

CANADIAN

HIV/AIDS POLICY & LAW

R E V I E W

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Human Rights in Vancouver: Do Injection Drug Users Have a Friend in City Hall?

In April 2003, the Vancouver Police Department (VPD) initiated a crackdown in the city's Downtown Eastside, an area frequented by drug users and the site of one of the developed world's worst AIDS epidemics. Human Rights Watch (HRW) visited the city and issued a report documenting first-hand accounts of unnecessary use of force by police officers and other human rights abuses. In this article, HRW staffers Joanne Csete and Jonathan Cohen describe how the initial euphoria that greeted the election of Vancouver Mayor Larry Campbell has worn off; how a crackdown that was supposed to be aimed at drug traffickers had the effect of driving drug users away from health and harm-reduction services; and how both the VPD and the city tried to discredit the HRW report. Finally, the authors discuss how concerns about the VPD have led to official complaints being filed, and they question whether police forces should be allowed to investigate themselves.

Human Rights Watch (HRW) was proud to join with the Canadian HIV/AIDS Legal

Network in September 2002 to honour the work of the Vancouver Area Network of

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Recent Developments in Privacy Legislation

In this article, Ruth Carey takes a critical look at recent privacy-of-personal-information legislation drafted in three Canadian provinces – Ontario, Alberta, and British Columbia. The article begins with a historical overview of international legal instruments and other privacy guidelines, and the Canadian experience with privacy protection. It then critically analyzes the provincial initiatives in the context of the federal Personal Information Protection and Electronic Documents Act and accepted privacy principles. The article goes on to highlight certain types of legislative provisions of particular interest to people with HIV/AIDS and those who advocate on their behalf. It concludes that the numerous legislative initiatives underway in Canada provide an opportunity to alter the public discourse around the virus, thereby improving the lives of people with HIV/AIDS.

Introduction

We believe that health information is among the most sensitive personal information which exists. Within that class of information, one's HIV positive status is arguably the most sensitive piece of information of all. During the

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CANADIAN HIV/AIDS POLICY & LAW REVIEW

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Canadian HIV/AIDS Legal Network

The Network is a charitable organization engaged in education, 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, write to info@aidslaw.ca or visit our website at www.aidslaw.ca/AbouttheNetwork/membership.htm.

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.

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FROM THE EDITOR

About This Issue

Several articles in this issue of the *Review* remind us once again that the law and the courts can be used both to improve the response to HIV/AIDS and to hinder that response. In her feature article, *Recent Developments in Privacy Legislation*, Ruth Carey describes legislative initiatives in Canada designed to protect the privacy of personal health information. She concludes that these initiatives have the potential to improve the lives of people living with HIV/AIDS, and that they also provide opportunities for people and organizations to engage with the legislative process and alter the public discourse on the epidemic. On the other hand, in their feature article, *Human Rights in Vancouver: Do Injection Drug Users Have a Friend in City Hall?*, Joanne Csete and Jonathon Cohen discuss how a police crackdown aimed at drug traffickers in Vancouver's Downtown Eastside has had the effect of driving drug users away from health and harm-reduction services.

The decision by the federal government to table a bill decriminalizing possession of small amounts of marijuana (see *Canadian News*) is a welcome step toward treating drug use as a health issue rather than a criminal issue. Unfortunately, that same bill toughened penalties for growing large amounts of marijuana, thus reinforcing the government's overall prohibitionist approach to illicit drug use.

In *HIV/AIDS in the Courts — Canada*, we report that a federal court has set aside an order that prohibited an HIV-positive refugee claimant from working in childcare, primary and secondary school teaching, health services, and agriculture. However, we also report on another federal court decision that upheld a ruling of the Immigration and Refugee Board stating that the fear of inadequate medical treatment in one's country of origin (in this case, the country was Cameroon) does not constitute a well-

founded fear of persecution for the purposes of assessing a refugee claim. (That case was filed when the old Immigration Act was in effect. The new Immigration and Refugee Protection Act, which came into force in June 2002, clearly states that a person will not be granted refugee protection if the risk faced by that person in returning to his or her country of origin is caused solely by an inability to provide adequate medical care.)

In *HIV/AIDS in the Courts — International*, we report on a similar case in the United States, where a court ruled that evidence of a person receiving substandard medical treatment in his or her country of origin (in this case, the Dominican Republic) did not constitute evidence of torture. The court upheld a tribunal decision deporting an HIV-positive Dominican national. However, in the same section we also learn about a decision of a court in Wales reducing the sentence of an offender because he is HIV-positive.

Other articles in this issue reveal how the courts can be used to redress grievances and to highlight issues that governments and other bodies need to deal with. In *Canadian News*, we report on a decision by a judge in Manitoba to refuse an application to transfer a 16-year-old offender to adult court based, in part, on the high rates of HIV and hepatitis C infection in the federal institution in that province. We also report on a lawsuit filed by an Ontario woman against three physicians who she says failed to offer her HIV testing during her pregnancy. Both the woman and her child have since tested HIV-positive. In *Global Access to Treatment*, we report on a woman in Nigeria who says that she was denied treatment solely because she is HIV-positive, and who has filed a lawsuit seeking damages as well as an injunction to prevent further discrimination against people living with HIV/AIDS who seek treatment.

One article in this issue highlights the fact that the courts are sometimes required to grapple with difficult ethical issues. In *HIV/AIDS in the Courts — International*, we report on an Australian court that found two physicians negligent for failing to take steps to make a recently married woman aware that she was at risk as a result of her husband's HIV infection. The couple had attended the physicians together for HIV testing but had received their test results separately.

Also in this issue, in *Canadian News*, in what is a very small and very slow step in the right direction, we report on the decision of the federal government to approve an application from the Vancouver Coastal Health Authority (VCHA) to operate two pilot supervised injection sites (SISs) in Vancouver. Since Health Canada announced in October 2002 that it was prepared to grant the ministerial exemptions necessary to allow SISs to operate, it has taken nine months for the guidelines to be issued and for the VCHA application to be submitted and approved. As of July 2003, operational funding for one of the sites (the one to be located in the Downtown Eastside) had not yet been secured. Furthermore, concerns have been raised about how much of an impact the Downtown Eastside site will have, given that there are several thousand injec-

tion drug users in the area and that the site will have only 12 seats for injecting. Meanwhile, community groups, dissatisfied with the lack of urgency with which governments are responding to a very serious health crisis in the Downtown Eastside, have begun operating unsanctioned sites.

Please note that, exceptionally, there is no prisons section in this issue. This section will return in the next issue.

Remembering Glen Hillson

We note with sadness the passing away on 12 June 2003 of Glen Hillson, longtime AIDS activist and, at the time of his death, a correspondent for the *Canadian News* section of the *Review*. Glen was one of the first people diagnosed with HIV in the early 1980s. He died of complications due to AIDS and co-infection with hepatitis C. For the past four years, Glen had been Chair of the British Columbia Persons with AIDS Society.

Human Rights in Vancouver: Do Injection Drug Users Have a Friend in City Hall?

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Drug Users (VANDU) with our AIDS and Human Rights Action Award. VANDU's work has justly garnered praise from many parts of the world as a model for organization and services based on respect for the rights of injection drug users. VANDU brings needle exchange and other life-saving services to the most marginalized users in the city's Downtown Eastside, the lowest-income neighbourhood in Canada and home to one of the developed world's worst AIDS epidemics.

Vancouver's municipal election campaign in the fall of 2002 drew international attention. It featured the election of a council dominated by the Coalition of Progressive Electors (COPE), led by mayoral candidate Larry Campbell, a rare group of politicians willing to hang their political futures on support for harm reduction. When COPE was swept into office in November 2002, we — like many others around the world — saw the election of Campbell and his colleagues as a moment of great promise. Finally, perhaps, drug users could look forward to enhanced services for humane treatment of their addiction, a place to inject safely, and strong support for needle exchange programs.

Campbell is a former narcotics police officer who promised a safe injection site as one of his first priorities and who spoke often about drug addiction as a medical problem in a city whose anti-drug strategies had been dominated by heavy-handed policing. If I thought tripling the police force would solve this problem,

I would do it, Campbell told the *Wall Street Journal* on 1 April 2003. But that's not the case. We're dealing with addiction and disease, and prison doesn't solve either of those problems. It seemed that injection drug users might have a true ally in City Hall.

Police Crackdown

It was not long before hope turned into disillusionment. On 7 April, six days after Campbell's remarks above and a few months into his term as mayor, the police presence was tripled in the Downtown Eastside, ostensibly to clear the neighbourhood of drug traffickers. Vancouver City Council had rejected the request of the Vancouver Police Department (VPD) for funds to support hiring additional officers to execute this crackdown, but it didn't matter. The VPD reallocated police from other parts of the city to the Downtown Eastside, increasing the number of police officers present on the streets of the ten-square-block neighbourhood from 20 to 60. It looked as though the promise of an anti-drug strategy that would be led by harm reduction, treatment, and prevention rather than by shoring up the police, was shattered.

HRW visited the Downtown Eastside for four days toward the end of the first week of the crackdown. We wanted to see what the initiative would mean for drug users and their ability to access services, including HIV prevention services. The crackdown had been preceded by three weeks of intensive issuing of arrest

The promise of an anti-drug strategy that would be led by harm reduction, treatment, and prevention appeared to be shattered.

warrants and actual arrests which, in some cases, imposed conditions of release that included not carrying syringes or drugs. In the short period of our visit, we heard numerous first-hand testimonies from drug users that were consistent with the concerns experts had raised about the way in which the war on drugs was being fought in Vancouver. A number of drug users recounted cases of unnecessary use of force, especially being punched or otherwise roughed up when they were already in handcuffs. Others said that they had been searched in ways that violated the search and seizure protections in the Canadian Charter of Rights and Freedoms as well as international human rights standards. According to witnesses, the police had also issued numerous citations for municipal by-law offences such as jaywalking, which seemed in many cases designed to legitimize searching and harassing drug users.

Equally worrying was the testimony of health-service providers and needle exchangers that the crackdown, which had the stated objective of targeting drug dealers and traffickers, was having the unintended effect

of driving drug users away from health and harm-reduction services. Street nurses told us that the police presence had been scattering their clients and making it difficult to find them in order to deliver services. Several nurses said that the impact of the crackdown on drug users might have been lessened had Vancouver's

The impact of the crackdown on drug users might have been lessened had Vancouver's long-awaited safe injection site been up and running.

long-awaited safe injection site been up and running, so that injection drug users displaced from their usual shooting locations on or near the streets would have had a safe place to go.

Reaction to the Report

On 7 May, we released our findings in a 26-page report.² The city's reaction to the report was to attempt to discredit the HRW, both in early press statements after its release and in an open letter from the mayor. Police officials told the press that the HRW had fabricated testimony and that, in any case, all the first-hand testimony that our report cited was hearsay.³ This was obviously an attempt to reduce the first-hand testimonies in the report to the level of rumour. It is the kind of response that government authorities around the world often make to our work when most of the testimony reported is from drug users, sex trade workers or other stigmatized groups.

In response to our concerns about the health impact of the police crackdown, both the city and the Vancouver Coastal Health Authority³ asserted that the crackdown had left health services in the Downtown Eastside undisturbed — indeed, that services may have benefited from the action. Police officials said that many injection drug users had thanked them personally for making the streets safer. The health authorities claimed that the numbers of needles exchanged in Vancouver had risen overall during the period of the crackdown, allowing that this was at least partly a function of the season, as more needles are exchanged during the warmer months. This claim is at odds with data comparisons done by researchers at the British Columbia Centre for Excellence in HIV/AIDS, which show a drop in needle exchange volumes between 2002 and 2003 during the March-to-May period.

Even if the overall needle numbers remained high, the Health Authority would be wrong not to focus on the services targeting the most vulnerable users. As documented in our report, the mobile nighttime needle exchange service of VANDU, which combs the sidewalks, alleys, and parking lots of the Downtown Eastside, saw a precipitous drop in its syringe numbers as of 7 April. Health officials characterized the VANDU experience as an outlier,⁴ noting that of the data they reviewed, only the VANDU data showed a significant decline in needles exchanged in the first weeks of the crackdown. The outlier characterization, which is an unscientific attempt to downplay the VANDU data, is only too true in the sense that the city perhaps did not intend: that the most marginalized users — those reached by the VANDU service — are themselves outliers, forced regularly

to the edges of safety. The VANDU numbers deserve serious attention, which the city and the Health Authority seem not to want to give them, because VANDU's services target people who are most likely to experience the worst health consequences when they are chased into unsafe shooting locations.

When we visited the nighttime mobile exchange of VANDU again in June, the numbers of syringes had risen somewhat — again perhaps partly as a function of the season — but the proportion of needles given out as cleaners (syringes given even though no used syringe was returned), as opposed to needles given out in exchange of used syringes, was high compared to the period before the crackdown. The VANDU workers attributed this to the fact that some users were afraid to carry syringes for fear that police would stop them and perhaps charge them for syringe possession. A high proportion of cleaners as a matter of public health concern. It indicates that many needles may be retained for re-use or sharing, or may be disposed of in an unsafe manner. This is one more reason why any evaluation of the health impact of the crackdown should take a close look at the impact on the population served by VANDU's volunteers.

Vancouver Activists Respond

On 7 April, shortly before we released our report, local activists in Vancouver opened up an illegal safe injection site to give drug users a safe place to inject during the crackdown. A registered nurse and staff person at the illegal site told the media that they could not sit by and watch more people dying when those deaths are preventable.⁵ Incredibly, the mayor

attempted in his rebuttal to our report to take some credit for allowing the site to operate. The fact that the site has not been shut down is not consis-

The findings of Human Rights Watch were not the first sign that something is amiss in the Vancouver Police Department.

tent with the tide of police oppression suggested by the HRW. The mayor said. An article in a US newspaper described the illegal site as "condoned by the new mayor" and "just one sign that Canada's drug policies are moving in a direction that diverges sharply from those in the United States" — making no mention of who opened the site or why.

The mayor and the police have asserted repeatedly that the HRW's recommendation for truly independent investigation of complaints against the police is redundant because independent investigation already exists. Oversight of the police in Vancouver is conferred to a provincial Police Complaints Commissioner. This position is indeed independent, but the usual procedure for handling complaints brought by the public against the police is to turn the investigation over to the police department against which the complaint is made. The current provincial Commissioner, Dirk Ryneveld, is someone with exceptional qualifications for the job, known not only for outstanding service as a prosecutor in British Columbia but for his four-year service to the International Criminal Tribunal for the Former Yugoslavia in The Hague.

But for a police department with the track record of Vancouver's force, the usual procedure for handling complaints should be questioned. The HRW's findings were not the first sign that something is amiss in the VPD. The full story has yet to be told of the police's handling or lack of handling of the case of 60 Vancouver women — many of them from the Downtown Eastside and some of them sex trade workers — who were reported missing over the last few years. The remains of many of these women were eventually found on a pig farm outside Vancouver. The police department has been widely criticized for neglecting the reports of the missing women made by family members and others. The Royal Canadian Mounted Police eventually had to step in to handle the case. As well, six VPD officers were recently prosecuted for physical abuse of three suspected drug dealers in the city's Stanley Park in January 2003. Furthermore, in October 2002, the Pivot Legal Society, a Vancouver-based organization, told the stories of 50 persons, many of them on the Downtown Eastside, who swore affidavits about their experiences of police misconduct.⁶

Formal Complaints Filed

On 9 June 2003, Pivot formally filed with the Police Complaints Commissioner a dossier of 50 sworn complaints, complete with names, dates, and badge numbers, against the VPD. Pivot is calling for a public inquiry rather than a referral of the complaints to VPD investigators. Pivot notes both that the volume of complaints exceeds the capacity of the department's inspectors, and that VPD officials have been publicly scornful of such complaints in the past and thus lack the objectivity to conduct

this investigation. The handling of this case, which should be followed by everyone in Canada interested in justice for injection drug users and persons vulnerable to HIV, will be revealing as to the city and the province's seriousness about protecting the rights of Vancouver's most vulnerable residents.

Our own experience reporting on Vancouver's recent police crackdown gives credence to Pivot's assertion that the VPD lacks the objectivity to investigate allegations of police misconduct. In a letter to a local newspaper, for example, the police inspector in charge of the current crackdown described the first-hand testimony in our report as "bizarre and ideological." He went on to say that "people who are arrested are not always happy about it and often tell a story at odds with the truth." These statements hardly inspire confidence that complaints of misconduct sent to the VPD will be given a fair hearing.

The attacks by the VPD and City Hall on our credibility were matched only by the volumes of hate mail we received from residents of Vancouver who support the police crackdown. People accused us of telling "brazen lies" and of "being interested more in being deceitful than in telling the real story." They referred to the drug users quoted in our report as "a disgraceful waste of human life," "wretches," and "a drain on the economics of ... today's society." Needless to say, we took these letters as further evidence of the stigma and discrimination faced by drug users every day, not least because Canada's drug laws define them as criminals.

The city of Vancouver was one of three cities being considered by the International Olympic Committee to host the 2010 Winter Olympic Games, and was selected as host city in July

2003. Over the years, the HRW has followed the pressures on various prospective Olympic host cities to clean up the streets. On order to win an Olympic bid, Beijing being the most recent example. One can only speculate about the degree to which being a candidate city has fed into Vancouver's decision to triple the police presence in the city's poorest and least attractive neighbourhood. The timing of the crackdown makes such speculation inevitable.

The mayor has said that the kind of investigation the HRW did in Vancouver might be appropriate for Afghanistan or Kosovo but not for Canada, where a free press and a functioning judiciary ensure that human rights abuses are rooted out. The HRW does more investigations

in the United States than any other country, and the United States also boasts of a free press and a functioning judiciary. The mayor's claim is one that we hear frequently when we work in democratic countries. In the end, the Vancouver story, including the city's reaction to our report and its insistence that the police force can investigate itself, shows that politics can get in the way of the best functioning of democratic institutions — as though anyone needed proof of that assertion.

— Joanne Csete and Jonathan Cohen

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¹ J Baglole. Vancouver drug facilities draw ire of U.S. officials. *Wall Street Journal*, 1 April 2003.

² Human Rights Watch. Abusing the user: Police misconduct, harm reduction and HIV/AIDS in Vancouver. *Human Rights Watch Report 2003*; 15(2B). Available online at www.hrw.org/reports/2003/canada/.

³ Health services in British Columbia are implemented through five regional health authorities. The Vancouver Coastal Health Authority is the regional authority that includes the city of Vancouver.

⁴ Pivot Newswire. Safer injecting site opens in the Downtown Eastside in response to "Project Torpedo." 28 April 2003.

⁵ C Krauss. Canada parts with U.S. on drug policies. *New York Times*, 18 May 2003.

⁶ Pivot Legal Society. To Serve and Protect. November 2002. Available at http://pivotlegal.org/beta/aff/pivot_toserveandprotect.pdf.

⁷ Police say they've reduced drug scene dangers. Letter from Inspector Doug LePard, Vancouver Police Department, published in the *Vancouver Sun*, 12 May 2003.

Recent Developments in Privacy Legislation

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course of our work, we have discovered that it is the norm, rather than the exception, that bad things happen to individuals living with HIV when their HIV status is disclosed without their consent.¹

Most Canadian jurisdictions, and much of the rest of the world, are currently experiencing a period of great change with respect to privacy legislation. There are legislative initiatives currently before a number of provincial legislatures, and privacy laws have recently been passed by the federal government and in the United States, Europe, and Australia.

