "property grabbing" from widows and orphans.

Commentary

The HIV epidemic has resulted in more women, especially widows and orphans, being threatened with the dispossession of their land and property rights. More women are becoming heads of households, often in the context of family resources having been depleted because of illness. Widows may be blamed for their husband's HIV infection and death, and it may be assumed that a widow is infected herself. This may be used as a justification to withdraw social support from a woman, and even to seize her property.

Women's inability to own, dispose of and inherit property creates economic dependence on men, trapping women in abusive relations where they are less empowered to protect themselves from HIV infection or seek treatment. Impoverished women also have reduced capacity to cope with the disease.

Property grabbing is a clear human rights violation and exacerbates the already devastating consequences of HIV on families. This new legislation in Malawi recognizes that women's property and inheritance rights are critical in addressing the HIV epidemic.

— Alison Symington

United Kingdom removes ban on blood donations from men who have sex with men

In September 2011, the health ministers of England, Scotland and Wales announced that men who have sex with men (MSM) would be permitted

to donate blood.[8] Commencing in November, only those who had sex with men in the preceding 12 months would be banned from donating blood.

The move followed a report by the government's Advisory Committee on the Safety of Blood, Tissues and Organs saying that a lifetime ban was no longer justifiable. Committee member Deirdre Kelly said the "latest scientific evidence…does not support the maintenance of a permanent ban."[9] She added that the epidemiology of HIV had changed and the technology for testing for tainted blood was now extremely accurate.

U.K. experts calculated that, with a lifetime ban, the theoretical risk of a unit of tainted blood slipping through was one in 4.41 million. With a one-year deferral period, the risk would be one in 4.38 million.[10]

Activists in the U.K. welcomed the lifting of the ban, but expressed dissatisfaction with the one-year deferral. Gay rights advocate Peter Tatchell said that all MSM should be allowed to donate, without deferral, "if they always have safe sex with a condom, have only one partner and test HIV-negative." He and other advocates argue that the fairest way to minimize the risk of a window-period infection is to assess donors as individuals, not as groups.[11]

— David Cozac

[1] Oslo Declaration on HIV Criminalisation, 13 February 2012. On-line: www.hivjustice.net/oslo/.

[2] Ibid.

[3] UNAIDS, "Countries questioning laws that criminalize HIV transmission and exposure," 26 April 2011.

[4] Oslo Declaration on HIV Criminalisation (supra).

[5] Lord Fowler (as Norman Fowler MP) was the Conservative Minister who steered the U.K.'s early response to HIV in the 1980s and ensured it was taken seriously, despite opposition within the government of Margaret Thatcher.

[6] Information provided by author. See also, for example, "Free HIV treatment on NHS for foreign nationals," BBC News, 28 February 2012. On-line: www.bbc.co.uk/news/health-17187179.

[7] Available on-line at www.malawilii.org/mw/legislation/act/2011/14.

[8] A. Picard, "U.K. lifts lifetime ban on gay men donating blood," *The Globe and Mail*, 8 September 2011. It was reported that Northern Ireland is to adopt the same measure soon.

[9] Ibid.

[10] Ibid.

[11] W. Saletin, "The cost of giving the gift of life," *The National Post*, 19 September 2011.

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.

Supreme Court of Canada orders minister of health to exempt supervised injection site from criminal prohibition on drug possession

In a unanimous decision, the Supreme Court of Canada ordered Canada's federal minister of Health to grant Insite an extended exemption from the criminal prohibition on drug possession in the *Controlled Drugs and Substances Act* (CDSA), thus permitting it to continue to operate. In the September 2011 decision, the Court held that, while the CDSA provisions were applicable to Insite as valid exercises of the federal government's criminal law power, the minister's refusal to extend Insite's *CDSA* exemption violated Canada's *Charter of Rights and Freedoms* ("Charter").[1]

In September 2003, the Vancouver Coastal Health Authority, in partnership with PHS Community Services Society, opened Insite in response to epidemic levels of infectious diseases and drug overdoses among people who inject drugs in the Downtown Eastside of Vancouver.

Section 56 of the CDSA permits the federal minister of health to issue exemptions from the application of all or any of the provisions of the CDSA if the exemption "is necessary for a medical or scientific purpose or is otherwise in the public interest."[2] Insite operated under the purview of an exemption from prosecution for possession and trafficking of a controlled substance contrary to sections 4(1) and 5(1) of the CDSA. The exemption was originally granted by the federal minister of health in 2003 and subsequently extended to June 2008.

The case was heard before the Supreme court of Canada in May 2011. Among the many interveners before the Court was a coalition of the Canadian HIV/AIDS Legal Network, Harm Reduction International and Cactus Montréal, which argued that: (1) blanket prohibitions on drug possession and trafficking effectively outlawed Insite, and thereby deprived people who would otherwise use Insite of their Charter rights to life, liberty and security of the person because of the increased risks to life and health faced by those denied access to it; (2) the deprivations were arbitrary when applied in the context of Insite because the British Columbia Supreme Court found that the CDSA had been ineffective in preventing trafficking, let alone use, of drugs in the neighbourhood surrounding Insite; and (3) the arbitrariness of the CDSA prohibitions was confirmed by reference to international law and practice, which affirm the effectiveness of harm reduction services such as those offered by Insite and recognize access to those services as an integral part of the right to health.

In its decision, the court recognized that "Insite has saved lives and improved health. And it did those things without increasing the incidence of drug use and crime in the surrounding area."[3] Significantly, it rejected the federal government's argument that any negative health risks drug users may suffer from Insite's closure were not caused by the CDSA, but rather were the consequence of the drug users' personal choice to use illegal drugs, and affirmed the B.C. Supreme Court's finding that addiction is an illness, in which the central feature is impaired control over the use of the addictive substance.

The court considered whether, as a result of the division of powers between Canada's federal government and its provinces, Insite was not bound by the CDSA prohibitions on possession and trafficking of controlled substances. It held that the CDSA's criminal prohibitions were constitutionally valid exercises of the federal criminal law power and applicable to Insite. The fact that those provisions had the incidental effect of regulating provincial health institutions did not mean that they were constitutionally invalid, and the mere fact that a province established that a particular activity served the public interest did not exempt that activity from the operation of federal criminal laws. Moreover, the doctrine of interjurisdictional immunity — which was already narrow — did not resolve the contest between the federal government and the provincial government because the delivery of health care services did not constitute a "protected core" of the provincial power over health care in Canada's Constitution.

With respect to the validity of the legislation under section 7 of the Charter, the court recognized that, without an exemption from the CDSA's prohibition on drug possession, health professionals working at Insite would (1) have their liberty interests engaged because their actions could be construed as the offence of possession, thus exposing them to the threat of being imprisoned for carrying out their duties; and (2) be unable to offer medical supervision and counselling to Insite's clients, thus depriving those clients of potentially life-saving medical care and engaging their rights to life and security of the person.

The court also recognized that the prohibition on drug possession directly engaged the rights to liberty, life and security of the person of Insite's clients. The court did not find the CDSA's prohibition on trafficking constituted a constitutional deprivation, since Insite's staff and clients were not involved in trafficking, and clients in particular did not obtain their drugs at the facility and were not permitted to engage in activities that could be construed as trafficking while on the premises.

The court proceeded to review the CDSA and found that general criminal prohibitions, subject to targeted ministerial exemptions, reflected the "dual purpose" of the CDSA: the protection of both public safety and public health.[4] Despite finding the criminal prohibition on drug possession violated the claimants' section 7 rights, the court held that, because the CDSA conferred on the minister the power to grant exemptions, it did so in accordance with the principles of fundamental justice. The minister's discretionary power to grant an exemption acted as a "safety valve" that prevented the CDSA from applying where it would be arbitrary, over-

broad or grossly disproportionate in its effects.[5]

However, the discretion vested in the minister of health was not absolute and had to be exercised in conformity with the Charter. The court held that the minister's decision not to provide an exemption violated the claimants' constitutional rights because it would have prevented people who inject drugs from accessing the health services offered by Insite, threatening their health and their lives. Since exempting Insite from the application of the prohibition on drug possession furthered the objectives of public health and safety, the government action qualified as arbitrary.

Furthermore, the effect of denying the services of Insite to the population it served was grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics, since the facility had been proven to save lives with no discernable negative impact on Canada's public safety and health objectives.

Thus, the minister's refusal to grant Insite an exemption was not in accordance with the principles of fundamental justice and unconstitutional. The court ordered the minister of Health to grant an exemption to Insite pursuant to section 56 of the CDSA and held that, on future applications for such exemptions, the minister must exercise that discretion within the constraints imposed by the law and the Charter. This meant striking the appropriate balance between achieving public health and public safety, and considering whether denying an exemption would cause deprivations of life and security of the person that are not in accordance with the principles of fundamental justice.

[1] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 (Supreme Court of Canada).

[2] *Controlled Drugs and Substances Act* (S.C. 1996, c. 19).

[3] *Canada (Attorney General)*, *supra*, at para. 19.

[4] Ibid., at para. 41.

[5] Ibid., at para. 113.

Ontario's appellate court gives partial victory to sex workers

On 26 March 2012, a majority of the Ontario Court of Appeal upheld the *Criminal Code* prohibition against communicating in public for the purpose of prostitution, limited the prohibition on "living on the avails" of prostitution to "circumstances of exploitation" and struck down the prohibition against common bawdy-houses.[1] The appellate court heard the case after the federal and provincial Crown appealed the September 2010 decision of an Ontario trial judge declaring those provisions unconstitutional because they prevented sex workers from taking steps that could enhance their safety.[2]

The respondents were former and current sex workers who challenged the constitutional validity of: s. 212(1)(j) of the *Criminal Code*, which makes it illegal for anyone, including support and security staff, to live on the avails of prostitution, regardless of whether the relationship is an exploitative one; s. 210, which

outlaws common bawdy-houses and prevents sex workers from offering their services out of fixed indoor locations such as brothels or their own homes; and s. 213(1)(c), which criminalizes communication for the purpose of prostitution and prevents sex workers from offering their services in public, and prohibits any attempt by street-based sex workers to screen potential customers by speaking with those customers in a public place for the purpose of prostitution.

The court held that each of the impugned provisions criminalized conduct that would mitigate the risks to those engaged in the otherwise legal endeavour of prostitution, and that the inability to quantify the added risk to sex workers flowing from the legislation was no bar to a finding that the provisions, individually and collectively, added risk sufficient to engage security of the person.

Referring to the Supreme Court of Canada's decision in *Canada (Attorney General) v. PHS Community Services Society*,[3] the court drew an analogy between people addicted to drugs, who "because of a criminal prohibition, cannot access a venue where they can safely self-inject and therefore must resort to dangerous venues, and prostitutes who, because of criminal prohibitions, cannot work at venues using methods that maximize their personal safety, but must instead resort to venues and methods where the physical risks associated with prostitution are much greater."[4]

Further, the court rejected the Crowns' submission that those who choose to engage in sex work are not worthy of the same constitutional protection as those who engage in other dangerous, but legal enterprises. As it provided, "Parliament has chosen not to criminalize prostitution …. A claim that a criminal law prohibition increases the risk of physical harm to persons who engage in prostitution must, for the purpose of the security of the person analysis, be examined in the same way as any other claim that a criminal law prohibition increases the risk of physical harm to persons engaged in any other lawful commercial activity."[5]

The court proceeded to analyze the respondents' security of the person claims, pursuant to section 7 of the *Charter of Rights and Freedoms* ("Charter"). In examining the prohibition against "living on the avails," the court held that it was intended to prevent the exploitation of sex workers by pimps, but was not arbitrary, since it was consistent with its legislative objective. However, the court found that the provision was overbroad because it captured conduct that was not exploitative. Its effects were also grossly disproportionate because it prevented sex workers from hiring bodyguards, drivers or others who could keep them safe, and could conversely increase the likelihood of exploitation by forcing sex workers to seek protection from those who were willing to risk a charge under this provision.

