CANADIAN
HIV/AIDS
POLICY & LAW
REVIEW

VOLUME 8, NUMBER 1, APRIL 2003

The UNGASS Declaration of Commitment on HIV/AIDS: One Year Later

This article is one of a series commissioned to mark the tenth anniversary of the Canadian HIV/AIDS Legal Network. It offers a critical assessment of the impact of the UNGASS Declaration of Commitment on national HIV/AIDS strategies and programs in relation to human rights one year after its adoption. The article reviews the process leading up to the Declaration and describes the limitations of the Declaration's explicit and implicit recognition of human rights. It summarizes information provided by countries one year later to the Secretary-General and to UNAIDS on their progress in meeting the goals and targets of the Declaration, particularly with regard to human rights. It comments on what we can learn from this about countries' recognition of the centrality of promoting and protecting human rights. Finally, it suggests ways to monitor more effectively and comprehensively the implementation of a human rights–based response to the HIV/AIDS epidemic.

Introduction

In late June 2001, government dignitaries and heads of state gathered in New York for a Special Session of the United Nation's General Assembly (UNGASS) on HIV/AIDS, to

cont'd on page 7

CANADIAN HIV•AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH•SIDA

Published by the Canadian HIV/AIDS Legal Network. A project funded in part by Health Canada under the Canadian Strategy on HIV/AIDS.

Canadian Strategy on HIV/AIDS

The UNGASS Declaration of Commitment on HIV/AIDS: A Review of Legislation in Six Southern African Countries

This article reviews legislation of six Southern African countries to determine what progress has been made after the UNGASS Declaration of Commitment on HIV/AIDS, particularly with regard to paragraph 58 on human rights and paragraph 69 on rights in the workplace. The article notes the complexities introduced by the coexistence of customary laws and practices and codified law. It describes certain features of specific codified and customary laws. It concludes that, with the possible exception of South Africa, the countries under review have not responded to the challenges the HIV/AIDS epidemic have confronted their legal systems with. They have resorted in the first instance to criminal law, and have allowed discriminatory customary laws and practices, which propel the epidemic, to continue to operate.

cont'd on page 14

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:

Canadian HIV/AIDS Policy & Law Review
Canadian HIV/AIDS Legal Network
417 Saint-Pierre, Suite 408
Montréal, Québec H2Y 2M4
Tel: 514 397-6828 Fax: 514 397-8570 Email: arenaud@aidslaw.ca

Circulation: 2000
ISSN 1195-5252

The publication of the *Canadian HIV/AIDS Policy & Law Review* is funded in part by Health Canada under the Canadian Strategy on HIV/AIDS.

The findings, interpretations, and views expressed in this publication are entirely those of the authors and do not necessarily reflect official policy or positions of the of Health Canada, UNAIDS, or the Canadian HIV/AIDS Legal Network.

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.

Comments? ***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.***

CONTENTS

cont'd

EDITORIAL

Transparency, Participation, and Accountability

Transparency, participation, and accountability. As David Patterson notes in the introduction to International News, these have come to be essential characteristics of policies and programs that respect, protect, and fulfill human rights. They are an inseparable trio, and for good reason. Transparency is a minimum condition for participation. It is hard to participate when one does not know what is going on, and even harder to participate in good faith if one knows information is held back. Participation is an incentive toward accountability. Organizations are more likely to be accountable for decisions when the decision-making process is participatory. And accountability is a necessary sequel to participation. Why participate if what one says does not make a difference?

Governments and other organizations are not unfailingly transparent, participatory, and accountable in their response to HIV/AIDS. The first annual report of the United Nations Secretary-General on the progress that countries have made toward the implementation of the Declaration of Commitment on HIV/AIDS is a painful reminder of this. The authors of a feature article on the Secretary-General's report, published in this issue, could not obtain copies of either the questionnaire sent to countries or the responses submitted by the countries, despite repeated requests to UNAIDS. They were informed that individual written permission from each country would be necessary in order to have the responses released.

Or, for an example closer to home, CBC News recently obtained a copy of a report, whose release was repeatedly delayed by the Correctional Service of Canada (CSC), on the rates of HIV and hepatitis C infection in federal prisons (see HIV/AIDS in Prisons in this issue).[1] The report suggests that at least 1.8 percent of all inmates have HIV and at least 25 percent of all inmates have hepatitis C. The rates are higher among women inmates alone – almost 5 percent are known to have HIV and more than 40 percent are known to have hepatitis C. The report states that, despite recommendations from within CSC that needle exchanges be available in prisons, there are no plans to provide them. Why was the report not made public in a more timely fashion? Who participated in the decision not to provide needle exchanges? Who within CSC is accountable for the fact that, as studies show, the risk of infection in prisons is higher than in the community?

Canada is fortunate to have public processes that afford at least some opportunity for participation and accountability. As reported in Canadian News in this issue, the federal House of Commons Standing Committee on Health recently held hearings on HIV/AIDS and on the Canadian Strategy on HIV/AIDS, and the House of Commons Standing Committee on Justice and Human Rights is about to review federal laws on solicitation. While such hearings may still produce recommendations that fall short of what we might wish, they at least afford the opportunity for representation and, more importantly, dissent. (The previous issue of the *Review* noted with appreciation the minority report of the House of Commons Special Committee on Non-Medical Use of Drugs.)

The *meaningful* participation of people with HIV/AIDS is one of the most effective avenues to transparency and accountability in making decisions about the HIV/AIDS epidemic. It shows respect for the human rights, experiences, and inherent dignity of people with HIV/AIDS. This was acknowledged almost a decade ago by heads of government at the Paris AIDS Summit.

Promoting the greater and more meaningful involvement of people with HIV/AIDS in the decisions that affect their lives and the lives of their communities is one of the goals of the Global Network of People Living with

HIV/AIDS. All organizations – governmental and non-governmental – involved in the response to HIV/AIDS need to continue to learn what this means in practice.

Were inmates, especially those with HIV/AIDS or hepatitis C, involved in the decision not to provide needle exchanges in prison? A transparent and accountable process for inmates to participate meaningfully in decisions about needles exchanges, drug treatment, and other controversial measures is needed to ensure that prison authorities in Canada truly respect, protect, and fulfill prisoners' inalienable right to health – a fundamental human right that is not suspended during incarceration.

---

[1] Canadian Broadcasting Corporation. HIV rates 10 times higher in prison. 22 April 2003.

The UNGASS Declaration of Commitment on HIV/AIDS: One Year Later

cont'd from page 1

declare publicly their commitment to overcoming this communicable disease and human rights crisis. The UNGASS was the culmination of a two-year process, following the UN conferences of the 1990s concerning human rights, population and development, women's equality, and social development.[1] These conferences produced important "outcome documents" – programs and platforms for action that evidenced international governmental consensus to work toward common goals. While not legally binding in the same way as international treaties, these documents have nonetheless worked to establish international norms and standards and to forge a common purpose between governments, international agencies, and international civil society. They serve as evidence of international political commitment, provide a clear mandate for the UN agencies that are directly concerned with their outcomes, and function as a lever to raise the visibility of, and resources for, the issues.[2]

The Declaration of Commitment on HIV/AIDS from the UNGASS,[3] like other UN conference documents, was the work of governments, intergovernmental agencies such as UNAIDS, and civil society organizations. Yet the Special Session was in many ways unprecedented. Although HIV/AIDS had been the subject of consideration by a number of UN bodies,[4] this was the first time that HIV/AIDS was specifically addressed by the General Assembly as a topic of global and urgent concern.[5] It established time-bound targets, which allow for the measurement of governmental accountability. And as the first UN conference devoted directly to HIV/AIDS, it was the first to explicitly involve a range of civil society groups in the entire process.

The process therefore raised many expectations – from universal access to antiretrovirals to the establishment of a Global Fund that would raise new and sufficient funds to combat HIV/AIDS. Some expectations were met in the final outcome document, others dashed. From the preamble to each chapter concerning leadership, prevention, care, treatment, support, and so on, governments (with civil society working behind the scenes) negotiated the language of the text in order to draw up an agreement that all could accept. Political processes by their nature produce compromise, and the Declaration of Commitment, particularly for those who had been elaborating a human rights–based approach to HIV/AIDS during the preceding decade, represented a compromise of a most disappointing sort.

HIV/AIDS and Human Rights – A Missed Opportunity

In the recent past, there has been a growing awareness at the global, national, and community levels that all human rights – civil, political, economic, social, and cultural – must be respected, protected, and fulfilled, not only because they are the binding legal obligations of governments, but because they are critical to an effective response to HIV/AIDS epidemic. In fact, such an insight led to the adoption of the UNAIDS Framework for Global Leadership on HIV/AIDS, which laid much of the foundation for the UNGASS.[6] The Declaration of Commitment recognized the rhetorical value of human rights in the context of HIV/AIDS and even includes a section entitled "HIV/AIDS and Human Rights." In this section, governments agreed:

- By 2003, to enact, strengthen, or enforce legislation to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights of people living with HIV/AIDS and members of vulnerable groups.[7]
- By 2005, to develop and accelerate the implementation of national strategies to promote the advancement of women and their full enjoyment of all human rights – including having control over and deciding freely and responsibly on matters related to their sexuality.[8]
- By 2005, to implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection.[9]
- By 2005, to develop and accelerate implementation of national strategies for women's empowerment to reduce their vulnerability to HIV/AIDS by eliminating discrimination, including gender-based forms of violence.[10]

That discrimination against women and girls received special mention,

along with discrimination against those living with and vulnerable to HIV/AIDS, was welcome but inadequate. Taken as a whole, all these human rights targets are necessary, but not sufficient. This section represents a much-diminished expression of the relationships to the promotion and protection of human rights, and

Governments resolutely rejected a human rights "chapeau" to the Declaration.

the reduction of HIV/AIDS risk, vulnerabilities, and impact.[11] In many ways, relegating human rights to a separate section, coupled with a focus on only these particular aspects, backtracked on the understanding engendered by years of activism and programmatic work on integrating human rights into the totality of the response to HIV/AIDS.

Governments – due to the strong persuasion of certain member states – resolutely rejected a human rights "chapeau" to the Declaration of Commitment. Instead, human rights were reduced to a focus on legal structures, to the exclusion of other tools and mechanisms. The document is virtually silent on the value and existence of rights-based approaches to HIV/AIDS policy and program work. That the identification of specific "vulnerable groups of individuals" – men who have sex with men, commercial sex workers, and injection drug users[12] – was repeatedly rejected by certain government delegations and did not find its way into the final outcome document also highlights the retrogressive nature of the political compromise behind the Declaration of Commitment.

Nonetheless, commitments were made that had positive human rights implications, such as access to medications. In the end, the 189 delegations from countries attending the Special Session agreed to more than 25 specific goals and targets relating to the complex dimensions of the epidemic, including:

- By 2003, to ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS.[13]
- By 2005, to ensure that a wide range of prevention programs, commodities, and services are available, particularly in the most affected countries.[14]
- By 2003, to ensure that national strategies are developed to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including antiretrovirals.[15]
- By 2003, to develop or strengthen national strategies, policies, and programs to promote and protect the health of particularly vulnerable groups.[16]

Moreover, all these goals and targets have been linked to the UN Millennial Development Goal of halting HIV/AIDS by 2015 – a development that may eventually assist in bringing about the realization of the substantive provisions of the Declaration of Commitment.[17]

Reporting to the Secretary-General and UNAIDS

One of the mechanisms established to oversee the implementation of the Declaration of Commitment is a reporting process. Governments that joined in the consensus adopting the Declaration of Commitment agreed to provide information on a yearly basis to be summarized in a report by the Secretary-General of the United Nations on progress made and obstacles encountered in implementation at the country level.[18] The Secretary-General issued his first report "on progress towards implementation of the Declaration of Commitment on HIV/AIDS" on 12 August 2002.

The Secretary-General's report was based "primarily on responses received to a questionnaire sent to Member States"[19] in March 2002; its purpose was to establish a baseline against which progress toward implementation of the Declaration of Commitment could be measured. Those involved in the reporting process themselves admitted it was less than seamless. The initial report from the Secretary-General was already somewhat delayed owing to the late submission of questionnaires in response to the survey sent out by UNAIDS (the Secretariat for the UNGASS, supporting the Secretary-General as well). At the time the report was finally issued, only 97 countries had filed reports.[20]

Limited public information

The original intention of this article was to examine all the individual country submissions in response to the UNAIDS questionnaire. Based on past experience with other UN conferences, such as the five-year review to the Fourth World Conference on Women, the UN agency questionnaire and the individual country reports are generally made available via the Internet.[21] That has not yet been the case for this UNGASS. To date, neither the questionnaire nor the country responses are publicly accessible.

Formal requests were made to UNAIDS to obtain the individual country responses to the questionnaire, as suggested on its website. No documents were made available; in fact a potential "legal problem" was referenced in making such documents public.[22] UNAIDS did make available an internal document listing the countries that had returned the questionnaires for the Secretary-General's report. We were informed that individual written permission from each country would be necessary in order to have the questionnaire responses released.[23]

To date, neither the questionnaire nor the country responses are publicly accessible.

It is unclear why government-generated reports on compliance with an internationally agreed to, and public, document appear to be "private." The unfortunate result is that the sources for this article are limited to the two published reports, one issued by the UN Secretary-General, the other by UNAIDS.[24]

The Secretary-General's Report

For all the good done by the increased visibility that the UNGASS gave to the HIV/AIDS pandemic, almost two years after the unanimous adoption of the Declaration of Commitment it appears from their own reports that governments have so far done little to advance the agenda and deliver on the goals and targets. In his summary, the Secretary-General writes:

> Implementation … is slow, in large measure owing to a lack of resources and technical capacity.…While many countries report progress in putting in place measures aimed at combating stigma and discrimination and reducing vulnerability, especially of women, HIV-related stigma and the continued marginalization of vulnerable populations impede effective efforts.[25]

The Secretary-General, reporting on the impact the Declaration of Commitment has made on country-level work in relation to human rights, states:

> Countries in every region report that HIV-related stigma and the marginalization of vulnerable populations impede efforts to fight the epidemic. A growing number of countries acknowledge the importance of respect for human rights, but most have not adopted enforceable measures to protect individuals infected with or affected by HIV from discrimination.[26]

From the perspective provided by the Secretary-General's report, little progress appears to have been made toward the realization of human rights in the context of HIV/AIDS. For example, the Secretary-General's report notes that in response to the Declaration of Commitment target to adopt national and legal policy frameworks on HIV and human rights protection in the workplace by 2003, slightly more than half the reporting countries from Latin America, and less than half from Africa, have such legislation.[27] Unfortunately, no concrete data are provided.

The UNAIDS Report

The UNAIDS Companion Report provides some additional insight into national-level developments, although again, information is related at the aggregate-regional level only.[28] It was issued specifically to supplement the information contained in the Secretary-General's report, as it states:

> This report complements the report of the Secretary-General by providing additional detail on progress achieved in different regions and examples of support to implementation of the United Nations in implementing the Declaration of Commitment on HIV/AIDS.[29]

The UNAIDS Companion Report, like that of the Secretary-General, is principally based on responses by countries to the March 2002 questionnaire sent to member states. Table 1 (page 10) provides a listing of those countries understood to have filled out and returned the questionnaire.

Little progress appears to have been made toward the realization of human rights in the context of HIV/AIDS.

Africa

Of the 45 countries that are understood to comprise the African region, 30 returned questionnaires to UNAIDS. Half the countries of sub-Saharan Africa stated that legislation, regulations, or other measures were in place to eliminate discrimination against people with HIV/AIDS. Forty percent of these countries mentioned they had laws and policies that protected people living with or affected by HIV/AIDS from discrimination in the workplace. Approximately 60 percent had national policies for working toward the rights of women affected by and vulnerable to HIV/AIDS. Almost all 30 countries that submitted a questionnaire claimed that their

Table 1: Countries Reporting to UNAIDS on the Declaration of Commitment[30]
(Source: unpublished UNAIDS document 'SG report 2002 responding countries.doc' on file with authors.)

	Global	Africa	Asia/Pacific	Latin America and the Caribbean	East Europe/ Central Asia	High Income
Total number stated in UNAIDS Companion Report as reporting	97	30	20	23	14	10
Countries stated as returning questionnaire to UNAIDS for inclusion in the Secretary-General's Report and the UNAIDS Companion Report.	[97]	Benin Burkina Faso Cameroon Congo (Kin.) Congo Cote d'Ivoire Egypt Equatorial Guinea Eritrea Ethiopia Gambia Ghana Guinea Kenya Liberia Madagascar Mali Mauritania Mauritius Morocco Mozambique Namibia Nigeria Rwanda Sierra Leone Swaziland Togo Uganda Zambia [29]	Cambodia China Fiji Indonesia Jordan Lao PDR Lebanon Malaysia Mongolia Myanmar Nepal Oman Pakistan Philippines Saudi Arabia Thailand Turkey Viet Nam [18]	Antigua Argentina Aruba Barbados Brazil Chile Colombia Cuba Dominican Republic Ecuador Guatemala Guyana Haiti Honduras Jamaica Mexico Nicaragua Paraguay Peru Suriname Trinidad & Tobago Uruguay Venezuela [23]	Armenia Azerbaijan Belarus Croatia Czech Republic Hungary Kazakhstan Latvia Macedonia Moldova Poland Romania Russian Federation Slovenia Tajikistan Ukraine FR Yugoslavia [17]	Australia Canada Finland Germany Netherlands Japan Spain Sweden Switzerland United States [10]

national HIV/AIDS programs were gender sensitive.[31]

Asia/Pacific

Of the countries that are understood to comprise the Asia/Pacific region, 18 responded to the questionnaire. Twelve respondents reported that legal measures were in place to eliminate HIV/AIDS discrimination and that national strategies were in place to promote and realize women's human rights. However, "many countries in the region … cite the absence of an enabling environment for the promotion and enforcement of human rights as an impediment to effective integration of human rights into national HIV/AIDS efforts."[32]

East Europe/Central Asia

Fourteen of the 30 countries that comprise this region reported to UNAIDS. Eleven of those reported

on their anti-discrimination legislation. Romania was notably singled out as a progressive example, although specifics were not related. Six other countries indicated that national strategies existed to ensure the realization of rights of women "affected by, or at risk of, HIV infection."[33]

Latin America and the Caribbean

Thirty countries are included in this region and 23 responded to the UNAIDS questionnaire. Seventy-five percent of respondents indicated that legal protections were in place to prevent HIV-related discrimination. Fifteen countries reported on specific programs to ensure the full enjoyment of the rights of women affected by HIV/AIDS. "Nearly half … indicate that implementation and enforcement of human rights protections have been slow."[34]

High-income countries

Of the countries classified as "high income," 10 reported, and stated that they "had legislation in place to prohibit HIV-related discrimination. Six of the 10 have policies to "ensure full realization of legal rights by women affected by HIV/AIDS."[35]

What Do These Reports Tell Us?

Even though country responses fall short of 100 percent and the story is far from complete, there is sufficient information to venture some observations.

As this was the first of the annual reports governments are responsible for filing, virtually no information relating to the *implementation* of laws and policies is contained in these reports. Yet recent, well-known cases of discrimination in India[36] and Nigeria,[37] for example, underscore the necessity to go beyond laws and policies in future reports. As the information summarized in relation to the Asia/Pacific and Latin American/Caribbean regions explicitly shows, the existence of good laws and policies alone does not mean that discrimination against people living with or affected by HIV/AIDS and against women disappears. And as the Secretary-General's report acknowledges, virtually every region reports that "HIV-related stigma and marginalization of vulnerable populations impede efforts to fight the epidemic.… [M]ost [countries] have not adopted enforceable measures to protect individuals infected with or affected by HIV from discrimination."[38]

> Countries understand that the promotion and protection of human rights figure throughout the Declaration, even if their actions appear to be insufficient.

As already mentioned, human rights have been part of the response to the HIV/AIDS epidemic since the creation of the first global AIDS strategy in 1987.[39] The classification of human rights in a discrete section of the Declaration of Commitment could leave the impression that human rights in the context of HIV/AIDS pertains only to matters discussed in that section: anti-discrimination laws, policies, and strategies; and improving the status of women. This is an unfortunate and narrow definition of human rights. It is clear, however, from the information reported to the Secretary-General that countries are aware of human rights in a broader context. They understand that the promotion and protection of human rights figure throughout the Declaration, even if their actions appear to be insufficient, particularly as they relate to the specifics of the human rights section.

The Secretary-General's report notes, for example, that prevention efforts must overcome stigmatization, discrimination, logistical difficulties, and laws criminalizing behaviours that increase the risk of HIV infection. It recognizes thereby that those individuals and populations that are most vulnerable are not well served.[40] Still, based on the information provided to the Secretary-General, most countries appear to have, at best, "occasionally" approached the issue. Much more could and must be done.

> Human rights–sensitive indicators should be established for each section of the Declaration.

With regard to access to care and treatment, the story is largely the same. The UNAIDS report states that "many sub-Saharan countries indicate that HIV-related stigma impedes efforts to expand health care services."[41] The Secretary-General's report notes that "approximately half of the countries in sub-Saharan Africa, Asia, and Eastern Europe indicate

that HIV-related stigma diminishes the effectiveness of national care strategies by discouraging people from seeking voluntary counseling and testing and, if needed, HIV-related care and treatment."[42] However, limited information was provided in the report as to what steps were being taken to address the host of issues raised by this recognition.

A Way Forward?

By way of conclusion, it might be useful to think about how explicit attention to promoting and protecting human rights might provide a sensitive barometer for measuring the implementation of the Declaration of Commitment. At a minimum, human rights–sensitive indicators should be established for each section of the Declaration, under which governments could report on progress made toward implementation. Within this framework, the rights to non-discrimination, equality, and participation would be given explicit attention in relation to the monitoring and evaluation of all HIV/AIDS-related efforts.

> One year in the face of HIV/AIDS is not just an ordinary year. There is an urgent need to ensure that the Declaration of Commitment need not be renamed the Declaration of Business as Usual.

For example, to ensure **non-discrimination**, member states would continue to report on national laws, policies, and practices – whether they are referring to discrimination as written or as applied – and bring this awareness to all sectors. Non-discrimination would then frame the realization of other rights such as association, travel, residence, education, employment, social services, and health care for people living with or affected by HIV/AIDS and all other vulnerable individuals and groups, including those who were implicitly included but not explicitly named in the Declaration of Commitment.

In ensuring **equality**, member states would focus on disaggregating the data to expose the significance not only of gender but also other characteristics, such as geographic and socioeconomic disparities, relevant to the population in question. States would indicate how national laws, policies, and practices impede and/or enhance the population's equality in relation to needed goods and services. This would include equality in relation to access to education; health-care information; health care, treatment, and services (including those related to sexuality, sexual health, and reproductive health); as well as participation in research and the fair allocation of resources necessary to enhance the response to HIV/AIDS.

Lastly, reporting on the **participation** of people living with or affected by HIV/AIDS in the design, implementation, monitoring, and evaluation of all relevant national laws, policies, and practices – reporting in which people with HIV/AIDS themselves are engaged – would help ensure their genuine, rather than token, participation in and connection to HIV/AIDS prevention, care, treatment programs, policy, and research. By attending to the involvement of women, young people, non-governmental organizations, and human rights institutions, countries would help draw a more complete picture of a national and human rights–based response to HIV/AIDS.

Conclusion

Taking stock of progress made one year after the adoption of a major international agreement can only be provisional, particularly given the cumbersome nature of national-level governments and international agencies. However, one year in a world with HIV/AIDS means 3.1 million deaths and approximately five million new infections.[43] One year in the face of HIV/AIDS is not just an ordinary year. On the basis of what governments appear to have reported so far to UNAIDS and the Secretary-General, there is an urgent need to ensure that the Declaration of Commitment need not be renamed the Declaration of Business as Usual. That the Declaration of Commitment has thus far made so very little difference in the lives of us all, and particularly in promoting and protecting human rights, ought to be a wake-up call. It ought to engender an increased focus on how the goals and targets set can ensure the full integration of human rights norms and standards into the continued and expanded response to the HIV/AIDS pandemic. It ought to make us ask – *and show* – how the Declaration can and does promote and protect the human rights of people living with or affected by HIV/AIDS, and their families and communities.

– Mindy Jane Roseman and Sofia Gruskin

Mindy Jane Roseman, JD, PhD, is Senior Research Officer, Program on International Health and Human Rights, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health. She can be reached at mroseman@hsph.

harvard.edu. Sofia Gruskin, JD, MIA, is Director, Program on International Health and Human Rights, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health. She can be reached at sgruskin@hsph.harvard.edu.

The authors gratefully acknowledge the assistance of Kristin Sandvik, LLM, in the research for this article.

Further Reading

S Gruskin. The UN General Assembly Special Session on HIV/AIDS: were some lessons of the last 20 years ignored? *American Journal of Public Health* 2002; 92(3): 337-338.

S Gruskin, D Tarantola. Health and human rights. In: R Detels, R Beaglehole (eds). *Oxford Textbook on Public Health*. 4th ed. Oxford: Oxford University Press, 2001, at 311-336. A comprehensive overview of human rights and health, including human rights–based approaches to health, available online (www.oup.co.uk/pdf/0-19-263041-5_04-1.pdf).

S Burris et al. Symposium: Health, Law, and Human Rights: Exploring the Connections. *Journal of Law, Medicine & Ethics*. 2002; 30(4): 492-763. A special issue of papers presented at an international meeting honouring the work and vision of Jonathan Mann. The papers explore the connections between health, human rights, law, and the social or structural causes of disease.

JM Mann et al. *Health and Human Rights: A Reader*. Routledge: New York and London, 1999. This collection of previously published articles – many of which appeared in the journal *Health and Human Rights* – surveys developments in thinking on health and human rights in the 1990s.

International Council of AIDS Service Organizations. Advocacy Guide to the Declaration of Commitment on HIV/AIDS. October 2001 (www.icaso.org/icaso/ungass/advocacyeng.pdf).

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*. Second International Consultation on HIV/AIDS and Human Rights, Geneva, 23-25 September 1996. New York and Geneva: United Nations, 1998 (www.unaids.org/publications/documents/human/law/JC520-HumanRights-E.pdf). The Guidelines provide a framework for a more comprehensive human rights–based approach to HIV/AIDS. The sixth guideline has been revised: 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 Guideline: Revised Guideline 6*. Second International Consultation on HIV/AIDS and Human Rights, Geneva, 25-26 July 2002. New York and Geneva: United Nations, 2002 (www.unaids.org/publications/documents/human/HIVAIDSHumanRights_Guideline6.pdf).

Government of Canada 2002 Report to the Secretrary General of the United Nations on the UNGASS Declaration of Commitment on HIV/AIDS (www.hc-sc.gc.ca/datapcb/iad/pdf/ungass2-e.pdf).

---

[1] World Conference on Human Rights, Vienna, 14-25 June 1993; International Conference on Population and Development, Cairo, 5-13 September 1994; Programme of Action, Fourth World Conference on Women, Beijing, 4-15 September 1995; Platform for Action, World Conference for Social Development, Copenhagen, 6-12 March 1995.

[2] For a review of some of these conferences and the ways in which the agreed-to language can be useful to governments and advocates, see S Gruskin, M Roseman, E Gibson. *Compendium of International Norms, Standards and Obligations relating to HIV/AIDS and Human Rights* (forthcoming).

[3] United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. Resolution A/Res/S-26/2, 27 June 2001 (www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf), hereinafter cited as Declaration of Commitment.

[4] See, especially, Commission on Human Rights resolutions 2001/51 on the protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and 2001/33 on access to medication in the context of pandemics such as HIV/AIDS, available via http://193.194.138.190/hiv/documents.htm by clicking on "Commission on Human Rights."

[5] Jonathan Mann addressed the United Nations General Assembly on the global HIV/AIDS epidemic as early as October 1987; see J Mann. Statement at an informal briefing on AIDS to the 42nd Session of the United Nations General Assembly, 20 October 1987, cited in R Parker, P Aggleton. *HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action*. Rio de Janeiro: Associação Brasileira Interdisciplinar de AIDS/London: Thomas Coram Research Unit, 2002, at 5.

[6] Framework for Global Leadership on HIV/AIDS (UNAIDS/PCB (10)/00.3), December 2000.

[7] Declaration of Commitment, supra, note 3 at para 58.

[8] Ibid at para 59.

[9] Ibid at para 60.

[10] Ibid at para 61.

[11] See S Gruskin. The UN General Assembly Special Session on HIV/AIDS: were some lessons of the last 20 years ignored? *American Journal of Public Health* 2002; 92(3): 337-338.