The ability to control knowledge of one's HIV status is a crucial right to be gained for people living with HIV/AIDS. The Ontario Advisory Committee on HIV/AIDS (OACHA) has stated that

there is often stigma associated with having any disease, particularly a life-threatening, communicable disease. Since HIV infection is often associated with particular sexual and drug-related activities, stigmatisation of PHAs is common. Disclosure can expose PHAs directly or indirectly to discrimination or rejection by family, friends and community.²

The law is an instrument of social policy and, as such, can have a positive (or negative) impact on the way societies treat minorities. In many ways, the stigmatization of people living with HIV/AIDS can be said to be a social construct. New laws are one way to change that social construct for the better. So, for people living with HIV/AIDS, the current flurry of legislative activity is impor-

tant. It is an opportunity to influence the discourse, and to improve respect for the autonomy and dignity of people living with HIV/AIDS. Conversely, new privacy legislation is a

The ability to control knowledge of one's HIV status is a crucial right to be gained for people living with HIV/AIDS.

potential threat to people living with HIV/AIDS. Legislatures may erode the few privacy rights people have by failing to use precise language, or by making deliberate policy choices that favour perceived scientific and other societal interests in disclosure over the individual's interest in privacy.

Historical Background

Historically, the vanguard of privacy protection has been within the arena of international law.³

Article 12 of the Declaration of Human Rights, adopted and proclaimed by the United Nations on 10 December 1948, states:

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.⁴

Article 17 of the International Covenant on Civil and Political Rights, adopted by the United Nations in December 1966, contains the same language.⁵ In 1988, the Office of the High Commissioner for Human Rights issued the following guideline for states that had adopted the International Covenant on Civil and Political Rights:

As all persons live in society, the protection of privacy is necessarily relative. However, the competent public authorities should only be able to call for such information relating to an individual's private life the knowledge of which is essential in the interests of society as understood under the Covenant.⁶

The first laws passed to protect information privacy were in European countries in the early 1970s.⁷

Sweden passed a Data Protection Act in 1973, with other European countries following suit (the German Federal Republic in 1977; and Norway, Denmark, and France in 1978).

The OECD Guidelines

As a result of this patchwork of European information privacy laws, the Organisation for Economic Cooperation and Development (OECD) became concerned that the protection of information privacy might impede trade or economic development. The OECD is an international organization of 30 member states (including Canada) with a commitment to a market economy and pluralistic democracy. Its goal is to promote economic development within a democratic framework. As a result of its concern about trade restrictions, in 1980 the OECD adopted *Guidelines on the Protection of Privacy and Transborder Flows of Personal Data*.⁸ The OECD

Guidelines were endorsed by all member states of the OECD (Canada endorsed them in 1984).

The OECD Guidelines are not about protecting privacy. Rather, they are designed to guide states that choose to draft information privacy laws so that any new law is drafted in a way that ensures there is no undue interference with flows of personal data between Member countries. Nevertheless, the OECD Guidelines contain a series of fair information principles that have been incorporated into most of the new legislation in this area. One such principle is that if one has to collect personal information, the data collected should be limited to the information necessary to meet the purpose of collection. So, if you are a person living with HIV/AIDS and you arrive at an emergency room with a broken leg and choose to disclose your HIV status, you should not be asked how you became infected with the virus. That information is not necessary for the purposes of treating you and therefore should not be collected.

Another fair-information principle in the OECD Guidelines is that when information is collected from you, you should be told what that information is going to be used for, and the data should not then be used for any other purpose. It is worth noting that Canadian hospital practices regularly and systemically infringe this principle when using health information for public policy and research purposes.¹⁰

Other principles in the OECD Guidelines include the following:

- ¥ that consent to disclosure or use of personal information is necessary unless it is otherwise authorized by law;

- ¥ that personal data should be protected by adequate security measures;

- ¥ that individuals should be able to access their own personal information and challenge its accuracy;

- ¥ that there should be a general policy of openness about policies and practices with respect to personal information; and

- ¥ that there should be someone you can contact who is accountable for ensuring that the principles are followed.

Despite the fact that these principles have existed for over 20 years, and that Canada adopted them in 1984, Canada has only recently incorporated these principles in legislation.

The Canadian experience

Historically, in jurisdictions other than Quebec,¹¹ the Canadian experience with information privacy has been twofold. First, the common law has not adequately protected privacy rights — there is no generally accepted tort of breach of privacy¹² — and attempts to create by statute a tort of breach of privacy have not been very successful.¹³ Second, information privacy legislation has generally been limited to information held by government. For example, the federal government passed the Privacy Act in 1983, but it only regulates the collection, retention, and disposal of personal information by federal government institutions and departments.¹⁴ Similar legislation (often combined in a single statute with provisions concerning access to government information) exists across Canada.¹⁵ Not only has the traditional legislative response in Canada been confined to government-held information, but the

statutes themselves have provided little in the way of privacy protection. For example, in Ontario, if a police officer discloses your HIV-positive status to your neighbour, you can file a complaint with the Office of the Information and Privacy Commissioner. But the Commission has no authority under its governing statute to provide you with a remedy against the police force. It can recommend a remedy, but it has few (if any) tools to force compliance. Similar structural flaws exist in most of the legislative schemes in the country.

In the past, it was very difficult for people living with HIV/AIDS to obtain any effective legal remedy when their personal information was disclosed to others without their consent.

As a result, in the past it was very difficult for people living with HIV/AIDS to obtain any effective legal remedy when their personal information was disclosed to others without their consent. This is now changing, in large part because of the European Union Directive 95/46/EC on the Protection of Individuals with Regard to the Processing of Personal Data and on the Free Movement of Such Data.¹⁶ The Directive was introduced in 1995 and became effective in October 1998. The EU Directive requires that the laws of member states prohibit the transfer of information from European countries to any trading partner unless the partner

has adequate information privacy protections in place. As a result, Canada found itself in the position of being forced to adopt information protection measures or risk an interruption in its trade with Europe.

This pressure eventually led the federal government to pass the Personal Information Protection and Electronic Documents Act (PIPEDA).¹⁷ Similar pressure on other non-European trading partners has resulted in legislative initiatives around the world, including in Australia, Argentina, New Zealand, and the United States.

Personal Information Protection and Electronic Documents Act

PIPEDA is designed to regulate the collection, use, and disclosure of personal information in the private or commercial sector. PIPEDA comes into effect in stages. As of 1 January 2002, the law applied to personal information in the federally regulated private sector, such as airlines, banking, broadcasting, interprovincial transportation, and telecommunications. It now also applies to transfers of information across provincial borders where the transfer is made for commercial purposes. Although PIPEDA is federal legislation, it is designed to apply to provincial businesses and commercial enterprises as of 1 January 2004. Pursuant to sections 26 and 30 of PIPEDA, any province that has substantially similar legislation to PIPEDA is exempted from the provisions of the Act. To date, only Quebec has been acknowledged as having substantially similar legislation by George Radwanski, who was the federal Privacy Commissioner until June 2003.

PIPEDA is extremely important legislation in the context of promoting the right of people living with

HIV/AIDS to control disclosure of their HIV status. Charnetski et al describe PIPEDA as follows:

It is sweeping legislation of broad application, which purports to regulate all collection, use and disclosure of personal information by private enterprise in the course of commercial activities, irrespective of whether such information has been obtained through or is related to on-line transactions or e-commerce. It also provides an operational standard to which affected organizations may be held in contexts outside of the Act, such as private civil actions including tort claims. While regulation of privacy and the collection, use and disclosure of personal information has long been part of the legislative landscape applied to the public sector, the Act represents the first time federal legislation of general application in this area will regulate private enterprise. In addition, the Act confers on individuals what, in time and through refinement by judicial consideration, may prove to be very powerful enforcement mechanisms to ensure the protection of personal information.¹⁸

PIPEDA explicitly incorporates the Canadian Standards Association's *Model Code for the Protection of Personal Information*, a set of principles for information handling practices similar to those set out by the OECD.¹⁹ These principles reflect a fundamental improvement in information practices and privacy standards that will be of great interest to people living with HIV/AIDS. Of prime importance is the central concept that the disclosure of personal information, or the use or collection of personal information, should only occur with the individual's consent, except in narrowly defined and limited circumstances.

As a result of this opportunity to opt out of the application of the feder-

The disclosure, use, or collection of personal information should only occur with the individual's consent, except in narrowly defined and limited circumstances.

al statute, the provinces and territories have adopted different strategies with respect to how to respond. The Atlantic provinces and the territories have decided not to enact provincial private-sector legislation; as a result, PIPEDA will apply to those jurisdictions as of 1 January 2004.²⁰ Ontario, British Columbia, and Alberta have all announced legislative initiatives in response to PIPEDA. These initiatives are discussed below.

New and Current Developments

Ontario

Ontario's response to the international and federal pressure to adopt fair information handling and privacy legislation has been to embark on numerous consultation processes in an attempt to draft legislation acceptable to multiple competing interests. In June 1996, the then Parliamentary Assistant to the Minister of Health, Helen Johns, released a *Legal Framework for Health Information Consultation Paper*.²¹ In the fall of 1997, the then Minister of Health, Jim Wilson, announced that the Ontario provincial government planned to introduce legislation regulating the collection, disclosure, and destruction of personal health information and records. Subsequently the government

released a draft statute for consultation. The draft act was called the Personal Health Information Protection Act, 1997.

In September 2000, the Ministry of Health and Long-Term Care started another consultation process. This one was called the Ontario Proposed Personal Health Information Privacy Legislation for the Health Sector (Health Sector Privacy Rules). At the same time as the Health Sector Privacy Rules consultation was going on, the Ontario Ministry of Consumer and Business Affairs was starting its own consultation. The September 2000 proposals envisioned an overall privacy law for the private sector, with attached schedules for different sectors of the economy. In December 2000, the provincial government introduced Bill 159 in the legislature. The bill was called the Personal Health Information Act, 2000, and was the subject of instant controversy.²² The provincial Information and Privacy Commissioner described the bill as "decidedly imperfect" and in need of "a lot of work."²³ The federal Privacy Commissioner went further in his comments to the Standing Committee on General Government in February 2001:

I regretfully find that, in its current form, it is an assault on health privacy rights, not a defence of them. The legislation appears designed, in fact, to ensure that the government of Ontario and a virtually unlimited range of other organizations and individuals could have unrestricted access to the most private health information of every Ontarian.²⁴

Bill 159 died on the order paper when the legislative session came to an end a few weeks later. In February 2002, the Ministry of Consumer and Business Services published yet another consultation paper that included yet

another draft statute, this time called the Privacy of Personal Information Act, 2002.²⁵ Well over 200 organizations submitted comments in response.²⁶ It was widely anticipated that the Ontario government would introduce a new bill in the fall of 2002. That did not and has not occurred, even though the final draft of the legislation is reported to have been completed.²⁷ As a result, Ontarians wait in limbo, uncertain whether or not PIPEDA will apply as of 1 January 2004 or whether a bill will be rushed through the legislature in the fall of 2003.

British Columbia

In 1999, the British Columbia legislature established a Special Committee on Information Privacy in the Private Sector. The Committee held public hearings in January 2000 and issued an extensive report of its findings in March 2001. In 2002, the Ministry of Management Services Corporate Privacy and Information Access Branch issued a consultation paper and announced that it planned to introduce personal information privacy legislation prior to the 1 January 2004 implementation date of PIPEDA. At that time, British Columbia expected that Alberta and Ontario would be introducing similar legislation, and publicly announced that the three provinces were working together to ensure a harmonious approach.

In April 2003, the BC government introduced Bill 38, the Personal Information Protection Act. It received second reading on 1 May 2003.²⁸ It was expected that the legislation would be rushed through the legislature and passed before the end of May 2003,²⁹ as evidenced by opposition comments made in the legislature on 1 May 2003.³⁰ But the federal Privacy Commissioner weighed in with a critical

response to Bill 38 that appears to have delayed passage. On 7 May 2003, the Commissioner wrote to BC Minister of Management Services regarding Bill 38 and posted his letter on his website in the form of a news release. The letter states that

Bill 38 has a number of grave deficiencies that would in my view, make it impossible for the Government of Canada to recognize this legislation in its current form as substantially similar to the federal [PIPEDA].³¹

The former federal Privacy Commissioner's criticisms of Bill 38 include the fact that the bill proposes to grandfather existing collections of data. In other words, if one had collected information before Bill 38 came into effect, one could continue to use and disclose that information without needing to comply with the new legislation. Professional fundraisers lobbied for this provision to ensure that they would be able to continue to use old donor lists. The Privacy Commissioner advanced the following additional criticisms:

- ¥ the bill would permit implied consent to the collection, use, and disclosure of personal information;
- ¥ the bill would allow employers to disclose employee information without consent;
- ¥ the provisions in the bill concerning the ability of employees to access their own records, or to correct them, were inadequate; and
- ¥ the language in the bill that would permit disclosures of information for investigations was too broad.

One crucial difference between PIPEDA and Bill 38 that the former federal Privacy Commissioner did not raise in his letter is the difference in remedies available under Bill 38 compared with

PIPEDA. Under PIPEDA, complainants whose complaints are upheld can, in certain circumstances, file an application in a court for monetary damages when a breach of PIPEDA is established. Complainants are entitled to compensation for humiliation they may have suffered.³² As a result, it is possible to receive a damage award from the Federal Court under PIPE-

PIPEDA explicitly recognizes that a breach of one's privacy engages the dignity interest and accepts that such breaches can be humiliating.

DA without proof of a monetary loss. In contrast, section 57 of Bill 38 specifically limits the damages remedy to damages for actual harm. It is often the case that a person living with HIV/AIDS will not be working, so a breach of privacy rights will not result in lost income, out-of-pocket expenses, or other monetary loss. PIPEDA explicitly recognizes that a breach of one's privacy engages the dignity interest and accepts that such breaches can be humiliating, and permits damage awards to compensate accordingly. Bill 38 does not do that, and therefore provides a narrower range of remedies for people living with HIV/AIDS.

BC Information and Privacy Commissioner reportedly disagrees with the conclusions reached by the former federal Privacy Commissioner and supports Bill 38. He has been quoted elsewhere stating: "I believe that this bill is an excellent made-in-British-Columbia solution that appro-

priately balances the privacy interests of individuals with the needs of all private-sector organizations." After the federal Privacy Commissioner's letter was made public, Bill 38 did not go back to the legislature for passage as had been anticipated. Instead, the legislature has risen for the summer and will not be back in session until October 2003. Bill 38, if passed as planned, is intended to come into effect on 1 January 2004.³⁴

Alberta

Alberta already has legislation in place that governs the collection, use, and disclosure of health information in the public sector.³⁵ The Health Information Act³⁶ came into force in April 2001. On 14 May 2003, Alberta introduced for first reading Bill 44, the Personal Information Protection Act, which would apply to the private sector and is Alberta's response to PIPEDA.³⁷ The Alberta legislature rose for the summer the next day.

As the former Privacy Commissioner of Canada observed, Alberta's Bill 44 is very similar to BC's Bill 38.³⁸ Predictably, then, the Commissioner publicly criticized Alberta's bill for many of the same reasons cited above.³⁹ In addition, he drew attention to the fact that under Alberta's bill people who request access to their own information may be charged a reasonable fee. In the context of a large file, a reasonable fee may in fact be quite costly. In contrast, PIPEDA says access to their own information must be given to a person at minimal or no cost. Alberta's bill also contains provisions that would allow the government to pass regulations eroding much of the privacy protection that the bill is supposed to provide. Finally, the Alberta bill would permit the government to exempt non-profit organizations or

bodies such as the College of Physicians and Surgeons from the application of the legislation.

To the knowledge of this writer, none of the other provinces or territories have initiated or are planning to introduce personal information protection legislation for the private sector prior to 1 January 2004.

As a result of the developments described above, the privacy rights of employees may vary, depending on where they live and who they work for. Employees in federally regulated industries are covered now by PIPEDA. Employees in provincially regulated industries will be covered by PIPEDA as of 1 January 2004 unless they live in provinces that have adopted substantially similar legislation: Substantially similar does not mean identical.

What People with HIV/AIDS Should Keep an Eye On

Privacy rights are central to the exercise of other fundamental rights and full social participation by people living with HIV/AIDS. The former federal Privacy Commissioner stated that

we must take the view that privacy is not just an individual right — it is a public good. It reflects decisions we have made as a people about how we will live as a society. Privacy is, as Justice La Forest of the Supreme Court of Canada has said, at the heart of liberty in a modern state. And we are, all of us, the loser if individual liberty is lost.⁴⁰

Those of us who work with HIV/AIDS-affected communities welcome additional tools that help people living with HIV/AIDS have greater control over the disclosure of their HIV status. When governments introduce and debate legislation that has the potential to deliver these tools, the draft

bills typically contain provisions that are of particular interest to people living with HIV/AIDS. Two of the more significant provisions are those that

“We must take the view that privacy is not just an individual right – it is a public good. It reflects decisions we have made as a people about how we will live as a society.”

permit disclosure without consent, and those that provide remedies for breach of the statute.

For example, BC's Bill 38 contains a clause that states that disclosure of personal information without consent is permitted where the disclosure is to a law enforcement agency to assist in an investigation, or in the making of a decision to undertake an investigation, to determine whether the offence has taken place.⁴¹ In other words, anyone who has confidential information can safely give that information to the police without consent, without a warrant or subpoena or any other judicial process. Clearly, such clauses erode the fundamental principles of confidentiality and need to be closely scrutinized.

Conclusion

People living with HIV/AIDS have a pressing and substantial interest in any legislation regulating the collection, disclosure and use of personal health information. HIV positive people are particularly vulnerable to the unauthorized release of personal health information given their significant and ongoing interaction with the health

care and related sectors which produces vast amounts of personal health information. Being HIV positive also means being particularly vulnerable to any erosion or failures of a system designed to protect the privacy of that personal health information.⁴²

This is an exciting time for privacy issues in Canada. The legislative initiatives currently underway provide an opportunity to alter the public discourse around HIV/AIDS and to slowly change what it is like to live with HIV in this country. It is my hope and belief that we should engage with the legislative process and work to make these new laws as effective as we collectively can. As the former federal Privacy Commissioner stated: Privacy will be the defining issue of this decade.⁴³

— Ruth Carey

Ruth Carey is a Barrister and Solicitor and Executive Director of the HIV & AIDS Legal Clinic (Ontario). She is a member of the Ontario Advisory Committee on HIV/AIDS and sits on the Board of Directors of the Canadian HIV/AIDS Legal Network. Ruth can be reached at careyr@lao.on.ca.

¹ HIV & AIDS Legal Clinic (Ontario). Submission to the Ministry of Consumer and Business Services on the Consultation Draft of the Privacy and Personal Information Act, 2002, 11 April 2002, at 2, available via www.halco.org.

² Ontario Advisory Committee on HIV/AIDS (OACHA). Disclosure of HIV-Positive Status to Sexual and Drug-Injecting Partners: A Resource Document, January 2003, at 8, on file with the author.

³ W. Charnetski, P. Flaherty, J. Robinson. *The Personal Information Protection and Electronic Documents Act: A Comprehensive Guide*. Aurora, ON: Canada Law Book, 2001, at 8.

⁴ The Universal Declaration on Human Rights is available at www.un.org/rights/50/decla.htm.

⁵ The International Covenant on Civil and Political Rights is available at [www.unhcr.ch/tbs/doc.nsf/\(symbol\)/CCPR+Canada+ratified+this+covenant+in+May+1976](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/CCPR+Canada+ratified+this+covenant+in+May+1976).

⁶ Office of the High Commissioner for Human Rights. CCPR General Comment 16 (8 April 1988), para 7, available at [www.unhcr.ch/tbs/doc.nsf/\(symbol\)/CCPR+General+comment+16.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/CCPR+General+comment+16.En?OpenDocument).

⁷ J. Higgins. Privacy Law: "Where did this come from?" Toronto: Ontario Bar Association, 20 November 2002, at 8. Much of this section of this article is based on John

Higgins's excellent paper:

⁸ OECD. Guidelines on the Protection of Privacy and Transborder Flows of Personal Data, 23 September 1980, available via www.oecd.org.

