

CANADIAN

# HIV/AIDS POLICY & LAW

R E V I E W

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## Human rights and HIV/AIDS in the context of 3 by 5: time for new directions?

Over the last decade, the success of the human rights-based approach to HIV/AIDS has been spotty, says Mark Heywood. In this feature article, the author describes the challenges that remain in implementing a human rights approach. He presents an analysis of questions raised by De Cock et al concerning the applicability of the human rights approach. The author argues that human rights advocacy needs to continue, but that new directions are required. The article outlines new directions in the areas of (a) confidentiality and openness, (b) HIV testing, and (c) health systems. The author concludes that the most serious threat to human rights remains the unwillingness of national governments to take all necessary measures to build health services and prevent epidemics.

It has been over 15 years since a “human rights approach to HIV/AIDS” was first articulated as being necessary to guarantee the success of prevention strategies that aimed to control the HIV/AIDS epidemic.<sup>1</sup> In 1993, Australian High Court judge Michael Kirby described this as the “AIDS paradox,” explaining that “one of the most effective laws we can offer to combat the spread of HIV is the protection of persons living with HIV/AIDS, and those about them, from discrimination. This is a paradox because the community expects laws to protect the uninfected from the infected. Yet, at least at this stage of this epidemic, we must protect the infected too.”<sup>2</sup> Kirby stated that the paradox derived from the fact that there was no vaccine or simple cure for HIV. Although there is still no vaccine or cure, since 1993 the scientific, social, and political environment surrounding HIV has changed dramatically. So has the demography

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## CANADIAN HIV/AIDS POLICY & LAW REVIEW

The *Review* is a summary of developments in HIV/AIDS policy and law in Canada and abroad. Its aim is to educate people about and inform them of policy and legal developments and to promote the exchange of information, ideas, and experiences.

It is published every four months by the Canadian HIV/AIDS Legal Network.

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

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### **Canadian HIV/AIDS Legal Network**

The Network is a charitable organization engaged in 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](mailto:info@aidslaw.ca) or visit our website at [www.aidslaw.ca/AbouttheNetwork/membership.htm](http://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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# EDITORIAL

When we talk about harm reduction in the context of the response to HIV/AIDS, the examples most often cited are needle exchange programs and methadone maintenance programs for people who inject drugs. Indeed, in the Prisons section in this issue, we report on calls for the introduction of such programs in Ireland and Russia. And we report on a decision by a prison in the US to pilot a methadone program.

But a harm-reduction response requires more than providing needle exchange and methadone maintenance. It means reducing other harms as well. For example, in the Prisons section, we report on a decision by the Correctional Service of Canada to launch safer tattooing pilot projects in six federal prisons.

And in several articles in the Canadian News and International News sections, we describe how actions by police forces can increase the harms experienced by drug users. For example, a police crackdown on drug users in Vancouver's Downtown Eastside moved some of the drug trade to other parts of the city. However, the relocation had little impact on drug use and drug prices, and it resulted in users being forced away from the harm-reduction and addiction treatment services available in the Downtown Eastside.

In Thailand, a report by Human Rights Watch (HRW) revealed how a brutal police crackdown on drug users resulted in 2700 alleged drug offenders being killed. Drug users were terrorized. They were forced into hiding, where they were even further beyond the reach of HIV

prevention and other services than they were before. In Russia, another HRW report documented human rights abuses against drug users by authorities.

These types of prohibitionist measures are seldom effective in reducing drug use. Yet, they cause enormous harms and are very, very expensive. The money would be far better spent in reducing the harms associated with drug use.

Drug use is not the only area where harm-reduction approaches are needed. We also need to reduce the harms experienced by sex trade workers as a result of prohibitionist laws and the ways in which these laws are enforced. An article in the Canadian News section in this issue describes two reports that were recently released on this topic and explains how laws prohibiting many activities related to the sex trade worsen the already harmful conditions under which sex workers live. As a result of the laws, and the enforcement practices, sex workers come into conflict with the law, are forced to work in unsafe conditions, and are stigmatized. They are less likely to access health and social services, and they are more likely to be exposed to violence.

The reports call for legislative reform, as well as changes to health and social services and policing practices. They also call for public education campaigns to draw attention to the discrimination, violence, and stigma faced by sex workers, and to promote the dignity and human rights of sex workers. These measures are long overdue.

## About this issue

In one feature article, Mark Heywood describes the challenges in implementing a human rights approach to HIV/AIDS, and argues that new directions are required in the areas of confidentiality and openness, HIV testing, and health systems.

Several other articles in this issue deal specifically with human rights. We report on a ruling by a US judge that said that Alabama prison officials violated the constitutional rights of HIV-positive prisoners by providing inadequate medical care. We detail how officials in the Philippines are violating the right to health of its citizens, including through the failure of the national government to purchase condoms with national funds, and through decisions by some local governments to prohibit the distribution of condoms and other contraceptives in state health facilities. We report on the findings of a comparative study of five nations in the Andean region of South America that revealed serious gaps in meeting international commitments to address HIV/AIDS-related human rights. Finally, we report on a settlement in an anti-discrimination complaint in the US that saw the Cirque du Soleil pay a record US\$600,000 to one of its former employees who was dismissed because he had HIV.

In our second feature article, Thomas Kerr, Megan Oleson, and Evan Wood describe the events surrounding the establishment, operation, and closing of an unsanctioned supervised injection site in Vancouver, and outline the lessons learned.

In our International News section, editor David Patterson reviews the role of the *Review* in publicizing national and international legal and policy responses to HIV/AIDS over the last 10 years.