[12] See Declaration of Commitment, supra, note 3 at para 62: "By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection…."

[13] Ibid at para 37.

[14] Ibid at para 52.

[15] Ibid at para 55.

[16] Ibid at para 64.

[17] See UNAIDS. *Action Guide for UN Country Teams: Implementing the Declaration of Commitment on HIV/AIDS – Meeting a Millennium Development Goal*. UNAIDS/02.56E. Geneva: Joint Programme on UNAIDS, 2002

(www.unaids.org/UNGASS/docs/JC868-ActionGuide_en.pdf).

[18] Declaration of Commitment, supra, note 3 at para 100.

[19] Report of the Secretary-General. On progress towards implementation of the Declaration of Commitment on HIV/AIDS, 12 August 2002, A/57/227 at 1, hereinafter cited as Secretary-General's Report.

[20] These countries are largely anonymous, identified by regional group, and occasionally by name in the Secretary-General's Report and the UNAIDS Companion Report, infra, note 24. See Table 1 for further details.

[21] See, eg, www.un.org/womenwatch/daw/followup/beijing+5.htm.

[22] Electronic correspondence from UNAIDS, on file with authors. Individual country information was obtained in some instances (and with varying degrees of success) from direct contact with UNAIDS country representatives and/or government sources.

[23] Ibid.

[24] UNAIDS, Companion Report, available via www.unaids.org/UNGASS/index.html, hereinafter cited as UNAIDS Report.

[25] Secretary-General's Report, supra, note 19 at 1.

[26] Ibid at 4.

[27] Ibid at 15.

[28] The UNAIDS Companion Report does not append a list of countries that reported.

[29] UNAIDS Report, supra, note 24 at 1.

[30] UNAIDS in its Companion Report notes that 97 countries (out of 170 officially engaged with UNAIDS; see www.unaids.org/hivaidsinfo/statistics/fact_sheets/by_region_en.htm) returned questionnaires to the Secretary-General, via UNAIDS, for his report. In a document naming the countries that submitted questionnaires to UNAIDS, there are 97 countries in total as well. (This internal UNAIDS document was sent, in the form of an electronic communication, dated 21 February 2003, and is on file with the authors.) Minor discrepancies that exist in the categorization of countries between the two documents – ie, the UNAIDS Companion Report uses the headings of Africa, Asia and the Pacific, Latin America and the Caribbean, East Europe/Central Asia, and High Income Countries, while the internal document does not – make it difficult to ensure that countries are correctly categorized in the table above.

[31] Ibid at 3.

[32] Ibid at 5.

[33] Ibid at 7.

[34] Ibid at 9.

[35] Ibid at 9.

[36] See J Csete. Epidemic of abuse: police harassment of HIV/AIDS outreach workers in India. *Human Rights Watch* 2002; 14(5) (www.hrw.org/reports/2002/india2/india0602.pdf).

[37] See F Morka. Nigeria – judge denies woman with HIV access to courtroom. *Canadian HIV/AIDS Law & Policy Review* 2001; 6(1/2): 77-78 (www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/internationalnews.htm).

[38] Secretary-General's Report, supra, note 19 at 4.

[39] World Health Assembly resolution 40.26, 15 May 1987.

[40] Secretary-General's Report, supra, note 19 at 12.

[41] UNAIDS Report, supra, note 24 at 3.

[42] Secretary-General's Report, supra, note 19 at 13.

[43] Office of Communications and Public Relations, National Institute of Allergy and Infectious Diseases, National Institutes of Health. Fact Sheet: HIV/AIDS Statistics. December 2002 (www.niaid.nih.gov/factsheets/aidsstat.htm).

The UNGASS Declaration of Commitment on HIV/AIDS: A Review of Legislation in Six Southern African Countries

cont'd from page 1

In June 2001, 189 member states at the Special Session of the United Nations General Assembly on HIV/AIDS (UNGASS) adopted the Declaration of Commitment on HIV/AIDS without reservation. The Declaration contains the commitment of leaders of governments and states to take action on HIV/AIDS in a number of areas, including leadership, prevention, care, support and treatment, and HIV/AIDS and human rights.[1] (For a summary of the UNGASS and the Declaration, see the cover article "The UNGASS Declaration of Commitment on HIV/AIDS: One Year Later" in this issue.)

This article focuses on paragraphs 58 and 69 of the Declaration. They are aimed at implementing legislation to eradicate HIV/AIDS discrimination and to ensure the enjoyment of human rights and fundamental freedoms by people with HIV/AIDS and other vulnerable groups affected by the epidemic. The article examines whether six Southern African countries – Botswana, Lesotho, Mozambique, South Africa, Swaziland, and Zimbabwe (the study group) – have made any progress in changing or enacting legislation to give effect to these paragraphs. It is based on a report made by the AIDS Law Project to the Human Sciences Research Council in South Africa in December 2002.[2]

The countries in the study group exhibit some of the highest HIV prevalence rates globally. Botswana, Zimbabwe, Swaziland, and Lesotho (in that order) are the countries with the highest HIV prevalence in the world, with adult prevalence rates of over 30 percent.[3] South Africa holds the sixth place and Mozambique the eleventh place in HIV prevalence in the world.[4] It is thus reasonable to expect the governments of the study group to engage with the AIDS epidemic in a serious and determined

manner and to pay particular attention to AIDS discrimination and stigma within their respective countries.

The UNGASS Declaration

One way of reducing the level of AIDS discrimination in a society is to enact legislation that explicitly protects the rights of people with HIV/AIDS and vulnerable groups affected by the epidemic, and assigns penalties to the violators of those rights.[5] The relationship between the protection of human rights and the reduction of vulnerability (and therefore levels of AIDS discrimination) was recognized specifically in the Declaration's chapter on HIV/AIDS and human rights. The preamble reads:

> Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response.[6]

Paragraph 58 of the chapter binds heads of states and government to:

> By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.

> The countries in the study group exhibit some of the highest HIV prevalence rates globally.

The Declaration goes further, identifying the workplace as an area of concern. Paragraph 69 of the chapter on alleviating social and economic impact commits heads of states and government to:

> By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking into account of established international guidelines on HIV/AIDS in the workplace.

The heads of government of the study group have therefore bound themselves to take the lead in transforming or strengthening their legal systems' response to the epidemic.

Customary Law and HIV/AIDS

It is important to note that dual legal systems, described as follows, operate within the study group:

> As a consequence of colonial rule in Africa, states in Africa provide for the recognition of various legal systems. Within these systems, customary and religious laws on the one hand, and the received laws, based on the law of the former colonial states, on the other hand, co-existed in certain fields, including family law and succession law.[7]

Customary law has been defined as:

> an established system of immemorial rules which had evolved from the way of life and natural wants of the people, the general context of which was a matter of common knowledge, coupled with precedents applying to special cases, which were retained in the memories of the chief and his counsellors, their sons and their sons' sons, until forgotten, or until they became part of immemorial rules.[8]

National law in the six countries is generally divided between customary laws and practices that are generally not written up, and that of more formalized Western forms of law drawing on English common law and Roman–Dutch law. In an attempt to maintain order and deliver justice, countries may have to try to strike an uneasy balance between these different kinds of law.

Both codified forms of law and unwritten customs or customary laws play an important role in curbing or exacerbating the AIDS epidemic. In his article on customary law and HIV/AIDS, Pieterse set out a number of examples of African customary practices and beliefs that can contribute to the spread of HIV/AIDS.[9] He illustrated how customs and cultural institutions like polygyny, customs aimed at procreation, ritual circumcision and skin-piercing procedures, and culturally related attitudes and beliefs in which patriarchy plays a dominant role, could increase vulnerability to HIV.

UNAIDS adds more examples of the interplay between vulnerability to HIV/AIDS and cultural practices:

- the practice of mandatory wife inheritance by a brother if a woman's spouse dies;
- the "cleansing" of virgins on reaching puberty through having forced sex with a disguised male; and
- the minority status of women under customary laws and

unequal educational opportunity for the girl child.[10]

Numerous customary laws and practices make women particularly vulnerable to human rights violations and therefore also to HIV infection. In a number of countries in the study group, women are regarded as minors: married women are under guardianship of their husbands, while unmarried women are under the guardianship of their fathers. This means, for example, that women cannot register immovable property in their name (eg, Lesotho), contract without her husband's consent (Botswana), or have access or rights to land without a husband or male relative (Swaziland and Zimbabwe). Other examples include:

Numerous customary laws and practices make women particularly vulnerable to human rights violations and therefore also to HIV infection.

- no recognition of marital rape;
- tribal courts treating adultery as a female crime only and/or assigning greater penalties to the woman for adultery; and
- mandatory wife inheritance by a brother if the woman's spouse dies.

It is clear that these practices and laws assign a lower social status to women, make them economically, physically, and socially dependent on males, and severely limit their ability and power to negotiate safer sex. These discriminatory traditions and laws therefore compound women's vulnerability to HIV infection and serve as powerful driving forces of the epidemic.

While many instances of customary law or practices are inequitable, discriminatory, or contrary to the principles of human rights, the value and weight of customary law for African communities have been stressed.[11] It was clear from field research done in the study group by the author that customary laws and practices play an influential role in the lives of the citizens of the study group and would have a significant impact on the spread of the epidemic.[12] It therefore follows that political and community leaders should identify aspects of customary laws operating in their countries that could advance the spread of HIV/AIDS, and should positively influence and transform these aspects to take into account the new challenges brought by the AIDS epidemic and globalization.

Legislation and HIV/AIDS

Table 1 contains a summary of legislation in the study group that specifically contains HIV/AIDS provisions. Little legislation with reference to HIV/AIDS has been enacted since the Declaration came into effect in June 2001. What follows is a brief description of the laws noted in the table, as well as those laws that could impact on the spread of the epidemic but do not expressly mention HIV/AIDS. Legislation and customary law that marginalize already vulnerable groups (such as gay men and lesbians, women, and sex workers), and therefore make them more susceptible to contracting HIV, are also noted.

Botswana

The Medical Council (Professional Conduct) (Amendment) Regulations make provision for the notion of "shared confidentiality" in which medical practitioners can disclose a patient's HIV status to caregivers or to family members without the patient's consent and without ensuring that these third parties will not disclose to others.[13]

The Penal Code (Amendment Act) assigns different punishments for rapists with HIV than for rapists who test HIV-negative. A person found guilty of rape will only be tested for HIV after conviction by a court. When the results of the HIV test are received, the rapist could be sentenced in the following ways:

- *tests HIV-negative*: the minimum sentence is 10 years, but could be higher if serious violence was committed during the rape;
- *tests HIV-positive without prior knowledge and diagnosis*: if the rapist does not know his HIV status at the time of the rape, the minimum sentence is 15 years; or
- *tests HIV-positive with prior knowledge and diagnosis*: if the rapist knew he was HIV- positive at the time of the rape, the minimum sentence is 20 years.[14]

Botswana's Penal Code makes it a criminal offence for any person to commit an act deemed "against the order of nature."[15] A judge interpreted "against the order of nature" to mean any act that involves anal or oral sex.[16] This legislation clearly marginalizes gay men and lesbians; it also severely limits access to information on safer same-sex sexual practices and on the dangers of HIV transmission through anal or oral sex. The Penal Code also makes sex work an offence.[17] There is a clear absence of domestic-violence legislation,[18] and

Table 1: Legislation Specifically Mentioning HIV/AIDS

Country	Legislation	Year Enacted
Botswana	Medical Council (Professional Conduct) (Amendment) Regulations	1999
	Penal Code (Amendment Act)	1998
Lesotho	None	
Mozambique	Labour Legislation (Act No. 5 of 2002)	2002
South Africa	Promotion of Equality and Prohibition of Unfair Discrimination Act	2000
	Employment Equity Act	1998
	Medical Schemes Act	1998
	Criminal Law Amendment Act	1997
	Criminal Procedure Second Amendment Act	1997
	National Education Policy Act	1996
	National Policy for Health Act	1990
Swaziland	None	
Zimbabwe	Sexual Offences Act	2001
	Labour Relations (HIV and AIDS) Regulations	1998

the law does not provide for marital rape.

Lesotho

Lesotho has no laws that refer specifically to HIV/AIDS. A Sexual Offences Bill is soon to be enacted that will provide for the following:

- widening the definition of rape to include an interpretation of marital rape;
- sentences that will take into account the HIV status of the rapist (a person who, knowing or having a reasonable suspicion that he has HIV, rapes another can be sentenced to death); and
- free medical attention to rape victims.

Another proposed piece of legislation entitled the Married Persons Equality Bill will attempt to rectify inequality between husbands and wives. Currently, under customary law women are regarded as minors, while married women are under the guardianship of their husbands and unmarried women are under the guardianship of their fathers.[19]

Mozambique

An untitled law called Act No. 5 of 2002 contains a number of provisions that deal with HIV/AIDS in the workplace. The Act prohibits pre-employment testing for HIV and guarantees the right to confidentiality with regard to HIV status in the workplace. In the event of occupational exposure to HIV, "guaranteed medical assistance as well as adequate medication" is provided for and must be paid for by the employer. This law makes it compulsory for employers to provide HIV/AIDS education, information, and advisory services to their employees. Dismissal on the grounds of HIV/AIDS is "regarded as dismissal without just cause."

No legislation currently exists in Mozambique that provides for the special needs of targets of domestic violence. According to Article 1674 of the Civil Code, the husband is seen as the head of the household, which effectively makes the wife his subordinate. The property of the wife is

given to the husband and she can only transact commercially with her husband's authorization.

South Africa

The Employment Equity Act prohibits unauthorized employment-related HIV testing.[20] It also provides that no person may unfairly discriminate against an employee or job applicant in any employment policy or practice on the basis of 20 listed grounds unless it is an inherent requirement of the job. "HIV status" is listed as one of the grounds on which an employee may not be discriminated against.[21]

The Criminal Law Amendment Act[22] provides for a higher minimum sentence in the absence of substantial and compelling circumstances for a first-offender rapist who knows that he has HIV than for a first offender who does not have HIV. The Criminal Procedure Second Amendment Act[23] provides for stricter bail measures. It denies bail to a person accused of rape who knows he has HIV unless exceptional circumstances are established.

The Medical Schemes Act[24] ensures that medical schemes may not exclude any person able to pay their contributions (this will include people with HIV/AIDS). HIV-associated diseases are now a category under the Prescribed Minimum Benefits, which provide for the compulsory coverage of medical and surgical management for opportunistic infections or localized malignancies.

The Promotion of Equality and Prevention of Unfair Discrimination Act[25] is intended to implement and give greater effect to the equality clause of South Africa's Constitution. Section 6 of the Act prohibits unfair discrimination on the ground of disability (which may be interpreted to include HIV/AIDS, but this is not expressly provided for in the Act). Section 34(1) contains specific directive principles on HIV/AIDS, while section 32 provides for the establishment of an Equality Review Committee mandated to meet within one year of promulgation of the Act to make recommendations to the Minister of Justice on whether "HIV status" and "AIDS" should be included in the Act as prohibited grounds of unfair discrimination.[26]

> It is imperative that the respective governments of these countries embark on a process of legislative reform. Strategies to transform discriminatory customary laws and practices are of particular importance.

Both the National Policy for Health Act[27] and the National Education Policy Act[28] contain provisions for the drawing up of policies on HIV/AIDS. Following these directives, the National Policy on Testing for HIV was published in August 2000, while the Minister of Education launched the National Policy on HIV/AIDS for Learners and Educators in 1999.

Swaziland

There is not yet any legislation that makes express mention of HIV/AIDS, but some changes to current Swazi laws have been proposed. The process of drafting an Employment Bill is under way. It is likely to incorporate most aspects of the various International Labour Organization conventions to which Swaziland is a signatory, as well as regional instruments such as the SADC Code on HIV/AIDS and Employment. A Public Health Bill is envisaged that will incorporate issues related to HIV/AIDS, while criminal and correctional services laws are to be amended to address the new challenges posed by HIV/AIDS. Funds have been allocated to assist the Correctional Services department to review legislation in order to make it responsive to the needs of prison inmates with HIV/AIDS.

Under Swazi common law and customary law, the status of women is that of legal minors. Women have to obtain permission from their husbands or guardians in all legal matters or important transactions. Swazi inheritance law prevents a woman from inheriting anything from her deceased husband's estate in her own right. Rural women can have access to land only through a husband if she is married, or through a male relative if she is single.

Zimbabwe

The Sexual Offences Act imposes greater penalties for rape on the perpetrator if he has HIV.[29] Section 15 of the Act makes it a criminal offence to wilfully infect another with HIV, while sections 9 and 11 criminalize sex work.

The Labour Relations (HIV and AIDS) Regulations of 1998 provide for the availability of HIV/AIDS education and information in the workplace and for confidentiality, while prohibiting pre-employment testing and unfair dismissal on grounds of HIV/AIDS.

According to customary laws, women have no independent access or rights to land, as they can access land only through their husbands or male relatives.

Conclusion

With the possible exception of South Africa, the countries of the study group have not adequately responded to the challenges the AIDS epidemic has confronted their respective legal systems with. The first reaction of many countries to the epidemic is to enact criminal laws. This approach may not only impair the effective and sensitive approaches necessary to control the epidemic;[30] it also often comes at the expense of putting into place laws that could target AIDS discrimination, provide special protection for people with HIV/AIDS, and strengthen the position of vulnerable groups such as women, gay men and lesbians, and sex workers. It is plain that discriminatory customary laws and practices operate powerfully in the study group and propel the epidemic.

It is commendable that three of the six countries – Mozambique, South Africa, and Zimbabwe – have enacted progressive workplace legislation in keeping with paragraph 69 of the Declaration. Yet there is no indication that Botswana, Lesotho, Mozambique, Swaziland, or Zimbabwe will be able to comply with the directives set out in paragraph 58 by 2003. Little or no progress has been made to eliminate HIV/AIDS discrimination, ensure the enjoyment of human rights by people with HIV/AIDS and other vulnerable groups affected by the epidemic, and reduce HIV/AIDS-related stigma and social exclusion.

It is thus imperative that the respective governments of these countries embark on a process of legislative reform to remedy these problems – one in which strategies to transform discriminatory customary laws and practices are of particular importance. Only after these strategies have been executed can it be said that heads of government have made progress in honouring their commitments on human rights and HIV/AIDS.

– Marlise Richter

Marlise Richter is a researcher at the AIDS Law Project, Centre for Applied Legal Studies, University of Witwatersrand, South Africa. She can be reached at richterm@law.wits.ac.za.

---

[1] United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. Resolution A/Res/S-26/2, 27 June 2001 (www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf).

[2] The research report, entitled "Review of HIV/AIDS Legislation in Six Southern African Countries," is available online (www.alp.org.za). The HSRC commissioned similar studies into the study group's HIV/AIDS policies, financing, and program implementation. These findings, together with the research on HIV/AIDS legislation, will be published in a final report in 2003.

[3] Joint UNAIDS Programme on HIV/AIDS and World Health Organization. *AIDS Epidemic Update: December 2002*. Geneva: Joint UNAIDS Programme on HIV/AIDS and World Health Organization, 2002, at 16 (www.unaids.org/worldaidsday/2002/press/update/epiupdate_en.pdf).

[4] See UN Department of Social and Economic Affairs – Populations Division. Years of life lost to AIDS: twenty countries with the highest HIV prevalence, 2000-2005 (www.un.org/esa/population/publications/aidswallchart/chart2.jpg).

[5] P Aggleton, R Parker. *A Conceptual Framework and Basis for Action: HIV/AIDS Stigma and Discrimination* UNAIDS Best Practice Collection. Geneva: Joint United Nations Programme on HIV/AIDS, 2002, at 12-13 (www.unaids.org/publications/documents/human/WACframework-English.pdf).

[6] Supra, note 1 at para 58.

[7] A Armstrong et al. Uncovering Reality: Excavating Women's Rights in African Family Law. Women and Law in Southern Africa Research Trust, Working Paper No 7, 1993, at 9-10.

[8] JC Bekker (ed). *Seymour's Customary Law in Southern Africa*, 5th edition, Cape Town: Juta, 1989, at 11.

[9] M Pieterse. Beyond the reach of law? HIV, African culture and customary law. *Tydskrif van die Suid Afrikaanse Reg* 2000; 3: 428-441.

[10] M Heywood. *A Human Rights Approach to AIDS Prevention at Work: The Southern African Development Community's Code on HIV/AIDS and Employment*. UNAIDS Best Practice Collection. Geneva: Joint United Nations Programme on HIV/AIDS, 2000, at 11 (www.unaids.org/publications/documents/human/law/Brochure_SADC.pdf).

[11] For example, participants at a workshop entitled "Human Rights and HIV/AIDS: Is Access to Treatment Changing the Context?" emphasized the importance of customary law and protested against suggestions to disregard or undervalue its role. The workshop was held in Windhoek on 25-26 October 2002 and was attended by delegates from the study group as well from Zambia, Angola, Namibia, and Malawi.

[12] The author travelled to Lesotho, Botswana, Zimbabwe, and Mozambique to conduct interviews with AIDS service organizations; non-governmental organizations, and community-based organizations involved with gender issues, human rights, legal work, public health, and HIV/AIDS; and national AIDS council structures and government. She also corresponded with contacts in Swaziland.

[13] See section 2 (b) of the Botswana Medical Council (Professional Conduct) (Amendment) Regulations of 1999. The term "communicable disease" is used in the provisions and has been interpreted to specifically include HIV/AIDS.

[14] See section 3 of the Penal Code (Amendment) Act (Act No 5 of 1998).

[15] Section 164 of the Penal Code (Chapter 08:01).

[16] Case No CRAF 94 of 95.

[17] Section 156 of the Penal Code.

[18] Work is currently underway on a domestic violence bill entitled The Protection from Domestic Violence Bill.

[19] P Lettuka et al. *Maintenance in Lesotho*. 2nd ed. Women and Law in Southern Africa Research Trust, 1997, at 4-5.

[20] Section 7(2) of Act No 55 of 1998. No employer may ask a job applicant or a current employee to take an HIV test at any time, except if the employer has applied to the Labour Court for permission for such testing, and it has been granted.

[21] Section 6(1).

[22] Act No105 of 1997.

[23] Act No 85 of 1997.

[24] Act No 131 of 1998.

[25] Act No 4 of 2000.

[26] At the time of writing, the Equality Review Committee had not yet released its report.

[27] Act No 116 of 1990.

[28] Act No 27 of 1996.

[29] Section 16 of the Sexual Offence Act (Act No 8 of 2001).

[30] Richard Elliott argues that use of the criminal law with regard to HIV/AIDS may give rise to the following problems: People with HIV/AIDS are seen as "potential criminals"; the law may deter people from finding out their own HIV status; it may compromise the confidential relationship that should exist in pre- and post-test counselling between the counsellor and the client, and create a false sense of security among people who may think they are HIV-negative. See R Elliott. *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper*. UNAIDS Best Practice Collection. Geneva: Joint United Nations Programme on HIV/AIDS, June 2002 (www.unaids.org/publications/documents/human/JC733-CriminalLaw-E.pdf).

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 obtained through scans of Canadian media. Regular correspondents are listed on page 2; information about occasional correspondents is provided with their contribution. Address correspondence to David Garmaise, the editor of Canadian News, at dgarmaise@rogers.com.

See Global Access to Treatments for an article on the results of the AIDSVAX B/B vaccine trial, which included participants from Canada.

Mandatory HIV Testing Used to Bar Potential Immigrants

Last year Canada turned away 75 people with HIV/AIDS because the federal government said that they would place excessive demands on publicly funded services. Another 207 people with HIV/AIDS were allowed to enter Canada, mainly because of exemptions to the excessive-demand provisions. HIV/AIDS organizations have objected to the government's policy of mandatory HIV-antibody testing of potential immigrants and have expressed concerns about the way in which excessive demand is calculated.

In 2002, Citizenship and Immigration Canada (CIC) refused to allow 75 people with HIV/AIDS to enter Canada on the grounds that they would place excessive demands on the country's health and social services systems. However, another 207 people with HIV/AIDS were allowed in.[1] Mandatory HIV-antibody testing of applicants for permanent residence was instituted on 15 January 2002. (Most short-term visitors are not tested.)

Under both the new Immigration and Refugee Protection Act,[2] which came into effect on 28 June 2002, and the previous Immigration Act, foreign nationals can be refused entry into Canada if they have a medical condition that would place excessive demands on government services. Under the new Act, there are several categories of people who are exempt from the excessive-demand provisions, including refugees, whether applying inside or outside Canada; and certain sponsored applicants for permanent residence in the family class – specifically spouses, common-law partners, and dependent children.[3]

The old Act did not contain any exemptions to the excessive-demand provisions. However, many refugees and sponsored family-class applicants who were HIV-positive were allowed in on compassionate grounds.

Interpretation of Excessive Demand

Demand is considered "excessive" if the estimated financial burden the individual would place on health and social services is greater than that of the average Canadian.[4] Estimated costs are calculated over a five- or ten-year period from the date of the person's latest medical examination. The cost for the average Canadian, which is determined from data provided by the Canadian Institute for Health Information, was set at $3572 for 2002. The figure changes each year.

CIC officials have indicated that applicants for permanent residence who are HIV-positive and are currently on antiretroviral medication

> People with HIV who are applying for permanent residence and who are currently on antiretroviral medication will be found to be medically inadmissible.

(whether or not they are in good health) will be found to be medically inadmissible. This is because the costs of the medication exceed those of the average Canadian and are paid for out of public funds (usually by provincial and territorial governments).[5]

According to CIC officials, applicants for permanent residence who are HIV-positive, are in good health, and are not on antiretroviral medication would not be considered likely to place excessive demands on Canada's health and social services, so their HIV status would not be a barrier to entering Canada. Applicants for permanent residence who are HIV-positive, are not in good health, but are not taking antiretroviral medication, would likely be declared medically inadmissible because immigration medical officials would conclude that the applicants may start taking antiretroviral medications within a few years of arriving in Canada.[6]

Many Canadian HIV/AIDS organizations have expressed their opposition to mandatory HIV-antibody testing of people seeking to enter Canada. They argue that any potential benefits of testing are outweighed by its potential harms. These organizations are also opposed to a system that bars potential immigrants living with HIV/AIDS based on a determination of excessive demand that includes the costs that would be incurred to treat them but that does not take into account their potential contributions to Canadian society.[7] The CIC has indicated that it is prepared to review how excessive demand is calculated.[8]

Because of the exemptions to the excessive-demand provisions, there are a significant number of people with HIV/AIDS entering Canada as permanent residents. Some concerns have been expressed about whether these people are being put in touch with HIV/AIDS services in Canada and whether these services are able to meet the needs of this population.

Shaun Mellors, an HIV-positive man who was declared medically inadmissible but was then granted a Temporary Residence Permit (TRP) to enable him to take up a two-year position with an international HIV/AIDS organization in Toronto,[9] saw his application to the Ontario government for health insurance coverage accepted. However, there have been reports of other people in similar circumstances in Ontario being denied coverage, so Ontario's policy is not clear. It is up to the provinces and territories to decide whether people admitted under TRPs will be covered under their health insurance plans.

> CIC has indicated that it is prepared to review how excessive demand is calculated.

For more information on how Canada's immigration law and regulations affect people with HIV/AIDS, see the set of questions and answers, Canada's Immigration Policies as They Affect People Living with HIV/AIDS, on the Network's website (www.aidslaw.ca/Maincontent/issues/Immigration/immigrationFAQ2003_part1.htm).

– David Garmaise

---

[1] L Priest. HIV test used to bar potential immigrants. *Globe and Mail*, 24 February 2003, at A5.

[2] Immigration and Refugee Protection Act, SC 2001, c 27 at s 38(1). The text of the Act is available on the CIC website via www.cic.gc.ca/.

[3] Ibid at s 38(2).

[4] Immigration and Refugee Protection Regulations, SOR/2002-227, s 1(1)(a). The text of the Regulations is available on the CIC website via www.cic.gc.ca/.

[5] Personal communication between the author and Dr Brian Gushalak, Director General, Medical Services Branch, CIC.

[6] Ibid.

[7] For an analysis of this and other immigration issues, see A Klein. *HIV/AIDS and Immigration: Final Report*. Montréal: Canadian HIV/AIDS Legal Network, 2001; and B Hoffmaster, T Schrecker. *An Ethical Analysis of the Mandatory Exclusion of Immigrants Who Test HIV-Positive*. Halifax: The Names Project, 2000. Both reports are available on the Network's website via www.aidslaw.ca/Maincontent/issues/immigration.htm.

[8] Meeting between representatives of the International Council of AIDS Service Organizations and officials from several government departments, including CIC, 4 November 2002.