⁹ C.J. Bennett. Prospects for an International Standard for the Protection of Personal Information: A Report to the Standards Council of Canada, August 1997, as reported in Higgins, *supra*, note 7 at 9.

¹⁰ Abstracts from discharge records from 85 percent of all Canadian hospitals are forwarded to the Canadian Institute for Health Information (CIHI). The abstracts do not contain patient names or addresses, but they do contain coded information on one's personal health number, gender, date of birth, postal code, and limited details about one's diagnosis, care, and treatment – such as the primary reason for one's hospital stay and the length of stay. Putting aside the question whether the collection of this data is a good thing for Canadian society, patients being admitted to hospitals are not usually informed that this information about them is being forwarded to CIHI for research purposes. Research in Canada clearly indicates that while most patients are in favour of their health information being used for research purposes, the majority are of the view that some sort of consent should be sought first. Furthermore, patients do not seem to change their minds when comparing how they feel about data collection when personal identifiers are removed from their records. See, for example, D.J. Willison et al. Patients' consent preferences for research uses of information in electronic medical records: interview and survey data. *British Medical Journal* (15 February) 2003; 326:373, available at <http://bmj.com/cgi/content/full/326/7385/373>. If most patients believe consent to the collection of their health information for research purposes is important, then one can assume there is a general consensus among patients that they should be informed when their health information is forwarded to CIHI for research purposes.

¹¹ The protection of privacy under the Civil Code of Lower Canada and the Civil Code of Québec is not reviewed in this article. Québec is the only province that has legislation in force, applicable to the private as well as the public sector, on the protection of personal information, including health information. Québec is also the only province to have enacted legislation recognized by the Privacy Commissioner of Canada as substantially similar to PIPEDA. See An Act respecting the protection of personal information in the private sector, RSQ c P-39.1; An Act respecting access to documents held by public bodies and the protection of personal information, RSQ c A-2; and Privacy Commissioner of Canada. Report to Parliament Concerning Substantially Similar Provincial Legislation. Ottawa: Minister of Public Works and Government Services Canada, May 2002.

¹² As Mr Justice Adams stated in *Ontario (Attorney General) v Diefman* (1994), 117 DLR (4th) 449 (OCGD) at 688: "It would appear that invasion of privacy in Canadian common law continues to be an inceptive, if not ephemeral, legal concept, primarily operating to extend the margins of existing tort doctrine."

¹³ B. Lawson, B. Jeffrey. *Privacy and Free Enterprise: The Legal Protection of Personal Information in the Private Sector*, 2nd edition. Ottawa: Public Interest Advocacy Centre, 1997, chapter 3.

¹⁴ RSC 1985, c P-21. Interestingly enough, prior to the enactment of the federal Privacy Act, there were some statutory provisions in existence in federal law concerning the protection of privacy. These provisions, which were contained in Part IV of the Canadian Human Rights Act, RSC 1985, c H-6, grew out of Canada's commitments to implement the international human rights instruments mentioned above.

¹⁵ The most recent of these is Prince Edward Island's Freedom of Information and Protection of Privacy Act, SPEI 2002, c F-15.01, proclaimed on 1 November 2002. A comprehensive list of the legislation of each province and territory can be found on the Privacy Commissioner of Canada's website at www.privcom.gc.ca/information/comms_e.asp. The various pieces of legislation can be accessed via www.legis.ca/.

¹⁶ The European Directive is available in multiple languages via the EU's website at www.europa.eu.int.

¹⁷ SC 2000, c 5.

¹⁸ Chametski et al, *supra*, note 3 at 1.

¹⁹ The ten principles contained in the Model Code are available at www.canada.justice.gc.ca/en/news/nr/1998/attback2.html.

²⁰ B Seaton. Chaos reigns! Health privacy in Canada. *Healthcare Information Management & Communications Canada*, March 2003; 17(1): 43, available at http://hccinc.qualitygroup.com/hccinc2/pdf/Vol_XVII_No_1/Vol_XVII_No_1_9.pdf

²¹ Copy on file with the author.

²² See, eg, T Boyle. Concern about misuse of medical files grows: critics slam Tory bill giving greater access to health records. *Toronto Star*, 9 December 2000, at A20.

²³ Hansard. Standing Committee on General Government, 1st session, 37th Parliament, 7 February 2001.

²⁴ *Ibid* at 8 February 2001.

²⁵ A copy of the consultation paper is available on the Ministry's website at www.cbs.gov.on.ca/mcbs/english/56HK6V.htm.

²⁶ Ontario Ministry of Consumer and Business Services. Freedom of Information Access Request No. 057-02. 20 November 2002, on file with the author.

²⁷ See the news release of the Office of the Information and Privacy Commissioner (IPC) dated 11 June 2003, available via the IPC website at www.ipc.on.ca.

²⁸ See www.legis.gov.bc.ca for the bill and Hansard.

²⁹ BC Keith. British Columbia's new privacy law: what's new or different? *Nymity Newsletter*, available at www.nymity.com.

³⁰ See, eg, the comments of J MacPhail in Hansard, 4th Session, 37th Parliament, 1 May 2003.

³¹ The former Privacy Commissioner's news release, including the text of his letter to the Honourable Sandy Santori, is available at www.privcom.gc.ca/media/nr-c/2003/02_05_b_030508_e.asp.

³² PIPEDA, s 16.

³³ Anon. BC's Bill 38: substantially similar? *Nymity Newsletter*, available at www.nymity.com.

³⁴ See s 60 of Bill 38.

³⁵ Manitoba (The Personal Health Information Act, SM 1997, c 51) and Saskatchewan (Health Information

Protection Act, SS 1999, c H-0.021) have also passed health information legislation applicable to the public sector: Manitoba's is currently in force; Saskatchewan's is not.

³⁶ RSA 2000, c H-5.

³⁷ Bill 44 is accessible at www.assembly.ab.ca/pro/bills/ba-main.asp.

³⁸ G Radwanski. Report to Parliament Concerning Substantially Similar Provincial Legislation. June 2003, at 8. This is not surprising, given the two governments' agreement to work on draft legislation together: As both British Columbia and Alberta have indicated they were also cooperating with Ontario, it is reasonable to surmise that the expected Ontario bill will also be similar.

³⁹ The Privacy Commissioner's news release in relation to the Alberta Bill 44, including the text of his letter to the Honourable David Coutts, is available at www.privcom.gc.ca/media/nr-c/2003/02_05_b_030527_e.asp.

⁴⁰ G Radwanski. Privacy: The Defining Issue of This Decade: A Speech to the Canadian Community Newspapers Association, 30 May 2003, available at www.privcom.gc.ca/speech/2003/02_05_a_030530_e.asp.

⁴¹ Bill 38, s 18(1)(j).

⁴² HIV & AIDS Legal Clinic (Ontario). Submission of the HIV & AIDS Legal Clinic (Ontario) on Bill 159, the Personal Health Information Privacy Act, February 2001, available via www.halco.org.

⁴³ G Radwanski. Workplace Privacy Conference Lancaster House. 29 May 2003, available at www.privcom.gc.ca/speech/2003/02_05_a_030529_e.asp.

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.

Supervised Injection Sites: Health Canada Approves Vancouver Pilot Sites, but Concerns Remain

The paperwork has been processed, and Health Canada says that two pilot supervised injection sites (SISs) in Vancouver can now proceed, but operational funding for the site to be located in the Downtown Eastside has yet to be secured. Meanwhile, tired of waiting for the sanctioned SISs to open, community groups in Vancouver have begun to operate unsanctioned sites. There are also concerns that even if operational funding for the Downtown Eastside site is obtained, the pilot SIS project is too small in scope to make a major impact on public health in the area.

On 24 June 2003, Health Canada announced that it had approved an application from the Vancouver Coastal Health Authority (VCHA) to operate two pilot SISs in Vancouver, one in the Downtown Eastside and

the other in the West End. Health Canada also agreed to provide up to \$1.5 million over four years to support the evaluation component of the project. The VCHA has said that it would like to have the Downtown

Eastside site opened in the fall of 2003. However, serious questions remain about where operational funding for the Downtown Eastside site will come from.

Back in October 2002, Anne McLellan, the federal Minister of Health, indicated that Health Canada would be prepared to grant ministerial exemptions from the application of the provisions of the Controlled Drug and Substances Act in order to allow SISs to operate on a trial basis. In January 2003, Health Canada issued guidelines for the operation of pilot SISs, and indicated that these guide-

lines would be the basis for reviewing applications for potential sites.¹

Immediately following the announcement of the Health Canada guidelines, the VCHA proposed a committee structure to oversee the implementation of North America's first pilot SIS. The structure included a Provincial Steering Committee, an Operating Advisory Committee, a Scientific Advisory Committee, and a Project Work Team, the last of which would consist primarily of VCHA staff. Federal, provincial, and municipal representatives, together with the Vancouver Police Department, approved the structure. The Project Work Team then assumed the bulk of the work, including the task of devel-

The Dr. Peter Centre's supervised injection program has continued without a Health Canada exemption.

oping a comprehensive application for the Health Canada exemption.

In February 2003, prior to the submission of the VCHA application, Health Quest, a newly formed non-profit society, publicly announced that it had established a fully functional SIS at 135 East Hastings Street. The directors of Health Quest included Dean Wilson, past president of the Vancouver Area Network of Drug Users (VANDU), and representatives of the Portland Hotel Society. The 1500-square-foot space, referred to as the On-Site, was located in the heart of the Downtown Eastside's open drug scene and reportedly cost \$30,000 to build. According to Health

Quest, the renovations were paid for through anonymous donations. The site featured a reception and waiting area, and a large room with six cubicles for injecting. Soon after the site was unveiled, representatives from Health Quest informed the VCHA that they wanted the site included in the application to Health Canada.

The VCHA application, which was submitted in March 2003, included two proposed pilot sites, one of which was the Health Quest site. The other site is to be located at the Dr. Peter Centre (DPC), a community-based HIV/AIDS organization located in the West End that operates an adult day program and residence for people living with HIV/AIDS. In April 2002, the nurses at the DPC disclosed that they were already supervising injections in their day program. The DPC supervised injection program has continued without a Health Canada exemption, and is expected to expand once the DPC relocates to a new building across the street from its current site.

In May 2003, after it took over the lease at the 135 East Hastings location, the VCHA demolished the Health Quest site, stating that the site was not built according to city building codes. The VCHA also said that it had plans to expand the site to include 12 injection cubicles, a post-injection chill-out room, and space for other complementary services. Renovations at the site are ongoing.

One of the more interesting developments occurred on 7 April 2003 — the same day the Vancouver Police Department (VPD) launched its highly controversial crackdown in the Downtown Eastside.² In direct response to the VPD initiative, a group called the Coalition for Harm Reduction opened a peer-supported supervised injection site in a store-

front space at 327 Carrall Street. According to the group, this unsanctioned Downtown Eastside site offered a space where users could inject under the supervision of a volunteer registered nurse, exchange

We could not sit by and watch more people dying when we know that those deaths are preventable.

syringes, and escape police intimidation and harassment. Megan Oleson, a registered nurse and staff person at the site, said, "We had to be proactive to respond to the immediate health needs of the community. The increased police presence in the Downtown Eastside is only exacerbating the public health emergency, and we could not sit by and watch more people dying when those deaths are preventable."

The site at 327 Carrall Street, which has continued to operate from 10 pm to 2 am seven days a week, is staffed by a volunteer nurse and many local drug users, including members of VANDU. The number of people attending the site has increased greatly since it opened. Since news of the site was made public on 29 April 2003, it has gained attention in local, national, and international media. Although the police have not moved to close the site, there have been reports that they have interfered with its operation by gaining municipal approval to establish a "police zone" in the space immediately adjacent to the 327 site. Ironically, the VPD has stated that one goal of its current operation is to create an environment where an SIS pilot project can

succeed. This claim seems rather dubious in light of a recent report by Human Rights Watch that documented the adverse affects of the VPD crackdown on access to health-care services in the Downtown Eastside.³

Since there is currently no source of operational funding for the Downtown Eastside pilot SIS, the target date of fall 2003 for the opening of the site may not be realistic. The BC Ministry of Health Services has stated that the VCHA will have to pay for the site out of its existing funding, which was recently cut by the Liberal government. The VCHA and the municipal government are reportedly looking to the federal government to fund the operation of the site. However, even if adequate funding is

found, local researchers and health activists question whether the proposed site will achieve the public health, community, and fiscal benefits typically associated with SISs, given that while the Downtown Eastside has several thousand injection drug users the VCHA is preparing to operate only one 12-seat SIS for 18 hours a day. Only time will tell whether Vancouver will see its much-anticipated SIS and whether this project will help to address the severe, ongoing public health emergency in Vancouver's Downtown Eastside.

— Thomas Kerr

[Editor's Note: On 20 July 2003, after this article was written, three police

officers forced their way into the SIS at 327 Carrall Street and detained and questioned people accessing the drop-in area of the site. The officers did not have a warrant or a reasonable cause to enter the premises. While the volunteers working at the site managed to urge the police to leave, there was reportedly a substantial decline in attendance at the site following the incident.]

¹ R. Jürgens. Supervised injection sites: Minister of Health ready to review applications for pilot research projects. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 25-27.

² See "Human Rights in Vancouver: Do Injection Drug Users Have a Friend in City Hall?" in the Features section of this issue.

³ Ibid.

Health Canada Unveils Plan to Distribute Marijuana for Medical Use

Under pressure from the courts, Health Canada reluctantly comes up with a distribution plan to provide dried cannabis and seeds to patients using medical marijuana. The plan has been greeted with considerable criticism.

On 9 July 2003, the federal Minister of Health, Anne McLellan, announced that Health Canada would supply dried marijuana and seeds to individuals authorized to use marijuana for medical purposes who are unable to produce it themselves.¹ The marijuana will be obtained from the crop grown in Flin Flon, Manitoba, for Health Canada by Prairie Plant Systems.²

The distribution plan was in response to a January 2003 court ruling in the case of *Hitzig v Canada*, which found that the Marijuana Medical Access Regulations (MMAR) were unconstitutional because they failed to provide a legal source of marijuana.³ Health Canada was given six months to provide a legal means of supply for patients who could not grow their own cannabis, and a legal

source of seeds for those who could. Health Canada waited until the last possible moment to make its announcement.

The plan allows holders of MMAR exemptions to purchase marijuana seeds or dried marijuana from Health Canada. Applicants must certify that they have no recourse but to petition the government for their supply. The cannabis will be provided on a cost-recovery basis. Seeds will be sold in packets of 30 for \$20, and shipped directly to applicants. Dried marijuana, at \$5 per gram, will be shipped to the applicant's physician.

Health Canada stressed that the plan is an interim policy ... pending clarification by the courts of the Government of Canada's roles and responsibilities with respect to the provision of marijuana for medical purposes.¹ The latter was a reference to the fact that Health Canada has appealed the *Hitzig* decision. In her comments to the media, McLellan frequently referred to the lack of clinical data regarding marijuana's safety and efficacy, and added that it was never the intention of us to sell product.²

The plan quickly drew a chorus of criticism from doctors, patients, and the media. Physicians expressed displeasure about not being consulted, about the potential security risks of having marijuana supplied through their offices, about the prospect of facing pressure from their patients to provide marijuana, and about the lack of information regarding marijuana's appropriate use and dosages.³ The Canadian Medical Association raised similar concerns, citing in particular the lack of medical evidence of marijuana's safety and efficacy, and expressing displeasure at having been excluded from the policy development process.⁴

Patients said that they were disappointed with the cost and the fact that the plan is still an interim one that could be cancelled.⁵ Phillippe Lucas, director of Canadians for Safe Access, called the plan a last-minute effort that smacked of bad faith.⁶ Libby Davis, a New Democratic Party Member of Parliament, said that she found the government message very contradictory. If they win [the court appeal], they're leav-

ing us with the impression that they will drop the whole thing.⁷

Media coverage has also been largely unfavourable, focusing on the eleventh-hour nature of the plan, and the medical community's displeasure at being unwilling gatekeepers. In an editorial, the *Globe and Mail* said that the Minister and Health Canada have

dragged their feet in a number of ways over the past few years, trying to avoid this decision.... Ottawa's record on this issue is not something to be proud of. It is a cavalcade of misinformation, lame excuses, delaying tactics and outright obstinacy that goes back more than six years.... If patients who are terminally or chronically ill believe that [marijuana] eases their pain, and the courts have agreed that they should be provided with it, why has the Health Minister done everything she can to deny them that right?⁸

A few days after the plan was announced, Dr Gregory Robinson, a Toronto doctor living with HIV/AIDS, quit his position on the Stakeholder Advisory Committee on Medical Marijuana, in protest. In his letter of resignation, Dr Robinson told the Minister that he had lost faith in her ability to understand compassion for seriously and chronically ill patients.⁹ Dr Robert Goyer, professor emeritus of pharmacology at the University of Montreal, and Chair of the Advisory Committee, said that there were numerous problems with the medical marijuana program and that it needs to be re-engineered.¹⁰

Meanwhile, in a related development, an Ontario medical marijuana

user has successfully written off marijuana purchases as medical expenses for income tax purposes. An earlier attempt by a Nova Scotia user to do the same was turned down by Canada Customs and Revenue. However, the Nova Scotia user had not submitted all the necessary documentation.¹⁴

— Derek Thaczuk

¹ Government of Canada adopts interim policy on the provision of marijuana for medical purposes. Health Canada news release, 9 July 2003, available at www.hc-sc.gc.ca/english/media/releases/2003/2003_54.htm.

² Whether the Flin Flon crop was intended for research or for use by persons authorized to smoke marijuana for medical reasons, or both, has been the subject of considerable debate. See D Thaczuk, Troubled times for Canada's medical marijuana program, *Canadian HIV/AIDS Policy and Law Review* 2003; 8(1): 22-23.

³ See G Betteridge, Marijuana Medical Access Regulations unconstitutional, *Canadian HIV/AIDS Policy and Law Review* 2003; 8(1): 57-60.

⁴ *Supra*, note 1.

⁵ B Laghi, MDS will dispense marijuana, *Globe and Mail*, 10 July 2003.

⁶ Ottawa pot plan unworkable: doctors, *CBC/CA News*, 11 July 2003, available at www.cbc.ca/storyview/CBC/2003/07/10/med_pot_rxn020710. See also: B Laghi, MDs balk at dispensing marijuana, *Globe and Mail*, 11 July 2003.

⁷ CMA asks government – where is the evidence to support your interim policy on the provision of marijuana for medical purposes? Canadian Medical Association news release, 9 July 2003, available at www.newswire.ca/releases/july2003/09/c1170.html.

⁸ B Laghi, Patients seek relief on price of medical pot, *Globe and Mail*, 10 July 2003.

⁹ B Laghi, *supra*, note 5.

¹⁰ *Ibid*.

¹¹ Giving a graceless okay to medical marijuana, *Globe and Mail*, 10 July 2003.

¹² V Lawton, Frustrated Toronto MD quits medical marijuana committee, *Toronto Star*, 16 July 2003.

¹³ D Bueckert, Head of medical-pot program resigns, Canadian Press, *Globe and Mail*, 17 July 2003.

¹⁴ A Fraser, Ontario user says it's possible to claim weed on income tax, *Halifax Herald*, 17 April 2003.

Clinical Trial on Medicinal Use of Marijuana Cancelled

Despite concerns expressed about the lack of scientific data on the safety and efficacy of marijuana (see previous story), no clinical trials on the medical uses of marijuana have been completed in Canada.

