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REVIEW

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Preventing Mother-to-Child Transmission: Landmark Decision by South African Court

On 14 December 2001, the High Court of South Africa delivered its judgment in *Treatment Action Campaign et al* v *Minister of Health et al*,[1] ruling that the government was in breach of its constitutional obligations and must promptly develop and implement a comprehensive national program to prevent mother-to-child transmission of HIV, including making antiretroviral drugs available for this purpose. This article summarizes the legal arguments and the outcome of a case that is of global significance in holding governments accountable for their obligations to progressively realize the human right to health.

On 26 November 2001, the High Court of South Africa began hearing the Treatment Action Campaign's case against the national Minister of Health and the members of the Executive Councils for Health of eight of South Africa's nine provinces.[2] This case – the culmination of almost four years of intense lobbying, advocacy, and public mobilization – dealt with issues of life and death, and has come to symbolize the failure of the South African government to deal decisively with the HIV/AIDS epidemic.

The background to the case is

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Compulsory HIV Testing after an Occupational Exposure

In December 2001, the Ontario legislature passed Bill 105, authorizing a Medical Officer of Health to order blood testing of a source person in the event that emergency service workers and "good Samaritans" (as well as other categories of people) may have been exposed to a communicable disease. Similar legislation (Bill C-217) was considered in February 2002 by a committee of the House of Commons, which recommended it not proceed. This article discusses the value of information about the health status of the source person, Bill C-217 and Bill 105, current public health guidelines, recent Canadian research, and the conclusions of a *Backgrounder* prepared by the Canadian HIV/AIDS Legal Network.

The Value of Information from Source Persons

In the event of an occupational exposure to blood or body fluids, information about the serological status, risk factors, and medical history of the person who may be the

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CANADIAN HIV/AIDS POLICY & LAW REVIEW

The *Review* is a summary of developments in HIV/AIDS policy and law in Canada and abroad. Its aim is to educate people about and inform them of policy and legal developments and to promote the exchange of information, ideas, and experiences. It is published every four months by the Canadian HIV/AIDS Legal Network.

Contributions are welcome and encouraged. Please contact Anne Renaud at the following address to discuss your article and to obtain a copy of our style guide:

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Canadian HIV/AIDS Legal Network
The Network is a charitable organization engaged in eduation, legal and ethical analysis, and policy development. We promote responses to HIV/AIDS that

- implement the International Guidelines on HIV/AIDS and Human Rights;
- respect the rights of people with HIV/AIDS and of those affected by the disease;
- facilitate HIV prevention efforts;
- facilitate care, treatment, and support to people with HIV/AIDS;
- minimize the adverse impact of HIV/AIDS on individuals and communities; and
- address the social and economic factors that increase the vulnerability to HIV/AIDS and to human rights abuses.

We produce, and facilitate access to, accurate and up-to-date information and analysis on legal, ethical, and policy issues related to HIV/AIDS, in Canada and internationally. We consult, and give voice to, Network members and a wide range of participants, in particular communities of people with HIV/AIDS and those affected by HIV/AIDS, in identifying, analyzing, and addressing legal, ethical, and policy issues related to HIV/AIDS. We link people working on or concerned by these issues. We recognize the global implications of the epidemic and incorporate that perspective in our work.

The Network is based in Montréal. We welcome new members. For membership information, contact Anne Renaud at arenaud@aidslaw.ca.

We would like to hear your views and opinions regarding the* Review, *its content and format. We also encourage comments on or responses to individual articles, and letters to the editor.

Comments?

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HIV/AIDS IN THE COURTS – INTERNATIONAL

EDITORIAL

Changes to the *Review*

The *Review* is making a number of changes with this issue. From now on, it will be published three times a year. Each issue will provide regular information about recent developments in four key areas: Canadian News, International News, Global Access to Treatments, and HIV/AIDS in the Courts – Canada and International. There will no longer be a separate section on criminal justice. Instead, articles on criminal law and HIV transmission/exposure will be included in the other regular sections. The *Review* will continue to publish feature articles on HIV/AIDS policy and law in Canada and abroad. However, it will no longer publish reviews of books and other literature. With the limited space available to it, the *Review* cannot hope to provide even selective coverage of recent literature on HIV/AIDS policy and law.

We are strengthening our coverage of Canadian News and International News. Each of these sections now has its own editor – David Garmaise for Canadian News, and David Patterson for International News. They are establishing a network of correspondents across Canada and throughout the world. We welcome these two editors and their correspondents – many of whom have contributed to this issue – and look forward to the news they will bring on developments in HIV/AIDS policy and law.

About This Issue

Recent events in Canada and internationally show once again how developments in one country resonate with those in another, both for good and for ill.

In International News, this issue reports on initiatives to inform parliamentarians in Africa, South and Central America, and the United Kingdom about the HIV/AIDS epidemic and engage them in collaborative efforts to address it. As the report of the UK All-Party Parliamentary Group on AIDS underscores, the International Guidelines on HIV/AIDS and Human Rights is an important tool in this regard. It can be used both to build parliamentary consensus and to evaluate governmental HIV/AIDS policies and programs.

The recent enactment of Bill 105 in Ontario, reported in Canadian News, is an example of what can happen in the absence of informed and engaged parliamentarians. Under the new legislation, a Medical Officer of Health can order blood testing of a "source person" when victims of crime, emergency service workers, and others have reason to believe that they may have been exposed to a communicable disease. The legislation was passed together with numerous other bills just before the legislature recessed in December 2001. There were no public hearings on the bill. The only witness called by the Standing Committee on Justice and Social Policy, the province's Chief Medical Officer of Health, opposed the legislation. Nevertheless, the bill was passed with only two members voting against it.

To pass such legislation *against* the advice of the Chief Medical Officer of Health and without publicly consulting all interested parties is a betrayal of the trust that the public places in its elected representatives.

When governments pass legislation or institute policy in the absence of public consultation, due consideration of all the evidence, and transparent reasoning, it may be necessary to turn to the courts. In South Africa, the Treatment Action Campaign, supported by the Save Our Babies Campaign and the Children's Rights Centre, successfully challenged the government's refusal to provide nevirapine to pregnant women with HIV or to set out a reasonable implementation plan for a program to prevent the transmission of HIV from mother to child (see the cover of this issue). In a judgment against the government, the High Court stated "that the policy of [the national government and eight of the nine provincial governments] in prohibiting the use of nevirapine outside the pilot sites in the public health sector is not reasonable and that it is an unjustifiable barrier to the progressive realization of the right to health care."

While it is heartening to see such a judgment rendered on the strength of arguments appealing to rights guaranteed to South Africans in their Constitution and under international law, there are better ways to develop policy and legislation relating to HIV/AIDS, even in situations (such as occupational exposure) where there are trade-offs that cannot easily be reconciled. But these ways require informed and engaged parliamentarians, as well as governments that respect the rights of their citizens, do not ignore evidence, and work through transparent and public processes

It is encouraging, therefore, that the Canadian House of Commons Standing Committee on Justice and Human Rights not only held public hearings on a federal private member's bill authorizing compulsory blood testing after an occupational exposure (Bill C-217, the *Blood Samples Act*), but also would recommend that the bill not go forward after hearing the grave concerns of the Privacy Commissioner of Canada, the British Columbia Civil Liberties Association, the Canadian Criminal Justice Association, the Canadian Bar Association, the Canadian Public Health Association, the Canadian Nurses Association, and several HIV/AIDS organizations, including the Network (see the cover of this issue). This confirms the important role that such organizations have in promoting, among parliamentarians as well as the public, laws and policies that respect human rights in relation to HIV/AIDS.

FEATURES

Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues

In the face of an ongoing and escalating health crisis among injection drug users in Canada, calls are coming from many quarters to initiate safe injection facilities as a way to reduce overdoses, the spread of bloodborne diseases, and other health and community problems associated with injection drug use. This article summarizes a paper on safe injection facilities released in April 2002 by the Canadian HIV/AIDS Legal Network.[1] The paper contributes to the policy discussion in Canada and sets out why and how the law should support the introduction of safe injection facilities.

What Are Safe Injection Facilities?

Injection drug use presents a growing health crisis for Canada. People who inject drugs face serious potential health risks, including risks of fatal and non-fatal overdoses and bloodborne diseases such as HIV/AIDS and hepatitis C.

One partial solution that has been suggested is the establishment – initially by way of a trial – of "safe injection facilities" (also known as "safe injection sites" or "supervised injection facilities"). This strategy has been used successfully in Switzerland, Germany, and the Netherlands and, most recently, at a trial facility in Australia. In November 2001, Canada's federal, provincial, and territorial ministers of health tasked an intergovernmental committee with examining the feasibility of establishing a safe injection facility as a scientific, medical research project.

Safe injection facilities are places where drug users are able to inject using clean equipment under the supervision of medically trained personnel. The drugs are not provided by anyone at the facility, but are brought there by the drug users. The professional staff do not help to administer the drugs, but assist users in avoiding the consequences of overdose, bloodborne diseases, or other negative health effects (such as abscesses) that may otherwise result from using unclean equipment and participating in unsafe injecting practices.

Safe injection facilities also help direct drug users to treatment and rehabilitation programs, and can operate as a primary health-care unit. Facilities provide free sterile equipment, including syringes, alcohol, dry swabs, water, spoons/cookers, and tourniquets. The facilities are intended to reduce incidents of unsafe use of injection drugs and to prevent the negative consequences that too often result from unsafe injection. They are not "shooting galleries," which are not legally or officially sanctioned and are often unsafe because they do not offer hygienic conditions, access to sterile injection equipment, supervision and immediate access to health-care personnel, or connections to other health and support services.

What Is the Goal of the Paper?

The goal of the Network's paper is to contribute to the informed development of Canadian law and policy that supports harm-reduction measures such as safe injection facilities. The paper demonstrates that promoting the well-being of both drug users and communities requires changes to drug laws and policies, including the introduction of safe injection facilities, and that such measures can and must be initiated, with a view to reducing the harms associated with drug use and the harms caused by drug policies themselves.

The paper follows the 1999 publication of the Canadian HIV/

AIDS Legal Network's Final Report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, which addressed a variety of issues but did not specifically analyze the legal and ethical questions related to safe injection facilities. It also follows numerous reports in Canada that have specifically addressed the issue of safe injection facilities and have called for the implementation or at least a trial of such facilities as one important part of Canada's overall strategy in responding to the use of injection drugs and related harms.[2]

> Numerous reports in Canada have called for the implementation or a trial of safe injection facilities.

What Does the Paper Contain?

The paper describes the extent and severity of Canada's injection drug use problem, and the ongoing health crisis among drug users. It describes the kinds of approaches adopted in response to drug use, ranging from those that are prohibitionist in nature to those that are multi-faceted and incorporate harm-reduction initiatives.

The paper then reviews the arguments for and against the introduction of safe injection facilities. It concludes that many of the arguments against are ill-conceived or overstated. Moreover, they are outweighed by the likely benefits of safe injection facilities.

The paper discusses the successful implementation of safe injection facilities in several European jurisdictions and recent initiatives in Australia. It concludes from the available evidence that including safe injection facilities as one harm-reduction component of a broader policy response to injection drug use is likely to produce significant benefits for both drug users and the general community, and that at the very least such initiatives must be tried.

Having reviewed the arguments for and against such facilities, and the experience to date with them in several other countries, the paper addresses international and domestic legal issues related to establishing safe injection facilities.

First, the paper explains why the refusal to introduce safe injection facilities may be a violation of Canada's human rights obligations under international law, particularly the legal obligation to take legislative and other measures to progressively realize the right to health of all Canadians, including those who use illegal drugs.

The paper then reviews international drug control treaties and concludes that they do not prevent Canada from establishing safe injection facilities, and in fact make allowances for such programs.

The paper also examines questions of criminal and civil liability raised by the operation of safe injection facilities, and concludes that such concerns can be addressed.

The paper briefly discusses the argument that, for failing to implement or at least experiment with safe injection facilities, governments might be held liable for negligence or for failing to discharge their constitutional obligations.

Finally, the paper outlines the legal mechanisms currently available in Canadian law that could be used to permit a trial of safe injection facilities, and presents several recommendations regarding key elements of a supportive legal framework to govern their operation.

What Are the Recommendations in the Paper?

The paper presents six recommendations for immediate action by government(s) in Canada regarding safe injection facilities:

1. The federal government should update Canada's Drug Strategy to expressly support trials of safe injection sites as harm-reduction measures that are an important component of the overall policy response to the harms associated with injection drug use.
2. The federal government should create a regulatory framework under the *Controlled Drugs and Substances Act* (CDSA) to govern safe injection facilities that would eliminate the risk of criminal liability for staff and clients and reduce the risk of civil liability for operating such facilities.
3. That regulatory framework should address such issues as the conditions of access to the facility, the activities and services permitted on the premises, and minimum administrative requirements aimed at ensuring facilities' safe and effective operation. In particular, the regulatory framework devised under the CDSA that would exempt approved facilities from the Act:
   - should not restrict access to safe injection facilities to adults only, but should allow for drug using youth;

- should not deny access to pregnant women;
- should not deny access to drug users accompanied by children;
- should not automatically deny access to drug users simply because they are intoxicated;
- should prohibit the sharing of injection equipment between clients of safe injection facilities;
- should prohibit the sharing or selling of drugs on the premises of the facility;
- should only allow clients to self-inject, prohibiting staff from assisting with injection;
- should require that security considerations be taken into account in the physical set-up of safe injection facilities and that security personnel be on site during all hours of operation; and
- should require that some staff be medically qualified nurses or physicians and that all staff be trained in basic first aid, responding to drug overdose, crisis management, and all facility policies and procedures covering matters such as security, confidentiality of client information, referrals to other services, etc.

4. In the interim, before such a regulatory framework is in place, the federal Minister of Health should grant ministerial exemptions from the application of relevant provisions of the CDSA to designated safe injection facilities (and needle exchange programs), and to their staff and clients, so that such facilities can operate on a trial basis.
5. Health Canada should fund the operation and evaluation of a multi-site scientific research trial of safe injection sites, including research studies assessing the impact of safe injection sites on the health and well-being of drug users, public health, and affected communities.
6. Federal, provincial/territorial and municipal officials with responsibilities in the areas of health, social services and law enforcement should collaborate to ensure that trials of safe injections sites can occur as soon as possible.

Conclusion

Establishing safe injection facilities is but one of many strategies proposed to combat some of the harms associated with injection drug use. This measure is intended to respond to a discrete problem, adding a missing dimension to an existing array of measures – some of which seek to reduce drug addiction, others of which seek principally to reduce the harms associated with drug use and to temper the unproductive harshness of punitive approaches. Safe injection facilities have deliberately limited aims and objectives, their primary focus being to reduce the risks associated with injecting drugs, while providing an additional opportunity to bring drug users into contact with other health and support services (including treatment for addictions) and reduce the negative effects on the community of an open drug scene.

Resisting the introduction of safe injection facilities is unethical, but also amounts to a breach of Canada's international human rights obligations – for example, to fulfil attainable health-care standards. Such initiatives are permissible under international drug treaties, as scientific experiments in preventing ill health and enhancing treatment and rehabilitation. If safe injection facilities prove successful in trials (already demonstrated in Australia, Switzerland, Germany, and the Netherlands), they may well become permanent features of multi-faceted harm-reduction strategies in Canada. This would be permitted under the drug control treaties to which Canada is a party, as part of each state's right to assess what measures may be taken in accordance with its "prevailing conditions" and domestic requirements. Nor does Canadian law necessarily stand in the way of safe injection facilities; in fact, it could accommodate them relatively easily.

> International drug control treaties do not prevent Canada from establishing safe injection facilities.

Switzerland, the Netherlands, and Germany have demonstrated that providing safe injection facilities is possible and effective. Australia has recognized the need and is experimenting. Canada has an ethical obligation, and arguably a legal obligation (at least under international law), to implement a trial of safe injection facilities as a measure that poses a reasonable likelihood of protecting and promoting the health of Canadians. Federal, provincial, and municipal governments cannot continue to ignore the health risks associated with injection drug use and with counterproductive prohibitionist approaches. The time is overdue for government action to prevent further

needless illness and death as a result of unsafe drug use.

– Richard Elliott, Ian Malkin, & Jennifer Gold

Copies of this paper (and a series of info sheets summarizing the paper) can be retrieved at the website of the Canadian HIV/AIDS Legal Network at www.aidslaw.ca, or ordered through the Canadian HIV/AIDS Clearinghouse at tel 613 725-3434, fax 613 725-1205, email aidssida@cpha.ca.

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[1] R Elliott, I Malkin, J Gold. *Establishing Safe Injection Sites in Canada: Legal and Ethical Issues*. Montréal: Canadian HIV/AIDS Legal Network, 2002 (available via www.aidslaw.ca). This paper is an adaptation of an original article by Malkin on the need for safe injection facilities in Australia: I Malkin. Establishing supervised injecting facilities: a responsible way to help minimise harm. *Melbourne University Law Review* 2001; 25(3): 680.

[2] See, for example: T Kerr. *Safe Injection Facilities: Proposal for a Vancouver Pilot Project.* Prepared for the Harm Reduction Action Society. Vancouver, 2000; JV Cain. Report of the British Columbia Task Force into Illicit Narcotic Overdoses (Cain Report). Victoria, BC: British Columbia Ministry of Health, 1994; E Whynot. Health Impact of Injection Drug Use and HIV in Vancouver. Vancouver: Vancouver Health Board, 1996; Provincial Task Force on Addictions. "Weaving the Threads." Report commissioned by the Premier of British Columbia, 2001; Reducing the Harm Associated with Injection Drug Use in Canada. Report of the Federal/Provincial/Territorial Advisory Committee on Population Health, 2001.

Report on Complementary/Alternative Health Care and HIV/AIDS

In 2001, the Canadian HIV/AIDS Legal Network published a lengthy report on *Complementary/Alternative Health Care and HIV/AIDS: Legal, Ethical & Policy Issues in Regulation*. The document is the first in a series of papers to be produced by the Legal Network on priority legal and ethical issues related to HIV/AIDS care, treatment, and support. The article below summarizes the contents of the report.

Why a Paper on Complementary/ Alternative Therapies and HIV/AIDS?

The last decade (particularly the past five years) has seen increased interest in the use of complementary/alternative medicine (CAM) in Canada. Research in this field has increased significantly. The federal government has created a new regulatory framework for natural health products, and there are ongoing developments at the provincial level with respect to the recognition and regulation of some CAM practitioners. Community-based organizations working in the field of HIV/AIDS in Canada have been increasingly discussing what steps are necessary to ensure that people with HIV/AIDS have access to a range of treatment options and the necessary information to make informed choices about them.

A significant and increasing number of Canadians are using CAM, and some evidence suggests that its use is even higher among people with HIV/AIDS, who use various kinds of CAM in order to exercise control over their health, deal with depression, boost general immunity, prevent infection or delay the progression of HIV disease, or cope with unpleasant side effects of conventional drugs.

However, it is also clear that many people with HIV/AIDS must make these treatment decisions with limited access to reliable information about

the safety and efficacy of the therapies they use, including information about possible interactions with conventional drugs and the possible effects specific to people with compromised immune systems. This raises ethical and legal questions for those who use CAM, for conventional health-care professionals treating people with HIV/AIDS, for manufacturers of natural health products, for practitioners of various complementary/alternative therapies, and for governments and professional regulatory bodies that need to strike the right balance between protecting consumers/patients and respecting their health-care choices.

What Is the Goal of the Paper?

The paper does not recommend for or against any particular complementary/alternative therapy or practice, and does not attempt to address the host of legal and ethical issues raised by the use of CAM by people with HIV/AIDS. The principal focus is on considering the approach to regulating the field of CAM (both products and practitioners). The goal is to ensure that Canadian law and policy in the area of complementary/alternative health care is informed by the available data, by ethical considerations, and by an understanding of the relevant legal frameworks and principles.

What Does the Paper Contain?

The paper:

- discusses the difficulties in defining the precise scope of the field of complementary and/or alternative medicine;
- reviews the available evidence regarding the use of CAM by Canadians generally;
- reviews the available evidence regarding the use of CAM by people with HIV/AIDS, identifying some of the key conclusions to be drawn regarding the prevalence of use, and how and why people with HIV/AIDS use CAM;
- comments on some specific issues relevant to Aboriginal people and traditional Aboriginal healing practices;
- provides an analysis of ethical issues raised by the use of CAM, particularly on the part of people with HIV/AIDS, by applying the principles of non-maleficence, beneficence, respect for personal autonomy, and justice, and draws a number of conclusions as to what is ethically required in law, policy, and practice; and
- examines legal and policy issues regarding the appropriate regulatory approach to CAM in the areas of federal regulation of natural health products and provincial and territorial regulation of practitioners; and
- discusses the issue of practitioner liability in the delivery of CAM.

Three key themes emerge from the review of the available evidence and the ethical and legal analysis:

- the need for additional and better research on CAM;
- the need for improved education and training of health-care practitioners, both conventional and complementary/alternative, with regard to HIV/AIDS and CAM; and
- the need for a regulatory approach to products and practitioners that appropriately balances the ethical considerations.

What Are the Conclusions and Recommendations?

The paper presents a number of conclusions and recommendations in these three key areas. Recommendations include:

- funding research into the use of CAM by people with HIV/AIDS, their knowledge about CAM, the barriers to accessing CAM for people with HIV/AIDS, and views with respect to insurance coverage;

> Many people with HIV/AIDS must make treatment decisions with limited access to reliable information about the safety and efficacy of complementary/alternative therapies.

- funding research into the safety and efficacy of various complementary/alternative products and therapies, particularly their use by people with HIV/AIDS, and with particular priority given to researching those products and therapies for which there are:
  (a) encouraging, reliable preliminary effectiveness data,
  (b) consistent anecdotal evidence of effectiveness,
  (c) evidence of common use among people with HIV/AIDS, and/or
  (d) evidence of known or potential significant adverse effects, including if used in conjunction with conventional HIV/AIDS treatments.

- supporting the development of research skills among CAM practitioners in Canada;
- ensuring that research conducted by or in Aboriginal communities regarding traditional healing practices be governed by the principles that Aboriginal people have articulated concerning their ownership and control of, and access to, the research process and outcomes, and the protection of traditional knowledge from appropriation and exploitation;
- incorporating basic education about CAM into the curriculum of conventional health-care practitioners, incorporating basic HIV/AIDS education into the training of complementary/alternative practitioners, and encouraging health-care practitioners to ask patients about their use of CAM as a matter of good practice and in the interest of patient well-being;
- addressing issues such as the standard of review before licensing; labeling requirements; surveillance of products once approved for sale in Canada to detect adverse effects; ensuring that those who manufacture or sell products comply with the requirements of the regulatory regime; and ensuring the independence of the Office of Natural Health Products as federal regulator, in connection with the new regulatory framework being developed for the licensing and sale of natural health products in Canada;
- the development of materials that would assist unregulated complementary/alternative practitioners to establish voluntary self-regulating mechanisms, should they wish to do so;
- funding research into various regulatory models to assess the feasibility and desirability of regulating various groups of complementary/alternative practitioners;
- a review of provincial laws and the policies of professional regulatory bodies for conventional health practitioners with respect to CAM, with a view to ensuring patients can make informed decisions about, and have access to, a range of qualified health-care practices and practitioners.

A summary of the recommendations is found at the end of the paper.

What Will Be Done with the Paper?

The paper has been sent to a broad range of individuals and organizations working in the areas of HIV/AIDS and CAM. It has also been sent to appropriate government policymakers, professional regulatory bodies and practitioner associations, universities and colleges that educate health-care practitioners, and other interested parties. Those receiving the paper have been asked for their comments and input on these issues and the recommendations, and their views on how best to move forward with implementing these recommendations.

In addition, info sheets on legal and ethical issues related to CAM and HIV/AIDS have been prepared. The info sheets summarize the contents of the paper in an easy-to-read format, making the report more accessible to a wider audience and providing useful tools for education and discussion on the issues raised in the report.

– Robert Crouch, Richard Elliott, Trudo Lemmens, & Louis Charland

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Copies of the paper and info sheets can be retrieved at the website of the Canadian HIV/AIDS Legal Network at www.aidslaw.ca, or ordered through the Canadian HIV/AIDS Clearinghouse at tel 613 725-3434, fax 613 725-1205, email: aidssida@cpha.ca.

HIV/AIDS in Prisons: New Developments

Former US president Bill Clinton decries high incarceration rates, saying that the US judicial system has played a major role in turning some correctional institutions into "incubators for drug addiction and for HIV and AIDS." Studies in Ireland confirm what we know from studies undertaken in other prison systems: rates of HIV/AIDS and hepatitis C in prisons are much higher than in the general population, and prisoners are at high risk of contracting HIV and other infections in prisons. Risk behaviours are prevalent, and some prison systems refuse to make methadone maintenance treatment more widely available to prisoners who are dependent on drugs (although a recent Canadian study clearly demonstrates the benefits of providing methadone maintenance treatment), or to introduce needle exchange programs. In Canada, prison systems are being sued by inmates who claim that they have contracted HIV in prison because of the prison system's negligence, and that, once infected, they have not received proper care. Meanwhile, in Spain, the government has ordered that needle exchange programs be available in all prisons. These and other developments are described in the collection of articles below, compiled by Ralf Jürgens, Executive Director of the Canadian HIV/AIDS Legal Network. Ralf can be reached at ralfj@aidslaw.ca.

Inmate Sues the Correctional Service of Canada

This article summarizes a lawsuit commenced recently in the Ontario Superior Court of Justice by an HIV-positive inmate in the federal penitentiary system against the Correctional Service of Canada (CSC). This action is an important part of the ongoing struggle to hold government and public officials accountable for failing to address the HIV/AIDS crisis in prisons. The suit contends that CSC must be held liable for the seroconversion of an inmate while in CSC's care and custody, and that it must also be held liable for the alleged negligent provision of medical care to HIV-positive inmates. The author, Darrell Kloeze, is a staff lawyer at the HIV & AIDS Legal Clinic (Ontario) and Mr Pothier's counsel in his action against CSC. He can be reached at kloezed@lao.on.ca.

Jason Pothier, a 25-year-old man who has been in detention for almost all of the last eight years, and in the federal penitentiary system since September 1997, is suing CSC for damages for the Service's negligence related to his infection with HIV and to his medical care after becoming infected with HIV. This action is based on common law principles of negligence, breach of fiduciary duty, and on the *Canadian Charter of Rights and Freedoms*.

The facts

Mr Pothier was infected with both hepatitis C and HIV while incarcerated in the federal prison system, through injecting himself with heroin using dirty needles. He became addicted to heroin after he entered the federal penitentiary system. He had not previously used heroin. Aware of the risk to himself of injecting with dirty needles, he asked to be put on a methadone maintenance treatment program on several occasions, but was refused each time. He was not eligible for methadone under CSC's policy guidelines because he had not been treated with methadone outside the prison system, and because he was deemed not to be a serious enough user of heroin. After being denied access to methadone, he seroconverted.

The arguments

Mr Pothier is suing CSC, alleging that the Service has to be held responsible for his HIV infection because of its failure to treat him with methadone when it knew that it was very likely he would contract HIV because of his heroin addiction (and the Service's refusal to make sterile injection equipment available in prison). In addition, Mr Pothier is alleging that CSC has failed to always provide him with his HIV medications on a timely basis. Because of this, his HIV has become resistant to several medications.

Mr Pothier is arguing, first, that CSC was negligent in its care and treatment of him, both before and after he contracted HIV. He alleges that the medical care and treatment he has received while in prison is not up

to the professional standards that CSC is obliged to give all inmates in its custody.

In establishing that CSC acted negligently in providing Mr Pothier with health care, Mr Pothier will have to show that the health care he received

> Mr Pothier was infected with both hepatitis C and HIV while incarcerated in the federal prison system.

while in prison did not meet acceptable standards of care. Mr Pothier is aided in this by section 86 of the *Corrections and Conditional Release Act*, which states that the Correctional Service shall provide every inmate with "essential health care" and that this health care "shall conform to professionally accepted standards."

Mr Pothier alleges that CSC's negligence was demonstrated by its refusal to provide him with methadone upon his express requests for methadone in order to reduce the risk of becoming infected with HIV after he became addicted to heroin.

Mr Pothier also alleges that the CSC has been negligent in failing to provide him with consistent HIV medical care after he became infected. His evidence is that he was not given his antiretroviral drug therapy on several occasions for up to a week or 10 days at a time. During the periods when the CSC neglected to maintain this important drug therapy, Mr Pothier developed resistance to these particular drug treatments. These lapses in treatment are compromising the ability of Mr Pothier's specialist physician to treat his HIV, and his health has suffered because of it.

CSC has submitted a defence to the action, maintaining that Mr Pothier voluntarily assumed the risk of becoming infected with HIV when he began injecting heroin, and also that he was contributorily negligent in his infection. Basically, the Service argues that Mr Pothier should accept the responsibility for his HIV infection.

In response to this, Mr Pothier can say that he did make efforts to reduce the risk to himself of his HIV infection – he asked for methadone on several occasions but was refused. As a side note, the bitter irony of CSC's guidelines for offering methadone treatment is that Mr Pothier has finally been accepted for methadone maintenance treatment, but only after he became infected with HIV. The rationale behind this, for the Correctional Service, is that Mr Pothier is now eligible for methadone treatment because of the serious consequences of his heroin addiction on his doctor's ability to treat his HIV.

Mr Pothier is also relying on the legal principle that CSC owes him a fiduciary duty to ensure his safety and well-being. The action alleges that there is a special relationship between CSC and inmates who are in its "care and custody." CSC has a special responsibility to ensure that inmates are receiving necessary health care, since they clearly cannot provide for their own health care. Establishing that there was a fiduciary duty in these circumstances may broaden Mr Pothier's opportunity for monetary damages. More important, it helps underscore the seriousness of CSC's responsibility to ensure that inmates in its care and custody are receiving all essential health care and health-care services in a professional and acceptable manner.

Mr Pothier is also relying on a number of provisions of the Charter as an independent basis for his action against CSC. These include section 7 of the Charter, which guarantees a person's "right to life, liberty and security of the person." Mr Pothier alleges that the unprofessional standard of health care he has received has materially affected the security of his person, in that he has become infected with HIV and has developed a virus that has become significantly resistant to medications, making him less susceptible to respond to treatment.

Mr Pothier is also relying on section 12 of the Charter, which guarantees his "right not to be subjected to any cruel and unusual punishment." Courts have in the past cited section 12 of the Charter to comment on the lack of adequate HIV treatment in Canadian prisons.

Finally, Mr Pothier is relying on section 15 of the Charter, which guarantees his "right to equal protection and equal benefit of the law without discrimination." His allegation is that his status as an inmate, as a person addicted to heroin, and as a person infected with HIV, have all impacted on the discriminatory health care he has received at the hands of CSC.