To remedy this, the court read in words of limitation so that the prohibition applied only to those who lived on the avails of prostitution in "circumstances of exploitation," a decision that was stayed for 30 days to permit all parties to consider their positions. In the court's view, this cured the constitutional defect and aligned the text of the provision with the vital underlying legislative objective.

In examining the prohibition on common bawdy-houses, the court found that its legislative objective was to combat neighbourhood disruption or disorder and to safeguard public health and safety. While not arbitrary, the court held that the blanket prohibition was overbroad as it criminalized not only large establishments (which were likely to contribute to neighbourhood disruption and disorder) but also a single sex worker operating discreetly in her own premises. Moreover, the provision was grossly disproportionate because it prevented sex workers from moving indoors to locations under their control, which the trial judge had held was the safest way to sell sex. Therefore, the court declared the bawdy-house prohibition unconstitutional, but suspended a declaration of invalidity for 12 months to provide Parliament an opportunity to draft a Charter-compliant provision, should it elect to do so.

Finally, the court considered the prohibition against communicating in public for the purpose of prostitution. While the trial judge found its purpose was to target the social nuisance associated with street prostitution, three of the five justices of the court held that she had underemphasized the importance of this legislative objective, locating street prostitution "towards the low end of the social nuisance spectrum" and minimizing its relationship with serious criminal conduct including drug possession, drug trafficking, public intoxication and organized crime.[6] The majority of the court held that there was evidence that enforcement of the communicating prohibition had been effective in protecting residential neighbourhoods from the harms associated with street prostitution;

therefore, the prohibition on communicating was not arbitrary.

The same justices also held that the provision was not overbroad or grossly disproportionate, finding that the trial judge overemphasized the impact of the communicating provision on the respondents' security of the person, though they accepted that it denied them the opportunity to have face-to-face contact with prospective customers. Nevertheless, those justices found that it was but one factor, among many, that together contributed to the risk faced by street-based sex workers. Accordingly, a majority of the Ontario Court of Appeal was satisfied that the communicating provision did not violate the principles of fundamental justice and remained in full force.

Notably, the remaining two justices issued a strong dissent on the majority's finding with respect to the communicating provision, holding that the trial judge was correct to find that "the effects of the communicating provision are grossly disproportionate to the goal of combating social nuisance" and that the provision therefore violated section 7 of the Charter. In particular, the dissenting judges noted that the communicating provision had equally serious (and perhaps worse) effects on sex workers' rights to life and security of the person as the bawdy-house and living on the avails provisions.[7] They also disputed the majority's view that continuing to criminalize communicating helped curb criminal activity such as the possession and trafficking of drugs, violence and pimping.

Most significantly, the dissenting judges held that, while screening may be imperfect, the record demonstrated "that it is nevertheless an essential tool for safety"[8] and that the majority ignored other ways in which the communicating provision adversely affects sex workers' safety, including by forcing them into isolated and dangerous areas and discouraging them from working together.

The dissenting judges also held that the majority failed to consider properly the vulnerability of the persons most affected by the communicating provision, and the ways in which street-based sex workers' vulnerability magnify the adverse impact of the law. In their view, the equality values underlying the Charter require careful consideration of the adverse effects of the provision on women (many of whom are Aboriginal), lesbian and gay individuals, and those addicted to drugs and alcohol that comprise the majority of street-based sex workers.

As Justice MacPherson held, "prostitutes' pre-existing vulnerability exacerbates the security of the person infringement caused by the communicating provision. It is precisely those street prostitutes who are unable to go inside or to work with service providers who are most harmed when screening is forbidden."[9]

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[1] *Canada (Attorney General) v. Bedford*. 2012 ONCA 186 (Ontario Court of Appeal).

[2] For an overview of this decision, see S. Chu, "Ontario: prostitution-related provisions of *Criminal Code* struck down," *HIV/AIDS Policy & Law Review* 2011 15(2): pp. 30–31.

[3] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 (Supreme Court of Canada).

[4] *Canada (Attorney General) v. Bedford* (supra) at para. 116.

[5] Ibid., at para. 123.

[6] Ibid., at para. 306.

[7] Ibid., at para. 344.

[8] Ibid., at para. 348.

[9] Ibid., at para. 358.

Federal Court dismisses application for judicial review of HIV-positive Mexican man

In September 2011, the Federal Court dismissed an application for judicial review of a decision of the Refugee Protection Division of the Immigration and Refugee Board, concluding that the Mexican applicant was not a Convention refugee or a person in need of protection pursuant to sections 96 and 97 of the *Immigration and Refugee Protection Act* (IPRA).[1]

The applicant, a citizen of Mexico, entered Canada on a visitor's visa in 2009 and subsequently learned he was HIV-positive. Shortly after his diagnosis, the applicant was detained by Canadian authorities for overstaying his visa. The applicant initially claimed refugee protection on the basis that he feared persecution by criminals, based on what appeared to be a gang shootout that he witnessed in 2008. In September 2010, the applicant filed an affidavit and additional evidence to be considered at his refugee hearing, adding to his refugee claim that he feared persecution and serious risk to his life or cruel and unusual treatment in Mexico as a result of being an HIV-positive gay man.

In considering the applicant's claim for protection based on his status as an HIV-positive gay man, the Immigration and Refugee Board held that the test was whether, "if the claimant is returned to Mexico, there is a serious possibility that he would suffer 'serious harm,' a sustained or systemic violation of basic human rights that is demonstrative of a failure of state protection, and that this treatment would have nexus to a Convention ground."[2]

The Board found that the applicant had not alleged that he faced any serious mistreatment or harm as a gay male in Mexico prior to coming to Canada. Moreover, the Board found that the documentary evidence indicated that Mexico has taken measures to provide protection from discrimination on the basis of sexual orientation, including legislation allowing same-sex marriage and prohibiting discrimination due to sexual orientation in employment, as well as the creation of a national body tasked with creating anti-discrimination programs and receiving and resolving complaints made in the public and private sectors, with a mandate including protection for victims facing discrimination based on sexual orientation.

While the Board recognized that there continues to be discrimination on the basis of sexual orientation in Mexico, it found that the situation is improving and the evidence did not demonstrate that state protection was inadequate. It thus concluded that the applicant did not face a serious possibility of suffering persecution or serious harm in Mexico.

Next, the Board considered the applicant's claim that he would face discrimination as an HIV-positive gay man in Mexico. In support of this claim, the applicant indicated that he would not be able to afford the required medical treatment, and that he would be denied medical treatment and face employment discrimination because of his HIV-positive status.

The Board found that the applicant had not provided persuasive evidence that adequate medical care is being denied to HIV-positive patients. The evidence regarding some hospitals' discriminatory treatment of patients living with HIV did not demonstrate persecution because there was no evidence that these were more than isolated instances or that the Mexican government was systematically denying treatment to such patients. Furthermore, the Board found that there is legislation in place to prevent employment discrimination on the grounds of sexual orientation, as well as a National Council to Prevent Discrimination. Therefore, the applicant would have recourse to remedies if he faced any discrimination in employment.

In its review of the Board's decision, the Federal Court found that there was no persuasive evidence presented on which the panel could reasonably conclude that health care is being denied to people living with HIV in Mexico for persecutorial reasons, and that the applicant's inability to pay for HIV medication did not amount to persecution. The Court further held that there was no persuasive evidence to conclude that discriminatory treatment against people living with HIV amounted to more than isolated instances or that the Mexican government is denying med-

ical care to persecute HIV-positive people on a systematic basis. The Board's conclusion was reasonably open to it on the evidence. Therefore, the Federal Court dismissed the application for judicial review.

[1] *G. v. Canada (Minister of Citizenship and Immigration)*, 2011 FC 1059 (Federal Court).

[2] Ibid., at para. 14.

Federal Court dismisses Cameroonian woman's application for humanitarian and compassionate relief

On 6 February 2012, the Federal Court dismissed an application for judicial review of an April 2011 decision of a senior immigration officer at Citizenship and Immigration Canada, refusing the Applicant's application for an exemption from deportation on humanitarian and compassionate grounds, pursuant to section 25(1) of the *Immigration and Refugee Protection Act* (IRPA).[1]

The Applicant, a Cameroonian citizen, came to Canada in September 2003, after she fled from Cameroon where she claimed she feared persecution because she is a lesbian and HIV-positive. She also claimed that she had suffered domestic abuse at the hands of her husband. In 2004, the Refugee Protection Division of the Immigration and Refugee Board denied the Applicant's claim for protection on the basis that she was not credible, was not a lesbian and had not established that she had suffered domestic abuse. The Applicant asked the Federal Court for leave and judicial review of this decision, which was denied.

As an unsuccessful refugee claimant, the Applicant was subject to a deportation order, so she applied for an exemption on humanitarian and compassionate grounds in January 2005. In December 2010, she also applied for a Pre-removal Risk Assessment.

In her application for an exemption on humanitarian and compassionate grounds, the Applicant said that she had become established in Canada and that she had had a difficult life in Cameroon, where she was in an abusive, polygamous marriage. She was also involved in a relationship with a widow, who was beaten to death by a mob after the Applicant's husband found out about their relationship. The Applicant submitted that she was told that she would be next because she could not be allowed to corrupt the girls in their village.

The Applicant drew attention to the fact that women in Cameroon suffer discrimination and sexual violence, that homosexuality is against the law in the country and that the same people who sought to harm her before she fled in 2003 would harm her if she returned. Moreover, the Applicant was living with HIV and hepatitis C, for which she would face discrimination and not be able to access medical treatment in Cameroon.

The immigration officer reviewed documents the Applicant submitted that indicated that homosexuality is illegal and there is discrimination against people living with HIV in Cameroon. He found that, although human rights were not always respected in Cameroon, the evidence did not suggest that the Applicant would face "unusual and undeserved or disproportionate hardship" if she had to return to Cameroon, the high threshold for relief under sub-section 25(1) of the IRPA.

The officer also found that, while the Applicant indicated that she needed ongoing medical treatment,

she did not specify what treatment she required and, correspondingly, what treatment she would be unable to receive in Cameroon. His review of the evidence indicated that anti-retroviral treatment was available in Cameroon. Therefore, the Applicant had not demonstrated that her health justified an exemption on humanitarian and compassionate grounds.

Finally, the officer examined how the Applicant had established herself in Canada. Despite her economic self-sufficiency, community involvement and strong social network, he found that the Applicant had not demonstrated how her ties to Canada would cause unusual and undeserved or disproportionate hardship if she were returned to Cameroon, where she had lived for more than 34 years and where she had family.

In reviewing the immigration officer's decision, the Federal Court held that an exemption on humanitarian and compassionate grounds is not intended to be "a back door into Canada when all other legal avenues have been exhausted."[2] Moreover, such applications are not designed to eliminate all hardship, but only a hardship that is unusual and undeserved or disproportionate.

The Federal Court noted that the Applicant did not specify what HIV treatment she was under in Canada that would be unavailable to her in Cameroon. Therefore, it was open to the officer to conclude, based on information available to him, that the Applicant had not provided sufficient evidence either of her condition, the treatment required or the availability or lack of the required treatment in Cameroon. The court also found that the Applicant did not show that anyone in Cameroon knows that she is HIV-positive, or that she would have to disclose her status to a potential employer.