The Community Research Initiative of Toronto (CRIT) has cancelled what would have been the first Canadian study evaluating the therapeutic effects of smoked marijuana. The study was to have assessed whether smoking marijuana can alleviate the debilitating nausea and weight loss experienced by many people living with HIV/AIDS. Research was to have begun in spring 2003 with a pilot study in Toronto involving a total of 32 individuals. More than three years of development and planning had gone into the study.

CRIT says that the study was cancelled because Health Canada decided not to renew funding.¹ Health

Canada had been providing funding for the trial through a series of contribution agreements. When approached for a comment, a Health Canada spokesperson declined to say why the funding was terminated, but expressed hopes that the research might continue with a new partner.²

As a result of the cancellation of the study, CRIT itself has folded. The organization did not have any core funding and was therefore dependent on project funding to maintain its operations.

The cancellation of the CRIT study means that four years after Allan Rock, the former Minister of Health, announced plans to assess the medical benefits of marijuana, not a

single study has been completed.

There is one study underway at McGill University on the use of marijuana to manage pain. Although the current Minister of Health, Anne McLellan, has repeatedly alluded to the lack of scientific evidence on the medicinal uses of marijuana, no new studies have been approved since she became Minister. In 2002, the Canadian Institutes of Health Research sent out a request for proposals. Three proposals were received, but none was approved.³

– David Garmaise

¹ Canada's first cannabis HIV/AIDS study suspended. News release from the Community Research Initiative of Toronto, available at www.newswire.ca/releases/June2003/19/c5318.html.

² D Bueckert. Medical pot advocates criticize Ottawa over delays. Canadian Press. Printed in the online edition of the *Globe and Mail*, 8 July 2003, available via www.globeandmail.com.

³ Ibid.

Ottawa Moves to Decriminalize Small Amounts of Marijuana

Making good on a promise made in December 2002,¹ the federal government has tabled a bill that would decriminalize possession of small amounts of marijuana. However, the bill would also toughen penalties for growing large amounts. The bill is part of a renewed Canada Drug Strategy that emphasizes the need to discourage cannabis use.

On 27 May 2003, Justice Minister Martin Cauchon tabled a bill in the House of Commons that would

decriminalize possession of small amounts of marijuana (up to 15 grams) and cannabis resin (hashish,

up to one gram). Under Bill C-38,² offenders would not receive a criminal record or face jail time, but would be fined between \$100 and \$400, depending on the age of the offender, the circumstances of the offence, and the amount involved. Possession of amounts of marijuana between 15 and 30 grams could lead to a ticket and

fine, or a criminal charge, at the discretion of the arresting officer.

The bill would toughen penalties for people who cultivate large amounts of marijuana. Under current law, cultivation of any number of cannabis plants is punishable by up to seven years imprisonment. The proposed new penalties for cultivation vary according to quantity:

- ¥ growing three plants or less becomes a summary conviction offence with a maximum \$5000 fine and/or 12 months in jail;
- ¥ growing between four and 25 plants could result in fines of up to \$25,000 and/or 18 months in jail (if prosecutors seek a summary offence conviction) or a jail term of up to five years less a day (if prosecutors proceed under an indictment);
- ¥ growing between 26 and 50 plants would be an indictable offence carrying a maximum penalty of 10 years imprisonment; and
- ¥ growing more than 50 plants would be an indictable offence carrying a maximum penalty of 14 years imprisonment.

The bill is the cornerstone of a renewed Canada Drug Strategy,³ announced on the same day by Martin Cauchon, by Anne McLellan, the Minister of Health, and by Wayne Easter, the Solicitor General.⁴ The new strategy promises that the federal government will invest \$245 million over five years in public education campaigns, research on drug trends, and measures designed to reduce the demand for, and supply of, drugs.

Recent reports from committees of the Senate⁵ and the House of Commons⁶ had recommended that possession of small amounts of cannabis be decriminalized.⁷ Both reports concluded that treating cannabis possession as a criminal offence has expended enormous judicial resources to little effect and that, in any event, cannabis is not a harmful enough drug to merit serious legal sanctions.

The new Canada Drug Strategy⁸ focus on a strong and sustainable enforcement response and on measures designed to discourage the use of cannabis through higher rates of enforcement of cannabis possession offences⁹ is at odds with the thrust of the parliamentary reports. Although the Senate and the Commons committees have not responded directly to Bill C-38 and the new Drug Strategy, most public and media reaction to the proposed bill emphasized its contradictions and mixed messages.⁹ Furthermore, although the federal government has been required by the courts to revise its flawed medical marijuana access program,¹⁰ neither the Strategy nor Bill C-38 explicitly addresses the flaws.

In related developments:

- ¥ An Ontario superior court has upheld a lower court decision that there are currently no laws against marijuana possession. The ruling is binding on judges in other Ontario courts.¹¹
- ¥ Marijuana activists gathered on the steps of Toronto downtown police headquarters on 19 June,

smoking their joints without being harassed by a single police officer.¹² The gathering was intended to test the effect of the Superior Court ruling.

— Derek Thaczuk

¹ See D Thaczuk, Troubled times for Canada's medical marijuana program. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(1): 22-23.

² An Act to Amend the Contraventions Act and the Controlled Drugs and Substances Act (Bill C-38), available at www.parl.gc.ca/37/2/paribus/chambus/house/bills/government/C-38/C-38_1/C-38_cover-E.html.

³ The new Canada Drug Strategy is described at www.hc-sc.gc.ca/hecs-sesc/cds/.

⁴ Renewal of Canada's Drug Strategy to help reduce the supply and demand for drugs. Health Canada news release, 27 May 2003, available at www.hc-sc.gc.ca/english/media/releases/2003/2003_34.htm.

⁵ Senate Special Committee on Illegal Drugs. *Cannabis: Our Position for a Canadian Public Policy*, September 2002, available on the website of the Parliament of Canada via www.parl.gc.ca/information/about/process/info/com/index.asp?lang=E. See also: D Thaczuk. Minister reaffirms commitment to provide medical marijuana. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 27-28.

⁶ House of Commons Special Committee on Non-Medical Use of Drugs. *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy*, December 2002, available on the website of the Parliament of Canada via www.parl.gc.ca/information/about/process/info/com/index.asp?lang=E. See also: R Jürgens. House of Commons committee releases report on Canada's Drug Strategy. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 9-12.

⁷ In fact, the Senate report went further, recommending complete legalization of possession of small amounts. Decriminalization removes the offence from the Criminal Code; legalization would remove legal penalties altogether. See *supra*, note 5.

⁸ *Supra*, note 4.

⁹ See, for example, V Lawton. Ottawa eases on pot but asks: 'Lay off it'; Drug scheme full of mixed messages. *Toronto Star*, 28 May 2003.

¹⁰ G Betteridge, Marijuana Medical Access Regulations unconstitutional. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(1): 57-60.

¹¹ C Freeze, K Lunman. No laws ban possession of marijuana, court rules. *Globe and Mail*, 17 May 2003.

¹² Toronto police ignore pot party in front of HQ. *Toronto Star*, 19 June 2003.

Commons Committee Recommends Significant Increase in Funding for AIDS Strategy

A House of Commons committee says that current funding for the Canadian Strategy on HIV/AIDS should be more than doubled. It calls for designated funding for inmates and First Nations and Inuit peoples, and for HIV vaccine research. Finally, it says that more federal government departments need to become involved in the response to AIDS.

The House of Commons Standing Committee on Health has called for annual funding for the Canadian Strategy on HIV/AIDS (CSHA) to be increased from the current \$42 million to \$100 million. The recommendation is contained in a report released by the committee in June 2003.¹ The committee echoed calls for increased funding made by a number of witnesses during public hearings organized by the committee in March 2003.²

Bonnie Brown, the committee Chair, noted that while Canadians continue to be infected with HIV at a rate of about 4000 a year, the resources allocated to the current CSHA have not changed in 10 years.³ The committee said that the increased funds were necessary to ensure:

- ¥ prevention successes similar to those achieved in the United Kingdom and Australia;
- ¥ expansion of effective harm-reduction initiatives;
- ¥ outreach to high-risk communities, especially youth;
- ¥ population health initiatives for people living with HIV/AIDS;
- ¥ enhanced community services by NGOs; and
- ¥ improved surveillance and research.

The committee recommended that the increased federal funding for the CSHA include designated funding of \$5 million annually for each of the two at-risk populations falling under federal jurisdiction: inmates, and First Nations and Inuit peoples. The committee also called for \$5 million annually to be designated for HIV vaccine research and development. The committee recommended that the increased funding be contingent on the development of five-year measurable goals and objectives for the CSHA.⁴

The committee pointed out that in order to address the current CSHA goals of minimizing the adverse impact of HIV/AIDS on individuals and communities, and of dealing with the social and economic factors that increase the risk of HIV infection, more federal government departments and agencies need to get involved. The committee said that in addition to the current partnership with Correctional Service Canada and the Canadian Institute of Health Research, the CSHA should also involve the Canadian International Development Agency on international issues, Indian and Northern Affairs Canada on Aboriginal issues, Human Resources Development Canada on issues relating to employment, Justice

Canada on human rights questions, Citizenship and Immigration Canada on immigration and refugee issues, and Industry Canada on vaccine development and drug-access issues.

The committee recommended that Health Canada take the lead in coordinating a renewed CSHA, that it establish a specific Canadian Strategy on HIV/AIDS secretariat, and that it report annually to Parliament on progress achieved.

The committee also recommended:

- ¥ that Correctional Service Canada provide harm-reduction programs similar to those available outside prisons, targeting inmates who inject drugs;
- ¥ that Health Canada increase prevention strategies targeted specifically to youth;
- ¥ that the CSHA provide stable, long-term funding for regional Aboriginal AIDS service organizations; and
- ¥ that the CSHA provide more support for individuals who are negatively affected by social stigma and discrimination associated with AIDS.

The Canadian Alliance members of the committee filed a dissenting opinion, in which they stated that while they agree that increased funding for

the CSHA is called for, they believe that \$85 million would be more appropriate than \$100 million. The Alliance also opposed the recommendation of the committee calling for harm-reduction strategies in correctional facilities, saying that this would lead to the introduction of needle exchanges in federal prisons, which will contribute to increased drug use among inmates and, consequently, higher levels of HIV/AIDS, hepatitis and other conditions and will subject guards to greater risk of injury and intimidation.⁵

Svend Robinson, the NDP member of the committee, issued a supplementary opinion, in which he said that the committee should have gone further in its recommendations in order to address issues concerning the costs of medications and access to medica-

tions, as well as the urgent need for Canada to contribute further resources to the global fight against AIDS. Specifically, Mr Robinson recommended that the federal government:

- ¥ work with the provinces and territories to establish a National Drug Agency for approving new drugs, and to review Canadian patent policies;
- ¥ provide leadership to ensure that developing countries are not hindered by the interests of international pharmaceutical companies in their attempt to provide inexpensive and effective drugs for their citizens living with HIV/AIDS; and
- ¥ increase its contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria.⁶

– David Garmaise

¹ *Strengthening the Canadian Strategy on HIV/AIDS*. House of Commons Standing Committee on Health, June 2003. The report is available on the Parliament of Canada website via www.parl.gc.ca. Click on "Substantive Reports of Committees."

² See D Garmaise. House of Commons committee holds hearings on AIDS. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(1): 23-24.

³ *Supra*, note 1 at v.

⁴ Health Canada is currently coordinating the development of a five-year CSHA Strategic Plan, which will contain measurable objectives. See D Garmaise. Work underway to develop a strategic plan for the AIDS Strategy. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(1): 28-29.

⁵ *Supra*, note 1 at 25.

⁶ *Ibid* at 27-28.

Ontario: Pressure from Stakeholders Leads to Improved Access to Selected Drugs

A campaign spearheaded by the Canadian Treatment Action Council, and involving other disease groups, has convinced the Ontario government to cover the costs of vaccines for HIV-positive children and to speed up access to other subsidized drugs.

In February 2003, as a result of pressure from groups representing the HIV/AIDS community, physicians, and other health advocates, the Ontario government agreed to cover the costs of vaccines for children in the province who are living with HIV, and to work with the groups to

improve access to a number of drugs covered under the Ontario Drug Benefits (ODB) Program. The list of drugs includes the antiretroviral medication Videx EC, a more tolerable formulation of ddI, as well as drugs for the treatment of other conditions common to people living with

HIV/AIDS or hepatitis C (eg, alendronate, valacyclovir, famciclovir, and Pegetron).

The ODB Program subsidizes some or all of the costs of medications listed on the ODB formulary for people on social assistance, seniors, and people with very high drug costs. In addition, coverage for drugs not listed on the formulary can sometimes be obtained through a special access process called a Section 8 Application.

The campaign for greater access to drugs in Ontario was spearheaded by the Canadian Treatment Action Council (CTAC). In November 2002, CTAC issued an Action Alert and called on the Ministry of Health and Long-Term Care to cover the cost of vaccines for HIV-positive children, to speed up the process for adding new medications to the provincial drug formulary (including Videx EC), and to speed up the process for approving Section 8 applications.

In January 2003, CTAC held a news conference along with the Toronto HIV Primary Care Physicians Group, the Canadian Hemophilia Society, the Colorectal Cancer Association of Canada, the Hepatitis C Society of Canada, Arthritis Consumer Experts, and Voices of Positive Women. The

media event focused on the ongoing lack of response from the Ontario government to drug-access issues.

A freedom-of-information request made in January 2003 revealed that there were approximately a hundred Section 8 requests for coverage of Videx EC pending at the time of the news conference. Since the government announcement, according to CTAC Chair Louise Binder, Section 8 requests for coverage of Videx EC have begun to be processed and approved in a timely manner. As of June 2003, however, Videx EC had still not been listed on the formulary and remained available only through the Section 8 application process.

Meanwhile, the Ministry has launched a Drug Strategy Review (DSR). The DSR will examine how drugs are chosen for listing on the

formulary, and whether mechanisms such as Section 8 applications are successful in getting drugs to people when they need them. The DSR has established a Steering Committee and three working groups: one on drug prescribing and use, one on cost-effectiveness and pricing, and one on drug programs administration. In May 2003, the Steering Committee issued a call for submissions from stakeholders. There were 34 responses, including submissions from CTAC and the Ontario AIDS Network. An interim report is expected in late summer 2003, and the Ministry has indicated the DSR is expected to be completed in the fall of the same year.

— Matthew Perry

Class Orders Now Possible under Ontario's Public Health Legislation

In April 2003, the Ontario Legislature amended the province's public health legislation as part of a package of amendments related to the recent outbreak of Severe Acute Respiratory Syndrome (SARS).

Although the amendments to the Health Protection and Promotion Act (HPPA)¹ were clearly designed to address emergency situations like SARS, they may have unintended and negative consequences for people living with HIV/AIDS.

Bill 1, the SARS Assistance and Recovery Strategy Act, 2003,² received first, second, and third reading on 30 April 2003. It received royal assent less than a week later and is now in force. Most of Bill 1 addresses SARS-specific measures such as pro-

tection for employees to ensure that they will not lose their jobs due to a SARS-related quarantine, and the removal of retail sales tax for hotels and tourist attractions until September 2003 to draw tourists back to Toronto. But the amendments to the HPPA are

more general in nature, including those to s 22. (Section 22 is the section under which public health can issue orders to enforce safe-sex compliance.³ It is also the section that was recently amended to permit certain individuals to apply for mandatory HIV testing orders.⁴)

As a result of the latest amendments, a local medical officer of health can now issue a compliance order to a *Class* of persons⁵ instead of simply to an individual.⁵ What constitutes a *Class* is not defined. Therefore, it is conceivable that such

an order could now be issued to a class such as all persons living with HIV/AIDS in a given municipality. The test for when an order can be issued to a class of persons remains the same as the test for individual orders — ie, the local medical officer of health has to have reasonable and probable grounds to believe that: (a) a communicable disease may exist; (b) the disease is a risk to residents of the local municipality; and (c) the order is necessary to decrease or eliminate the risk to health presented by the disease.⁶

The normal procedure under the HPPA is that compliance orders are served in person. Under the amendments, the same procedure will be used for class orders, except when delivery of the notice to each member of a class of persons is likely to cause a delay that could, in the opin-

ion of the medical officer of health, significantly increase the risk to the health of any person.⁷ In these circumstances, it is permissible for the order to be served by way of any communications media that seem appropriate, such as the local newspaper or radio station.⁸ Individuals affected by such class orders have the same right of appeal to the Health Services Appeal and Review Board as was already in place for individual compliance orders.⁹

With unanimous consent of the legislature, Bill 1 was not debated and was put immediately to second and third reading without amendment.¹⁰ To date, there appear to be no policies in place to assist local medical officers of health in identifying situations where class orders may be appropriate.

— Ruth Carey

¹ RSO 1990, c H.7, as amended.

² SO 2003, c 1. A copy of the bill is available at www.ontla.on.ca/documents/Bills/37_Parliament/Session4/b001ra_e.htm.

³ Typically, the orders issued under s 22 require individuals always to disclose their HIV-positive status before sexual activity, to use a condom or latex barrier for any penetrative sexual contact, including oral sex, and to refrain from sharing needles or drug-injecting equipment.

⁴ See: T de Bruyn, R Elliott. Compulsory HIV testing after an occupational exposure. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 1, 24-31. See also: R Carey. Ontario adopts "Blood Samples" legislation. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 39-40.

⁵ SARS Assistance and Recovery Strategy Act, 2003, s 15(1), amending s 22 of the HPPA by adding subsection (5.0.1).

⁶ HPPA, s 22(2).

⁷ Ibid, s 15(1), amending s 22 of the HPPA by adding subsection (5.0.3).

⁸ Ibid.

⁹ Ibid, s 15(1), amending s 22 of the HPPA by adding subsection (5.0.5).

¹⁰ Hansard. 37th Parliament, 4th Session, 30 April 2003, available at www.ontla.on.ca/hansard/house_debates/37_pari/Session4/L001.htm.

Commons Committee Calls for More Leadership and Resources to Fight AIDS in Africa

The House of Commons Standing Committee on Foreign Affairs and International Trade issues a report that concludes that the magnitude and urgency of the AIDS crisis in sub-Saharan Africa requires additional action and resources from the federal government.

A House of Commons committee has called on the federal government to take a greater leadership role in the response to AIDS in sub-Saharan Africa, to triple its current contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and to make access to medicines in poor countries a priority in its negotiating

position within multilateral trade organizations. These recommendations were contained in a report released by the committee in June 2003.¹

The committee called the HIV/AIDS pandemic the single most devastating humanitarian crisis in sub-Saharan Africa and said that it has

the potential to destroy entire communities, societies and countries.² In its report, the committee said that it agreed with Stephen Lewis, the UN Secretary-General's Special Envoy for HIV/AIDS in Africa, who testified before the committee that the HIV/AIDS pandemic desperately needs a voice among industrial

nations and that Canada is uniquely positioned to be that voice.¹

The committee said that the best available vehicle for an international response is the Global Fund. Canada's current contribution to the Global Fund is \$150 million spread over four years. In addition to substantially increasing its contribution to the Global Fund, the committee says, the federal government should take the initiative internationally, through its membership in the G8, the Francophonie, the Commonwealth and the United Nations, to ensure that the fight against HIV/AIDS in sub-

Saharan Africa is accorded the highest priority.²

The committee called on the federal government to review the bilateral development assistance and humanitarian aid programs administered by the Canadian International Development Agency (CIDA). The committee said that these programs are thinly spread across about 100 countries, and that CIDA should focus its resources and programs in fewer sectors and fewer countries to make them more effective.³ The committee added that the aid programs need to reflect the fact that in many African coun-

tries, HIV/AIDS is inextricably linked with other issues, including food shortages and famine, armed conflict and political violence, and problems of governance.⁴

— David Garmaise

¹ *HIV/AIDS and the Humanitarian Crisis in Sub-Saharan Africa*. House of Commons Standing Committee on Foreign Affairs and International Trade, June 2003. The report is available on the Parliament of Canada website via www.parl.gc.ca. Click on "Substantive Reports of Committees."