[9] See D Garmaise. Canada refuses to issue a visa to an HIV-positive worker on antiretroviral drugs. *Canadian HIV/AIDS Policy & Law Review 2002*; 7(2/3): 24-25.

Troubled Times for Canada's Medical Marijuana Program

Health Canada finally produces a good marijuana crop, but its medical marijuana program is in a state of upheaval as it faces internal dissent regarding a crucial aspect of its mandate, as well as fundamental challenges from the courts. Meanwhile, the Justice Minister said that the government will introduce legislation to decriminalize the possession of small amounts of marijuana.

The Health Canada–sponsored marijuana-growing facility in Flin Flon, Manitoba, has produced its first batch of cannabis that is "compliant with good manufacturing practices."[1] The previous crop was withheld from use due to problems with consistency, standardization, and quality control.[2]

The availability of a viable crop once again raises the question of precisely what it will be used for. Some or all of the marijuana, which was produced by Prairie Plant Systems, Inc, is earmarked for clinical trials of its efficacy and safety in the management of medical conditions such as HIV/AIDS, glaucoma, and chronic pain. However, whether the federal government also intends to distribute it to people who have received permission to use marijuana for medical reasons (and who are not enrolled in any trials) is a question that has vexed Health Canada since the inception of its medical marijuana program.[3]
A draft policy document from the Office of Cannabis Medical Access (OCMA), which was recently made public, reveals that there is dissent within the Office on this very issue.[4]

The draft policy, entitled Medical Marijuana – Supply and Distribution, dated 31 May 2002, says that Health Canada would "provide access to (research grade) marijuana for medical purposes for patients unable to enrol in clinical trials."[5] However, Cindy Cripps-Prawak, Director of the OCMA, has opposed such distribution, and has stated that "the recommendation should be to not deviate from the current policy of directing the product to research purposes only."[6]

Ms Cripps-Prawak objects to distribution to patients not enrolled in trials for two reasons. She believes: (a) that such distribution would undermine the drug-approval process, which relies on demonstrated clinical evidence of safety and efficacy; and (b) that the government would be in a conflict of interest if it served as both the regulator and distributor of a drug. She denied that this stance represents an about-face from what some people believe was a commitment to distribute the Flin Flon crop to patients: "From my perspective, we never shifted gears.… Maybe it was a problem with language."[7]

Court Decisions

As reported below in HIV/AIDS in the Courts – Canada, recent court decisions have had significant repercussions for Canada's marijuana laws,[8] and in particular for access to medical marijuana. A Court of Québec judge stayed trafficking charges laid against two men in conjunction with a medical marijuana compassion club.[9] The judge determined that it would be unjust to allow the prosecution to continue because the criminal law against trafficking unjustifiably infringed the accuseds' Charter rights by prohibiting them from distributing marijuana for medical purposes when no legal source or supply existed.

Meanwhile, the government's Marihuana Medical Access Regulations (MMAR)[10] were struck down in *Hitzig*.[11] The MMAR were Health Canada's response to the Ontario Court of Appeal's decision declaring the laws prohibiting marijuana possession were invalid because they did not permit the use of marijuana for medical reasons.[12] The MMAR have been criticized for being overly restrictive and unworkable.[13] In *Hitzig*, the Ontario Superior Court of Justice determined that the MMAR fail to provide for a legal source and safe supply of marijuana. This failure unjustifiably infringed the applicants' Charter rights to liberty and security of the person. The Court declared the MMAR invalid but suspended its order for six months to allow the government to decide how to create a legal source and supply of medical marijuana. The decision has been appealed.

Decriminalization

It appears that the federal government is steadily moving toward decriminalizing marijuana possession altogether. On 9 December 2002, Justice

Minister Martin Cauchon announced that the federal government would introduce legislation to abolish criminal penalties for the possession of small amounts of marijuana for personal use, and that this might happen as early as the spring of 2003.[14] Days later, a special House of Commons report recommended decriminalization of the personal use and cultivation of marijuana.[15] Decriminalization would remove prohibitions against marijuana possession from the Criminal Code, making it an offence punishable by a fine rather than a criminal conviction.

– Derek Thaczuk

[1] F Landry. Government pot ready. *Winnipeg Sun*, 11 January 2003. Available online on the website of medicalmarihuana.ca (www.medicalmarihuana.ca/scandal.html).

[2] See D Thaczuk. Minister re-affirms commitment to provide medical marijuana, but delays continue. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 27-28.

[3] Ibid.

[4] D Beeby. Ottawa's marijuana maven puts brakes on distribution proposal: documents. *Canadian Press*, 15 January 2003; available online (www.medicalmarihuana.ca/scandal.html).

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] See G Betteridge. Possession of cannabis legal for now, infra.

[9] *R* v *St-Maurice*, [2002] JQ No 5670 (CQ) (QL). See G Betteridge. Criminal charges against marijuana compassion club volunteers stayed on constitutional grounds, infra.

[10] The Regulations are available on the OMCA website via www.hc-sc.gc.ca/hecs-sesc/ocma/ by clicking on "Legislation."

[11] *Hitzig* v *Canada*, [2003] OJ No 12 (SCJ) (QL). See G Betteridge. Marihuana Medical Access Regulations unconstitutional because they do not provide for legal source or supply of marijuana, infra.

[12] *R* v *Parker* (2000), 49 OR (3d) 481 (OCA). For a more extensive analysis of *Parker* and previous developments with respect to marijuana, see R Elliott. Recent court rulings on medical and non-medical marijuana. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 9-12.

[13] See D Garmaise. Physicians dislike new medical marijuana regulations. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 34; and L Scanlon. Government delays release of medical marijuana supply. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 34-35.

[14] K Lunman. Ottawa set to ease pot laws. *Globe and Mail*, 10 December 2002.

[15] See R Jurgens. House of Commons Committee releases report on Canada's Drug Strategy. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 9-12.

House of Commons Committee Holds Hearings on AIDS

Community groups, scientists, and organizations representing people with HIV/AIDS testified during three days of public hearings before the Standing Committee on Health. They unanimously called for an increase in the annual funding for the Canadian Strategy on HIV/AIDS from $42.5 million to $85 million.

In March 2003, the House of Commons Standing Committee on Health held three days of hearings on HIV/AIDS. The Committee heard consistently from witnesses that funding levels for the Canadian Strategy on HIV/AIDS are inadequate and should be doubled. Funding for the strategy has been level at $42.5 million a year since 1992. Since then, the estimated number of people with HIV/AIDS in Canada has risen from less than 30,000 to more than 54,000. The number has been increasing at a rate of about 4000 new infections a year.

Witnesses at the hearings pointed out that the epidemic is far from under control. The demographics have changed vastly, and HIV infection is spreading rapidly in vulnerable populations such as injection drug users, Aboriginal people, people of colour, the homeless, sex workers, prisoners, women living in poverty, and street youth. The fastest-rising rates of infection are among Aboriginal people and black people. Infection rates among Aboriginal people in Vancouver's Downtown Eastside are 40 to 50 percent, as high as the rates in Botswana and South Africa. Furthermore, infection rates among gay men are on the rise again.

In their presentations to the Committee, many witnesses talked about the economic burden of AIDS. They pointed out that each case of AIDS costs a minimum of $150,000 to treat, which means that 1000 new cases of HIV infection represent future costs of $150 million. Investing in prevention now, the witnesses said, will pay big dividends down the road.

Committee members were receptive to the call for doubling the Strategy's funding. At the end of the final day of hearings, the Committee Chair, Liberal MP Bonnie Brown, said: "I don't think we're going to find too much opposition within the committee to coming up with a report that recommends what you're looking for."[1]

Appearing before the Committee were representatives of the Canadian Aboriginal AIDS Network, the Canadian AIDS Society, the Canadian Association for HIV Research, the Canadian HIV/AIDS Legal Network, the Canadian HIV Trials Network, the Canadian Treatment Action Council, the McGill AIDS Centre, Voices of Positive Women, and YouthCo AIDS Society. A copy of the presentation made by the Canadian HIV/AIDS Legal Network is available on its website (www.aidslaw.ca/Maincontent/otherdocs/Aidsstrategy/e-Jurgens-speakingnotes.pdf).

– David Garmaise

[1] 37th Parliament, 2nd Session, Standing Committee on Health, Evidence, Monday, 24 March 2003. Available via the website of the Parliament of Canada (www.parl.gc.ca) by clicking on "Committee Business," "House of Commons," "Committee List," "Health," and "Evidence and Index." Transcripts of the other two days of hearings (17 and 19 March 2003) are also available on this site.

Survey Reveals Human Rights Abuses in Alberta

A survey of people with HIV/AIDS in Alberta suggests that there are serious deficiencies in the provision of pre- and post-test counselling to people undergoing HIV-antibody testing.[1] Survey respondents also identified human rights abuses in employment, housing, and other areas.

Almost three-quarters of the people with HIV/AIDS who participated in a recent human rights survey in Alberta reported that they did not receive counselling before they were tested for HIV. More than a third of the respondents said that they did not receive counselling even after being told that they had tested HIV-positive. The results suggest that some medical professionals in Alberta are failing to provide adequate pre- and post-test counselling, despite the existence of ethical guidelines stating that such counselling must be provided.[2]

The survey was conducted by means of a written questionnaire administered to 34 people with HIV/AIDS from across Alberta who attended the Expanding Your Horizons Symposium, a conference for people with HIV/AIDS held in October 2002. The survey was a preliminary step in a new Human Rights Project at AIDS Calgary. The project aims to develop rights-based educational, empowerment, and advocacy tools for use by people with HIV/AIDS and service providers in the Calgary region.

Almost a third of those who participated in the survey reported being treated unfairly by employers or coworkers as a result of their HIV status. Respondents described being terminated by employers, being asked to quit, and having their hours severely reduced. Fifteen percent of respondents reported having problems finding a place to live due to their HIV status; two respondents reported being evicted or harassed by landlords. As Alberta human rights legislation prohibits discrimination on the basis of a disability, such treatment is in clear contravention of the law.

About a quarter of the respondents reported having difficulty accessing health care, for reasons ranging from inadequate access in rural areas to difficulties finding a general practitioner willing to provide treatment. About half the respondents reported breaches of confidentiality concerning their HIV status, either at the hospital or at work.

More than a third of the survey participants had spent time in prison. Among this group, 42 percent reported difficulty accessing harm-reduction materials – including condoms, bleach, and clean needles – while in prison, while 25 percent said they had problems accessing HIV medications.

– Jessica Leech

Jessica Leech is the Human Rights Worker at AIDS Calgary. For further information on the survey and on AIDS Calgary's Human Rights Project, contact Ms Leech at jleech@aidscalgary.org. Survey results are also available on AIDS Calgary's website via www.aidscalgary.org/. The Human Rights Project is funded by the Alberta Lotteries Fund through the Human Rights, Citizenship, and Multiculturalism Education Fund.

[1] AIDS Calgary human rights questionnaire, October 2002, available on AIDS Calgary's website via www.aidscalgary.org/ by clicking on "Human Rights Project."

[2] See Canadian Medical Association. *CMA Policy: Acquired Immunodeficiency Syndrome (Update 2000)*, available on the CMA website via www.cma.ca/ by clicking on "Inside CMA" and "Where We Stand." See also HIV Testing: Counselling, one of a series of info sheets on HIV Testing issued by the Canadian HIV/AIDS Legal Network in 2001 (www.aidslaw.ca/Maincontent/issues/testing/e-info-ta8.htm).

Home Care and Prescription Drugs to Be Funded Under Medicare

Canada's first ministers have signed a health accord that could potentially lead to significant changes to Canada's health-care system. But the agreement is short on details and the new initiatives may not keep pace with the expectations of Canadians.

Some of the costs of home care and prescription drugs will soon be publicly funded in Canada under provincial and territorial medicare programs, as a result of a health accord signed in February 2003. Under the accord, the federal government will invest an additional $34.8 billion over the next five years in the country's health-care systems, with about half this amount being made available in the first three years.

The accord calls for the establishment of a $16-billion Health Reform Fund that will be used primarily for home care, catastrophic drug coverage, and primary health-care reform. The accord provides few details on how these funds will be spent. It does not spell out how a catastrophic drug plan would work. Nor does it define exactly what services will be covered under home care, except to say that it will include short-term acute home care, acute community mental-health care, and palliative care. By September 2003, the country's health ministers are supposed to develop a minimum list of home-care services to be provided.

The provinces and territories will likely want to use the home-care funds primarily to enable hospitals to discharge patients sooner after surgery. This will not be of much benefit to people with HIV/AIDS or other chronic conditions, or to elderly people, who may require long-term home care to prevent or delay institutionalization.

With respect to primary health-care reform, the federal government and the provinces and territories have agreed to a goal of ensuring that within eight years at least 50 percent of Canadians will have access to an appropriate health-care provider, 24 hours a day, seven days a week. The accord did not spell out how this will be achieved. The goal may be met simply by adding nurse practitioners to some medical clinics and ensuring that there is a 24-hour clinic within a specific geographic area; this would fall far short of having doctors' offices open around the clock.[2]

> In many respects, the accord falls short of the recommendations of the Romanow Commission.[1]

The accord provides funding for the development of electronic patient-record systems. Concerns have been raised in the HIV/AIDS community that such systems could lead to breaches of confidentiality of patients' private medical information.

Under the accord, the federal government has promised to provide a compassionate-care benefit under the Employment Insurance Program that will allow people to take time off from their jobs to care for family members who are gravely ill. The accord also includes additional funding for hospital stays and physician care (the core services of medicare) and $1.5 billion for new diagnostic medical equipment.

Under the accord, the provincial and territorial governments will report annually (within their own jurisdictions, but using a common set of indicators) on progress achieved in implementing the new initiatives covered by the Health Reform Fund and, more generally, on how their health dollars are being spent. As well, a national Health Council will be established to monitor and report on the implementation of the accord. It will report annually to the country's health ministers; the reports are to be made public. The Council will include experts and representatives of both orders of government and of the public.

– David Garmaise

---

[1] For information on the recommendations of the Romanow Commission, see RJ Romanow. *Building on Values: The Future of Health Care in Canada – Final Report.* Ottawa: Commission on the Future of Health Care in Canada, 2002 (www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf). For additional information about the commission, see www.healthcarecommission.ca/.

[2] A Picard. Can the deal meet expectations? *Globe and Mail,* 6 February 2003.

Study Shows Aboriginals Who Inject Drugs Are at Higher Risk for HIV

One in five Aboriginal people enrolled in a Vancouver study of people who inject drugs became HIV-positive over a five-year period ending in May 2001. This is twice the rate among non-Aboriginal people in the study.

Aboriginal injection drug users are being infected with HIV at twice the rate of non-Aboriginal users, according to a study by researchers at the BC Centre for Excellence in HIV/AIDS.[1] The results were obtained from 941 participants in the Vancouver Injection Drug User Study (VIDUS), a longitudinal study of injection drug users recruited in Vancouver's Downtown Eastside between May 1996 and December 2000.

The participants were HIV-negative at the time of recruitment. The study found that by May 2001, 21.1 percent of the Aboriginal injection drug users had become HIV-positive, compared with 10.7 percent of non-Aboriginal users. This elevated risk was present in equal measure among both male and female Aboriginal people.

The study found that frequent use of speedballs (cocaine and heroin combined) was a predictor of HIV seroconversion among both male and female Aboriginal injection drug users. Speedballs were also associated with an increased risk of overdose death. Other predictors of HIV infection among Aboriginal users were going on binges of injection drug use (among males) and frequent cocaine use (among females).

The researchers concluded that there is an "urgent need for an appropriate and effective public health strategy – planned and implemented in partnership with Aboriginal AIDS service organizations and the Aboriginal community – to reduce the harms of injection drug use in this population."[2] The researchers also said that interventions such as needle exchange programs may not be enough to deal with the problem, particularly if they are restrictive in their distribution policies; and that a more comprehensive response is required, including measures to increase the safety of drug injection and of methadone maintenance programs.[3]

> There is an urgent need for a public health strategy to reduce the harms of injection drug use in this population.

The researchers pointed out that at the time they were recruited into the study, none of the Aboriginal men and few of the Aboriginal women were enrolled in methadone treatment programs. The researchers called for increased efforts to identify the barriers to receiving methadone maintenance therapy among Aboriginal people and to explore alternative therapies for opiate addiction.[4]

Aboriginal HIV/AIDS organizations in British Columbia and the rest of Canada have long been concerned about the lack of access to methadone maintenance therapy and the lack of supervised injection sites for Aboriginal injection drug users.

– Kim Thomas

At time of writing, Kim Thomas was National Projects/Programs Consultant for the Canadian Aboriginal AIDS Network and correspondent on Aboriginal issues for the *Review*.

---

[1] KJP Craib et al. Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver. *Canadian Medical Association Journal* 2003; 168: 19-24.

[2] Ibid at 19.

[3] Ibid at 23.

[4] Ibid at 24.

In Brief

Study Questions Effectiveness of the War on Drugs

A massive seizure of heroin in Vancouver in September 2000 had no measurable public health benefit, according to a study by researchers at the British Columbia Centre for Excellence in HIV/AIDS.[1] The study was based on data acquired from interviews with participants in the Vancouver Injection Drug User Study, a cohort study that began in 1996. The interviews were conducted both before and after the seizure of 100 kg of uncut heroin by law enforcement officials.

The study found that good-quality heroin was just as easy to find on the street (and no more expensive) after the seizure as before. It also found no differences in drug-use patterns, including the frequency of heroin injection and cocaine injection, after the seizure. Nor did the number of fatal overdoses decrease.

According to the Auditor General of Canada, of the $454 million spent in 1999-2000 to deal with illegal drugs in Canada, an estimated $426 million (93.8 percent) was devoted to reducing supply.[2] The authors of the study stated that "our findings raise serious questions about the potential for Canada's drug policies to adequately control the drug use epidemic through supply-side interventions … and support the strong consensus that curbing the HIV and overdose epidemics will require a shift in emphasis toward alternative strategies based on prevention, treatment and harm reduction."[3]

– David Garmaise

War on Drugs Very Much Alive in Surrey, BC

While Vancouver is about to get its first supervised injection sites, the Vancouver suburb of Surrey is pursuing a very different path. Surrey has declared war on harm-reduction measures.

In October 2002, in an effort to shut down some of the pharmacies that dispense methadone, city council raised the annual business-licence fees of methadone dispensaries from $195 to $10,000. Methadone dispensaries are defined as any pharmacy deriving more than 50 percent of its revenues from the sale of methadone.[4]

In February 2003, city council proposed a bylaw that would require that all methadone prescribed by pharmacies be taken in the pharmacists' presence. Council said that it was trying to reduce the amount of methadone being traded on the streets. Others expressed concern that the bylaw would make it harder for people to access methadone, and questioned whether the city was acting within its authority.[5]

In January 2003, the city erected a concrete roadblock 200 metres from a needle exchange facility in what many observers described as a blatant effort to discourage people from attending the needle exchange. Surrey Mayor Doug McCallum had declared a war on drugs in the downtown section of Surrey and had vowed to clean up the city block by block. The mayor said that the needle exchange was a magnet for undesirables.[6] At various times, he insisted that the needle exchange must be relocated[7] and that it must be shut down.[8]

– David Garmaise

HIV Now Reportable in BC

In February 2002, British Columbia added HIV infection to its list of reportable communicable diseases, becoming the last province to do so. Provincial officials said that the move will help to track HIV more rapidly and to protect the public.

HIV/AIDS community organizations have expressed concerns that enforcing reportability will have a detrimental impact because of potential breaches of confidentiality concerning the identity of HIV-positive individuals.[9]

– David Garmaise

Ontario Proclaims Blood Samples Legislation, Delays Privacy Bill

The Ontario government has announced that Bill 105, the Health Protection and Promotion Amendment Act, 2001, known as the "Blood Samples" legislation, will be proclaimed on 1 May 2003. The Act allows emergency workers, victims of crime, and good Samaritans to demand blood tests of people whose bodily fluids they have come into contact with.[10]

The Ontario government has recently consulted with selected stakeholders on a draft of potential regulations that would determine which emergency workers would be entitled to demand blood tests and which communicable diseases would be covered by the legislation. The government has indicated that any regulations would be released before the Act is proclaimed.

Meanwhile, Ontario has failed to introduce privacy legislation after promising to do so before the end of 2002. A draft Privacy of Personal Information Act (PPIA) was released for consultation in the fall of 2001.[11] The PPIA would control and restrict access to personal information, such as health records, in the private sector. Ontario is required to enact privacy legislation that is "substantially similar" to the federal Privacy of Information and Protection of Electronic Documents Act by 1 January 2004, or else the federal legislation will apply to commercial activity in Ontario. Ontario Privacy Commissioner Ann Cavoukian wrote to Premier Ernie Eves in December 2002, expressing concern over the delay. The government has indicated that it hopes to introduce legislation in the spring 2003 session. However, a provincial election widely expected to be called in the spring may disrupt these plans.

– Matthew Perry

Second Methadone Clinic Opens in NB[12]

New Brunswick opened its second methadone clinic in Fredericton in January 2003. Within a week of opening, the clinic had a waiting list of more than 20 people.

The only other long-term methadone program in the province is in Moncton. It is also full. There is no clinic in Saint John. The Executive Director of AIDS Saint John, Julie Dingwell, has called for a province-wide methadone program. She says that such a program would save the government money in the long run because it will reduce crime as well as health-care costs.

– David Garmaise

House of Commons Committee to Review Sex-Trade Laws

The House of Commons Standing Committee on Justice and Human Rights will review federal laws on solicitation, with a view to recommending changes that would reduce dangers facing sex-trade workers and ensure safer and healthier communities.[13]

The instruction to the committee came as a result of a private member's motion introduced by Libby Davies, the New Democratic Party MP for Vancouver East. The motion received strong support from all political parties. Davies has advocated for changes that will reduce the harm to sex-trade workers since she was elected in 1997.

Meanwhile, in December 2002, Bloc Québécois MP Réal Ménard tabled a private member's bill (Bill C-339) that would: (a) decriminalize certain aspects of prostitution; (b) authorize the establishment of licensed places of prostitution; and (c) provide benefits and other assistance for sex-trade workers.[14] The bill will come up for debate only if it is randomly selected in a lottery of private members' bills.

– David Garmaise

HIV Edmonton Faces Discrimination during Office Relocation

During a frustrating search for new office space in 2002 that lasted several months, the HIV Network of Edmonton Society (HIV Edmonton) encountered several landlords who refused to rent space to the organization. Frequently, the reason cited by the landlords was that while they themselves supported the aim of the agency, other tenants might not find it acceptable to have the agency and its clients in the building.

HIV Edmonton eventually found a location near the inner city with a reluctant, but ultimately willing, landlord. The new space will cost the organization about a third more than its previous premises, even though the facilities are inferior.

"It was a real eye opener," said Kate Gunn, the interim Executive Director of HIV Edmonton. "It was a shock to realize that in everyday life, when push comes to shove, the fear and discrimination facing people with HIV and those working with them is still there. It may be cloaked in business terms, or be less overt, but that makes it scarier somehow, because it is harder to pinpoint and to change." Ms Gunn added that even after 20 years of hard work by AIDS service organizations, there is still a significant need for education and awareness on HIV/AIDS.

– Rebecca Scheer

Work Underway to Develop a Strategic Plan for the AIDS Strategy

In December 2002, about 30 HIV/AIDS experts from across Canada gathered in Sainte-Adèle, Québec, to help draft a five-year strategic plan for the Canadian Strategy on HIV/AIDS. The meeting was organized by Health Canada.

The experts developed goals, objectives, and actions in 12 areas: communications and awareness; dynamic prevention; care and treatment; drug policy and harm reduction; research; community-based agencies; positive action; strategies for unique populations; social justice; the global response; a strategic approach to funding; and governance.

Subsequently, a small group of people was asked to prepare the draft plan, based on input from the meeting. National consultations on the draft are planned for the spring of 2003. The final plan is scheduled to be completed by 1 December 2003.

– David Garmaise

Quebec Adopts Anti-Poverty Law

In December 2002, Bill 112, a law drafted by community groups and designed to cut poverty in half over the next 10 years, was passed unanimously by the Québec National Assembly. Bill 112 commits the provincial government to establishing an anti-poverty action plan within two months after the law is officially proclaimed,[15] and to providing a progress report on its fight against poverty every three years. It also sets a minimum level for social assistance payments, creates a monitoring agency, and provides funds for special anti-poverty initiatives.

The law is the work of a coalition of 22 civil society organizations, including housing, literacy, and human rights groups; trade unions; and groups representing social assistance recipients. The coalition has been fighting since 1999 to get the bill passed.

– Richard Elliott

---

[1] E Wood et al. Impact of supply-side politics for control of illicit drugs in the face of the AIDS and overdose epidemics: investigation of a massive heroin seizure. *Canadian Medical Association Journal* 2003; 168(2): 165-169.

[2] Illicit drugs: the federal government's role. In: *2001 Report of the Auditor General of Canada*, 2001, available on the website of the Office of the Auditor General (www.oag-bvg.gc.ca/domino/reports.nsf/html/01menu_e.html).

[3] Supra, note 1 at 168.

[4] T Colley. Methadone fee challenged. *NOW Newspaper*, 16 January 2003.

[5] K Diakiw. Doctors decry Surrey's latest meth plan. *Surrey Leader*, 16 February 2003.

[6] K Spencer. Whalley war on drugs hits roadblock. *Vancouver Province*, 30 January 2003.

[7] Ibid.

[8] Needle exchange needed for now: MLAs. *Surrey Leader*, 3 February 2003.

[9] See T Quandt. Report recommends that HIV become reportable in BC. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 35-36.

[10] The Act was passed by the Ontario Legislature in December 2001. A copy of the Act is available on the Legislature's website (www.ontla.on.ca/documents/Bills/37_Parliament/Session2/b105ra_e.htm). See also: R Carey. Ontario adopts "Blood Samples" legislation. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 39-40.

[11] A copy of the draft legislation is available on the website of the Ontario Ministry of Consumer and Business Services (www.cbs.gov.on.ca/mcbs/english/pdf/56XSMB.pdf). See also: M Perry. Ontario set to introduce new privacy bill. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 39.

[12] The information for this article is derived from M Urquhart. Methadone program a good investment: AIDS Saint John. *Saint John Telegraph-Journal*, 18 January 2003.

[13] News release from the office of Libby Davies, MP, available on Ms Davies's website (www.libbydavies.ca/mpupdate/missingwomen1.html).

[14] The text of the bill is available on the Parliament of Canada website (www.parl.gc.ca/37/2/parlbus/chambus/house/bills/private/C-339/C-339_1/C-339_cover-E.html).

[15] The law was proclaimed on 6 March 2003. However, about a week later, the National Assembly was prorogued and general elections were called for 14 April 2003.

INTERNATIONAL NEWS

This section provides brief reports on developments in HIV/AIDS-related law and policy outside Canada. Contributors to International News in this issue are Michaela Clayton, Joanne Csete, Martin Kirk, Lisa Power, Carlos Valero, Delphine Valette, Helen Watchirs, and the Persons with HIV/AIDS Rights Advocacy Association of Taiwan. We welcome information about new developments for future issues of the Review. Address correspondence to David Patterson, the editor of International News, at dpatterson@aidslaw.ca.

In this issue we include a number of articles on recent developments in the United Kingdom. The history of HIV/AIDS-related law and policy development in the UK is particularly interesting because the contesting parties – government, civil society, people living with or directly affected by HIV/AIDS, and the private sector – are all actively engaged in responding to the many legal and policy challenges of HIV/AIDS and related areas. And this occurs in the context of strengthening pan-European obligations, whether from European Communities directives in areas such as equal employment opportunity, or the incorporation into domestic law of the European Convention for the Protection of Human Rights and Fundamental Freedoms.

Although the UK does not yet have the best policies on HIV/AIDS in some areas (eg, discrimination on the grounds of asymptomatic HIV infection remains lawful), the vigorous engagement of groups such as the All-Party Parliamentary Group on AIDS[1] and civil society and private-sector organizations such as the National AIDS Trust, the Terrence Higgins Trust, the British Medical Association, and the Association of British Insurers demonstrate key elements of the rights-based approach to HIV/AIDS policy and law development: participation, accountability, and transparency. Perhaps reflecting this experience more generally, the UK government is also exploring extending the rights-based approach to its international development assistance.[2] Hence examining the pitfalls and successes of the UK experience can assist law and policy development in both rich- and developing-world contexts.

---

[1] See Parliamentarians take the initiative on HIV/AIDS *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 43-45 (www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6no3-2002/internationalnews.htm#in2).