In the Federal Court's view, the officer thoroughly weighed the evidence that was before him and came to a conclusion that was not perverse or capricious. He did not ignore material facts, and his conclusion that the Applicant's HIV-positive status would not result in unusual and undeserved or disproportionate hardship was open to him on the evidence and should not be interfered with. Although the immigration officer concluded that there might be some hardship, this did not rise to the level of unusual and undeserved or disproportionate hardship required for humanitarian and compassionate relief.

[1] *A. v. Canada (Minister of Citizenship and Immigration)*, 2012 FC 158 (Federal Court).

[2] Ibid., at para. 38.

Federal Court grants HIV-positive Nigerian's applications for judicial review

In November 2011, the Federal Court granted applications for judicial review of a Pre-removal Risk Assessment (PRRA) decision and a Humanitarian and Compassionate (H&C) decision involving an HIV-positive Nigerian citizen, O.O. Both decisions were made by the same PRRA officer in January 2011.[1]

In his first decision, the officer rejected O.O.'s PRRA application after concluding that neither a risk of persecution, a danger of torture, a threat to life, nor a risk of cruel and unusual treatment or punishment under the *Immigration and Refugee Protection Act* (IRPA) had been established. In the second decision, the officer denied the applicant's request under the IRPA to have his application for permanent residence processed from within Canada on H&C grounds.

The applicant challenged the PRRA officer's conclusions with

respect to his HIV-positive status. On this issue, the officer believed that the applicant was indeed HIV-positive, but found that he did not show that there was more than a mere possibility of being denied health services or being persecuted in Nigeria due to his HIV status, or that he would be subject to torture or serious mistreatment for being HIV-positive. Moreover, the officer concluded that the applicant's level of establishment, his family and community relations and his work would not result in disproportionate hardship if the applicant left Canada permanently.

The Federal Court held that the PRRA officer's evaluation of the evidence was reviewable on the standard of reasonableness and that deference was owed to the evaluation conducted by the PRRA officer. However, on the basis of the evidence and the parties' submissions, the court found that the officer's evaluation of the risks for an HIV-positive individual living in Nigeria was unreasonable.

The court held that the officer was obliged to address documentary evidence before him that dealt with the risk of having an HIV-positive individual like the applicant return to Nigeria. The officer focused on evidence indicating that a major barrier to treatment in Nigeria was the cost of travel from the countryside to cities, but did not consider that there is also: (1) severe discrimination by health care providers and the general population; (2) that individuals living with HIV could be denied medical care or refused admittance to hospital and confidential medical data could be disclosed without patient consent; and (3) people living with HIV often lost their jobs, which in turn, has an impact on the cost of and access to treatment.

In the court's view, it might have been an option for the officer not to give much weight to these factors in light of the overall evidence, but it was not open to the officer to ignore this evidence. The officer's selective use of evidence led him to make an error in evaluating both applications. The PRRA applications for judicial review were thus granted and the matters were referred back for redetermination by a different PRRA officer with respect to the findings concerning HIV.

[1] *O. v. Canada (Minister of Citizenship and Immigration)*, 2011 FC 1331 (Federal Court).

Ontario Court of Appeal recognizes new privacy tort

On 18 January 2012, the Ontario Court of Appeal's decision in *Jones* v. *Tsige*[1] brought Ontario law a significant step further to recognizing a general tort of invasion of privacy. The court recognized a tort of "intrusion upon seclusion," which is limited in scope but paves the way for recognition of similar privacy torts.

The facts of the case were mostly not in dispute and not complicated. Ms. Jones and Ms. Tsige are both employees at the Bank of Montreal. Tsige was in a relationship with Jones's ex-husband. Over the course of four years, Tsige looked at the details of Jones's electronic accounts at the bank 174 times.

Jones commenced proceedings for, among other things, invasion of privacy. In a summary judgment motion, the motions judge found that there was no tort of invasion of privacy in Ontario. Jones appealed.

The Court of Appeal recognized a tort of intrusion upon seclusion and set out these elements: the defen-

dant's conduct must be intentional, including reckless; the defendant must have invaded, without lawful justification, the plaintiff's private affairs or concerns; and a reasonable person would regard the invasion as highly offensive causing distress, humiliation or anguish.

The court found that not every kind of privacy intrusion will attract legal consequences. The court stated that intrusions into certain matters would be more likely to be seen to be highly offensive, including financial or health records, sexual practices or orientation, and employment.

It is not a requirement of the tort that the plaintiff prove actual harm. The judgment stated that, in most cases, damages will be low and set an upper limit at CAN$20,000. The court left open the possibility of adding aggravated or punitive damages. Ms. Jones was awarded CAN$10,000.

Commentary

We know from this case that looking at someone's bank records without consent would be an invasion into their private affairs or concerns. We do not know yet whether a court would say that disclosure of someone's HIV status without their permission would also be an invasion into their private affairs.

Each case is different and there may be some situations in which the disclosure of HIV status without permission would fit into the definition of "invasion." It remains to be seen whether a court will agree.

Even if disclosure of HIV status is not seen to be an "invasion" for the purposes of this new tort, this judgment is encouraging. The court could have rejected a privacy tort outright, but it chose not to. In fact, the judgment contains a very good analysis of why the right to privacy ought to be protected by the law. This analysis should help lay a solid foundation for further expanding a tort of privacy, at least in Ontario.

— Renée Lang

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[1] *Jones v. Tsige*, 2012 ONCA 32.

Federal Court dismisses case contesting religious freedom to produce and possess marijuana

On 15 November 2011, the Federal Court of Canada dismissed an application for judicial review of a decision by the minister of health not to issue a statutory exemption that would have permitted the Applicant to produce and possess enough marijuana to use seven grams of the drug every day without violating the *Controlled Drugs and Substances Act* (CDSA).[1]

The Applicant, a member of the Church of the Universe since 1990, submitted that he believed that cannabis is the "tree of life" and that he smoked marijuana in a religious way. He argued that, as a result, both the statutory prohibitions on the possession and production of marijuana in the CDSA and the denial of his request for ministerial exemption violated his rights under sections 2(a), 7 and 15 of the

Canadian Charter of Rights and Freedoms ("Charter").

Under section 56 of the CDSA, the minister of health is vested with the discretion to "exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest." In 2009, the Applicant sent a letter to the minister requesting that she exercise her discretion under this provision to permit the Applicant to produce and possess enough marijuana to smoke seven grams of the drug per day without violating the prohibitions against illicit drug possession and production in the CDSA. This request was rejected on the basis that granting the requested exemption would not be in the public interest.

The Federal Court held that the minister's decision was to be reviewed on a deferential standard of reasonableness. In its view, courts must show deference when reviewing discretionary decisions that involve a complex weighing of interest even where that weighing involves the assessment of a claimant's rights under the Charter.

The Federal Court dismissed the Applicant's Charter arguments on the basis that both his practice of smoking seven grams of marijuana per day and the underlying belief that cannabis is the tree of life are secular in nature. As Justice Shore held, the evidence did not demonstrate "the requisite nexus" as it established only that the Applicant held "a sincere belief that the cannabis plant is a panacea for various societal ills. It does not establish that either this belief or his daily marijuana consumption has any nexus with a 'particular and comprehensive system of faith and worship.'"[2] In the court's view, such lifestyle choices were not protected by the right to freedom of religion under the Charter.

The Federal Court further found that the restriction on the Applicant's ability to produce and possess marijuana did not violate his right to security of the person, as he had provided no evidence showing that the law had any impact on his health or psychological well-being. Although the threat of imprisonment engaged the Applicant's right to liberty under section 7 of the Charter, the Applicant had failed to establish a corresponding inconsistency with the principles of fundamental justice. Moreover, the Applicant had not established any breach of his right to equality under section 15 of the Charter as he had not identified a distinction on an enumerated or analogous ground by which to expose any disadvantage that promotes prejudice or stereotyping.

[1] *Bennett v. Canada (Attorney General)*, 2011 FC 1310 (Federal Court).

[2] Ibid., at para. 77.

Criminal law and cases of HIV transmission or exposure

HIV-positive man found not guilty of aggravated assault for spitting incident

On 9 August 2011, Clifford Bear was found not guilty of aggravated assault but convicted of theft and three counts of assault arising from an incident that occurred at a retail store in Winnipeg, Manitoba in August 2009.[1] During a scuffle in the store, two store employees, who tried to apprehend Bear on suspicion of his having stolen video games, suffered minor injuries. Bear's convictions for theft and two counts of assault were related to this scuffle.

That same evening, Bear was apprehended by police, who testified that he seemed intoxicated, was talking about HIV and made comments about spitting. At the time, Bear had scrapes to his neck and arms and a

cut lip that was bleeding, as well as spots of blood on his shoes that the officers assumed had been incurred in the fight at the store. The police put a spit sock on Bear's head.

Bear was placed in a holding cell, where the officers testified he subsequently hid out of view and did not respond to their calls. When one of the officers unlocked the cell door to check on him, Bear emerged and spat in the officer's face, having pushed the spit sock up above his nose. The spit landed on the officer's nose, in his eye and on his forehead. The officer then punched Bear, who fell to the ground and was eventually subdued and returned to his cell. Bear required hospital treatment after this altercation.

The officer was also taken to the hospital for treatment and began post-exposure prophylaxis treatment, but was only able to stay on the drug for four days because it made him very ill. Since the incident, the officer had tested negative for HIV.

Bear was charged with aggravated assault for spitting in the officer's face in an attempt to infect him with HIV. The court found that the evidence overwhelmingly supported a finding that Bear assaulted the officer when he spat in his face, and that it was an intentional act based on the comments he had made earlier about HIV and spitting, his lifting of the spit sock, his refusal to answer the officer's calls at the cell door and his hiding himself from view in an obvious attempt to surprise the officer when he opened the door.

The Crown argued that the assault was aggravated, in that it endangered the life of the officer because Bear attempted to infect the officer with HIV. Defence counsel submitted that Bear was — at most — guilty of assault, as the officer's life was not endangered.

The court heard from HIV clinicians that HIV is not found in saliva, including a nurse who testified that the risk of infection where blood is mixed with saliva or tears was "low to negligible."[2] The court also heard from a physician who opined that Bear, who tested positive for HIV in May 2007, would have had a "steady, moderately high viral load" at the time of the incident.[3] The same doctor testified that it was his view that Bear could transfer HIV through blood and that one could not eliminate the possibility of it being transferred through blood mixed with saliva.

In coming to its conclusion, the court cited *R. v. Mabior*[4] and held that, although HIV did subject an individual to serious bodily harm, elimination of risk of such harm was not the test, and the evidence was insufficient to prove a charge of aggravated assault because it was unavailable. The Crown had not established beyond a reasonable doubt that the risk of serious bodily harm was significant without knowing the quantity of blood to which the officer was exposed or which quantity would be necessary to pose a significant risk when mixed with saliva. Therefore, Bear was found not guilty of aggravated assault and convicted of the included offence of assault.

Conditional discharge for girl who pleads guilty to common nuisance

A 17-year old girl accused of having unprotected sex without disclosing her HIV-positive status was given a conditional discharge in February 2012.[5] Originally charged with two counts of aggravated sexual assault, the girl pleaded guilty to one count of common nuisance.

The charges were initially filed in August 2011 by Edmonton police, after two male youths came forward alleging that they had unprotected sex with the girl without knowing that she was HIV-positive. The girl and the two complainants, whom she met in the spring of 2011, were all homeless.