² *Ibid* at 20.

³ *Ibid* at 23.

⁴ *Ibid* at 22.

⁵ *Ibid*.

In Brief

Saskatchewan Agrees to Cover New HCV and HIV Drugs

The Saskatchewan government has approved coverage of Pegatron and Valcyte, two drugs used to treat hepatitis C (HCV) and HIV. Both drugs will be available under the Exceptional Drug Status (EDS) program.

To be eligible for EDS, people infected with HCV or HIV must have a Saskatchewan Health number, and must have applied for and received special support status. The criterion for obtaining special support status is based on a formula that takes into account the person's income and the cost of the drugs. Anyone on welfare or social assistance would qualify, though they would be assessed a \$2 dispensing fee for each prescription filled. Others might qualify under a

co-pay system that requires them to pay a small percentage of the costs of the medications.

Pegatron is the newest drug available in Canada for people fighting infection with HCV. Pegatron is actually two medications, peginterferon and ribavarin, bundled together. Valcyte is used to treat the cytomegalovirus (CMV) which causes the serious eye infection CMV retinitis, a common opportunistic infection affecting people living with HIV/AIDS.

— Roger Procyk

Still No HIV/AIDS Strategy in New Brunswick

During the recent New Brunswick election campaign, Shawn Graham, leader of the opposition Liberals,

promised to implement a provincial HIV/AIDS strategy if his party won the election. The Liberals lost in a tight race to Bernard Lord, Conservatives. As a result, New Brunswick remains one of the few provinces in Canada that either does not have an HIV/AIDS strategy, or is not in the process of developing one.

New Brunswick had begun to work on an HIV/AIDS strategy, but the Conservatives put the brakes on in February 2002, citing a lack of funds. According to Haley Flaro, Executive Director of AIDS New Brunswick, much of the key HIV-related work in the province has been halted for the past several years. For instance, she said, methadone and needle exchange programs (NEPs) remain few and far between, even though there is a clear need for such programs and even though they have been successful in

other provinces for many years. The only two methadone programs in the province currently have waiting lists of 100 to 200 people. The only two NEPs in the province have more than doubled their number of needles distributed over the past two years. Neither NEP receives any operational funding from government.

The Conservatives lost 19 seats in the election. On election night, Bernard Lord told New Brunswickers that he heard their message. While there is no assurance that work on the HIV/AIDS strategy will begin in the near future, now that the issue has been raised by the Liberals it will likely remain on the political radar screen.

— Caroline Ploem

Health Canada Announces Public Consultations on Proposed Health Legislation

On 9 June 2003, Minister of Health Anne McLellan announced that the federal government will launch public consultations on a proposed new Canada Health Protection Act. The proposed legislation would replace the Food and Drugs Act (1953), the Hazardous Products Act (1969), the Quarantine Act (1872), and the Radiation Emitting Devices Act (1970). Other existing health-protection statutes, such as the Tobacco Act, would be integrated into the new framework. These statutes were adopted over many decades, each to address specific issues. The objective

of this initiative is to strengthen and improve current federal health-protection laws, integrating them into a comprehensive regime to better protect the health and safety of Canadians.

In the fall of 1998, national consultations were held to identify issues that the new legislation should address. A second round of consultations will begin in the fall of 2003 and will be based on two documents: Health and Safety First and Health Protection Legislative Renewal — A Detailed Proposal. Interested parties can provide their comments on the proposal documents by answering questions found on the Health Canada website, or by submitting written comments by email, regular mail, or fax. As well, Health Canada is organizing a series of public meetings. After the results of these consultations have been analyzed, a bill will be drafted and presented to Parliament.

— Ian Culbert

See the Health Canada website at <http://renewal.hc-sc.gc.ca> for copies of the two documents and for more information on the consultation process. Information can also be obtained by calling 888 288-2098.

Woman Sues Physicians over Failure to Offer Prenatal HIV Test

According to media reports, an Ontario woman is suing three physicians whom she saw during her pregnancy and all of whom failed to offer HIV testing.¹ The woman gave birth in Ontario in 2000. She subsequently learned that she and her child were

HIV-positive after the baby became ill. She is seeking damages for her newborn's infection. The lawsuit cites studies showing that preventative treatment during pregnancy can reduce the risk of perinatal transmission to one to two percent.²

In December 2002, as part of a new HIV Prenatal Testing Program, the Ontario government encouraged physicians to offer HIV testing to all pregnant women as a routine part of prenatal care. As of October 2002, 80 percent of Ontario women were seeking HIV testing during pregnancy. In 2002-2003, the government committed to spending \$1.6 million to ensure that women have access to HIV testing during pregnancy. In January 2003, the Ministry of Health and Long-Term Care produced numerous pamphlets, posters, and guides in multiple languages as part of the program.³

In Ontario, it is the position of the government that consent to HIV testing must be voluntary and fully informed, in accordance with the requirements of the Health Care Consent Act, 1996.⁴

— Ruth Carey

¹ Canadian Press. Mom of HIV baby sues docs. *Toronto Sun*, 7 May 2003: 46.

² In the developed world, research has shown that perinatal transmission can be reduced dramatically through the appropriate use of highly active antiretroviral therapy to as little as 0.5 percent. See, eg J Keller et al. Women's health issues: news from the XIV International AIDS Conference in Barcelona. *The Hopkins HIV Report* 2002, available at http://hopkins-aids.edu/publications/report/nov02_5.html.

³ Copies of these materials are available at www.health.gov.on.ca/english/providers/pub/aids/prenatal/catalogue.html.

⁴ SO 1996, c 2, Schedule A, s 10. For more about HIV and testing, see: P Kenney. Medical association calls for routine HIV testing of pregnant women. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2/3): 32-33.

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 Edwige Fortier, Maria Nengeh Mensah, Jean Marie Talom, and Delphine Valette. 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.

US International AIDS Funding Will Also Advance a Moral Agenda

The US Congress has adopted comprehensive legislation that both authorizes the allocation of up to US\$15 billion to fight the global AIDS epidemic during the period 2004-2008, and aims to ensure that the programs thus funded will advance a conservative moral agenda. The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (the Act)¹ was signed into law by President Bush on 27 May 2003.

The Act promotes the role of faith-based organizations in the provision of development assistance, noting that "The Catholic Church alone currently cares for one in four people being treated for AIDS worldwide. Faith-based organizations possess infrastructure, experience, and knowledge that will be needed to carry out these programs in the

future and should be an integral part of United States efforts" (s 2(19)).

The Act notes that "HIV/AIDS is first and foremost a health problem" (s 2(15)), and calls for the establishment of an "integrated, five-year strategy to combat global HIV/AIDS that strengthens the capacity of the United States to be an effective leader in the international campaign against HIV/AIDS." While this strategy is to include multi-sectoral approaches, the Act also provides that organizations receiving funding shall not be required to endorse or utilize a multi-sectoral approach, or endorse, utilize, or participate in a prevention method or treatment program to which the organization has a religious or moral objection (s 301). In addition, the Act provides that of the funding to be allocated to HIV/AIDS prevention, "3 per cent

should be expended for abstinence-until-marriage programs" (s 402).

The following are some of the additional features of the legislation:

¥ **Terrorist states.** The Act provides that the United States "Contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria will be reduced dollar for dollar for fund disbursements to the government of any country that 'has repeatedly provided support for actions of international terrorism'" (s 202).

¥ **Drug re-importation.** Reflecting concerns that drugs made available at no cost or at sharply discounted prices in developing countries may be illegally imported into the United States, the Act requires a report to be prepared for Congress on the

issue, with recommendations for both the United States and developing countries on how to minimize the practice (s 307).

¶ **Legal rights for women and children.** The Act requires the United States Agency for International Development to investigate program responses that ensure the importance of inheritance rights of women, and provide appropriate counselling and legal assistance for the appointment of guardians and the handling of other issues relating to the protection of children (s 314).

¶ **Prostitution and sex work.**² In the preamble, the Act notes that "Prostitution and other sexual victimization are degrading to women and children and it should be the policy of the United States to eradicate such practices" (s 2(23)). Section 301(e) amends the Foreign Assistance Act of 1961 to provide that "No funds may be used to promote or advocate the legalization or practice of prostitution or sex trafficking." Section 301(f) of the Act amends the Foreign Assistance Act of 1961 to ensure that no funds be made available to "any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking."

Comment

While the funding for AIDS programs is clearly welcome, there are concerns about the public health impact of some sections of the Act. For example, HIV/AIDS programs that operate in countries where prostitution (as opposed to exploitation and pimping) is legal will no longer be eligible for US funding. Yet in the context of sex work, HIV/AIDS prevention and care

are most effective when organizations engage in a range of harm-reduction strategies and activities intended simultaneously to enable sex workers to negotiate condom use with clients, to protect the basic human rights of sex workers, and to provide alternatives to precarious working conditions associated with occupational health hazards. The intent of the Act is to prohibit funding of these risk-reduction approaches to sex work and to instead fund rescue-oriented initiatives aimed at closing brothels and helping sex workers leave prostitution.

Internationally, and often in the absence of viable economic alternatives to feed and clothe themselves and their families, sex workers have resisted efforts to be rescued, and have instead demanded what they consider to be better solutions, such as health care, improved working conditions, and access to condoms. Not only does the Act disregard the demands of sex workers, but it will also result in reduced initiatives to reach those most vulnerable to HIV/AIDS, including trafficked persons who have no access to prevention and care.

For example, the Sonagatchi project in Kolkata, India (a peer education project that trains sex workers to educate one another on condom use), and EMPOWER Thailand (an organization that assists women working in prostitution to obtain high-school diplomas and other employment skills), may face difficulty obtaining US funds under the Act. These groups do not take positions unequivocally opposing prostitution because to do so would cause them to lose credibility with the populations they seek to serve, and would also further feed the stigma and discrimination that make it so difficult for sex workers to secure

their own rights. Conversely, strategies that rely on expounding the immorality of prostitution, or that exacerbate the stigma and discrimination associated with sex work, make it more difficult to protect public health and sex workers.

Therefore, while the decision of the US leadership to allocate substantial funds to support AIDS programs in developing countries is clearly welcome, the sections of the Act that deny support for organizations with a demonstrated track record in working with vulnerable populations will most likely have a negative public health impact, and should be closely monitored.

[Editor's Note: Of the US\$15 billion authorized by the legislation for the period 2004-2008, US\$3 billion was allocated to the first year (fiscal year 2004, which starts in October 2003). In the US, after passage of legislation authorizing funding for a new program, the actual expenditures still have to be approved by the appropriations committees in both houses of Congress. In July 2003, the House of Representatives Appropriations Committee authorized only US\$1.45 billion for the first year; the Senate Appropriations Committee authorized only US\$1.35 billion. Members of the House and Senate will now meet to establish the final figure. When President Bush set out on his African tour that same month, there were concerns expressed that the full US\$15 billion would never be allocated. These concerns appear to have been justified.]

¹ PL 108-25.

² See, generally, Center for Health and Gender Equity (www.genderhealth.org). See also the Prostitution and HIV/AIDS section of the Canadian HIV/AIDS Legal Network website at www.aidslaw.ca/Maincontent/issues/prostitution.htm.

Zambia: Judges Workshop Addresses HIV/AIDS

In June 2003, the Zambia AIDS Law Research and Advocacy Network (ZARAN) facilitated an HIV/AIDS workshop for the Zambian judiciary. The object of the workshop was to explore the role of the law in addressing HIV/AIDS, as well as the necessity and opportunity for the judiciary to provide leadership in dealing with the pandemic. The workshop was attended by His Lordship the Chief Justice of the Supreme Court of Zambia and four other Supreme Court Justices, including Madam Justice Chibesa-kunda, Chairperson of the Permanent Human Rights Commission. Justices of the High Court and the Magistracy also participated.

In his opening address, the Chief Justice acknowledged that HIV and AIDS are serious threats to humankind and to the enjoyment of human rights. He said that because stigma and discrimination continue to surround HIV, there is a need for human rights protection both for infected and affected communities. He also said that while the obligation to respect, protect and promote these rights rested with government, the judiciary has a critical and pivotal role to play in this process. The Chief Justice noted that Zambian jurisprudence has yet to deal with HIV. He attributed this to the fact that people have not come forward to move the courts to intervene on their behalf. He challenged the judiciary to rise to the occasion and be proactive in the fight against HIV/AIDS-related stigma and discrimination.

Mr Justice Edwin Cameron, of the South Africa Supreme Court of Appeal, gave the keynote address. He

commended the Zambian judges and government for their open acknowledgment of the extent of the problem. Justice Cameron contrasted this with South Africa, where widespread denial still exists. He noted that, like apartheid, HIV/AIDS dehumanizes people, and he said that the law must not be the instrument under which this happens. Justice Cameron shared his own experience of being HIV-positive and of how antiretroviral drugs have saved his life. He said that he was able to be open about his HIV status, as well as about the fact that he is gay, because he could freely make the choice without fearing discrimination vis-à-vis losing his job, or rejection from loved ones. He emphasized the need for treatment to add meaning to the response to HIV, and for measures to establish a non-discriminatory environment to ensure that the response is effective.

During the course of the day, several issues were identified that could lead to future action, including the following:

- ¥ there is a need to clarify the role of the criminal law in addressing HIV. To this end, the experience of the South African Law Commission, which has done work on this matter, could be consulted;
- ¥ as part of legislative reform, anti-discrimination legislation should be broadened to include sufficient protection for people living with HIV/AIDS;
- ¥ domestication and implementation of international treaties and declarations regarding human rights

must be done without fail; and
¥ more must be done to involve the judiciary in addressing HIV/AIDS.

This workshop was part of a larger project for which ZARAN receives financial and technical assistance from the Canadian HIV/AIDS Legal Network, through funding that the Network obtained from the Canadian International Development Agency. The project, which involves enhancing ZARAN's institutional capacities and improving linkages with other organizations, is implemented in Zambia by the International HIV/AIDS Alliance. In 2003, with support from Pact, an organization dedicated to improving the capacity of local NGOs, ZARAN commenced a five-month project to raise awareness of the legal, ethical, and human rights dimensions of discrimination in health care, employment, and the legal process.¹

¹ For more information, see the ZARAN website at www.zaran.org or write to zaran@zamtel.zm. For an analysis of the HIV/AIDS policy context in Zambia, see L. Garbus, *HIV/AIDS in Zambia*. University of California, Country AIDS Policy Analysis Project, 2003 (available at ari.ucsf.edu/policy/countries.htm).

UK Report on Migration and HIV Rejects Mandatory Testing

The United Kingdom All-Party Parliamentary Group on AIDS (APPGA) has recommended that the government not adopt a policy of mandatory HIV testing with the aim of excluding from the UK anyone who tests HIV-positive. The recommendation is contained in a report that was released in June 2003,¹ at the same time as the British Cabinet Office was believed to be inquiring into the issue of imported infections² and the possible adoption of a policy of testing migrants for serious communicable diseases.²

Member of Parliament Neil Gerrard, Chair of the APPGA and the All-Party Parliamentary Group on Refugees, stated in a media release at the launch of the report: "We feel that the current Government position on asylum seekers and migrants with HIV has been largely developed in response to reports based on fear and stigma rather than factual evidence."

The report notes that health-care workers are being increasingly asked to serve multiple roles in the clinical setting as immigration officers, social welfare officers, support liaisons, and

care workers. They feel that they are being continually faced with the ethical issue of whether to deny treatment to individuals with HIV who are in need but who are not entitled, by virtue of their immigration status, to National Health System care.

The report also notes the intrinsic link between what is happening at the national level and at the global level. The APPGA recognizes that population movements have always existed as people seek refuge from political persecution in order to resettle with families or go in search of work or educational opportunities. The report says that as HIV prevalence rises globally, it is logical that the number of people living with HIV/AIDS coming to the UK will also rise.

The report suggests that it does not make sense for the UK government to try to exclude individuals from the UK on the basis of poor health, while simultaneously working to provide access to health in developing countries. Instead, the report says, the UK should be addressing the factors that push people to migrate from developing countries — factors such as poverty,

lack of access to health care, conflict, the impact of environmental adversity, and social exclusion.

The APPGA is a group of 175 members of the UK Parliament from all political parties. Its objectives are to raise the profile of HIV/AIDS, both as a domestic and an international issue, to encourage cross-party consensus, and to act as a bridge between Parliament, government, and people living with or working with HIV/AIDS.⁴

¹ Migration and HIV: Improving Lives in Britain – An Inquiry into the Impact of the UK Nationality and Immigration System on People Living with HIV. London: All-Party Parliamentary Group on AIDS, 2003. Copies of the report are available on the APPGA website via www.appg-aids.org.uk.

² *AIDS Update*. London: All-Party Parliamentary Group on AIDS; 23 June 2003. Available on the APPGA website, *ibid*, or by subscribing to an email list (contact info@appg-aids.org.uk). For information on Canada's policy on HIV and migration, see the Immigration and HIV/AIDS section of the Legal Network's website at www.aidslaw.ca/Maincontent/issues/immigration.htm.

³ Cross-bench MPs and peers say government immigration policy undermines public health (available at www.tht.org.uk/press_desk/press_pdf/asylum_rep.pdf).

⁴ For further information on parliamentarians and HIV/AIDS, see: Parliamentarians take the initiative on HIV/AIDS. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 43-45.

Caribbean Nations Hold First Training Workshop on AIDS Laws and Policies

In June 2003, the Caribbean Community (CARICOM) and the Pan Caribbean Partnership on HIV/AIDS (PANCAP) organized the first-ever regional training workshop for HIV/AIDS-related law and policy

reform. The workshop was consistent with a resolution adopted by the United Nations General Assembly in 2001 that called on member states, *inter alia*, to enact, strengthen or enforce legislation, regulations, and

other measures to eliminate HIV/AIDS-related discrimination.¹

The workshop, held in St Lucia, was the first of its kind in the region and possibly globally. It aimed to share regional and international

experience in this area, to develop capacity to undertake national needs assessments for law and policy reform in the context of HIV/AIDS, and to plan for the next steps at the country level. Technical assistance was provided to CARICOM/PANCAP by the Canadian HIV/AIDS Legal Network and the Guyana Human Rights Foundation.

The workshop followed the recommendations developed in 2002 through a Caribbean regional consultative process. In June 2002, CARICOM/PANCAP developed an Action Plan on Law, Ethics and Human Rights. At a regional workshop in Tobago. The Action Plan will support the implementation of Priority Area 1 of the Caribbean Regional Strategic Framework for HIV/AIDS 2002-2006.² Priority Area 1 of the framework addresses advocacy, policy development, and legislation. The Action Plan focuses on law, ethics, and human rights.

Partial funding for the St Lucia workshop was provided by the Canadian International Development Agency (CIDA) as part of a larger regional program on law, ethics, and human rights funded by CIDA for the period 2003-2006. Additional workshop funding was obtained from the United States Agency for International Development.

The goal of the CIDA-funded program is to build the capacity of countries in the region to respond to the legal, ethical, and human rights challenges of HIV/AIDS. Components of the program include financial and technical support for national needs

assessments for policy and law reform; national consultations; analysis and consultations on specific aspects of law reform; development of regional model policies, guidelines, and codes of practice; and training of legal aid providers and organizations of people living with HIV/AIDS.