[2] The UK Department for International Development Civil Society Challenge Fund aims to "support the capacity of poor people, living within eligible countries, to understand and demand their rights – civil, political, economic and social – and to improve their economic and social well-being ... [and to] empower poor people, strengthen their ability or opportunity to speak for themselves, do things for themselves and make demands of those in power." See Civil Society Challenge Fund Guidelines for Applicants, Information and Civil Society Department, Department for International Development, 6 May 2002 (www.dfid.gov.uk/Pubs/files/cscf_guide.htm). See also D Patterson. Reviewing Programming on HIV/AIDS, Human Rights and Development. XIV International AIDS Conference, Barcelona, 7-12 July 2002. Abstract TuOrG1168 (www.aidslaw.ca/barcelona2002/humanrightsandHIV.pdf).

Law Reform in the UK

This article reports on several developments in 2003: the implementation of the European Communities Framework Employment Directive, the introduction of a private member's Equality Bill, and the publication of the National AIDS Trust's report on UK anti-discrimination law.

In 2003 the UK government will move to implement the 2000 European Communities Framework Employment Directive.[1] This Directive will have a significant impact on UK anti-discrimination law since it prohibits, inter alia, discrimination on the ground of sexual orientation, which is not currently prohibited in the UK.[2] The scope of the Directive is limited to employment and vocational training, and its implementation through regulations (not legislation) means that the government will not broaden the scope of the legislation or allow Parliament the opportunity to do so.

Implementation of the Directive through regulations also limits the opportunity for further necessary reform, including changing the definition of disability under the Disability Discrimination Act 1995. The Act prohibits discrimination only on the ground of HIV at the symptomatic stage of the disease, although the government has pledged to extend the definition of disability to cover HIV status from the moment of diagnosis. The regulations on sexual orientation and disability are expected to come into force in December 2003 and October 2004 respectively.

In 2000 the Cambridge Centre for Public Law published an independent review of UK anti-discrimination.[3] The recommendations of this report gave rise to a draft bill that was circulated in 2002 for public consultation by The Odysseus Trust (www.odysseustrust.org/) and has since been redrafted to take account of the responses to the consultation.

The Equality Bill 2003 was introduced as a private member's bill in the House of Lords in January 2003 by Lord Lester of Herne Hill.[4]

The Bill sets out a comprehensive framework for eliminating discrimination and promoting equality, and establishes a single equality commission. In relation to HIV/AIDS, the Bill prohibits discrimination on the ground of actual or perceived HIV status as well as on the basis of association with a person with HIV/AIDS. The Bill also addresses the problem of multiple discrimination, which is a key element of HIV/AIDS-related discrimination (eg, in the intersection of HIV/AIDS with male homosexuality).

National AIDS Trust Anti-discrimination Law and Campaign

In May 2003 the National AIDS Trust (NAT) will launch its own report on HIV/AIDS-related discrimination and UK anti-discrimination law. NAT will also host a conference on the adoption of comprehensive equality legislation, together with Justice (the British Branch of the International Commission of Jurists) and the Trade Union Congress. For further information, contact the National AIDS Trust (info@nat.org.uk).

Prior to this, in March 2003, NAT (www.nat.org.uk/) launched a National Public Awareness Campaign – "Are You HIV Prejudiced?" (www.areyouhivprejudiced.org/) – to increase awareness of HIV/AIDS and challenge discriminatory attitudes and HIV stigma among the general public. The advertising campaign (press and radio) is supplemented by the distribution of resource materials, including a kit containing information about the objectives of the campaign and fact sheets on HIV/AIDS stigma and discrimination, to the media, community groups, and key stakeholders. For more information, contact Keith Winestein, NAT Campaigns Development Manager (Keith.Winestein@nat.org.uk).

---

[1] Council Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation (http://europa.eu.int/comm/employment_social/soc-dial/labour/78ec/ad_en.pdf).

[2] Ibid at para 12.

[3] B Hepple et al. *Equality: A New Framework: The Report of the Independent Review of the Enforcement of UK Anti-Discrimination Legislation*. Oxford: Hart Publishing, 2000.

[4] The Bill is available online (www.publications.parliament.uk/pa/ld200203/ldbills/019/2003019.htm).

UK Doctors Given New Guidance on Revealing HIV Test and Sexual History to Insurers

The British Medical Association (BMA) and the Association of British Insurers (ABI) have issued new guidance to doctors, patients, and insurers on what information about HIV and sexual health can be supplied to insurers by general practitioners.[1] The policy removes the right of insurance companies to ask, and practitioners to answer, speculative questions about a person's lifestyle, and restricts questioning on isolated or non-serious instances of sexually transmitted infections.

Under the guidelines, insurers may only ask whether an applicant has had a positive HIV test result or is receiving treatment for HIV/AIDS. For large-value policies, or where there is a need to clarify the level of risk, insurance companies may send applicants a supplementary questionnaire and/or request an HIV test. Written consent and pre-test counselling requirements will apply if a test is requested.

Regarding life insurance, the policy notes:

> Existing life insurance policies will not be affected in any way by taking an HIV test, even if the result is positive. Providing that the applicant did not withhold any material facts when the life policy was taken out, life insurers will meet all valid claims whatever the cause of death, including AIDS-related diseases. Material facts the applicant might need to reveal include information about activities that increase the risk of HIV infection.[2]

The policy also specifies the insurance applicant's right of access to information and the right to withdraw consent at all stages of the process.

The policy was developed in consultation with the BMA's Medical Foundation for AIDS and Sexual Health (MedFASH) and the Terrence Higgins Trust (THT). In early 2003 the THT was also negotiating with the ABI as to how insurance companies deal with HIV generally, and how they perceive and act on perceptions of risk.[3] For further information, contact Martin Kirk (martin.kirk@tht.org.uk).

---

[1] Joint guidelines from the British Medical Association and the Association of British Insurers, December 2002 (www.bma.org.uk/ap.nsf/content/medicalinfoinsurance).

[2] Ibid.

[3] See the ABI Statement of Practice – Underwriting Life Insurance for HIV/AIDS, 25 July 1994, reprinted 1997 (available via www.abi.org.uk/Public/Consumer/Codes).

UK Blood Tests for New Health-Care Workers

Under new draft guidelines,[1] the UK government has proposed that physicians, nurses, and other health-care workers starting with the National Health Service will be required to test negative for HIV and hepatitis B and C before taking up posts that involve "exposure-prone procedures."

Exposure-prone procedures are defined as "those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker."[2] They do not include procedures such as drawing blood, giving injections, routine vaginal or rectal examinations, or minor suturing.

Nursing students will not be screened under the proposed guidelines, whereas the screening of medical students will be a matter for individual medical schools to decide. The draft guidelines note that the practical skills required to obtain General Medical Council registration do not include exposure-prone procedures.

The final guidelines will be issued later in 2003. For further information on HIV testing, including occupational exposure and forced HIV testing, see www.aidslaw.ca/Maincontent/issues/testing.htm.

---

[1] Health clearance for serious communicable diseases: new health care workers (www.doh.gov.uk/healthclear).

[2] Ibid at 5.

AIDS and Rights Alliance for Southern Africa

The AIDS and Rights Alliance for Southern Africa (ARASA) opened its regional office at the AIDS Law Unit of the Legal Assistance Centre in Windhoek, Namibia, on 1 March 2003. ARASA was established by organizations working on HIV/AIDS and human rights in the region to act as a regional alert network to respond to human rights infringements. The alliance will also organize and facilitate training opportunities on HIV/AIDS and human rights for members, disseminate information on regional developments concerning HIV/AIDS and human rights, and organize annual meetings on HIV/AIDS and human rights in the region.

An advisory board composed of representatives from the AIDS Law Project (South Africa), the AIDS Law Unit (Namibia), Women and Law in Southern Africa (Swaziland), SAfAIDS (Zimbabwe), ZARAN (Zambia), Lironga Eparu (Namibia), and Programa de Direitos Humanos (Angola) has been established to guide ARASA's work.

ARASA was formed following a regional meeting of organizations working on HIV/AIDS and human rights in the Southern African Development Community (SADC) region in October 2002, co-hosted by the AIDS Law Unit of the Legal Assistance Centre of Namibia and the AIDS Law Project of South Africa. The meeting was attended by 60 participants representing 10 SADC countries, namely South Africa, Botswana, Zambia, Swaziland, Tanzania, Zimbabwe, Malawi, Angola, Mozambique, and Namibia. Emma Tuahepa, Director of Lironga Eparu, the Namibian national association of people with HIV/AIDS, opened the meeting, and a keynote address was delivered by Mr Justice Edwin Cameron of South Africa. For further information, or to be put on ARASA's mailing list, contact Collette Campher at arasa@lac.org.na.

Sexual Abuse and HIV/AIDS in Zambia

In Zambia, as in a number of countries in eastern and southern Africa, the HIV prevalence rate among girls up to age 18 or 19 is several times higher than for boys in the same age group. In 2002 Human Rights Watch documented a wide range of situations of sexual abuse and coercion that puts girls in Zambia at high risk of HIV transmission.[1] Many of the girls interviewed had been orphaned by AIDS, and some of them recounted sexual abuse at the hands of their guardians or members of their foster families.

Girls are at particular risk in many African countries for numerous reasons. They are generally the first to be pulled out of school when someone in the household becomes ill with AIDS. They are called on to be breadwinners and often have no recourse but to trade sex for survival, particularly in countries where unemployment and poverty are deeply entrenched, as in Zambia. Those who manage to stay in school may be preyed upon by teachers and other adults in positions of responsibility. There are laws against sexual abuse and sexual violence against girls, but they are poorly enforced.

Human Rights Watch has called on the government of Zambia to strengthen basic protections for girls and women against sexual abuse, including to reinforce the capacity of victim-support units of the police and to provide legal assistance to girls who want to bring cases against the perpetrators of these crimes. Zambia has received over US$100 million in donor assistance for HIV/AIDS programs. Human Rights Watch has urged donors to ensure that protection of girls from sexual violence and abuse is central to these efforts.

[1] J Fleischman, J Csete. *Suffering in Silence: The Links between Human Rights Abuses and HIV Transmission in Zambia*. New York: Human Rights Watch, 2002 (www.hrw.org/reports/2003/zambia).

Community Consultation on Indian AIDS Bill

Following the recommendations from the May 2002 International Policy Makers Conference, the Lawyers Collective HIV/AIDS Unit (www.lawyerscollective.org) has been engaged by the National AIDS Control Organisation to prepare draft legislation on HIV/AIDS, to be presented to Parliament in 2003.

The Unit began by undertaking a comprehensive examination of legal developments around HIV/AIDS in other countries in order to contextualize the Indian experience within the global pandemic, and to borrow from other legislative experiences to create the basis for draft legislation for India. Following this research, the Unit will develop background papers on the legal, ethical, and human rights issues that HIV/AIDS has raised over the course of the epidemic. The next phase of the process is drafting the legislation, which will be based on human rights models present worldwide, with particular emphasis on common law regimes that are similar to India's legal system. The goal is to create a comprehensive law that protects the rights of people with HIV/AIDS and to provide protection from discrimination for other marginalized groups.

The Unit then proposes to conduct a nationwide consultation on the draft legislation between February and April 2003. The Unit will integrate the feedback into the draft legislation and annex the report of the consultation to the draft legislation. For further information, contact the Lawyers Collective HIV/AIDS Unit (aidslaw@vsnl.com).

Singapore HIV Blood Testing Spat Highlights Research Links with Human Rights

In a 2002 article in the *Lancet*, Chris Beyrer and Nancy Kass, researchers at Johns Hopkins University, argue that research ethics reviews should consider the political and human rights context in which research is to be undertaken.[1] The authors give as an example the case of Singapore, where violation of laws prohibiting private consensual sex between men can lead to prison terms, and the government reportedly uses clandestine informants to obtain convictions. The authors note that while the HIV infection rate in men is nine times that of women, nearly all males surveyed reported heterosexual sex as their only sexual activity. However, the authors point out that "[s]ince the nine-to-one prevalence pattern is typical of communities in which HIV infection is spread through male-to-male sexual or drug transmission, the interpretation of the study findings must be seen as highly suspect. Hence, prevention programmes will be based on questionable findings, resulting in potentially unsound interventions and dangerous and inappropriate blood-donor criteria."[2]

The Singapore Ministry of Health responded that the current trend in HIV infection in Singapore is related to commercial sex, and that "although reporting of infectious diseases is mandatory, as it is in many countries, there are legal provisions to protect the confidentiality of HIV-infected persons."[3] In reply, Beyrer and Kass cite Singapore Penal Code section 377a, which provides up to two years' imprisonment for gross indecency between men, and note that even "rigorous" antibody testing of blood donations cannot exclude HIV-infected donations from persons in "preseroconversion windows."[4] They cite the United Nations Human Rights Committee in *Nicholas Toonan* v *Australia*, which observed in 1991 that "the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the

spread of HIV/AIDS.... [B]y driving underground many of the people at risk of infection ... [it] would appear to run counter to the implementation of effective education programmes in respect of HIV/AIDS prevention."[5]

Beyrer and Kass have raised legitimate concerns about both the impact of negative human rights and legal environments on HIV research, and on prevention initiatives and other responses based on this research. For further information on HIV testing and confidentiality, see www.aidslaw.ca/Maincontent/issues/testing.htm; for information about gay and lesbian legal issues and HIV/AIDS, see www.aidslaw.ca/Maincontent/issues/gayandlesbian.htm.

[1] Human rights, politics, and reviews of research ethics. *Lancet* 2002; 360: 246-251.

[2] Ibid at 248.

[3] P Chui, SK Chew. Appropriateness of Singapore's HIV/AIDS control programme. *Lancet* 2002; 360: 1982.

[4] Authors' reply. *Lancet* 2002; 360: 1982-1983.

[5] Human Rights Committee, Communication No 488/1991, *Nicholas Toonan* v *Australia* (views adopted on 31 March 1994, fiftieth session). *Official Records of the General Assembly, Forty-ninth Session, Supplement No. 40* (A/49/40), vol II, annex IX EE, para 8.5, cited in *HIV/AIDS and Human Rights: International Guidelines* (Geneva: UNAIDS and OHCHR, 1998, at 49).

Costa Rican Ombudsman Tackles HIV/AIDS

An analysis of seven cases reported from 1993 to 2002 has demonstrated that the role of the Ombudsman Office of Costa Rica has been decisive in the improvement of respect for the fundamental rights of people with HIV/AIDS in Costa Rica.[1] The Ombudsman Office has resolved complaints of discrimination under the General Law on HIV/AIDS and other legislation that protect the rights of people with HIV/AIDS in areas such as life insurance, access to antiretroviral treatment, quality of hospital services, access to work and educational opportunities, and prisons.

For further information, contact Carlos Valerio, Ombudsman Office of Costa Rica (cajovamo@racsa.co.cr).

[1] For information about strengthening national institutions' role and capacity to address HIV/AIDS issues in other regions, see the article on the Asia/Pacific Workshop on HIV/AIDS and Human Rights, in International News – Other Developments. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 46-47.

Taiwan Electronic Health Record Plan Raises Privacy Concerns

People living with HIV/AIDS and other groups in Taiwan are concerned that the proposed "Taiwan Healthcare IC Card" – a smart card that will record a patient's health details on an electronic chip – may increase discrimination in access to health care rather than improve patient services.

According to the Bureau of National Health Insurance, the new IC card will eliminate the inconvenience of carrying several different paper documents when visiting hospitals or clinics. More important, the mechanism will enable health authorities to exert tighter control over treatment expenses, where excesses have allegedly been due to either the patient or the medical institution.

The IC card will contain four sections of information: basic personal information (such as user's name and date of birth), NHI-related information (such as the user's status and remarks about catastrophic diseases), records of medical services (such as history of allergies and long-term prescriptions), and a public health administration section (such as intent to donate organs). Although HIV status is not made explicit in the database, a patient's record of treatment with

antiretroviral drugs would nonetheless indicate HIV infection.

According to community advocates, many health professionals in Taiwan remain unwilling to treat people with HIV/AIDS.[1] Advocates anticipate that the IC card will reduce service access and may lead to further alienation of people with HIV/AIDS. In spite of government assurances of numerous meetings with civil society representatives, people with HIV appear not to have been consulted. Information on the IC card is available from the Bureau of National Health Insurance (www.nhi.gov.tw/00english/e_index.htm). For further information, contact the Persons with HIV/AIDS Rights Advocacy Association of Taiwan (praatw@yahoo.com.tw).

[1] Editor's note: A conference organized by the Taipei City STD Control Center on Integrating Community Services for HIV/AIDS, 30-31 October 2002, Taipei, heard many reports of discrimination toward people with HIV/AIDS by health-care providers and in health-care facilities.

Australian Workshop Puts Auditing in Perspective: Regulatory Tool, Moribund Remedy, or Democratic Champion?

In February 2003, the Regulatory Institutions Network (RegNet) of the Australian National University held a multidisciplinary workshop on "auditing" – including the use of tools to measure compliance with standards such as the International Guidelines on HIV/AIDS and Human Rights. The purpose of the workshop was to explore the concept of audit in various areas – eg, human rights, social, democratic, corporate, environmental, medical, and public-sector audits. It followed up themes discussed by the keynote speaker, Professor Michael Power of the London School of Economics, in his book *The Audit Society* (Cambridge, MA: Oxford University Press, 1996). The workshop encouraged a dialogue on what constitutes good auditing principles, design, and practices, such as independence, replicability, reliability, and inclusion of deeper narrative analysis (as well as quantitative measures).

There was general agreement that there had been an "audit explosion" and that the usefulness of the methodology varied according to the context in which it was used. In traditional areas of financial auditing, it had encouraged a "dead end" of risk complacency by producing certificates of "cold comfort," as seen with the collapse of several large corporations such as Enron. However, there was a potential for audit to champion normative concepts such as human rights and democracy if it fully engaged stakeholders in standard-setting. The audit process may create discomfort with the status quo through raising rights consciousness, understanding, and public debate.

In the HIV/AIDS context, an audit could measure compliance with the International Guidelines on HIV/AIDS and Human Rights,[1] and systematically assess whether progressive implementation (as opposed to backsliding) has occurred in the law. It is a diagnostic tool that highlights gaps and best practices, and is applied using tripartite representation – experts, civil society, and government. This methodology can assist in energizing, focusing, and equalizing participation of non-governmental organizations in law-reform agendas by using audit as an advocacy tool both at country and international levels. Results from audits could be incorporated into reports to the United Nations treaty-monitoring committees.

The draft audit has been piloted in Australia and will soon be applied in a developing country, probably Cambodia. Papers from the auditing workshop will be published on the RegNet website (http://regnet.anu.edu.au). For further information, contact Helen Watchirs (Helen.Watchirs@anu.edu.au).

In 2003-2004, the Canadian HIV/AIDS Legal Network will use

audit techniques to measure Canadian compliance with the International Guidelines on HIV/AIDS and Human Rights. For further information, see the Network's project on promoting a rights-based approach to HIV/AIDS at www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach.htm or contact Theo de Bruyn (tdebruyn@aidslaw.ca).

[1] 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.* Second International Consultation on HIV/AIDS and Human Rights, Geneva, 23-25 September 1996. New York and Geneva: United Nations, 1998, at paras 84-131 (www.unaids.org/publications/documents/human/law/JC520-HumanRights-E.pdf). The sixth guideline has been revised: 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 Guideline: Revised Guideline 6.* Second International Consultation on HIV/AIDS and Human Rights, Geneva, 25-26 July 2002. New York and Geneva: United Nations, 2002 (www.unaids.org/publications/documents/human/HIVAIDSHumanRights_Guideline6.pdf).

"Abstinence Only until Marriage": US Approach Undermining HIV Prevention

The rise in the political power of Christian fundamentalists in the United States has contributed over the last one or two decades to the erosion of government support for programs that provide sex education in public schools. The Bush Administration has made "abstinence only until marriage" programs an integral part of its domestic HIV/AIDS prevention strategy. In early 2003, the Administration sent a budget to Congress that calls for major increases in federal funding for "abstinence only until marriage" programs for both public schools and other uses such as public service advertising campaigns.

Critics of these programs in the US are fearful that the government will also begin pressuring US-funded HIV prevention programs in developing countries to adhere to abstinence-only approaches in information programs. Existing US policy prohibits foreign non-governmental organizations from receiving US funds if they provide abortions (except in the case of rape, incest, or when the woman's life – but not health – is endangered), provide abortion counselling or referrals, or lobby for abortion-law reform. This policy is named the Mexico City Policy because it was announced in Mexico City by President Reagan in 1984. It was suspended by the Clinton Administration in 1993, but reinstated by President Bush in 2001 on his first working day in office. The application of the Mexico City Policy to international HIV/AIDS programs has been criticized in an editorial in the *Lancet* in January 2003.[1]

In a recent report focusing on the state of Texas, Human Rights Watch documented that government-funded "abstinence only" programs not only keep students from receiving basic information on HIV prevention, but also provide information asserting that condoms are ineffective in preventing HIV transmission.[2] In addition, because such programs must teach that heterosexual marriage is the only legitimate context for sex, they discriminate against gay and lesbian students, who are not legally able to marry in the United States. Many of these programs also encourage young people to make virginity pledges or, for those already sexually active, pledges of "secondary virginity" – which, among other things, may mislead young people about the degree to which virginity pledges afford protection against sexually transmitted diseases. And by restricting the information provided by HIV/AIDS prevention experts and other receipents of federal HIV-prevention money, Texas's commitment to abstinence-only ideology has crowded out other sources of HIV/AIDS prevention information for young people.

Based on these findings, Human Rights Watch has strongly advocated that both the federal and state governments in the US abolish these programs and allocate funding to comprehensive sex education based on scientifically sound information.

[1] "Pro-life" policy threatens US HIV/AIDS initiatives. *Lancet* 2003; 361(9361) (www.thelancet.com/journal/vol361/iss9361/full/llan.361.9361.editorial_and_review.24938.1).

[2] R Schleifer. *Ignorance Only: HIV/AIDS, Human Rights and Federally Funded Abstinence-Only Programs in the United States.* New York: Human Rights Watch, 2002 (www.hrw.org/reports/2002/usa0902).

GLOBAL ACCESS TO TREATMENT

This section of the *Review* addresses issues related to improving access to adequate and affordable care, treatment, and support everywhere. It also includes an article examining the implications of the release of the AIDSVAX B/B vaccine trial results. We report on the failure to meet the deadline on commitments made at the WTO's Fourth Ministerial Conference in Doha, Qatar, in November 2001 regarding access to generic drugs; efforts by the South African Treatment Action Campaign to step up pressure on governments in South Africa to provide access to treatment; a decision by the Supreme Court of Canada upholding the validity of the Canadian patent on AZT; efforts by GlaxoSmithKline to block Canadian-based internet pharmacies from exporting medicines to the United States; recent developments in Jamaica and Honduras related to access to treatment; and the engagement of student organizations in Canada in the global fight.

WTO: Failure to Meet Deadline on Doha Commitments Regarding Access to Generic Drugs

In November 2001, the adoption in Doha, Qatar, of the Declaration on the TRIPS Agreement and Public Health represented an important victory in the fight for global access to treatment. Since then, however, several developed countries, including Canada, the European Community countries, Japan, Australia, and Switzerland have joined with the United States in efforts to narrow the scope of any "solution" to one of the problems that were left unresolved in Doha: that developing countries with inadequate domestic manufacturing capacity may face difficulty in "making effective use" of compulsory licensing.

Background

At their Fourth Ministerial Conference in Doha, Qatar, in November 2001, the trade ministers of countries belonging to the World Trade Organization (WTO) unanimously adopted a Declaration on the TRIPS Agreement and Public Health. This move was in response to insistence by developing countries (particularly the Africa Group, Brazil, and India) and non-governmental organizations that the provisions on patents in the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights ("TRIPS") hindered countries in their efforts to secure access to less expensive medicines, including those for treating diseases such as HIV/AIDS.[1]

The Declaration was an important victory for activists and developing countries. It provided strong political confirmation that countries should be able to use "to the full" the provisions in TRIPS that provide some policy

flexibility to countries in bringing down the costs of medicines – such as compulsory licensing, parallel importation, and allowing "limited exceptions" to exclusive patent rights – without facing legal challenges before WTO tribunals. It was also important legally, in that it directed that TRIPS "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."[2]

However, WTO members did not solve the recognized problem that developing countries with inadequate domestic manufacturing capacity may face difficulty in "making effective use" of compulsory licensing. The TRIPS Agreement restricts countries that do have this capacity, and that could therefore be potential suppliers of generic medicines, in their use of this policy measure. Specifically, Article 31(f) of TRIPS restricts production of generic drugs under compulsory licence (issued while the original drug is still under patent) to being "predominantly" for the domestic market. This hinders exports of cheaper generics to countries in need, even if the drug is not under patent or a compulsory licence has been issued in the importing country. WTO members promised to find an "expeditious solution to this problem" by the end of 2002.

Failure to Reach an Agreement

Over the following year, several developed countries, including Canada, the European Community countries, Japan, Australia, and Switzerland joined with the United States in efforts to narrow the scope of any "solution," imposing various conditions and restrictions that were at odds with the text and spirit of the Doha Declaration, such as limiting which countries would be able to use it, and for which diseases, as well as imposing onerous obligations on attempts to do so.

Notwithstanding this, by December 2002 a draft text of an agreement was approved by all WTO countries but one. The text contained numerous restrictions that were heavily criticized by non-governmental organizations and AIDS activists as unjustifiably putting the commercial interests of patent-holding pharmaceutical companies before access to more affordable medicines for people in developing countries.

The United States refused to approve the agreement, insisting on the further restriction that the "solution" should be limited to facilitating import of cheaper generics only for HIV/AIDS, malaria, tuberculosis, or "similar infectious disease of comparable gravity and scale." The solution would not be available to address the need for medicines for other health conditions. Developing countries, activists, and the World Health Organization all expressed their opposition to this further, serious restriction on using compulsory licensing. In particular, they pointed out that developed countries with a domestic pharmaceutical manufacturing capacity were not so restricted, and that such a limitation finds no support in the text of either TRIPS or the Doha Declaration.[3]

Talks broke down over this point, with no agreement reached by the end of 2002. Subsequently, the US announced its unilateral "moratorium" on dispute settlement proceedings, stating that it would not take action at the WTO against countries in cases that fell within the terms of its own narrow "solution." Canada's representatives have also stated that "until a multilateral solution is achieved, Canada will not take dispute settlement action against measures intended to assist a poor country with limited or no manufacturing ability needing access to medicines to treat a public health crisis such as HIV/AIDS or other epidemics," but had not issued a press release or official document as of March 2003.[4] The US and Canadian statements are limited to promising no WTO challenges on narrow grounds restricted to only certain diseases (eg, those that are "epidemics") or situations (eg, "crises").

As of publication, no agreement had yet been reached on easing this restriction in the TRIPS Agreement, despite ongoing discussions in early 2003. The issue could be another high-profile point of contention at the Fifth WTO Ministerial Conference in Cancún, Mexico, in September 2003 – almost two years after the promises made in Doha with the launch of a "new" round of trade negotiations that supposedly would include addressing concerns of developing countries with globalization according to WTO trade rules.

Aside from seeking a truly workable solution at the WTO, Canadian advocates have also argued that the Canadian government should amend its domestic patent laws to recognize, as a "limited exception" to patent rights permitted under TRIPS, the production of generic versions of drugs patented in Canada when the generic versions are produced for export to developing countries where the drug is either not patented or where a compulsory licence or other appropriate legal authorization has been issued according to the laws of that country.

– Richard Elliott

Richard Elliott is Director, Policy & Research, Canadian HIV/AIDS Legal Network (on leave of absence until 1 September 2003). He can be reached at relliott@aidslaw.ca.

For additional information and documents about ongoing post-Doha negotiations at the WTO, see the following websites: Consumer Project on Techology (www.cptech.org), Médecins Sans Frontières (www.msf.ca/programs/access.htm), Health GAP Coalition (www.healthgap.org). For information on advocacy efforts by Canadian NGOs, see the Canadian HIV/AIDS Legal Network website (www.aidslaw.ca).

---

[1] The TRIPS Agreement and the Doha Declaration (WT/MIN(01)/DEC/2) can be found on the WTO website at www.wto.org.

[2] For a summary and commentary on the Declaration, see: R Elliott. WTO Ministerial Conference adopts Declaration on TRIPS and Public Health. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 50-52. For commentary on post-Doha developments, see also: R Elliott, MH Bonin. Patents, International Trade Law and Access to Essential Medicines. Backgrounder produced by the Canadian HIV/AIDS Legal Network & Médecins Sans Frontières Canada, revised 2003 (available at www.aidslaw.ca/Maincontent/issues/B2).