Remedies

Mr Pothier is seeking damages for the negligence, breaches of fiduciary duty, and Charter breaches by CSC. Recognizing, however, that it is impossible to fully compensate the serious loss of health that Mr Pothier has suffered, he is also seeking broader institutional change on the part of CSC. An important goal is to change the way that inmates with HIV are

treated in the prison system. Mr Pothier also hopes that this action will bring about more awareness at CSC about the issues affecting inmates with HIV and AIDS, and lead to more realistic and necessary programs addressing the reduction of risk of HIV transmission.

Next steps

CSC is defending the action. The next step in the litigation is to participate in a mandatory mediation process instituted by the Ontario Superior Court of Justice. The litigation will then continue with examinations for discovery, and the trial, not anticipated for at least a year.

Canada: Another Inmate Sues Prison

In January 2002, an HIV-positive inmate filed suit against the British Columbia government and the Kamloops Regional Correctional Centre. He has been in the prison since August 2001 and claims a doctor prescribed him anti-HIV medication in September 2001. He claims that since then he has been overmedicated three times and on one occasion went without his pills because the prison pharmacy failed to reorder the medicine as required. He is claiming damages for injury to his emotional and physical health, including suicide ideation.[1]

Canada: Study Demonstrates Positive Effect of Methadone Treatment

A recent study on methadone maintenance treatment (MMT) in federal correctional institutions demonstrates that MMT has a positive impact on release outcome and on institutional behaviour.[2] The study provides support for the need to expand access to MMT in prisons. Importantly, it concludes that the CSC may spend less money on offenders who are on MMT in the long term, saying that "the cost of the institutional MMT program may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving MMT."

Background

In January 1998, CSC implemented Phase 1 of a National MMT Program for federal offenders with heroin or other opioid addictions.[3] Phase 1 was designed to continue methadone treatment that began in the community. In March 1999, Phase 1 of the MMT Program was modified to allow, in exceptional circumstances, the option of providing methadone treatment to severely heroin-addicted offenders presently not eligible for MMT. To be eligible, the following criteria must be met: all available treatments and programs have failed; the health of the offender continues to be seriously compromised by addiction; and there is a dire need for immediate intervention.[4]

According to CSC, the goal of the MMT Program is to "minimize the adverse physical, psychological, social, and criminal effects associated with opioid use, including the spread of HIV and other infectious diseases in CSC operational units."[5]

Purpose of the study

The purpose of the study undertaken by CSC's Research Branch was to examine the release outcome of offenders who have participated in CSC's MMT Program. The MMT offenders were compared to a group who tested positive for heroin use while incarcerated and who were identified as having a substance abuse problem, but who did not participate in the MMT program. The study also examined the effect of MMT participation on institutional behaviour.

> Mr Pothier has finally been accepted for methadone maintenance treatment, but only after he became infected with HIV.

Specifically, institutional misconduct and time spent in segregation were examined before and after MMT initiation.[6]

According to the study,

> [r]esearch on the impact of MMT will identify the possible benefits of MMT and its potential contribution to community safety. MMT is an expensive program that requires considerable economic and human investment. Knowledge about the outcome of the program will provide decision-makers with the information they need to evaluate the potential impacts of an expanded program that could address the needs of offenders who have not previously been on an MMT program. The current study is the first step in developing the required information.[7]

The study sample[8]

The MMT group consisted of all 303 offenders identified as having received MMT in a federal institution from 20

November 1996 to 20 October 1999. Among these offenders, approximately 62 percent were released from custody before 15 May 2000 and these offenders were used for the follow-up analyses.

As mentioned above, the key characteristic for members of the comparison group was that they be known heroin users and have a substance-abuse problem. To identify heroin users, urinalysis data were examined, and to identify a substance abuse-problem offender, intake assessment data were reviewed. To be included in the non-MMT group, an offender had to have at least one positive urinalysis result for opiates or opiates A (heroin metabolites) in random and systematic testing from 1 January 1998 to 20 October 1999. To confirm a drug problem, the offender intake assessment and correctional plans were examined. There were 215 offenders in the non-MMT group, and approximately 52 percent were released from the institution prior to 15 May 2000 and could be used in the follow-up analyses.

Outcome

Outcome following release was measured as any readmission to a federal correctional institution. Readmission included both readmissions due to technical violations and readmissions due to the commission of a new offence.

Measures of institutional behaviour, such as number and type of institutional misconduct and time spent in segregation, were collected from the Offender Management System. Institutional charges were examined in terms of three general types: drug, violent, and other. Drug disciplinary offences included possession of alcohol, drugs, or drug paraphernalia, refusing to provide urine sample, failing urine sample, taking intoxicants into the body, and involvement in drug trade. Violent charges included "disrespectful/abusive to staff, fights/assaults/threatens staff/inmates, and creates/participates in disturbance to jeopardize security." All other charges included: "disobeys written rule/direct order, possession/deals in contraband, possession of unauthorized/stolen property, damages/destroys property."[9]

Results

Offenders in the MMT group were less likely to be readmitted and were readmitted at a slower rate than offenders in the non-MMT group. Offenders in the MMT group were less likely to have their conditional release revoked because they were unlawfully at large or in violation of the abstinence condition (alcohol). Finally, the MMT group was less likely to have committed a new offence.

In terms of offenders' institutional behaviour, differences between the MMT and non-MMT groups were observed with respect to a number of variables, but the only change associated with participation in the MMT was for serious drug charges. The MMT group did have significantly fewer total institutional charges, fewer serious institutional charges, and fewer periods of involuntary segregation than the non-MMT group. But this was not associated with participation in the MMT. The study concluded: "These results may indicate that MMT participants have already begun to change their behaviour prior to starting MMT or that offenders applying for and receiving MMT have fewer behaviour problems while incarcerated. Behaviour change prior to participation in MMT could be part of the process of choosing to pursue MMT."[10]

Discussion

The results of the study, as acknowledged in the report prepared by CSC's Research Branch, "provide support for the need to initiate MMT in the institutional setting."[11] In particular, the study suggests that MMT participation has a beneficial effect on post-release outcome in terms of readmission to a federal penitentiary. As CSC's report highlights, an "important implication of these findings is that CSC may spend less money on these offenders in the long term. The cost of the institutional MMT program may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving MMT. In addition, health related costs such as treatment for HIV or Hepatitis C infection could be affected by MMT availability in prisons."[12]

Unfortunately, the study did not assess the positive impact of MMT on the health of inmates on MMT. Nevertheless, it provides important evidence for the need (and cost-effectiveness) of expanding access to MMT in prisons – something that organizations, including the Canadian HIV/AIDS Legal Network, have been recommending for many years.[13]

Spain: Government Orders Distribution of Clean Needles in Prisons

In a previous issue of the *Review* we published an article about the positive results of the evaluation of the first needle exchange

programs in Spanish prisons.[14] Recently it was reported that Spain's Ministry of the Interior has ordered that sterile needles be distributed in prisons.

According to an article in *El País*, participating inmates will be required to acknowledge injection drug use to a doctor in the prison infirmary. In addition to providing a sterile needle, the doctor will advise the inmate on the potential harms from injection drug use and means of reducing that harm.[15]

The spokesperson for the Spanish Penitentiary Institute stressed that the goal of making injection equipment available in prisons and counselling the participating inmates is not to fight drug use in prisons, but rather to reduce the spread of communicable diseases.

According to the article, an estimated 50 percent of Spanish prison inmates are addicted to drugs. Of the 162 inmates who died in Spanish prisons during 1999, roughly one-third had AIDS.

Evaluation of the prison needle distribution pilot project that preceded the decision to order needle distribution in all prisons had shown that prisoners do not use needles as weapons. Nevertheless, violent inmates deemed at risk of using needles as weapons will not be permitted to participate in the program. Despite the experience of the pilot project, concerns over syringe attacks continue. A Spanish labour union stated that it preferred the creation of safe injection rooms instead of the distribution of needles.

Ireland: HIV and Hepatitis C in Prisons

Two studies from the Department of Community Health and General Practice at Trinity College, Dublin, have highlighted the extent of the HIV and hepatitis C (HCV) crisis in Irish prisons. The studies confirm that rates of HIV and HCV are disproportionately high in Irish prisons, and that high risk behaviours are commonplace. This article is by Rick Lines, who was formerly the Prison Outreach Coordinator for the Toronto-based Prisoners with HIV/AIDS Support Action Network (PASAN) and is now working on drug and alcohol program and policy issues in Ireland. He can be reached at ricklines@yahoo.com.

The first study

The first study, *Hepatitis B, Hepatitis C, and HIV in Irish Prisons: Prevalence and Risk*, by Allwright et al, was published in 1999 and involved over 1200 incarcerated men and women. The findings revealed an overall HIV infection rate of two percent and an HCV infection rate of 37 percent. Among women, rates of infection were even higher, with nearly half the incarcerated women testing positive for HCV.[16]

The second study

In 2000, a Trinity College research team published a companion study titled *Hepatitis B, Hepatitis C and HIV in Irish Prisoners, Part II: Prevalence and risk in committal prisoners 1999*, by Long et al. The report examined nearly 600 committal (remand) prisoners in Dublin, and found HIV rates of two percent and HCV rates of nearly 22 percent.[17] Again, the rates of infection among women prisoners were higher: almost 10 percent were HIV-positive, and 56 percent were HCV-positive.[18]

In comparison, rates of both HIV and of HCV in the general Irish population are estimated to be 0.10 percent.[19]

> One in five injection drug users stated that they first injected inside prison.

Risk behaviours in prisons

Both studies found that high-risk activities were prevalent among prisoners.

Allwright et al "found evidence of sexual contact between men in prison and an association between both hepatitis B and HIV infection and sex between men."[20] Approximately two percent of the men surveyed admitted to having anal sex with men while incarcerated.[21] Given societal homophobia, and the societal stigma against admitting same-sex relationships, it can be assumed that the actual prevalence of anal sex is higher. More than 10 percent of those engaging in anal sex were found to be HIV-positive.[22]

Long et al found that approximately one percent of male remand prisoners admitted to having anal sex with other men in prison. However, the actual numbers are likely higher, and the authors noted that questions on same-sex sexual activity "were the least likely to have been answered truthfully" by the study participants.[23]

Tattooing practices and risk of infection were also examined in Long et al. The report found that almost half of the prisoners surveyed were tattooed, and that a quarter of those (nearly 15 percent of study participants) had received a tattoo while incarcerated.[24] The researchers found

that HCV "was more common in those with a tattoo than those without a tattoo." They also found that those who had been tattooed in prison were more likely to test HCV-positive than those who were tattooed outside prison.[25]

Both reports also conducted detailed research on injection drug practices and their relationship to HIV and HCV infection. More than 40 percent of the 1200 participants surveyed in Allwright et al reported injecting at least once in their lives. Among women participants, the rates were even higher: 60 percent admitted to past or current injection drug use. One in five injection drug users stated that they first injected inside prison. Almost half of those who reported injecting at least once in their lives also reported injecting while incarcerated, and nearly three in five reported sharing injecting equipment in prison. Allwright et al found that 87 percent of those who had shared injection equipment in prison were HCV-positive.[26]

Long et al found that 28 percent of the remand prisoners surveyed had used injection drugs in their lives. Again, rates among incarcerated women were higher. As in Allwright et al, 60 percent admitted to having used injection drugs at least once in their lives. Of these, nearly 20 percent first injected in prison, and 40 percent admitted to sharing injection equipment while incarcerated. The study found that 90 percent of those who had shared injection equipment in prison tested positive for HCV.[27]

Conclusions

Both studies clearly indicate that injection drug use, and the sharing of injection equipment, is commonplace in Irish prisons. In particular, the studies confirm the findings of other international research that (1) there is a compelling relationship between the sharing of injection equipment in prison and the transmission of bloodborne disease; and (2) significant numbers of prisoners first inject drugs while incarcerated.

Both of these key findings have been further supported by a report released in 2001, titled *Drug Use Among Prisoners: An Exploratory Study*. The author of the report conducted in-depth interviews with a selected sample of 29 prisoners in a large Dublin institution. Among other things, she reported that 10 percent of her study sample were known to be HIV-positive, and 14 percent reported injecting for the first time while incarcerated.[28]

The Irish Prisons Service to date has failed to respond in a comprehensive manner to address this health crisis. Condoms and bleach are not available to Irish prisoners, and methadone is available only on a limited basis.[29] Despite the high prevalence of injection drug use and needle sharing – which prompted Allwright et al to recommend that "a strictly controlled supply of clean needles and syringes should be available for those prisoners who will continue to inject opiates"[30] – the Irish Prisons Service has thus far refused to consider providing needle exchange for prisoners.

US: Condoms Distributed to Gay Inmates in LA

The Los Angeles County Sheriff's Department has quietly begun distributing condoms to gay inmates at its downtown jail, joining just six other jails and prisons in the US that make condoms available to prisoners in an effort to reduce the spread of HIV and other sexually transmitted diseases in prisons.[31]

According to an article in the *Los Angeles Times*,

> The Sheriff's Department, which runs the largest jail system in the country, spends $180,000 a month on AIDS medications to treat 220 inmates. Officials say they are identifying 500 inmates per month who are HIV-positive. And Los Angeles County health officials found 100 new HIV cases – nearly 14% of the 723 screenings given to men over 10 months this year – in the gay section of the jail. The health department also found 27 cases of chlamydia, 16 new cases of gonorrhea and several cases of early syphilis in that unit.

Chief Taylor Moorehead, who oversees the county jails and made the decision to allow the condom distribution, said:

> This is a health issue.… I did it only for health reasons. It's a sign of the times… and a reality-based response from me that says I acknowledge the fact that fatal disease is spread in this fashion.

Condoms are being provided by an outside nonprofit group, Correct HELP, which provides a weekly AIDS education lecture and then distributes the condoms. Each condom has a sticker on it with the group's hotline telephone number for inmates' questions.

While some have criticized the initiative to make condoms available, others have suggested that it does not go far enough and should be extended

to other inmates "aside from just those who have identified themselves as gay and are housed in a special segregated unit of the jail."

Outside the US, condoms have been made available to prisoners in a large number of prison systems for many years.[32]

US: Former President Clinton Decries High Incarceration Rates

Speaking at a town hall meeting on "Black Inmates and the Spread of HIV" in Chicago, former US president Bill Clinton said that the US judicial system has played a major role in turning some correctional institutions into "incubators for drug addiction and for HIV and AIDS" by incarcerating large numbers of nonviolent offenders for prolonged periods of time.[33]

According to Clinton, "[t]he AIDS rates would go down and other good things would happen if we didn't send so many people to jail for so long who do not present a physical threat."[34] He called for greater efforts to stop the spread of HIV both inside and outside correctional institutions. "If people are going to jail, they need to be educated right away," said the former president. "If they don't have AIDS and they go to jail, we need to do what we can to prevent them from getting AIDS in jail."

Ted Hammett, another speaker at the town hall meeting, described HIV/AIDS behind bars as a "prevalent problem – many times more prevalent among prison and jail inmates than [in] the total population of the United States." According to Hammett, "[o]ne fourth of all people living with HIV or AIDS pass through a prison or jail in a given year."[35]

Two million people are incarcerated in the US at any given time. Eleven million, though, are released from prisons and jails each year.

In its 1996 report on *HIV/AIDS in Prisons*, the Canadian HIV/AIDS Legal Network had highlighted that "[m]any of the problems raised by HIV/AIDS in prisons are the result of Canada's drug policy."[36] It made the following recommendation:

> Reducing the number of drug users who are incarcerated needs to become an immediate priority. In order to reduce the problems created by HIV, other infectious diseases, and drug use in prisons, alternatives to imprisonment, particularly in the context of drug-related crimes, need to be developed and made available.[37]

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[1] HIV-infected inmate sues BC government, provincial jail over medication. *CP Wire*, 8 January 2002 (Kamloops Daily News).

[2] Correctional Service Canada. *Research Report: Institutional Methadone Maintenance Treatment: Impact on Release Outcome and Institutional Behaviour*. Ottawa: CSC Research Branch, September 2001 (2001 N° R-119). Copies can be obtained from the Research Branch, Correctional Service of Canada, 340 Laurier Ave West, Ottawa K1A 0P9.

[3] For more info, see Correctional Service Canada. *National Methadone Maintenance Treatment Program Phase 1. Resource and Information Package*. Ottawa: CSC, 1999.

[4] CSC 2001, supra, note 2 at 1-2.

[5] Ibid at 2, with reference to CSC 1999, supra, note 3.

[6] Ibid at 7-8.

[7] Ibid at 2.

[8] See ibid at 9-10.

[9] Ibid at 12.

[10] Ibid at 27.

[11] Ibid at 29.

[12] Ibid at 30-31.

[13] See, eg, R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1996, at 67-73 and 108-109; *Prevention and Treatment: Methadone* (Info sheet 7 in the series of info sheets on HIV/AIDS in prisons). Montréal: Canadian HIV/AIDS Legal Network, 2nd edition, 2001. Both documents are available at www.aidslaw.ca/Maincontent/issues/prisons.htm.

[14] Menoyo C, D Zulaica, F Parras. Needle exchange programs in prisons in Spain. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 20-21 (available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol5no42000/prisons.htm).

[15] *El País*, 4 December 2001. Reported in The Lindesmith Center - Drug Policy Foundation eNewsletter (www.drugpolicy.org/listserve.html).

[16] Allwright S, Barry J, Bradley F et al. *Hepatitis B, Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk*. Dublin: The Stationery Office, 1999, at 10.

[17] Long J, Allwright S, Barry J et al. *Hepatitis B, Hepatitis C and HIV in Irish Prisoners, Part II: Prevalence and risk in committal prisoners 1999*. Dublin: The Stationery Office, 2000, at 8.

[18] Ibid at 20.

[19] UNAIDS/World Health Organization. *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: 2001 Update*. Geneva: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2001 (available at www.unaids.org). This report cites an HIV seroprevalence rate in Ireland of 0.10 percent. See also: Prevalence of hepatitis C virus infection ten years after the virus was discovered. *Eurosurveillance Weekly* 1999; 51 (16 December) (available at www.eurosurv.org). This study cites a hepatitis C seroprevalence rate in Ireland of 0.10 percent.

[20] Allwright et al, supra, note 16 at 30.

[21] Ibid at 20.

[22] Ibid at 21.

[23] Long et al, supra, note 17 at 15.

[24] Ibid at 16.

[25] Ibid.

[26] Allwright et al, supra, note 16 at 16-19.

[27] Long et al, supra, note 17 at 13-16.

[28] Dillon L. *Drug Use Among Prisoners: An Exploratory Study*. Dublin: The Health Research Board, 2001, at 82, 109.

[29] See Lines R. Irish prison guards call for expansion of methadone access. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 71-74.

[30] Allwright et al, supra, note 16 at 32.

[31] Shuster B. *Los Angeles Times*, 30 November 2001.

[32] See, eg, *Prevention: Condoms* (Info sheet 3 in the series of info sheets on HIV/AIDS in prisons). Montréal: Canadian HIV/AIDS Legal Network, 2nd edition, 2001 (available at www.aidslaw.ca/Maincontent/issues/prisons.htm).

[33] Former President decries higher incarceration rates, longer prison terms and impact on HIV/AIDS cases. *Positive Populations* 2001; 3(2): 4-7. *Positive Populations* is available free of charge. For subscription info, call (304) 262-2371 or email MMSJEL@aol.com with a subscription request.

[34] Ibid at 4.

[35] Experts see unmistakable link between corrections and communities. *Positive Populations* 2001; 3(2): 1-8 at 2.

[36] Supra, note 13 at 116-117.

[37] Ibid (recommendation 14).

Preventing Mother-to-Child Transmission: Landmark Decision by South African Court

cont'd from page 1

well known. The government itself estimates that approximately 70,000 children are born with HIV in South Africa every year. In April 2001, the Medicines Control Council (MCC),

> The Department of Health would not make nevirapine universally available in the public sector where the majority of poor women receive medical treatment.

the statutory body responsible for registering medicines in South Africa, registered Viramune™ (nevirapine) for reducing the risk of HIV transmission during labour and delivery. The MCC must investigate whether medicines are suitable for the purpose for which they are intended, safe, of acceptable quality, and therapeutically efficacious. Registration of any drug means that all of these have been investigated. The Department of Health announced that it would not make nevirapine universally available in the public sector (where the majority of poor women receive medical treatment), but would confine its use to two pilot sites in each province,[3] in effect depriving the vast majority of women and children of access to potentially life-saving medication.

Brief History

Various organizations such as the AIDS Law Project, the AIDS Consortium, and others had been involved in discussions with the Department and Minister of Health regarding the implementation of an integrated mother-to-child-transmission (MTCT) program since 1998, when the results of the Bangkok Perinatal AZT Study were announced. (That study recommended the use of AZT from the 36th week of pregnancy and appeared to be more cost-effective for resource-poor settings than the long course of AZT that had become the standard of care for women in industrialized nations.) In February 1998, the Department of Health in the province of Gauteng announced the implementation of pilot sites to test the use of the short-course AZT. Despite extensive preparations for the implementation of those sites, in May 1998 the Minister of Health announced the national government had withdrawn its support for the project, which was then shelved.

The Treatment Action Campaign (TAC) was formed in December 1998 to fight for affordable treatment for people with HIV. During 1999 and 2000, the TAC had several meetings with the Minister of Health. Both in these meetings and publicly, the Minister of Health continued to defend the government's refusal to implement an MTCT program, often advancing contradictory reasons for the failure.

In a speech made in November 1999, the Minister indicated that AZT was too expensive, and nevirapine, although cost-effective, not registered for use in MTCT programs. In the same speech, she also highlighted the government's concerns about the toxicity of antiretrovirals. In April 2000, she stated the government was concerned about the long-term safety of the use of nevirapine, which had by then been registered by the MCC. The Minister declared the government would not embark on "immoral and unethical"[4] conduct by making nevirapine available before "the full results of the clinical trials of the drug"[5] were available. She then announced in August 2000 that a pilot project involving two sites in each province would commence, and that the use of nevirapine would be limited to these sites: it would not be made available to any public-sector facilities falling outside the pilot projects.

According to documents produced by the Department of Health and made available to the court at the hearing, the objectives of the pilot program were to assess "the operational challenges inherent in the introduction of anti-retroviral regimens for the reduction of vertical transmission in rural settings as well as urban settings."[6] The documents unequivocally acknowledge that, at least as far as the authors were concerned, "there is sufficient scientific evidence confirming the efficacy of various anti-retroviral (ARV) drug regimens in reducing the transmission of HIV from mother to child."[7]

By August 2001, the results of the SAINT trials on the use of nevirapine to prevent mother-to-child HIV transmission had been available for over a

year, and nevirapine was being widely used in the private sector. In July 2000, at the time of the XIII International AIDS Conference in Durban, the government had received an offer from manufacturer Boehringer Ingelheim for a supply of free nevirapine for a period of five years. Nevertheless, the government clung to its position that it did not have sufficient information about the safety and efficacy of the drug and would not extend the pilot projects in the immediate future and would not make nevirapine available outside the pilot sites.

Faced with the refusal of government to provide nevirapine to pregnant women with HIV or to set out reasonable implementation plan for an MTCT program, the TAC elected to take the issue to the courts. In August 2001, the TAC, supported by the Save Our Babies Campaign and the Children's Rights Centre, challenged this failure, arguing that it constituted a violation of the rights of access to health care,[8] equality,[9] life,[10] dignity,[11] reproductive choice,[12] and the rights of children.[13] The TAC also argued that the failure amounted to a violation of the duties of public officials[14] and a violation of the rights of pregnant women and children below the age of six years to have access to free health services.[15]

This article will deal with the arguments relating to the right to access health care and, more briefly, the right to make reproductive choices.

Legal Arguments Advanced by the TAC

Right to access health-care services, including reproductive health care

Section 27 of the Constitution states that

(1) Everyone has the right to have access to … health care services, including reproductive health care;

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve progressive realization of each of these rights.

In attempting to flesh out the ambit of the duty created by section 27, the TAC argued that it created both positive and negative obligations on the state. Relying on the judgment handed down by the Constitutional Court in *Grootboom*,[16] the TAC argued that although the state clearly has a duty to ensure that it and others do not impair the right of access to health-care services, section 27 also created a positive duty on the part of the state to "create the conditions for access to health care services for people at all economic levels of society."[17]

The TAC contended that by denying doctors in public hospitals the right to prescribe nevirapine, the "MTCT programme self-consciously denies … right of access to pregnant mothers and children who are not treated at designated sites.… [T]here is a clear violation of section 27(1) which is incapable of justification."[18]

In assessing whether the state had fulfilled its duty to take reasonable measures in terms of section 27(2), the TAC again relied on the principles set out in *Grootboom* and argued that the state's MTCT program "falls lamentably short on virtually every one of these constitutional requirements."[19] It argued that the state had failed to

- desist from "preventing or impairing"[20] the right of access to health care since many women and children were not able to access nevirapine because they were unable to reach a designated pilot site;
- take account of the needs of those who are most vulnerable in society;[21]
- adequately assess its capacity to deliver the program;

> TAC argued that the state had a duty to create the conditions for access to health-care services for people at all economic levels of society.

- ensure that the program is "a comprehensive one determined by all three spheres of government in consultation with each other as contemplated by Chapter 3 of the Constitution";[22]
- ensure that the program was reasonable in both conception and implementation;[23] and
- ensure that the "programme is balanced and flexible and makes appropriate provision for attention to … short, medium and long term needs."[24]

Finally, the TAC argued that the free offer of nevirapine meant that the government could not raise concerns about the cost of the drug. This was supported by evidence indicating that a full MTCT program would be not only cost-effective but would result in cost savings to government in the long term.

The TAC concluded its argument on section 27 by stating :

> It is no answer to contend that what has been done in execution of the MTCT programme by the

respondents is a major achievement or that large sums of money have been spent and a significant a number of people provided with access to the programme. Nor is it an answer to contend that considerable thought, energy, resources and expertise have been and continue to be devoted to the process of effective delivery. Even if this was the case, which is denied, it is not dispositive, for "a question that nevertheless must be answered is whether the measures adopted are reasonable". As has been indicated above, the measures cannot be reasonable if they are "haphazard" and not a "systematic response to a pressing social need."[25]

TAC argued that pregnant women who fell outside a pilot site were not provided with information that would enable them to make informed choices.

Right to bodily and psychological integrity, including reproductive choice

Section 12(2) of the Constitution provides that:

> (2) Everyone has the right to bodily and psychological integrity, which includes the right (a) to make decisions concerning reproduction; […]

The TAC adduced evidence of the magnitude of the psychological impact on women with HIV who gave birth outside of the pilot sites. The trauma was compounded by the knowledge that not only could they transmit the virus to their unborn children, but that a drug existed that was cheap and easily available and that could significantly reduce this risk. The main obstacle to access was the policy of the state that limited its availability to the pilot sites. It was argued that this entailed "a clear violation of section 12(2) … and is incapable of justification."[26]

More important, from the perspective of women's human rights, it was argued that the second part of this right – the right to make decisions about reproduction – must include the right to make informed choices about birth and interventions to reduce the risk of mother-to-child transmission of HIV. The TAC argued that the evidence it had provided indicated that pregnant women who fell outside a pilot site were not provided with information that would enable them to make informed choices. Even if women were provided with information that would allow them to make informed choices, a majority would be unable to implement a decision to take nevirapine because of the state's policy to limit its availability. This amounted to an unjustifiable violation of the right set out in section 12(2)(b).

The State's Arguments

The state indicated in its heads of argument that it viewed the main issue as "whether the [national and provincial governments] have complied with the State's obligations, as set out in s 27(1) read with s 27(2) of the Constitution."[27] Although it recognized that "all rights in the Bill of Rights are interrelated and a denial of health care services, including reproductive healthcare, may conceivably also be a denial or a breach of the right to life, dignity, equality, etcetera,"[28] no arguments were advanced in respect of the breach of those rights. The government confined its legal submissions to arguments concerning section 27 and, although more briefly, to section 28 (the rights of children).

The state argued that it had in fact complied with its obligations under sections 27(1) and (2). It argued that there could not have been a breach of the negative right of section 27(1) because pregnant women with HIV had not been provided with access to antiretrovirals, so they had not been deprived of this access and had not been limited or restricted in any way by the state's conduct.

The state argued that it had taken all reasonable steps, within its available resources, to achieve the progressive realization of health care, including reproductive health care. It further argued that, given the complexities related to the delivery of health-care services in general and given that a comprehensive MTCT program formed only one aspect of this "multifarious and intricate"[29] system, its present pilot program was reasonable. The test for reasonableness laid down in *Grootboom* was rejected on the ground that "the provision of housing to a person or family is a once-off matter. The provision of health care to an individual, on the other hand, is on-going and complex."[30]

The state argued that the correct approach to be adopted by the court was that articulated in *Soobramoney*.[31] In that case, the Constitutional Court noted that the state's obligations under section 27 "are dependent upon the resources available ... and that the correspond-

ing rights themselves are limited by reason of the lack of resources."[32] The Court also noted that the courts "will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters" because it is "undesirable for a court to make an order as to how scarce medical resources should be applied."[33]

Judgment

The judgment supported the arguments raised by the state in one respect, in that it also identified the "real issue"[34] as being whether or not the state had complied with its constitutional obligations under section 27(2).

The court found the *Grootboom* case "most instructive"[35] and followed the principles laid down in it. The court found that, although "the respondents cannot be faulted for having decided to establish two research and training sites, or pilot sites, in each province,"[36] it was "of the view that the policy of [the national and eight of the nine provincial governments] in prohibiting the use of nevirapine outside the pilot sites in the public health sector is not reasonable and that it is an unjustifiable barrier to the progressive realization of the right to health care."[37] In light of this finding, the court granted the TAC's request for a declaration of the state's obligation to make nevirapine available outside the pilot sites and ordered the governments to do so.

The court also examined the program of the state and found that "there is no comprehensive and coordinated plan for a roll out of the MTCT prevention programme."[38] It further stated that:

> About one thing there must be no misunderstanding: a countrywide MTCT prevention programme is an ineluctable obligation of the State. The respondents alleged that it was unaffordable with AZT. It is clear that Nevirapine is affordable.… To the extent that the impression was created in the affidavits filed on behalf of some of the respondents that further roll out of the programme will depend on the availability of the resources, it must be dispelled. The resources will have to be found progressively.[39]

The court granted the further relief sought by the TAC, which included ordering the government to develop a comprehensive national MTCT prevention program that it was obliged to submit to the court for consideration and to the TAC for its comments. The government was ordered to report back to the court, under oath, by 31 March 2002, on the steps taken and intended to develop and implement the program. The court also ordered the government to pay the costs of the case.