The CARICOM/PANCAP approach is based on international legal principles as reflected in the International Guidelines on HIV/AIDS and Human Rights.³ Thirty-two people from the Caribbean region participated in the workshop. Participants came from Antigua and Barbuda, Dominica, Grenada, Guyana, St Lucia, St Vincent, and Trinidad and Tobago. They included representatives of national AIDS programs, NGOs working in HIV/AIDS, the offices of Attorneys General, and human rights organizations. They also included lawyers and legislative drafters, people with training in medicine and public health, and people living with HIV/AIDS. Also attending as resource persons were people who had been involved in prior country assessments in Belize,⁴ Jamaica,⁵ and Suriname.⁶ Expertise in HIV treatment access advocacy was provided by the Agua Buena Human Rights Association, from Costa Rica. People from key regional organizations, including the CARICOM Legislative Drafting Facility and the Caribbean Network of People Living with HIV/AIDS, also participated.

As part of its post-workshop activities, CARICOM/PANCAP will

provide financial and technical support for the national assessments, including support for a national consultant to undertake the research in each designated country. A further regional training workshop is planned for October 2003. This workshop will increase the capacity of the national consultants to undertake the assessments, and ensure they have support from key stakeholders in government and the community.

For further information contact Alicia Sands, PANCAP Information Officer at asands@caricom.org.

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. Available at www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf. See also MJ Roseman, S Gruskin. The UNGASS Declaration of Commitment: one year later. *Canadian HIV/AIDS Policy and Law Review* 2003; 8(1): 1-14.

² Both the Regional Strategic Framework and the Action Plan are available via www.caricom.org.

³ The original guidelines, published in 1998, are available at www.unaids.org/publications/documents/human/law/JC520-HumanRights-E.pdf. The revised Guideline 6 (Access to prevention, treatment, care and support), published in 2002, is available at www.unaids.org/publications/documents/care/general/JC905-Guideline6_en.pdf.

⁴ In Belize, the research was commissioned by the National AIDS Commission, which is chaired by the Honourable Dolores Balderamos-Garcia, Minister of Human Development, Children, Women and Civil Society. Further information is available at www.belizenac.bz.

⁵ Legal, Ethical and Human Rights Issues of HIV/AIDS in Jamaica. Kingston: National AIDS Committee, 2001. The report was prepared by McNeil and McFarlane, Legal Consultants, and is available at www.nacjamaica.com/subcom/legal_ethical/index.htm.

⁶ In Suriname, in early 2003, Projecta and LEFT Consultancy completed a comprehensive report on national policy and law relating to HIV/AIDS and other sexually transmitted infections. The report also reviews international and national law and policy on HIV/AIDS in the workplace, gender and HIV/AIDS, and care and treatment, as well as the use of the criminal law as a preventive tool. See M Castelen, R Antonius. PAF II Report on Advocacy for Change in STI Legislation and Policy and Sensitisation. Paramaribo: Projecta and LEFT Consultancy (forthcoming).

GLOBAL ACCESS TO TREATMENT

This section of the *Review* addresses global issues related to improving access to adequate and affordable care, treatment, and support. It contains a report on a Canadian summit on “Global Health is a Human Right!” – which brought together people and organizations interested in jointly advocating for the realization of the human right to health in developing countries. We also report on a lawsuit launched by a woman in Nigeria who was denied treatment because of her HIV-positive status. This section is edited by Richard Elliott, Director, Policy & Research, Canadian HIV/AIDS Legal Network. He can be reached at relliott@aidslaw.ca.

Canada: National Summit on “Global Health is a Human Right!”

Held in Ottawa on 21-22 May 2003, a national summit on “Global Health is a Human Right!” brought together 86 people representing over 60 Canadian civil society groups interested in joint advocacy on realizing the human right to health in developing countries. The summit focused particularly on addressing the global crises of communicable diseases such as HIV/AIDS, tuberculosis, and malaria.

The summit was organized by the Global Treatment Access Group (GTAG), a working group of over a dozen Canadian civil society organizations sharing information and undertaking joint activities aimed at improving access to essential medicines and other aspects of care, treatment, and support for people living with HIV/AIDS and people with other health needs in developing countries.

The summit was co-sponsored by the Canadian Labour Congress, the Canadian HIV/AIDS Legal Network, the Interagency Coalition on AIDS and Development, Médecins Sans Frontières (MSF), the Council of Canadians, Rights & Democracy, the Canadian Union of Public Employees, and the United Steelworkers.

The objective of the summit was to identify ideas for policy advocacy and

action with respect to three themes: trade and globalization, financing global health, and corporate social responsibility. The summit’s agenda was organized according to these themes.

Panel Discussions

A panel on the impact of trade and globalization on commitments to achieve the international goal of Health for All by the year 2000 included speakers from Brazil, Argentina, and Canada. Panellists discussed international trade treaties

such as the Agreement on Trade-Related Aspects of Intellectual Property Rights of the World Trade Organization (WTO) and the Free

The state is central in ensuring health for all, as a matter of human rights; this responsibility must be coherent with trade negotiations.

Trade Areas of the America (FTAA). They also addressed the threat to public health services posed by the WTO's General Agreement on Trade and Services, and the dangers of Canada's global trade policies for both Canadians and those in other countries. Panellists agreed that the state is central in ensuring health for all, as a matter of human rights; and that this responsibility must be coherent with trade negotiations.

Speakers on the second panel, *Financing Global Health: Canada's Foreign Aid, the Global Fund, and Debt Cancellation*, included representatives of Canadian NGOs working on financing issues, as well as a representative from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The speakers addressed the need for a health-systems approach in Canada's official development assistance, the funding (or lack thereof) and functioning of the Global Fund, and the relationship between the debt of Southern countries and their capacity to finance health domestically. For each of these areas, speakers urged concrete action by Canada that could make a significant difference to realizing the health of millions in the South.

Corporate Social Responsibility in Supporting Public Health in Developing Countries was the title of the third panel. The panellists represented both local and global organizations working on these issues, with speakers from the University of Toronto and MSF, a South African union, and a community development group in Niger. While speakers agreed that there is a role for the private sector to play in health issues, they also said that partnerships involving the private sector must be clearly defined, and must not impede the ability of the state to ensure accessible public health care.

Discussion followed each panel. Over the course of the summit, participants debated a wide range of issues, including:

- ¥ the privatization of health care;
- ¥ public—private partnerships;
- ¥ the growing reach of international trade agreements and their impact on the ability of governments to fulfill their part of the social contract;
- ¥ adequate Canadian funding for the Global Fund and aid for health more broadly;
- ¥ the urgent need to eliminate the debt of developing countries;
- ¥ linking expertise to action;
- ¥ the application of a feminist analysis to global health; and
- ¥ clarification of the role between government, civil society, and the private sector.

There was general consensus that the state has a central role to play in ensuring health for all, and that the responsibility of the state to ensure health must be coherent with the positions adopted by the state in trade negotiations and agreements and in other multilateral forums.

Key Messages

Speakers who gave the opening, lunchtime, and closing addresses at the Summit delivered several key messages, including the following:

- ¥ we have a human right to be healthy and to expect proper care when we are sick;
- ¥ the pressures on our own health system are the same pressures faced by health systems around the world;
- ¥ government must regulate in the interest of the public, not of the regulated; and
- ¥ partnerships between the public and the private sector cannot be allowed to subvert public interests for private profits.

Global health comes down to a very simple choice: either people are at the centre, or greater profits for big business are at the centre.

Participants concluded that we can achieve health for all so long as we are enraged, engaged, and willing to organize for change; and that, fundamentally, global health comes down to a very simple choice: either people are at the centre, or greater profits for big business are at the centre.

The two keynote speakers also focused on the theme of global health as a human right. Maude Barlow, of the Council of Canadians, delivered a clear, concise message: the single most important action civil society groups of the so-called *Quad* countries (the four most powerful members

of the WTO — the United States, the European Union, Japan, and Canada) can take in the struggle against HIV/AIDS is to fight their own governments and corporations, and the policies and ideologies they are forcing on an increasingly divided world. James Orbinski, who is with the University of Toronto and MSF, echoed Ms Barlow's comments. He also enunciated distinct roles for government, civil society, and the private sector in the area of health: the interest of the private sector is profit, while the role of civil society is to reclaim its position as citizens, and to demand that governments govern in the public interest.

A highlight of the summit's second day was a march through downtown Ottawa by participants carrying a banner proclaiming Global Health is a Human Right! The march proceeded to Parliament Hill and then to the office of the Prime Minister, where marchers delivered over 15,000 postcards from Canadians demanding adequate funding for

global health needs, and support for changes to the international trade regime to ensure access to less expensive, generic medicines for developing countries. The postcards were assembled by MSF Canada as part of an ongoing campaign. Also delivered was a letter from the Student-Led Access to HIV Medicines (SLAHM) Campaign, organized by students from the McGill International Health Initiative and endorsed by 14 student unions across Canada, representing over 165,000 university students.

On the afternoon of the second day, the summit participants broke up into workshops, each based on one of the three themes. The workshops were devoted to identifying elements of a Common Platform on Global Health as a Human Right. Participants further debated the issues raised at the summit and began to formulate common language. GTAG is following through on the outcomes of the workshop, and will produce a draft Common

Platform to be released later in 2003. GTAG has also continued organizing in relation to events such as a conference on contributions to the Global Fund, held in July 2003, and upcoming meetings of the WTO and of FTAA countries.

— *oline Twiss and Richard Elliott*

oline Twiss is a member of the Global Treatment Access Group (GTAG) and was coordinator of the summit. Richard Elliott works with the Canadian HIV/AIDS Legal Network, a founding member organization of GTAG.

For more information about the summit, see the agenda, background paper, speakers' presentations, photographs, and other materials at www.aidslaw.ca/Maincontent/issues/cts/GTAGsummit.htm. For more information about GTAG and global treatment access more generally, see www.aidslaw.ca/Maincontent/issues/care-treatment.htm#B2. To contact the Legal Network regarding its work or the work of GTAG on treatment access, contact Richard Elliott at relliott@aidslaw.ca.

Nigeria: HIV-Positive Woman Launches Suit after Being Denied Treatment

A 39-year-old woman who was denied treatment at a hospital in Lagos simply because she is HIV-positive is fighting back through the courts. The Center for the Right to Health has filed a lawsuit on her behalf, seeking damages as well as an injunction to prevent further discrimination against people with HIV/AIDS who seek treatment.

The Center for the Right to Health, a non-governmental human rights

organization based in Lagos, Nigeria, has filed an action in the Lagos High

Court on behalf of a woman living with HIV/AIDS who was denied access to treatment solely because of her serostatus. The suit names as respondents the Attorney General of Lagos State, the Commissioner for Health for Lagos State, the Permanent Secretary [of the] Lagos State Health

Management Board, and the Lagos State Health Management Board.

The 39-year-old woman was denied access to treatment by the General Hospital in Lagos sometime in March 2002, when she visited the hospital for treatment of opportunistic infections. The hospital refused to provide her with medical attention, claiming that people living with HIV/AIDS were never admitted for treatment. Among the reliefs being claimed by the woman are the following:

- ¥ a declaration that the denial of treatment to her based solely on her HIV status constituted an act of unfair discrimination against her, contrary to the Constitution of the Federal Republic of Nigeria

1999, the African Charter on Human and Peoples' Rights (African Charter), and other international human rights instruments ratified by Nigeria;

- ¥ a declaration that the refusal to give medical attention to her based solely on her HIV status is illegal, unlawful, and unconstitutional, and constituted an act of inhuman and degrading treatment, contrary to the Nigerian constitution and African Charter;
- ¥ a declaration that the denial of treatment when she was in critical condition amounted to a violation of her right to life guaranteed under the Nigerian constitution and the African Charter;
- ¥ a perpetual injunction restraining the respondents' agents from fur-

ther discriminating against the applicant and HIV-positive persons in any general hospital in Lagos State; and

- ¥ an order awarding the sum of 10 million naira (about US\$77,000) as damages to the applicant for the violation of her fundamental human rights as guaranteed by the Nigerian constitution.

This is the first court case challenging denial of treatment for people living with HIV/AIDS in Nigeria.

– *Ebenezer Durojaye Tope*

Ebenezer Durojaye Tope is the Staff Attorney for the Center for the Right to Health in Nigeria. He can be reached at ebenezer1170@yahoo.com or crhuids@yahoo.com.

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 Glenn Betteridge, editor of this section, at gbetteridge@aidslaw.ca. All the articles in this section were written by Mr Betteridge.

Court Sets Aside Immigration Employment Authorization Containing HIV-Related Job Restrictions

In an order issued on 30 May 2003, the Federal Court – Trial Division set aside an employment authorization that prohibited an HIV-positive man from working in childcare, primary and secondary school teaching, health services, and agriculture.¹ The court directed immigration medical officers to decide whether a new medical examination is required. This is a significant case for HIV-positive immigrants and refugees who are required to hold an employment authorization if they intend to work in Canada while their applications for permanent residence are decided, a process that can take years.

Mr R arrived in Canada in September 1987 and claimed refugee status upon arrival. He was found to have a credible basis for his refugee claim, passed his medical admissibili-

ty exam, and was issued an employment authorization. There were no conditions placed on the type of job he could hold. In April 1994, he was provided with an indefinite extension

of his employment authorization pending the final disposition of his refugee claim. Once again, no conditions were placed on the type of job he could hold. In January 1995, Mr R started work at a daycare centre. His duties included planning and preparing snacks and lunches for children aged three months to six years, washing dishes, ordering supplies, and organizing and maintaining his work area.

Mr R was diagnosed HIV-positive in May 1996. He disclosed his HIV status to his employer. His employer

obtained information about HIV in the workplace, consulted with the Ontario Human Rights Commission, and concluded that Mr R's HIV status was of no concern. In March 2001, upon being granted a Minister's Permit to reside in Canada, an immigration officer advised Mr R that he would require a new employment authorization and that it would be restricted in such a way that he could not work in childcare or food services. Mr R applied for, and subsequently received, an employment authorization containing the following restrictions: "Not authorized to work in childcare, primary and secondary school teaching, health services field, agricultural occupations." Mr R retained the services of a legal clinic to challenge the restriction. Citizenship and Immigration Canada (CIC) advised his lawyers that there were no written reasons for the restrictions because the decision was based solely on CIC's Temporary Foreign Worker Guidelines (FW Guidelines), which required the restrictions, and that the immigration officer had no discretion to act otherwise.

Mr R challenged in the Federal Court on several grounds the restrictions placed on his employment authorization. First, he argued that an immigration officer had no power to impose health-related restrictions on an employment authorization since, under the Immigration Act² and Regulations,³ only a medical officer can make a determination about public health or safety. Second, he argued that Minister's Permit holders were not subject to the FW Guidelines for employment authorizations. Third, he argued that even if the FW Guidelines should have been applied, the immigration officer failed to consider relevant factors in deciding whether or not to impose conditions

on Mr R's employment authorization. Fourth, he argued that the restrictions were unreasonable having regard to the facts: he had been employed at the same daycare for seven years; his employer is aware of his HIV status

Mr R argued that the restrictions were based on prejudicial fears about HIV/AIDS that had no basis in medical or scientific reality.

and has no objections; his medical condition is stable; there is overwhelming medical evidence that HIV is not transmitted through casual contact; he is self-supporting and independent; and his employment provides him health insurance that is essential to meeting his health needs. Fifth, he argued that the FW Guidelines, the Immigration Act and Regulations unjustifiably infringed his s 15 Charter right to non-discrimination on the ground of disability. Specifically, he argued that the restrictions were based on prejudicial fears about HIV/AIDS that had no basis in medical or scientific reality, and that the restrictions threatened his livelihood and well-being.

Dr Philip Berger, a medical expert in research and treatment of HIV/AIDS, provided evidence that Mr R presents a "zero risk (of transmission) to the children of the daycare in which he works" and that it is "perfectly safe for HIV infected persons to work with children, whether at daycares, in schools or in athletic activities."

The Federal Court — Trial Division did not provide written reasons for its

order. However, the terms of the order make it clear that the Minister of Citizenship and Immigration consented to having the decision to impose restrictions set aside "for the reason that it was based upon prevailing medical knowledge which no longer applies." As a result, the sole issue before the court was whether it should issue a direction that Mr R not be required to undergo a new medical assessment. The court determined that it did not have adequate information to make such an order. The operative part of the court's order reads: "This application for a judicial review be allowed and the employment authorization dated February 4, 2002 be set aside with the Direction that the Respondent [Minister of Citizenship and Immigration] medical officers decide whether a new medical examination by a designated medical practitioner is or is not required, and if a new medical examination is required, it be at the cost of the Respondent."

Comment

This case was decided based on provisions of the Immigration Act and Regulations that have since been repealed. However, the new Act contains similar health-related limitations on the granting of work permits. Under the new Immigration and Refugee Protection Act⁴ and Regulations,⁵ foreign nationals who want to work in Canada in an occupation in which the protection of public health is essential must submit to a medical examination.⁶ According to the FW1 Foreign Worker Manual, the protection of public health is essential in: health services; teaching in primary or secondary schools or teaching other small children; domestic work or live-in caregiving; in-home care for children, the elderly, and the disabled; day-nursery work; and agricultural

work performed by workers from designated countries.⁷

It is regrettable that the court did not issue written reasons in this case, since most people living with HIV/AIDS do not have the financial means or access to legal aid to challenge CIC decisions of this nature. It is also regrettable that the court referred the matter back to CIC officers. Given the overwhelming scientific and medical evidence that HIV is not transmitted through casual contact, and the specific evidence in the case concerning Mr R's health, there was sufficient basis for the court to direct the Minister to issue an employment authorization without conditions. A positive decision made on this basis would have been a welcome precedent. Nonetheless, a close analysis of the court's order demonstrates that it accepted Mr R's argument that immigration officers should not make decisions about health-related restrictions on employment authorizations without the benefit of a medical examination.

¹ Counsel for the Applicant has asked the editors of the *Canadian HIV/AIDS Policy & Law Review* to preserve her client's anonymity by not publishing his name. The editors have agreed to do so. The Applicant is referred to under the pseudonym Mr R. Copies of the Order of Mr Justice Kellen of the Federal Court – Trial Division (30 May 2003) and of the Applicant's Application Record can be obtained from Amina S Sherazee, Barrister & Solicitor; at a.sherazee@utoronto.ca.

² RSC 1985, c I-2 (repealed effective 28 June 2002).

³ Immigration Regulations, SOR/78-172 (repealed effective 28 June 2002).

⁴ SC 2001, c 27.

⁵ Immigration and Refugee Protection Regulations, SOR/2002-227.

⁶ Ibid, s 30(1)(b).

⁷ Citizenship and Immigration Canada. *FW I Foreign Worker Manual*, available at www.cic.gc.ca/manuals-guides/english/fw/fwe.pdf.

Immigration Removal Order Stayed on Humanitarian and Compassionate Grounds

The Immigration Appeal Division of the Immigration and Refugee Board (IRB) has stayed a removal order against a man living with HIV and HCV on humanitarian and compassionate grounds.¹ Taking an enlightened approach, the IRB found that Gurbinder Randhawa's efforts at rehabilitation for his drug dependence was a positive factor in staying the removal order.

Mr Randhawa was subject to a removal order under the Immigration and Refugee Protection Act² because he was convicted of attempted breaking and entering of a dwelling house, an indictable offence under the Criminal Code punishable by a maximum term of life imprisonment. He was sentenced to a suspended sentence plus 18 months' probation. Mr Randhawa appealed the removal order to the IRB and requested that it be stayed on humanitarian and compassionate grounds. The IRB accepted that as a child Mr Randhawa suffered a horrendous history of chronic physical and emotional abuse. It also accepted that he had abused alcohol, and eventually heroin and cocaine, to numb the pain resulting from the abuse. Mr Randhawa testified that he became infected with HIV and HCV from injection drug use.