[3] For this draft text and other, related documents, see the website of the Consumer Project on Technology at www.cptech.org/ip/wto/p6/.

[4] Correspondence from Catherine Dickson, Director, Intellectual Property, Information and Technology Trade Policy Division, Department of Foreign Affairs and International Trade, Canada, dated 25 February 2003 (on file).

South Africa: Treatment Action Campaign Steps Up Pressure

In December 2002, in its ongoing efforts to secure access to affordable HIV/AIDS treatment for all South Africans, the grassroots organization Treatment Action Campaign (TAC) initiated two new proceedings over governmental failure to act to prevent mother-to-child transmission of HIV. In March 2003, it launched a national civil disobedience campaign to pressure government into implementing a national treatment and prevention plan, including taking measures to ensure access to affordable medicines.

Proceedings Allege Contempt of Court for Failure to Act on Mother-to-Child Transmission

On 2 December 2002, TAC filed a complaint with the Human Rights Commission alleging that the government and Member of Executive Committee (MEC) for Health in the province of Mpumalanga were in contempt of court.[1] On 17 December, TAC initiated proceedings in the High Court seeking a finding of contempt of court by the Mpumalanga provincial government.[2]

The court order invoked in these proceedings was the July 2002 order from the country's highest court that government must act to increase access to the antiretroviral drug nevirapine in order to prevent mother-to-child transmission of HIV. That order was the result of litigation initiated by TAC. The Constitutional Court ordered the national Minister of Health and her provincial counterparts to take specific steps "without delay" to prevent avoidable infections and death, including: removing existing restrictions on the provision of nevirapine to pregnant women outside existing pilot sites; permitting and facilitating the use of nevirapine where medically indicated for preventing mother-to-child transmission; training counsellors on its use for this purpose, where necessary; and taking "reasonable measures" to extend HIV testing and counselling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of nevirapine.[3]

TAC alleges in these two proceedings that, through willful misrepresentation of the Constitutional Court's order and failure to act in accordance with that order, Mpumalanga's government is in contempt of court. It seeks an investigation from the Human Rights Commission. In its High Court motion, it asks the Court to find Mpumalanga in contempt of the Constitutional Court judgment. In addition, it asks (1) an order com-

pelling Mpumalanga's MEC for Health to provide information on what steps she has taken, and steps she intends to take and when, to implement the Constitutional Court judgment; and (2) an order that the national government and Minister of Health ensure implementation of the judgment by Mpumalanga.

TAC Launches Civil Disobedience Campaign

On 20 March 2003, TAC launched its civil disobedience campaign. The campaign began on the eve of Human Rights Day, which commemorates the day in 1960 on which thousands of black African people in South Africa left the passes required by apartheid law at home and marched peacefully en masse to police stations to turn themselves in for arrest. The campaign follows months of negotiations with government, through the National Economic Development and Labour Council (NEDLAC), that have failed to produce a firm commitment to a national HIV/AIDS prevention and treatment plan, and denials by the government that it had agreed to sign such a plan. As part of the campaign, 600 volunteers marched to police stations to lay charges of culpable homicide against the Minister of Health and the Minister of Trade and Industry. They handed over a "people's docket" detailing the basis for these charges and demanding that police open an investigation into the deaths of thousands of people from HIV/AIDS that could have been prevented had these ministers implemented legislation enacted by parliament to increase access to affordable medicines and discharged their legal duties to take such measures as issuing compulsory licences. The TAC submission points to accumulated evidence, including that generated by the government itself, as to the scope of the AIDS epidemic, the efficacy of antiretroviral drugs in reducing morbidity and mortality, as well as research showing the economic feasibility of a national treatment plan and international guidance from the World Health Organization, UNAIDS, and the Office of the UN High Commissioner for Human Rights.[4]

– Richard Elliott

[1] Treatment Action Campaign. Contempt of Constitutional Court Order: Complaint Against the MEC for Health in Mpumalanga: Request for an Urgent Investigation, filed 2 December 20002 with the Human Rights Commission (available via www.tac.org.za).

[2] Notice of Motion. *Treatment Action Campaign* v *MEC for Health, Mpumalanga and Minister of Health*, High Court of South Africa (Transvaal Provincial Division), 14 December 2002 (available via: www.tac.org.za).

[3] *Minister of Health and Others* v *Treatment Action Campaign and Others*, (1) 2002 (10) BCLR 1033 (CC) (available via www.tac.org.za). For a summary, see: L Gerntholtz. South Africa: Highest court orders government to provide antiretrovirals to prevent mother-to-child transmission. *Canadian HIV/AIDS Policy & Law Review* 2003; 7(2/3): 50-52.

[4] The TAC documents detailing the basis of the charges can be found via www.tac.org.za.

Canadian Supreme Court Upholds, but Limits, AZT Patent

On 5 December 2002, the Supreme Court of Canada ended a long-running dispute when it unanimously upheld the validity of the Canadian patent on the antiretroviral drug zidovudine (AZT) held by Glaxo Wellcome (now GlaxoSmithKline).[1]

AZT was already a known compound, synthesized in 1964 and tested as a possible cancer treatment. However, under Canadian law, a patent is available for a new use for a known chemical compound. Glaxo claimed the patent for discovering its use against HIV. When Glaxo applied for the patent on 16 March 1985, AZT had only been tested on mice, while testing by scientists at the US National Institutes of Health to assess its anti-HIV properties in human cells was still underway.

Two Canadian generic drug companies, Apotex Inc and Novopharm Ltd, had argued that Glaxo's patent was invalid because it was based on mere speculation that AZT might be effective against HIV/AIDS in humans. The Supreme Court rejected

the generic companies' challenge. It found that, while Glaxo had shown little gratitude to NIH scientists who carried out additional research that Glaxo could not undertake itself, these scientists were not "co-inventors" and Glaxo's patent was valid because it had sufficient information at the time of its patent application to make a "sound prediction" that it would be useful in the treatment and prophylaxis of HIV/AIDS in humans. Glaxo had also made very broad claims for the scope of its patent, such as trying to patent AZT for treating human retroviruses other than HIV. Some of these claims had been struck out by lower courts. The Supreme Court upheld those conclusions, agreeing that in some areas, Glaxo's patent claims went beyond the limits within which its predictions remained sound.

The Supreme Court said that, in order for a patent to be valid, the doctrine of sound prediction required that three things be established at the time of applying for a patent: (1) a factual basis for the prediction about AZT's utility in treating HIV/AIDS; (2) a "sound" line of reasoning from the factual basis to the use(s) being patented; and (3) proper disclosure of the invention. The Court emphasized the importance of carefully applying these requirements in order to protect the public interest. The requirement of "sound prediction" should not be diluted to allow patents, and the associated monopoly rights, to be granted based on a "lucky guess" or "mere speculation."

Other Developments

A few months later, on 5 March 2003, a US district court judge in California dismissed a lawsuit filed in July 2002 by the AIDS Healthcare Foundation alleging Glaxo's patent on AZT was invalid. Glaxo had moved to have the suit dismissed on the basis that its claims were without merit and offered no new information.[2] Meanwhile, the AHF has also initiated a separate suit against Glaxo, alleging it has engaged in false advertising for claiming that they are supplying antiretrovirals "at cost" to developing countries and thereby making "no profit." AHF says generic companies are proving able to charge lower prices, and is seeking an injunction to prohibit Glaxo from making these statements and a court order requiring it to surrender profits "wrongfully obtained" by such advertising.[3]

– Richard Elliott

---

[1] *Apotex Inc* v *Wellcome Foundation Ltd*, 2002 SCC 77. The Federal Court of Appeal judgment is reported as *Apotex Inc* v *Wellcome Foundation Ltd*, [2001] FC 495 (CA), (2000), 195 DLR (4th) 641; the trial judgment is reported as *Apotex Inc* v *Wellcome Foundation Ltd* (1998), 145 FTR 161. For a detailed summary of the proceedings below, see: R Elliott. Canadian court upholds Glaxo's patent on AZT. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 53-57; and R Elliott. Court rules on patent dispute over AZT. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 11-12.

[2] Judge dismisses AZT patent challenge to GlaxoSmithKline. Gfn.com News, 13 March 2003; Judge dismisses AIDS Healthcare Foundation anti-trust lawsuit against GlaxoSmithKline, *Kaiser Daily HIV/AIDS Report*, 13 March 2003; GlaxoSmithKline. Press release: California court dismisses AIDS Healthcare Foundation lawsuit, 10 March 2003 (via www.gsk.com). See also: AHF. Press release: AIDS Healthcare Foundation sues Glaxo for antitrust, 1 July 2002 (via www.aidshealth.org).

[3] AHF. Press release: Glaxo hit with false advertising lawsuit over AIDS drug pricing, 12 February 2003 (via www.aidshealth.org); L Zehr. Glaxo hit over on-line stand, AIDS. *Globe and Mail*, 13 February 2003: B11; AIDS Healthcare Foundation sues GlaxoSmithKline for false advertising regarding AIDS drug pricing. *Kaiser Daily HIV/AIDS Report*, 14 February 2003.

Canada/US: Competition Bureau Will Not Investigate GSK Efforts to Stop Cross-Border Sales by Internet Pharmacies

On 21 March 2003, the Competition Bureau of Canada announced it would not proceed against GlaxoSmithKline (GSK) for its actions to block Canadian-based internet pharmacies from exporting medicines to the United States.[1]

Many such internet pharmacies are located in Manitoba. The Manitoba International Pharmacists Association (MIPA), representing over 100 online/mail-order pharmacies, estimates that approximately a million US residents obtain their drugs from such pharmacies because of significantly lower prices in Canada due to price controls and the US/Canadian dollar exchange rate. MIPA estimates annual sales by Canadian online pharmacies at around US$600 million. US

residents, particularly seniors, living near the Canadian border have also organized cross-border shopping trips to purchase less expensive medicines in person.

The US is the only G7 country without price controls on medicines. In Canada, the Patented Medicines Prices Review Board (PMPRB) is a quasi-judicial body with the authority to prevent drug companies from "excessive" pricing on patented drugs.[2]

On 3 January 2003, GSK notified Canadian online, mail-order pharmacies by letter that it would cease supplying them with its products as of 21 January 2003 unless they stopped cross-border sales to consumers in the US.[3] GSK argues that selling patented medicines to US consumers violates its patent rights, and that it is enforcing the terms of sale to pharmacies, which specify that products sold to Canadian wholesalers are for distribution in Canada only. On 21 January 2003, GSK stopped selling its drugs to 29 wholesalers and pharmacies that ship products to consumers outside Canada,[4] cutting off access for both Canadian and US customers of those pharmacies unless the pharmacies agreed to stop supplying US customers. Some pharmacies complied.[5]

While cutting off supply, GSK expressed concern that cross-border sales to the US "put a strain on supply of medicines for Canadians."[6] It also described the drugs purchased from these online pharmacies as "unregulated Canadian medicines."[7] GSK further claimed that drugs could be damaged during shipping, risking patients' health. MIPA and the Canadian International Pharmacy Association (CIPA) rejected this concern, noting that GSK itself ships its products great distances without any threat to the product's integrity, and that all its members are licensed pharmacies complying with appropriate Canadian regulatory standards.[8] They also pointed out that all CIPA-member pharmacies only fill prescriptions supplied by patients' physicians and require detailed personal health information that is reviewed by a Canadian physician to ensure the prescription is appropriate.[9]

> In response to US customers purchasing medicines from Canada at lower prices, it can be expected that pharmaceutical companies will increase their longstanding efforts to eliminate Canada's price controls on patented medicines.

In early February 2003, 21 members of the US Congress wrote to GSK urging it to reconsider its decision.[10] On 12 February, a coalition of health-care and business groups began a public ad campaign condemning GSK's actions.[11] The same day, GSK announced that in 2002 its sales rose seven percent to US$31.8 billion, and its profit climbed 11 percent to US$6.9 billion.[12]

In early March 2003, the Competition Bureau of Canada confirmed it had received a complaint alleging "anti-competitive" practices by GSK.[13] Under the Competition Act, suppliers may set the terms and conditions of sales to businesses provided these have a "reasonable business justification." The Bureau concluded that GSK had such a justification after being informed by the US Food and Drug Administration (FDA), in a letter of 12 February 2003, of the FDA's position that "interstate" shipment of prescription drugs (which includes importing into the US) without FDA approval contravenes US law.[14] The Bureau also stated it had found no evidence to suggest a possible violation by GSK of the criminal provisions of the Competition Act.

GSK welcomed the Bureau's decision. CIPA said it was surprised and disappointed, pointing out that

> [m]ulti-national pharmaceutical companies are the first to seek the benefits of free trade and globalization. However, at the first sign of consumers wanting to benefit from free trade, those same multi-national corporations rely on various regulations that restrict free trade in their products.[15]

MIPA has indicated it is considering private legal action against GSK.

In 2001, the National Association of Pharmacy Regulatory Authorities (NAPRA) in Canada approved model standards for Canadian internet pharmacies. These are similar to the Verified Internet Pharmacy Practices Site (VIPPS), a voluntary certification program established by its US counterpart, the National Association of Boards of Pharmacy (NABP).[16] Also in 2001, the two organizations agreed to jointly develop a VIPPS program in Canada to be administered exclusively by NAPRA.[17] Approval by VIPPS establishes that an online pharmacy complies with applicable licensing and inspection requirements, as well as standards regarding patient privacy and the authentication of orders.[18] In late 2002, it was reported that Canadian online pharmacies shipping drugs to US customers would be denied the VIPPS seal of approval.[19]

In response to US customers purchasing medicines from Canada at lower prices, it can be expected that pharmaceutical companies will increase their longstanding efforts to eliminate Canada's price controls on patented medicines and other, provincial measures through public health insurance systems that seek to control drug costs.

– Richard Elliott

[1] Competition Bureau of Canada. Media release: Competition Bureau responds to complaints regarding supply of Canadian-based Internet pharmacies, 21 March 2003 (via http://strategis.ic.gc.ca).

[2] Additional information about the PMPRB is available at www.pmprb-cepmb.gc.ca.

[3] In late 2002, another company, Merck & Co Inc., sent letters to several Canadian internet pharmacies alleging the illegality of cross-border sales by online pharmacies, but did not threaten to stop supplying them: L Zher. Manitoba net pharmacies may sue if Glaxo halts sales. *Globe and Mail*, 14 January 2003: B2.

[4] L Zehr. Glaxo to stop US-bound drugs. *Globe and Mail*, 22 January 2003: B3; T Cohen. GlaxoSmithKline cuts supplies to Internet pharmacies selling to US. *Associated Press*, 30 January 2003; B Whitwham. Dispute over online pharmacies heating up, *e-CMAJ (Canadian Medical Association Journal)*, 31 January 2003 (via www.cma.ca/cmaj); GlaxoSmithKline. Press release: GlaxoSmithKline responds to critics of its cross-border Internet sales policy, 13 February 2003.

[5] AIDS Healthcare Foundation. Press release: US' largest AIDS organization urges widespread support for boycott of Glaxo for blacklisting Canadian pharmacies, 7 February 2003 (via: www.aidshealth.org).

[6] GlaxoSmithKline. Press release: GlaxoSmithKline welcomes Competition Bureau decision, 21 March 2003. GSK media releases are available via www.gsk.com.

[7] Ibid.

[8] Manitoba International Pharmacists Association. Press release: Manitoba on-line pharmacies slam Glaxo drug ban, 12 January 2003 (via www.mipa.ca); Canadian International Pharmacy Association. Press release: Canadian pharmacy association asks GlaxoSmithKline to stop ban against affordable drugs, 17 January 2003 (via www.ciparx.ca).

[9] CIPA, ibid.

[10] G Gately. Cross-border battle over internet drug sales heats up. *HealthScoutNews*, 10 February 2003.

[11] L Zehr. Glaxo hit over on-line stand, AIDS. *Globe and Mail*, 13 February 2003: B11. See also MIPA and CIPA websites at www.mipa.ca and www.ciparx.ca.

[12] Ibid.

[13] Competition watchdog to investigate Glaxo actions. *Globe and Mail*, 6 March 2003: A4.

[14] Competition Bureau, supra, note 1; B Whitwham. US voters' love of Canada's Internet drugstores making politicians cautious. *Canadian Medical Association Journal* 2003; 168: 1033.

[15] CIPA. Media release: Canadian International Pharmacy Association expresses disappointment with the decision of the Competition Commissioner, 24 March 2003 (via www.ciparx.ca).

[16] These are available on NAPRA's website at www.napra.org/practice/information/internet_standards.html.

[17] NABP/NAPRA sign memorandum of understanding. *NABP Newsletter*, January 2002; NAPRA. "VIPPS Certified" – NAPRA licensed to certify Internet pharmacies in Canada. *Outlook*, Winter 2002. For additional information about NAPRA and the issue of online pharmacies, see www.napra.org/.

[18] M Meadows. Imported drugs raise safety concerns. *FDA Consumer Magazine*, Sept-Oct 2002 (at www.fda.gov/fdac/features/2002/502_import.html).

[19] C Ukens. Canada adopts VIPPS for on-line pharmacies. *Drug Topics*, 16 December 2002.

Vaccine Trial Results Generate Debate and Calls for Further Research

The first large-scale human trial of an HIV vaccine produces disappointing results overall, but finds that the vaccine may have been effective among some of the minority populations participating in the trial. Whatever the significance of this finding (the debate continues), there was a consensus: (a) that the trial provided very useful information on how to conduct large-scale HIV vaccine trials; (b) that further research needs to be conducted; (c) that governments need to contribute more to vaccine research and development; and (d) that existing prevention efforts must be maintained or expanded.

While the results of the AIDSVAX B/B vaccine trial showed that the vaccine was not effective in providing protection from HIV infection among the overall trial population, there has been considerable debate on the significance of the finding that the vaccine appeared to provide protection among African-American and other non-Hispanic minorities participating in the trial. The results of the trial, which was run by VaxGen, a US-based biotechnology company, were released on 24 February 2003. The results were based on an initial analysis of the data. VaxGen has said that further analysis will be conducted.

AIDSVAX B/B is the first HIV vaccine to be tested in large-scale human trials. The vaccine was designed to elicit a response to sub-

type B of the AIDS virus, the subtype most prevalent in North America, Western Europe, Australia, and New Zealand. About 5400 people from the United States, Canada, and the Netherlands participated in the trial. All participants were counselled on safer sex practices and other ways to avoid being infected. Two-thirds of the participants were given the vaccine, while one-third received a placebo. By the end of the trial, 5.8 percent of the placebo group had become infected with HIV, compared with 5.7 percent of the group who received the vaccine. The difference is not statistically significant.

About 500 of the participants were African-Americans and other non-Hispanic minorities. In these populations, 8.1 percent of the placebo group became infected as opposed to 2.0 percent of the vaccine group, which means that there were 66.8 percent fewer infections among those who received the vaccine. VaxGen said that the differences between the two groups were statistically significant.

Reaction

Since the results were released, researchers and others have been debating the significance of the findings among African-Americans and other non-Hispanic minorities. Some have argued that the numbers are too small to provide reliable results. Others have questioned the methods used to analyze the raw data from the trial. Almost everyone agrees, however, that the findings are intriguing and that further research is warranted.

> "HIV vaccine research remains an urgent global need."
>
> – WHO and UNAIDS

While acknowledging that the VaxGen trial has contributed valuable information, both international and Canadian organizations have emphasized that the effort to develop an effective vaccine remains an urgent priority and must be stepped up. The World Health Organization and the Joint United Nations Programme on HIV/AIDS said that many more trials are required, especially to develop vaccines that will be effective in sub-Saharan Africa.[1] The Canadian AIDS Society (CAS) and the Canadian HIV/AIDS Legal Network said that as a rich country Canada has a moral obligation to contribute generously to the international HIV vaccine effort and to play a leading role in the global coordination of HIV vaccine development and delivery.[2] All agreed that, in any event, prevention efforts must continue and be expanded.

As a recent article in the *Review* has argued, governments are under public health, ethical, and legal obligations to develop and provide access to HIV vaccines.[3] In response to calls from CAS and the Legal Network, Health Canada has agreed to coordinate and provide funding for a Canadian HIV Vaccine Plan.[4] Health Canada has not said when the plan will be ready.

VaxGen is also conducting a trial of a similar vaccine, AIDSVAX B/E, in Thailand. The results of this trial are expected by late 2003. Other AIDS vaccines employing different design strategies are now in development, and some have already entered human trials.

– David Garmaise

David Garmaise is a consultant in HIV/AIDS and the editor of the Canadian News section of the *Review*. He can be reached at dgarmaise@rogers.com.

---

[1] Joint press release issued on 24 February 2003 (www.unaids.org/whatsnew/press/eng/VaxGen240203_en.html). See also the statement of the International AIDS Vaccine Initiative, issued on 24 February 2003 (www.iavi.org/press/2003/n20030224.htm).

[2] Joint press release issued on 25 February 2003 (www.aidslaw.ca/Media/press-releases/e-press-feb2003.htm).

[3] S Avrett, C Collins. HIV vaccines: current challenges and future directions. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 1, 20-25.

[4] See D Garmaise. Canada will have a national HIV vaccine plan. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 29. The need for a Canadian HIV Vaccine Plan is one of the issues examined in a background paper and series of info sheets on *HIV Vaccines in Canada: Legal and Ethical Issues*, available on the Legal Network website (www.aidslaw.ca/Maincontent/issues/vaccines.htm).

Honduras: Government Intimidates People with HIV/AIDS Asserting Right to Medicines

In August 2002, the Honduran Ministry of Health violated the human rights of four Hondurans living with HIV/AIDS by releasing their names to a national newspaper.

The newspaper published the names. The four individuals had previously succeeded in obtaining "temporary protective orders" (*medidas cautelares*) from the Inter-American Commission on Human Rights, ordering the government to provide antiretroviral medications. In the original order, the Commission had stipulated that the names of the petitioners were to be kept strictly confidential.

Activists said that a representative of the health ministry had repeatedly stated in public meetings that seeking such redress was "unpatriotic" and that ministry officials had implied that funding would be terminated for any organization supporting such efforts. According to the Agua Buena Human Rights Association, the publication of the names had led to "severe consequences" for each of the four petitioners. Since the newspaper article appeared, no one else in Honduras has been willing to file a petition with the Commission. On 26 November 2002, the Executive Secretary of the Commission wrote to the Honduran government expressing concern that the names of the petitioners had been disclosed in spite of the Commission's prior request. Agua Buena criticized the Commission's response as "well-intentioned, but very weak" given the chill the government's actions have placed on future attempts by Hondurans to pursue their human rights. It is estimated that about 4000 people in Honduras need antiretrovirals, but only about 230 are receiving them.[1]

[1] Agua Buena Human Rights Association. Honduran government stops "medidas cautelares" with threats and intimidation, 26 December 2002 (available via www.aguabuena.org).

Jamaica: Petition for Antiretroviral Drugs Filed

In February 2003, five Jamaican women with HIV/AIDS filed petitions with the Inter-American Commission on Human Rights seeking an order that the government provide them with antiretroviral drugs, in fulfillment of its obligations under the American Convention on Human Rights to respect the right to health and the right to enjoy the benefits of scientific progress.

The women were assisted by the Costa Rica–based Agua Buena Human Rights Association, which has worked with other non-governmental organizations and individual activists to bring similar, successful petitions in seven countries in Latin America.

An estimated 25,000 Jamaicans are living with HIV/AIDS. About 4500 of them currently need antiretroviral treatment, but only about 150 have access. Jamaica provides antiretroviral drugs only to prevent mother-to-child transmission and only during pregnancy.[1]

[1] Agua Buena Human Rights Association. News release: Jamaicans living with HIV/AIDS ask for protection from Human Rights Commission, 23 February 2003; P Watson. Breaking the silence on HIV/AIDS – Jamaicans file petition with Human Rights Commission. *Jamaica Gleaner*, 2 March 2003. For additional information about treatment access in Jamaica, see: R Stern. Jamaican bays, beaches offer no safe harbor for people with HIV/AIDS. Published 29 January 2003 by Agua Buena Human Rights Association, via www.aguabuena.org.

Canadian Students Join Struggle for Access to Treatment

Canadian students have joined the struggle for global access to treatment. This article describes initiatives at McGill University and the University of Toronto.

McGill International Health Initiative

The McGill International Health Initiative (MIHI) is a group of students dedicated to improving the health of the poor around the world. Founded by four medical students in 1984 (and then known as the Osler Medical Aid Foundation), it is McGill's oldest student group dedicated to international health.

This year MIHI organized several lectures to educate the McGill community about social justice issues in responding to the HIV epidemic. MIHI began the year with a lecture entitled "Social Justice in International Health: Treating HIV and Multi-Drug Resistant Tuberculosis in Poor Settings" by Dr Michael Rich, a physician with the Peru-based Socios en Salud. On 17 October 2003, MIHI joined thousands around the world in the Global Day of Action Against Coke, held to pressure the multinational to improve its HIV-treatment policy for its bottlers in poor countries.

With a firm conviction that lifesaving treatment for HIV should be readily available to all people, MIHI started the nationwide Student Led Access to HIV Medicines (SLAHM) Campaign, collaborating with the University of Toronto's Students Against Global AIDS (SAGA). The aim of the SLAHM Campaign is to get student unions across the country to endorse a letter to the Canadian government, demanding greater action to bridge the global treatment gap. The letter, drafted by McGill medical students Faiz Ahmad and Stéphane Voyer, has so far been endorsed by student unions at the University of Toronto, Concordia University, Université de Sherbrooke, McGill University, and St Francis-Xavier University.

In an act of "direct, urgent solidarity," MIHI is fundraising for the Association Africaine Solidarité, an organization in Burkina Faso (run mostly by HIV-positive Burkinans) that seeks to provide free HIV treatment.

To end off a successful year, MIHI invited Alec Irwin, of Partners In Health, to give a lecture entitled "Global AIDS: Myths and Facts." Alec Irwin is co-editor and co-author of *Dying for Growth: Global Inequality and the Health of the Poor*. His most recent book is entitled *Global AIDS: Myths and Facts.* The book shatters 10 myths about HIV/AIDS treatment and prevention – such as "AIDS is an African problem," "treatment in developing countries is not technically feasible," and the "myth of limited resources" – while calling for an international movement to fight the disease.

University of Toronto Students Against Global AIDS

SAGA is a University of Toronto student group dedicated to raising awareness of the global HIV/AIDS crisis. The group's initiatives include invited speakers, letter-writing campaigns, and petitioning the Canadian government to increase its funding for the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. To mark World AIDS Day 2002, SAGA co-sponsored the display of a CARE Canada photo exhibit of AIDS in Zambia at the university, and hosted representatives of CARE Canada to discuss their experiences in fighting AIDS in Zambia.

SAGA was born out of deep dismay at the unwillingness of the Canadian government to confront this crisis directly, as well as out of alarm at the lack of student involvement in Canada in combating HIV/AIDS. At present, the Canadian government is providing roughly one-tenth of what it should contribute to the Global Fund if it were to contribute in proportion to its share of the United Nations budget. SAGA firmly believes that it is the responsibility of the Canadian government to do far more to fight diseases such as HIV/AIDS.

SAGA is virtually unique on Canadian university campuses as a student group dedicated principally to combating HIV/AIDS. Its activities have been inspired by the success of student groups in the United States such as the Student Global AIDS Campaign and other organizations calling attention to this crisis. SAGA hopes that a concerted effort on university campuses across Canada will

convince the Canadian government to increase its support for the Global Fund to the level needed for the fund to succeed.

SAGA's first concern has been to develop a firm base among University of Toronto students. SAGA has established links with other on-campus groups such as the University of Toronto International Health Programme. An important objective for SAGA is to increase ties with university campuses across Canada. To that end, SAGA has established links with groups at other universities, such as McGill University in Montréal.

– Faiz Ahmad and Bruce Blain

Faiz Ahmad is coordinator of the McGill International Health Initiative (MIHI). For more information, contact him at mihi_hiv@yahoo.ca. The SLAHM Campaign letter may be seen, in English and French, at www.aidslaw.ca/ (click on "What's New" and "Added in March 2003). Bruce Blain is a member of SAGA. For more information, contact him at bruce.blain@utoronto.ca.