Edmonton police subsequently issued a public safety warning naming her and asking anyone who had engaged in sexual activity with the girl to call police and to seek medical attention.[6] Because of her age, police obtained a court order to release her name, picture and other personal information. Although the court order was only applicable until the girl was taken into police custody (one day after it was first circulated), her name had already been widely circulated in the media by the time of her arrest. Edmonton police also did not immediately remove all identifying information about her from the Internet.

Since her HIV diagnosis in the fall of 2011, the girl had attended medical appointments regularly and provided blood samples to monitor her HIV status to determine if her illness was serious enough to require medication. According to an agreed statement of facts presented in Alberta provincial court, the girl did not require medication as her viral load was very low.[7]

An HIV expert retained by the Crown estimated that the girl's chances of transmitting HIV were 5 in 30 000 for each time she had sex. The judge concluded that the girl's HIV infection was controlled by doctors and accepted that she was a low risk to infect others.

The court ordered the girl to obey several conditions for the next six months, including abstaining from drugs or alcohol, regularly reporting to a probation officer, attending counselling as directed and disclosing her HIV status to any sexual partner.

Ontario court convicts man of attempted aggravated sexual assault for HIV non-disclosure

In December 2011, the Ontario Superior Court of Justice convicted a man of attempted aggravated sexual assault in relation to HIV non-disclosure to his female partner.[8] The sexual relationship had been ongoing for several years before the accused tested positive for HIV during a physical examination in support of his immigration application.

A key factual issue in the case therefore was whether unprotected sex continued following his diagnosis. The court found that it had continued following his diagnosis and that he did not inform her of his HIV-positive status. She was infected with HIV at some point during their relationship.

The Crown acknowledged that it could not be determined on the evidence whether she was infected before or after he learned that he was HIV-positive. As a result, the Crown could not make out the endangerment of life element of the charge of aggravated sexual assault. A conviction was therefore sought on the charge of attempted aggravated sexual assault.[9]

The defence argued that the Crown had not proved all of the necessary elements of the offence, namely deprivation, which requires proof of either actual harm or risk of actual harm, because it did not lead expert evidence to establish the extent of the risk.[10] The court rejected this argument, finding that the "significant risk" requirement of *Cuerrier* was intended to limit "the category of lies that might vitiate a complainant's consent to those that are objectively significant."[11] It was not intended to require expert evidence or a statistical analysis of the probability of harm occurring to the complainant.[12]

The court also found that it was not necessary to consider evidence regarding HIV treatment because HIV infection remains incurable and life-altering, and the accused was not on treatment at the relevant time.[13] The court accepted that it is "beyond dispute" that unprotected vaginal intercourse between an HIV-positive man and a woman risks infecting her with HIV; in the absence of evidence to establish circumstances that would materially reduce the risk of infection, the court accepted that the risk of infection meets the "significant risk" standard for determining whether the complainant's consent had been vitiated by fraud.[14]

In February 2012, the court sentenced the man to two years less one day of incarceration, which would give him a right of appeal against deportation, a possibility given the conviction against him. In considering the appropriate sentence, the court noted that the man had no prior criminal record, had been on bail for 4 ½ years without incident and was well-thought of in his community.[15]

— Alison Symington and Sandra Ka Hon Chu

Ontario court dismisses aggravated sexual assault charge against HIV-positive man

An HIV-positive Ontario man, J.U., faced charges in relation to three separate and distinct sexual assault allegations. His status was only relevant to one charge, which was an allegation of having consensual intercourse with the complainant, J.S., without disclosing his status to her. On 29 July 2011, he was acquitted on this count.[16]

The court accepted J.S.'s testimony that she had sexual relations (including vaginal, anal and oral sex) with the defendant on three occasions, twice with condoms and once without. Counsel had agreed that protected vaginal and anal intercourse with a person who is HIV-positive does not pose a significant risk of bodily harm; therefore, the proceedings revolved around the one unprotected sexual encounter.[17]

In analyzing the legal argument and expert evidence, the judge noted that, to prove a lack of consent to sex, the Crown must show that there was both deceit and deprivation. He stated that "[d]eceit is conceded, since the defendant did not disclose his medical status to her. Clearly, he had a moral duty to warn. However, not every immoral or reprehensible act will necessarily result in criminal liability. There must also be corresponding deprivation."[18]

He observed that the application of the legal test from *R. v. Cuerrier* must evolve to account for developments in the science related to HIV, and that courts since *Cuerrier* have recognized that other factors beyond

condom use can reduce the risk of transmission to the point where it is no longer legally significant, such as if the individual has an undetectable viral load.[19]

Based on the totality of evidence, the court concluded that the chance of transmission of HIV to the complainant did not meet the legal test of either significant risk of serious bodily harm or endangerment of life. The factors that raised a reasonable doubt included that there was only one instance of unprotected sex, there had been no ejaculation, he had a low viral load and the statistical risk of transmission was at most 1 in 333.[20]

In conclusion, the judge stated that "[w]hile the risk might be too high for the complainant, from a subjective standpoint, viewed objectively, the probability of infection in this case has not reached the required threshold to convict."[21]

— Alison Symington

Two years' imprisonment for HIV-positive man who pleaded guilty to aggravated sexual assault

On 20 October 2011, A.T.R. was sentenced to two years' imprisonment followed by three years' probation, and required to provide a DNA sample and to register as a sex offender after having plead guilty to aggravated sexual assault on 25 May 2011. A.T.R. admitted to having had unprotected sex with two women between December 2008 and February 2010 without disclosing his HIV-positive status to them. Neither woman was infected with HIV.[22]

In reviewing his case, the British Columbia Provincial Court noted that A.T.R. experienced a troubled and challenging childhood through various foster placements and group homes due to his mother's mental health and substance-abuse issues. He had also been diagnosed with several behavioural and emotional disorders, as well as depression. At 22, A.T.R. contracted HIV and reacted with shock and then denial, ignoring his status for several years, as well as any obligation he had to his sexual partners.

The court observed that the Crown had potential problems with proof of its case against A.T.R., specifically concerning how to quantify the risk that he had posed to the complainants. When A.T.R. tested positive for HIV in 2003, his viral loads were deemed "too low for transmission." Although A.T.R.'s viral load tested "sufficiently high" to transmit HIV by late 2010 (i.e., a risk of approximately one partner infection per 1000 exposures), the court observed that there was "no way for the Crown to establish through medical evidence at what point between those dates his viral load became sufficiently high to make him criminally responsible."[24]

Therefore, counsel for A.T.R. and the Crown submitted that their joint sentencing position was a compromise in light of the fact that A.T.R.'s viral load could not be ascertained at the time of the offences, and because A.T.R. entered a guilty plea despite the potential problems with proof of the case against him, sparing the complainants the need to testify against him and saving the court time that would have been required to secure a conviction, if that were the result.

HIV-positive Quebec man convicted of aggravated sexual assault

An HIV-positive Quebec man faced charges of aggravated assault and aggravated sexual assault in relation to sexual encounters with another man between July and August 2005. The aggravated sexual assault charge was for alleged non-disclosure of his HIV-positive status before unprotected anal intercourse.[25]

The accused advanced a defence based on the idea of "implicit consent." The argument was that people who engage in unprotected sex in a sauna or bathhouse for gay men, without asking about sexual health or HIV status, are willing or indifferent to becoming infected with HIV. As the accused met the complainant in a bathhouse, the accused argued that he presumed the complainant was implicitly assuming the risk of HIV infection.[26] He disclosed his HIV-positive status to the complainant only after they had unprotected sex.

The court rejected this defence, finding that consent must be clear and unequivocal, not implied.[27] The court found that the complainant would not have engaged in unprotected intercourse with the accused if he had disclosed his HIV status and that the sexual acts were risky. Therefore, the accused was found guilty of aggravated sexual assault.[28]

— Alison Symington

Six years for three counts of aggravated sexual assault

After pleading guilty to three counts of aggravated sexual assault, Xavier Bissonnette was sentenced to six years in prison by an Alberta provincial court in October 2011.[29]

Bissonnette, 56, was diagnosed with HIV in 1998.[30] He was charged with aggravated sexual assault earlier in 2011 after having unprotected sex with a 17-year old girl and two women without disclosing his HIV-positive status, all of whom he met through an on-line dating website.

Aggravated sexual assault charge withdrawn in case of HIV non-disclosure

On 18 November 2011, the Crown Attorney withdrew a charge of aggravated sexual assault against N.Z. at the Ontario Court of Justice, upon N.Z.'s completion of a precondition that she attend counselling with the Peel Region Public Health Department.[31]

Originally from Zimbabwe, N.Z. was charged in September 2010 after being accused of having unprotected sex with a man and failing to inform him of her HIV-positive status. The complainant has since tested negative for HIV.[32]

— Cynthia Fromstein

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[1] *R. v. Bear*, 2011 MBQB 191 (Manitoba Court of Queen's Bench).

[2] Ibid., at para. 43.

[3] Ibid., at para. 53.

[4] 2010 MBCA 93.

[5] R. Cormier, "HIV-positive teen avoids jail for unprotected sex," *Edmonton Journal*, 22 February 2012.

[6] J. Cummins, "HIV-positive teen arrested, charged; 17-year-old girl faces two counts of aggravated assault," *Edmonton Journal*, 8 August 2011.

[7] R. Cormier, *supra*, note 1.

[8] *R. v. T.*, 2011 ONSC 7136 (Ontario Superior Court of Justice)

[9] Ibid., at paras. 8 and 53–5. The Crown's argument followed *R. v. Williams*, 2003 SCC 41.

[10] Ibid., at paras. 56–7.

[11] Ibid. at para. 66.

[12] Ibid. at para 67.

[13] Ibid. at para 79.

[14] Ibid., at para 83.

[15] *R. v. T.*, 2012 ONSC 1201 (Ontario Superior Court of Justice).

[16] *R. v. J.U.*, [2011] O.J. No. 4143.

[17] Ibid., at para. 75.

[18] Ibid., at paras. 118–9.

[19] Ibid., at para. 125 and 133.

[20] Ibid., at para. 146.

[21] Ibid., at para. 148.

[22] *R. v. A.T.R.*, 2011 BCPC 283 (B.C. Provincial Court).

[23] Ibid., at para. 14.

[24] Ibid.

[25] *R. v. W.*, [2011] Q.J. No. 13378 (Court of Quebec).

[26] Ibid., at paras. 3 and 70–6.

[27] Ibid., at paras. 81, 151 and 236.

[28] Ibid., at para 205 and 243.

[29] D. Slade, "HIV-positive man jailed for sex with three women," *Calgary Herald*, 7 October 2011.

[30] J. McMurray, "Have you had sex with this man?; HIV-positive suspect accused of not disclosing disease," *Calgary Sun*, 22 August 2011.

[31] Information provided with consent of N.Z.

[32] "Woman charged with HIV crimes in Canada," NewZimbabwe.com, 17 August, 2011.

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.

Ukraine: doctor who provided opioid substitution therapy acquitted of drug trafficking

On 8 November 2011, the Odessa Regional Court of Appeal upheld the June 2011 decision of the Odessa District Court, which had acquitted Dr. Ilya Podolyan of charges of drug trafficking.[1]

In 2005, Podolyan had launched an opioid substitution therapy (OST) program in Odessa for people who use drugs. It operated until 11 March 2010, when officers from the Odessa police entered the premises of the drug treatment clinic in order to conduct an "unscheduled inspection." The clinic's lawyer was not

allowed to be present. Podolyan, two nurses, the OST program coordinator and the regional coordinator of the International HIV/AIDS Alliance — Ukraine in the Odessa region were arrested on suspicion of drug trafficking. Rooms where OST drugs were stored and issued to the patients were sealed and all medical records seized.[2]

Following the interventions of human rights lawyers, both the OST program coordinator and Alliance regional coordinator were released without charge after having spent 24 hours in police custody. One of the detained nurses was released from custody on 14 March, while the other was kept under police guard in an Odessa hospital and only released by court order due to her deteriorating health.