Subsequent Developments

On 19 December 2001, the national government declared it would appeal, saying the ruling unacceptably interferes with policymaking by the executive branch of government. The government filed its application for leave to appeal in January 2002. At the same time, the TAC launched an application to compel the government to ensure that nevirapine is immediately available in all public-sector facilities.[40] Both applications will be heard on 1 March 2002.

In the meantime, despite widespread approval of the judgment, and calls from prominent South Africans (including Archbishop Tutu) for the government not to appeal from the decision, the government continues to support the pilot projects. On 22 January 2002, drawing criticism from the national health minister, the Premier of KwaZulu-Natal announced that the province (which has the highest rate of HIV infection in the country) would begin to implement a full scale MTCT program.[41] Although this may be a hopeful sign that provinces may begin to place the lives of their citizens before political expedience, the lives of women and children continue to be ravaged by the epidemic and by political intransigence.

> The High Court stated that a countrywide MTCT prevention programme is an ineluctable obligation of the state.

– Liesl Gerntholtz

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Editor's note: On 22 February 2002, the South African government announced that it would expand research into the use of nevirapine to limit mother-to-child transmission of HIV, but would not make the drug universally available. However, the premiers of Western Cape and Gauteng joined the premier of KwaZulu-Natal in deciding to make nevirapine universally available in their provinces.[42]

[1] Case No 21182/2001, 14 December 2001, High Court of South Africa (Transvaal Provincial Division), Botha J. The judgment and some of the accompanying court documents (including TAC's affidavits and written legal argument, as well as two of the government's affidavits) can be found online at www.tac.org.za.

[2] Although the Western Cape Province was initially cited as a respondent, the TAC did not pursue an order against the province in light of its response, which included a description of the MTCT program in that province and its plans to extend it to include the entire province.

[3] One criterion for inclusion as a pilot site was 5000 live births per annum. In total, the sites are intended to catch a mere 10 percent of all live births in South Africa.

[4] TAC founding affidavit, para 200.

[5] Ibid.

[6] Ibid at para 148.

[7] Ibid at para 149.

[8] Constitution, Act 108 of 1996, s 27.

[9] Ibid at s 9.

[10] Ibid at s 11.

[11] Ibid at s 10.

[12] Ibid at s 12(2).

[13] Ibid at s 28.

[14] Ibid at s 195.

[15] Government Notice 657 provided that pregnant women and children below the age of six years were entitled to receive free health services from state health-care facilities, state-aided hospitals, and district surgeons. It was argued that the notice had created a legitimate expectation and the state had unlawfully thwarted this.

[16] *President of the Republic of South Africa* v *Grootboom and others*, 2001(1) SA 46 CC.

[17] TAC's Heads of Argument, Part II, para 4.7.3.

[18] Ibid at para 4.12.

[19] Ibid at para 4.15.

[20] *Grootboom*, supra, note 16 at para 34.

[21] Ibid at paras 34-35.

[22] Ibid at para 40.

[23] TAC's Heads of Argument, Part II, para 4.15.5.

[24] *Grootboom*, supra, note 16 at para 43.

[25] TAC's Heads of Argument, Part II, para 4.16.

[26] Ibid at para 5.42.

[27] Respondents' Heads of Argument, para 33.

[28] Ibid at para 43.

[29] Ibid at para 63.2.

[30] Ibid at para 66.

[31] *Soobramoney* v *Minister of Health, KwaZulu-Natal*, 1998(1) SA 765 CC.

[32] Ibid at para 11.

[33] Ibid at paras 29-30.

[34] *TAC et al* v *Minister of Health et al*, supra, note 1 at 50.

[35] Ibid at 51.

[36] Ibid at 55.

[37] Ibid at 59.

[38] Ibid at 61.

[39] Ibid at 62.

[40] The TAC's Notice of Application is available online via www.tac.org.za.

[41] H Ashraf. S Africa state offers HIV drug to pregnant women. *Lancet* 2002; 359 (2 February): 416.

[42] Reuters Medical News. South Africa will not provide nevirapine to all HIV-positive mothers. 21 February 2002.

Compulsory HIV Testing after an Occupational Exposure

cont'd from page 1

source of infection (source person) can relieve uncertainty as to whether there was in fact an exposure to hepatitis B virus (HBV), hepatitis C virus (HCV), or HIV, and can contribute to decisions about preventing further transmission, post-exposure prophylaxis (PEP), testing, and follow-up for the exposed worker.

If the test results of the source person are negative and there are no risk factors, the exposed worker may be reasonably certain that there was not a significant exposure, be relieved of anxiety, and forego PEP. (PEP is available only for HBV and HIV, not HCV.) This is a significant benefit in the case of exposure to HIV, because although PEP is available and is effective in preventing transmission, it is also accompanied by debilitating side effects and, in some cases, serious adverse events.

If the test results of the source person are positive *or* if the results are negative but the source person has risk factors (so that one cannot rule out the possibility that the test may have been taken during the window period, when infection is present but may not be detected), the exposed worker would have to take steps to prevent further transmission, consider PEP (depending on the nature of the exposure), and be tested at a later time. One cannot conclude that the exposed worker was infected on the basis of a positive test result from the source person, or that the exposed worker was not infected on the basis of a negative test result from the source person when risk factors are present.

Most source persons agree to be tested and permit relevant information to be provided to the exposed worker, when they are approached in a sensitive manner and the importance of the

information is explained.[1] But there are instances in which source persons refuse to be tested. This has led to a number of proposals to compel source persons to be tested, including the *Blood Samples Act* before the federal Parliament (now Bill C-217; formerly Bill C-244), Ontario Bill 105 (enacted in December 2001), and a resolution adopted by the 1999 General Council of the Canadian Medical Association (subsequently rescinded in 2000).

Bill C-217

Bill C-217 (the *Blood Samples Act*), a private member's bill, passed second reading in the House of Commons on 16 October 2001 and was referred to the Standing Committee on Justice and Human Rights. Bill C-217 would permit court-ordered blood testing of persons for HBV, HCV, and HIV where peace officers, firefighters, and other emergency services personnel or health-care workers may have been exposed to the risk of infection. It also proposes imprisonment for up to six months of any person who refuses court-ordered testing.

An identical bill (C-244) had been before the Standing Committee in the previous session of Parliament. At that time, the Canadian HIV/AIDS Legal Network made submissions to the Committee and the federal Minister of Justice to the effect that legislating compulsory testing for occupational exposure was unnecessary, unethical, and unconstitutional.[2] Bill C-244 did not proceed because Parliament was dissolved for a federal election. In the new session of Parliament, the bill was reintroduced as Bill C-217.

The Standing Committee heard from the Canadian Police Association and others in support of the bill.[3] However, it also heard presentations and received letters from numerous organizations that had grave concerns about the bill, including the Canadian HIV/AIDS Legal Network, the Canadian AIDS Society, the British Columbia Persons with AIDS Society, the HIV & AIDS Legal Clinic (Ontario), the Canadian Public Health Association, the Canadian Nurses Association, the Canadian Criminal Justice Association, the Canadian Bar Association, and the British Columbia Civil Liberties Association.[4]

The Privacy Commissioner of Canada, George Radwanski, also opposed the bill. In his presentation to the Standing Committee on 21 February 2002, he noted that "compulsory blood testing, and compulsory disclosure of the results of blood testing, is a massive violation of privacy and the personal autonomy that flows from privacy." In his view, Bill C-217 meets none of the four tests required of any proposed measure to limit or infringe privacy (necessity, effectiveness, proportionality, and absence of a less invasive measure).[5]

As this issue was about to go to print, the Network learned that Bill C-217 would likely not proceed to third and final reading. The Standing Committee will report back to the House of Commons that it recommends the bill not go forward, and that the issue be referred to the Uniform Law Conference of Canada and the Council of [federal, provincial and territorial] Justice Ministers for consideration. (The Uniform Law Conference of Canada makes recommendations for changes to federal criminal legislation based on identified deficiencies, defects or gaps in the existing law, or based on problems created by judicial interpretation of existing law.[6]) In addition, Health Canada will be asked to do more research on the exposure of health-care workers and others to infected blood.

As this issue was about to go to print, the Network learned that Bill C-217 would likely not proceed.

Bill 105

In Ontario, legislation very similar to the federal Bill C-217 was passed in December 2001. The *Health Promotion and Protection Amendment Act, 2001*,[7] which began as a private member's bill (Bill 105), allows a Medical Officer of Health (MOH) to order that a blood sample be taken from a person and tested for communicable diseases. (For a description of the legislation, see the article by Ruth Carey at page 39 in this issue.)

The Ontario legislation may go further than the federal bill in that the latter applies only to HBV, HCV, and HIV, whereas the Ontario legislation refers to communicable diseases that will be prescribed by regulations. In addition, the Ontario legislation allows victims of crime to seek an order for compulsory testing, whereas this is not contained in the proposed federal law.

Bill 105 received the strong backing of the Police Association of Ontario, representing police officers across the province. The Ministry of

Health indicated that it did not support the bill, but did not appear before the committee. The Minister of Health did not seek the advice of his Advisory Committee on HIV/AIDS regarding the bill. The Standing Committee held no public hearings on the legislation, nor was there any consultation with federal or provincial medical associations.

The Chief Medical Officer of Health stated that Bill 105's approach is generally not an appropriate or effective first response from a public health perspective.

The only witness heard by the committee, shortly before the provincial government moved to enact the bill, was the province's Chief Medical Officer of Health. He said that "Bill 105's approach is generally not an appropriate or effective first response from a public health perspective."[8] He noted that there have been no reports of occupationally related disease transmission in Ontario or Canada among emergency service workers. He criticized the bill for putting medical officers of health in the position of "judge" between the person applying for an order and the source person. He indicated that compulsory testing would represent a significant violation of personal privacy and bodily integrity (which is ignored in the bill), and would provide information "of possibly little or no value, rather than focusing on fully assessing the situation of the person who may be at risk [of infection]." He stressed that the current system of universal precautions and education was generally adequate for preventing occupational transmission of bloodborne diseases.

Bill 105 was brought forward in December 2001 by the provincial government, together with a number of other pending bills, in the days before the legislature recessed. The bill was passed without further debate in the legislature on 13 December 2001, and royal assent was given the next day. The Police Association of Ontario applauded its passage.[9] The Director of Ethics of the Canadian Medical Association (CMA) stated the bill was at odds with the CMA's policy on HIV infection in the workplace (see below) and that "there does not seem to be a need for this drastic type of law."[10] The Canadian HIV/AIDS Legal Network criticized the new law and the process leading up to its adoption.[11]

CMA Policy

The CMA policy on HIV infection in the workplace states that the risk of HIV transmission in police work, firefighting, and garbage collection is "extremely low" and that the risk of HIV transmission in health-care settings, although greater than in the general workplace, is "very low."[12] This risk can be reduced by using routine precautions and by rigorously implementing infection-control guidelines. In the event of an exposure, the worker should be assisted with counselling, voluntary testing, and prophylactic treatment.

With regard to testing of source persons, the policy states:

> The patient should be asked to undergo voluntary HIV antibody testing and to consent to communication of the results to the injured worker, unless it is already known that the patient is HIV positive. Such testing should always be accompanied by pretest and post-test counselling. Compulsory testing is unjustified.[13]

The CMA's policy was developed after lengthy consideration of a proposal to require testing of the source person. In 1999, the General Council of the Canadian Medical Association (CMA) passed a resolution that "patients undergoing any procedure where a health care worker could be accidentally exposed to the patient's bodily fluids be required to sign a waiver that would allow appropriate testing of the patient's serological status of HIV and hepatitis if such exposure should occur, while ensuring patient confidentiality."[14] The resolution was criticized in the *Canadian Medical Association Journal* as "vague, impractical, detrimental, pointless and unnecessary."[15] The Board of the CMA struggled with the resolution "because it violated several sections and many of the values of the CMA Code of Ethics." [16] Moreover, "mandatory testing of nonconsenting patients was a direct and nontrivial violation of an individual's rights to 'security of person' and 'protection from unreasonable search and seizure,' both of which are guaranteed under the Canadian Charter of Rights and Freedoms."[17] The CMA commissioned a background document[18] and two legal opinions, and eventually referred the motion back to the General Council in 2000. The delegates voted to rescind the motion,[19] and a subsequent resolution enabling mandatory testing of source persons was defeated.

Positions of Other Professional Associations

The Canadian Nurses Association and the Canadian Association of Nurses in AIDS Care have also recently published or updated policies on occupational exposure to bloodborne pathogens. They maintain that compulsory testing of source persons is unjustified and unethical.[20] The Canadian Police Association and, with qualifications, the International Association of Fire Fighters, support compulsory testing.[21]

Public Health Guidelines

Health Canada has published a protocol to manage exposures to HBV, HCV, and HIV among health-care workers.[22] Several provinces have published similar protocols.[23] Health Canada has also published guidelines for the establishment of post-exposure notification protocols for emergency responders who may have been exposed to certain airborne or bloodborne infectious agents, including HIV.[24] These protocols require appropriate pre- and post-test counselling and the informed consent of the source person prior to testing and release of test results.

Recent US guidelines

The US Department of Health and Human Services has recently updated and integrated its guidelines for the management of occupational exposures to HBV, HCV, and HIV.[25] The guidelines provide detailed information on all aspects of occupational exposure to HBV, HCV, and HIV.

When the infectious status of the source person is unknown, the guidelines recommend testing, with informed consent, in accordance with state and local laws.[26] (Many states do not require consent in such circumstances.[27]) The guidelines suggest that an approved rapid HIV-antibody test should be considered, particularly if testing by an enzyme immunoassay (EIA) cannot be completed within 24 to 48 hours. Direct viral assays (eg, HIV p24 antigen EIA or tests for HIV RNA) are not recommended. In addition to test results, information about behavioural risks and clinical symptoms should be gathered to complete the evaluation.

If the source person is infected with HIV, information about the person's stage of infection, results of viral-load testing, current and previous antiretroviral therapy, and results of genotypic and phenotypic viral-resistance testing can assist in choosing or modifying an appropriate PEP regimen for the exposed worker.[28] (When HIV PEP is indicated by the circumstances of an exposure, it should begin as soon as possible. Subsequent information can be used to modify or discontinue the regimen.[29]) The guidelines provide important information about toxicities associated with HIV antiretroviral drugs and resistance to these drugs, both of which should be factored into decisions about HIV PEP.[30] The guidelines also make recommendations about when – and when *not* – to prescribe HIV PEP, and whether the regimen should include two or three drugs.[31] The guidelines caution against over-prescribing HIV PEP,[32] and emphasize that exposed workers need emotional support and access to people who are knowledgeable about occupational HIV transmission.[33]

Recent Canadian Studies

CMAJ review

The *Canadian Medical Association Journal* has recently published a review of the transmission and post-exposure management of bloodborne pathogens in health-care settings.[34] The review summarizes current information about frequency of exposures, transmission of bloodborne pathogens from patients to health-care workers and from health-care workers to patients, the risk of transmission, and current post-exposure management recommendations. It is based on the background document prepared for the CMA to inform its deliberations after the 1999 resolution.[35]

> In a survey of Canadian hospitals, the frequency of source persons refusing to be tested was estimated to be from 0.2 percent to 0.5 percent.

One of the questions raised by the 1999 CMA resolution requiring testing of source persons was whether the proposed policy was in fact necessary. Critics of the resolution noted that over a ten-year period at St Paul's Hospital in Vancouver only two patients in an estimated 1700 accidental exposures refused to be tested for HIV (0.1 percent of instances).[36] A survey of other Canadian hospitals confirmed this finding. The estimated frequency of refusal was small, ranging from 0.2 percent to 0.5 percent.[37]

With regard to testing, the review concludes:

> Because HBV can be prevented with immunization and postexposure treatment for HCV exposure is not available, the primary purpose of source testing is to establish HIV serologic status.

Forty-five percent of percutaneous injuries might have been prevented by proper handling and disposal of used needles, and two-thirds of mucocutaneous exposures might have been prevented by the use of protective eyewear or face shields.

> HIV PEP reduces the risk of transmission and must be started within hours of exposure. A negative result is not totally reassuring because of the potential for a window period of infection without the presence of antibodies, however, a patient's refusal to be tested will impair fully informed decision-making concerning PEP, increase HCW [health-care worker] anxiety and possibly result in unnecessary PEP side effects. Policy-making in this area must weigh the relative infrequency of such refusals and the consequences for PEP recommendations with the ethical and legal considerations of bypassing informed consent and mandating testing.[38]

The review also discusses potential transmission of bloodborne pathogens from health-care workers to patients. It is not possible to summarize the discussion here, but the review concludes that "it is unlikely that a policy of mandatory postexposure HCW testing would contribute to the reduction of HCW-to-patient transmission of [bloodborne pathogens]."[39]

Canadian Needle Stick Surveillance Network update

The Canadian Needle Stick Surveillance Network (CNSSN), begun in 2000, recently reported the first year of surveillance data (1 April 2000 to 31 March 2001).[40] The data were gathered at 12 participating hospitals across Canada. In the period under consideration, 1436 exposures to blood and body fluids occurred among health-care workers. Of these, 84 percent were percutaneous exposures (eg, contact with tissue under the skin through a needle stick, cut, scratch, or bite), and 16 percent were mucocutaneous exposures (eg, contact with the mucous membranes through a splash to the eyes, nose, or mouth). The rate of injury was higher for percutaneous exposures (3.59 per 100 full-time equivalent positions or FTEs) than for mucocutaneous exposures (0.66 per 100 FTEs).

Nurses accounted for half of all exposures. However, the rate of exposure was much lower among nurses (4.88 per 100 FTEs) than among phlebotomists (personnel who draw blood, among whom the rate of exposure was 42.78), medical residents (20.97), nuclear medical technicians (13.59), sterilization attendants (12.14), or medical specialists (10.06).

The source persons were identified in 84 percent of the 1436 exposures. Of the 1203 identified sources, 10 percent were not tested for bloodborne viruses. Among those tested, 15 tested positive for HBV, 77 for HCV, and 24 for HIV. Ten source persons were co-infected with two or three viruses. The prevalence of bloodborne pathogens among identified and tested source persons were one percent for HBV, seven percent for HCV, and two percent for HIV – levels that the authors considered worrisome.[41]

To date, none of the exposed workers has become infected with HBV, HCV, or HIV as a result of the exposure.

The authors caution that the results are subject to limitations inherent in a voluntary registry, and that the data are not representative of all hospitals across Canada. Nevertheless, they call attention to the disproportionate risk of occupational exposure among personnel engaged in drawing blood and in sterilization. They suggest that, considering the rate of needle sticks and the higher risk of infection associated with injuries involving a large-gauge hollow-bore needle inserted directly into an artery or vein, prevention programs need to focus on preventing such injuries. They note that 45 percent of percutaneous injuries might have been prevented by proper handling and disposal of used needles, and that two-thirds of mucocutaneous exposures might have been prevented by the use of protective eyewear or face shields. They suggest that the "application of recommended control measures such as engineering controls (safety devices, sharp disposal containers), administrative controls (timely and effective post-exposure protocol) and work-practice controls (immunization,

hands-free technique in the operating room, universal precautions) may decrease the number of significant exposures."[42]

Evaluation of PEP in BC

HIV PEP consists of a four-week course of two or three antiretroviral drugs. The decision to recommend or offer PEP, and the number of drugs in the treatment, depends on the assessment of the risk incurred in the exposure. Guidelines typically distinguish between higher risk of transmission (treatment with three drugs), moderate risk of transmission (treatment with two drugs), and negligible risk of transmission (treatment is *not* recommended).[43] (The recently revised guidelines of the British Columbia Centre for Excellence in HIV/AIDS now distinguishes only two categories of risk: significant and negligible.)[44] However, all HIV antiretroviral drugs have side effects,[45] a main reason why exposed workers do not complete the full course of PEP. Most of these side effects resolve after treatment is discontinued, but there have been cases of serious adverse events.[46] Therefore, the *CMAJ* review suggests that workers being offered HIV PEP "must be fully aware of the potentially serious risks of some antiretroviral drugs and balance these against the relatively low risk of becoming infected with HIV."[47]

There is evidence, however, that HIV PEP is not being used appropriately. A recent study by the British Columbia Centre for Excellence in HIV/AIDS of the province's HIV PEP program found that 30 percent of people who received three drugs should not have (according to existing HIV PEP guidelines), 30 percent of people who received two drugs should not have, and 54 percent of people who received treatment should not have.[48] The actual cost of the program was $538,098. If the drugs had been dispensed according to existing guidelines, the expected cost would have been about $239,283 – about $298,000 less than the actual cost. In a related study, the British Columbia Centre for Excellence in HIV/AIDS found that the likelihood of receiving three-drug HIV PEP did not correspond to what one would expect according to existing guidelines.[49] The authors suggest that more education is needed among health-care providers, particularly in rural areas, to ensure that issues related to the transmission of HIV, the risks and benefits of PEP, and the content of PEP guidelines are more thoroughly understood.[50]

What Should Be Done?

The Canadian HIV/AIDS Legal Network recently published a *Backgrounder* on compulsory testing in the event of occupational exposure. It concluded that more could be done to prevent accidental occupational exposure, support workers, and obtain voluntary consent for testing from source persons *without* having recourse to mandatory testing of source persons. Studies in Canada, the United States, and Europe have found evidence of unsafe practices in disposing of needles, failure to use routine precautions, continuing rates of injury, delays in administering PEP, and insufficient expertise in assessing exposures and recommending PEP.[51] Improvements could be made by:

- implementing existing guidelines and protocols on preventing and managing accidental occupational exposures to infectious diseases;
- conducting regular annual education and training for workers in infectious diseases, engineering safeguards, and protective practices;

A recent study found that 54 percent of people who received HIV PEP in BC should not have, according to existing guidelines.

- introducing engineering safeguards, such as needle-less systems, needles with safety features, high-quality latex gloves, and puncture-resistant gloves;
- designating and training personnel to respond to accidental occupational exposures, to counsel workers, and to act as a liaison with source persons;
- strengthening post-exposure counselling, support, and follow-up for exposed workers, their co-workers (if necessary), and their families;
- implementing workplace programs to correct misconceptions and reduce stigma related to infectious diseases;
- improving training and expert support for health-care providers responsible for administering post-exposure prophylaxis to ensure that it is prescribed only as recommended by current guidelines; and
- introducing provisions to protect the privacy and confidentiality of source persons, such as non-nominal requisition and reporting of test results, destruction of any records related to the test, and regulations, policies, and protocols regarding confidentiality of test results.

The experience of the Canadian Medical Association shows that proposals for compulsory HIV testing must be subjected to thorough epidemiological, ethical, and legal scrutiny. It is noteworthy that the professionals who are at greatest risk of occupational exposure to HIV – nurses and physicians – have been guided by their codes of ethics *not* to endorse compulsory testing of source persons.

Nurses and physicians – professionals who are at greatest risk of occupational exposure to HIV – have been guided by their codes of ethics *not* to endorse compulsory testing of source persons.

The evaluation of BC's PEP program, which found that the treatment prescribed is frequently in excess of what is warranted by the exposure, suggests that much more could be done to educate PEP providers and to counsel exposed workers about the probable risk of transmission, which is sometimes very small.

The anxiety and stress experienced by a worker after an occupational exposure is considerable, and the risks and side effects of HIV PEP are not insignificant. But it is far from clear that compulsory testing of source persons who do not consent to be tested is the answer. Because of the uncertainties inherent in the window period and the risks associated with certain behaviours, a negative test result from a source person will not necessarily provide the assurances a worker seeks. For the anxiety and stress associated with an occupational exposure, counselling and support are the appropriate – and indispensable – response.

– Theodore de Bruyn and Richard Elliott

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Copies of the Network's *Backgrounder* and a series of info sheets can be retrieved at the website of the Canadian HIV/AIDS Legal Network at www.aidslaw.ca, or ordered through the Canadian HIV/AIDS Clearinghouse at tel 613 725-3434, fax 613 725-1205, email aidssida@cpha.ca. A transcript of the Network's presentation on 19 February 2002 to the Standing Committee on Justice and Human Rights is available at the Canadian Parliament website via www.parl.gc.ca/InfoComDoc/37/1/JUST/Meetings/Minutes/JUSTmn62%287770%29-E.htm (click on "Evidence" in the table). A copy of the Network's brief is available at www.aidslaw.ca/Maincontent/issues/testing.htm.

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[1] See T de Bruyn. Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Backgrounder. Montréal: Canadian HIV/AIDS Legal Network, 2001, at 21.

[2] See R Elliott. Reform MP proposes compulsory testing. Canadian HIV/AIDS Policy & Law Newsletter 2000; 5(2/3): 25-27.

[3] Canadian Police Association. Brief to the Standing Committee on Justice and Human Rights Regarding Bill C-217. 19 February 2002.

[4] Canadian HIV/AIDS Legal Network. Brief to the House of Commons Standing Committee on Justice and Human Rights: Bill C-217 ("Blood Samples Act"), 19 February 2002 (available at www.aidslaw.ca/Maincontent/issues/testing.htm). Letter from Michael Yoder, Chair, Board of Directors, Canadian AIDS Society, to the Honourable Martin Cauchon, Minister of Justice, 25 January 2002. Glen Hillson. Presentation to the Select Standing Committee [on] Justice and Human Rights, 19 February 2002; HIV & AIDS Legal Clinic (Ontario). Brief to the House of Commons Standing Committee on Justice and Human Rights: Bill C-217 ("Blood Samples Act"), 21 February 2002. Letter from Mr Gerald H Dafoe, Chief Executive Officer, Canadian Public Health Association to the Standing Committee on Justice and Human Rights, 26 February 2002 (www.cpha.ca/english/policy/advoc/oppsc217.htm). Letter from Dr. Ginette Lemire Rodger, President, Canadian Nurses Association, to the Honourable Andy Scott, Chair, Standing Committee on Justice and Human Rights, 14 February 2002. Canadian Criminal Justice Association. Brief to the Standing Committee on Justice and Human Rights on Bill C-217, 19 February 2002. Letter from Heather Perkins-McVey, Chair, Canadian Bar Association National Criminal Justice Section, to the Honourable Andy Scott, Chair, Standing Committee on Justice and Human Rights, 26 February 2002. British Columbia Civil Liberties Association. Bill C-217 "The Blood Samples Act": Submission before the Standing Committee on Justice and Human Rights, 26 February 2002. Transcript of presentations to the committee are available on the Canadian Parliament website via www.parl.gc.ca/InfoComDoc/37/1/JUST/Meetings/Minutes/JUSTmn62%287770%29-E.htm (click on "Evidence" at the date on which the presentation was made).

[5] Privacy Commissioner of Canada. Opening statement, appearance before the House of Commons Standing Committee on Justice and Human Rights regarding Bill C-217 (Blood Samples Act) (www.privcom.gc.ca/speech/02_05_a_020222_e.asp.)

[6] See the website of the Uniform Law Conference of Canada at www.ulcc.ca/en/about.

[7] SO 2001, c. 30. The full text of the law can be found on the website of the Ontario legislature at www.ontla.on.ca/library/bills/105372.htm.

[8] Dr Colin D'Cunha, Chief Medical Officer of Health for Ontario. Submission to Standing Committee on Justice and Social Policy: Bill 105. 4 December 2001 (on file).

[9] Police Association of Ontario. News release, 14 December 2001.

[10] B MacKay. New Ontario law could allow force [sic] blood sample collection. e-CMAJ News Desk, 16 January 2002.

[11] R Elliott. Blood-test bill a violation of privacy. Toronto Star, 8 January 2002: A17.

[12] Canadian Medical Association. CMA Policy: HIV Infection in the Workplace (Update 2000), 11 December 2000 (available at www.cma.ca and clicking on "Where We Stand"). Cf de Bruyn, supra, note 1 at 27-28.

[13] Canadian Medical Association, supra, note 12.

[14] MW Tyndall, MT Schechter. HIV testing of patients: Let's waive the waiver. Canadian Medical Association Journal 162(2): 210-211.

[15] Ibid.

[16] J Hoey. CMA rescinds controversial policy. Canadian Medical Association Journal 2000; 163(5): 594.

[17] Ibid.

[18] BW Moloughney. Bloodborne pathogen source testing: A review of the evidence. Ottawa: Canadian Medical Association, 2000; subsequently published as BW Moloughney. Transmission and postexposure management of bloodborne virus infections in the health care setting: Where are we now? Canadian Medical Association Journal 2001; 165(4): 445-51.

[19] Hoey, supra, note 16.

[20] de Bruyn, supra, note 1 at 25-27.

[21] Ibid at 29-31.

[22] Health Canada. An integrated protocol to manage health care workers exposed to bloodborne pathogens. Canada Communicable Disease Report 1997; 23 (Suppl 23S2): 1-14.

[23] British Columbia Centre for Excellence in HIV/AIDS. Therapeutic Guidelines for the Treatment of HIV/AIDS and Related Conditions, Section 7: Management of Accidental Exposure to HIV, revised December 2001 (available at http://cfeweb.hivnet.ubc.ca/guide/open.html);

Saskatchewan Technical Subcommittee on HIV/AIDS. Guidelines for the Prevention of Hepatitis B, Hepatitis C, HIV and Other Bloodborne Pathogens in Work-Related Exposures. September 1997; Manitoba Health. Integrated Post-Exposure Protocol: Guidelines for Managing Exposures to Blood/Body Fluids. October 2000; Ministère de la Santé et des Services Sociaux. Recommendations visant la prise en charge des travailleurs exposés au sang et aux autres liquides biologiques. Québec: Ministère de la Santé et des Services Sociaux – Direction des communications, 1999.

[24] Health Canada. A national consensus on guidelines for establishment of a post-exposure notification protocol for emergency responders. Canada Communicable Disease Report 1995; 21(19): 169-175 (available at www.hc-sc.gc.ca/hpb/lcdc/dpg_e.html#infection).

[25] US Department of Health and Human Services. Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. Morbidity and Mortality Weekly Report 2001; 50(RR-11) (www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm).

[26] Ibid at 19-20.

[27] See de Bruyn, supra, note 1 at 10.

[28] US Department of Health and Human Services, supra, note 23 at 20.

[29] Ibid at 20, 26.

[30] Ibid at 10-15.

[31] Ibid at 23-26.

[32] Ibid at 26-27.

[33] Ibid at 28.

[34] Maloughney. Transmission and postexposure management of bloodborne virus infections in the health care setting, supra, note 18.

[35] Ibid.

[36] Tyndall & Schechter, supra, note 14 at 211.

[37] Moloughney. Transmission and postexposure management of bloodborne virus infections in the health care setting, supra, note 18 at 448-449.