The factors considered by the IRB in reaching its decision included the degree of Mr Randhawa's rehabilitation, his risk of reoffending, the degree of his establishment in Canada, and the hardship that would be imposed on him if he were to be returned to the country he would most likely be returned to. The IRB found that virtually all Mr Randhawa's crim-

inal activities were related to his drug use and that, although numerous, his criminal offences were not serious. The IRB also found that he had taken major steps in his own rehabilitation, principally by enrolling in a methadone maintenance program. While Mr Randhawa had not initiated medication for his HIV or HCV infection, the IRB seemed to accept his doctor's opinion that Mr Randhawa would benefit from receiving this treatment in Canada. Significantly, the IRB assessed his degree of establishment in Canada in terms of the impact that his HIV and HCV infections would have, both positive and negative:

It is unlikely that the appellant will ever make a major contribution to Canada's economic life due to his HIV and Hep C infections and associated health problems. However, provided the appellant continues his commitment to an addiction-free lifestyle, I believe he will not be a drain on Canada's resources and will continue to be a valuable asset to those who also suffer from the same afflictions and who are also in need of the same treatment and comfort. He said he would like to work with other suffering addicts. The appellant receives a disability pension.³

The IRB concluded that, taken together, the factors relating to Mr Randhawa's establishment were neutral. After a review of all the circumstances, the IRB stayed the execution of the removal order for five years, subject to certain terms and conditions, to be reviewed in November 2005 and again in November 2007.

Comment

The IRB's decision shows an enlightened approach to the issue of drug dependence, criminal behaviours related to drug dependence, and the impact of disability on a person's contribution to Canadian society. The decision is based on an understanding that when people suffer physical and emotional abuse, it can increase their vulnerability to illnesses such as drug dependence, and HIV and HCV

infection. The IRB also takes a broad view of what it means to contribute to Canadian society. It recognizes that while Mr Randhawa will never make a major economic contribution to the economy, he is a valuable asset to Canadian society because of his work with people addicted to illegal drugs. This balanced approach stands in contrast to the medical inadmissibility provisions of the Immigration and Refugee Protection Act and Regulations.⁴ Those provisions only take into account the economic costs associated with disability when determining if a person is inadmissible because he/she will place an excessive demand on health and social services, and they ignore both potential economic and non-economic contributions of people with disabilities.⁵

¹ *Randhawa v Canada (Minister of Citizenship and Immigration)*, [2003] IAAD No 140 (IRB) (QL).

² SC 2001, c 27.

³ *Randhawa*, supra, note 1 at para 32.

⁴ See Immigration and Refugee Protection Act, SC 2001, c 27, s 38; Immigration and Refugee Protection Regulations, SOR/2002-227, s 1(1) definition of "excessive demand" and s 34.

⁵ For further analysis of the Immigration and Refugee Protection Act and the regulatory provisions related to inadmissibility on health grounds, see the Canadian HIV/AIDS Legal Network's *Questions and Answers: Canada's Immigration Policies as They Affect People Living with HIV/AIDS* (21 March 2003), and *Submission to the Standing Committee on Citizenship and Immigration on the Regulations made under the Immigration and Refugee Protection Act* (5 February 2002), both available via www.aidslaw.ca/Maincontent/issues/immigration.htm.

Immigration Act Medical Inadmissibility Provision Survives Constitutional Challenge

In a decision issued on 27 June 2002, the Federal Court of Canada ruled that the medical inadmissibility provision of the Immigration Act did not infringe sections 7 or 15 of the Canadian Charter of Rights and Freedoms.¹ Although the Immigration Act² was repealed effective 28 June 2002 with the coming into force of the Immigration and Refugee Protection Act³ (IRPA), the court's reasons are relevant to some HIV-positive people seeking admission to Canada under the new legislation.

As reported in a previous issue of the *Review*, Ms Chesters, a woman with multiple sclerosis who was found medically inadmissible as an immi-

grant to Canada, challenged the medical inadmissibility provision of the Immigration Act.⁴ That provision rendered inadmissible to Canada any

potential immigrant whose admission would cause or might reasonably be expected to cause excessive demand on health and social services.⁵ Ms Chesters argued that the provision offended the equality rights guarantee, s 15 of the Charter, because it identified a class of people who were singled out for closer scrutiny on the basis of disability.⁶ Alternatively, she argued that the provision had an adverse, discriminatory impact on

people with disabilities, a group already vulnerable to discrimination.

Under s 7 of the Charter, Ms Chesters argued that her right to security of the person was infringed because of the mental and psychological stress she endured as a result of the rejection of her application for permanent residence, and the continued insecurity she faced while in Canada on a discretionary Minister's Permit.⁷ She also argued that she suffered insecurity because she was ineligible for provincially funded Medicare while on a Minister's Permit. Furthermore, Ms Chesters argued that the excessive-demand criterion used to determine medical inadmissibility, and the process by which her circumstances were assessed against that criterion, were unconstitutionally vague and thus in violation of s 7.

The Council of Canadians with Disabilities (Council) intervened in the case in support of Ms Chesters. The Council adopted her arguments, and also argued that the medical inadmissibility provision failed to allow for balancing the potential contributions to Canadian society of people with disabilities against expected costs to health and social services. The Council contrasted the medical inadmissibility provision with the criminal inadmissibility provisions. The latter allow a balancing between the interests of the individual and the state, insofar as they permit a convicted criminal to demonstrate his or her rehabilitation.

The Federal Court rejected Ms Chesters's 15 arguments. It found that there was no direct discrimination. In conducting the comparative analysis under s 15(1), the court disagreed that her situation should be compared with that of able-bodied spouses of Canadian citizens seeking

The Council of Canadians with Disabilities argued that the medical inadmissibility provision failed to balance the potential contributions of people with disabilities against expected costs to health and social services.

admission to Canada. Instead, it compared her with other members of the family class of people seeking to immigrate to Canada. The court found that the medical inadmissibility provision applied to all family-class applicants, so there was no direct discrimination. The court also found that the medical inadmissibility provision does not indirectly discriminate against Ms Chesters (ie, the provision does not have an adverse impact). The court found no evidence of adverse impact on family-class applicants, especially in the context of immigration law. For potential immigrants, the court said, entry into Canada is a privilege and its grant lies within the purview of the Canadian government which is entitled to establish entry standards, including an assessment of potential excessive demand on health services.

It also rejected Ms Chesters's 7 arguments. It found that her right to security of the person was not infringed as a result of the application of the medical inadmissibility provision. She was not a victim of state action, since she had no right to enter Canada as the spouse of a Canadian citizen. The court found that the

excessive-demand criterion was not vague, since there were tools to guide the medical assessment and inform legal debate (the Medical Officers Handbook and regulatory criteria) and since the assessment procedure was not arbitrary. The court accepted the evidence of the two immigration physicians who assessed Ms Chesters as being "something higher than average." It did not address the Council's submissions in its reasons for decision.

Comment

Under the new IRPA, Ms Chesters would not have been inadmissible to Canada on health grounds. Close relatives sponsored for admission to Canada are exempted from the application of those provisions.¹⁰ However, all other people seeking admission to Canada as immigrants will be excluded if it is anticipated that they will place excessive demand on health or social services. Unlike in the former Immigration Act and Regulations, "excessive demand" is now defined by way of regulation made under the IRPA.¹¹ Thus, it will be difficult to argue that the criterion is unconstitutionally vague. The definition of "excessive demand" was widely criticized when it was released in draft form.¹² One basis of criticism was the definition's failure to allow for balancing the potential contributions to Canadian society of people with disabilities against expected costs to health and social services. This was the argument made by the Council in the Chesters case, an argument the court failed to address. Given the high costs of treating HIV infection, including the costs of HIV antiretroviral medication, the definition of "excessive demand" will render inadmissible the vast majority of immigrants to Canada who are living with HIV.

The Federal Court's decision in *Chesters* is poorly reasoned. Arguably, the Charter analysis is flawed. Therefore, the decision should not present a significant impediment to a person found inadmissible on health grounds under the IRPA who challenges the constitutionality of the legislation.

¹ *Chesters v Canada (Minister of Citizenship and Immigration)*, [2002] 1 FC 361 (TD).

² RSC 1985, c 1-2.

³ SC 2001, c 27.

⁴ See R Elliott. Constitutional challenge to "medical inadmissibility" provisions in Immigration Act. *Canadian HIV/AIDS Policy and Law Review* 2002; 6(3): 58-59.

⁵ The medical inadmissibility provision is section 19(1)(a)(ii) of the Immigration Act, supra, note 2.

⁶ Section 15(1) of the Charter provides: "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

⁷ Section 7 of the Charter provides: "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."

⁸ *Chesters*, supra, note 1 at para 120.

⁹ *Ibid* at para 135.

¹⁰ IRPA, supra, note 3 at s 38(2). For a more complete explanation of the effect of HIV status under the IRPA,

see the Canadian HIV/AIDS Legal Network's Questions and Answers: Canada's Immigration Policies as They Affect People Living with HIV/AIDS (21 March 2003) available via www.aidslaw.ca/Maincontent/issues/immigration.htm.

¹¹ Section 1(1) of the Immigration and Refugee Protection Regulations, SOR/2002-227 defines "excessive demand" as: "(a) a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required by these Regulations, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or (b) a demand on health services or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of the denial or delay in the provision of those services to Canadian citizens or permanent residents."

¹² See, for example, the Canadian HIV/AIDS Legal Network's Submission to the Standing Committee on Citizenship and Immigration on the Regulations Made under the Immigration and Refugee Protection Act (5 February 2002), available via www.aidslaw.ca/Maincontent/issues/immigration.htm.

Fear of Lack of Adequate Medical Care Not Well-Founded Fear of Persecution

The Federal Court – Trial Division refused to set aside the Immigration and Refugee Board's (IRB) decision that a refugee claimant was not a Convention refugee because she had not proven a well-founded fear of persecution based on her HIV status or AIDS diagnosis.¹ The court emphasized that the fear of a lack of adequate medical treatment, without a clear link to a ground under the United Nations Convention relating to the Status of Refugees, does not constitute a well-founded fear of persecution.

Ms Tchiegang, a 33-year-old citizen of Cameroon, arrived in Canada in February 2000 and claimed Convention refugee status later that year, under the Immigration Act.² Convention refugees are persons who are outside their country of nationality or habitual residence and who are unable or unwilling to return to that country because of a well-founded fear of persecution for reasons of race, religion,

political opinion, nationality, or membership in a particular social group. Ms Tchiegang feared persecution by the Cameroon government and security forces because of her political activity. She also feared returning because she is HIV-positive and would not be able to access treatment, and because she would be a social outcast and have no support. The IRB found that she was not credible, did

not accept that she was politically active in Cameroon, and did not find sufficient evidence that she faced a serious possibility of persecution on a Convention ground in Cameroon because of her HIV status or diagnosis of AIDS. There was no documentary evidence before the IRB as to the treatment of people living with HIV/AIDS in Cameroon.

Ms Tchiegang sought judicial review of the IRB decision on three grounds: the IRB was biased; it ignored relevant evidence and made findings unsupported by the evidence; and it failed to seek evidence of the treatment of persons with HIV/AIDS

in Cameroon. In relation to the third ground, she argued that the IRB should have advised her and her counsel that they should provide it with some documentary or expert evidence on the treatment of persons with HIV/AIDS in Cameroon. The court dismissed this argument because, on two occasions during the hearing, the presiding IRB member had indicated her concern regarding the lack of such evidence. The court found that these statements were sufficient to inform Ms Tchiegang of the case she had to meet and pointed out that, in fact, her counsel indicated to the IRB that he had looked for this evidence but could not find it.

The court found that Ms Tchiegang's testimony indicates that she did not fear persecution because of her illness; rather, she feared inadequate medical treatment and isolation

from her family and friends.¹ The court went on to discuss the difference between a fear of lack of adequate medical treatment, and a well-founded fear of persecution, the latter being the test a person seeking Convention refugee status must meet:

ÉThe fear of the lack of adequate medical treatment, without a clear link to a Convention ground, does not constitute persecution.ÉThe Applicant did not provide the Board with any evidence that she would be denied medical treatment based on a Convention ground. As a result, there was no basis for the Board to grant Convention refugee status on this ground.⁴

Comment

The distinction between a fear of lack of adequate medical treatment

and a well-founded fear of persecution drawn by the court has been enacted in the Immigration and Refugee Protection Act (IRPA), which came into force on 28 June 2002.⁵ Under the IRPA, a person will not be granted refugee protection (either as a Convention refugee or as a person in need of protection) if the risk faced by that person is caused solely by the inability of a country to provide adequate health or medical care.⁶

¹ *Tchiegang v Canada (Minister of Citizenship and Immigration)*, [2003] FCJ No 343 (FCTD) (QL).

² RSC 1985, c 1-2.

³ *Tchiegang*, supra, note 1 at para 31.

⁴ Ibid at para 32.

⁵ SC 2001, c 27.

⁶ Ibid at s 97(1)(b)(iv).

New Tainted-Blood Class Actions in Québec and Alberta

In two cases in Québec and Alberta, people infected with HIV and HCV through infected blood and blood products have successfully defended motions to strike out all or parts of their legal actions against federal and provincial governments and the Canadian Red Cross Society (CRCS). On 16 January 2003, the Québec Superior Court ruled that the plaintiffs in a class action could rely on the Krever Commission Report in their application for certification of a class proceeding.¹ On 20 February 2003, the Alberta Court of Queen's Bench dismissed an application brought by the Canadian and Alberta governments to strike out the legal action brought against them.² These cases illustrate that the settlement schemes proposed by the federal and provincial governments and the CRCS, and approved by the courts, have not put an end to the civil and constitutional claims brought by people seeking compensation for infection through tainted blood.

The plaintiffs in the Québec case are seeking certification of a class action. In their statement of claim, they rely to a great extent on the voluminous final report of the Commission of Inquiry on the Blood System in Canada (Krever Commission Report) as evidence of their allegations.³ The Krever Commission Report contains findings of fact concerning the conduct of the people responsible for Canada's blood system during the early 1980s. The Attorneys General of Canada and Québec, and the

CRCS, brought a motion to strike out the allegations in the statement of claim that were based on the Krever Commission Report. They argued that the report was irrelevant and hearsay, and thus was not evidence that the court could accept in deciding whether to certify the class of plaintiffs to proceed with its action.

The Quebec Superior Court disagreed. It found that Quebec civil law is flexible in its treatment of evidence in such matters. It said that hearsay evidence is admissible in court, and it will be up to the court to determine the credibility of the evidence in deciding each allegation. It dismissed as premature the motion to strike out the allegations based on the Krever Commission Report. It commented that the attempt by the Attorney General of Canada to bury the report of the Krever Commission, including notably its conclusions and recommendations, demonstrated a certain disloyalty, given the amount of time and effort that went into the preparation of the report.

The plaintiffs in the Alberta case, who number in the hundreds, are seeking damages from the govern-

ments of Canada and Alberta for injuries resulting from receiving blood tainted with HCV and HIV. The Attorneys General of Canada and Alberta brought an application to strike out the plaintiffs' claim. They argued that the claim was an abuse of the court's process, since an Ontario court had approved settlements in similar class actions, and that these settlements should be binding in Alberta. The two settlements approved by the Ontario court compensated people infected between 1986 and 1990, and people infected before 1986 and after 1990, respectively. However, the two groups did not receive the same level of compensation because the compensation fund available to the second group was limited due to the bankruptcy of the CRCS. The governments of Canada and Alberta did not participate in, or contribute any money to, the compensation fund for people infected before 1986 and after 1990.

The Alberta Court of Queen's Bench ruled that the plaintiffs' action was not an abuse of process because the action had a chance of success. The court found that the federal, provincial, and territorial govern-

ments continued to face liability in relation to the people infected before 1986 and after 1990. In addition, the plaintiffs' claim was based on the Canadian Charter of Rights and Freedoms, whereas the two Ontario class actions that were settled were based in tort law and did not address the issue of government liability under the Charter. The court found that the group of people infected before 1986 and after 1990 are entitled to s 15 Charter equality protection since they were denied equal benefit of the law when compared with the group of people infected between 1986 and 1990 — specifically, that they were disabled as a result of their infection, that less compensation was provided to them because of the CRCS bankruptcy, and that this differential treatment was based solely on the date of their infection.

¹ *Desjardins v Société canadienne de la Croix-Rouge*, [2003] JQ No 69 (CS) (QL).

² *Adrian v Canada (Minister of Health)*, [2003] AJ No 203 (QB) (QL).

³ Commission of Inquiry on the Blood System in Canada. Final Report. Ottawa: Minister of Public Works and Government Services Canada, 1997. Available via www.hc-sc.gc.ca/english/protection/krever/.

Judge Refuses to Reduce Damage Award to HIV-Positive Man

In a recent judgment,¹ the British Columbia Supreme Court held that it would be wrong to reduce a damages award for loss of future income based on judicial notice of a relationship

between HIV positive and reduced life expectancy.² The case involved Mr Hunter and Mr Adkens, who had a troubled landlord—tenant relationship that culminated in Mr Hunter assault-

ing Mr Adkens. Mr Adkens, who was HIV-positive, suffered total and permanent loss of sight in his right eye and facial disfigurement as a result of the assault. He was no longer able to

work as an assistant prop master in theatre and television production.

Mr Adkens sued Mr Hunter, based on the tort of assault. The judge found that Mr Hunter's actions constituted an assault in law. Mr Hunter argued that the amount of damages he was

liable to pay Mr Adkens on account of loss of future earnings should be reduced because of Mr Adkens's reduced life expectancy due to HIV infection. There was no evidence before the judge on decreased life expectancy and HIV.

¹ *Adkens v Hunter*, [2003] BCJ No 462 (SC) (QL).

² *Ibid* at para 94.

Infection Rates in Penitentiary Influence Judge's Decision Not to Transfer Young Offender to Adult Court

A Manitoba Provincial Court judge has rejected a government application to transfer JF, a 16-year-old young offender, to adult court, based in part on the dangers posed by the high incidence of HIV and HCV in Stony Mountain Institution.¹

Under the Young Offenders Act,² the Crown can apply to have a young person over the age of 14 transferred to ordinary court. If the young person is found guilty in ordinary court, any sentence of incarceration is served in an adult facility. The Act says that in deciding whether to transfer a young person, the judge shall take into account, among other factors, the availability of treatment or correctional resources, any representations made to the court on behalf of the young person, and any other factors the court considers relevant.³

In this case, witnesses described the facilities, programs, and conditions in two provincial youth facilities and one adult federal institution, Stony Mountain Institution. The judge commented on the potential risks to JF from violence, drug use, and infectious diseases should he end up serving time in Stony Mountain:

Égang recruitment and violence continue to pose significant problems at Stony Mountain. This is especially the case for vulnerable inmates, which would normally include younger inmates and those serving their first penitentiary term. ÉInmates sometimes come to Stony Mountain naïve, and come out much more hardened. Some inmates deteriorate in other ways as a result of their sentence. Despite many measures taken to prevent their entry, drugs remain very

prevalent. At Stony Mountain, HIV/AIDS and Hepatitis C are also concerns. Dr. Somers referred to Hepatitis C as being a disease of epidemic proportions in federal penitentiaries. It is spread by sharing needles for intravenous drug use and by homemade tattoo guns. An inmate who is young or new to a federal institution may also be more vulnerable to sexual assaults.⁴

The judge found that the two youth institutions do not have significant problems with drugs, and that HIV/AIDS and hepatitis C are not issues there.

¹ *R v JF*, [2003] MJ No 120 (Prov Ct) (QL).

² RSC 1985, c Y-1.

³ *Ibid* at s 16(2).

⁴ *JF*, *supra*, note 1 at paras 86 to 89.