Podolyan was prosecuted under Article 309(1) of the *Criminal Code* of Ukraine for the illegal possession of narcotic drugs, for 34 ampoules of Sibazon containing the psychotropic substance Diazepam (0.43 grams), which were discovered during a search of his residence.[3] He was released on bail on 15 March.

The investigation continued and, two months later, new charges were brought against Podolyan, accusing him of drug trafficking (Article 307(2) of the *Criminal Code*), an offence punishable by up to ten years' imprisonment. The indictment indicated that Podolyan "had sold OST medications (buprenorphine) to 42 patients of Odessa Regional Narcological Dispensary, illegally prescribing drugs to them"[4] at a time when the drug treatment clinic did not have a valid licence for handling narcotic substances.[5]

On 31 May 2010, the Malinowskiy District Court of Odessa issued a pre-trial detention order for Podolyan so that he could not evade prosecution and continue his activities. The court ignored the fact that the accused suffered from many illnesses, including hypertension, diabetes and arrhythmia, and that the detention facilities lacked staff who could attend to him properly.[6] 25 On September, after almost four months in pre-trial detention, Podolyan was released on bail.

It emerged over the course of the proceedings against Podolyan that police unsuccessfully tried to obtain evidences from OST patients that he had received money from them. In addition, for several months before the 11 March police visit to the clinic, detectives had placed a tap on its phones; however, they failed to gather any proof of illegal activities.

OST has been in Ukraine since 2004. As of January 2012, there were 6632 patients of OST programs in 133 hospitals in all 27 administrative regions of the country.[7] According to the *Law of Ukraine "On AIDS Prevention and the Social Protection of the Population,"* as amended on 23 December 2010, access to OST programs shall be guaranteed for all people who inject drugs.[8]

— Pavlo Skala

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[1] An English translation of the decision can be found here: www.aidsalliance.org.ua/ru/news/pdf/09.11.2011podolyan/Court_Verdict_29.06_english.pdf. Podolyan was convicted of a single charge for the psychotropic drug Sibazone, which was found at his residence and was not related to opioid substitution therapy.

[2] See www.segodnya.ua/news/14122296.html (in Ukrainian).

[3] Decision to prosecute a defendant as of 28 May.2010, issued by Karaush AA, the investigator of Malinowskiy district police department of Odessa.

[4] Ibid.

[5] Over a year before the events took place, the drug treatment clinic had changed its legal name, which, according to Ukrainian legislation, requires an organization to update its licence for handling drugs.

[6] Certificate No. 5/12-13138 issued on 20.07.2010 by Chief Officer A. Mytrophanov, Odessa Pre-trial Facility.

[7] Statistics on SMT patients from the Ukrainian Institute on Public Health Policy, available on-line: www.uiphp.org.ua/media/1459 (in Ukrainian).

[8] *Law of Ukraine "On AIDS Prevention and Social Protection of Population"*. See http://zakon1.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=2861-17 (in Ukrainian).

Kenya: ruling ensures access to generic HIV medicines

On 20 April 2012, the High Court of Kenya ruled that legislators must reconsider the *Anti-Counterfeit Act* of 2008 because it could threaten the importation of generic anti-retroviral medicines.[1]

"The act is vague and could undermine access to affordable generic medicines since the act had failed to clearly distinguish between counterfeit and generic medicines," Judge Mumbi Ngugi said in her ruling.[2] She directed the government to amend sections 2, 32 and 34 of the *Anti-Counterfeit Act* that prohibits the use of generic medicines.

The Kenyan parliament will now have to review the legislation and remove ambiguities that may result in arbitrary seizures of generic medicines under the guise of fighting counterfeits.

The High Court decision affirmed a conservatory order issued on 23 April 2010 by Justice Roseline Wendoh that stopped the government from implementing the *Anti-Counterfeit Act* until the case was determined.

Petitioners Patricia Asero Achieng, Maureen Murenga and Joseph Munyi had sought to have the legislation declared unconstitutional on the grounds that it infringed on their right to life by giving a broad definition and interpretation of what constitutes counterfeit medicines. They argued that the Act threatened their access to generic medicines and right to life.[3]

"This was a poorly-drafted law from the outset that must be urgently reviewed to avoid threatening public health programmes such as the national treatment programme on HIV, which is predominantly dependent on access to generic anti-retrovirals," said Jacinta Nyachae, executive director of the AIDS Law Project.[4]

The ruling is thought to set a positive precedent for the entire East Africa region, as most countries within the East African Community are considering anti-counterfeiting laws that may threaten generic medicines.

— David Cozac

David Cozac (dcozac@aidslaw.ca) is the managing editor of the HIV/*AIDS Policy & Law Review*.

[1] "Kenyan court ruling upholds access to generic drugs," Reuters, 20 April 2012.

[2] Ibid.

[3] M. Kalekya, "Kenyans can access cheap ARVs, court rules," Kenya Broadcasting Corporation, 20 April 2012.

[4] Ibid.

Chile: court upholds decision against health provider for revealing patient's serostatus

In January 2012, the Supreme Court of Chile upheld a decision from the Fifth Civil Court that the health provider Servicio de Salud Valparaíso-San Antonio must pay a fine of 10 million Chilean pesos (CAN$20,600) to a patient after the Dr. Eduardo Pereira Hospital in the city of Valparaíso had disclosed his HIV-positive status without his consent.[1]

The complainant had been admitted to the hospital in July 2007 to receive treatment for biliary cramping. At that time, he notified staff that he had been HIV-positive for 20 years and

requested that it not be revealed to his family and friends. However, during his stay at Dr. Eduardo Pereira, nurses and other medical staff disclosed his serostatus to other patients and to family members who visited him. In one instance, a doctor informed medical students who were completing their internship at the hospital of the patient's diagnosis, including the bed and room number where he was located.[2]

The Supreme Court justices unanimously rejected the appeal of Servicio de Salud Valparaíso-San Antonio, confirming the lower court ruling that had found hospital staff negligent in disclosing the patient's HIV-positive status, in spite of his expressed request that it remain confidential.

— David Cozac

[1] "Suprema condena a servicio de Salud de Valparaíso por revelar diagnóstico de VIH de paciente," Latercera.com, 24 January 2012.

[2] Ibid.

U.S. Supreme Court dismisses privacy suit by HIV-positive pilot against government agencies

On 28 March 2012, the United States Supreme Court dismissed a lawsuit by pilot Stan Cooper against the Social Security Administration — which was sending him disability benefits — alleging that it had improperly shared his HIV status with transportation officials.[1]

A small-plane pilot, Cooper gave up his licence after he was diagnosed with HIV in 1985, when Federal Aviation Administration (FAA) rules still denied licences to anyone with the virus. He re-applied in 1994 without disclosing his condition. His health briefly worsened in 1995 and he applied for Social Security benefits, with the assurance that his medical records would remain confidential.

Although the FAA repealed its HIV ban several years later, the agency revoked his licence in 2005 after obtaining his medical records from the Social Security administration. Cooper pleaded guilty in 2006 to a misdemeanour charge of making a false statement and was fined US$1,000 (CAN$1,000), but managed to get his pilot's licence back from the FAA later that year.

The 5–3 ruling overturned a federal appeals court decision in 2010 that would have allowed Cooper to seek damages against the government for invading his privacy when it disclosed his medical condition. The Supreme Court said that Cooper could not seek damages against the agencies that shared his medical files because the federal *Privacy Act* authorizes damages only for monetary losses and not for humiliation or emotional distress. Cooper did not claim financial losses in his suit.[2]

The *Privacy Act*, passed in 1974, allows individuals to recover "actual damages" when federal agencies deliberately disclose their confidential records. Because the law does not define "actual damages," the court majority interpreted it to mean reimbursement for financial losses.[3]

Counsel for Cooper, Raymond Cardozo, said the ruling gutted the legislation.

"When you invade someone's privacy, the most natural form of harm is mental and emotional," claims that must now be dismissed, he said.[4]

— *David Cozac*

[1] C. Johnson, "Supreme Court Limits Damage Payments to Whistle-Blowers," National Public Radio, 28 March 2012.

[2] B. Egelko, "Supreme Court restricts privacy law in pilot's case," *San Francisco Chronicle*, 29 March 2012.

[3] Ibid.

[4] Ibid.

Criminal law and cases of HIV transmission or exposure

New Zealand: court rules unprotected sex without disclosure can amount to sexual violation

On 12 March 2012, the Court of Appeal of New Zealand decided that HIV non-disclosure prior to engaging in unprotected sex can amount to fraud vitiating consent to sexual intercourse and would constitute a sexual violation, allowing compensation for mental injury resulting from non-disclosure under the *Accident Compensation Act* (the "Act").[1]

The Appellant had sought compensation for mental injury suffered after she learned that her partner, with whom she had unprotected sex, was HIV-positive.[2] Her partner did not disclose his status during their relationship. Although she did not become infected, she suffered post-traumatic stress disorder as a result of the experience. Her partner was convicted of criminal nuisance for failing to disclose his HIV-positive status.

The Appellant sought compensation under section 21(1) of the Act, which provides compensation for mental injury suffered by a person as a result of any act that falls within the description of one of the offences listed in Schedule 3 of the legislation. Schedule 3 does not refer to criminal nuisance — for which the respondent was convicted — but does refer to sexual violation by rape.

Therefore, the main issue in the appeal was whether, for the purpose of the application of the Act, the failure to disclose one's HIV-positive status before unprotected sex falls within the description of a sexual violation, which is covered by the Act.

The court had to decide first whether the Act allows for a different interpretation of sexual violation to that found in the criminal law, which would have to prove both the Appellant's lack of consent and that the Respondent had sex without believing on reasonable grounds that the Appellant had consented to sex.

The Court of Appeal of New Zealand ruled that it was not conceivable that parliament intended to provide compensation for mental injury resulting from consensual sexual intercourse. However, where intercourse was non-consensual, the other party's reasonable belief in consent was no bar to accident compensation coverage because of its focus on the victim.[3]

Based on that analysis, the Court of Appeal had to decide whether sex in that particular case was non-consensual — that is, whether HIV non-disclosure vitiated consent to sex with the effect that coverage would be available.

Referring to the decision of the Supreme Court of Canada in *R. v. Cuerrier* — where it was decided that HIV non-disclosure may amount to fraud vitiating consent to sex — the Appellant argued that HIV non-disclosure gave rise to a *mistake about the nature and quality of the sexual act* vitiating consent (under section 128A(7) of the *Crimes Act 1961*). "Even where the risk is small, the

consequences associated with non-disclosure are so great that it changes the nature of the act."[4]

The Attorney General, as an intervener, argued that HIV non-disclosure should not vitiate consent. It argued that any change in that position should be a matter for Parliament, given its social and policy implications, and expressly referred to the practical difficulties arising from the decision in *Cuerrier* in determining where to draw the line between what is criminal and what is not.