[38] Ibid at 449.

[39] Ibid at 450.

[40] M Nguyen, S Paton, PJ Villeneuve. Update – Surveillance of healthcare workers exposed to blood/body fluids and bloodborne pathogens: 1 April, 2000 to 31 March, 2001. Canada Communicable Disease Report 2001; 27(24): 201-212.

[41] Ibid at 209.

[42] Ibid.

[43] Supra, notes 23 and 25.

[44] Supra, note 23.

[45] US Department of Health and Human Services, supra, note 25 at 10-15.

[46] Ibid at 12-15.

[47] Moloughney, Transmission and postexposure management of bloodborne virus infections in the health care setting, supra, note 18 at 448.

[48] P Braitstein et al. Another reality check: The direct costs of providing post-exposure prophylaxis in a population-based programme. AIDS 2001; 15(17): 2345-2347.

[49] P Braitstein et al. Determinants of receiving three-drug post-exposure prophylaxis against HIV in a population-based setting. Tenth Annual Canadian Conference on HIV/AIDS Research 2001 (abstract 269P), Canadian Journal of Infectious Diseases 2001; 12(Suppl B): 45B.

[50] Ibid, comments made in the conclusion of the poster; see also PR Grime et al. A survey of the use of post-exposure prophylaxis for occupational exposure to human immunodeficiency virus. Occupational Medicine 2000; 50(3): 164-166.

[51] de Bruyn, supra, note 1 at 33-34.

CANADIAN NEWS

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 supplied by scans of Canadian media. Address correspondence to David Garmaise, the editor of Canadian News, at dgarmaise@rogers.com.

Concerns Raised about New Immigration Rules

A new immigration law has been passed and will come into force in the near future. Community organizations have been critical of the proposed Regulations that will accompany the new law. Meanwhile, the federal government has instituted mandatory HIV testing of potential immigrants. Concerns have been voiced about how this testing will be carried out.

The federal government has released proposed Regulations under the new *Immigration and Refugee Protection Act* (IRPA).[1] Among other things, the Regulations provide details about when foreigners can be excluded from Canada on the basis of their health condition. In February and March 2002, community organizations had an opportunity to comment on the Regulations during hearings of the House of Commons Standing Committee on Citizenship and Immigration.

Background

The IRPA was passed on 1 November 2001, but will only come into force once the Regulations are finalized, probably during the summer of 2002. Like the *Immigration Act* it is replacing, the IRPA allows people to be excluded from Canada if their health condition is likely to pose a threat to public health or safety, or to place excessive demands on the public purse. However, unlike the old Act, the IRPA exempts sponsored spouses, common-law (ie, unmarried) partners, children of a Canadian citizen or permanent resident, and refugees from exclusion based on excessive demand.

Earlier, in September 2000, Elinor Caplan, the then Minister of Citizenship and Immigration, had announced plans to test prospective immigrants and refugees for HIV and to exclude those who are HIV-positive – unless they are refugees or certain sponsored family class immigrants – on *both* public health and excessive cost grounds. This was a surprising development because, since 1991, people living with HIV/AIDS had not generally been considered a threat to public health under Canadian immigration law.

Many organizations and individuals expressed concern about the plan. In June 2001, the Canadian HIV/AIDS Legal Network released *HIV/AIDS and Immigration: Final Report*,[2] criticizing the decision to introduce mandatory testing and any exclusion on public health grounds. That same month, Caplan partly reversed her position. She announced that while her department would go through with the plan to implement mandatory testing, people with HIV/AIDS would not be considered a threat to public health. They could, however, still be subject to exclusion on grounds of excessive demand.

Mandatory HIV testing of immigrants and refugees began on 15 January 2002. Most testing will be done abroad, in the applicant's country of origin. This has given rise to concerns about the standards of testing with regard to informed consent, pre- and post-test counselling, and confidentiality, since practices outside Canada often fall short of both international and Canadian standards. Citizenship and Immigration Canada sent a letter to physicians who perform immigrant medical examinations, instructing them to conduct

HIV testing on all adults and certain children seeking to immigrate to Canada. The letter also said that people living with HIV/AIDS should not generally be considered a threat to public health unless there are exceptional circumstances.

One important innovation in the IRPA is the inclusion of common-law couples in the family class. Both same-sex and opposite-sex common-law partners of Canadian sponsors can, under the IRPA, be processed under the family class. Common-law partners are entitled to a number of benefits, including an exemption from inadmissibility based on excessive demand on health and social services.

Comments on the Proposed Regulations

The Canadian HIV/AIDS Legal Network submitted a brief to the Standing Committee outlining its concerns about the Regulations under the IRPA,[3] and appeared before the Committee on 5 February 2002.

In its brief, the Legal Network welcomed the fact that, for the first time, the term "excessive demand" has been defined in the Regulations. However, it expressed concerns about the content of the definition. Under the proposed Regulations, demands on public services are deemed to be excessive if they exceed the demands of the average Canadian. If immigration officials look only at the cost applicants would impose, without considering contributions they could be expected to make (such as income taxes paid to the government), applicants could be excluded based solely on half a balance sheet. Applicants could be excluded even when their contributions would more than cover any costs resulting from their medical condition.

In addition, under the Regulations, expected costs are projected over a five-year period, but the period can be extended up to ten years for chronic illnesses like HIV/AIDS. The Legal Network argued that an estimate of costs extending more than five years into the future would probably be inaccurate because new treatments are always being developed and the prices of drugs fluctuate over time. It said that excluding applicants on such speculative estimates would be unfair.

Although the IRPA states that common-law partners are exempt from inadmissibility based on excessive demand on health and social services, many bona fide couples risk not being able to benefit from this provision. Under the definition of "common law" in the proposed Regulations, partners must be currently cohabiting and must have been cohabiting for at least a year. In the immigration context, many couples in genuine, committed conjugal relationships are often not able to live together. Unlike opposite-sex couples, same-sex couples do not have the option of getting married to remedy the situation and bring themselves within the family class.

In arguing for a change to the definition of "common law" in the Regulations, EGALE, a national advocacy group for lesbian, gay, bisexual, and transgendered people, told the Standing Committee that the Supreme Court of Canada has stated that *all* circumstances, not merely cohabitation, must be taken into account when deciding whether the law will treat a couple as being in a family relationship. Other circumstances include personal behaviour, social activities, economic support, and the impressions of people who come into contact with the couple.

If immigration officials look only at the cost applicants would impose, without considering their expected contributions, applicants could be excluded based solely on half a balance sheet.

Community organizations believe that the implementation of the IRPA and its Regulations will need to be carefully monitored. Now that mandatory HIV testing is being conducted routinely on almost all immigrants and refugees, it is critical that the conditions of testing and exclusion be based on a coherent policy that respects the fundamental rights of applicants, and that assesses each applicant on an individual, case-by-case basis, in accordance with Canada's immigration tradition.

– Alana Klein

Alana Klein is a student at the Faculty of Law of McGill University and the author of *HIV/AIDS and Immigration: Final Report*. She can be reached at amsk100@aol.com.

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[1] The regulations are available on the website of Citizenship and Immigration Canada at www.cic.gc.ca/english/about/policy/imm-act.html. The text of the *Immigration and Refugee Protection Act* (SC 2001, c 27) is also available on that site.

[2] Klein A. *HIV/AIDS and Immigration: Final Report*. Montréal: Canadian HIV/AIDS Legal Network, 2001 (available at www.aidslaw.ca/Maincontent/issues/immigration.htm).

[3] The brief is available on the Network's website at www.aidslaw.ca/Maincontent/issues/immigration.htm.

Physicians Dislike New Medical Marijuana Regulations

Associations representing physicians are concerned about the medical declaration physicians are required to complete under new Health Canada regulations relating to applications for the use of marijuana for medical purposes. Some physicians are refusing to complete parts of the declaration.

Physicians are concerned about the regulations for the medical use of marijuana adopted by Health Canada in July 2001.

Under the regulations, individuals who want to use marijuana for medical reasons must submit an application to Health Canada. As part of the application process, a physician must complete and sign a medical declaration stating that the recommended use of the marijuana would positively mitigate the symptoms, and that the benefits to the applicant from the recommended use of the drug would outweigh any risks associated with that use. The physician must also provide the recommended dosage of the marijuana, as well as the recommended route and form of administration. For applicants who have a terminal illness and who are expected to die within 12 months, their family physician can sign the declaration. For other applicants, a medical specialist (and, in some cases, two medical specialists) must sign.

In a letter to then Health Minister Allan Rock, dated 8 November 2001,[1] the Canadian Medical Association (CMA) said that the regulations are flawed and that they place an unfair burden on physicians. The CMA expressed concern that physicians are being asked to act as "gatekeepers" for an unproven drug, in the absence of any guidelines for the use of that drug.

The Canadian Medical Protective Association (CMPA), a medical mutual-defence organization that provides some financial assistance to physicians in the event of legal actions based on allegations of malpractice or negligence, has also expressed concerns about the regulations. In an information sheet for physicians issued in October 2001,[2] the CMPA advises physicians not to complete the portion of the medical declaration in which they are required to state that the benefits to the applicant from the recommended use of marijuana would outweigh any risks associated with that use, unless they feel that they have detailed knowledge of the effectiveness of marijuana use for the patient's particular condition.

The CMPA also states that a physician would likely have difficulty determining the recommended dosage of marijuana and the recommended route and form of administration, given the lack of research in this area and the general unfamiliarity of the medical profession with the benefits of marijuana for medical purposes. The CMPA is concerned that if some harm to the patient results from the use of marijuana obtained through this process, the physician who signed the medical declaration could be held liable. In its letter to Minister Rock, the CMA said that the regulations place physicians in a precarious legal position.

The CMPA recommends that physicians who do not feel qualified to make any of the declarations required by the regulations should not feel compelled to do so. In Ontario, there have been reports of family physicians refusing to complete all parts of the medical declaration, either because they are not willing to state that their patient has only 12 months to live, or because they do not feel comfortable stating that marijuana will mitigate the symptoms.

When the regulations were first released, many people said that they were unnecessarily and unjustifiably restrictive and that this would impede access to marijuana for medical use. If many physicians refuse to complete the required medical declaration, access will be even more difficult.

– David Garmaise

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[1] Available on the CMA's website at www.cma.ca (under News Releases).

[2] What to do when your patients apply for a licence to possess marijuana for medical purposes. Canadian Medical Protective Association, October 2001 (available on the CMPA's website at www.cmpa.org/cmpaweb/public/english/index-e.cfm).

Blood Donor Screening Practices Criticized

Critics say that the question about gay men on the questionnaires used to screen blood donors is outdated and discriminatory. But a consensus panel formed to examine the screening process says that the safety of the blood supply is paramount and that any changes to the questionnaire might undermine public confidence in the system.

Gay groups and student associations told a conference on blood donor screening practices that the question about gay men on the questionnaires used to screen donors is outdated and discriminatory. The organizations were presenting at a consensus conference on the blood donor selection process held in Ottawa on 7-9 November 2001. The conference was organized by the Canadian Blood Services (CBS) and Hema-Québec.

The questionnaires include the following question (posed only to men): "Have you had sex with a man even one time since 1977?" If a potential donor answers in the affirmative, he is barred for life from donating blood. The gay groups and student associations said that the question is too blunt and that it is too vague to accomplish the objective of turning away infected donors. They said it should be replaced with a question, or series of questions, that focus specifically on whether potential donors, homosexual and heterosexual, have engaged in high-risk sexual activities such as unprotected anal sex.

One of the presenters, EGALE Canada, a national advocacy group for lesbian, gay, bisexual, and transgendered people, said that the current screening practices were inconsistent with public health guidelines on HIV/AIDS, which stress high-risk activities, not high-risk groups.[1] It pointed out that this discordance may increase the risk of exposure to HIV both inside and outside the blood system. EGALE said that the current practices contribute to homophobia and undermine the confidence of Canadians in the equity, effectiveness, and safety of the blood system.

However, an 11-member consensus panel formed by the conference organizers, issued a draft statement at the end of the conference that steered away from recommending any changes to the questionnaire.[2] Instead, the panel, which was composed mostly of doctors, lawyers, and ethicists, focused on a series of guiding principles for donor screening, including the principle that the safety of the blood system is paramount. The panel said that a policy of excluding certain groups may be justified where there is scientific information to back up the policy. It also said that any proposed changes in the wording of the questionnaire should be weighed against the possibility that changes in the document could reduce confidence in the blood system. The panel did acknowledge, however, that any exclusion of high-risk groups must be justified to those groups and to the general public.

The consensus panel will produce a final statement which will be published in the spring of 2002 in the *Transfusion Medical Review*. The CBS had indicated that it will consider the final consensus statement in future when it looks at the blood donor screening criteria. It said that any changes to the criteria would have to be approved by the regulator, Health Canada.

– David Garmaise

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[1] EGALE presentation to the conference, on file.

[2] M Kennedy. Safety of blood system paramount: Critics tell conference question about sex between men is outdated, too blunt. *Windsor Star*, 10 November 2001.

Drug Treatment Court Opens in British Columbia

British Columbia has launched its first drug treatment court. Designed as a mandated addiction treatment alternative to incarceration, the court will attempt to steer drug users charged with drug-related offences away from jail and into rigorous supervised addiction treatment. While some have applauded this recent development, local experts have criticized the move, citing the lack of evidence supporting the efficacy of drug courts and the need for more voluntary treatment programs.

The Drug Treatment Court of Vancouver (DTCV) officially opened its doors on 4 December 2001. Drug treatment courts have flourished in the United States in response to rising incarceration rates among drug users,[1] and in 1998 a drug treatment court program was initiated in Toronto. The underlying assumption driving this form of intervention is that addiction and drug use are often not deterred by criminal justice sentences.[2] Drug treatment courts have been designed to provide a combination of judicial supervision and intensive drug treatment that promotes treatment compliance, reduced drug use, and decreased recidivism.[3]

The DTCV initiative, which is a demonstration project, is a joint effort by the governments of Canada, British Columbia, and the City of Vancouver. The project is funded in part by the Crime Prevention Investment Fund through the National Strategy on Community Safety and Crime Prevention. The Ministry of the Attorney General of British Columbia will oversee the project, which will take place over a four-year period from December 2001 to November 2005. Included is a project evaluation that will focus on both process and outcome indicators.

Under the DTCV program, "non-violent offenders charged under the Controlled Drugs and Substances Act with possession, trafficking and possession for the purpose of trafficking of either cocaine or heroin"[4] can be considered for inclusion in the program. The DTCV team consists of a judge, prosecutor, defence counsel, case managers, and treatment providers. As a first step, each potential participant is screened by a health professional who determines whether substance dependency exists. An individual deemed eligible will have a choice to participate in "an intensive and co-ordinated combination of judicial supervision, multi-phased treatment … and a range of community supports."[5] If a participant successfully completes the program, a non-custodial sentence may be granted or charges may even be dropped.[6] Conversely, participants who opt out of the program or fail to meet program demands must return to a regular court process and sentencing.

The excitement surrounding drug treatment courts has been tempered by criticisms by local experts. In a recent article, Professor John Anderson of the Department of Psychiatry at the University of British Columbia has questioned the wisdom of establishing a drug treatment court program in Vancouver. In his review of drug treatment court research, Dr Anderson concludes:

> Despite the popularity of drug courts, there is no evidence that drug court programs produce outcomes that are superior or even equal to outcomes achieved by voluntary treatment programs. Canadian drug policy should promote expansion of proven effective voluntary treatment for illicit drug misusers before endorsing unproven mandatory treatment programs, e.g., drug courts, that rely on legal coercion.[7]

While numerous evaluations of drug treatment courts have been completed, most have suffered from methodological shortcomings or have produced modest or insignificant findings, leading Anderson and other researchers to question whether "drug courts are more 'popular' than 'good.'"[8] Some of the major problems relate to limited tracking of long-term outcomes such as post-program recidivism and drug use, and to a lack of randomization of participants and appropriate control or comparison groups. As well, evaluations completed to date have indicated that program completion rates are low (in most cases less than 50 percent). In Toronto, only one participant had successfully completed the drug treatment court program after one year.

Critics have also suggested that drug treatment courts may not be a good fit in the Vancouver context. Anderson's article cites results from a US study that found participants with alcohol or marijuana problems and full-time employment were most

likely to complete a drug court program. Anderson points out that this profile is strikingly different from the street-based cocaine and/or heroin user that frequents Vancouver's Downtown Eastside.

Given the growing consensus that drug addiction is first and foremost a health problem, the implementation of a judicially enforced drug treatment approach may seem to some like a retreat into enforcement-based drug policy. Others may see drug courts as a sign that the judicial system is becoming more liberal in its treatment of drug users. Regardless, only time and rigorous evaluation will reveal whether the DTCV can contribute to a reduction of drug-related harm in Vancouver.

– Thomas Kerr

[1] J Anderson. What to do about "much ado" about drug courts. *International Journal of Drug Policy* 2001; 12: 469-475.

[2] D MacPherson. A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver. City of Vancouver, 2001.

[3] Anderson, supra, note 1.

[4] Drug Treatment Court of Vancouver Program. Department of Justice, 2001. Retrieved from http//: Canada.justice.gc.ca/en/news/nr/2001/doc_27970.html.

[5] Ibid.

[6] MacPherson, supra, note 2.

[7] Anderson, supra, note 1 at 469.

[8] Ibid at 470.

BC Introduces a New Social Assistance Benefit, Slashes Others

A new $225 monthly health benefit for food, vitamins, minerals, and bottled water is introduced while other health benefits are cut.

In October 2001, the government of British Columbia introduced a new health benefit for individuals on income assistance who are living with a serious progressive disease. The new benefit provides a monthly health allowance of up to $225 for food, vitamins, minerals, and bottled water. For individuals eligible for the benefit, their monthly income will be increased by 28.6 percent (from $786.42 to $1011.42).

While this benefit appears to be a positive step toward meeting the health needs of disabled individuals, a number of other health benefits were unfortunately repealed at the same time. Medications not covered by Pharmacare (the provincial program providing drug coverage for British Columbians), counselling for suicide ideation, and complementary health therapies are examples of health benefits that have been lost. As a result, the net benefit of the changes to HIV-positive individuals and the entire disability community is unclear.

As well, the British Columbia Persons with AIDS Society (BCPWA) has expressed grave concerns that the eligibility criteria and assessment process for the new benefit are confusing for doctors and are highly restrictive.[1] BCPWA is aware of a number of individuals who have been denied the benefit but who legitimately need it.

BCPWA has lobbied the provincial government for many years to provide a monthly health allowance to people with HIV/AIDS. In the spring of 2001, BCPWA and the cross-disability community worked with the then NDP government of British Columbia to develop and implement a new monthly health benefit of $300 that would not erode any other health benefits. This benefit would have included all persons living with a serious progressive disease. Unfortunately, the new Liberal government has refused to consult with the community on the development and implementation of its revised benefit.

The impetus for the new benefit was the overwhelming success of community groups in winning monthly health allowances through the income assistance appeal process. Starting in 1996, BCPWA developed a legal argument to the effect that the government was obligated under its income assistance legislation to provide additional funding to people with HIV/AIDS for nutritious food, vitamins, minerals, and safe bottled water to enhance health and to slow the progression of the disease. In the last five years, BCPWA has applied for over 450 monthly health allowances for people with HIV/AIDS, averaging over $400 a month. Each application

was denied by the government and was subsequently won on appeal. The benefits secured by BCPWA for people with HIV/AIDS over this period amount to over $5 million.

While the application process was successful in securing additional benefits for individuals, the process itself took a significant amount of time and many people died waiting. Once an application was submitted, the process typically took about a year. In addition, BCPWA has been overwhelmed by the demand and has a waiting list of over 500 people needing its services. On average, individuals wait 2.5 years before receiving an appointment with a BCPWA advocate. BCPWA concluded that a lower benefit, provided expeditiously, would give more people the money they needed to purchase necessary health products.

For more information, please contact the intake desk at the BCPWA Advocacy Department at 604 893-2284.

– Tarel Quandt

[1] Letter from Glen Hillson, Chair, BCPWA to Hon. Murray Coell, Minister of Human Resources, Government of British Columbia. 7 November 2001 (on file).

British Columbia Poised to Reduce Drug Coverage

The government of British Columbia is reviewing its Pharmacare program and plans to de-list drugs currently covered. The British Columbia Persons with AIDS Society has objected to the plan and has called on the government to consider other ways of addressing the rising costs of prescription drugs.

The British Columbia Persons with AIDS Society (BCPWA) is lobbying the BC government to avoid de-listing drugs from the province's Pharmacare program and instead to consider other measures to address the rising costs of prescription drugs. Pharmacare is the program that provides varying coverage for prescription drugs to all British Columbians. Individuals living on social assistance and seniors receive 100 percent coverage. All others not covered by a private plan pay only the first $800 each year, after which Pharmacare covers 70 percent of costs up to $2000 and 100 percent of the costs beyond that.

The government is currently conducting a review of Pharmacare. It plans to reform the program and to de-list many drugs currently covered by the program, presumably as a cost-cutting measure. Although organizations such as the BC College of Pharmacists and the national organization of brand-name pharmaceuticals manufacturers were asked to provide input into the review, the government has failed to consult community organizations. BCPWA sent in an unsolicited submission and also called on the government to consult more openly and more widely.

Under the current Pharmacare program, HIV/AIDS drugs are fully covered. In its submission, BCPWA argued that such coverage saves the province money because it allows many British Columbians to continue in gainful employment rather than be forced by the high costs of the drugs to quit work and go on social assistance just to maintain coverage. BCPWA also argued that the current system of coverage in BC has resulted in very high enrollment in the province's HIV/AIDS drug treatment program, thereby facilitating effective individual treatment and the collection of valuable information about treatment practices.

BCPWA said that Pharmacare cutbacks could lead to greater acute and chronic care costs. As well, it said that the government should grapple with the difficult issues of excessive patent protection, inadequate price controls, and over-prescription and inappropriate prescription of pharmaceuticals instead of trying to cut costs by cutting access to drugs.

In its submission,[1] BCPWA proposed several measures the government could consider to control drug costs, including the following:

- British Columbia should advocate for, and participate in, the creation of a national Crown corporation that would act as the sole purchaser and distributor of pharmaceuticals listed on the drug formularies of all provinces and territories.
- The government should undertake public education campaigns

aimed at consumers, physicians, and pharmacists on the merits of the current reference-based pricing program. Such a campaign would allow the government to show that the current program helps to counteract the growing problems of drug promotions targeted at physicians and direct-to-consumer advertising.

- British Columbia should pressure the federal government to toughen regulations concerning pharmaceutical advertising.
- The government should implement new administrative systems for the distribution and tracking of the consumption of pharmaceuticals. Such systems would assist in identifying and moderating instances of over-prescription and inappropriate prescription.

– Tarel Quandt

[1] Letter from Glen Hillson, Chair, BCPWA to Hon. Colin Hansen, Minister of Health Services, Government of British Columbia. 28 September 2001 (on file).

Manitoba to Develop Aboriginal AIDS Strategy

Manitoba has embarked on a process to develop a Provincial Aboriginal AIDS Strategy separate from the Provincial AIDS Strategy.

Manitoba is developing a separate AIDS strategy for Aboriginal people. The Provincial Aboriginal AIDS Strategy will complement the Provincial AIDS Strategy but will be separate from it.

So far, a community advisory board has been established, and focus group meetings have been held with frontline workers. A report on the focus group meetings is expected to be released in early 2002. It will be followed by a process of dialogue among Aboriginal leadership, regional health authority leadership, and provincial government officials about what the strategy should contain, how it should be implemented, and what resources will be required. This dialogue will involve individual meetings with the leaders, followed by a joint round table to discuss options.

Aboriginal people account for about one-third of new HIV infections in Manitoba.

For more information, contact Helen Young, the Manitoba representative on the Board of Directors of the Canadian Aboriginal AIDS Network, at 204 627-1500, hyoung@tribalhealth.ca.

– David Garmaise

Ontario Adopts "Blood Samples" Legislation

Under the new legislation, a Medical Officer of Health can order blood testing when victims of crime, emergency service workers, "good Samaritans," and others have reason to believe that they may have been exposed to a communicable disease.

On 13 December 2001, the Ontario Legislature passed a private member's bill that authorizes a Medical Officer of Health to order a blood sample to be taken from a person and tested for a communicable disease. Bill 105, introduced by Garfield Dunlop, a backbencher in the Conservative government, is formally titled "An Act to amend the Health Protection and Promotion Act to require the taking of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons."[1] The legislation is similar to Bill C-217 (the *Blood Samples Act*), a Canadian Alliance private member's bill intro-

duced in the House of Commons (see the article in this issue on compulsory testing of source persons in the event of an occupational exposure).

The only witness called by the Standing Committee was Dr Colin D'Cunha, the Chief Medical Officer of Health, who opposed the legislation.

The Ontario legislation is designed to provide victims of crime, emergency service personnel, people who provide first aid, or those performing jobs defined by future regulations with the ability to force a person who is the source of an exposure to a bodily substance to undergo blood testing. The rationale is that if an exposure has occurred, and the disease status of the source person is unknown, non-consensual testing is justified because it will result in peace of mind for the exposed person and allow for timelier and better decisions about prophylaxis.

Under the legislation, the person who wants the testing done has to apply to a local Medical Officer of Health. The applicant has to establish that they are in one of the classes of people who have the right to apply for such an order. The Medical Officer of Health must conclude that reasonable grounds exist for believing that the applicant may become infected as a result of an exposure to a prescribed communicable disease. The Medical Officer of Health can then issue an order requiring a person to submit to giving a blood sample for testing. The person ordered to give a blood sample may appeal the order within 15 days to the Health Services Appeal Board. The applicant who wants the testing done can appeal to the province's Chief Medical Officer of Health if their application is denied at the local level.

On 11 October 2001, the HIV & AIDS Legal Clinic (Ontario) notified caregivers and service providers around the province about Bill 105 and encouraged people to try to present their views to the Standing Committee on Justice and Social Policy, which examined the bill after it received second reading in the Legislature. Those who contacted the clerk of the Standing Committee to request an opportunity to speak to the bill were informed that no decision had been made about oral presenters, but that people were welcome to send in written submissions. Without any notice to those who had expressed a desire to address the Committee, the Standing Committee met to discuss Bill 105 on 4 December 2001. The only witness called by the Standing Committee was Dr Colin D'Cunha, the Chief Medical Officer of Health for Ontario, who opposed the legislation.[2]

Concerned individuals, doctors, lawyers, and AIDS activists wrote letters and emails to their MPPs and the Minister of Health about the bill. As a result, the government decided to send the bill back to the Standing Committee to consider amendments that it had drafted.

The amendments, all of which were eventually incorporated into the legislation, do not significantly alter the thrust of the bill. The amendments require that an applicant who wants the testing undergo a medical examination and submit a physician's report; that the physician performing the examination be empowered to order the applicant to undergo baseline testing, counselling, and treatment; that the physician's report be filed with the Medical Officer of Health when an application for an order is made; and that the report be considered by the Medical Officer of Health before an order can be issued.

When the bill was passed by the Ontario Legislature, late on 13 December 2001, only two MPPs, both opposition members, voted against it. On 14 December 2001, the bill received royal assent and became law in Ontario. At the time of writing, the bill had not yet been proclaimed into force, as details of its application were being worked out by the provincial government.

For more information, contact the HIV & AIDS Legal Clinic (Ontario) at 416 340-7790 or email to talklaw@halco.org.

– Ruth Carey

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[1] SO 2001, c 30. The full text of the law can be found on the website of the Ontario legislature at www.ontla.on.ca/library/bills/105372.htm.

[2] Dr Colin D'Cunha, Chief Medical Officer of Health for Ontario. Submission to Standing Committee on Justice and Social Policy: Bill 105. 4 December 2001.

New *Ontarians With Disabilities Act* Finally Adopted

After several false starts, Ontario has passed legislation designed to remove barriers faced by disabled persons, including the barrier of stigma.

On 13 December 2001, the Ontario legislature finally adopted a new *Ontarians with Disabilities Act* (ODA).[1] The Act has not been well received by the disability community.

In May 1995, the government promised in writing to pass legislation to remove barriers preventing the full integration of disabled people into all walks of life in Ontario.[2] The first attempt to pass an ODA was in the fall of 1998. The bill received so much criticism that the government allowed it to die on the order paper. In 1999, a motion requiring the government to enact an effective ODA before 23 November 2001 passed unanimously in the legislature.[3]

The ODA requires the government and related agencies to file annual plans detailing how they are going to address and remove barriers to disabled people within their organizations. Failure to file an annual plan can result in a fine of $50,000. Unfortunately, the ODA contains no provisions to force compliance with any of these plans. Furthermore, the Act does not cover private-sector employers and facilities.

The ODA is of interest to HIV/AIDS-affected communities because it defines the term "barrier" to include "attitudinal" barriers. As a result, the Act could be used by advocates to address some of the stigma associated with HIV/AIDS.

An excellent analysis of Bill 125, the legislation that was adopted in December, has been published by ARCH: A Legal Resource Centre for Persons with Disabilities, in the 20 November 2001 edition of "ARCH Alert." Copies of the analysis can be obtained by contacting Bettina Worth at 416 482-8255, worthb@lao.on.ca, or from the ARCH website at www.arch-online.org. Another excellent online source of information about the ODA is the website maintained by the Ontarians with Disabilities Act Committee, a coalition of individuals and community organizations that lobbied for new legislation, at www.odacommittee.net.

– Ruth Carey

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[1] A copy of the ODA can be obtained on the website of the Legislative Assembly of Ontario at www.ontla.on.ca (look for "Bill 125").

[2] Letter from Ontario Premier Mike Harris to David Baker, Executive Director of the Advocacy Resource Centre for the Handicapped (ARCH), 24 May 1995 (available on the website of the Ontarians With Disabilities Act Committee at www.odacommittee.net/promise.html).

[3] Hansard of the Legislative Assembly of Ontario. 23 November 1999 (available on the website of the Assembly at www.ontla.on.ca).

INTERNATIONAL NEWS

This section provides brief reports on developments in HIV/AIDS-related law and policy outside Canada. The coverage is selective, and court cases are covered in HIV/AIDS in the Courts – International. Contributors to International News in this issue are: Hilde Basstanie, David Garmaise, Stella Iwuagwu, Kaumbu Mwondela, Lisa Oldring, Carla Rivera-Avni, Anand Tewari, Beate Trankmann, and Simon Wright. We welcome information about new developments for futures issues of the Review. Address correspondence to David Patterson, the editor of International News, at dpatterson@aidslaw.ca.