HIV/AIDS IN PRISONS

Past issues of the *Review* have featured updates on developments in prisons around the world. With this issue we are establishing a regular section for this purpose. The section is dedicated to the memory of Xavier Sanchez Horno, a prisoners' rights advocate who provided support to prisoners with HIV in British Columbia. Xavier died of AIDS-related diseases on the Easter weekend, and will be dearly missed. The articles have been compiled by Ralf Jürgens, Executive Director of the Canadian HIV/AIDS Legal Network. Ralf can be reached at ralfj@aidslaw.ca.

We begin with two reports on infectious diseases in federal penitentiaries in Canada. A report from the Correctional Service of Canada (CSC) was "released" by CBC on 22 April 2003. A report from the Prisoners' HIV/AIDS Support Action Network (PASAN) on women prisoners and HIV and HCV was released in March 2003. Both highlight the extent of the HIV and HCV epidemics in Canadian prisons, and envisage stepped-up efforts to combat the epidemics behind bars. Once again, notably absent from CSC's report is a commitment to pilot prison needle exchange programs, although a review of such programs we report about in this section shows that they are feasible and beneficial. Other developments covered include the withdrawal of a coalition of Canadian prison organizations from the consultation process with CSC; the victory of a South African prisoner infected with HIV in prisons who sued the South African prison system for damages; new developments in Russia that provide hope that the prison population there may decrease; and a report that in the US the prison population now exceeds two million.

Canada: CBC "Releases" CSC Report on Infectious Diseases Prevention and Control

On 22 April 2003, after CBC Radio started reporting on it during its morning news,[1] CSC posted a report called *Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries 2000-01* on its website.[2] The report had been featured many months ago in a Health Canada publication, the *HIV/AIDS Communiqué*,[3] and people asking for copies had been told that it was delayed, but would be released in March 2003. The report presents surveillance data collected by CSC during 2000 and 2001 on reportable infectious diseases in Canadian federal penitentiaries.

Findings

Some of the main findings in the report include the following.

- Between 1989 and 2001, positive HIV test reports for federal inmates increased by an average

of 15 cases per year, from 24 in 1989 to 223 in 2001. At year-end 2001, 223 (1.8 percent) inmates in federal penitentiaries were reported by CSC institutions to be HIV-positive, compared to 214 (1.7 percent) inmates at the end of 2000.
- The number of new positive HIV test reports decreased from 45 in 2000 to 16 in 2001.
- The HIV infection rate among women (4.7 percent in 2001, 5 percent in 2000) was higher than among men (1.7 percent in 2001, 1.6 percent in 2000).
- In 2001, 173 HIV-positive inmates were released from CSC.
- Between 1997 and 2001, new HCV-positive test reports averaged close to 526 cases per year.
- The number of reported HCV-positive inmates increased from 2542 cases at year-end 2000 to 2993 cases at the end of 2001, representing 20.1 percent and 23.6 percent of the incarcerated population respectively.
- Reported rates of HCV were higher among women (41.2 percent in 2001, 42.4 percent in 2000) than among men (23.2 percent in 2001, 19.7 percent in 2000).
- In 2001, 1506 HCV-positive inmates were released from CSC.
- Testing uptake levels for HIV and HCV indicate that up to 70 percent of inmates choose not to be tested while in prison. As a result, as the report states, "reported infection rates may severely underestimate the true burden of disease within federal correctional facilities."[4]
- During 2001, 41 federal inmates were newly initiated on voluntary HIV treatment. At year-end 2001, 113 of 223 HIV-positive inmates (50.7 percent) were following a course of HIV treatment.

Future Directions

The report notes that the high rates of infectious diseases in federal penitentiaries raise several concerns relating to (1) the greater demand for appropriate care, treatment, and support for infected inmates; (2) the risk to staff and inmates of disease transmission in the event of exposure to blood or body fluids from an infected inmate; and (3) the increased risk to public health upon reintegration of an infected offender into the community.[5] It continues by saying that "[a] combination of testing, treatment and education is essential for preventing the transmission of infectious diseases in correctional settings."[6] The report concludes:

> To achieve sustained declines in infectious diseases and to interrupt the cycle of disease transmission greater efforts are needed to identify seropositive individuals and provide effective risk reduction interventions. An efficient preventive strategy must optimize use of harms reduction initiatives, while providing gender-specific and culturally-specific education programs. The strengthening of links between penitentiaries and public health services in the community can ensure the continuity of care for inmates upon their release.[7]

Earlier in the report, however, it is stated that, at this time, "CSC ha[s] no plans for a needle-exchange program within its institutions,"[8] despite its own working group recommending pilot testing needle exchange programs in all five CSC regions as early as 1999, and despite a recent review of prison-based needle exchange programs showing that these programs are feasible and provide substantial benefits without any unintended negative consequences.[9]

– Ralf Jürgens

---

[1] Canadian Broadcasting Corporation. HIV rates 10 times higher in prison. 22 April 2003.

[2] *Infectious Diseases Prevention and Control in Canadian Federal Penitentiaries 2000-01*. A Report of the Correctional Service of Canada's Infectious Diseases Surveillance System. Ottawa: CSC, 2003. Available via CSC's website (www.csc-scc.gc.ca/).

[3] See at www.hc-sc.gc.ca/hppb/hiv_aids/communique_jan.html - 5.

[4] Supra, note 1 at 3.

[5] Ibid at 25.

[6] Ibid.

[7] Ibid at 27.

[8] Ibid at 20.

[9] K Dolan, S Rutter, AD Wodak. Prison-based syringe exchange programmes: a review of international research and development. *Addiction* 2003; 98: 153-158. For more information, see the article below.

Canada: New Report on HIV, HCV, and Women Prisoners

In March 2003, the Prisoners' HIV/AIDS Support Action Network (PASAN) released *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C*, a qualitative, evaluative study investigating the perceptions and lived experiences of federally incarcerated women regarding HIV/AIDS and hepatitis C (HCV).[1]

Unlocking Our Futures is the first study of its kind in Canada specifically addressing the needs of incarcerated women. Research for the project was conducted during 2001 and 2002, and involved interviews with 156 federal women prisoners housed in nine facilities across Canada. This represents approximately 40 percent of the total population of federally incarcerated women. Based upon these interviews, the study documents the specific needs of federal women prisoners regarding HIV/HCV prevention, care, treatment, and support. Drawing upon the women's experiences, *Unlocking Our Futures* explores the current responses of both correctional and community services, and examines issues such as need, accessibility, quality, satisfaction level, and trust.

In many cases, the research found that current programs and services are marked by inconsistent implementation and accessibility, both within individual institutions and across the federal prison system as a whole. Concerns about confidentiality are pervasive, and affect program participation and access throughout the various topic areas examined.

The data identified areas where new or innovative initiatives are required in order to effectively meet the needs identified among study participants. In addition to identifying gaps in services, the report also identifies elements of good practice in the provision of HIV and HCV services. These are drawn from the information provided by the women themselves, as well as from national and international recommendations and experience.

Some of the report's key findings include the following.

- High-risk behaviours for the transmission of HIV and HCV are common among federally incarcerated women. One in four women reported engaging in tattooing, one in four reported having unprotected sex, and one in five reported engaging in injection drug use.
- The provision of harm-reduction measures such as condoms, dental dams, lubricants, and bleach is inconsistent. Harm-reduction measures such as syringe exchange, safer tattooing options, and information on safer slashing/cutting are not provided, despite significant evidence of high-risk behaviours related to these practices, and the desire of women to access such measures.
- There is a high uptake of both HIV and HCV testing among incarcerated women. However, the provision of pre- and post-test counselling is poor, with 64 percent of women reporting receiving no counselling.
- There is overall dissatisfaction with the quality and accessibility of medical services. Fewer than one in ten women describe their interactions with prison health services as positive.
- Access to community-based HIV/HCV services is inconsistent.

Based upon the data collected, *Unlocking Our Futures* provides a series of recommendations for the Correctional Service of Canada, Health Canada, public health departments, community health centres, and community-based organizations. Recommendations are made in the areas of HIV and HCV prevention education; prevention and harm-reduction measures; testing and confidentiality; medical care and treatment; and support, counselling, and information. These recommendations are intended to assist in the development and implementation of a "best practice" framework, and to ensure that the diverse needs of incarcerated women living with HIV and/or HCV are met in a comprehensive and compassionate manner.

Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C is available on PASAN's website (www.pasan.org/).

– Rick Lines

Rick Lines prepared *Unlocking Our Futures* for PASAN. He can be reached at ricklines@yahoo.com.

[1] AM DiCenso, G Dias, J Gahagan. *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C.* Toronto: PASAN, 2003.

Canada: Community Stakeholders Withdraw from Consultation Processes with CSC

In November, a group of twelve community-based HIV/AIDS organizations and service providers announced their decision to withdraw from participation in consultation processes and committees of the Correctional Service of Canada (CSC).

The group took the decision because of a "lack of CSC commitment to engage in a serious process of community consultation and collaboration that could lead to substantive improvements in HIV and hepatitis C services for prisoners."

The organizations and individuals taking this action are the British Columbia Persons With AIDS Society, the Canadian Aboriginal AIDS Network, the Canadian AIDS Society, the Canadian HIV/AIDS Legal Network, the Canadian Public Health Association, the Canadian Treatment Action Council, Dr Peter Ford of Queen's University, the Hepatitis C Society of Canada, the HIV & AIDS Legal Clinic (Ontario), HIV/AIDS Regional Services (Kingston), the Ontario Aboriginal HIV/AIDS Strategy, PASAN, and 2-Spirited People of the 1st Nations.

These organizations and individuals have been involved in multiple national and regional CSC consultation processes over a number of years. However, they took the decision to withdraw because of their frustration at the lack of action by CSC to implement new, much-needed HIV and HCV services, and to improve existing programs and services based upon the groups' feedback.

In a letter sent to CSC Commissioner Lucie McClung, the group stated:

> Until we see evidence that the federal correctional system takes the issue of HIV/AIDS and hepatitis C seriously, we will no longer participate in ineffectual consultative processes. While maintaining this illusion may benefit CSC, it is of no benefit to us, to the thousands of prisoners who continue to be denied access to necessary HIV and hepatitis C prevention measures, to prisoners living with HIV/AIDS and/or hepatitis C who are often denied adequate care, or to those communities in [sic] which these prisoners return.

At the same time as it announced its withdrawal from the ineffective CSC consultation processes, the group decided to significantly step up and to better coordinate its own efforts directed at improving access to care, treatment, and support for prisoners living with HIV and/or HCV, as well as to HIV and HCV prevention measures in prisons. The group has also asked to meet with the Solicitor General and the Health Minister, to raise their concerns and offer potential solutions.

– Rick Lines

Rick Lines prepared *Unlocking Our Futures* for PASAN. He can be reached at ricklines@yahoo.com.

Alberta Court Orders Methadone Maintenance Therapy for Prisoner on Interim Basis

On 2 May 2003, Justice VO Ouellette of the Alberta Court of Queen's Bench ordered the Director of the Fort Saskatchewan Correctional Centre to provide methadone maintenance treatment (MMT) to Milton Cardinal on an interim basis.[1] Prior to his arrest and incarceration, Mr Cardinal had been receiving MMT to treat opiate addiction. Following the expiration of 30 days from his arrest and incarceration, he was placed under the blanket "mandatory withdrawal policy" enforced by Alberta correctional authorities.

As a result of his forced withdrawal from MMT, Mr Cardinal experienced profound physical and psychological suffering, including constant and prolonged physical pain (particularly in his head, joints, and extremities), nausea and vomiting, burning fever, insomnia, loss of appetite, nightmares, extreme anxiety, trembling, memory loss, blackouts, loss of consciousness, and two seizures.

Justice Ouellette held, in part, that the risk of such harm as HIV infection from intravenous drug use would cause Mr Cardinal irreparable harm pending the determination of the main application.[2] As a result, he ordered the Director of Fort Saskatchewan Correctional Centre to accept delivery of methadone as prescribed by Mr Cardinal's community doctor. He further ordered the Director to take steps to allow the doctor to conduct examinations and follow up as deemed appropriate by the doctor, and to follow the administration, dosing, and record-keeping protocol established by the doctor. Justice Ouellette's order will be in effect until the Court hears and decides upon Mr Cardinal's main application.

The main application is scheduled to be heard 23 to 25 June 2003.[3] Counsel for Mr Cardinal is Nathan Whitling of the Edmonton law firm of Parlee McLaws LLP. During the hearing of the main application, Mr Whitling intends to lead expert evidence related to the availability of MMT in correctional institutions in other Canadian jurisdictions as an HIV and HCV harm-reduction measure. Mr Cardinal will be asking the Court to prohibit the Alberta correctional authorities from interfering with his liberty to receive appropriate treatment and medication pursuant to a medically prescribed MMT program. In addition, he will ask the Court to declare that the past deprivation of his liberty to receive appropriate treatment and medication pursuant to a medically prescribed MMT program while incarcerated constituted a violation of his constitutional rights as guaranteed by sections 7, 12, and 15 of the Canadian Charter of Rights and Freedoms.[4] Finally, he will be asking the Court to reduce his sentence under section 24(1) of the Charter to time served, quash his warrant of committal, and direct his immediate release, or in the alternative, reduce his sentence by such period of time as the Court deems to be just and appropriate in the circumstances.

This is a significant, precedent-setting case. It is the first time that a Canadian court has ordered that a prisoner be provided with MMT during his or her period of incarceration. In previous cases, correctional authorities have provided access to methadone in response to prisoners' legal suits.[5] A court has ordered an offender to take MMT where it has been available in prison and as a condition of probation.[6]

The Cardinal case is a direct challenge to Alberta's longstanding, and arguably unconstitutional, policy and practice of tapering prisoners off methadone 30 days after they enter the correctional system. Given Justice Ouellette's interim order, and in light of the recent recognition by the Correctional Service of Canada that prisoners have a right to receive MMT as essential health care,[7] the government of Alberta will have a difficult time justifying its current policy and practice. Moreover, Charter guarantees of liberty, security of the person,

equality, and the prohibition against cruel and unusual punishment all support Mr Cardinal's position.

– Glenn Betteridge

Glenn Betteridge is Acting Director of Policy & Research, Canadian HIV/AIDS Legal Network. He can be reached at gbetteridge@aidslaw.ca.

[1] *Milton Cardinal* v *The Director of the Fort Saskatchewan Correctional Centre and The Director of the Edmonton Remand Centre* (Action No 021531397P1) (Alta QB). Copies of the originating Notice of Motion, interim Notice of Motion, and interim order on file with the author.

[2] Personal correspondence with Nathan Whitling, counsel for Mr Cardinal.

[3] Ibid.

[4] Part I of the *Constitution Act, 1982,* Schedule B to the *Canada Act 1982* (UK), 1982, c 11 (Charter).

[5] C McLeod. Is there a right to methadone maintenance treatment in prison? *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(4): 22-23; R Jürgens. HIV/AIDS in prisons: more new developments. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 15-17.

[6] *R* v *Povilaitis*, Québec Superior Court, Criminal Division, 1996, 450-01-004040-965, unreported. See a discussion of the case in B Turcotte. Judge orders methadone maintenance treatment in prison. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 3(1): 16-18.

[7] R Jürgens, supra, note 5.

Russia: New Criminal Process Code Promises a More Tolerant Incarceration Policy

The population of Russian prisons is one of the largest in the world: as of 1 April 2002, there were 1,220,368 people living in prisons in the country.[1] Some data suggest that 15 to 20 percent of all people living with HIV/AIDS in Russia are in prisons and detention facilities.[2]

Due to repressive drug policies and a quite liberal interpretation of pre-trial detention laws, a large number of drug users often find themselves in already overcrowded prisons, where TB, HIV, drug use, and violence are rampant. A suspect could spend years in pre-trial detention centres before ever appearing in court.

A new Criminal Process Code was adopted in December 2001 and entered into force on 1 July 2002. Opinions about the Code are quite divided, but many lawyers and human rights activists agree that it represents a major improvement in defendants' rights, as well as a dramatic shift from an inquisitorial to an adversarial process. Sanctioning of arrests has been given to courts, and pre-trial detention should be used only as an "extreme measure."[3] At the same time, Russian courts are already overburdened and it is unclear how they will be able to cope with their new responsibilities of sanctioning arrests and issuing detention orders in a timely manner. Some experts also observe that there is increased interest in alternatives to imprisonment.[4] At the same time, the new Code was criticized by law-enforcement authorities. Some representatives of the Ministry of Interior Affairs claimed that it was "totally copied from Western legislation and not applicable to Russian standards," and that its implementation would reduce the quality of criminal investigation, especially in matters related to illegal drug trafficking and other crimes related to drugs.[5]

Human rights activists also criticized certain aspects of the Code, as it allows the investigative authorities to detain any person for 120 hours without a court warrant. Moreover, under the new procedure, the investigator is authorized to block lawyers' access to their clients before the first questioning takes place. The first questioning should he held within 24 hours of detention.

In addition to these criticisms, it is by no means clear that the new Code will be implemented. Russia has been known for its inability to adhere to the rule of law. If it is indeed implemented, the new Code does give hope that there will be fewer incarcerations and unlawful detentions, which would also mean that fewer people will be at risk of TB, HIV, violence, and drug use, which are all rampant in the Russian prison system.

– Anna Alexandrova

Anna Alexandrova can be reached at AnnaAlexandrova@aol.com.

[1] Factsheet, *AIDS Foundation East-West*, online in English at www.afew.org/.

[2] Gazeta. Interview with the Head Sanitary Doctor of the Russian Federation, 11 November 2001. Online in Russian at www.gzt.ru/.

[3] Criminal Process Code of the Russian Federation (18 December 2001), Law No 174-FZ, article 108.

[4] For example, the Centre for Justice Assistance carried out several workshops on the matter, introducing alternatives to imprisonment in accordance with UN recommendations.

[5] The Prosecutor's Office of St Petersburg is afraid that the new Criminal Process Code will result in lower-quality criminal investigation of drug-related crimes. Prokurorsky Nadzor, 18 February 2003, online in Russian at www.nadzor.vvsu.ru/ (accessed 18 February 2003).

Review of Prison-Based Needle Exchange Programs Published

A recent review of prison-based syringe-exchange (PSE) programs concludes that such programs "are feasible and do provide benefit in the reduction of risk behaviour and the transmission of blood-borne infection without any unintended negative consequences."[1]

The review identified journal publications and conference presentations on PSE programs by means of a comprehensive search of electronic databases. Experts involved with the development and evaluation of current PSE programs or policy were contacted for reports, documents, and unpublished material.

The main findings of the review are that all evaluations of PSE programs have been favourable; reports of drug use decreased or remained stable over time; reports of syringe sharing declined dramatically; and no new cases of HIV, hepatitis B, or hepatitis C transmission were reported. The evaluations found no reports of serious unintended negative events, such as initiation of injection or the use of needles as weapons. Staff attitudes were generally positive.

Experts interviewed for the review reported that, in addition to existing programs in prisons in Switzerland, Germany, Spain, Moldova, and Kyrgyzstan, PSE programs are at the planning stage in Italy, Portugal, and Greece.[2]

– Ralf Jürgens

[1] Dolan et al, supra, "Canada: CBC "Releases" CSC Report on Infectious Diseases Prevention and Control," note 8 at 153.

[2] Ibid at 157.

South African Prisoner Wins Payout after Prison HIV Infection

An ex-prisoner who sued South Africa's prison authorities after contracting HIV has obtained a landmark payout – the first time the South African government has been held accountable for the spread of HIV in overpopulated prisons, Reuters reported on 12 February 2003.[1]

AIDS activists cautioned that, because the out-of-court deal was confidential, it would not necessarily set a legal precedent that could open the door to more such lawsuits.

South Africa has the world's highest number of people with HIV. One in five South Africans, more than 4.5 million, are believed to be living with HIV, and the epidemic is believed to be spreading even faster in the prison system.

In his 1.1 million rand (US$132,500) lawsuit, the former inmate said he contracted HIV from a fellow inmate while in prison from 1993 to 1994, when prison authorities did not warn inmates about the dangers of unprotected sex or supply condoms.

"A material portion of prisoners were HIV-positive at the time. It is inevitable that prisoners who engaged in sex would have been infected with the HIV virus," the plaintiff said in court papers, adding that officials were aware of sex between prisoners.

He said he would not have had sex and, subsequently, contracted the

virus had he known of the risk.

Under the terms of the deal, the Department of Correctional Services denied any liability but admitted prisoners were not allowed to have condoms until 1996, when policy changed.

Department spokesman Luzuko Jacobs confirmed that the government had made a financial offer to settle the case, but declined to give further details.

In an earlier draft settlement, the parties had agreed to compensation of no less than 100,000 rand (US$12,048) plus medical and legal costs, without an admission of liability.

– Ralf Jürgens

[1] Reported by Reuters (Cape Town), Wednesday, 12 February 2003. See also Former South African prison inmate awarded "landmark" court settlement after being infected with HIV in prison. *Kaiser Daily HIV/AIDS Report*, 14 February 2003; Former inmate suing South African prison over HIV infection. *Kaiser Daily HIV/AIDS Report*, 10 June 2002; E Ellis. Ex-convict infected with HIV sues prison authorities. *Cape Argus* [Cape Town], 7 June 2000 (http://allafrica.com/stories/200206070036.html).

In Brief

Alberta Bill Aimed at Cracking Down on Drug Use

Canadian Press reported on 12 March 2003 that Alberta Solicitor General Heather Forsyth introduced amendments to the Corrections Act to allow random drug testing in Alberta jails. "Routine random drug testing will help deter inmates from illegal drug use," Forsyth said. Currently, prisoners are only tested when it is suspected they have used drugs.[1]

CDC Recommendations on HCV

The US Centers for Disease Control and Prevention (CDC) issued new recommendations on "Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings" on 24 January 2003. The recommendations are available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5201a1.htm.

US: Two Million Inmates, and Counting

In an editorial of 9 April 2003, the *New York Times* reported that the population of jails and prisons in the US passed two million in 2002, for the first time in history. The editorial says:

> The United States has one of the highest incarceration rates in the world, and one that falls unevenly. An estimated 12 percent of African-American males between 20 and 34 are behind bars, more than seven times the rate for white men the same age. Our overflowing jails and prisons come at a high price, in dollars and in wasted lives.

The editorial points out that the soaring incarceration rates in the US are not tied to the violent crime rate, and that 60 percent of federal prisoners and more than 20 percent of state inmates are in custody on drug charges, in many cases low-level crimes.

At the same time, according to a report released by the National Commission on Correctional Health Care on 28 January 2003, "inadequate health care in US correctional facilities poses a serious threat to the nation's public health."[2]

US: New Prevention Strategy Released

In its new HIV/AIDS prevention strategy, unveiled on 17 April 2003, the CDC announced that it would fund "new demonstration projects using OraQuick [a rapid test for HIV] to increase access to early diagnosis and referral for treatment and prevention services in high–HIV prevalence settings, including correctional facilities."[3] Not surprisingly for the US, the strategy does not mention access to needle exchange programs in prisons, or even access to other preventive measures that have been successfully implemented in other countries. It also downplays the concerns related to rapid HIV testing in correctional settings, where there is limited counselling and support.[4]

– Ralf Jürgens

[1] J Necheff. *Canadian Press*, 12 March 2003.

[2] For more information regarding health status of prison inmates in the US, visit www.ncchc.org/.

[3] Advancing HIV prevention: new strategies for a changing epidemic – United States, 2003. *Morbidity and Mortality Weekly Report* 18 April 2003; 52(15): 329-332.

[4] For a discussion of legal and ethical issues related to rapid HIV testing, see R Elliott, R Jürgens. *Rapid HIV Screening at the Point of Care: Legal and Ethical Questions*. Montréal: Canadian HIV/AIDS Legal Network, 2000 (available at www.aidslaw.ca/Maincontent/issues/testing.htm).

HIV/AIDS IN THE COURTS – CANADA

This section presents a summary of Canadian court cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on criminal and civil cases. The coverage aims to be as complete as possible, and is based on searches of Canadian electronic legal databases and on reports in Canadian media. Readers are invited to bring cases to the attention of Ralf Jürgens, editor of this section, at ralfj@aidslaw.ca.

Marihuana Medical Access Regulations Unconstitutional Because They Do Not Provide for Legal Source or Supply of Marijuana

In a 9 January 2003 ruling in *Hitzig,*[1] the Ontario Superior Court of Justice determined that the Marihuana Medical Access Regulations[2] (MMAR) fail to provide for a legal source and safe supply of marijuana. This failure infringed the applicants' section 7 Charter rights to liberty and security of the person in a manner inconsistent with the principles of fundamental justice.[3] The MMAR could not be saved under section 1 of the Charter.[4] The Court declared the MMAR invalid, but suspended that order for six months to allow the government to decide how to create a legal source and supply of marijuana.

From *Parker* to the MMAR

The MMAR represent the government's attempt to remedy the unconstitutionality of the old system of regulating marijuana for medical use in Canada. Under that system, based on section 56 of the Controlled Drugs and Substances Act[5] (CDSA), the Minister of Health could exercise discretion to exempt a person from criminal prosecution for marijuana possession and cultivation. In *Parker*,[6] the Ontario Court of Appeal ruled that the legal prohibition on the possession of marijuana without an exception for medical use violated Mr Parker's right to liberty and security of the person. By way of remedy, the Court of Appeal struck down the CDSA section 4(1) prohibition on possession of marijuana, but suspended its ruling for one year to allow Parliament the opportunity to enact a constitutional system for the use of marijuana for medical purposes.

Under the MMAR, people suffering from a terminal illness, a specified medical condition – including

HIV/AIDS – or listed symptoms can apply for exemptions from the CDSA prohibition on marijuana possession, production, and trafficking.

> "I have great reservations about a regime which is supposed to grant legal access to marijuana while controlling its illicit use, but instead grants legal access by relying on drug dealers to supply and distribute the required medicine."
>
> – Mr Justice Lederman[7]

The Minister can issue an authorization to possess dried marijuana and a licence to produce marijuana. There are two types of licence to produce marijuana, a personal-use production licence and a designated-person production licence. Physicians are the gatekeepers in the system. Applicants must get one or two doctors or specialists each to complete a medical form, depending on the nature and severity of the medical condition and symptoms. They must fill out one or two additional forms, depending on whether or not they are also applying to produce marijuana, and provide photos. Finally, where applicants have designated another person to produce marijuana on their behalf, that person must also complete a number of forms. The MMAR also establish technical rules about the maximum legal quantity of marijuana a person can possess or grow at any one time, and strict limitations on the means and location of production.

The MMAR do not provide for a legal source of the seeds required to grow marijuana plants, or a legal source to obtain dried marijuana. The only legal way to obtain marijuana under the MMAR licence to produce is to grow it oneself, or to designate a person to do so. Buying or accepting marijuana from another person, including a compassion club, remained illegal under the CDSA.

The Applicants' Position

The 11 applicants before the Court in *Hitzig* advanced three arguments why the MMAR infringed their Charter right to liberty and security of the person (section 7). First, medical marijuana remains effectively unavailable to many people because of the barriers to access established by the MMAR. These barriers include the unwillingness of physicians to complete the required forms, the requirement that specialist physicians complete forms in certain circumstances, and the long waiting lists to consult a specialist physician, especially in non-urban areas.

Second, the MMAR do not provide people who are able to get exemptions with a legal source or supply of marijuana. People suffering from chronic medical conditions often do not have the time, resources, energy, or expertise required to successfully grow marijuana for themselves, or are unable to find another person willing to do so, given the stringent rules around growing imposed by the MMAR. Many are forced to obtain marijuana illegally, risking imprisonment, and are thus deprived of their Charter right to make medical decisions of fundamental personal importance without the threat of imprisonment (the "liberty interest") and to make autonomous decisions about their bodily integrity (the "security of the person interest").