After reviewing the relevant case law in other common-law jurisdictions, the Court of Appeal was convinced by the approach of dissenting Justices McLachlin and Gonthier in *Cuerrier*. Their approach was summarized by the Court of Appeal as follows: "fraud vitiate[s] consent to contact where there is a deception as to the (…) presence of a sexually transmitted disease giving rise to serious risk or probability of infecting complainant".[5]

The Court of Appeal noted that McLachlin and Gonthier were clear that fraud would not arise in cases of protected sex, while the majority of the Supreme Court of Canada majority only suggested it.[6]

Following that approach, the Court of Appeal decided that, in cases of unprotected sex without disclosure, consent by the appellant was vitiated by a mistake as to the nature and quality of the act (s. 128A(7)) or in the alternative under s. 128A(8) of the *Crimes Act 1961*, which specifies that the list of circumstances where a person does not consent under s. 128 is not exhaustive. HIV non-disclosure prior to unprotected sex is thus sufficient to vitiate consent to sexual intercourse so as to constitute a sexual violation for the purpose of coverage for mental injury under the Act.[7]

Commentary

Although this decision only concerns the application of the *Accident Compensation Act*, it sets a dangerous precedent. It opens the door to potential criminal prosecutions for HIV exposure on the basis of the law of sexual assault rather than the lesser charge of criminal nuisance currently used in New Zealand.

— Cécile Kazatchkine

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USA: HIV-positive man convicted for having unprotected sex despite disclosure

On 7 October 2011, a court in Minneapolis convicted an HIV-positive man of attempted first-degree assault for having unprotected sex with another man despite the fact that he had disclosed his status to his sexual partner.[8]

D.J.R. was convicted under a 16-year old Minnesota statute, *609.2241 Knowing Transfer of Communicable Disease*, which states that

> It is a crime…for a person who knowingly harbors an infectious agent to transfer, if the crime involved:
>
> (1) sexual penetration with another person without having first informed the other person that the person has a communicable disease;
>
> (2) transfer of blood, sperm, organs, or tissue, except as deemed necessary for medical research or if disclosed on donor screening forms; or
>
> (3) sharing of nonsterile syringes or needles for the purpose of injecting drugs.[9]

The jury found D.J.R. not guilty under the first section because the accused had disclosed his status to his partner. However, he was convicted on the second, for the jury believed it applied to any transfer of sperm, even though counsel for D.J.R. argued that it was not intended to apply to sexual intercourse. D.J.R. was found guilty of attempted first-degree assault because it could not be proved that he had transmitted HIV to his partner.[10]

D.J.R. was ordered to serve five years on probation. According to the judge, while his partner's awareness did not warrant throwing out the conviction, it justified a lesser sentence than the four-year jail sentence requested by the prosecutor.[11]

D.J.R.'s lawyer has expressed his client's intent to appeal the conviction and to fight the constitutionality of the statute as an interference with his client's right to privacy.[12]

— Cécile Kazatchkine

[1] *KSB v. Accident Compensation Corporation*, [2012] NZCA 82.

[2] "Women gets compensation for HIV-scare stress," Television New Zealand, 12 March 2012.

[3] *KSB v. Accident Compensation Corporation* (supra) at para. 31.

[4] Ibid., at para 35.

[5] Ibid., at para 52.

[6] Ibid., at para. 89.

[7] Ibid., at paras. 98–99.

[8] A. Simons, "Probation set in Hennepin County HIV Case," *The Minneapolis Star Tribune,* 28 November 2011.

[9] *609.2241 Knowing Transfer of Communicable Disease* is available on-line at: https://www.revisor.mn.gov/statutes/?id=609.2241.

[10] A. Simons (supra).

[11] Ibid.

[12] Ibid.

WHERE REASON FEARS TO TREAD:

Ongoing HIV ignorance and discrimination in criminal and civil settings in the United States[1]

The American Bar Association has maintained that HIV law and policy must be rights-based and evidence driven. While the United States has taken an important step toward tackling the domestic epidemic by launching the National HIV/AIDS Strategy, ignorance and fear continue to drive laws and policies that ignore the scientific evidence base. Despite enormous advances in our knowledge of both HIV and effective prevention and treatment options, discrimination based on poorly drawn conclusions on the risk and consequences of HIV transmission and harm reduction efforts persist. There is now widespread criminal prosecution of HIV exposure, nondisclosure and transmission among the states. Congress has recently reinstated a ban on federal funding for syringe exchange programs, vital to HIV prevention efforts. Meanwhile, the case of a young boy denied admittance to a private boarding school because his HIV was considered a "threat" to other students received national attention, and the case of a qualified police officer candidate denied employment solely because of his HIV status was recently argued in the U.S. Court of Appeals.

The following article was commissioned in advance of the XIX International AIDS Conference — to be held in July 2012 in the U.S. for the first time since 1990 — to discuss these issues in order to provide an overview of the current disconnect between evidence and law in the country and to discuss how best to address them.

[1] This article is published for informational purposes and expresses the views of its authors. Except as specified otherwise, the article does not necessarily reflect official policy of the American Bar Association.

In the thirty years since the HIV epidemic was first recognized, an estimated 1 108 611 people in the United States have been diagnosed with AIDS and 594 500 people have died.[1] From the beginning, the HIV epidemic has been marked by discrimination and associated stigma toward those living with HIV and those considered at highest risk of HIV infection. As of November 2011, the Centers for Disease Control and Prevention (CDC) estimates that 1.2 million people in the country are currently living with HIV, with one in five unaware of their status.[2] Approximately 50 000 Americans become infected with HIV each year.[3] Federal funding for the domestic epidemic has increased only marginally since 2006,[4] with potentially devastating consequences. HIV now affects primarily low-income communities of colour, including women and youth, who have long experienced more limited access to public health systems, including to HIV prevention, care, treatment and support services.[5]

The American Bar Association (ABA) established the AIDS Coordinating Committee (ACC) in 1987 in recognition of the unique legal issues raised by the then-five year epidemic. The ABA has since taken policy positions on a diverse number of issues involving or pertaining to HIV/AIDS, always emphasizing both the rights of individuals and the need to base policies on accurate and up-to-date evidence.[6] This dual emphasis on rights and sound science has been necessary, not least because the HIV epidemic spawned a sister epidemic of stigma and discrimination against those living with HIV, largely through ignorance of the specifics of HIV transmission and transmission risks, and due to high levels of existing stigma toward those first affected by the virus in this country: gay men and injecting drug users.[7]

While we are no longer living in the fear-charged days of the 1980s, when paranoia over a mysterious and fatal new illness drove massive and frantic speculation over how the virus is transmitted, ignorance and misunderstanding of HIV/AIDS remains significant and widespread. In a 2011 Kaiser Family Foundation report on public opinion on HIV, a third of both blacks and whites believed they could get HIV from sharing a drinking glass with a person living with HIV, swimming in a pool with someone living with HIV or using the toilet after someone living with HIV, misconceptions that were common at the onslaught of the epidemic.[8] This ignorance in turn fuels continuing onslaughts on the rights of those living with and at risk of HIV[9] and enables political responses to the problem to continue to be more responsive to perceived popular fears or misconceptions — often directed at or at the expense of communities most at risk — without regard to existing science.

The science of HIV: then and now

Prior to the discovery of effective HIV treatments in the mid 1990s, HIV infection almost always led to illness and early death.[10] However, the introduction and now widespread use of anti-retroviral drugs has led to dramatic reductions in HIV-related illnesses and deaths, where treatment has been available.[11] The latest science shows that, where diagnosis and antiretroviral therapy (ART) occur early (before significant damage has been done to the immune system), those infected can go on to have a near-normal lifespan.[12]

Today, a great deal is known about HIV viral loads, per-act transmission risk and effective prevention methods that may affect the possibility of HIV transmission or exposure. Although viral load is the greatest risk factor for all modes of transmission, initiation of antiretroviral therapy (ART) can reduce the level of the virus in the bloodstream (plasma viral load) to undetectable levels,[13] rendering the person less infectious and less likely to transmit HIV via sexual contact.[14] Initiation of ART has been shown to reduce sexual transmission rates by 96 percent.[15] Additionally, a large body of scientific evidence shows that male latex condoms, when used correctly and consistently, have an 80 percent or greater protective effect against the sexual transmission of HIV and other sexually transmitted infections (STIs).[16] While these rates evidence the current understanding of the science as of 2012, it is nonetheless important to assess the actual risk of exposure and transmission using the most recent available data.

National HIV/AIDS Strategy

On 13 July 2010, U.S. President Barack Obama released the National HIV/AIDS Strategy (NHAS), the country's first-ever comprehensive coordinated HIV/AIDS roadmap.[17] The stated vision of the NHAS is that the "US will become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."[18]

The NHAS was developed with three primary goals: reducing the number of people who become infected with HIV; increasing access to care and optimizing health outcomes for people living with HIV; and reducing HIV-related disparities.[19]

Ignorance and misunderstanding of HIV/AIDS remains significant and widespread in the U.S.

Importantly, the NHAS includes specific statements and directives on HIV-related stigma and consequent discrimination, to be addressed. Noting that state HIV-specific criminal laws reflect or result from (long-outdated or repudiated) misperception of HIV's modes and relative risk of transmission, the NHAS also pointed to both the lack of evidence that these laws had any positive public health impact, as well as their negative impact on public health.[20] The NHAS suggests that "[i]n many instances, the continued existence and enforcement of these types of laws …may undermine the public health goals of promoting HIV screening and treatment."[21]

However, despite this laudable language, significant challenges remain. The U.S. government continues to act in both disregard and defiance of the scientific evidence base, as demonstrated, not least, most recently by the re-adoption of the ban on federal funding for syringe exchange programs. While the NHAS calls upon state and local governments to join in the effort, the strategy has done little to end not only many state and local laws that criminalize HIV exposure and transmission, but pervasive federal policies inconsistent or at odds with NHAS, including those that exclude people with HIV from entering the military and the application of severe criminal charges and penalties to U.S. service members who seroconvert while in service and are accused of sexual misconduct.[22]

In short, while the NHAS talks the talk about reducing stigma and discrimination against people living with HIV/AIDS, to date it has led to few specific, consequential policy commitments to demonstrate that the NHAS is, in fact, the priority for the administration it professes to be.

Criminalization of HIV transmission and exposure

Criminal law in the U.S. has traditionally been, and remains, a matter handled by the states. All 50 states and the District of Columbia have their own penal codes, although Congress has used its jurisdiction to enact criminal law in certain, limited and specific areas. In most states, people living with HIV have been or are susceptible to criminal sanctions for HIV non-disclosure, exposure or transmission.[23]

Some states have relied upon general criminal laws and offences such as reckless endangerment, assault, terrorist threats, homicide and attempted homicide to address HIV transmission.[24] Many states have "communicable" or "contagious disease" control statutes that criminalize exposure to STIs, many of which in theory could include HIV, but for the most part are rarely applied.[25] State prosecutors rarely use these general STI misdemeanour laws against those with any form of STI, including HIV; rather, in cases of alleged HIV exposure or non-disclosure, most states rely on HIV-specific statutes or more serious criminal laws on, for example, attempted murder, reckless endangerment and sexual assault.[26]

Proof of intent to transmit HIV, or actual transmission, typically are not elements of these prosecutions.[27] Failure to disclose one's HIV status to a partner is most often the triggering basis for prosecution, rather than intent to infect someone else or actual transmission of HIV.[28] Spitting or throwing HIV-infected bodily fluids at another person while in prison is also an offence in some states.[29] Before 2001, 23 percent of U.S. cases that had passed through the courts were for spitting, biting, scratching or throwing body fluids, despite scientific evidence that such behaviour cannot transmit HIV.[30]

Studies to date demonstrate that these laws have little or no impact on risk-taking behaviour.[31] Many state laws, and their enforcement, have been "overbroad," resulting in convictions where there was no scientific basis to conclude that there was a risk of transmission or endangerment.[32] By defining prohibited conduct in terms of HIV-status and activity, individuals are prevented from demonstrating that their conduct was not sufficiently risky to merit criminalization, and the laws are thus over-inclusive.[33]

Testimony of defendants with HIV is often discounted, particularly in cases where the defendant is accused

of non-disclosure of HIV status by a sexual partner.[34] Prosecutions under HIV-specific statutes are particularly prone to targeting marginalized groups and reflecting jury prejudices.[35]

The HIV-related laws in question were initially driven by the *Ryan White Care Act* of 1990 (U.S. federal legislation that required states to introduce laws criminalizing exposure to HIV as a condition of federal funding).[36] Today, increasing calls for criminalizing HIV transmission and exposure — primarily driven by the fear and prejudice that has accompanied the pandemic since it first appeared — now appear to be resulting from the failure of governments and non-governmental organizations to equally and adequately reach key populations in HIV outreach, education, care and treatment.