United Nations Declaration of Commitment on HIV/AIDS

The United Nations General Assembly Declaration of Commitment on HIV/AIDS calls for a fundamental shift in the response to HIV/AIDS.

In June 2001, the United Nations General Assembly met in a Special Session (UNGASS) to consider the international response to the HIV/AIDS epidemic. The major output of the Special Session was a Declaration of Commitment on HIV/AIDS – a practical blueprint for action. All 189 UN member states adopted the Declaration of Commitment by acclamation. Although there was obvious disappointment with compromises on some of the key issues, the Declaration is nevertheless a strong document and an unprecedented achievement. Not all the elements in the Declaration are new, but the political endorsement of its basic principles, combined with an annual progress review by the UN Secretary-General and the UN General Assembly, should lend impetus to international efforts to combat the epidemic.

The Declaration of Commitment calls for a fundamental shift in the response to HIV/AIDS. HIV/AIDS is now viewed by world leaders as a global economic, social, and development issue of the highest priority, and the single greatest threat to the well-being of future generations in many parts of the world. The implications of this shift for all countries are profound and far-reaching. Effective responses to the epidemic will require innovative and expanded interventions with unprecedented levels of broad-based multi-sectoral collaborations.

The Declaration of Commitment recognizes that:

- the full realization of human rights is an essential element in all areas of the global response;
- the full and meaningful involvement of people living with HIV/AIDS is required in all aspects of the response;
- prevention is the mainstay of the response and that prevention, care, support and treatment, including access to medicines, are mutually reinforcing elements of the response;
- the response must focus on those people who are vulnerable and at highest risk of infection;
- gender equality and empowerment of women are fundamental elements of prevention and reducing vulnerability;
- the HIV/AIDS pandemic is having a devastating effect on development;
- HIV/AIDS has a reciprocal relationship to poverty;
- the creation of enabling environments is necessary to foster and sustain an effective response;
- new and innovative types of leadership are required – leadership from government, communities, people living with HIV/AIDS, and the private sector; and
- an international response is a prerequisite to effective action.

In particular, the Declaration commits states to "enact, strengthen or enforce

as appropriate, legislation, regulations and other measures" to address discrimination and promote human rights.

Canada was praised internationally for its leading role in involving civil society at the Special Session and its preparations.

Canada's official delegation included two representatives of the HIV/AIDS community, one of whom was a person living with HIV/AIDS. Health Canada funded the participation of seven Canadian NGOs accredited to the Special Session. The Canadian International Development Agency provided assistance for the participation of civil society from developing countries.

Health Canada has published a report that contains some key documents from the Special Session as well as reports on Canada's participation in this historic and unprecedented event.[1] It also contains information on where to find copies of other relevant UNGASS documents.

United Nations Resident Coordinators Promote Declaration of Commitment

UN Resident Coordinators are responsible for promoting coordination of United Nations operations at the country level. Following the UN General Assembly Special Session on HIV/AIDS in June 2001, the UN Development Group circulated a guidance note to Resident Coordinators explaining the Declaration of Commitment and setting out principles that should guide UN system support to the Declaration. These guidelines included the statement that "[t]he UN system should support prevention, care and treatment programmes, which place respect for human rights at their core." The note also stresses the principles of non-discrimination, equality, and participation. Full documentation is available, following free registration, at www.dgo.org.

ICASO Advocacy Guide

In October 2001, the International Council of AIDS Service Organizations published the *Advocacy Guide to the Declaration of Commitment on HIV/AIDS*. The Guide provides suggestions for ways in which non-governmental organizations can use the Declaration to enhance the response to HIV/AIDS at the national and regional levels, including by endorsing the Declaration. On its website, ICASO will keep a register by country of organizations endorsing the Declaration. For further information, contact ICASO by email at ungass@icaso.org or on its website at www.icaso.org.

[1] *Report on the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS*. Ottawa: International Affairs Directorate, Health Canada, 2001 (available at www.hc-sc.gc.ca/datapcb/iad/ih-e.htm).

Parliamentarians Take the Initiative on HIV/AIDS

In 1999 UNAIDS and the Inter-Parliamentary Union jointly published the *Handbook for Legislators on HIV/AIDS, Law and Human Rights*.[1] This section describes initiatives taken by parliamentarians to promote legal and policy responses to the HIV/AIDS epidemic which respect human rights.

Joint Declaration on the Role of Parliamentarians

At the UN General Assembly Special Session on HIV/AIDS in June 2001, a joint declaration on the role of parliamentarians in the fight against HIV/AIDS was issued by four regional parliamentary networks on population and development (Asia, African/Arab, Inter-American and Inter-European) and the United Kingdom All-Party Parliamentary Group on HIV/AIDS. The statement can be obtained in English, French, and Spanish from the Inter-European Parliamentary Forum on Population and Development (available via www.europarlyvoices.org).

Inter-Parliamentary Union Adopts Wide-ranging Resolution

In September 2001, the 106th Inter-Parliamentary Conference, meeting in Ouagadougou, Burkina Faso, called on all parliamentarians "to step up their national efforts to establish effective national and international AIDS policies and programmes … including the use of condoms, measures to counter discrimination, and the provision of care to affected persons, including orphans." The resolution urged governments to give human rights precedence over trade rights, and urged pharmaceutical companies to reduce the prices of medicines "above all in developing countries." A full text of the resolution can be found at www.ipu.org.

Southern African Parliamentary Forum Creates Standing Committee on AIDS

The Southern African Development Community (SADC) Parliamentary Forum brings together the speaker and three members of parliament from different parties from each of the twelve SADC member countries. On 26 March 2001, the Forum's Plenary Assembly held a discussion on HIV/AIDS, with the participation of representatives of the UK All-Party Parliamentary Group on AIDS. One of the outcomes was a decision to create a standing committee on HIV/AIDS. Each parliamentary delegation also committed to investigate setting up backbench committees or groups on HIV/AIDS to establish a stronger role for parliamentarians (except for South Africa, which already has an All-Party Parliamentary Group on AIDS). The Forum also resolved that it wished to see a conference or seminar on the role of backbench parliamentarians in tackling HIV/AIDS, although this did not take place in 2001 due to lack of funds. For further information on the SADC Parliamentary Forum, see its website at www.sadcpf.org.

Tanzanian President Launches Parliamentary Coalition (TAPAC)

TAPAC was registered as an NGO in April 2001 and was launched officially by the President of Tanzania on 3 November 2001. TAPAC has over a hundred members and its objectives include the promotion of appropriate legislation and human rights. The Chair, the Honourable Lediane Mafuru Mung'ong'o, an MP from Iringa Urban, has been mobilizing MPs around HIV/AIDS issues since she became a member of Parliament in November 2000.

Two information seminars were held in November 2001, on "Facts about HIV/AIDS" and "Stigma and HIV/AIDS." TAPAC has an office adjacent to Parliament for an information centre, and will shortly provide counselling and testing services. TAPAC members have resolved to engage in advocacy in their districts and constituencies. For further information, contact Hilde Basstanie, UNDP Tanzania (hilde.basstanie@undp.org).

Inter-American Parliamentary Group Publishes Legislative Training Module

In 2000 the Inter-American Parliamentary Group on Population and Development (IAPG) published an HIV/AIDS legislative training module for parliamentarians in the Latin American and Caribbean region. The module compiles HIV/AIDS legislation in nine countries of the region, and offers conceptual tools to identify the fundamental rights that should be taken into consideration in HIV/AIDS legislation. It also identifies obstacles in the adoption and implementation of HIV/AIDS legislation in the region. The training module will soon be available in English, and was published with the financial support of the Central American HIV/AIDS Prevention Project (available via www.pasca.org/).

On 16-17 September 2001, the IAPG held a meeting in Barbados with Caribbean parliamentarians to discuss collaboration between regional agencies such as the Caribbean Community and the Caribbean Epidemiology Centre, government representatives, United Nations agencies, and family planning associations. One of the main topics was the impact of the HIV/AIDS epidemic in the Caribbean, especially among adolescents, and strategies and concrete initiatives to combat the epidemic. For further information about any of these initiatives contact Carla Rivera-Avni (crivera@ippfwhr.org).

UK All-Party Parliamentary Group on AIDS Releases Report and Recommendations

In July 2001 the UK All-Party Parliamentary Group on AIDS (APPGA) released a report of the inquiry into the UK's respect for and promotion of the International Guidelines on HIV/AIDS and Human Rights. This is the first time a parliamentary group has reviewed national compliance with the Guidelines.

In a previous issue of the Review,[2] it was noted that follow-up to the

1996 International Guidelines on HIV/AIDS and Human Rights,[3] published by UNAIDS and the Office of the High Commissioner for Human Rights, has been lacking. This is disappointing because the Guidelines offer a framework for the adoption of a rights-based approach to HIV/AIDS. The APPGA initiative in convening the inquiry and publishing the Report provides a model of what countries could or should do to increase compliance with the International Guidelines.

The APPGA is not an official committee of the UK Parliament, but is recognized by the Speaker and entitled to use the facilities to enable parliamentarians to develop their areas of interest. Founded in 1986, it now comprises 160 MPs. Its objectives are to raise the profile of HIV/AIDS, both as a domestic and an international issue, to encourage cross-party consensus, and to act as a bridge between Parliament, the government, and people living with or working with HIV/AIDS.

The Report of the Inquiry examines how well the UK has respected and promoted the International Guidelines, and outlines political actions that are urgently required. It looks at each of the twelve points in the International Guidelines and makes 136 observations and recommendations on how the British government can better incorporate each guideline into policies and practice. Both domestic and international situations are examined, with specific examples from the UK.

Recommendations for action are given, including better interdepartmental cooperation, both on domestic and international HIV issues; greater consultation with people with HIV and from affected communities; amendments of domestic legislation, including the criminal law, so as not to discriminate between homosexual and heterosexual acts; maintaining and extending harm-reduction approaches to injecting drug use; a comprehensive review of the laws relating to prostitution; and the introduction of needle and syringe programs and other measures in prisons. The APPGA will actively pursue the implementation of these recommendations through parliamentary questions, debates, and direct contacts with ministers.

While the report has direct relevance to UK policy domestically and internationally, the APPGA itself, and the process of consultation that led to the report, have now become models for parliamentarians engaging with government policy on HIV/AIDS. For a copy of the report, see the APPGA website at www.appg-aids.org.uk. (For another example of what can be done to promote the International Guidelines, see the Australian implementation measuring tool.[4])

Indian Parliamentarians Establish Parliamentary Forum on AIDS

In December 2001, seven MPs from the Indian federal parliament visited London to meet the UK All Party Parliamentary Group on AIDS, as well as visit a number of projects and government departments. The visit was supported financially by UNAIDS. Following the UK visit, about 40 MPs met in New Delhi on 21 December 2001 to establish a Forum on HIV/AIDS open to all MPs, who will be encouraged to chair local HIV/AIDS committees in their constituencies. The first Chair of the Forum will be Mr Oscar Fernandes, General Secretary of the Congress Party. All major Indian political parties were represented. For further information contact Anand Tewari (anandt@youandaids.org).

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[1] Geneva: UNAIDS and the Inter-Parliamentary Union, 1999.

[2] D Patterson. International Guidelines on HIV/AIDS and human rights – three years on. *Canadian HIV/AIDS Policy and Law Newsletter* 1999; 5(1): 30-31.

[3] Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. *HIV/AIDS and Human Rights: International Guidelines*. United Nations, New York and Geneva, 1998 (HR/PUB/98/1), section 28(b) at 12 (available on the UNAIDS website via www.unaids.org).

[4] H Watchirs. International HIV/AIDS guidelines: does Australia comply? In: Australian Federation of AIDS Organisations. *HIV/AIDS Legal Link* 2000; 11(1)(March): 1. The rights analysis instrument can be obtained from the Australian Council on AIDS, Hepatitis C and Related Diseases at www.ancahrd.org/pubs/index.htm#hiv.

Other Developments

Nigerian Seminar for Judges and Magistrates

On 19 September 2001, over 70 judges, magistrates, and others attended a sensitization seminar on HIV/AIDS in Lagos hosted by the Center for the Right to Health. In the keynote address the Chief Judge of Lagos State, the Honourable AI Sotuminu, noted that one of the biggest problems was the violations of the human rights of people living with HIV/AIDS. Presentations were also made by Dr Aderemi Desalu of the Lagos State AIDS Control Agency, Dr Pat Matemilola of the Network of People Living with HIV/AIDS in Nigeria, and by Justice Izuako of Idemili High Court, Anambra State, who cited decisions from other jurisdictions such as South Africa, Canada, and the US, and urged Nigerian courts to borrow from the experience of these jurisdictions. The Center for the Right to Health prepared a booklet summarizing key cases, which was presented to the participants. For further information, contact Stella Iwuagwu, Center for the Right to Health (iwuagwus@yahoo.co.uk).

Zambian Draft National AIDS Policy Addresses Human Rights

In 2001 the Zambian National HIV/AIDS/STD/TB Council prepared a draft National AIDS Policy that recognizes stigma and discrimination as adverse impacts of the pandemic. The policy also recognizes the need for legislation and policy addressing HIV specifically, and proposes government action as follows:

- *HIV testing*: encourage voluntary counselling and testing, maintain confidentiality, legalize mandatory testing for sexual offenders, do not encourage anonymous testing without consent except in research;
- *Partner notification*: legislate against those who deliberately withhold their HIV status from their partners;
- *People with disabilities*: integrate HIV/AIDS into existing delivery systems;
- *Children and young people:* penalize parents for neglect of street children, protect confidentiality of children's HIV status; and
- *Wilful transmission*: legislate against perpetrators and introduce victim support systems.

In another development, in 2001 the Network of Zambian People Living With HIV/AIDS (NZP+), in partnership with organizations including the Legal Resources Foundation, Women and Law in Southern Africa, Kara Counseling, the YWCA, and the Zambia AIDS-Law Research and Advocacy Network (ZARAN), launched a Human Rights Referral Centre in Lusaka. For further information, contact Kaumbu Mwondela, Zambian AIDS-Law Research and Advocacy Network (kaumbu@yahoo.com).

Tanzanian HIV/AIDS and Human Rights Project

In 2002, the Arusha-based AIDS NGO Network of East Africa will undertake a project on human rights and HIV/AIDS, funded by UNAIDS. The project will support a human rights lawyer to undertake a situation assessment on HIV/AIDS-related human rights issues. A stakeholder workshop on HIV/AIDS and human rights to discuss the findings and develop a plan of action will take place in June 2002. For further information contact Hilde Basstanie, UNDP Tanzania (hilde.basstanie@undp.org).

Kenyan National Consultation on Law Reform

The Legal Task Force on Issues Relating to HIV/AIDS was established by the Attorney General of Kenya, the Honourable Amos Wako, in June 2001, to make recommendations to the government on a possible legal framework for HIV/AIDS. It will finish its work in June 2002. On 6-7 December 2001, the Task Force held a workshop in Nairobi. Papers were presented on a wide range of topics, including access to treatments, prisons, education, insurance, inheritance, patents, and privacy. Papers on the legal responses in Canada, South Africa, and the US were also presented. For further information, contact the Task Force Chair, Ambrose Rachier (rachier@africaonline.co.ke).

Asia Pacific Workshop on HIV/AIDS and Human Rights

On 7-8 October 2001 the Asia Pacific Forum of National Human Rights Institutions (APF) held a workshop on HIV/AIDS and human rights in Melbourne, Australia, as a satellite meeting of the Sixth International Congress on AIDS in Asia and the Pacific (ICAAP). The goal of the

workshop was to enhance awareness of, and cooperation on, HIV/AIDS-related human rights issues in the Asia Pacific region through the promotion and strengthening of national human rights institutions. Specific objectives were to increase the understanding of the role of national human rights institutions in addressing HIV/AIDS-related human rights issues, including through the development of joint projects, training programs and staff exchanges, and the development of practical strategies for national human rights institutions to use in addressing HIV/AIDS-related human rights issues.

The workshop focused on HIV/AIDS-related human rights issues – including the right to health, the right to education, the right to equality and non-discrimination and the right to information and education – and how the core functions of national human rights institutions (complaint handling and investigation, education and promotion and legal reform) can address these issues. It also addressed regional issues of concern, including migration and population mobility, commercial sex, trafficking, and conflict and displacement. It provided APF members with a better understanding of the role of national human rights institutions in addressing HIV/AIDS-related human rights issues through their own shared experiences. For further information contact Lisa Oldring, Office of the High Commissioner for Human Rights (loldring.hchr@unog.ch).

China Launches HIV/AIDS Law Reform Project

In 2001 China launched a project titled "Promoting an enabling policy environment and quality legislation for HIV/AIDS prevention and care" with funding from UNAIDS and the UN Development Programme. The objectives of the project include the promotion of harm-minimization principles to effectively address the problems and risks associated with prostitution, injection drug use, and blood donation; and the promotion of an enabling environment for the continued economic and social life of Chinese citizens living with HIV/AIDS. Activities include an analysis of laws and regulations; workshops for government officials, police, the judiciary, and community representatives; and the formulation of policy recommendations. Further information can be found at http://ns.unchina.org/unaids/.

UK Report on Discrimination against People with HIV

In November 2001, the Terrence Higgins Trust, the largest HIV/AIDS charitable organization in the country, released a report showing that roughly 20 percent of people with HIV/AIDS in the United Kingdom had experienced discrimination in the previous 12 months. *Prejudice, Discrimination and HIV: A Report* points out that the UK's Disability Discrimination Act "has made discrimination in the workplace against a person illegal when they are unwell through HIV, but this does not cover the stigma and prejudice which they often face from their colleagues even when well."[1]

The Report also addresses discrimination in health care, from family and friends, and from the wider community. The Report discusses how various forms of discrimination based on HIV, sexuality, race/ethnicity, gender and/or drug use can manifest in such ways as harassment in the community, denial of services, bullying in schools, denial of insurance, etc. Discrimination, and the fear of it, results in people not seeking support from friends and family, not taking up employment, and not accessing HIV testing, treatment, or care. It also has led to reticence to direct HIV-prevention messages to specific populations because of the persecution they might subsequently experience.

About 20 percent of people with HIV/AIDS in the United Kingdom experienced discrimination in the previous 12 months.

The Report makes 13 recommendations to government, HIV/AIDS organizations, health-care providers, and medical schools aimed at addressing discrimination and its effects. The Report can be found on the Terrence Higgins Trust website at www.tht.org.uk/policy_discrim.htm.

UK Disability Rights Commission Calls for Amendment to Disability Discrimination Act

Under the 1995 Act, a disability is defined as "a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities" (s 1), which is widely interpreted not to cover

asymptomatic HIV infection. The UK Disability Rights Commission has called for a revision of the current law to protect people with HIV infection from discrimination from the time of diagnosis. For further information, see the 2001 Annual Review of the Disability Rights Commission at www.drc-gb.org/drc/default.asp.

UK Department of Health Revises Guidelines for Health-Care Workers with HIV

On 28 November 2001, the UK Department of Health announced that henceforth patients would not always be told if their care provider was infected with HIV. Previous policy was to inform patients regardless of how likely they were to be exposed to infection (see the report of the case of the UK health-care worker at page 75 in this issue). Under the new policy, the need to inform patients of any HIV transmission risk will be decided on a case-by-case basis. In early 2002, the Department of Health will determine, in consultation with patients and health professionals, which clinical procedures pose an actual risk of transmission. Information about UK government policy on health-care workers with HIV can be found at www.doh.gov.uk/aids.htm.

UNESCO Publishes Kit on HIV/AIDS and Human Rights for Youth Organizations

In 2001, UNESCO published a kit of ideas for youth action on human rights and HIV/AIDS. The kit was prepared in close consultation with youth organizations, in particular with students from the International Federation of Medical Students Associations and the International Pharmaceutical Students Federation. Subjects addressed include public and peer education, advocacy, and care and support. The kit adopts the International Guidelines on HIV/AIDS and Human Rights as a platform for action. The kit can be obtained from the UNESCO website at www.unesco.org/human_rights/index.htm. It will soon be available in French, Spanish, and Russian.

US CDC Revises Model Bioterrorism Law to Exclude HIV/AIDS

In October 2001, the US Centers for Disease Control and Prevention released a draft model statute, prepared by the Center for Law and the Public's Health at Johns Hopkins and Georgetown Universities, designed to give sweeping powers to state health officials in the event of a bioterrorist attack or epidemic of infectious disease. The draft statute was revised in December 2001 following widespread concerns that, while it was not intended to address HIV/AIDS, the definition of epidemic disease could have been interpreted to include HIV/AIDS, thus granting broad powers of compulsory testing and contact tracing. The December 2001 version of the model law defines a "public health emergency" as "an occurrence of imminent threat of an illness or health condition that is believed to be caused by … the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin … and that poses a high probability" of death or harm (s 104(m)). The model statute can be found via www.publichealthlaw.net.

US CDC Promotes Legal Services Referral

Revised Guidelines for HIV Counseling, Testing and Referral issued by the CDC include, for the first time, a recommendation that counselors refer people for legal services "as soon as possible after learning their test result for counseling on how to prevent discrimination in employment, housing and public accommodation by only disclosing their status to those who have a legal need to know."[2]

Kirby Honours Mann at US Conference

In September 2001, the American Society of Law, Medicine & Ethics 2001 conference "Health, Law and Human Rights: Exploring the Connections" brought together over 350 participants from 23 nations in Philadelphia, US. In his keynote address, Justice Michael Kirby of the High Court of Australia paid tribute to the pioneering work of Dr Jonathan Mann in articulating the links between HIV/AIDS and human rights. The text of Justice Kirby's address, "Thoughts in Dark Times of a World Made New," and other information about the conference can be found at www.aslme.org/humanrights2001/health_hrights_postconf.html.

VaxGen Releases Interim Results of the Clinical Trial of Its Experimental Vaccine

On 29 October 2001, the Data Safety and Monitoring Board, an independent board overseeing the Phase III clinical trial of the experimental vaccine AIDSVAX, released the results of its interim analysis. The Board said that it is not yet possible to

conclude whether the product is effective or ineffective. Therefore the trial will continue until its scheduled completion at the end of 2002. Final results are expected to be released in early 2003.

AIDSVAX is a candidate vaccine designed to prevent HIV infection. The interim analysis applies to a trial being run at three sites in Canada (Vancouver, Toronto, and Montréal) and at a number of sites in the United States and the Netherlands. A second Phase III trial of a different formulation of AIDSVAX is being conducted in Thailand; the interim results announced in October do not apply to the Thailand study.

With respect to safety, the interim analysis confirmed that AIDSVAX is safe and that it does not increase vulnerability to HIV infection.

The release of these interim results underscores the need for countries to begin to develop an HIV vaccine-delivery strategy, in order to be prepared for the day when an effective vaccine becomes available. If the preliminary results had shown conclusively that AIDSVAX was effective, the trial would have been stopped and VaxGen could have proceeded to apply for a licence to market the vaccine. This would have precipitated a host of questions about delivery, such as how to ensure an adequate supply of the vaccine, how to determine who will be vaccinated, who will coordinate delivery, and what strategies will be used to distribute the vaccine.

Study Shows a Quarter of World's Population Subject to Coercive Legal Measures

A global review of the WHO Directory of Legal Instruments Dealing with HIV Infection and AIDS has found that a quarter of the world's population is subject to coercive HIV/AIDS legal measures. The study by Raffaele D'Amelio and colleagues from the WHO's Department of Communicable Disease Surveillance and Response, the Italian Ministry of Defence, and the Civil-Military Alliance to Combat HIV and AIDS analyzes health legislation referring to HIV or AIDS in 121 countries, representing 85 percent of the world's population. The study notes that 11 countries have a "requirement for quarantine, isolation, or coercive hospitalization for HIV-infected people or AIDS patients with STDs in general."[3]

Although this review of legislation gives some indication of legislative trends, it should be interpreted with caution for several reasons: (1) the Directory of Legal Instruments on which the study is based is incomplete and in many cases out of date, as it relies mostly on states' voluntary notification of HIV-related law reform; (2) the Directory only records legal instruments that specifically mention HIV or AIDS whereas, for example, laws that provide protection against discrimination on the general ground of disability (judicially interpreted to include HIV or AIDS) would not be included; (3) in many cases it may be unnecessary or inappropriate to legislate directly on HIV/AIDS because existing legislation may suffice (eg, criminal provisions relating to negligence or assault causing grievous bodily harm may be sufficient to address concerns about the "wilful" spread of HIV infection); (4) there is an implicit assumption that "the more HIV-specific laws, the better;"[4] and (5) the authors make assertions not supported by the research. For example, although the article laudably cites the International Guidelines on HIV/AIDS and Human Rights, which rule out mandatory testing without informed consent,[5] the authors then state that HIV testing of pregnant women without any counselling "should probably be considered, if instrumental to a [sic] easier reaching of the target" (eg, provision of short-course antiretroviral therapy to reduce mother-to-fetus transmission of HIV).[6] This is also contrary to UNAIDS guidance on this issue[7] and, if it represents the WHO's view, demonstrates a continuing lack of policy coherence, which the creation of UNAIDS in 1996 was intended to correct.

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[1] J Kinniburgh et al. *Prejudice, Discrimination and HIV: A Report*. London: Terrence Higgins Trust, 2001, at 3, available at www.tht.org.uk/policy_discrim.htm.

[2] Revised guidelines for HIV counseling, testing and referral. *Morbidity and Mortality Weekly Report* 2001; 50 (RR-19) at 37 (www.cdc.gov/nchstp/od/draft.htm).

[3] R D'Amelio et al. A global review of legislation on HIV/AIDS: the issue of HIV testing. *Journal of Acquired Immune Deficiency Syndromes* 2001; 28:173-179 at 175.

[4] Contra M Kirby. The new AIDS virus – ineffective and unjust laws. *Journal of Acquired Immune Deficiency Syndromes* 1988; 1:304-312.

[5] Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. *HIV/AIDS and Human Rights: International Guidelines*. United Nations, New York and Geneva, 1998 (HR/PUB/98/1), section 28(b) at 12 (available on the UNAIDS website via www.unaids.org).

[6] D'Ameilo et al, supra, note 1 at 176. For a full discussion of these issues in the Canadian context see L Stoltz, L Shap. *HIV Testing and Pregnancy: Medical and Legal Parameters of the Policy Debate*. Ottawa: Health Canada, 1999 (www.aidslaw.ca/Maincontent/issues/testing/e-preg.pdf).

[7] Counselling and voluntary HIV testing for pregnant women in high HIV prevalence countries: elements and issues. Geneva: UNAIDS, 1999, 2001 (available in English at www.unaids.org/publications/documents/health/counselling/Couns2001-E.pdf, and in French at www.unaids.org/publications/documents/health/counselling/Couns_F.pdf).

GLOBAL ACCESS TO TREATMENT

At the XIII International AIDS Conference in Durban in July 2000, one of the key issues receiving long-overdue attention was that of access in developing countries to desperately needed drugs and other medical care. The Conference highlighted the role of laws on intellectual property and of international trade agreements in creating barriers to global health by maintaining drug prices beyond the reach of most developing countries and most of the world's people with HIV/AIDS and other serious illnesses.

The Conference also signaled the need for a global movement for access to treatment. Through the hard work of many organizations and activists, these issues of access to essential medicines have garnered public attention around the world. In past issues of the *Review* we addressed these issues in a section called "Patents and Prices." However, because the issues go beyond "patents and prices," we have re-named this section. From now on, in a regular section on "Global Access to Treatment," we will address issues related to improving access to adequate and affordable care, treatment, and support everywhere.

All articles in this section are written by Richard Elliott, Director, Policy & Research, Canadian HIV/AIDS Legal Network. He can be reached at relliott@aidslaw.ca.

See also the feature article "Preventing Mother-to-Child Transmission: Landmark Decision by South African Court" at page 1 in this issue.

WTO Ministerial Conference Adopts *Declaration on TRIPS and Public Health*

In November 2001, the 4th Ministerial Conference of the World Trade Organization adopted a Ministerial Declaration on public health and the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (the "TRIPS Agreement"). The Declaration represents a modest advance in addressing concerns that strict patent laws, and threats of trade sanctions, will be a barrier to most of the world's people with HIV/AIDS accessing affordable medicines. The full significance of the Declaration remains to be seen, as it depends on what political impact it has at the WTO and on its member countries, and what legal impact it will have on the interpretation of the TRIPS Agreement.[1]

Background

One of the key issues on the agenda of the WTO meeting was the need to ensure that the TRIPS Agreement (which covers patents on pharmaceutical inventions in countries that belong to the WTO) does not constrain the ability of developing and least-developed countries to protect

the public health by making important medicines more affordable.

Canada had joined a handful of wealthy countries, led by the United States and Switzerland, in opposing calls by roughly 80 developing countries for a clear Declaration by the WTO ministers aimed at ensuring that the TRIPS Agreement would not be allowed to block access to affordable medicines. In particular, one of the key elements sought by developing countries was a clear statement that "nothing in the TRIPS Agreement shall be used to prevent countries from taking measures to protect public health."[2] Numerous Canadian non-governmental organizations worked together with the goal of changing Canada's position.[3]

Developments at Doha

The Ministerial Conference ran from 9–14 November 2001 in Doha. After a great deal of hard work by advocates from around the world, both before and at the Doha meeting, the WTO ministers issued two Ministerial Declarations. One of these was a separate Declaration on the TRIPS Agreement and Public Health.

The main Declaration stresses the "importance" that the ministers attach to the interpretation and implementation of the TRIPS Agreement "in a manner supportive of public health, by promoting both access to existing medicines and research and development into new medicines." The ministers indicated that they were therefore also adopting a separate declaration on this issue. The Declaration on the TRIPS Agreement and Public Health then sets out seven paragraphs that aim to "clarify" the Agreement.

Commentary

The WTO meeting is a qualified victory for treatment advocates. Three key elements stand out as noteworthy, although their ultimate significance remains to be seen.

First, it is important that there is relatively strong language in the Declaration about the relationship between TRIPS and public health concerns. In the Declaration, the WTO ministers state:

> We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all. In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

While not as strong as a declaration that nothing in the TRIPS Agreement "shall" prevent countries from taking measures to protect public health, the final text should nonetheless be helpful in two ways:

- by guiding the interpretation of the TRIPS Agreement in future WTO disputes in a fashion that is more friendly to public health objectives than has so far been the case; and
- by helping developing countries fend off pressure tactics by rich countries who invoke the TRIPS Agreement and the threat of trade sanctions when developing countries limit companies' exclusive patent rights.

WTO ministers agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health.