Finally, the applicants argued that the infringements to their section 7 rights did not accord with the principles of fundamental justice because the MMAR restrictions are arbitrary, do not advance a compelling state interest, establish an illusory regime, and deny access to a legal source of marijuana.[8]

> "[I]ndividuals in Canada have a s. 7 right to use marijuana as a medicine to treat serious or life-threatening illnesses."
>
> – Mr Justice Lederman[10]

The respondents argued that the MMAR were introduced to comply with the constitutional requirement set out by the Ontario Court of Appeal in *Parker*.[9]

Section 7 Rights Breached

The Court found that the liberty interest of one applicant without an authorization to possess was infringed by the MMAR because she was required to obtain medical certification from a specialist physician that she required marijuana, but was unable to do so due to long waiting lists. The Court chose to deal with the liberty interest of applicants with authorizations to possess in its analysis of the security of the person interest. These applicants argued that the MMAR requirements around production licences denied them the ability to legally obtain marijuana for medical use.[11]

The Court found that the MMAR breached the applicants' right to security of the person in a number of ways, depending on whether or not the applicant had an authorization to possess. For applicants without an authorization:

> For those applicants with a reasonable medical need to use marijuana, the MMAR establish requirements which restrict their ability to legally access the medicine. As in Parker, these applicants still face prosecution under the CDSA because of the delay and impediments to access inherent in the MMAR. Despite their health being in danger, they must choose between legal but inadequate treatment or face imprisonment in using an effective medical treatment. To force such a choice on seriously ill people is to violate their security of the person…. These applicants are forced to make medical decisions based on criteria unrelated to their own priorities and aspirations, interfering with their bodily integrity in both a physical and emotional sense.[12]

Applicants with authorizations to possess and personal-use production licences, on the other hand, had to rely on the black market to purchase marijuana. The government argued that these people could apply for designated-person production licences, meaning that the MMAR did not restrict their ability to legally obtain marijuana. The Court rejected this argument because the CDSA prohibits the trafficking and importation of cannabis, meaning that even with the exemptions allowed under the MMAR, there is no legal way to obtain the marijuana plants or cannabis seeds required to grow marijuana – the "first seed" problem.[13] The Court remarked on the "serious problems with forcing individuals authorized to possess or grow marijuana to turn to black market drug dealers for their supply,"[14] as this exposes them to marijuana of unknown quality and is a "further risk to their personal safety."[15]

The Court found that applicants faced prosecution under the CDSA because of impediments to access inherent in the MMAR.

"Black Market" Buying Not in Accordance with Principles of Fundamental Justice

Violations of section 7 rights are permitted where they are "in accordance with the principles of fundamental justice" found in the "basic tenets of our legal system."[16] The Court decided that the MMAR application process, specialist requirement, and daily-dosage provisions were neither arbitrary nor unfair, and were in accordance with the principles of fundamental justice.[17] It recognized the tradition of involving medical specialists in decisions about medication and noted that many people had been approved under the MMAR process.[18] However, the Court decided that the MMAR infringement of the applicant's security interest, specifically the failure of the MMAR to address the supply problem, was not in accordance with the principles of fundamental justice. The government cannot rely on the "criminal underworld" to supply holders of authorizations to possess and of production licences with marijuana and seeds.[19]

For similar reasons, the Court determined that the MMAR were not "saved" by section 1 of the Charter.

The MMAR do not remedy all the constitutional violations outlined in the *Parker* case.

Federal Government Has Six Months to Remedy the Problem

The applicants had asked the Court to order the government to distribute the marijuana already grown under its contract with Prairie Plant Systems. The Court rejected this solution, and instead declared the MMAR of no force and effect but suspended that declaration for six months. By doing so, the Court granted the government time to fix the MMAR or otherwise provide for a legal source and supply of marijuana.[20]

The *Hitzig* decision presents the federal government with a serious challenge. In order to respect the constitutional right of seriously ill Canadians, it must put in place a system to provide them with marijuana for medical purposes. Yet becoming involved in the distribution of marijuana is something that the current federal Minister of Health, Health Canada, and the Office of Cannabis Medical Access appear reluctant and ill prepared to do.[21] Elements within the United States government are also exerting pressure on the Canadian government to maintain current criminal prohibitions related to marijuana.[22]

If the federal government does nothing within the six-month period,

the MMAR will no longer exist in law. This would not solve the source and supply problem, and would leave people who hold authorizations to possess and/or production licences with no legal authority to possess or grow marijuana under the MMAR. Yet, as the Court made clear, individuals in Canada have a constitutionally guaranteed right to use marijuana as a medicine to treat serious or life-threatening illnesses. In other words, a court would have no legal authority to convict any seriously ill person of possessing or growing marijuana for his or her own medical purposes under the CDSA.

The Court's decision also makes clear that the government has a constitutional obligation to put in place a system to provide seriously ill people with marijuana for medical purposes. In the absence of such a system, there is a strong argument that any so-called black-market activity related to production and trafficking of marijuana for medical purposes is constitutionally protected.

The Court's ruling in *Hitzig* is only one of the factors that the government will have to take into account in the next six months while addressing the medical marijuana issue. Three other recent developments will undoubtedly influence the government's attempts to respect the constitutional rights of and fulfill its constitutional obligations to seriously ill Canadians who use marijuana for medical purposes. First, the House of Commons Special Committee on Non-Medical Use of Drugs recommended that the Minister of Justice and the Minister of Health develop a comprehensive strategy for decriminalizing the possession and cultivation of not more than 30 grams of cannabis for personal use.[23] Second, the Ontario Court of Justice has ruled in two cases that there is no valid law prohibiting the possession of marijuana for personal use in an amount not exceeding 30 grams.[24] Third, a Québec court ordered a stay of proceedings against two compassion club volunteers charged under the CDSA with possession of and trafficking in cannabis.[25] These developments are analyzed in the following articles in this section.

Both sides in the *Hitzig* case have filed a notice of motion for leave to appeal to the Ontario Court of Appeal.

– Glenn Betteridge

Glenn Betteridge is Acting Director of Policy & Research, Canadian HIV/AIDS Legal Network. He can be reached at gbetteridge@aidslaw.ca.

---

[1] *Hitzig* v *Canada*, [2003] OJ No 12 (SCJ) (QL).

[2] SOR/2001-227.

[3] Part I of the Constitution Act, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11 (Charter). Section 7 of the Charter reads: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

[4] Section 1 of the Charter reads: The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[5] SC 1996, c 19 (CDSA).

[6] *R* v *Parker* (2000), 49 OR (3d) 481 (CA). For a more extensive analysis of *Parker* and previous developments with respect to marijuana, see R Elliott. Recent court rulings on medical and non-medical marijuana. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 9-12.

[7] *Hitzig*, supra, note 1 at para 145.

[8] Ibid at paras 64-67.

[9] Ibid at para 69.

[10] Ibid at para 120.

[11] Ibid at paras 122-127.

[12] Ibid at paras 132-134.

[13] Ibid at paras 137-145, 159.

[14] Ibid at para 141.

[15] Ibid at para 142.

[16] Ibid at para 146.

[17] Ibid at para 155.

[18] Ibid at para 156.

[19] Ibid at para 161.

[20] See ibid at paras 179-191 for the Court's reasons for the appropriate remedy.

[21] L Scanlon. Government delays release of medial marijuana supply. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 34-35. See also A Picard, C Abraham. Uneasy McLellan backs off plan to supply patients with federally grown marijuana. *Globe and Mail*, 20 August 2002; Canadian Press. Feds will supply medicinal pot: McLellan. *Toronto Star*, 26 August 2002; D Beeby. Ottawa's marijuana maven puts brakes on distribution proposal: documents. *Canadian Press*, 14 January 2003.

[22] Canadian Marijuana Reform Concern to U.S. *Globe and Mail*. 13 May 2002; E Anderssen. Would softer pot laws stir wrath of US? *Globe and Mail*, July 13, 2002; J Ibbitson. The latest weed in the Canada-U.S. garden. *Globe and Mail*, 3 March 2003, at A13.

[23] House of Commons Special Committee on Non-Medical Use of Drugs. *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy*. Ottawa: Public Works and Government Services – Publishing, December 2002, at 127-131.

[24] *R* v *JP*, [2003] OJ No 1 (OCJ) (QL); *R* v *Barnes*, [2003] OJ No 261 (OCJ) (QL).

[25] *R* v *St-Maurice*, [2002] JQ No 5670 (CQ) (QL).

Possession of Cannabis Legal for Now

In two recent rulings[1] the Ontario Court of Justice threw out charges of possession of cannabis contrary to section 4(1) of the Controlled Drugs and Substances Act (CDSA).[2] The courts found that the accused in each case had been charged with an offence not known to law. Parliament never re-enacted the CDSA section prohibiting simple possession of cannabis (marijuana) after it was struck down by the Ontario Court of Appeal in the *Parker* case.[3]

The *JP* Case

The Ontario Court of Appeal's decision in *Parker* is having a profound effect not only on legal developments about medical marijuana,[4] but also on the non-medical marijuana cases. (For a summary of *Parker* see the preceding article in this section.)

The main issue in *JP* was the effect of the Court of Appeal's ruling in *Parker*, and whether the federal government had taken the steps necessary to save or re-enact CDSA section 4(1). Subsequent to the *Parker* decision, Parliament did not amend the CDSA. The federal Liberal government, as distinguished from Parliament, enacted the Marihuana Medical Access Regulations[5] (MMAR) in an attempt to solve the constitutional violations identified in *Parker*. In the Canadian system of government, statutes must be enacted through Parliament. Regulations can be proclaimed by the Cabinet through a Governor-in-Council order. The Court was clear that the government cannot legitimately delegate the authority to Cabinet to craft solutions to an unconstitutional statute by passing regulations.[6]

The Court in *JP* noted that one year had passed since the *Parker* judgment and that Parliament had not re-enacted the section 4 prohibition on marijuana. [7] Nor had Parliament otherwise amended the CDSA. The Court emphasized that *Parker* had explicitly called on Parliament to enact a law that would provide suitable guidelines for a reasonable medical exemption system. The Court concluded that "since a statutory framework with guiding principles was not enacted within the period of the suspension of the declaration of invalidity, it follows … that the declaration [of invalidity of section 4(1) of the CDSA] is now in place."[8] The government has appealed the decision.[9]

> The government cannot pass regulations to remedy unconstitutional statutes of Parliament.

The *Barnes* Case

In *Barnes*, the accused was charged with possession of marijuana under section 4(1) of the CDSA and with operating a vehicle in a manner dangerous to the public, contrary to the Criminal Code. In reaching its decision, the Court had the benefit of the reasons in *Hitzig* and *JP*. The Court characterized the issue as "relatively simple and straightforward":[10] Section 4(1) of the CDSA no longer exists; the accused was charged with an offence not known to law; on its face the information that contained the charge was null and void; the only appropriate remedy was to quash the charge.[11]

Implications for Law Reform and Medical Marijuana Users

These cases are sure to add to the public confusion regarding the legal status of marijuana in Canada. But for people living with HIV/AIDS who use marijuana as medicine, the decisions in *JP* and *Barnes* may also result in greater personal autonomy. In the short term, at least in Ontario, courts have declared that possession of marijuana for personal use is not illegal under the Criminal Code. This may change if the Superior Court of Justice overturns the ruling in *JP*. But until it is overturned or Parliament enacts a new law prohibiting possession of marijuana, people who use medical marijuana do not require an MMAR authorization to possess to legally possess marijuana.

If a court does not overturn *JP*, the federal government will no doubt

introduce legislation to regulate and/or criminalize the possession of marijuana. The government will receive some guidance from the Supreme Court of Canada's analysis of the constitutionality of the criminal prohibitions related to non-medical use of marijuana.[12] All these cases present the federal government with an impetus to act on recent recommendations calling for the decriminalization of possession of small amounts of marijuana for personal use.

The House of Commons Special Committee on Non-Medical Use of Drugs released its report, *Policy for a New Millennium: Working Together to Redefine Canada's Drug Strategy*, in December 2002.[13] The Committee was seized with examining the issue of substance use and its impact on Canadian communities. The Committee made two recommendations regarding cannabis. First, that the possession of cannabis continue to be illegal and that trafficking in any amount of cannabis remain a crime.[14] Second, that the Minister of Justice and the Minister of Health establish a comprehensive strategy for decriminalizing the possession and cultivation of not more than 30 grams of cannabis for personal use. The strategy should include prevention and education programs and development of more effective tools to facilitate enforcement of Criminal Code driving-while-impaired prohibitions.[15] Under the second recommendation, possession of small amounts of cannabis for personal use would be treated as a regulatory offence, "with consequences not unlike those attached to minor motor vehicle infractions under provincial legislation."[16]

Many people with HIV/AIDS report problems with obtaining the medical approval(s) required under the MMAR application procedure.[17] If Parliament decriminalizes the possession and cultivation of less than 30 grams of cannabis for personal use, people living with HIV/AIDS would not have to deal with the MMAR system of exemptions. However, simple decriminalization will not solve the constitutional infringements inherent in the MMAR, as set out in the *Hitzig* decision.[18] Decriminalization will not solve the lack of a safe and affordable supply of marijuana for medical users.

Ultimately, if the government decides to distribute medical marijuana, it will certainly require that recipients have an authorization to possess or some other medical certification acceptable to the government. Whatever solution the government arrives at, it must respect the right to health (which includes access to medical treatment) of people who rely on marijuana as medicine. The government must also take care to avoid enacting legislation under which medical marijuana users receive less benefit of the law, or encounter greater obstacles as a result of the law, than recreational users.

– Glenn Betteridge

[1] *R* v *JP*, [2003] OJ No 1 (OCJ) (QL); *R* v *Barnes*, [2003] OJ No 261 (OCJ) (QL).

[2] SC 1996, c 19 (CDSA). Section 4(1) reads: "Except as authorized under the regulations, no person shall possess a substance included in Schedule I, II or III." Cannabis, its preparations, derivatives, and similar synthetic preparations, including cannabis resin and marijuana, are included in Schedule II. Under section 4(5) and Schedule VIII of the CDSA, where a person is guilty of possessing less than 30 grams of marijuana they are guilty of an offence punishable on summary conviction and liable to a fine not exceeding $1000 or to imprisonment for a term not exceeding six months, or to both.

[3] *R* v *Parker* (2000), 49 OR (3d) 481 (CA). For a more extensive analysis of *Parker* and previous developments with respect to marijuana, see R Elliott. Recent court rulings on medical and non-medical marijuana. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 9-12.

[4] On the medical marijuana front, the court in *Hitzig* v *Canada*, [2003] OJ No 12 (SCJ) (QL) relied extensively on the reasons in the *Parker* case in finding that the Marihuana Medical Access Regulations were unconstitutional. *Hitzig* is summarized in the preceding article in this section.

[5] SOR/2001-227.

[6] *JP*, supra, note 1 at para 46.

[7] Ibid at para 39.

[8] Ibid at para 46.

[9] Ibid at para 15.

[10] *Barnes*, supra, note 1 at para 26.

[11] Ibid at para 25.

[12] *David Malmo-Levine* v *Her Majesty the Queen* (Supreme Court of Canada, Docket No 28026); *Victor Eugene Caine* v *Her Majesty the Queen* (Supreme Court of Canada, Docket No 28148); *Christopher James Clay* v *Her Majesty the Queen* (Supreme Court of Canada, Docket No 28189). On 13 December 2002, the Supreme Court adjourned the hearing of these cases to the Spring 2003 session.

[13] House of Commons Special Committee on Non-Medical Use of Drugs. *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy*. Ottawa: Public Works and Government Services – Publishing, December 2002.

[14] Ibid at 131.

[15] Ibid.

[16] Ibid at 128.

[17] Based on author's personal experience working as a staff lawyer at the HIV & AIDS Legal Clinic (Ontario) from October 2000 to February 2003.

[18] Supra, note 4.

Criminal Charges against Marijuana Compassion Club Volunteers Stayed on Constitutional Grounds

A Court of Québec judge stayed trafficking charges laid in February 2000 against two Montréal men in conjunction with the operation of a medical marijuana compassion club.[1] The judge determined that it would be unjust to allow the criminal procedure to continue. Section 5 of the Controlled Drugs and Substances Act[2] (CDSA) unjustifiably infringed the accuseds' Charter rights to life, liberty, and security of the person (section 7) by prohibiting the distribution of marijuana for medical purposes when no legal source or supply existed at the time.

This is not the first case in which in which a person has avoided conviction on drug-trafficking charges related to the distribution of marijuana for medical purposes.[3] Perhaps the most significant evidence in *St-Maurice* was the Attorney General of Canada's admission that, at the time of the charges, "[i]n Canada … there was no legal source by which a person could obtain marijuana."[4] To date, the federal government has not implemented a legal source of medical marijuana for people who are permitted by law to possess marijuana for medical purposes (see the first article, on *Hitzig*, in this section). In the absence of a legal source, many people with HIV/AIDS buy marijuana, at their own expense, from compassion clubs. Despite *St-Maurice*, trafficking charges are proceeding against volunteers of at least one other Canadian compassion club.[5]

– Glenn Betteridge

[1] *R* v *St-Maurice*, [2002] JQ No 5670 (CQ) (QL).

[2] SC 1996, c 19 (CDSA). Section 5 of the CDSA prohibits trafficking in controlled substances, including cannabis, and sets out the punishment for those found guilty of trafficking.

[3] *R* v *Krieger* (11 December 2000, 9901-1016 CI, Alta QB, unreported). See also J Gold, R Elliott. Jury finds in favour of man who "trafficked" marijuana out of necessity. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 9-10.

[4] *St-Maurice*, supra, note 1 at para 172 [trans].

[5] *Hitzig* v *Canada*, [2003] OJ No 12 (SCJ) (QL), at para 89.

Inquest Jury Recommends Fundamental Change to Ontario Welfare System

In a verdict released on 19 December 2002,[1] the coroner's jury in the inquest into the death of Kimberly Ann Rogers recommended changes to the Ontario Works program.[2] Ms Rogers died under house arrest after her conviction for "welfare fraud." Because of that conviction her Ontario Works benefits, including her prescription drug benefits, had been cancelled. The jury recommendations are aimed at preventing another death in similar circumstances.

Many people with HIV/AIDS and their families in Ontario rely on Ontario Works (OW) and the Ontario Disability Support Program[3] (ODSP) for income support and health benefits, including prescription drug coverage. Under the system in place at the time of Ms Rogers's death, anyone found guilty of fraud involving OW or ODSP would have their benefits terminated for three months.[4] Anyone found guilty of fraud under current OW and ODSP laws is ineligible to receive benefits under either program for the rest of their life.[5]

On 9 August 2001, Ms Rogers was found dead in her Sudbury, Ontario, apartment. The jury ruled that the cause of death was suicide due to an overdose of the prescription drug amitriptyline. She had been under house arrest after being convicted of fraud under the Criminal Code for collecting OSAP loans while on Ontario Works. She was eight months' pregnant. Ms Rogers pleaded guilty to welfare fraud in April 2001 and was sentenced to six months' house arrest and 18 months' probation, and was ordered to pay back over $13,000 to OW. Her OW benefits were automatically suspended for a period of three months. Although Ms Rogers had her benefits temporarily reinstated as a result of a court order, her total entitlement amounted to only $468 a month.[6]

The jury made 14 recommendations. Six were directed at the Minister of Community, Family and Children's Services, who is responsible for administering OW and the ODSP. The jury recommended that the Minister eliminate the temporary and lifetime ban for welfare fraud under OW; give local OW administrators legislative discretion when using suspensions that could be life-threatening; assess the adequacy of all social assistance rates based on actual costs within a community; establish a stakeholder committee to develop a model for assessing fraud allegations that takes into account a person's life circumstances and the consequences of a fraud conviction; and maintain the prescription drug benefit for life-threatening or serious medical conditions during suspensions.

Comment

If implemented, these recommendations would have a positive impact on the lives of everyone in receipt of OW. Presumably, the Minister would make parallel amendments to OW and ODSP legislation. For many people with HIV/AIDS, OW or ODSP benefits are their sole source of income, prescription medications, and other health-related benefits. The recommendations related to suspension and lifetime ban would only have an impact on a small number of people, given the low number of welfare fraud convictions.[7] The recommendation that all social assistance rates be based on actual costs within a community would have a significant and immediate positive impact on the well-being of Ontarians receiving OW or ODSP. It would also promote the right to food, housing, and adequate income of people with disabilities, including HIV/AIDS. Recent data indicate that OW and ODSP rates in Ontario are inadequate to cover costs of living such as food and shelter.[8] Due to inflation and static benefit levels since 1995, the constant-dollar value of benefits has decreased significantly, while rents in major Ontario cities have risen from 11 to 21 percent over the past six years.[9]

Socioeconomic status, based on income, is one of the most important determinants of health.[10] Socioeconomic disparities have been shown to increase vulnerability to HIV/AIDS,[11] and low income has been associated with increased incidence of disease among people with HIV/AIDS.[12] It stands to reason that inadequate OW and ODSP benefit rates increase the detrimental impact of HIV/AIDS in Ontario. The jury recommendations provide clear direction for legislators and policy-makers to correct this threat to health and to human rights.

– Glenn Betteridge

---

[1] Verdict of the Coroner's Jury into the Death of Kimberly Ann Rogers (19 December 2002). On file with the author and available on the Income Security Advocacy Centre's website (www.incomesecurity.org/).

[2] Ontario Works Act, 1997, SO 1997 C25, Sched A; O Reg 134/98 (General).

[3] Ontario Disability Support Program Act, 1997, SO 1997 C25, Sched B; O Reg 222/98 (General).

[4] O Reg 134/98 s 36, prior to being amended by O Reg 48/00 s 1 (effective 1 April 2000).

[5] O Reg 134/98 s 36; O Reg 222/98 s 25.

[6] Background information on Ms Rogers and the Coroner's inquest into her death is available on the Income Security Advocacy Centre's website (www.incomesecurity.org/).

[7] See *Ontario Lifetime Ban Statistics*. Toronto: Income Security Advocacy Centre, 2002. From 1 April 2000 to 27 November 2002, 106 people had been convicted of welfare fraud.

[8] G Bernard. The Experience of People with Disabilities in Ottawa and the Ontario Disability Support Program (ODSP). Ottawa: Ottawa Social Planning Council, 2001, at 26; Hunger in Ontario in the Year 2000: Common, but Senseless. Ontario Association of Food Banks, 2000, at 1 to 3; Income Security Legal Clinic. Submissions to the Standing Committee on Finance and Economic Affairs, February 2002, at 2.

[9] Income Security Legal Clinic, supra, note 8 at 2. Further information about vacancy rates and rent for Canadian cities is available on the Canada Mortgage and Housing Corporation website (www.cmhc-schl.gc.ca/).

[10] See, generally, Federal, Provincial and Territorial Advisory Committee on Population Health. *Toward a Healthy Future: Second Report on the Health of Canadians*. Ottawa: Minister of Public Works and Government Services, 1999; M Spigelman Research Associates. HIV/AIDS and Health Determinants: Lessons for Coordinating Policy and Action: A Discussion Paper for the Ministerial Council on HIV/AIDS. January 2002, at 7-15.

[11] See S Zierler et al. Economic deprivation and AIDS incidence in Massachusetts. *American Journal of Public Health* 2000; 90(7): 1064-1073, and the US, Canadian, Australian, and Spanish studies cited at 1073 nn 11-14, 36-38.

[12] Spigelman, supra, note 10 at 13-14.

Taxi Passenger Accidentally Stuck by Syringe Awarded $15,000

In January 2003, a British Columbia Supreme Court judge awarded $15,000 for mental anguish to a woman who was stuck by a syringe found in the back of a taxicab.[1] In assessing damages, the Court took into account the woman's possible exposure to HIV and the reasonableness of her belief that she was at risk of seroconverting.

The judge determined, based on the civil standard of proof – ie, the balance of probabilities – that Ms Fitzgerald had been stuck in the hand by a hypodermic needle while she was a passenger in the back seat of a taxi operated by Mr Tin. The taxi was operating on Vancouver's Downtown Eastside, where injection drug use, hepatitis C (HCV) infection, and HIV infection are prevalent.[2] Presumably, a previous passenger had left the needle in the taxi. Ms Fitzgerald was stuck with the needle while reaching to take it from her infant daughter, who had found it in the taxi. Shortly after the incident, Ms Fitzgerald attended the hospital emergency department on the advice of her family doctor. She tested negative for hepatitis B and C and initiated what one assumes was post-exposure prophylaxis for HIV – 13 pills a day for 10 days. She was also provided with written information about hepatitis and HIV. Approximately seven months after the incident, Ms Fitzgerald tested negative for HIV. Her doctor assured her that she had not contracted the hepatitis A or B virus or HIV.

The Court held that the taxi company owed a duty to its customers to remove hazards that a careful and reasonable examination of its vehicles would have revealed. In finding the taxi driver and taxi company negligent, the Court determined that the driver breached a duty of care owed to Ms Fitzgerald and that she suffered damages as a result of that breach. While the taxi company did have an inspection procedure in place, it was not adequate to fulfill the duty. Nor did the driver follow that procedure.

Ms Fitzgerald testified that she was emotionally affected by the incident, as reflected in her claim for damages. She claimed that her possible exposure to HIV resulted in the breakup of her relationship, caused ongoing insomnia and a switch to night-shift work, fear that she might seroconvert as much as seven years later, and continued weight loss.

"Actual Exposure" vs "Possible Exposure"

Analyzing the damages claimed for pain and suffering, the Court considered one Canadian case and numerous American cases. In the Canadian case of *Garner*,[3] the Court awarded $5000 for loss of enjoyment of life resulting from possible HIV transmission after a needlestick injury, also in a taxi. The Court noted that *Garner* "appears to be the only Canadian decision where a court has dealt with the damages flowing from the possibility that HIV has been contracted."[4]

In contrast, the Court cited numerous American cases falling into two broad categories. In the majority of US jurisdictions, courts have adopted an "actual exposure" approach requiring the plaintiff to prove actual exposure to HIV in order to recover damages. The other approach is the more liberal "possible exposure" approach under which the mere possibility of exposure to HIV can result in a successful claim so long as the plaintiff proves her fear was reasonable. The US cases also limit the period of time plaintiffs can be compensated for. Under the "window of anxiety" or the "window of recovery" principle, recovery is limited to the period from the time of possible exposure to the point when the plaintiff knew or should have known that they were not infected. After that point any continuing distress must be deemed unreasonable as a matter of law and not compensable.[5] US jury awards have ranged from $3000 to $2 million.[6]

The Court adopted the "possible exposure" approach and the "window of anxiety/recovery" set out in the US cases, and awarded Ms Fitzgerald $15,000 on that basis.

> Until it can be shown with reasonable certainty that a plaintiff is not HIV positive, that plaintiff suffers the mental anguish of having a reasonable fear that they have become HIV positive. It was reasonable for Ms Fitzgerald to fear HIV infection after being exposed to a syringe. A syringe is clearly a medically viable channel of

> transmission of the HIV virus. The applicable standard of medical care requires that a person such as Ms Fitzgerald conduct her life as if she had been actually exposed to HIV-positive fluids until such time as blood tests reveal, to a certain statistical level of confidence, that she is not HIV positive. During that time, it is not unreasonable, speculative, or fanciful for such a person to have a real and intense fear that he or she is HIV positive. Until seven months after the incident, Ms Fitzgerald had a reasonable and genuine concern arising out of her fear of HIV infection and she should receive compensation for the resulting mental suffering.[7]

The Court explicitly rejected compensating Ms Fitzgerald for the anguish she felt after relying on the "misguided and thoughtless" view of friends that it would be six or seven years before she would know her HIV status for sure.[8] In the Court's view, such reliance and the resulting mental anguish were unreasonable, given her doctor's medical advice.[9]

Comment

Courts must have a complete and accurate understanding of the scientific and medical facts to make sound decisions in cases involving possible accidental HIV and viral hepatitis infection. It is significant that the Court relied on scientific and medical evidence about the window period for HIV transmission to limit the damages awarded to Ms Fitzgerald. The window period describes the period when a virus (HCV or HIV, for example) may be present in the body but antibodies to the virus are not present in blood and cannot be detected with confidence by current antibody tests. In most people, seroconversion to HCV and HIV occurs within six months.[10]

Courts must have a complete and accurate understanding of the scientific and medical facts to make sound decisions in cases involving possible accidental HIV and viral hepatitis infection.

However, the Court failed to adequately assess "possible exposure" and "actual exposure" in light of current scientific evidence about the risks of HIV and HCV transmission. The risk of infection from a needle stick varies according to the circumstances of the exposure.[11] The Court assumed that there was a significant risk of HIV transmission in this case. It is not clear that the Court had sufficient information to make this assessment. Ideally, the Court should have inquired whether Ms Fitzgerald's injury (ie, her mental anguish) was caused by the actual risks she faced as a result of the needle stick or by her assumptions about the risk.

– Glenn Betteridge

---

[1] *Fitzgerald* v *Tin*, [2003] BCJ No 203 (BCSC) (QL).

[2] R Elliott, I Malkin, J Gold. *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*. Montréal: Canadian HIV/AIDS Legal Network, 2002, at 2.

[3] *Garner* v *Blue & White Taxi Co-operative Ltd.*, [1995] OJ No 2636 (Ont Gen Div) (QL).

[4] *Fitzgerald*, supra, note 1 at para 45.

[5] Ibid at para 48, quoting *DeMilio* v *Shrager*, 666 A2d 627 (NJ Super Ct 1995).

[6] Ibid at para 52.

[7] Ibid at para 50.

[8] Ibid at para 52.