Criminalizing HIV transmission and exposure results only in further marginalization of key populations and reinforces HIV-related stigma.

The efforts at criminalization are misplaced and counter-productive, resulting only in further marginalization of key populations, preventing them from seeking or obtaining appropriate education, care or treatment. These laws further contribute to and reinforce HIV-related stigma and discrimination, especially when such cases are sensationalized by the media. The harm caused by unjustified prosecutions and convictions and stigma is not counter-balanced by any evidence of public health benefits of this use of criminal law. These laws should urgently be repealed or reformed as part of a shift to strategies centred on individual rights and accurate medical science.

Ban on federal funding of syringe exchange programs

In the U.S., injection drug users (IDUs) represented 9 percent of new HIV infections in 2009 and 17 percent of those living with HIV in 2008.[37] The Centers for Disease Control (CDC) estimate that people who use drugs, their partners and their children comprise one-third of all AIDS cases.[38] Syringe exchange programs have long demonstrated the increase in the availability of sterile syringes and consequent, reliable reduction in needle sharing among IDUs. Properly designed, such programs will provide sterile injection equipment to IDUs ensure used needles and syringes are returned for new ones and make the supply of free and legal sterile injection equipment constant.[39]

Moreover, as program staffers' contact with IDUs increases, the goal is to establish trust and rapport and to facilitate not only "safer" injection practices but entry into treatment for drug abuse. They are an important tool for reducing HIV infection and other blood-borne diseases among IDUs and their often unknowing sexual partners and children.[40]

Extensive studies have shown that syringe exchange programs do not increase the number of new drug injectors.[41] Further, where such programs include drug counselling and treatment program referrals, they actually reduce drug use and crime.[42]

The American Medical Association (AMA) has long recognized the value of syringe exchange for reducing HIV.[43] In 1997, the ABA issued the following policy recommending the removal of legal barriers to syringe exchange programs:

> RESOLVED, That in order to further scientifically based public health objectives to reduce HIV infection and other blood-borne diseases, and in support of our long-standing opposition to substance abuse, the American Bar Association supports the removal of legal barriers to the establishment and operation of approved needle exchange programs that include a component of drug counselling and drug treatment referrals.[44]

In issuing this recommendation, the ABA relied upon the significant and serious weight of scientific evidence showing the value of syringe exchange in the prevention of HIV and other blood-borne diseases, and recognizing the need to remove legal barriers to syringe exchange programs that were blocking the implementation of the medical science on HIV prevention.[45]

Despite this evidence and the recommendations of neutral experts and advocates alike, the federal government imposed a ban on federal funding for syringe exchange programming in 1998. In the case of the District of Columbia, Congress went even further by banning the District from using even its own, local funds for such programs.[46] As a result, by 2009, the city's prevalence[47] was a shocking 3 percent, well above the 1 percent benchmark for a generalized epidemic[48] and more than 20 percent

of the persons living with HIV in the city were infected via intravenous drug use.[49]

As the data rolled in and the runaway DC epidemic gained headlines, advocates continually fought for the repeal of the ban. Finally, in 2010, more than twenty years after its imposition, Congress passed the *Consolidated Appropriations Act of 201*0, which allowed state and local health departments to use federal funds to establish syringe exchange programs.[50]

Evidence shows that syringe exchange programs are positive public health interventions that do not lead to increased drug use.

Unfortunately, Congress recently reinstated the ban on the use of federal funds for syringe exchange programming, once again citing concern that it promotes drug use, despite evidence that continues to show that such programs are positive public health interventions that do not lead to increased drug use.[51]

Although the latest version of the ban does not prohibit the District of Columbia from using its own funds for syringe exchange, it precludes the use of vital additional federal funding to both the District and the states. With local and state governments suffering budget shortfalls, federal funds were and remain critical to the continued existence of syringe exchange programs that meet local needs and protect communities.

In the state of New York, for example, syringe exchange programs authorized by the state health commissioner collectively provide three million sterile syringes annually, along with HIV and hepatitis prevention and testing and linkage to primary care and drug treatment. Syringe exchange programs in New York have made more than 175 000 referrals to detoxification and substance abuse treatment programs, health care services, HIV counselling and testing, and social services.

New York's syringe access programs represent a national model and a major success story in the fight against HIV/AIDS: the proportion of new diagnoses in New York attributable to injection drug use decreased from 52 percent of new AIDS cases in 1992 to 5.4 percent of new HIV cases in 2008. As the historic epicentre of the HIV/AIDS epidemic in the U.S., New York relies on preserving flexibility in use of federal funds for syringe exchange in order to meet the continued challenges of disease prevention and public health.

HIV and the American Disabilities Act

The federal *Americans with Disabilities* Act (ADA) and other federal and state laws prohibit places of 'public accommodation' from discriminating on the basis of a real or even a perceived disability,[52,53] including HIV status.[54]

There is an exception within the ADA for the "direct threat" situation. A place of public accommodation can deny the accommodation if the individual poses a "direct threat" to the health or safety of others.[55] "Direct threat," as defined by the statute, describes the existence of "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."[56] Thus, although the plaintiff may have a disability (i.e., HIV), and the defendant is a qualifying entity under the ADA (i.e., a place of public accommodation), the plaintiff is not otherwise qualified for protection by the ADA because he or she is perceived or determined to pose a direct threat.

To determine whether an individual poses a "direct threat," the place of public accommodation must make "an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk."[57]

The analysis will turn on the court's weighing of the available medical evidence. A service provider is not entitled to demand absolute safety, but can rely only upon the direct threat defence in response to significant risks.[58] The issue of whether and under what circumstances an individual's HIV status could be considered to pose such a "direct threat" is at the heart of a current lawsuit over discrimination on the basis of HIV status.

On 30 November 2011, the AIDS Law Project of Pennsylvania filed a federal discrimination lawsuit against the Milton Hershey School in Hershey, Pennsylvania, for refus-

ing to enrol an HIV-positive honour roll pupil, using the pseudonym "Abraham Smith."[59] The complaint, filed in U.S. District Court in Philadelphia, alleges that the school "violated multiple anti-discrimination laws" when it refused to enrol the student for the 2011–12 school year, based solely on his HIV status. Among other things, the suit seeks to have the school admit the 13-year-old, develop an anti-discrimination policy and conduct sensitivity training for all staff regarding HIV disease.

The Milton Hershey School is a cost-free, private, coeducational home and school for pre-kindergarten through 12th grade.[60] It requires students to "come from a family of low income, limited resources, and social need; be from the ages of 4–15 years old; have the ability to learn; be free of serious emotional and behavioral problems … ; be able to take part in the School's program; and be born in the United States."[61] The school denied Smith admission on the basis of his HIV-positive status, but asserted that they did so within the confines of the law.

The school was primarily concerned that, as it is prohibited by law from informing the community regarding Smith's HIV-positive status, Smith may potentially engage in sexual activity under its care. The school acknowledges that HIV is not transmitted through casual contact and that universal precautions can prevent transmission in typical school settings.[62] Indeed, according to the National Association of State Boards of Education, "the presence of a person living with HIV infection or diagnosed with AIDS poses no significant risk to others in school, day care, or school athletic settings."[63]

However, it argues that its residential setting poses unique concerns.[64] Despite the school's efforts to encourage abstinence and other sexual education, teens may engage in sexual contact.[65] The school also acknowledges that, when an individual is on antiretrovirals, risk of transmission is low. Nonetheless, it (or the School) concluded that "the risk was significant, and rose to the level of a direct threat to the health and safety of others."[66] In a world where people are not aware of the science of HIV transmission risk or are plagued by stigma, the virus becomes perceived as a "direct threat."

AIDS Law Project Executive Director Ronda B. Goldfein is representing Abraham Smith in his suit against the school. Goldfein has remarked on the similarities between her client and the late Ryan White, an HIV-positive student who became a national spokesman for AIDS research and public education and against HIV discrimination and stigma.[67] Like White, Smith is a 13-year-old boy seeking to enter the 8th grade, confronting the same unfounded fear and ignorance about HIV. The key difference is that, in 1985, little was known about how people contracted HIV, AIDS hysteria was rampant and little was known or understood about transmission and risk, much less treatment. Today, the science of HIV prevention, care and treatment is well known and understood.

In the climate of fear and ignorance about HIV, White was expelled from 8th grade in Indiana. He endured a long legal battle fighting for the right to go to school and eventually became a national spokesman for AIDS research and education, and the namesake for the *Ryan White Comprehensive AIDS Resources Emergency (CARE) Act*.[68] Nearly two decades after Ryan White was denied a seat in class, the Hershey School has turned back time to an age of fear of ignorance.

"Like Ryan White, this young man is a motivated, intelligent kid who poses no health risk to other students, but is being denied an educational opportunity because of ignorance and fear about HIV and AIDS," Goldfein noted.[69] According to the complaint, Smith "is an honor roll student and an avid athlete." He controls his HIV through a regimen of medication that "do[es] not impact his school schedule." Goldfein asserts that Smith meets the admission criteria, but "just also happens to have HIV — which the school has determined is a 'documented need' it cannot meet. But my client does not need any special accommodations, nor did he ask for any."

Conclusion

Our scientific understanding of HIV, AIDS and the nature of the epidemic has come a long way since 1981. Policies and official government action in the U.S. have not kept pace and remain significantly influenced by stigma and discrimination stemming from ignorance and fear about the disease. This must end. HIV-specific criminal laws should urgently be repealed or reformed as part of a shift to strategies centred on individual rights and accurate medical science. The ban on federal funding for syringe exchange programming should be lifted, as public health laws should be grounded in public health science. Individuals living with HIV should have the same opportunities as those without the virus and should not be excluded or discriminated against on the basis of their HIV

status. It is time to put our scientific understanding into action and end HIV discrimination in the U.S.

— Ginna Anderson and Amy Hsieh

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[1] Centers for Disease Control and Prevention, *HIV in the United States*. November 2011. On-line: www.cdc.gov/hiv/resources/factsheets/us.htm.

[2] Ibid.

[3] Ibid.

[4] See Kaiser Family Foundation, *HIV/AIDS Policy Fact Sheet: U.S. Federal Funding for HIV/AIDS: The FY 2009 Budget Request.* April 2008. On-line: /www.kff.org/hivaids/upload/7029-041.pdf.