Second, it is positive that the Declaration clarifies that the Agreement "shall" be interpreted in the light of its "object" and "purpose." These clauses in the Agreement make express reference to the importance of countries being able to adopt measures necessary to protect public health, to promote the public interest in sectors of vital importance to their development, and to ensuring a balance of rights and obligations in patent laws so as to ensure that protecting intellectual property rights are to the "mutual advance" of both producers and users of inventions in "a manner conducive to social and economic welfare." To date, it seemed from the existing WTO rulings that little consideration was being given to these sections in the Agreement in interpreting the other sections dealing with matters such as exclusive patent rights of pharmaceutical companies, so this direction may be helpful for obtaining more health-friendly interpretations in the future.

Finally, on a less positive note, the Declaration does not represent any

significant movement on the very critical issue that some of its provisions may still present a barrier for many countries in accessing affordable medicines. In particular, although the TRIPS Agreement does

> Some provisions of the TRIPS Agreement may still present a barrier for many countries in accessing affordable medicines.

allow for countries to issue "compulsory licences" that would permit the manufacture of generic versions of a patented drug during its patent term, it imposes the restriction that this authorization must be "predominantly" for the supply of that country's own domestic market.[4] This is of little benefit to countries that do not have the industrial capacity to produce their own generic medicines (which are likely to include some of the countries most in need of cheaper medicines). These countries must import the medicines from countries that do have this capacity. But the countries that might be able to supply these medicines are bound by this same restriction. This means that they cannot authorize anything more than a limited production of generic drugs for export to countries that need them.

Unfortunately, rather than remove this barrier, the WTO Ministerial Declaration simply instructs the WTO's subsidiary body, the Council for TRIPS, "to find an expeditious solution to this problem" and to report back before the end of 2002. This remains a major concern for treatment advocates, and will require ongoing campaigning to ensure that a solution to this problem is indeed found.

On 28 January 2002, six leading non-governmental organizations wrote to the members of the Council for TRIPS presenting possible solutions to this problem. They have urged the WTO to approve an interpretation of Article 30 of the TRIPS Agreement, which allows WTO member countries to provide "limited exceptions" to exclusive patent rights in their own laws, that would recognize countries' freedom to

> permit all acts associated with the production for export to a third country of a patented product or a product produced by a patented process, where the export addresses health needs in the third country, and the product and/or process is either (a) not patented; or (b) a compulsory license has been granted or government use made of the relevant patent in the third country.[5]

The European Communities and their member states ("EC") have also submitted a "concept paper" on this issue to the Council for TRIPS considering this option, as well as the option of amending Article 31 of the TRIPS Agreement to create an exception, under certain conditions, for the export of products produced under compulsory licences in one country to another country where a compulsory licence authorizing imports of such products has been issued. It does not directly address the issue of authorizing production for export to a country in which the product is not patented. The concept paper would also narrow the broad "public health" language in the Declaration adopted at Doha by referring only to "serious" public health problems.[6]

This issue will remain a major topic of discussion at the upcoming 2002 meetings of the Council for TRIPS.

– Richard Elliott

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[1] The TRIPS Agreement can be found at www.wto.org/english/tratop_e/trips_e/t_agm0_e.htm. The text of the Declaration on TRIPS and Public Health is available on the WTO website at www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.

[2] The text of the various proposals put forward in the lead-up to the Doha WTO meeting can be found on the WTO website at www.wto.org/english/tratop_e/trips_e/councilsep01_e.htm.

[3] Further information and campaigning materials are on the website of the Canadian HIV/AIDS Legal Network at www.aidslaw.ca/Maincontent/issues/care-treatment.htm#B2.

[4] TRIPS Agreement, Article 31(f).

[5] Joint letter from Consumer Project on Technology, Essential Action, Médecins Sans Frontières, Oxfam International, Health GAP Coalition, and Third World Network to the World Trade Organization's TRIPS Council concerning TRIPS-Compliant Exports of Compulsory Licensed Goods, 28 January 2002 (available at www.cptech.org/ip/health/art30exports.html).

[6] The EC's concept paper can be accessed (in English only) at http//lists.essential.org/pipermail/ip-health/2002-February/002674.html.

South Africa: Defiance Campaign Continues

The Treatment Action Campaign (TAC) has continued its "defiance campaign against patent abuse and AIDS profiteering." In partnership with Médecins Sans Frontières (Doctors Without Borders), and with the support of Oxfam and the Council of South African Trade Unions (COSATU), on 28 January 2002 three TAC members returned to South Africa from Brazil carrying generic versions of the antiretroviral drugs zidovudine (AZT), lamivudine (3TC), and nevirapine (NVP). Some of the imported capsules contain a combination of AZT and 3TC.

These medicines were manufactured by FarManguinhos, the Brazilian national pharmaceutical producer, which is part of a public research body funded by the Brazilian government. Under a Médecins Sans Frontières (MSF) agreement with the research body, the funds paid by MSF to purchase these medicines will go directly into research and development for AIDS and neglected diseases.

All three of these drugs are under patent in South Africa, meaning the companies owning the patents have the exclusive right to import them into the country, enjoying a monopoly in the South African market. Importing these drugs without the permission of the patent holders is an infringement of patent rights. GlaxoSmithKline holds the patent on AZT and 3TC and Boehringer Ingelheim holds the patent on NVP. Glaxo has offered the combination of AZT and 3TC to the South African government at US$2 a day. FarManguinhos sells it to MSF at less than half that price. Boeringer Ingelheim sells NVP for $US1.19 a day in South Africa. FarManguinhos sells it to MSF for half that price.

TAC and MSF held a press conference at which they announced the importation.[1] They explained that the Medicines Control Council, the South African drug regulatory authority, had registered these medicines previously as being safe and effective. The medicines are to be used by MSF in its AIDS treatment program in Khayelitsha, a township outside Cape Town. TAC and MSF repeated their challenge to the South African government to pursue voluntary and compulsory licences with respect to patented medicines to treat people with HIV/AIDS, and their challenge to the pharmaceutical companies to offer non-exclusive voluntary licences on their essential medicines.

A voluntary licence is an agreement by the company holding the patent on a medicine to allow others to make and sell the drug. A compulsory licence can be issued by the government or a court if the patent holder does not voluntarily grant a licence, with "adequate remuneration" in the circumstances paid to the patent holder. Such licensing introduces competition into the market, bringing down the price of medicines so more people can afford them.

[1] See Joint Press Release of MSF, TAC, and Oxfam: "Generic AIDS Drugs Offer New Lease on Life to South Africans – Importation of generics cuts price in half." 29 January 2002; and accompanying COSATU Statement on the Importation of Generic Antiretrovirals from Brazil, and the "Questions and Answers About TAC and MSF Importing Generic Medicines from Brazil," all available via the TAC website at www.tac.org.za.

Canada/US: Bioterrorism Highlights Double Standard for Access to Medicines

In September 2001, shortly after terrorist attacks in the United States, the issue of bioterrorism – and specifically fear about reported cases of anthrax in the US – led the Canadian Minister of Health to be concerned about the available stocks of the drug ciprofloxacin to treat this disease.

As it happens, on 13 September 2001, the Federal Court of Appeal upheld Bayer Inc's patent in Canada on the drug. Generic drug manufacturer

Apotex Inc had applied for a "notice of compliance" (NOC) from Health Canada with respect to its generic version of ciprofloxacin hydrochloride.[1] Issuance of such a notice is required before a drug can legally be sold in Canada. Apotex alleged that Bayer's patents for ciprofloxacin were invalid, and it was therefore entitled to be issued a NOC and sell its generic version. Bayer succeeded in getting an order prohibiting the Minister of Health from issuing a NOC to Apotex until Bayer's patents expired.[2]

In the weeks that followed the terrorist attacks, the Canadian government arranged to purchase generic ciprofloxacin from Apotex, despite the infringement on Bayer's patent (which the court had just upheld). Following criticism from Bayer, some Members of Parliament, and some media that the government was violating its own *Patent Act*, the government eventually negotiated a deal that got it out of its contract with Apotex and yielded a lower price from Bayer and a commitment to provide adequate supplies in the event of a major bioterrorist attack. No cases of anthrax related to bioterrorism have yet been reported in Canada.

At the same time, the United States, where roughly a dozen cases of anthrax presumed to be the product of bioterrorism had then been reported, the government was also threatening to purchase generic ciprofloxacin, thereby infringing Bayer's patent, unless the company offered major price reductions (which it eventually did). The US government had previously repeatedly criticized the Brazilian government for using the threat of compulsory licensing unless major pharmaceutical companies offered substantial reductions in the price of HIV/AIDS drugs. The Brazilian government provides free treatment to some 100,000 people in Brazil with HIV/AIDS, which has led to substantial reductions in hospitalizations and deaths due to AIDS. The US government has also repeatedly opposed, in international forums, efforts to ensure that developing countries facing devastating epidemics of diseases such as HIV/AIDS, tuberculosis, and malaria are free to use measures such as compulsory licensing to make medicines more affordable.

The "cipro affair" happened two months before the WTO Ministerial Conference in Qatar, where the issue of intellectual property rights and access to affordable medicines in poor countries was on the agenda. It illustrated the double standard applied by the governments of wealthy countries when it comes to protecting the public health through access to affordable medicines.

– Richard Elliott

[1] *Bayer AG v Apotex Inc*, 2001 FCA 263.

[2] *Bayer AG v Apotex Inc* (1998), 156 FTR 303 (TD).

Chile: Supreme Court Overturns Ruling Granting Publicly Funded Antiretrovirals

In September 2001, the Court of Appeals for Santiago ruled in favour of three people with HIV/AIDS who had filed a constitutional claim before the courts seeking access to state-funded treatment including antiretrovirals as required by their right to life. Under many Latin American legal systems, a claim of *amparo* is an appeal for judicial protection of a constitutional right that has been violated or threatened, a quick interim procedure aimed at preventing an imminent violation or remedying a current violation of constitutional rights. The complainants in this case invoked their constitutional right to life, arguing that the failure of the state to provide access to necessary medicine violated this right. The appellate court agreed, and ordered the Ministry of Health to provide the necessary care.

However, the Chilean government argued that it was adequately addressing the health-care needs of people with HIV/AIDS even though resources allocated for the purchase of medicines are inadequate. On 18 October 2001, the Supreme Court of Chile overturned the appellate court's ruling, leaving the three complainants without access to treatment paid for by public funds.[1]

[1] El Sida en la justicia. *La Tercera*, 1 December 2001; Policía reprime a enfermos de sida que claman atención en Chile. *Reuters*, 19 October 2001.

Reports Lay Out Requirements for Addressing Global Health Needs

In December 2001, the Commission on Macroeconomics and Health of the World Health Organization (WHO) released a major report outlining key elements of what is needed to address the health crises of the world's poor countries and people. *Investing in Health for Economic Development* calls for increasing official development assistance (ODA) for health spending from US$6 billion a year to $27 billion a year. Contributions from wealthy countries would amount to roughly 0.1 percent of their combined gross national product (GNP). It also calls for developing countries to increase their domestic spending on health care by one percent of GNP by 2007 and by two percent of GNP by 2015 compared with current levels.

The report also recommends a new global framework for "differential pricing" for essential drugs for poorer countries. It recommends that the WHO work with pharmaceutical corporations (both patent-holding and generic companies) and low-income countries to develop guidelines. It also urges that the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights ("the TRIPS Agreement") be "interpreted broadly" to ensure that poor countries without the capacity to make their own generic drugs can still access generic medicines made in other countries that do. (Currently, the TRIPS Agreement states that generic versions of patented drugs produced under a "compulsory license" in a country must be "predominantly" for supplying that country's domestic market, restricting the export of those cheaper, generic medicines to other countries that cannot afford to pay higher monopoly prices charged by the patent holder.)[1]

In January 2002, the WHO, in conjunction with several other organizations such as UNAIDS and the World Bank, also released a report at the World Economic Forum. *Scaling Up the Response to Infectious Diseases: A Way Out of Poverty* reiterates the vicious circle of ill-health and poverty. It argues that the benefits of a massive effort against HIV/AIDS, tuberculosis, and malaria far outweigh the costs of their control. The report documents interventions that have proven effective in responding to these three diseases, outlines how health services in developing countries can be strengthened and expanded to provide these interventions, and explores how health behaviour on the part of those at risk of these diseases can be promoted. For each of these, it considers what resources are available and required, what strategies are successful, and what models demonstrate the successful application of these strategies. Finally, it proposes how to "get to scale" with efforts to curb these diseases and break the link between destitution and disease.[2]

WHO report recommends a new global framework for "differential pricing" for essential drugs for poorer countries.

[1] *Macroeconomics and Health: Investing in Health for Economic Development*, available via www3.who.int/whosis/cmh. The executive summary and many components of the report are available in English, French, and Spanish; the background papers of working groups are available in English only.

[2] *Scaling Up the Response to Infectious Diseases: A Way Out of Poverty*, www.who.int/infectious-disease-report/2002.

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. (Previously in the *Review*, criminal cases were reported in a separate section.) The coverage aims to be as complete as possible, and is based on searches of Canadian electronic legal databases and reports in Canadian media. Readers are invited to bring cases to the attention of Ralf Jürgens, editor of HIV in the Courts, at ralfj@aidslaw.ca.

Ontario Appellate Court Denies HIV-Positive Man's Constitutional Claim to Medical Marijuana

In January 2002, the Ontario Court of Appeal denied a claim by a Toronto man living with HIV/AIDS that Canada's laws prohibiting marijuana possession and cultivation infringe his constitutional rights to liberty and security of the person.[1]

Jim Wakeford uses marijuana for medical purposes. He is legally entitled to cultivate and possess the drug by virtue of a ministerial exemption from criminal liability, granted in June 1999 under the *Controlled Drugs and Substances Act* (CDSA).[2] The exemption was to be temporary, operating only until the federal government established a meaningful program for distributing marijuana to Wakeford and other patients like him.

In June 2000, Health Canada granted a new exemption to Wakeford, but with stricter conditions on the amount he could produce and possess at one time. Health Canada also announced in December 2000 that it had hired a Canadian company to grow affordable, quality, standardized marijuana for medical and research purposes, but that it would be at least a year before this product would be available. Developments since then indicate that the product will only be available for research and that patients would only be able to access marijuana by participating in a clinical trial, which trial has been delayed. (Wakeford's evidence pointed out that there are legal sources of research-grade marijuana available from the UK and the US.)

Wakeford argued the exemption is too narrow because it does not exempt his caregivers from criminal liability for possession or trafficking of drugs if they assist him in cultivating or obtaining marijuana. Furthermore, others are unavoidably exposed to this risk of prosecution because delays by the federal government in making medicinal marijuana available force him to resort to illegal sources. His evidence was that some of his caregivers have been charged with trafficking, and others risked prosecution for cultivating marijuana in order to assist him.

Therefore, Wakeford applied to the court for a declaration that his constitutional rights to "life, liberty and security of the person" under the *Canadian Charter of Rights and Freedoms* (s 7) had been infringed because the state has denied him access to a safe, clean, and affordable source of medicinal marijuana. He sought an order that any person acting as a caregiver to him is exempt from

charges of possession, trafficking, or cultivation while engaged in assisting with his medicinal needs. The Ontario Superior Court of Justice dismissed his application in May 2000.[3] Wakeford appealed.

In July 2001, shortly after Wakeford's appeal was argued, the federal government implemented the new *Marihuana Medical Access Regulations* to govern the granting of exemptions.[4] Wakeford's lawyers made further submissions to the appellate court identifying continued shortcomings in the regulatory regime that meant his rights were still infringed, although the Court ultimately declined to admit this evidence, as it was "entirely hypothetical" because neither Wakeford nor his caregivers had yet applied for exemptions under them. (Wakeford's current ministerial exemption runs until April 2002.)

Wakeford's claim that his rights were infringed rested on (1) the lack of an exemption for caregivers, and (2) the lack of a safe supply of marijuana for medicinal use.

The Ontario Court of Appeal agreed with the lower-court judge that those aspects of Wakeford's case that challenge the adequacy of his ministerial exemption, or the Minister's failure to exempt his caregivers under the CDSA, are aimed at obtaining judicial review of the Minister's actions. Therefore, they are matters that fall within the exclusive jurisdiction of the Federal Court of Canada by virtue of the *Federal Court Act* (s 2) and could not be dealt with by Ontario courts.

However, Wakeford's claim that his rights were infringed could also be based on the failure of the CDSA itself to provide an exemption from criminal liability for his caregivers, and this claim is within the jurisdiction of a provincial superior court. Therefore, the Ontario Court of Appeal considered only this basis for Wakeford's claim of unconstitutional government (in)action.

But it then decided on narrow technical grounds that the Act did not infringe his rights. First, it said that if his caregivers have been unable to obtain exemptions, it is either because they have not applied (in which case it is not the state that has infringed Wakeford's rights) or because the Minister has refused to give one (in which case the Minister's refusal could only be judicially reviewed by the Federal Court). (With respect to the first point, it should be noted that there is nothing in the law that clearly contemplated caregiver exemptions until after the Court had first heard his appeal, so it is questionable whether this was a fair criticism by the Court.)

Second, Wakeford's claim could be that the CDSA sections outlawing trafficking and production of marijuana infringe his rights because they do not exempt his caregivers. But the Court ruled this could not be enough to entitle him to challenge their constitutionality because he is not the one facing prosecution in such circumstances. Furthermore, his anxiety about the risk of others being prosecuted is not a serious enough state-imposed psychological stress that it would amount to an infringement of his liberty or security.

(With regard to this suggestion that a caregiver accused of trafficking could challenge their prosecution on constitutional grounds, another recent court decision should be noted, in which a man accused of trafficking challenged the constitutionality of the prohibition on trafficking even to people entitled to use it as medicine. Two months before the ruling in Wakeford's case, a Québec trial court dismissed this argument, saying that a person's "rights to possess marijuana for personal therapeutic use, do not translate into a right [for someone else] … to traffic."[5] However, it did so without offering any reasoning for its statement, simply noting that the accused had not produced evidence of the health condition of his "prospective buyers." This means the issue has not received the judicial consideration it warrants, and it may yet be that a person charged with trafficking or cultivating for providing marijuana for medicinal use will bring a challenge as suggested by the Ontario Court of Appeal in Wakeford's case.)

> Through a series of narrow technical rulings, the Court of Appeal avoided addressing the central substantive claim advanced by Wakeford – namely, that it is unacceptable to force sick people to manufacture their own medicines which they are legally entitled to use.

Third, Wakeford's claim could be that the failure to exempt caregivers violates his right to security of the person because it effectively deprives him of a secure supply of medical marijuana. On this point, the Court of Appeal chose to simply accept the finding of fact by the court below that Wakeford "has no real difficulty

in obtaining marijuana for medicinal purposes." Therefore, even though some of the evidence outlined Wakeford's problems with access, the Court concluded these were not significant enough that they threatened his security of the person.

Finally, the Court noted that Wakeford could not mount a direct constitutional challenge to the CDSA for not exempting caregivers unless he gave notice to the federal and provincial Attorneys General.

The Court took a similarly restrictive approach to Wakeford's claim that Charter s 7 rights had been infringed by the government's failure to make available a safe supply of marijuana for medicinal use. The court below had found that Wakeford "is not dependent on government to supply him with marijuana." The appellate court did not disturb this finding.

Through this series of narrow technical rulings, the Court of Appeal avoided addressing the central substantive claim advanced by Wakeford that goes beyond his own, disputed circumstances – namely, that it is unacceptable to force sick people to manufacture their own medicines, which they are legally entitled to use.

In November 2001, Wakeford was charged in British Columbia (where he had since moved) with trafficking marijuana, which he claims was for supplying people who use it medicinally.[6] It may be that these charges will provide the basis for him to mount the constitutional challenge to the CDSA provisions and the *Medical Marihuana Access Regulations* as too restrictive.

Also in November 2001, establishments opened in Vancouver and Gibsons (British Columbia) and Winnipeg (Manitoba) offering to provide medicinal marijuana to patients.[7] Meanwhile, the month before, the Dutch cabinet approved a bill to allow pharmacists in the Netherlands to fill prescriptions for marijuana, and a bill was expected to go before the legislature in the months following to put medicinal marijuana on the national health plan.[8]

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[1] *Wakeford* v *Canada*, [2002] OJ No 85 (CA) (QL).

[2] SC 1996, c 19, s 56.

[3] *Wakeford* v *Canada*, [2000] OJ No 479 (SCJ) (QL), summarized at R Elliott. Recent court rulings on medical and non-medical marijuana. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 9-12.

[4] The comments of the Canadian HIV/AIDS Legal Network on the draft regulations may be found at www.aidslaw.ca/Maincontent/issues/cts/marijuana_submissions.htm. The final text of the regulations does not differ significantly from the draft, and may be found via the Health Canada website at www.hc-sc.gc.ca/english/protection/marijuana.html. The Canadian Medical Association (CMA) objected to the final regulations the day they were released, saying that "they put physicians and their patients in the precarious position of attempting to access a product that has not gone through normal protocols of rigorous pre-market testing"; see: Media release: CMA strongly opposed to Marijuana Medical Access Regulations, 4 July 2001 (via www.cma.ca). See also PH Barrett, CMA President. Open letter to CMA members, 3 August 2001 (via www.cma.ca).

[5] *R* v *Turmel*, [2001] QJ No 5875 (SC) (QL), at paras 130-131.

[6] K Makin. Police charge marijuana activist again: HIV-infected man says he wants the right to produce the drug for himself and others. *Globe and Mail*, 16 November 2001: A11.

[7] I Bailey. Vancouver teahouse to specialize in marijuana: Chronically ill patrons licensed by Health Canada to use pot, police to monitor. *National Post*, 1 November 2001: A4; Pot operations offer the sick a place to take their medicine. *Times Colonist* (Victoria), 2 November 2001: D14; [headline unavailable]. *Broadcast News* (Winnipeg Sun), 1 November 2001.

[8] A Deutsch. Marijuana prescription law OK'd. *Newsday* (New York), 19 October 2001.

Constitutional Challenge to "Medical Inadmissibility" Provisions in the *Immigration Act*

In a case with significant implications for people living with HIV/AIDS who wish to immigrate to Canada, in January 2002 a woman with multiple sclerosis launched a constitutional challenge to the "medical inadmissibility" provisions in the *Immigration Act*.[1] The provisions state that any would-be immigrant may be denied permission to immigrate "if their admission would cause or might reasonably be expected to cause excessive demands on health or social services."

Angela Chesters is a 44-year-old non-Canadian married to a Canadian citizen. In 1994, her application for landed immigrant status was rejected but she was granted a "ministerial permit" to live in Canada for five years. Such permits are usually granted on humanitarian and compassion-

ate grounds. People in Canada on a Minister's permit are generally not allowed to work or study, and cannot acquire citizenship for at least five years and then only at the further discretion of the Minister.

In addition, people who are deemed "medically inadmissible" but are allowed to enter or remain in Canada on a Minister's permit are generally excluded from the definition of eligible "residents" covered by public health insurance in the province where they live. This has been upheld as constitutionally permissible in the recent *Irshad* case.

In *Irshad*,[2] a child of landed immigrants who is severely disabled by cerebral palsy was denied coverage under Ontario's public health insurance plan (OHIP). The Ontario Court of Appeal rejected the Irshads' challenge, ruling that the denial was the result of the "medical inadmissibility" designation by the federal government (which designation could conceivably change in future), and not the result of the provincial government's definition of eligible "residents" – even though the definition in provincial law relies upon and incorporates the federal decision-making scheme regarding medical inadmissibility. The Court rejected the claim that this amounted to unconstitutional discrimination by the province based on disability, saying the underlying federal legislation and decision-making had not been constitutionally challenged.

However, the Court did say that the "interface" between the immigration process and the provincial determination of eligibility for public health insurance

> is not entirely satisfactory. It seems inherently contradictory, if not cruel, to permit a young boy like Raja [Irshad] to enter Canada on compassionate grounds so that he might live with the rest of his family who have been allowed to settle in Canada, while at the same time not taking cognizance of Raja's need to access expensive medical services that can, to some degree, at least alleviate his severe physical disability. While I have found no constitutional violation, I would think that the federal and provincial authorities could work together to find some way to extend our country's compassion beyond permission to enter Canada to include access to medical services available through [the Ontario Health Insurance Plan] to persons like Raja.

The case brought by Angela Chesters is now advancing the challenge to the federal legislation that the Court of Appeal said was absent in the *Irshad* case.

As a result of being denied permanent resident status in Canada, Chesters returned to Germany in 1995 to accept a teaching position, and she and her husband initiated their litigation. The matter finally came to trial seven years later, after offers by the government to grant her permanent residence in Canada in exchange for dropping her case.

Chesters argued that the "excessive demands" provision in the *Immigration Act* impermissibly infringes her rights to liberty and security of the person (contrary to s 7 of the *Canadian Charter of Rights and Freedoms*), and also discriminates against her on the basis of disability (contrary to s 15 of the Charter). She is seeking a declaration of unconstitutionality and Cdn$100,000 in damages for the infringement and accompanying distress.

In December 2001, the federal government tried to argue that Chesters's case had become moot and that it should be allowed to bring a motion for summary judgment dismissing the case. The government pointed to the new *Immigration and Refugee Protection Act* passed by Parliament, which received royal assent in November 2001 (although the government has delayed proclaiming it in force until regulations under the Act are finalized). Under the new legislation, applicants like Chesters who are part of the "family class" by virtue of their relationship to a Canadian citizen would no longer be subject to this "medical inadmissibility" bar to immigrating to Canada. Other applicants will still face this bar.

The Court denied the government's request,[3] and the hearing proceeded in January 2002. The Council of Canadians with Disabilities was granted intervenor status in the proceedings. No decision had been reported as of the time of publication.

– Richard Elliott

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[1] RSC 1985, c I-2, s 19.

[2] *Irshad (Litigation guardian of) v Ontario (Ministry of Health)* (2001), 55 OR (3d) 43 (CA), application for leave to appeal dismissed 13 September 2001, [2001] SCCA No 218 (QL).

[3] *Chesters v Canada (Minister of Citizenship and Immigration)*, 2001 FCT 1374 (6 December 2001).

Judge's Statements in Sentencing HIV-Positive Man Misinformed

In February 2002, Bourassa J of the Territorial Court of the Northwest Territories (NWT) stated from the bench that it is "well known" that HIV can be transmitted through bodily fluids like spit. He made the statement in the course of sentencing a Yellowknife man on a variety of charges. One charge was for assaulting a police officer, based on an incident in which the convicted man spat in the officer's face while being arrested, which the judge described as "disgusting and despicable." An expert with the Territories' Department of Health stated the judge's comments were incorrect. AIDS Yellowknife criticized the judge for contributing to misinformation about HIV/AIDS.[1]

[1] K Wilson. Judge's AIDS comments raise concerns. *Yellowknifer*, 6 February 2002: 4.

Tax Court Allows Tax Credit for Herbs and Vitamins, Not for Massage

In August 2001, the Tax Court of Canada issued its most recent judgment on the tax deductability of expenses for complementary/alternative therapies. The decision in *Pagnotta* v *Canada*[1] is significant for people with HIV/AIDS who use such therapies. It also illustrates how provincial and federal laws regulating health-care practitioners and natural health products have a financial impact on the cost of accessing treatment.

Under the *Income Tax Act* (ITA), a "medical expense credit" can be applied against the income tax a person must pay in a given year.[2] Pagnotta, who lived in Alberta, suffered from severe chronic pain and used both "Western" and complementary medicine, including massage therapy and Chinese herbs, nutraceuticals, and vitamins. She claimed that these were all eligible "medical expenses" that she should be able to deduct from her payable taxes. Revenue Canada rejected her claim and did not allow this tax credit in assessing her income tax owed.

Under the ITA, a tax credit may be claimed for amounts paid to a "medical practitioner" for "medical services."[3] The Act also states that this means a person authorized to practise as such under the laws of the jurisdiction where the service is rendered. But under Alberta law, a massage therapist is not a "medical practitioner," or even a member of a "designated health discipline."[4] Therefore, even the most liberal interpretation of the ITA would not allow massage therapy fees as a medical expense.

However, the Court did allow that Pagnotta was entitled to a tax credit for at least some of the expenses for enzymes, vitamins, minerals, and nutraceuticals. The "medical expenses" allowed under the ITA include "drugs, medicaments or other preparations or substances" that are used in diagnosis, treatment, or prevention of disease, disorder or their symptoms and that are "prescribed by a medical practitioner" and "recorded by a pharmacist."

The Court accepted that this was not limited only to *prescription* drugs, but was a broader category that could include the herbs, nutraceuticals, and vitamin supplements used by Pagnotta. It also accepted that her health practitioner, who was qualified as both a Western physician and a specialist in Chinese medicines, recommended these, and she used them, for treatment purposes. The Court also concluded that these substances could

be "prescribed," as a prescription could be understood liberally to simply mean a doctor's direction to someone to dispense the substance to a patient in certain amounts.

However, the major stumbling block was the requirement that, in order to give rise to a tax credit, the substances must be "recorded by a pharmacist." The Court was prepared to apply a liberal interpretation of what is meant by "recorded."[5] But it was not prepared to ignore the statutory requirement of a pharmacist:

> However, the substances must still be acquired through a pharmacist. There is simply no way around that requirement. Until the Government of Canada, through initiatives such as the development of a regulatory framework for natural health products, makes the necessary legislative changes, I must apply, albeit liberally, the requirement that substances be recorded by a pharmacist. As Chinese herbs, nutraceuticals and vitamins become regulated, it is easy to foresee that our tax laws will be amended accordingly. Until then, I can only find that those substances acquired from a pharmacy can fall within the meaning of paragraph 118.2(2)(n) [as an expense for which a tax credit can be claimed].[6]

Therefore, the Court allowed Pagnotta a tax credit only for those substances she acquired from two pharmacists, and disallowed the rest.

For people who use complementary therapies, this case signals that purchasing natural health products from a pharmacy will be necessary if these expenses are to have any chance of being considered eligible expenses for which a tax credit can be obtained. In the longer term, it means that replacing pharmacist requirement in the *Income Tax Act* with a more flexible approach is required if natural health products are to be covered by the medical expense tax credit. Finally, it also indicates that provincial recognition of complementary practitioners will determine whether or not their services are medical expenses for which a tax credit can be claimed.

– Richard Elliott

For people who use complementary therapies, this case signals that purchasing natural health products from a pharmacy will be necessary if these expenses are to have any chance of being considered eligible expenses for which a tax credit can be obtained.

[1] [2001] TCJ No 582 (QL).

[2] RSC 1985, 5th Suppl, s 118.2.

[3] Ibid, s 118.2(2)(a).

[4] See *Medical Professions Act*, RSA 1980, c M-12 and *Health Disciplines Act*, RSA 1980, c H-3.5.