[9] Ibid at para 51.

[10] For a more detailed explanation of the window period, 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 16.

[11] See 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) at 19 and 23-26 (www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm).

CPP Same-Sex Survivors Class Action to Proceed on a National Basis

By agreement between the Attorney General of Canada and the lawyers for same-sex surviving partners who were denied survivor's benefits under the Canada Pension Plan (CPP),[1] the cases will now be heard together in one national class action. The surviving partners have been denied survivor's benefits due to their sexual orientation. Many of the people denied benefits are people with HIV/AIDS whose partners died of HIV/AIDS-related illnesses. The case will be heard in the Ontario Superior Court of Justice.

As previously reported in this publication[2], one Ontario[3] and one British Columbia[4] class action had been commenced on behalf of the survivors and, in some cases, their estates. The plaintiffs are challenging significant negative differences between the way the CPP treats same-sex survivors as compared with opposite-sex survivors. The BC survivors had been certified as a class,[5] and the Ontario survivors were awaiting the hearing of the class certification. An agreement between lawyers for the Attorney General of Canada and the lawyers for the various groups of survivors will mean that the common issues affecting the survivors throughout Canada can be decided in one action in the Ontario Superior Court of Justice.

The agreement was formalized in an order of the Superior Court dated 6 December 2002. Under the terms of the order, the class covers same-sex common-law partners of a CPP contributor throughout Canada who died on or after 17 April 1985 and before 1 January 1998 who have not received a CPP survivor's pension as a result of the death. As a condition of the order, the *Brogaard* action will be stayed and the BC class decertified. Members of that class who do not wish to be bound by the Court's decision may opt out on or before 16 May 2003. The case is scheduled to be heard in September 2003.[6]

– Glenn Betteridge

[1] RSC 1985, c C-8 (CPP).

[2] R Carey. Discrimination in same-sex survivor amendments to the Canada Pension Plan. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 70-71.

[3] *Hislop* v *Canada (Attorney General)* (Ont SCJ File No 01-CV-221056 CP)

[4] *Brogaard* v *Canada* (Attorney General) (BCSC Vancouver Registry No L013317)

[5] Brogaard *v* Canada *(Attorney General)*, [2002] BCJ No 1775 (SC) (QL).

[6] Personal communication with R Douglas Elliott of Toronto's McGowan Elliott & Kim LLP, Barristers & Solicitors, who have been appointed counsel for the plaintiffs in the national class action.

Criminal Law and HIV Transmission/Exposure: Two New Cases

In a regular column, we review new developments in the area of criminal prosecutions for HIV transmissions or exposure. Since the last issue of the *Review*, two new Canadian cases have come to our attention. A Swedish case is reported in HIV/AIDS in the Courts – International.

Guilty Plea to Nuisance Charge Nets 18-Month Suspended Sentence

A 28-year-old woman with HIV and hepatitis C (HCV) had unprotected sex with a man who had molested her since the age of 13. She admitted her HIV and HCV status to the man after having sexual intercourse in the summer of 2002. Originally charged with aggravated sexual assault, the woman pleaded guilty to the lesser offence of

common nuisance. She was sentenced to an 18-month suspended sentence and ordered to abstain from sex unless she first reveals her illness. The sentencing decision has not been reported.[1]

Sixteen Years for Lying and Infecting Two Women

In a highly publicized Québec case, a man had unprotected sex with at least seven women over an approximately 10-year period. He lied about his HIV status when asked. Two women became HIV-positive at the age of 16 as a result. The man pleaded guilty to aggravated assault charges and received a 16-year sentence. The sentencing decision has not been reported.[2]

– Glenn Betteridge

---

[1] Woman with AIDS had unprotected sex. *Calgary Herald*. 21 December 2002, at A13.

[2] G Kalogerakis. Reckless Casanova sentenced. *Montreal Gazette*. 21 January 2003, at A1.

HIV/AIDS IN THE COURTS – INTERNATIONAL

This section presents a summary of important international cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on civil and criminal cases. Coverage is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the *Review*. Coverage of US cases is very selective, as 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 this section, at ralfj@aidslaw.ca.

South Africa: Constitutional Court Rejects Constitutional Challenge to Law Criminalizing Prostitution

On 9 October 2002, a majority of South Africa's Constitutional Court dismissed appeals from convictions for prostitution and keeping a brothel, rejecting arguments that the law was unconstitutional.[1] However, the minority decision, endorsed by five of eleven judges, found that the provision that made the sex worker but not the client guilty of a criminal offence was discriminatory and should be struck down.

The appeal was brought by a brothel owner, a brothel employee, and a sex worker convicted under South Africa's Sexual Offences Act ("the Act"). The Act makes "keeping a brothel" and "living on earnings of prostitution or committing or assisting in the commission of indecent acts" criminal offences but does not make it an offence to pay for sex.

A number of *amici curiae* participated in the proceedings, all arguing that the Act should be found unconstitutional. These included the Sex Worker Education and Advocacy Taskforce, the Centre for Applied Legal Studies, the Reproductive Health Research Unit, and the Commission for Gender Equality, along with several brothel owners.

The constitutional challenge was based on rights of equality, dignity, freedom and security of the person, privacy, and the right to freely engage in economic activity. All the judges agreed that the challenge on the grounds of dignity, privacy, freedom and security of the person, and economic activity failed. The disagreement between the majority and minority decisions was whether or

not the section of the Act that made receiving, but not paying, money for sex illegal infringed the equality rights guaranteed by the constitution.

The majority of the Court found the Act does not discriminate either directly, on the basis of gender, or indirectly, because it punishes the sex worker and not the client. The Act penalizes "any person" who engages in sex for reward, which clearly applies to male as well as female sex workers, and although the Act does not penalize the customers, they are guilty of criminal acts both under common law and statute, the Riotous Assemblies Act making the customers liable to the same penalties as the sex workers.

The minority judgment found that, because sex workers are overwhelmingly female and their customers overwhelmingly male, the section of the Act that made the conduct of the prostitute – but not that of the customer – criminal, discriminated unfairly on the basis of sex or gender. The minority stated:

> The differential impact between prostitute and client is … directly linked to a pattern of gender disadvantage which our constitution is committed to eradicating.

However, the constitutional invalidity could be cured as well by making both the sex worker and the customer equally subject to criminal prosecution under the Act as by decriminalizing the conduct of the sex workers.

The purpose of the Act is to suppress commercial sex. Counsel for the state advanced a number of reasons for doing this, including that prostitution: is degrading to women; is conducive to the violent abuse of prostitutes; is connected with other crimes such as rape, assault, and drug abuse; is associated with international trafficking in women; leads to child prostitution; results in "frequent and persistent" public nuisance; and carries an intensified risk of the spread of sexually transmitted diseases, especially HIV/AIDS.

The appellants and *amici curiae* argued that these problems could be more effectively dealt with by the decriminalization and regulation of the sex trade and that, in fact, criminalizing the sex trade made many of these problems worse. The Court would not deal with this controversy. All the judges agreed that how to deal with the sex trade, whether by criminal sanctions or by regulation, was a legislative matter as long as the constitution is respected: "Legislatures in open and democratic societies may legitimately and reasonably disagree as to the most appropriate legal response in their own society."

– John Nelson

John Nelson is a lawyer and freelance writer. He can be reached at john.nelson@utoronto.ca.

[1] *S v Jordan*, [2002] SAJ No 87.

European Court of Human Rights Agrees to Hear Challenge to Long-Term "Preventive Detention" of HIV-Positive Man

On 10 December 2002, the European Court of Human Rights agreed to hear the case of a Swedish man who has been subject to a continuing series of mandatory isolation orders since 1995.[1]

On 16 February 1995, the County Administrative Court issued an order under section 38 of Sweden's 1988 Infectious Diseases Act ("the Act") for the mandatory isolation of Eie Enhorn. A series of six-month extensions was obtained under section 41 of the Act, maintaining the isolation order for six years at the time of his hearing before the European Court of Human Rights. In 1999, Enhorn appealed one such extension order to the Administrative Court of Appeal, but the appeal was denied. The Supreme Administrative Court refused leave to appeal from the decision of the Administrative Court of Appeal.

Enhorn then brought his case to the European Court of Human Rights. He contends that his continued detention under the mandatory isolation order is a violation of Article 5 of the European Convention on Human Rights

and Fundamental Freedoms ("the Convention"). Article 5 protects the right of liberty and security of the person and states, in part, that "[n]o one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law…."

The Swedish government maintains that the isolation order and detention are justified under the following exceptions specified in Article 5(1):

(b) the lawful arrest or detention of a person for non-compliance with a lawful order of a court or in order to secure the fulfillment of any obligation prescribed by law;

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases….

Enhorn contends the order itself is not lawful because section 38 of the Act is too vague and his compulsory isolation has continued for such a long time that it is disproportionate to the aim of the legislation. The criteria in section 38 for making a mandatory isolation order include cases where "there is *reasonable cause* to suppose that the infected person is not complying with the practical instructions issued and this omission entails a *manifest risk* of the infection being spread" (emphasis added). Enhorn maintains that notions of reasonable cause and manifest risk are not precise or foreseeable and are not defined in the legislation.

The Court concluded that Enhorn's complaint "raises serious issues of fact and law under the Convention," is "not manifestly ill founded," and no other ground for declaring it inadmissible has been established. The application is therefore admissible and will proceed to a full hearing on the merits.

– John Nelson

John Nelson is a lawyer and freelance writer. He can be reached at john.nelson@utoronto.ca.

[1] *Enhorn* v *Sweden*., European Court of Human Rights, Application no. 56529/00. The text of this decision can be viewed online (http://hudoc.echr.coe.int/Hudoc2doc2/HEDEC/200301/56529_00_da_chb4_enhorn.doc).

United Kingdom: HIV-Positive Asylum Seeker Denied Judicial Review of Removal Decision

The High Court of Justice had dismissed an application for a judicial review of a decision by immigration officials not to grant the applicant leave to remain in the UK on the basis of her HIV status. In December 2002, the Court of Appeal denied the applicant permission to appeal the High Court's decision, reasoning that an appeal under section 65 of the Immigration and Asylum Act, already initiated, would be more appropriate and advantageous.

Amina Kiwanuka, a Ugandan citizen, arrived in the UK in 1994 and unsuccessfully applied for asylum. Denied leave to appeal to the Special Adjudicator, she unsuccessfully applied to the Immigration Appeal Tribunal for leave to appeal. In February 1996, she was diagnosed HIV-positive. In April 1999, she applied for "exceptional leave" to remain in the UK on the basis of her HIV status. An immigration officer turned her application down, citing evidence showing the availability of treatment in Uganda.

She then appealed under section 65 of the Immigration and Asylum Act. Her appeal invoked Article 3 of the European Convention on Human Rights and Fundamental Freedoms, which states that "no one shall be subjected to … inhuman or degrading treatment or punishment," and the UK Human Rights Act 1998, which makes the Convention directly

applicable in UK law.

Simultaneously, Kiwanuka applied to the High Court of Justice for judicial review, arguing that the Chief Immigration Officer incorrectly applied the wrong policy of the asylum directorate.[1] The policies at issue provided immigration officers with guidelines in determining removal orders against persons needing medical attention. A 1995 policy required the officers to consider "the availability of treatment for AIDS in the appellant's own country."[2] A policy adopted in March 1998 "contra-indicated" removal where "[t]here is credible medical evidence that return would result in substantial damage to the physical or psychological health of the applicant or dependants."[3] In addition, a third policy, adopted in May 1998, prohibited removal unless "the medical evidence available is sufficient to satisfy the Department that the person is not fit to travel and/or their life expectancy would be substantially shortened if they were removed or deported."[4]

The High Court dismissed Kiwanuka's application for judicial review, saying her appeal under section 65 of the Immigration and Asylum Act was an alternative, more appropriate remedy. She sought permission to appeal this decision to the Court of Appeal.

In December 2002, the Court of Appeal issued its ruling denying her permission to appeal.[5] The Court considered whether judicially reviewing the application of the 1995 and 1998 policies was more appropriate than the remedy of a section 65 appeal in ruling on Kiwanuka's underlying claim for "exceptional leave" to remain in the UK on the basis of her HIV status. The Court held that judicially reviewing the application of these policies would not afford any particular advantage to Kiwanuka in the consideration of her claim. Furthermore, it stated that a policy could not be interpreted precisely by a court; "it is indicative rather than determinative of outcome." If the 1995 policy were applied, there would be a sound argument regarding the term "availability" of treatment, given the high cost of AIDS drugs in Uganda and their likely unaffordability for most people. However, the Court confirmed that the lower court had already addressed the issue of availability with specific reference to the applicant's particular situation.

The Court further noted that whether these policies were applied together or separately, judicially review of their application would encounter much the same hurdles as would arise under her section 65 appeal. Given the applicant's latest medical condition, proceeding with the alternative remedy (section 65 appeal) would provide her more advantages than relying on judicial review of the 1995 and 1998 policies. The adjudicator in the section 65 appeal would not be bound by in-house policies, as was the Immigration Officer, but would also consider the European Convention on Human Rights and Fundamental Freedoms, the Human Rights Act 1998, and relevant jurisprudence. The adjudicator would also consider all relevant issues, including the short- and long-term medical condition of the applicant.

The Court therefore refused Kiwanuka permission to proceed with having the application of these policies judicially reviewed, leaving her to pursue her section 65 appeal on human rights grounds.

– Kibrom Teklehaimanot

Kibrom Teklehaimanot is a lawyer and Fellow, Reproductive and Sexual Health Law, Faculty of Law, University of Toronto. He can be reached at kibrom99@yahoo.com.

---

[1] *Kiwanuka* v *Immigration Officer*, [2002] EWJ No 4249, [2002] EWHC 2013 (Admin), CO/881/00.

[2] Ibid at para 6.

[3] Ibid.

[4] Ibid at para 7.

[5] *Kiwanuka* v *Immigration Officer*, [2002] EWJ No 6082, [2002] EWCA Civ 1958, C1/2002/2180.

United Kingdom: Denying Children's Milk Allowance to HIV-Positive Mother Seeking Asylum Is Discriminatory

In July 2002, the High Court of Justice found that, in denying the milk allowance, the Home Office had failed to realize the real risk that the mother might breastfeed her daughter and that the daughter might be infected with HIV. The Court also ruled that the Home Office's action was discriminatory under Article 14 of the European Convention on Human Rights and Fundamental Freedoms.

The claimant, "T," an Ethiopian citizen, arrived in the UK in July 1999 and sought asylum. With her case pending on appeal, T was diagnosed HIV-positive in December 2001. She gave birth to a daughter, "S," who was not infected. To prevent the transmission of HIV from T to her daughter, health personnel advised T to avoid breastfeeding and to feed her daughter with powdered milk instead.

According to the Social Security Act 1988, T was entitled to income support. However, in April 2000 a new Act came into force and T became subject to a new allowance scheme, the National Asylum Support Service (NASS). Given the high price of milk, the amount of money she received under the NASS did not cover her weekly expenses. Parents in similar economic conditions received two benefits to which T was not entitled because of her immigration status. While the first benefit, family premium, related to a child less than 16 years of age, the second benefit provides a child under the age of one year with a certain quantity of dried or liquid milk.

T challenged the allowance scheme, bringing her proceeding against two government departments, the Department of Health and the Department of the Home Office. She invoked Articles 2 and 8 of the European Convention on Human Rights and Fundamental Freedoms, which provide for respect for the right to life and to family life, respectively. T also invoked the right to equality protected by Article 14, arguing that excluding a child from the benefit because of her parent's immigration status was discriminatory. In July 2002, the High Court of Justice ruled in her favour.[1]

T's counsel requested that the Department of Health amend the welfare scheme so that children of asylum-seeking parents would be entitled to free milk tokens. However, the Court found this Department was not the government body responsible for supporting asylum seekers; its role was limited to providing medication. T's counsel also claimed the Home Office should increase her asylum allowance, considering the "exceptional" situation she was in; without milk tokens, T would breastfeed S out of desperation. The Court ruled T's situation might not be "exceptional" if she were entitled to as much allowance as other asylum-seeking parents, no matter how insufficient to cover living expenses that allowance might be. However, the Court concluded T's situation was "exceptional" given the consequences that S might suffer if she was infected with HIV and the expenses for HIV drugs. The Court found the Home Office had failed to realize the "real" risk that T might breastfeed her daughter and the "real" risk S might thereby be infected with HIV.

Finally, the Court addressed the issues related to the human rights provisions of the Convention. Article 8 sets out respect for family life, among other things. The Court held that, although providing adequate nutrition might lead to good health and avoids absence from the family for medical treatment, the connection between providing milk and the fundamental objective of Article 8 was remote. The claim did not fall within the scope of the Article. Further, Article 2 requires states to take appropriate measures to obviate threats to life. The Court ruled the main purpose of milk tokens was to promote health rather than to avert the real threat of death, despite the risk of HIV transmission through breastfeeding. The link between provision of milk and risk of death was too remote.

However, the Court held the Home Office had infringed Article 14, which requires equality before the law. It ruled that the grounds for non-discrimination enumerated under Article 14 are not exhaustive, given that the article refers to grounds for discrimination "such as" those expressly listed. The fact that S was not entitled to milk tokens because of her mother's immigration status amounted to discrimination.

– Kibrom Teklehaimanot

Kibrom Teklehaimanot is a lawyer and Fellow, Reproductive and Sexual Health Law, Faculty of Law, University of Toronto. He can be reached at kibrom99@yahoo.com.

[1] *T* v *Secretary of State for Health*, [2002] EWJ No 4089, [2002] EWHC 1887 (Admin), CO/2042/2002.

United Kingdom: HIV Status, Psychiatric Problems of Asylum Seeker Did Not Stop Removal

In November 2002, the High Court of Justice rejected an application for judicial review of a decision to remove an Ivoirian asylum seeker to France, despite her HIV status, tuberculosis, psychiatric condition, and attempted suicides. The Court argued that removal to France would not necessarily result in a return to Ivory Coast or in poorer health care.

Tenin Soumahoro, a citizen of Ivory Coast, arrived in the United Kingdom in April 2000 and sought asylum. In addition to being diagnosed HIV-positive, she had tuberculosis and psychiatric problems. Her application for asylum was denied and an order was issued for her removal from the UK to France, as authorities there had issued her a business visit visa.[1] Soumahoro applied for judicial review of the Secretary of State's decision, arguing that the removal amounted to inhuman and degrading treatment in violation of Article 3 of the European Convention on Human Rights and Fundamental Freedoms.

In November 2002, the High Court of Justice rejected her application, saying:

> There is … no suggestion that removal of the Claimant to France would involve return to the Ivory Coast, contrary to the Refugee Convention or the European Convention on Human Rights, in as much as France would necessarily take that step. Nor, equally, is there any suggestion that treatment for her positive HIV status, or indeed full blown AIDS, her tuberculosis, or her psychiatric problems, would not, in itself, be equally good in France as here. The case before the Adjudicator and the Immigration Appeal Tribunal turned on whether the risk of the Claimant killing herself and the risk of exacerbation of her psychiatric condition, if sent to France, was real and not speculative, and whether any increase in that risk would occur as a result of being sent there so as to make the removal of her to France in itself inhuman or degrading treatment, contrary to Article 3 of the European Convention on Human Rights.[2]

Based on expert reports, Soumahoro's counsel argued that she would be deprived of the network she had built up and the care and support she enjoyed in the UK. The Court accepted evidence showing that "the claimant has had a longstanding mental disorder, stemming from her time in the Ivory Coast, caused by a dysfunctional upbringing and traumatic events in her life. She has an irrational fixated idea that removal to France will mean removal to the Ivory Coast, when it is clear, on an objective basis, that France will take full account of her Convention rights in any decision they may make on her application for asylum."[3] The evidence also indicated that she had previously made at least one, and possibly two, suicide attempts.

The Court ruled the act of removal to France in itself did not amount to inhuman or degrading treatment. To fall within the scope of Article 3 of

the Convention, the "suffering and humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment."[4]

The Court found that the psychiatric evidence "by no means established … a high risk of suicide." Soumahoro's previous suicide attempts by overdose were questioned by the Court because "she took steps to avoid the effects of overdosing." The increased risk of suicide was "comparatively short-term," given the short time required to effect her removal.

The Court therefore concluded that her expulsion could not be considered "inhuman treatment." The UK government was to take "the necessary steps" to safeguard her from the time the Court's decision was published "until handover to the French authorities, who must be fully appraised of the position so that any risk is indeed minimised to the maximum possible extent."[5]

– Kibrom Teklehaimanot

Kibrom Teklehaimanot is a lawyer and Fellow, Reproductive and Sexual Health Law, Faculty of Law, University of Toronto. He can be reached at kibrom99@yahoo.com.

[1] *Soumahoro* v *Secretary of State for the Home Department* [2002] EWJ No 5521, [2002] EWHC 2651 (Admin), CO/2496/2000.

[2] Ibid at para 3.

[3] Ibid at para 27.

[4] Ibid at para 24, citing: *Kudla* v *Poland*, European Court of Human Rights, Application No 30210/96 (para 92).

[5] Ibid at para 32.

India: Supreme Court Resiles from Earlier Statements Denying Right to Marry

In 1998, the Supreme Court of India had heard a case in which the plaintiff sued a hospital for testing him for HIV without his consent and breaching his confidentiality by informing others, leading to his ostracism, loss of his intended marriage, etc. Although the issue was not before it in that case, the Supreme Court made numerous statements to the effect that a person with HIV was prohibited by law from marrying.[1] The Lawyers Collective HIV/AIDS Unit filed a petition to have the judgment set aside. The Court treated it as an application for clarification of its earlier decision.

In ruling on the application on 10 December 2002, the Supreme Court accepted that there had been no need for it, in its 1998 decision, to make these declarations on the question of marriage by people with HIV; it held that its observations were "unnecessary" and "uncalled for."[2] According to the Lawyers Collective, in effect this restores the right of a person with HIV to marry. The duty on those who know their HIV-positive status to obtain informed consent from their spouse before marriage remains.

– Richard Elliott

Richard Elliott is Director, Policy & Research, Canadian HIV/AIDS Legal Network (on leave of absence until 1 September 2003). He can be reached at relliott@aidslaw.ca.

[1] *Mr X* v *Hospital Z*, (1998) 8 SCC 296, AIR 1998 SCW 3662. The two judgments can be found on the website of the Lawyers Collective HIV/AIDS Unit via www.lawyerscollective.org, as can an article critiquing the 1998 judgment (under "Publications – Miscellaneous").

[2] *Mr X* v *Hospital Z*, 2002 SCCL.COM 701.

Venezuela: Tribunal Affirms Rights of HIV-Positive Football Player

In December 2002, an HIV-positive football player brought an *amparo* action, a proceeding challenging breaches by his employer of his constitutional rights. He alleged the employer had tested him for HIV without his consent, had communicated his positive test results to co-workers and others in the professional sports field, had imposed restrictions on him as a player, and then terminated his contract. The player's claim was based on human rights provisions in international law and the Venezuelan constitution, and also invoked the International Guidelines on HIV/AIDS and Human Rights.

On 6 February 2003, the tribunal ordered his reinstatement with full employment entitlements and bene-

fits. Establishing an important precedent, it also ruled void the "agreement" he had signed, under employer pressure, waiving his rights. The tribunal also prohibited the employer from any conduct interfering with the player's "physical, mental or moral integrity" based on his HIV status.

– Edgar Carrasco

Edgar Carrasco is a lawyer with ACCSI, a non-governmental organization based in Caracas, fighting for the human rights of people with HIV/AIDS. He can be reached at ecarrasco@internet.ve.

US: Supreme Court Refuses to Hear Case of Fired HIV-Positive Dental Hygienist

On 28 May 2002, the US Supreme Court declined to hear an appeal by Spencer Waddell, an HIV-positive dental hygienist fired after his employer learned of his status.[1] Waddell lost his claim under the Americans with Disabilities Act (ADA) before the trial court; in December 2001 the appellate court upheld this ruling.[2] The case was seen as an opportunity to clarify the rights of people with disabilities under the ADA, which provides that an employer is allowed not to hire or retain a person who poses a direct threat to others' health and safety. Numerous health professionals' organizations had intervened in support of Waddell, as had the Equal Employment Opportunity Commission, arguing the "vanishingly small" risk of HIV transmission to Waddell's patients did not justify his dismissal. The Supreme Court's refusal to hear the case leaves the appellate court's decision standing.

– Richard Elliott

Richard Elliott is Director, Policy & Research, Canadian HIV/AIDS Legal Network (on leave of absence until 1 September 2003). He can be reached at relliott@aidslaw.ca.

[1] *Waddell* v *Valley Forge Dental Association, Inc.*, Order 01-1423, US Supreme Court, 28 May 2002.

[2] See summary at: R Elliott. US: appeals court dismisses employment discrimination suit by HIV-positive dental hygienist. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 70-71.

Australia: Court Reduces Prison Sentence of Person with HIV

In August 2002, the Court of Appeal of the state of Victoria, Australia, reduced the non-parole portion of a man's prison sentence from two years to 18 months because imprisonment would be a greater burden on someone with HIV than on a healthy person.[1]

In July 2001, Thinh Van Ta was convicted of fraud and sentenced to three years and six months' imprisonment, with a non-parole period of two years. He was not aware that he had contracted HIV. Subsequent to his sentencing he was diagnosed as HIV-positive. He appealed the sentence, arguing that having HIV "makes imprisonment more burdensome upon the applicant than was envisioned at the time of sentence."

Medical reports indicated that Ta's treatment was inhibited due to the

lack of direct access to diagnostic facilities and his circumstances had resulted in sub-optimal clinical response to antiretroviral medications. As a result, it is more difficult for Ta to gain maximum benefit from his treatment than for someone not incarcerated. The reports also revealed that Ta was shunned by other prisoners and subjected to abuse. He was at risk of developing a depressive illness and, being in prison, had no satisfactory access to support programs available to those with HIV in the general community.

Ta relied on an earlier case, which stated that "[g]enerally speaking ill health will be a factor tending to mitigate punishment only when it appears that imprisonment will be a greater burden on the offender by reason of his state of health or where there is a serious risk of imprisonment having a gravely adverse effect on the offender's health."[2]

The Court granted Ta's appeal and reduced the non-parole period of his sentence from two years to 18 months. However, the judges expressed concern that the medical evidence did not come directly from prison authorities. They stated that in future there should be evidence from the correctional health service regarding the appellant's treatment and up-to-date evidence as to what facilities were available for treatment of the particular illness in question.

– John Nelson

John Nelson is a lawyer and freelance writer. He can be reached at john.nelson@utoronto.ca.

[1] *R* v *Ta*, [2002] VSCA 142.

[2] *R* v *Eliasen* (1991), 53 A Crim R 391.

Malaysia: Damages Awarded after Mother Infected through Transfusion during Pregnancy

On 9 November 2002, the High Court in Malaysia awarded a sum of approximately US$130,000 to an eight-year-old boy who was born HIV-positive as a result of his mother having received a transfusion of HIV-tainted blood while pregnant. Mohd Hanis's mother died five years after the transfusion. The child and his father sued the hospital director and the government for negligence in supplying blood not certified as free of HIV. The defendants admitted liability.[1]

– Richard Elliott

Richard Elliott is Director, Policy & Research, Canadian HIV/AIDS Legal Network (on leave of absence until 1 September 2003). He can be reached at relliott@aidslaw.ca.

[1] R Idrus. RM500,000 for HIV boy. *New Straits Times*, 9 November 2002.

Criminal Law and HIV Transmission/Exposure: Another Swedish Case[1]

In a regular column, we review new developments in the area of criminal prosecutions for HIV transmission or exposure. Two Canadian cases are reported in HIV/AIDS in the Courts – Canada.

On 4 January 2003, a Swedish woman with HIV was sentenced to one year in jail and a fine of 120,000 kroner (about US$13,800) after being found guilty of having unprotected sex with three men without disclosing her status. None of the men contracted HIV. Protesting the decision, members of Act Up–Paris threw red dye and paint-filled condoms at the Swedish embassy, issuing a statement that "AIDS is a disease, not a weapon."[2]

– Richard Elliott

Richard Elliott is Director, Policy & Research, Canadian HIV/AIDS Legal Network (on leave of absence until 1 September 2003). He can be reached at relliott@aidslaw.ca.

[1] A previous case was reported at: Criminal law and HIV transmission/exposure: a Swedish case. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 79.

[2] R Wockner. Prison for unsafe sex. *Wockner Wire International News* #456, 20 January 2003; AIDS group paints Swedish embassy red to protest woman's sex conviction. *Agence France Presse*, 15 January 2003.