[5] The black community, for example, has been disproportionately affected by HIV/AIDS since the epidemic's beginning, and that disparity has deepened over time. Blacks account for more new HIV infections, AIDS cases, people estimated to be living with HIV disease and HIV-related deaths than any other racial/ethnic group in the U.S. Although blacks represent only 14 percent of the US population, an estimated 44 percent of new HIV infections in 2009 were from the black community. In addition, the epidemic has had a disproportionate impact on black women, youth and men who have sex with men, and its impact varies across the country. See Centers for Disease Control and Prevention, *HIV among African Americans*. November 2011. On-line: www.cdc.gov/hiv/topics/aa/index.htm. See also Kaiser Family Foundation, *HIV/AIDS Policy Fact Sheet: Black Americans and HIV/AIDS*. October 2008. On-line: www.kff.org/hivaids/upload/6089-061.pdf.

[6] See, e.g., *ABA General Policy on HIV and AIDS* (Adopted 1989, revised 1990) (recommending, among other recommendations, that state and local governments enact and enforce legislation prohibiting discrimination in employment, housing, or other government services on the basis of HIV status, ensure that minority communities receive equal access to HIV-related treatment, prevention, and research programs, affirming that a student should not be excluded from school because of known or perceived HIV status, and recommending that state and localities support appropriate public health education and medical interventions); see also, *ABA Recommendation on Needle Exchange* (Adopted 1997) ("[I]n order to further scientifically based public health objectives to reduce HIV infection . . . the American Bar Association supports the removal of legal barriers to the establishment and operation of approved needle exchange programs . . . ."); *ABA Recommendation on International Human Rights and HIV* (adopted 2004) (urging "the Government of the United States to implement legislation, policies, programs, and international agreements that address or are relevant to the HIV/AIDS pandemic in a manner consistent with international human rights law and science-based prevention, care, support, and treatment.").

[7] See, e.g., G.M. Herek, "AIDS and stigma," *American Behavioral Scientist*, 42 (1999): pp 1102–1112. ("Whereas the characteristics of AIDS as an illness probably make some degree of stigma inevitable, AIDS has also been used as a symbol for expressing negative attitudes toward groups disproportionately affected by the epidemic, especially gay men and injecting drug users (IDUs).").

[8] Kaiser Family Foundation, *HIV/AIDS at 30: A Public Opinion Perspective.* December 2011. On-line: www.kff.org/kaiserpolls/upload/8186.pdf.

[9] See, e.g., G.M. Herek and J.P. Capitanio, "AIDS stigma and sexual prejudice," *American Behavioral Scientist*, 42 (1999): pp. 1126–1143. (The study found that "[m]ost heterosexuals continue to associate AIDS primarily with homosexuality or bisexuality, and this association is correlated with higher levels of sexual prejudice (antigay attitudes)").

[10] The World Health Organization and UNAIDS estimate that the number of years a person living with HIV survives without treatment is, on average, eleven years. See UNAIDS, *AIDS epidemic update*. December 2007.

[11] The age-adjusted HIV-related death rate in the United States dropped from 17 per 100 000 people in 1995 to about 5 per 100 000 people by the end of the decade. See Centers for Disease Control and Prevention, *Trends in Annual Age-Adjusted Rate of Death due to HIV Disease, United States, 1987 — 2006.*

[12] See, e.g., A. Van Sighem A, "Life expectancy of recently diagnosed, asymptomatic HIV-infected patients approaches that of uninfected individuals." Seventeenth Conference on Retroviruses and Opportunistic Infections, San Francisco, abstract 526 (2010) (available at AIDSmap.com); see also K.M. Harrison, "Life expectancy after HIV diagnosis based on national surveillance data from 25 states," *Journal of Acquired Immune Deficiency Syndromes* 53(1) (2010): pp. 124–30.

[13] A viral load test shows how much HIV there is in a small sample of blood. The lower the viral load, the less HIV is found in the blood. The aim of HIV treatment is to reduce viral load to a level that is too low to be measured by standard tests, also known as an "undetectable" viral load. This means HIV is still present in your body, but at a low level. The HPTN 052 study showed that initiation of ART, which reduces and controls viral loads, can reduce sexual transmission rates by 96 percent. As research is rapidly developing in this area, it is critical to rely on the most current data available regarding exposure and transmission risk.

[14] Centers for Disease Control and Prevention, *Effect of Antiretroviral Therapy on Risk of Sexual Transmission of HIV Infection and Superinfection*. August 2009. On-line: www.cdc.gov/hiv/topics/treatment/resources/factsheets/art.htm.

[15] M. Cohen et al, "Prevention of HIV-1 Infection with Early Antiretroviral Therapy," *New England Journal of Medicine* 365 (2011): pp. 493–505

[16] World Health Organization, *Condoms for HIV Prevention*. On-line: www.who.int/hiv/topics/condoms/en/; D. Wilkinson, "Condom effectiveness in reducing heterosexual HIV transmission," *The WHO Reproductive Health Library.* On-line: http://apps.who.int/rhl/hiv_aids/dwcom/en/index.html.

[17] *National HIV/AIDS Strategy for the United States*. On-line: www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

[18] Ibid. at iii.

[19] Ibid. at vii.

[20] Ibid. at p. 36.

[21] Ibid. at pp. 36–7.

[22] *United States v. Schoolfield*, 40 M.J. 132 (C.M.A. 1994) (holding that HIV-positive service member who had unprotected sex with a woman on five occasions without disclosure of his HIV status, but without evidence that he intended to infect her with HIV, was guilty of aggravated assault), cert. denied, 513 U.S. 1178 (1995).

[23] Kaiser Family Foundation, *Criminal statutes on HIV transmission.* 2008. On-line: www.statehealthfacts.org/comparetable.jsp?ind=569&cat=11.

[24] See, e.g., ALA. ADMIN. CODE r. 420-4-1-.03(2008). Alabama law defines a person as acting "knowingly" when "he is aware that his conduct is of that nature of that the circumstance existed." ALA. CODE § 13A-2-2(1975).

[25] See, e.g., CAL. HEALTH & SAFETY CODE § 120600 (West 2010); LA. REV. STAT. ANN. § 40:1062 (2008); MONT. CODE ANN. § 50-18-112 (1989); N.Y. PUB. HEALTH LAW § 2307 (McKinney 2001); S.C. CODE ANN. § 44-29-60 (2009); TENN. CODE. ANN. § 68-10-107 (2010); VT. STAT. ANN. TIT. 18 § 1106 (1973); W. VA. CODE § 16-4-20 (2010). There has never been a prosecution for HIV exposure under any of these statutes. Prosecutions for HIV exposure, if any, have arisen out of the general criminal law or HIV-specific exposure statutes of these states.

[26] R. Bennett-Carlson et al., *Ending & Defending against HIV Criminalization: A Manual for Advocates Vol. 1*, 1st ed., Positive Justice Project, Center for HIV Law & Policy and Lambda Legal, 2010. On-line: www.hivlawandpolicy.org/resources/view/564.

[27] Ibid. at p. 222.

[28] Ibid. at p. 134.

[29] See, e.g., *Ginn v. State*, 667 S.E.2d 712 (Ga. Ct. App. 2008) (affirming conviction in case that resulted from the defendant's former sexual partner applying for an arrest warrant with magistrate court and giving a statement to sheriff's department against the defendant for failing to inform him of her HIV status, although her HIV status was published on the front page of a local newspaper before she commenced the sexual relationship).

[30] Z. Lazzarini et al., "Evaluating the Impact of Criminal Laws on HIV Risk Behavior," *Journal of Law, Medicine and Ethics* 30 (2) (2002).

[31] *National HIV/AIDS Strategy for the United States* (supra) at p. 37.

[32] R. Bennett-Carlson et al. (supra).

[33] M. Kaplan, "Restoring Reason to HIV-Exposure Laws," *Indiana Law Journal* 87 (2011).

[34] Ibid.

[35] Ibid.

[36] *Ryan White Comprehensive AIDS Resources Emergency Act of 1990,* Title XXVI — Preventive Health Services with respect to Acquired Immune Deficiency Syndrome, §2609.

[37] Centers for Disease Control and Prevention, *HIV in the United States* (supra).

[38] TheBody.com, *Needle Exchange Questions and Answers.* 2009. On-line www.thebody.com/content/whatis/art46390.html.

[39] "Editorial: The Evaluation of Needle Exchange Programs," *American Journal of Public Health* 89 (1994): p. 1890.

[40] Center for AIDS Prevention Studies, *Does Needle Exchange Work?* On-line: /www.caps.ucsf.edu/pubs/FS/NEPrev.php#2.

[41] D. Vlahov et al., "Needle exchange programs for the prevention of human immunodeficiency virus infection: epidemiology and policy," *American Journal of Epidemiology* 154 (2001): pp. S70–S77.

[42] C.A. Latkin et al., "Needle exchange utilization and entry to drug treatment: is there a long-term connection in Baltimore, MD?" *Substance Abuse and Misuse* 14 (14) (2006): pp. 1991–2001.

[43] American Medical Association, Policy Compendium, House of Delegates Policy 95.958.

[44] ABA Resolution Regarding Needle Exchange (Resolved August 1997). On-line: www.americanbar.org/groups/individual_rights/projects/aids_coordinating_project/policy.html.

[45] Ibid.

[46] The District of Columbia is a federal district and therefore Congress has ultimate control over its local government, including how it may use its funds.

[47] HIV prevalence is the percentage of the population living with HIV.

[48] *District of Columbia HIV/AIDS Epidemiology 2008 Report.* On-line http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/pdf/dc_hiv-aids_2008_updatereport.pdf.

[49] DC Department of Health, *DC Behavior Study #3.* On-line: http://newsroom.dc.gov/file.aspx/release/22050/DC%20IDU%20Study%202011.pdf

[50] See, e.g., Gay Men's Health Crisis, "President Obama and Congress Remove Federal Ban on Syringe Exchange Programs," news release, 16 December 2009 (welcoming the removal of the ban for the prevention of HIV and as a means to link injecting drug users with treatment and care).

[51] DC Department of Health (supra).

[52] 42 U.S.C. §12182, et seq.; 28 C.F.R. §36.102, et. seq.

[53] 42 U.S.C. §12181(7)(J).

[54] *Abbott v. Bragdon*, 107 F.3d 934, 939 (1997).

[55] 42 U.S.C. § 12182(b)(3)*;* *Abbott v. Bragdon* (supra).

[56] *Abbott v. Bragdon* (supra).

[57] Ibid.

[58] Ibid. at 948.

[59] *Smith v. Milton Hershey School*, 2:2011cv07391, Pennsylvania Eastern District Court (2011). On-line: www.aidslawpa.org/wp-content/uploads/2011/01/FederalComplaint.pdf.

[60] Milton Hershey School, "Statement from Milton Hershey School on Lawsuit Filed by the AIDS Law Project of PA," 2011. On-line www.mhs-pa.org.

[61] *Smith v. Milton Hershey School* at p.5 ¶26.

[62] Milton Hershey School (supra).

[63] National Association of State Boards of Education, *Someone at School has AIDS: A Complete Guide to Education Policies Concerning HIV Infection*. 2001. On-line: www.eric.ed.gov/ERICWebPortal/contentelivery/servlet/ERICServlet?accno=ED465735.

[64] Milton Hershey School (supra).

[65] Ibid.

[66] Ibid.

[67] AIDS Law Project of Pennsylvania, "Milton Hershey School is Hit with Federal Lawsuit for Refusing to Enroll HIV-positive Honor Roll Pupil," news release, Philadelphia, 30 November 2011.

[68] *Ryan White Care Act*, Ryan White, Pub.L. 101–381, 104 Stat. 576, enacted August 18, 1990.

[69] AIDS Law Project of Pennsylvania (supra).