[5] This is what the Court did in an earlier case, in which it allowed a woman living with HIV to claim a tax credit for vitamin supplements: *Frank* v *Canada*, [2001] TCJ No 416 (QL), summarized at: Woman wins claim for tax deductibility of complementary/alternative medical expenses. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 14-15. Erratum: Note that an error was made in that summary in referring to the court allowing a deduction from the claimant's "taxable income." A medical expense credit is a deduction from the claimant's "income tax payable."

[6] *Pagnotta*, supra, note 14 at para 30.

Court Orders Publication Ban in Trial for Identity of HIV-Positive Witness

In September 2001, an Ontario trial judge in a criminal assault case ordered a ban on publishing the identities of both the HIV-positive complainant and the man accused of assaulting the complainant, or any evidence from the legal proceedings that would tend to identify them.[1]

The accused was charged with assault and assault with a weapon and alleged that the altercation "arose as a result" of the disclosure to him of the complainant's HIV-positive status. Both defence and Crown lawyers asked for the ban, and the judge agreed that it should be granted because of the "serious potential for harm to the complainant and to the accused as a result of prejudice and fear in the community."

1 *R* v *FMB*, [2001] OJ No 4436 (OCJ) (QL).

Court Dismisses Appeal for Right to Assisted Suicide

On 7 December 2001, the Ontario Court of Appeal dismissed Jim Wakeford's appeal in a case in which he sought recognition of the right to assisted suicide.[1]

Wakeford, a man living with HIV/AIDS, had launched a suit against the Attorney General of Canada in September 1999, challenging the constitutionality of sections of the *Criminal Code* that criminalize assisted suicide.[2] In February 2001, an Ontario trial court dismissed his challenge.[3] The appellate court agreed with the trial judge's reasoning and dismissed the appeal with no further comment.

[1] *Wakeford* v *Canada (Attorney General)*, [2001] OJ No 4921 (CA) (QL).

[2] See summary of argument and trial judge's ruling at: R Elliott. Criminalization of assisted suicide challenged. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 5(1): 12-13.

[3] *Wakeford* v *Canada (Attorney General)*, [2001] OJ No 390 (SCJ) (QL). Summarized at: R Elliott. Court dismisses constitutional challenge to ban assisted suicide. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 35-36.

Ontario Appellate Court Overturns Judgment for Plaintiffs Infected through Tainted Blood

On 29 November 2001, the Ontario Court of Appeal issued a lengthy decision overturning a lower-court judgment in favour of three hemophiliacs infected with HIV in 1985 through contaminated blood-factor concentrate. The joint decision in the three cases of *Robb*, *Rintoul*, and *Farrow*[1] is the latest decision in litigation dating back to 1992. The plaintiffs alleged negligence by the Canadian Red Cross Society and the Canadian government for delays in introducing heat-treated concentrate after the risks posed by unheated product were known.

In June 2000, the Ontario Superior Court of Justice had found the Red Cross negligent and ordered it to pay over Cdn$1.6 million and court costs to the three plaintiffs and their families.[2] The Red Cross had issued a third-party claim against the federal government, and the trial judge held the federal government should indemnify the Red Cross for 25 percent of this amount. Both the Red Cross and the government appealed.

Claim against Red Cross

There was no dispute that the Red Cross owed a legal duty of care to the plaintiffs, because it was reasonably foreseeable that they could be infected with HIV if they received contaminated blood-factor concentrate. The issues were (1) whether it had breached that duty by failing to meet the standard of care required of it, and if so, (2) whether this failure had caused the plaintiffs' infection.

The trial judge ruled that the Red Cross faced an "exacting and high standard,"[3] and that it "had a duty to take immediate action … by doing everything possible to facilitate the transition from non-heated to heat-treated products."[4] She found that that "rather than taking steps to make the transition to heat-treated products as quickly as possible, the evidence suggests that the [Red Cross] embarked on a course of action which delayed the transition," and that the plaintiffs' infection could have been avoided had it not done so.[5]

However, the Court of Appeal took a different view, saying that the Red Cross's duty was to not interfere with or slow down the regulatory process leading to the federal government issuing the required permit

(Notice of Compliance" or NOC) for the sale of heat-treated product.

The Court pointed out that the Red Cross could only lawfully distribute heat-treated product once the NOC had been issued, and issuing the NOC was solely the federal government's responsibility. Furthermore, the Red Cross was not responsible for any delay by the product manufacturer in providing the federal regulator with the scientific data necessary to show that heat treatment in fact eliminated HIV in the product and would not harm hemophiliacs receiving the product. The Court said there was no evidence the Red Cross did anything that delayed the issuance of the NOC.

In any event, the Court found that "the evidence does not even suggest that the process could have been safely hastened."[6] Furthermore, the trial judge erred in saying the Red Cross had a duty to do "everything possible" to introduce heat-treated product. The Court of Appeal said this placed the standard of care too high, at "a level that ignores regulatory reality."[7] The Court noted that there was no substitute for this particular blood-factor concentrate, so withdrawing the unheated product pending the issuance of permit for heat-treated product was not a viable option.

And even if the Red Cross had breached its duty of care to the plaintiffs, the Court said there was no evidence that this caused their HIV infection. Even if the plaintiffs were infected in April and May 1985, as the trial judge had concluded, the conduct of the Red Cross would not have changed this, since through no fault of its own, heat-treated product was not legally available for distribution in Canada until 30 May 1985.

After a detailed review, the Court of Appeal also concluded that the plaintiffs had failed to prove, on a balance of probabilities, the dates upon which they were infected. Therefore, they had not shown that the Red Cross's conduct (even if it were negligent) had caused their infections.[8] The Court also found that the trial judge had based her judgment on adverse inferences drawn against the Red Cross for failing to call certain witnesses. The Court ruled these inferences unwarranted, and given their significance to her judgment, meant it could not stand. The judgment against the Red Cross and federal government was set aside.

Claim against Federal Government

The Court of Appeal also overturned the trial judge's finding that the federal government had been negligent: "Even assuming that Canada, as regulator of blood products, had the duty to expedite the regulatory process (as found by the trial judge), we are not satisfied that there was any basis in the evidence to find that Canada breached this duty."[9]

The Court reiterated that the principal cause of the government's delay in approving heat-treated product for sale was the time it took to obtain the necessary scientific data from the manufacturer showing the safety and efficacy of heat-treated product. There was no evidence at trial that Canada could have caused the manufacturer to send the data sooner, or that it could have dispensed with the requirement for such data. Therefore, the judgment against the federal government was also overturned.

No application for leave to appeal had been filed during the requisite sixty days following the judgment, so it appears this will be the final decision in the matter.

– Richard Elliott

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[1] Robb v St Joseph's Health Centre; Rintoul v St Joseph's Health Centre; Farrow v Canadian Red Cross Society, [2001] OJ No 4605 (CA) (QL) [hereinafter "Robb (CA)"].

[2] Robb v St Joseph's Health Centre; Rintoul v St Joseph's Health Centre; Farrow v Canadian Red Cross Society, [2000] OJ No 2396 (SCJ) (QL) [hereinafter "Robb (SCJ)"]. This decision is summarized at: R Elliott. Red Cross and federal government held liable for hemophiliacs' HIV infection. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 5-7.

[3] Robb (SCJ), at para 72.

[4] Ibid at para 75.

[5] Ibid at para 76.

[6] Robb (CA), at para 79.

[7] Ibid at para 63.

[8] Ibid at paras 120-156.

[9] Ibid at para 175.

Criminal Law and HIV Transmission/ Exposure: Three New Cases

In a regular column, we have reviewed new developments in the area of criminal prosecutions for HIV transmission or exposure.[1] Since the last issue of the *Review*, three new Canadian cases have come to our attention. A recent Swedish case is summarized elsewhere in this issue (see page 80).

Newfoundland: First Case to Reach Appellate Courts since *R* v *Cuerrier*

On 10 October 2001, the Court of Appeal for Newfoundland issued its judgment in the case of *Williams*, in which an HIV-positive man appealed his criminal conviction for unprotected sex with his ex-partner without disclosure of his status.[2] This is the first case to reach a Canadian appellate court since the *Cuerrier*[3] decision in 1998, and applies that decision to a new set of facts.

Williams began having unprotected sex with JM in June 1991. He learned in November 1991 that he was HIV-positive. Neither then nor later did he tell her of this. They continued to have unprotected sex until their relationship ended a year later in 1992. JM tested HIV-positive in 1994. It was accepted at the time of trial that Williams had infected JM. It was also accepted that it is possible he infected her before learning of his status.[4]

Williams was convicted in April 2000 of *aggravated assault* and *common nuisance*, but a charge of *criminal negligence causing bodily harm* was dismissed.[5] He was sentenced to a prison term of five-and-a-half years on the assault charge and 18 months on the nuisance charge, to be served concurrently.[6] He appealed these convictions, arguing that they were wrong in law.

The Court of Appeal upheld Williams's conviction for common nuisance. It overturned his conviction for aggravated assault, but found instead that he was guilty of *attempted* aggravated assault. (His appeal against his sentences had been deferred pending the outcome of his appeal against the convictions. No further decision on the sentence appeal was reported by the time of writing.)

Application of aggravated assault offence

In the earlier *Cuerrier* case, the Supreme Court of Canada ruled that an HIV-positive person could be charged with aggravated assault for having sex carrying a "significant risk" of transmitting HIV if they did not disclose their status to their sexual partner.

Under Canada's *Criminal Code* (s 265), a person's consent to physical contact is "vitiated" (ie, not legally valid) if it is obtained by "fraud." In *Cuerrier*, the Supreme Court said that fraud existed where there was some form of dishonesty that caused some sort of "deprivation" (ie, harm) to another person. The Court reasoned that not disclosing one's HIV infection would be considered "dishonest" by a reasonable person, and if there were a significant risk of transmission to the other person, then not disclosing amounts to fraud in obtaining consent to sex. This makes the sex an assault. The Court also expressly stated that the duty to disclose "will not arise" unless there is a "significant risk of serious bodily harm."[7]

But the twist in this case before the Newfoundland courts was that Williams and JM had unprotected sex on at least several occasions before Williams knew or suspected he was infected. Furthermore, the parties had agreed, and the Court accepted, that "a single act of unprotected vaginal intercourse carries a significant risk of HIV transmission" and that "epidemiological studies have found that in sexual intercourse it is seventeen times more likely that a man will infect the woman if she is uninfected than a woman will infect the man."[8] So JM might already have been infected by the time Williams learned he was HIV-positive.

Therefore, argued Williams's lawyer, it could not be proven that, *after* learning of his status, Williams exposed JM through unprotected sex to a significant risk of HIV infection. Therefore, he had no legal duty to disclose his status, meaning there was no

fraud on his part and he could not be convicted of assault.

However, the Newfoundland Court of Appeal rejected this argument and interpreted the Supreme Court's *Cuerrier* decision more broadly, noting that the Supreme Court had urged "flexibility" in the application of the "significant risk of serious harm" test.[9] In the Newfoundland court's view, this case "provides an example where flexibility in applying the test is appropriate."[10]

The Newfoundland Court of Appeal agreed that it could not be proven that Williams infected JM *after* he knew he was HIV-positive and "the likelihood is that she was infected before he was tested or advised of the positive result."[11] However, the Court was still of the view that JM suffered a "deprivation" as a result of Williams's dishonesty, so he had still obtained her consent by fraud:

> Williams continued to engage in unprotected sexual intercourse with the complainant, without disclosing his infection, for a full year after he knew he had tested HIV-positive. He did not disclose his infection when they terminated their relationship. As a result, the complainant failed to obtain medical care until, by chance, she became aware that she was exhibiting symptoms of HIV infection in March 1994. Without the knowledge that she may have been infected by Williams, she was precluded from taking steps to ensure she did not infect others, including her infant son and other sexual partners. Further, she was denied the opportunity to obtain treatment as quickly as possible after being infected. There is no evidence as to the effect of delaying treatment. However, the inference may be drawn that she would have sought medical care as soon as she became aware of Williams's infection.[12]

Therefore, because Williams's dishonesty had caused harm to JM, he was properly convicted of assault.

A charge of *aggravated* assault (which carries a harsher penalty) requires that the assault "endanger the life" of the complainant. Again, the defence argued that, because JM was likely already infected before Williams learned of his own HIV infection, it could not be proved that continued unprotected sex past that point endangered her life. The Court agreed there was a "reasonable doubt" on this point, and the prosecution needed evidence to show that Williams was creating a significant risk to JM's life, even if she was already infected, by continuing to have unprotected sex with her.

The Court noted that this could be shown by evidence that the risk is increased by multiple exposures to HIV, or by exposing a person to a different strain of the virus over several months of intercourse. The Court also suggested that a significant risk to JM's life might be shown by her delay in receiving medical care because of Williams's non-disclosure. But "the evidence did not establish beyond a reasonable doubt that Harold Williams endangered the complainant's life after he knew he was HIV-positive because there was a significant likelihood she had already been infected."[13] Therefore, the Court concluded that Williams could not be convicted of aggravated assault.

However, it did find that Williams could be convicted of *attempted* aggravated assault. Canadian law does not recognize a defence of "impossibility."[14] So even if it were impossible for Williams, after knowing he was HIV-positive, to have endangered JM's life through unprotected sex because she was already infected, he could still be convicted of attempting to do this. The Court therefore substituted this conviction in place of the assault charge itself.

Common nuisance charges

The Court also upheld Williams's conviction for *common nuisance*, because he failed to discharge a legal duty and thereby endangered the lives, health, or safety of the public (*Criminal Code*, s 180).

The Court said his legal duty was to refrain from conduct which it is reasonably foreseeable could cause serious harm to other persons.[15] The Court found that it was reasonably foreseeable that not disclosing his HIV status to JM could cause serious harm to her and, through her, to others through blood donation, unprotected sex, etc. The Court noted that JM named 14 people with whom she had sexual contacts from shortly before she met Williams to the point three years later when she tested HIV-positive.

The Court also rejected arguments that the phrase "the public" was too ambiguous and that Williams's conduct in not disclosing to JM could not be said to endanger the public. Again the Court pointed to the possibility that JM could have infected others through donating blood or through sex. The Court also ruled that "the public" need not mean just the public at large but also includes simply "members of the public" who were endangered by Williams's conduct in having unprotected sex without disclosing his status to JM.

Other noteworthy aspects

Two other aspects of the decision warrant brief comment. First, in one passage the Court accepts that the "careful use of condoms" defence referred to by the Supreme Court in *Cuerrier* is still up for consideration (although the Court did not need to consider it in this case).[16] No case yet reported in Canada has led to a court decision on this specific issue. (Note, however, that a June 2001 decision from a Nova Scotia trial court presented a situation in which the prosecution accepted that performing unprotected oral sex on an HIV-positive man is conduct "at low risk" that would not bring it within the assault provisions of the *Criminal Code* in the light of the *Cuerrier* decision.[17]) Therefore, it remains an open question in Canadian law whether an HIV-positive person may avoid criminal charges for assault by practising "safer sex."

Second, in this case, the Newfoundland Court of Appeal made the interesting observation that:

> A single act of unprotected vaginal intercourse carries a significant risk of HIV transmission. It is important to note that the risk is described as significant, not moderate or minimal. This risk applies particularly where it is the man who is infected with the virus. Female to male transmission does not carry a similar level of risk.[18]

By far the majority of criminal prosecutions in Canada (and other countries) of HIV-positive people for sexual conduct that risks HIV transmission have been laid against HIV-positive men for sex with women. It is in that context that discussions about risks of harm and a legal duty to disclose have been considered. These comments in *Williams* suggest at least some courts may be willing to acknowledge the gender differences in the transmissibility of HIV. Whether the different risk of transmission from an HIV-positive woman to a male partner through unprotected vaginal sex will translate into a different legal conclusion remains to be seen.

Alberta: Guilty of Assault Causing Bodily Harm for Biting

On 18 January 2002, a jury found an Edmonton man with HIV guilty of assault causing bodily harm for having bitten a police office and then minutes later having told the officer "Welcome to the world of AIDS." He denied this version of events, and claimed the officer had assaulted him after rousing him from sleep.[19] No sentence had yet been reported at the time of publication.

Ontario: Six Criminal Charges against HIV-Positive Man

A Kitchener man living with HIV was charged in October 2001 and the following months with a total of six criminal charges involving four women who claim he had unprotected sex with them without disclosing his HIV status.

One of the women has tested HIV-positive and the prosecution alleges he infected her. With regard to that complainant, he is facing one charge of each of aggravated assault, unlawfully causing bodily harm, and criminal negligence causing bodily harm. He also faces one charge of aggravated assault in relation to each of the three other women, who do not appear to have been infected but whose life it is alleged he endangered by exposing them to the risk of infection.[20]

– Richard Elliott

[1] See, eg, R Elliott. Criminal law and HIV/AIDS: Update V. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 17-23.

[2] *R v Williams*. 2001 NFCA 52, [2001] NJ No 274 (QL) [hereinafter "*Williams* (CA)"].

[3] *R v Cuerrier*, [1998] 2 SCR 371, 127 CCC (3d) 1, summarized at: R Elliott. Supreme Court rules in *R v Cuerrier*. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 1, 17-24. For an in-depth analysis of that decision, including a discussion of a possible "safer sex" or "lower risk" defence to assault charges, see: R Elliott. *After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status*. Montréal: Canadian HIV/AIDS Legal Network, 1999 (at www.aidslaw.ca/Maintcontent/issues/criminallaw.htm).

[4] Erratum: A note regarding this case was included in Criminal law and HIV/AIDS: Update V. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 17 at 21, where it was incorrectly reported that the complainant in this case was not infected with HIV by Williams. The complainant was infected and this was agreed by the Crown and defence at trial.

[5] *R v Williams*, [2000] NJ No 138 (SCTD) (QL) [conviction, 26 April 2000]. For a summary, see: R Elliott. Criminal law and HIV/AIDS: Update III. *Canadian HIV/AIDS Policy & Law Newsletter* 2000; 5(2/3): 33-34.

[6] *R v Williams*, [2000] NJ No 166 (SCTD) (QL) [sentencing, 23 May 2000]. A previous report noted his guilty plea and sentencing to an additional five years in prison on charges of aggravated assault with respect to two other women with whom he had unprotected vaginal sex without disclosing his HIV status: Criminal law and HIV/AIDS: Update V. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 17 at 21.

[7] *Cuerrier*, supra, note 3 at para 129.

[8] *Williams* (CA), supra, note 2 at para 7, excerpting the Agreed Statement of Facts before the trial court.

[9] *Cuerrier*, supra, note 3 at para 139.

[10] Ibid at para 34. See *Cuerrier*, supra, note 3 at para 139: "The phrase 'significant risk of serious harm' must be applied to the facts of each case in order to determine if the consent given in the particular circumstances was vitiated…. There must be some flexibility in the application of a test to determine if the consent to sexual acts should be vitiated. The proposed test may be helpful to courts in achieving a proper balance when considering whether on the facts presented, the consent given to the sexual act should be vitiated."

[11] Williams (CA), supra, note 2 at para 36.

[12] Ibid at para 38.

[13] Ibid at para 86.

[14] *United States* v *Dynar*, [1997] 2 SCR 462; *Theroux* v *R*, [1993] 2 SCR 5.

[15] *Thornton* v *R* (1990), 3 CR (4th) 381 (CA), affirmed [1993] 2 SCR 445. Note that it is questionable whether this "common law" duty can be the basis for a criminal charge. The *Criminal Code* (s 8) prohibits the use of common law criminal offences in Canadian law. Furthermore, this imports a simple negligence standard from tort law into the criminal law, even though "*gross* negligence" is generally required for criminal culpability.

[16] *Williams* (CA), supra, note 2 at para 31.

[17] *R v Edwards*, 2001 NSSC 80, [2001] NSJ No 221 (QL). See summary at: R Elliott. Criminal law and HIV/AIDS: Update V. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 17 at 17-19.

[18] *Williams* (CA), supra, note 2 at para 53.

[19] HIV man jailed for biting officer. *Edmonton Sun*, 19 January 2002: 13.

[20] Man faces more charges of giving women HIV. *Ottawa Citizen*, 13 December 2001; More charges for man accused in HIV case. *Kitchener-Waterloo Record*, 13 December 2001.

HIV/AIDS IN THE COURTS – INTERNATIONAL

This section presents a summary of important international court cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on civil and criminal cases. (Previously in the *Review*, criminal cases were reported in a separate section.) While the coverage of Canadian cases aims to be as complete as possible, the coverage of international cases is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the *Review*. The coverage of US cases is very selective. Reports of US cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of Ralf Jürgens, editor of HIV/AIDS in the Courts, at ralfj@aidslaw.ca.

US: Supreme Court Adopts Narrow Definition of "Disability" under Anti-discrimination Law

In January 2002, the US Supreme Court issued the latest in a series of court judgments adopting a narrow interpretation of the Americans with Disabilities Act (ADA). The unanimous decision is fundamentally flawed in several important respects. It does not bode well for people with disabilities seeking protection from discrimination in employment.

Toyota Motor Manufacturing, Kentucky, Inc v *Williams*[1] dealt with a lawsuit by a woman fired from her job on an automobile assembly line. Williams's repetitive work with pneumatic tools eventually caused pain in her hands, wrists, and arms, and she was diagnosed with carpal tunnel syndrome. Her physician placed her on permanent work restrictions that precluded her from lifting heavy objects, constant repetitive flexion or extension of her wrists or elbows, performing overhead work, or using pneumatic tools. She was assigned to other duties, some of which she could perform, but other jobs given to her caused inflammation and pain by requiring overhead work. After some ongoing disputes with her employer, Williams eventually filed suit, claiming she was disabled from (1) lifting, (2) working, and (3) performing manual tasks (ie, those of her job), and that her employer had failed to provide her with reasonable accommodation as required by the ADA.

Toyota moved for a summary judgment dismissing Williams's suit. The trial court granted the motion and dismissed her suit, saying that her impairment was not a "disability" under the ADA because it had not "substantially limited any major life activity." It found there was insufficient evidence to show she was substantially limited in the activities of "lifting" or "working." It also found that she was not substantially limited in "performing manual tasks" because she was able to perform manual tasks in some of the positions she had been placed in. But these findings ignored her inability to perform other manual tasks assigned because of injury and pain, which was the basis for requesting the accommodation and of her disability claim.

The US Court of Appeals (6th Circuit) took a more progressive position, overruling the trial court. It

found that Williams was "disabled" because she was substantially limited in her ability to perform a "class" of manual activities – such as gripping tools, and repetitive work with hands and arms extended at or above shoulder level for extended periods of time – thereby affecting her ability to perform tasks at various kinds of jobs. Because it found her disabled from "performing manual tasks" that affected her ability to do her job and similar jobs, the appeals court ruled in her favour on this basis. Therefore, it did not address the separate question of whether she was substantially limited in the activity of "working." It granted Williams partial summary judgment, stating that she was "disabled" under the ADA.

The US Supreme Court was called upon to determine whether Williams was disabled with respect to "performing manual tasks."

Toyota appealed. The US Supreme Court was called upon to determine whether Williams was disabled with respect to "performing manual tasks." It was not directly addressing the issue of whether Williams was disabled with respect to "working" – although clearly this was at issue for Williams, given the manual nature of her job.

In order to qualify as a "disability" under the ADA, an impairment must "substantially limit" a "major life activity." The Court ruled that "substantial" meant the impairment limits the person's activities to a "large degree." But there are significant problems with the rest of the Court's approach to interpreting this reasonable definition of disability.

First, the Court ruled that "major life activities" are activities "of central importance to daily life," and that for "performing manual tasks" to fit into this category, the tasks must be central to daily life. This is a reasonable interpretation. But the Court then declared that "the central inquiry" must be whether the person "is unable to perform the variety of tasks central to most people's daily lives." The Court offers no principled basis for this test. Why should the determination of whether a person is disabled be made by reference to what is important to the lives of "most people"? A preferable approach would have been to focus on – or at least give considerable weight to – those tasks or activities that are central to the life of the specific person claiming disability.

Indeed, this would have been consistent with the Court's statement elsewhere in the judgment that the existence of disability must be determined in a case-by-case manner. The Court was at pains to point out that an individualized assessment of the effect of impairment is particularly necessary when the impairment is one in which symptoms vary widely from person to person.[2] So, if the effects of impairment are to be assessed on an individual basis, how can this not include examining the effects of the impairment on the activities that are of central importance to that individual's daily living? The Court itself cited its own jurisprudence in affirming that the person has to offer evidence of substantial limitation from their impairment "in terms of their own experience."[3]

Second, the Court ruled that in order to be substantially limited in performing manual tasks, the impact of the impairment must also be permanent or long term. This appears to be legally wrong. In support of this statement, the Court simply cites, without any examination, a provision in the regulations made under the ADA. However, the regulation cited by the Court simply lists three factors to be considered in determining whether an individual is substantially limited in a major life activity. One factor is "the duration or expected duration of the impairment." Another is "the permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment."[4]

The section makes it clear that these are factors to be considered, not minimum requirements for finding disability. Furthermore, by misinterpreting the section with this categorical statement, the Court appears to ignore the possibility of temporary disabilities. Yet many people experience at some point in their life an impairment that has a significant impact on the activities of daily living (including performing manual tasks) that is time-limited. The Court does not point to any convincing evidence that Congress intended to deny protection against disability discrimination in the workplace in those circumstances.

Finally, even if the appropriate standard is "activities of central importance to most people," the Supreme Court then applied this standard very narrowly, with seeming disregard for the importance of being able to perform one's job. The Supreme Court wrote:

> When addressing the major life activity of performing manual tasks, the central inquiry must be whether the claimant is unable to perform the variety of tasks central to most people's daily lives, not whether the claimant is unable to perform the tasks associated with her specific job. […T]he manual tasks unique to any particular job are not necessarily important parts of most people's lives. As a result, occupation-specific tasks may have only limited relevance to the manual task inquiry. In this case, "repetitive work with hands and arms extended at or above shoulder levels for extended periods of time,"… the manual task on which the Court of Appeals relied, is not an important part of most people's daily lives. The court, therefore, should not have considered respondent's inability to do such manual work in her specialized assembly line job as sufficient proof that she was substantially limited in performing manual tasks.
>
> At the same time, the Court of Appeals appears to have disregarded the very type of evidence that it should have focused upon. It treated as irrelevant "[t]he fact that [respondent] can… ten[d] to her personal hygiene [and] carry[y] out personal or household chores…. Yet household chores, bathing, and brushing one's teeth are among the types of manual tasks of central importance to people's daily lives, and should have been part of the assessment of whether respondent was substantially limited in performing manual tasks.[5]

In other words, even though her impairment prevents her from performing manual tasks fundamental to some aspects of her assembly-line job, because Williams can do some other manual tasks such as household chores and brushing her teeth, she does not have a "disability" that entitles her under the ADA to protection against discrimination or to reasonable accommodation in the workplace.

Most people would consider the manual tasks that are fundamental to their job to be "central" to their daily lives. The Supreme Court apparently does not agree. But this failure to appreciate the significance of employment in the lives of most real people manifests itself elsewhere in the judgment. The Supreme Court even goes so far as to say: "Because of the conceptual difficulties inherent in the argument that working could be a major life activity, we have been hesitant to hold as much, and we need not decide this difficult question today."[6]

It must seem strange to anyone who spends half or more of their waking hours working for a living – such as the majority of people in the US – that this could not be considered a "major life activity." The Court's statement also flies in the face of the ADA regulations, which expressly include "working" on a (non-exhaustive) list of "major life activities" and set out a long list of considerations in determining whether impairment substantially limits someone in this activity (which list the Court notes elsewhere).[7]

The Supreme Court's narrow reasoning guts the ADA of effective protection against disability-based discrimination in the workplace. This has obvious negative implications for people living with HIV/AIDS in the United States. The reasoning in *Toyota Motor Manufacturing* should not be adopted by courts in other countries. In recent cases such as *Boisbriand*,[8] the Supreme Court of Canada has taken the more progressive view that legislation prohibiting disability discrimination is to be given a liberal interpretation aimed at ensuring that the purpose underlying such laws is realized and that emphasizes human dignity, respect, and the right to equality. This attitude is preferable to one that denies people with disabilities effective protection against discrimination in the workplace.

Most people would consider the manual tasks that are fundamental to their job to be "central" to their daily lives. The Supreme Court apparently does not agree.

– Richard Elliott

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1 *Toyota Motor Manufacturing, Kentucky, Inc* v *Williams*, (No.00-189, 8 January 2002) [2002] SCT-QL5.

2 Ibid at para 33.

3 Ibid at para 32, citing *Albertson's, Inc* v *Kirkingbird*, 527 US 555 (1999) at 567.

4 29 CFR §§1630.2(j)2(iii) (2001).

5 *Toyota Motor Manufacturing*, supra, note paras 36-39 at 15-17.

6 Ibid at para 35.

7 29 CFR §1630.2(i), 1630.2(j)(3).

8 See joint decision in *Québec (Commission des droits de la personne et des droits de la jeunesse)* v *Montréal (City)*; *Québec (Commission des droits de la personne et des droits de la jeunesse)* v *Boisbriand (City)*, 2000 SCC 27, [2000] SCJ No 24 (QL), summarized at: R Elliott. Supreme Court rules on disability discrimination. *Canadian HIV/AIDS Policy & Law Newsletter* 2000; 5(2/3): 1, 14-15.

US: Appeals Court Dismisses Employment Discrimination Suit by HIV-Positive Dental Hygienist

Shortly before the decision in *Toyota Motor Manufacturing*, the US Court of Appeals (11th Circuit) issued another restrictive judgment, in a case dealing specifically with HIV-based discrimination. On 21 December 2001, in *Waddell* v *Valley Forge Dental Associates Inc*,[1] it dismissed the case of a dental hygienist who sued his employer for suspending him from treating patients after he tested HIV-positive. The decision is a setback for efforts to ensure that the Americans with Disabilities Act translates into actual protection against discrimination for people with HIV/AIDS.

Spencer Waddell was employed as a dental hygienist for almost two years cleaning patients' teeth. He tested HIV-positive in September 1997. The doctor who administered the test telephoned Waddell's employer and revealed this information. (There was no reported lawsuit against the doctor over whether this breach of confidentiality was defensible.) Valley Forge put Waddell on paid leave while it assessed the situation and consulted the Centers for Disease Control and Prevention (CDC). Valley Forge then told Waddell he could no longer treat patients because he was HIV-positive and offered him a clerical job at half his salary as a hygienist. He refused and was fired.

Waddell sued under the Americans with Disabilities Act (ADA). Numerous organizations intervened in his support, including the American Dental Hygienists' Association, the American Dental Association, the American Public Health Association, the Infectious Diseases Society of America, the Association of State and Territorial AIDS Directors, and the federal Equal Employment Opportunity Commission.