HIV/AIDS IN THE COURTS – INTERNATIONAL

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

Australia: Court Orders Doctors to Pay Damages to Woman Who Contracted HIV from Her Husband

In a case that received extensive media coverage, the New South Wales Supreme Court has found two doctors negligent for failing to take steps to make a bride aware that she was at risk as a result of her prospective husband's HIV infection. The court awarded the woman AUD\$727,437 in damages. The couple had attended the physicians together to be tested for HIV and other sexually transmitted infections, but had received their test results separately. She subsequently contracted HIV as a result of unprotected sexual intercourse with him.¹

In 1998, a woman (PD) and her future husband (FH) jointly consulted the Alpha Medical Centre in Sydney, Australia. Both underwent blood tests to ensure that neither car-

ried HIV or any other sexually transmitted infections. Dr Chen was the medical director of the centre and Dr Harvey was employed there on a regular basis. In the course of a joint

pre-test consultation with PD and FH, PD revealed that she was very concerned about HIV infection, especially since FH was originally from Ghana.

During the consultation, PD and FH advised that they were having protected sex. Both PD and FH were tested for HIV, hepatitis C, and other sexually transmitted infections. During the consultation, Dr Harvey did not discuss the post-test procedure, including how the results of the tests would be reported. Specifically,

Dr Harvey did not inform either PD or FH that unless consents were given, he believed that he was legally prohibited from disclosing any medical information, including HIV status, about one to the other due to the statutory confidentiality obligations set out in the New South Wales Public Health Act 1991.²

PD and FH received their test results separately. PD, who was given her results by a receptionist, was HIV-negative. The receptionist told her that she could not have a copy of FH's test results, as they were confidential. FH tested positive for both HIV and hepatitis B. Dr Harvey advised FH not to have unprotected sex and not to try to father children, and scheduled an appointment for FH with the Royal Prince Alfred Immunology Clinic. FH never showed up for the appointment.

FH was also seen by Dr Chen. Dr Chen told FH that he had AIDS (instead of saying that he was HIV-positive), that it kills, and that treatments were expensive. Dr Chen stated to the court that he did not properly inform FH about the implications of being HIV-positive because, since FH was a neatly dressed man who appeared to be educated and since he was African, Dr Chen expected that he would know what HIV was and understand the basic nature of the disease. Dr Chen urged FH to attend the immunology clinic. Neither Dr Harvey nor Dr Chen asked FH if he intended to tell PD about his test results.

FH did not reveal to PD that he was HIV-positive. In fact, he showed her fraudulent medical papers indicating that he was HIV-negative. FH and PD started living together in April or May of 1998 and engaged in

unprotected sexual intercourse. They were married in July 1999. Later in 1999, PD was admitted to hospital with high fever and rashes. She received her HIV-positive diagnosis in January 2000, just prior to the birth of her child.

The Lawsuit

PD sued Dr Harvey and Dr Chen in tort for breach of duty of care and, in the alternative, Dr Harvey for breach of contract. Justice Cripps of the New South Wales Supreme Court dismissed the breach-of-contract argument because, at the medical practitioners were not liable in tort they would not be liable in contract. Justice Cripps decided the case on the basis of tortious liability for negligence, the central issue being whether the physicians breached a duty of care owed to PD as a patient.

PD argued that the standard of care should include appropriate counselling by medical practitioners. Specifically, she asserted that a physician must remind infected patients of their obligations under the law, including: (a) that it is an offence under section 11 of the Public Health Act to fail to take precautions against spreading HIV; and (b) that under section 13 of the Act, it is illegal for persons who know they have a sexually transmissible infection to have unprotected sexual intercourse with another person unless, prior to intercourse, they have informed the other person of the sexually transmissible infection, and the person has voluntarily agreed to accept the risk.

Dr Harvey argued that he was prevented from disclosing FH's HIV status to PD by law. He asserted that the unlawful disclosure of medical information might amount to professional misconduct or expose him to

liability for disclosing confidential information.

Justice Cripps concluded that both physicians fell far short of what was expected of a general practitioner in all circumstances. Specifically, he found that the defendants failed in

The physicians failed in their duty to provide appropriate pre- and post-test counselling.

their duty to provide appropriate pre- and post-test counselling as required by Health Department guidelines, particularly in the area of joint consultation. Justice Cripps went on to define the scope and content of the duty of care that the medical practitioners owed PD in the light of protection of confidentiality set out in the Public Health Act 1991.

Section 17 of the Act makes special provisions for the protection of confidentiality for HIV- and AIDS-related information. The Act nevertheless allows for confidentiality to be broken in the public interest or for the protection of another person. Moreover, s 7(2) of the Regulation made under the Act permits the disclosure of HIV/AIDS status to the Director-General of the Department of Health where a failure to disclose information could place the public health at risk, in order that the Director-General or his or her delegate could perform the necessary tracing and take the necessary actions to protect public health.³

In analyzing the effect of these provisions, Justice Cripps stated that the physicians were not at liberty to tell her of the information they had concerning FH's HIV status but they

could and should have taken other steps to ensure that, as far as legally possible, PD was aware of the danger she was in. Accordingly, Justice Cripps said, the statutory obligation

The physicians could and should have taken steps to ensure that, as far as legally possible, the woman was aware of the danger she was in.

operated as a constraint only and did not preclude members of the practice taking the steps I have concluded they should have taken, but did not, and which resulted in the plaintiff becoming HIV positive.

In Justice Cripps view, physicians should have sought advice from medical experts in the field of HIV testing, the Medical Defence Union, or the Department of Health. If they had done so, he said, they would have been made aware of their obligation to refer FH for counselling in circumstances where he could be persuaded to disclose his HIV status to PD. Other options open to the physicians were: (a) to remind FH about his legal obligations under public health legislation; and (b) to advise FH of the physicians' entitlement (if not obligation) to contact public health officials who could have warned PD about her dangerous position. Justice Cripps added that, in the circumstances, the doctors should also have followed up to make sure that FH kept his specialist appointment.

Significantly, Justice Cripps was not persuaded that the duty of care

the physicians owed to PD extended to the period after PD ceased to be a patient. However, this aspect of his judgment was not relevant to the outcome of the case because of his finding that the physicians breached the duty owed to PD during the period when she was a patient.

Summary

Justice Cripps found that the scope of the duty of care in this case required the medical practitioners to take all reasonable steps to protect PD from what was clearly a foreseeable danger. The duty of care did not impose an obligation to ensure that PD did not become infected with HIV, but imposed on the medical practitioners the obligation to ensure, as far as could be lawfully done, that she [PD] had information concerning her proposed husband's HIV status and the risk to which she was exposed while she remains a patient. The total damages awarded to PD was AUD\$727,437, comprised of AUD\$209,000 for general damages (including damages for loss of expectation of life) and interest on general damages; AUD\$191,568 for loss of earning and loss of earning capacity; and the balance for future medical expenses.

On 12 June 2003, the Australian Medical Association issued a news release in response to the decision. The Association's President, Dr Bill Glasson, said that the case was an example of where the public interest and possible risk to another person override patient—doctor confidentiality. Dr Glasson's comments echo the Australian Medical Association Code of Ethics 2003, which says:

Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the

patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests.⁴

Dr Glasson went on to state that the scope and content of the duty of care under a patient—doctor relationship depends on diverse factual setting and may greatly vary. He concluded that it is not easy to formulate clear boundaries.

Two international documents take differing views of the appropriate way to resolve the ethical and legal dilemma that doctors face when confidentiality obligations conflict with ethical obligations to prevent harm to a third party. In an 18 May 2003 press release, the World Medical Association reports on a resolution passed by its Council advocating that: When law is in conflict with medical ethics, physicians should work to change the law. In circumstances of such conflict, ethical responsibilities supersede legal obligations.⁵

In contrast, the International Guidelines on HIV/AIDS and Human Rights suggest that public health legislation should authorize, but not require, that health professionals decide on the basis of each individual case and ethical considerations whether to inform their patient's sexual partners of the HIV status of their patient.⁶ According to the International Guidelines, two of the factors that should be taken into account are whether the health professionals perceive that a real risk of transmission exists and whether the HIV-positive person has refused to notify his/her partner. Justice Cripps' reasoning is consistent with the International Guidelines.

—Emmanuelle Marceau

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¹ *PD v Dr Nicholas Harvey & 1 Ors* [2003] NSWSC 487, available via www.austlii.edu.au.

² Public Health Act 1991, s 75. The Act is available via www.legislation.nsw.gov.au.

³ Public Health Regulation 1991, since repealed and replaced by Public Health (General) Regulation 2002, available via www.legislation.nsw.gov.au. Section 10(2) of the new Regulation is parallel to s 7(2) of the repealed Regulation.

⁴ Australian Medical Association. Code of Ethics 2003 at s 1(l), available at www.ama.com.au.

⁵ World Medical Association. *The Law and Medical Ethics* (18 May 2003) available at www.wma.net/e/press/2003_6.htm.

⁶ See: 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*. New York and Geneva: United Nations, 1996 at Guideline 3 (Public Health Legislation), para 28(g).

European Court of Human Rights Accepts Blood Donor Screening Based on Sexual Orientation

In a series of three rulings released simultaneously on 15 October 2002, the European Court of Human Rights dismissed complaints that Italy's approach to screening blood donors infringed privacy rights and discriminated against lesbians and gay men.¹

Under a 1991 decree of the Italian Minister of Health, persons who have engaged in homosexual relations, both men and women, were excluded from donating blood. In January 1999, the three petitioners (Crescimone, a lesbian, and Faranda and Tosto, two gay men) sought to donate blood and were denied. The next day they initiated proceedings under the European Convention for the Protection of Human Rights and Fundamental Freedoms.

The complainants argued that the exclusion of blood donors based on sexual orientation breached the European Convention on Human Rights, specifically the right to privacy (Article 8) and the right to equality (Article 14). They argued that the presumption that having homosexual relations would automatically carry a risk of HIV infection is merely unsci-

entific prejudice. They pointed to data showing a decline in HIV cases among Italian gay men, and cases among lesbians are practically nonexistent, while there has been a significant increase in new cases attributed to heterosexual transmission.

In January 2001, Italy changed its policy in order to implement a recommendation from the Council of Europe that altered the questions used to screen would-be donors. Under the new policy, male donors were to be asked if they had ever had sex with another man, and female donors were to be asked if they had, within the preceding 12 months, had sex with a man who, to their knowledge, had had sex with another man.

The Court found the new policy did not exclude donors based on sexual orientation, but based on risk activities. Finding that the complainants

were no longer barred from donating blood on the basis of their sexual orientation, the Court ruled it was no longer justified to continue the examination of their applications. The Court did not directly address the question of whether prohibiting a man from donating blood if he has ever had sex with another man amounts to discrimination based on sexual orientation. The privacy arguments were quickly dismissed by the Court.

– Richard Elliott

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¹ *Crescimone v Italy*, Application No 49824/99; *Faranda v Italy*, Application No 51467/99; *Tosto v Italy*, Application No 49821/99. The ECHR's decisions in each of these cases is available via www.echrcoe.int/Eng/Judgments.htm by clicking on "Search the Case Law," checking off "Admissibility decisions," filling in the name of the applicant and the date, clicking on "Search" and then on the file. Texts of the decisions are available in French only.

US: Court Rules Deportation of HIV-Positive Dominican Does Not Violate Convention Against Torture

The US District Court for New York has upheld a tribunal decision deporting an HIV-positive Dominican national.¹ The court held that the tribunal did not err in finding that Rogelio Reyes-Sanchez had failed to show that he would more likely than not be subject to torture if deported. The court agreed that evidence suggesting that people living with HIV/AIDS may receive substandard medical treatment from public and private hospitals in the Dominican Republic did not constitute evidence of torture.

Rogelio Reyes-Sanchez, a citizen of the Dominican Republic, challenged a final decision of the Board of Immigration Appeals (BIA) denying his applications for withholding and deferral of removal pursuant to the Immigration and Nationality Act and the Convention Against Torture. The Convention has been in effect in the United States since 20 November 1994. Reyes-Sanchez was criminally convicted in the US for attempted sale of cocaine, which is classified as a particularly serious crime under the regulations of the Bureau of Immigration and Customs Enforcement.

Reyes-Sanchez had argued before the BIA that Dominican Republic government policy regarding HIV medication would deprive him of the life-sustaining medication he requires. According to Reyes-Sanchez, in the Dominican Republic some state doctors are afraid of individuals with HIV/AIDS and do not provide them with appropriate medical care. Moreover, he said, there is a pre-

sumption that any man with HIV/AIDS is a homosexual and some doctors refuse to give homosexuals the same medical treatment they accord heterosexuals.

The BIA had concluded that Reyes-Sanchez, who has AIDS, failed to prove that it was more likely than not that he would be tortured on account of his medical condition if deported to his country of origin. In the BIA's opinion, to be successful in his appeal, Reyes-Sanchez would have had to have proved that public officials in the Dominican Republic have intentionally created, and continue to maintain, substandard medical conditions for people with HIV/AIDS, which could constitute torture within the meaning of the Convention.

The BIA explained that although the evidence in the record suggested that people living with HIV/AIDS may receive substandard medical treatment from public and private hospitals, these conditions do not constitute torture within the mean-

ing of the Convention. As incorporated into US law, the definition of torture does not include lesser forms of cruel, inhuman, or degrading treatment or punishment. In addition, torture must be state-instigated or -inflicted or carried out with the consent or acquiescence of the state.

The US District Court, Southern District of New York, noted that the Convention is not a self-executing treaty and does not create individual rights, which can give rise to habeas relief. It said that US interpretation of the treaty requires that it is more likely than not that an applicant would be tortured, which Reyes-Sanchez has not been able to prove. The court therefore concluded that the BIA did not err in its interpretation and was right to reject Reyes-Sanchez's claim.

– Emmanuelle Marceau

¹ *Rogelio Reyes-Sanchez v Ashcroft* [2003] WL 2006615 (US Dist Ct NY).

UK: Welsh Court Reduces Sentence, Cites HIV Status

A Welsh appeal court has reduced the sentence handed down to an offender because of his HIV status, despite his lengthy criminal record.¹ The court reduced the sentence from five to three-and-a-half years' imprisonment.

On 26 July 2002, the accused, Parker, pleaded guilty to criminal offences including theft and having an offensive weapon, driving while disqualified, using a vehicle without insurance, possession of a class A drug (heroin and cocaine) with intent to supply, and possession of cannabis. Parker already had a considerable criminal record. Since 1983 he had appeared in court 27 times charged with 74 offences. While the offences were predominately fraud- and property-related, his criminal record also included offences against the person. He had served six prison sentences, the longest being three years in 1990. In addition, Parker breached many community orders aimed at rehabilitating him. Parker was on probation at the time of the commission of the most recent offences.

In handing Parker a sentence of five years' imprisonment, the sentencing judge remarked on Parker's failure to follow the advice of the probation service or medical services in the past. The judge stated that 'the only place where you are safe and you can get treatment – because you will not take it otherwise – and the only place that the public can be protected from your

continual offending behavior is by staying in prison for sufficient time for you to dry out and to have your medical condition properly attended.'

Parker appealed the sentence on the basis that the sentencing judge failed to give adequate (or any) consideration to Parker's compelling personal circumstances; and that the judge paid too much attention to the perceived cause of his medical condition while giving insufficient attention to the effect of this sentence on his health. Parker has been HIV-positive since 1993. Recent medical reports stated that Parker's health condition is deteriorating, that he cannot anticipate dramatic improvement in the future, and that there was some risk that he would not receive treatment [in prison].

Parker asked the appeal court to exercise mercy because of his medical condition and to reduce the sentence from what would otherwise be an appropriate one. The appeal court accepted the argument and reduced Parker's sentence to three-and-a-half years' instead of five years' imprisonment. This decision contrasts with the traditional position of British courts, as reflected in the following example.

In 1997, a British criminal court declared that 'the fact that an offender is HIV positive, or has a reduced life expectancy, is not generally a reason which should affect [a] sentence.'

In contrast to the position of the British courts, which have only recently allowed sentences to be reduced based on HIV status, Australian courts have regularly recognized that health impairments may be a factor when considering sentencing options. Details of the Australian position are presented in the *HIV/AIDS Sentencing Kit* published in 1996 by the HIV/AIDS Legal Centre in New South Wales, Australia.³ This kit provides an overview of the relevance of HIV/AIDS status to sentencing, and assesses both the legislative framework and decided cases. It also provides useful advocacy strategies for criminal defence lawyers and other advocates.

– Emmanuelle Marceau

¹ *R v Parker* [2003] UWJ No 2352 (CA Crim Div England & Wales).

² *R v Bernard* [1997] 1 Cr App R (S) 135.

³ *HIV/AIDS Sentencing Kit*, 3rd ed. New South Wales: HIV/AIDS Legal Centre, 1996 (available at www.halc.org.au/files/sentencing_kit.pdf).

Asylum Seeker with AIDS Loses Fight against Relocation within the UK

An English court has upheld the decision to relocate an asylum seeker living with AIDS from London to Leeds.¹ The court decided that the public interest in housing asylum seekers where accommodation is available outweighed the woman's interest in remaining in London, where she had an established support network, including medical care. The government has undertaken not to implement the order until her application for asylum is ruled on.

Originally from Uganda, Ms Muwangusi is seeking asylum in the UK under the Immigration and Asylum Act 1999 (IAA). She arrived in the UK as a visitor in October 2000 and was diagnosed HIV-positive soon after. She has been on social assistance since February 2001 and has received treatment for her HIV disease at St George's Hospital in London. The first-level adjudicator refused her asylum application and Ms Muwangusi appealed to the Immigration Appeal Tribunal.

Coincidentally, the UK Secretary of State decided to relocate Ms Muwangusi from London to Leeds under his obligation to provide support, including accommodation, to asylum seekers under s 95 of the IAA.² At the time of the Secretary's decision, Ms Muwangusi was living in emergency housing. Permanent housing was available to her in Leeds. She filed a claim to prevent her relocation. The basis of Ms Muwangusi's claim was that the decision of the Secretary of State was irrational and breached the claimant's right to respect for private and family life. Her

solicitor argued that the relocation would have devastating effects on her health condition due to the stress involved. Her physicians provided evidence that she is extremely distressed about the thought of being dispersed to Leeds where she knows nobody and that she is suffering from depressive symptoms due to her unexpected diagnosis of AIDS and imminent removal to Leeds. In London, Ms Muwangusi was involved in her local community and church, and attended HIV/AIDS-related support groups. There was also evidence before the judge that her community involvement and support network has had beneficial impacts on her mental health.

At the outset of his analysis, Justice Goldring of the High Court of Justice states that "It is agreed that the claimant would receive proper medical treatment when in Leeds." He also recognized the importance of the plaintiff's community bonds in London and the extent to which it would be disruptive to relocate her due to her fragile state of mind. Nevertheless, he determined that the

compassionate factors must be balanced against the overall public interest of providing asylum seekers with accommodation where it is available, which is principally outside London. Justice Goldring further concluded that Ms Muwangusi's mental illness did not appear to be sufficient to lead her to commit suicide or self-harm. On the issue of access to medical treatment, Justice Goldring said that she would be able to receive proper medication in Leeds and re-establish a community network. In deciding to order Ms Muwangusi relocated to Leeds, Justice Goldring said that he took into account the fact that the Secretary of State indicated that no action would be taken pending the decision of the Immigration Appeal Tribunal in Ms Muwangusi's asylum claim.

– Emmanuelle Marceau

¹ *Muwangusi v Secretary of State for the Home Department* [2003] EWJ No. 1889 (HCJ QB Admin Ct) (QL).

² Section 95(1) of the Immigration and Asylum Act 1999 provides that the Secretary of State may provide or arrange for the provision of support for asylum seekers who appear to the Secretary to be destitute or appear likely to become destitute.