Under the ADA, to make out a prima facie case of disability discrimination, Waddell had to show that (1) he is disabled, (2) he is qualified for the position, and (3) he was subjected to unlawful discrimination because of his disability.

The bulk of the evidence presented focused on whether Waddell's HIV-positive status presented a threat to patients, which would mean he was not "qualified" for the position. The trial court concluded Waddell's job entailed "exposure-prone" procedures under the CDC's definition, and that this meant he was not qualified because of his HIV status. The court granted summary judgment to Valley Forge, dismissing Waddell's suit. He appealed.

The Court of Appeals noted:

> The term "direct threat" is defined as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation." 42 USC § 12111(3). Addressing this issue, the Supreme Court explained in *School Board of Nassau County* v *Arline* that "[a] person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk.… To determine whether an employee who carries an infectious disease poses a significant risk to others, the Supreme Court has stated that courts should consider several factors, which include: [findings of] fact, based on reasonable medical judgments given the state of medical knowledge about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm."[2]

In the 1998 case of *Bragdon* v *Abbott*,[3] the US Supreme Court had ruled that an employment decision concerning an infected employee must be "reasonable in light of the available medical evidence," regardless of whether the decision is made in good faith. And in one of its earlier decisions, *Onishea* v *Hopper*,[4] the 11th Circuit Court of Appeals had earlier considered the issue of HIV transmission risk. It ruled that

> when the adverse event is the contraction of a fatal disease, the risk of transmission can be significant even if the probability of transmission is low: death itself makes the risk "significant." […W]hen transmitting a disease inevitably entails death, the evidence supports a finding of "significant risk" if it shows both (1) that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease…. [Although

> the] asserted danger of transfer must be rooted in sound medical opinion and not be speculative or fanciful[,] … this is not a "somebody has to die first" standard, either: evidence of actual transmission of the fatal disease in the relevant context is not necessary to a finding of significant risk.[5]

The Court agreed with the analysis of the trial court that there was a risk that Waddell could cut or prick himself, or be bitten by a patient, and bleed into an open wound or abrasion in the patient's mouth. Furthermore,

> none of Waddell's medical experts … appear to dispute that transmission theoretically could happen, even though the risk is small and such an event never before has occurred. This is enough to constitute a significant risk under *Onishea*, given that HIV has catastrophic effects and is inevitably fatal if transmitted to a patient.[6]

As a result, the Court of Appeals upheld the original trial court's ruling dismissing Waddell's case. Waddell is considering an appeal to the US Supreme Court. However, that Court's obviously narrow approach to protecting against disability discrimination in the workplace, as demonstrated by the *Toyota Motor Manufacturing* decision discussed above, does not bode well.

– Richard Elliott

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[1] *Waddell* v *Valley Forge Dental Associates, Inc*, No. 00-14896, US Court of Appeals (11th Circuit), 21 December 2001 (available at www.law.emory.edu/11circuit/dec2001/00-14896.opn.html).

[2] Ibid at para 7, with reference to *Arline*, 480 US 237 at 287 (note 16), 107 S Ct 1123 at 1131 (note 16) (1987).

[3] *Bragdon* v *Abbott*, 524 US 624, 118 S Ct 2196 (1998). See also *Lowe* v *Alabama Power Co*, 244 F 3d 1305 (11th Cir 2001) at 1338.

[4] *Onishea* v *Hopper*, 171 F.3d 1289 (11th Cir 1999) (en banc).

[5] Ibid at 1297, 1299.

[6] *Waddell*, supra, note 1 at para 17.

US: Hospital Negligent for Failing to Warn Prior Patient of Risk of HIV Infection by Transfusion

The Supreme Court of Tennessee has ruled that a university hospital was negligent for not contacting patients who had received blood transfusions in the early 1980s to advise them of the risk of HIV infection. In *Amos* v *Vanderbilt University*,[1] it awarded US$4.3 million in damages to the estate and family of a woman who died eight years after receiving HIV-tainted blood during surgery.

Julie Story had jaw surgery at Vanderbilt University Medical Center in August 1984. Without her knowledge, she received four units of blood during surgery, one of which contained HIV. At that time, blood banks did not screen for HIV and the hospital had no policy requiring that patients be notified when they received blood during surgery. After HIV screening became possible, Vanderbilt did not undertake to identify and warn all prior patients who had received transfusions of the risk of HIV exposure.

Five years later, Julie Story married Ron Amos and had a daughter Alison who contacted HIV in utero. Julie Amos learned of her HIV infection when her daughter was diagnosed. Her medical records showed that she had received blood from a donor whose blood had been given to another transfusion patient who was also infected with HIV. Alison died at the age of two from pneumocystis pneumonia. Julie and Ron Amos both sued Vanderbilt for wrongful birth, negligence, and negligent infliction of emotional distress. They also sued the American Red Cross, but that claim was settled. Julie Amos died during the litigation, but the claim continued on behalf of her estate.

The Tennessee Supreme Court affirmed the principle that a physician may have a legal duty to exercise reasonable care to protect third persons against foreseeable risks associated with their patient. It referred to earlier court decisions that had specifically imposed this kind of duty in the context of protecting third parties from the risks of a patient's disease.[2] It concluded that:

> It was reasonably foreseeable that Mrs. Amos would one day marry and have a family. Her future husband and daughter were within the class of identifiable third persons at risk for exposure to HIV.… The duty contemplated here is not one to warn Mr. Amos himself of Mrs. Amos's exposure to HIV but to warn Mrs. Amos so that she might take adequate precautions to prevent transmission of the disease to Mr. Amos and their child. Vanderbilt's breach of that duty caused the reasonably foreseeable injuries suffered by Mr. Amos.[3]

The Court reinstated the original damages awarded by the jury at trial:

US$2.7 million to the estate of Julie Amos and US$1.6 million to Ron Amos.

This case is very similar to the 1994 Ontario case of *Pittman* v *Bain*.[4] In that case, a patient received a blood transfusion during surgery in late 1984 before HIV screening began. A year later, after screening was introduced, the donor was identified as HIV-positive. Three years later the physician learned that his patient had received blood that might have contained HIV. Concerned about the patient's heart condition and, incorrectly assuming the patient was not having sex with his wife, the physician did not notify the patient. The patient died of pneumonia a year later, at which time his wife learned she was also HIV-positive.

The Ontario trial court did not rule on the question of whether the physician had a duty directly to his patient's wife that required him to breach patient confidentiality and warn her of the risk of HIV infection. Rather, it ruled that the physician had a duty to tell his patient, and the evidence established that he would have told his wife, thereby avoiding (further) risk of infecting her (assuming she had not already been infected).[5] The court found the physician liable in negligence. This was the same approach taken by the Tennessee Supreme Court in *Amos*.

- Richard Elliott

The Tennessee Supreme Court affirmed the principle that a physician may have a legal duty to exercise reasonable care to protect third persons against foreseeable risks associated with their patient.

[1] *Estate of Julie Amos* v *Vanderbilt University et al*, No. M1999-00998-SC-R11-CV, Supreme Court of Tennessee, 20 December 2001, [2001] TN-QL 1970 (QL).

[2] *Bradshaw* v *Daniel*, 854 SW.2d 865 (Tenn 1993); *Vallery* v *S. Baptist Hospital*, 630 So 2d 861 (La Ct App 1993).

[3] *Amos*, supra, note 77 at paras 21-22.

[4] *Pittman Estate* v *Bain* (1994), 19 CCLT (2d) 1 (Ont Ct Gen Div).

[5] Ibid at 145 (para 696).

US: Health Department Liable for Incorrectly Telling Man He Had HIV

In January 2002, a jury in Oklahoma City awarded US$1.4 million in damages to a man who was incorrectly told in October 1993 by the county health department that he was HIV-positive.

Almost four years later, in June 1997, he tested HIV-negative, prompting a review of his medical records, which revealed that his initial test had in fact been negative. But in the intervening years, he had suffered depression and attempted suicide twice, and had also engaged in unprotected sex with other HIV-positive men, incorrectly thinking he was already infected. A subsequent test in October 1997 came back HIV-positive. (This suggests that either he was infected between the time of his negative test in June 1997 and his positive test in October 1997, or that he was in fact already infected as of June 1997 but was in the "window period" and his negative result was a false negative.) The jury found that the health department had been negligent in incorrectly diagnosing the man. Under Oklahoma state law, the county's liability is limited to US$100,000. The county's lawyer indicated the county was considering an appeal.[1]

[1] *Northcutt* v *City–County Board of Health of Oklahoma County*, No. CJ-98-4016-66 (Oklahoma Co, Okla., Dist Ct, 16 January 2002); P Page. Man wrongly told he had HIV gets it, wins $1.4M. *National Law Journal*, 29 January 2002 (via www.law.com); Jury awards nearly $1.4 million to man who received incorrect HIV test result. *Associated Press*, 16 January 2002.

South Africa: Damages Awarded to Woman Infected by Husband

In mid-2001, the High Court of South Africa issued its judgment in *Patricio* v *Patricio*,[1] a civil case in which a woman sued her HIV-positive husband for infecting her with HIV.

The suit was undefended by the husband. Her evidence was that they married in 1995 and she only learned of his HIV infection, and then hers, when he was diagnosed with AIDS in 1998. Her evidence was that her husband admitted he knew he was HIV-positive when he first met her, but he "could not disclose it to her."

The court reviewed the impact on the plaintiff, noting the discrimination she has experienced from health-care providers, lawyers, and her family, friends, and close-knit community, as well as her depression and feeling "dirty, segregated, humiliated and embarassed" and her "constant fear of death." She was unable to afford the costs of an ongoing medication regimen and her husband refused to assist her with these costs. The court awarded her just under one million rand in damages for past medical expenses, future medical costs, and pain and suffering and the projected progressive loss of amenities of life.

[1] Case No. 0026053/2000, High Court of South Africa (Witwatersrand Local Division), Pandya AJ (judgment on file).

UK: Compensation for Woman Infected through Unprotected Sex

In November 2001, the British Criminal Injuries Compensation Board (CICB) awarded US$32,000 to a woman infected with HIV by a man through unprotected sex.

In the first such case under Scottish law, Stephen Kelly was convicted in February 2001 in Glasgow of "culpable and reckless conduct" for having unprotected sex with his then girlfriend over a period of several months in 1993 and 1994. In March 2001, he was sentenced to five years in prison.[1] The British CICB awarded his ex-girlfriend US$29,000 for her injuries and disablement (the maximum under the legislation) and an additional US $2900 for "mental anguish." However, the Board also reduced the award by US$8,000 because, by not using a condom during sex, she had been "negligent with her own safety." In the law, if a person's own negligence contributes to their injury, then any compensation payable to them may be reduced proportionately.[2]

[1] See: Scotsman sentenced to five years for HIV transmission. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1): 21-22.

[2] British woman infected by man who knew he had HIV awarded "record" $32,000 in damages. *Kaiser Daily HIV/AIDS Report*, 6 November 2001 (www.kaisernetwork.org/dailyreports/hiv).

UK: Court Orders Publication Ban in Case of HIV-Positive Health-Care Worker

In November 2001, an HIV-positive health-care worker brought legal proceedings to prevent the National Health Service from notifying his previous patients that he is infected. The health authorities had intended to carry out a "look back" exercise to notify patients that they may have been exposed.

However, the health-care worker – identified only as "H" – claimed that his right to privacy under the Human Rights Act, 1998 takes precedence, and that the Data Protection Act prevents him from identifying his patients. His field required him to routinely wear rubber gloves as a precaution, he has not practised since his diagnosis, and has no plans to return to work. Furthermore, not a single patient traced in such cases in Britain in the past has ever been found to be infected, and there have been only two documented cases of HIV transmission from a health-care worker to a patient – a dentist in Florida who had failed to follow basic prevention precautions, and a surgeon in France. H argued that the "look back" exercise would cause "great and unnecessary distress" to patients.

The case attracted media attention. On 17 November 2001, H obtained an injunction to stop newspapers from identifying him, his specialty, and the health authority at which he worked. The newspapers challenged the publication ban as infringing press freedom. In December 2001, Gross J of the High Court partially overturned the original order, allowing the media to name the health authority, but continuing the prohibition on publishing H's identity and specific profession. However, H obtained a temporary injunction preventing any such publication pending his appeal of Justice Gross's decision.[1]

The UK Department of Health has also re-considered its practice of automatically notifying ex-patients. On 28 November 2001, it announced that it would produce a framework with criteria for a case-by-case assessment of the risk of transmission to patients, and that the extent of patient notification (if any) would depend on the level of risk of exposure (see the article in International News at page 48 in this issue).

UK Department of Health has reconsidered its practice of automatically notifying ex-patients if their health-care worker was infected with HIV.

[1] HIV health worker "in privacy fight." *BBC News Online*, 17 November 2001 (www.bbc.co.uk); J Meikle. Privacy claim by NHS worker with HIV. *Guardian*, 19 November 2001 (www.guardian.co.uk); Judge's gag order over AIDS threat to patients in England. *Mail on Sunday*, 18 November 2001; J Morgan. MoS demands repeal of Human Rights Act. *Press Gazette Online*, 22 November 2001 (www.pressgazette.co.uk); J Seymour. HIV positive health worker wins injunction to preserve anonymity. *British Medical Journal* 2001; 323: 1207 (24 November 2001); M Wells. Mail close to naming health authority. *Guardian*, 5 December 2001; S Boseley. HIV worker should keep their secret. *Guardian*, 6 December 2001; J Morgan. Press freedom victory for MoS as judge lifts HIV gag. *Press Gazette Online*, 6 December 2001; Editorial: Privacy for patients who are health-care workers. *Lancet* 2001; 358: 1919 (www.thelancet.com).

UK: Court Upholds Ban on Condoms at Psychiatric Hospital

In September 2001, a gay man with hepatitis C held as a patient at a high-security psychiatric hospital applied for judicial review of the hospital's policy banning access to condoms for patients. His application was denied by the High Court on 30 October 2001.[1]

The Royal Ashworth Hospital has a "no sex" policy.[2] Its policy also states that "there is an acknowledged risk that unacceptable sexual activity may occur between patients whilst they are within the Hospital. This Policy manages, but cannot remove that risk."[3] It also notes:

> In institutions such as prisons, condoms have been issued to manage the health risk of high risk sexual behaviours. Condoms are considered within the high secure [sic] hospital to represent a security risk in relation to secretion of prohibited items, and the possibility of their use in harm to self and others. They are therefore not allowed in the possession of patients. If found they would be removed on the basis of the risk to security.… Condoms are not issued. Their issuing would place those staff involved in a position where they were not able to follow policies consistently and would place serious tensions [sic] and possibly compromise multidisciplinary working arrangements with the Hospital.[4]

H's evidence was that since his admission in 1996 he has engaged in sexual activity with other patients, even after being diagnosed with hepatitis C, and that this continues. He alleged that he knew of at least two dozen patients who were also engaged in same-sex activity. A consultant psychiatrist also provided evidence that, despite observation, it is unlikely that all interactions, especially sexual activities, would be witnessed by staff, particularly between patients on ground parole or during social and recreational activities.

The hospital questioned the weight that should be given to H's evidence, given his diagnosis of psychopathic disorder. It also offered justifications for its "no sex" policy, and stated that:

> It is our belief that no sexual activity should take place or indeed should be permitted to take place and therefore condoms should not be provided. We also believe that if condoms were supplied, by whatever method, patients are more likely to seek ways in which to conduct sexual activity. That may have relatively little impact for those who seek such activity but we also have to consider the impact on those who are approached and may be exploited in such situations.[5]

The hospital also claimed that condoms presented a security risk because they could be passed to another patient who might be "unsuitable" who would seek to engage in sexual activity to the detriment of their own treatment and that of the other person. Furthermore, condoms could be used to transport illicit substances to avoid detection.

H did not challenge the "no sex" policy. He sought judicial review only of the prohibition on condoms, on three grounds.

First, H argued the policy was unreasonable. Bellamy J reviewed the policy in detail and the rationale offered by the hospital, and rejected this argument, finding that it was not so unreasonable that it should be disturbed by the courts.

Second, citing the earlier *Fielding*[6] decision regarding general access to condoms in prisons (as opposed to access by prescription only), H argued that the hospital has a duty to protect the health of its patients by preventing the transmission of disease. H did not claim that condoms should be generally available, but that a blanket policy unlawfully fettered the hospital's discretion to allow condoms in appropriate cases. The considerations relating to the "no sex" policy or the hospital's administrative difficulties were not adequate justification for overriding the obligation to protect the health (and possibly life) of the patient at risk of a sexually transmissible disease. However, Bellamy J read the policy as allowing the Medical Director of the hospital the possibility of examining the circumstances of an individual case, and noted that "if new or exceptional circumstances were to arise (for example if the risk of infection were for any reason to be substantially greater than at present, or if

…continued from previous page

HIV were, for example, to present a substantial risk), the defendant would be under a legal duty to review its policy."[7] (The court had accepted the hospital's evidence that no patients were HIV-positive.)

Finally, H argued that the ban on condoms breaches the right to life (Article 2) and the right to respect for his private life (Article 8) under the European Convention on Human Rights and Fundamental Freedoms.[8] Reviewing previous jurisprudence from the European Court of Human Rights, Bellamy J dismissed these arguments. He agreed there was a risk of unprotected anal sex occurring, but that it was very small, and that, given the low risk of transmission of HCV, the prohibition on condoms could not be said to present a "real and immediate threat to life" as required under Article 2 of the Convention. The judge also agreed that protecting a person's physical integrity is part of the concept of "respect for private life," but that again H had not established a "real and immediate" risk to his health.

– Richard Elliott

[1] *RH* v *Ashworth Hospital Authority*, [2001] EWJ No 4881, [2001] EWHC Admin 872 (QL).

[2] Ibid at para 6, reproducing: Royal Ashworth Hospital. Patients' Relationship Policy (adopted October 2000), para 3.5.

[3] Ibid (Policy, para 4.3).

[4] Ibid (Policy, paras 4.4-4.5).

[5] Ibid at para 19.

[6] *R* v *Secretary of State for the Home Department ex parte Fielding*, [1999] COD 525 (Latham J).

[7] *Ashworth Hospital Authority*, supra, note 1 at 137.

[8] The Convention applies directly in UK law since October 2000 under the Human Rights Act 1988.

India: Constitutional Challenge to Anti-sodomy Law

On 7 December 2001, the Naz Foundation India Trust filed a petition with the Delhi High Court alleging that the prohibitions on sodomy in Indian law are unconstitutional.

Section 377 ("Unnatural Offences") of the Indian Penal Code punishes "carnal intercourse against the order of nature with any man, woman or animal" with a maximum penalty of life imprisonment.

The Naz Foundation India Trust, an organization doing HIV/AIDS prevention and support work among gay men and other men who have sex with men, argues that the provision predominantly penalizing men having sex with men in private as consenting adults violates constitutional rights to liberty (including protection from state intrusion on "intimate associations") and to equality without any compelling state interest to justify the infringement. It also argues that the legislation undermines its HIV prevention work, and is seeking a permanent stay on police action against consenting adults for engaging in gay sex. The court asked the respondents, including government agencies, to file their replies in the case and have asked the Attorney General to appear for the Union of India at the next instance on 23 April 2002.[1]

[1] Gay activists get court to examine Article 377. *Hindustan Times*, 7 December 2001; Homosexuals move HC seeking "fundamental rights." *The Hindu*, 8 December 2001; R Wockner. Indian sodomy ban challenged. *International News* #398, 10 December 2001; Communication with V Divan, Lawyers Collective HIV/AIDS Unit, 8 February 2002. The originating petition will soon be available at www.hri.ca/partners/lc/unit/index.shtml.

International Update on Litigation on Blood and Blood Products

This article summarizes recent developments from around the world on litigation on blood and blood products.

Japan: Court Clears Doctor, Convicts Former Health Ministry Official for Negligence in HIV-Tainted Blood Products[1]

On 28 March 2001, in the second criminal proceeding in Japan related to contaminated blood products, a Tokyo court cleared Dr Takeshi Abe, a leading Japanese authority on hemophilia and former head of a government panel on AIDS, of criminal responsibility in the death from AIDS of a man with hemophilia. The man who died was one patient among dozens of hemophiliacs infected with HIV at Teikyo University Hospital in Tokyo through contaminated imported blood products administered by Abe's subordinate. Prosecutors had been seeking a three-year prison term for Abe. On 10 April 2001, they filed an appeal of this decision with the Tokyo High Court.

In Japan, roughly 1800 hemophiliacs were infected with HIV in the 1980s through the use of unheated blood-clotting agents, and 500 of them are estimated to have died. In 1983, a group of hemophiliacs filed a petition with the Ministry of Health and Welfare to replace unheated blood products from the US with safer alternatives. While the Ministry approved heated blood products in 1985, it did not order a recall of unheated products.

Abe was charged with negligence for allowing the use of unheated products tainted with HIV on three occasions between May and June 1985. Prosecutors alleged that Abe, the head of a government panel on AIDS in 1983, helped delay the approval of heated products in order to prevent Japanese pharmaceutical companies, who had large stocks of unheated product, from incurring losses. They also alleged that Abe "must have known the high risk of HIV contamination in unheated blood products" because he had been told in September 1984 by Robert Gallo, a leading expert on AIDS at the US National Institutes of Health, that 23 of 48 hemophiliacs given such products at Teikyo University Hospital had tested HIV antibody–positive.

Prosecutors also put forward evidence that Abe had "close ties" with Green Cross Corporation, a "major" importer of unheated blood-clotting products in Japan, including Green Cross allegedly financing Abe's research. In February 2000, in the first criminal proceeding in Japan relating to contaminated blood products, the Osaka District Court had convicted three former heads of Green Cross of professional negligence resulting in the death of a liver-disease patient. The court found they had failed to stop sales of blood products from the US even though they knew the products could be contaminated with HIV, and said they put "profits before safety." They were sentenced to prison terms ranging from 16 months to two years. Those convictions are under appeal. Four years earlier, in 1996, the government and five pharmaceutical companies had settled a civil suit by a group of Osaka plaintiffs who contracted HIV through tainted blood products, paying each plaintiff 45 million yen.

Judge Toshio Nagai ruled that, at the time, unheated blood products were "lauded for their efficiency in stopping bleeding and causing fewer side effects." He added that nobody should be "convicted of professional negligence when merits of medical treatment would offset risk of the method," and that Abe could not be considered negligent because experts knew little about AIDS at the time and "any other doctor would have done the same in the same position." However, the judge also noted that Abe "understood the dangers of using unheated blood products but could not have known that so many hemophiliacs would be infected."

Finally, a third proceeding in Japan relating to contaminated blood products reached the courts in 2001. Akihito Matsumura was the head of the biologics and antibiotics division in the Health and Welfare Ministry between 1984 and 1986, where he

was in charge of authorizing the production and importation of blood products. He was charged with two counts of professional negligence related to the death of two men who died of AIDS as a result of receiving HIV-contaminated blood products (including the man for whose death Abe was on trial). He pleaded not guilty.

On 28 September 2001, Judge Toshio Nagai found him guilty of negligence for failing to order the recall of non-heat-treated blood products that were used in April 1986 to treat a patient. This makes him the first public servant held personally responsible for failing to take meaningful action to prevent a tragedy. The court said that Matsumura "was responsible for avoiding deaths from AIDS by taking measures to ban doctors from using unheated blood products. But the accused neglected the responsibility and continued allowing pharmaceutical firms and doctors to sell and use the products."

Matsumura was cleared of the second charge. He was sentenced to one year in prison, but the sentence was suspended for two years. On 9 October 2001, he filed an appeal of his conviction.

China: Court Orders Compensation in Case of Woman Infected with HIV through Blood Transfusion

On 10 September 2001, the Wuxian People's Court in Jiangsu Province ordered a hospital in Nanzhang County to pay US$1.2 million to the family of a woman who died after contracting HIV through a blood transfusion in 1998 during labour. Her husband and three-year-old daughter were also found to be HIV-positive. The blood at the hospital had been collected without a licence and had not been screened for HIV. The court ordered that they each receive US$24,700 as a lump sum, plus an annual sum of over US$10,000. This is the first time a Chinese court has given such a large award to a person who received HIV-contaminated blood, although it is possible the hospital will declare itself bankrupt rather than pay the compensation ordered.[2]

United Kingdom: Judgment in Favour of People with Hepatitis C

On 26 March 2001, hearing claims by six "test case" plaintiffs in Wales, the Queen's Bench Division of the High Court ruled in favour of claimants who were infected with hepatitis C (HCV) from blood and blood products. The plaintiffs sued the National Blood Authority, and the Velindre NHS Trust (which is responsible for running the Welsh blood service) under the Consumer Protection Act, 1987. That Act imposes strict liability on the producer of a defective product that has caused damage, meaning the plaintiffs were not required to prove negligence on the part of the defendants. This was the first multi-party case brought under the law. In the six test cases, Burton J made individual awards of between £10,000 and £210,000, and ruled that all 114 claimants from England and Wales in the same position were entitled to compensation.[3]

The UK government had refused to order a public inquiry into the tainted-blood scandal, and had ruled out compensation for hemophiliacs infected with HCV, although some 1200 people infected with HIV in the same way have been compensated via a trust fund.[4]

Despite the ruling south of the border, the Scottish Executive continued to reject calls for compensation for all people infected. (The ruling is not legally binding in Scotland.) The Scottish Health Minister did, however, instruct lawyers for the National Health Service to begin negotiating settlements with those infected after March 1988, as their cases are "directly analogous" to those covered by the ruling in England and Wales. Only about 20 people would be included in this group. In October 2001, the Scottish Parliament's health committee issued a report calling for compensation for those infected with HCV regardless of whether government negligence can be proven, saying the government has a "moral duty" to do so. Over 300 Scottish hemophiliacs are estimated to have been infected with HCV through blood products.[5]

United States: FDA Seeks Contempt Order against American Red Cross

On 13 December 2001, the US Food and Drug Administration (FDA) filed a request before the US District Court for an order holding the American Red Cross (ARC) in contempt of court and granting the FDA the authority to fine the organization for tens of thousands of dollars for "persistent and serious violations" of rules to protect the safety of the blood supply. The ARC supplies about 45 percent of the nation's blood.

In 1993, a consent decree was issued in which the ARC agreed to improve its management and quality control over its processes for collecting, testing, and distributing blood. However, the FDA claimed that its most recent inspections of ARC blood centres found numerous failures,

including the release of blood "possibly tainted" with cytomegalovirus, failure to screen out donors with syphilis, failure to update a national registry of unsuitable donors, and computer problems that could lead to the release of blood before it has finished all safety testing. The ARC challenged the FDA's motion.[6]

– Richard Elliott

[1] Doctor cleared in HIV scandal. *BBC News Online*, 28 March 2001 (www.bbc.co.uk, accessed 27 July 2001); and see the following articles from *Japan Times Online* (www.japantimes.co.jp, accessed 27 July 2001): Abe acquitted of negligence in HIV blood-products scandal, 29 March 2001; K Aita. Surprise ruling won't wash with the victims, 29 March 2001; H Matsubara. HIV-hit hemophiliacs fight on, 29 March 2001; "Not guilty" is not innocent, 31 March 2001; Abe's acquittal in HIV case appealed, 11 April 2001; J Watts. Japanese official found guilty in HIV-blood trial. *Lancet* 2001; 356: 1166 (6 October 2001); Japan blood scandal official convicted. *BBC News*, 28 September 2001 (news.bbc.co.uk); Ex-official freed despite deadly AIDS decision. *Mainichi Daily News Interactive*, 28 September 2001 (mdn.mainichi.co.jp); Former Japanese health ministry official appeals conviction for contaminated blood product sales. *Kaiser Daily HIV/AIDS Report*, 11 October 2001 (www.kaisernetwork.org/dailyreports/hiv). For more background details, see: DP Hamilton. Japan AIDS scandal seen as sign of regulatory failure. *Wall Street Journal*, 9 October 1996 (www.aegis.com/news/wsj/1996/wj961002.html); First convictions in Japan HIV blood scandal, *Reuters News*, 24 February 2000. See also: Aids scandals around the world. *BBC News*, 9 August 2001 (news.bbc.co.uk).

[2] Chinese court orders hospital to compensate family of woman who died after receiving HIV-infected blood. *Kaiser Daily HIV/AIDS Report*, 11 September 2001 (www.kaisernetwork.org/dailyreports/hiv); W Hayes. China court orders AIDS compensation. *BBC News*, 11 September 2001 (news.bbc.co.uk).

[3] *A* v *National Blood Authority*, [2001] TNLR No 200 (QB Div) (QL) (Burton J).

[4] No compensation for infected blood. *BBC News Online*, 7 March 2000 (www.bbc.co.uk, accessed 27 July 2001).

[5] See the following articles from *BBC News Online* (www.bbb.co.uk, accessed 27 July 2001): Hepatitis patients win compensation, 26 March 2001; Hepatitis ruling to cost NHS millions, 26 March 2001; Fury over hepatitis C decision, 6 April 2001; Hepatitis patients blame transfusions, 9 April 2001; Executive to examine blood ruling, 26 April 2001; Minister refuses blood payout calls, 23 May 2001; Payout call after hepatitis infections, 2 October 2001. See also: Scottish health minister moves to compensate patients who contracted hepatitis C from transfusions. *Kaiser Daily HIV/AIDS Report*, 30 August 2001; Scottish Members of Parliament call for blanket compensation for those infected with hepatitis C through contaminated blood products. *Kaiser Daily HIV/AIDS Report*, 5 October 2001 (www.kaisernetwork.org/dailyreports/hiv).

[6] FDA asks federal judge to hold Red Cross in contempt, impose fines over blood-collecting practices. *Kaiser Daily HIV/AIDS Reports*, 14 December 2001 (www.kaisernetwork.org/dailyreports/hiv).

Criminal Law and HIV Transmission/Exposure: A Swedish Case

In a regular column, we have reviewed new developments in the area of criminal prosecutions for HIV transmission or exposure.[1] Three new Canadian cases are summarized elsewhere in this issue (see pages 64 to 67). This short note is about a recent Swedish case.

In February 2002, a Swedish court convicted Fawzi Ali Batum, age 25, of aggravated assault for having infected two women with HIV through unprotected sex between 1997 and 2000 while knowing he was HIV-positive. He was sentenced to five years in prison and ordered to pay damages to the two complainants. Batum was diagnosed with HIV in 1993 upon arriving in Sweden from Somalia. Noting Batum's physical and mental health and the instability of Somalia, the court denied the prosecutor's request to deport him after he serves his sentence.[2]

[1] See, eg, R Elliott. Criminal law and HIV/AIDS: Update V. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 17-23.

[2] Man sentenced to five years for infecting two women with HIV. *Associated Press*, 20 February 2002.