There are several articles in this issue dealing with HIV testing. Two deal with workplace issues. In Québec, the College of Physicians publicly stated that mandatory HIV testing of physicians is not medically required and could be counterproductive. In Botswana, two court cases underscored the need for specific legislation in that country outlawing mandatory HIV testing in the workplace. Another article reports on a law adopted by the Alberta legislature that could force individuals to be tested for HIV and other bloodborne diseases if their body fluids come into contact with police officers, corrections officers, other emergency personnel, and Good Samaritans. Finally, we report on a situation in Hungary where anonymous HIV testing is theoretically available but only for a substantial fee, thus rendering the tests inaccessible for many vulnerable and disadvantaged individuals.

On the immigration front, we report on a joint statement by UNAIDS and the International Organization for Migration to the effect that where restrictions are placed on the immigration of people living with HIV/AIDS on economic grounds (eg, the cost of health care and social services), the restrictions should be implemented in a way that respects the country's human rights obligations and that gives due weight to humanitarian considerations. We report on a ruling in a particular case by the Migration Review Tribunal in Australia, which said that the decision on whether or not to allow an HIV-positive applicant to immigrate must take into account the applicant's potential contribution to society. We also report on a decision by the federal Immigration Court in the US which ruled that a Zambian woman can stay in the US because her HIV-positive status gives her a well-founded fear of persecution in Zambia, a country where there is extensive discrimination against people living with HIV/AIDS.

# Human rights and HIV/AIDS in the context of 3 by 5: time for new directions?

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of the epidemic. Of particular significance today are the facts that:

- The nucleus of the global epidemic has “settled” but has remained explosive in countries of the Third World, sub-Saharan Africa in particular, and Eastern Europe.<sup>3</sup>
- Projections made in the late 1980s of the potentially devastating societal impact of AIDS have been borne out, and are undermining prospects for achieving many of the Millennium Development Goals.<sup>4</sup>
- Antiretroviral medicines that treat HIV have nearly 10 years of proven efficacy, and drug regimens have been made simpler. In the words of Médecins Sans Frontières (MSF), “Two Pills a Day Saves Lives.” This fact, together with knowledge about which approaches to HIV prevention and treatment work, can save the lives of people already infected and could facilitate a radically different and more effective approach to HIV prevention.
- There is a growing moral outcry and recognition that HIV/AIDS is exacerbating inequities between rich and poor countries, and a conviction that the right to health and life should not be dependent on ability to pay for medicines and health services.

These realities helped create the momentum for the World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), and the Global Fund to Fight AIDS, TB and Malaria to launch the Treat 3 Million by 2005 (3

by 5) Initiative in September 2003, declaring that “a growing worldwide political mobilization, led by people living with HIV/AIDS, has educated communities and governments, affirming treatment as a human right.”<sup>5</sup> The 3 by 5 campaign needs the active support of human rights activists of all hues. At heart, 3 by 5 is a public health initiative, as grand in ambition as the Global Polio Eradication Initiative. But it also aims to lessen the inequity that exists in access to medicines between First and Third Worlds. However, 3 by 5 is a major risk strategy for the WHO and UNAIDS, and thus for human rights. Just as it can raise global expectations, it can also dash them. There are several scenarios for 3 by 5. It can be:

- (a) a dismal failure with only a fraction of the target reached;
- (b) a partial success, where the target is not reached but there is a significant expansion in access to treatment and a momentum and belief is built up that continues after 2005; or
- (c) a success, where the target is reached and work continues toward the ultimate goal of universal access to antiretrovirals for everyone who requires such therapy.

Finally, the success of 3 by 5 depends not only on achieving the target, but also on the sustainability of treatment access that is achieved, and evidence of an improvement in the quality and duration of life for millions of people who live with HIV/AIDS in developing countries. This will require, in a very short time, a tangible and rapid

improvement in the quality and accessibility of health-care services.

The success of 3 by 5 depends not only on achieving the target, but also on the sustainability of treatment access that is achieved.

## 3 by 5 and human rights

Human rights advocates can take comfort in the fact that the 3 by 5 initiative is driven by the conviction that access to health care and treatment is a human right. This is a notion that was expressed many years ago in the Universal Declaration on Human Rights and the International Covenant on Economic, Social and Cultural Rights. In recent years, globalization and the AIDS epidemic have forced national governments, the UN system, and health activists to develop a more detailed explanation of what the right to health entails and obliges governments to do.<sup>6</sup> But it is also important to try to analyze the impact that the 3 by 5 campaign might have on related “traditional” human rights issues, and how human rights principles will be advanced in the 3 by 5 period and beyond. A new AIDS paradox might be that as much as 3 by 5 is an endorsement of a human rights approach to the epidemic, if its implementation leads to shortcuts around core principles such as informed consent for HIV testing, or to a weaken-

ing of patient autonomy in decisions about disclosure, it could also be a threat to human rights.

Over the last decade, the success of the human rights approach to HIV/AIDS (as first articulated by Jonathan Mann, the UN International Guidelines on HIV/AIDS and Human Rights, etc) has been patchy.

A great deal of lip service has been paid to the AIDS paradox, and it would appear that the human rights approach is firmly entrenched in the global response to HIV/AIDS. It is undoubtedly a positive development that today in many countries there is extensive legislation, policy, and case law protecting the human rights of people infected or affected by HIV. In reaction to trade liberalization, and to the WHO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in particular, human rights arguments around health as a right have dramatically impacted on global thinking, pharmaceutical company conduct and, in some cases, state practice.<sup>7</sup> However, the degree to which all these protections actually benefit people in affected communities depends generally either on their governments' commitment to the rights in question (which is rare), or on the extent to which activist organizations are able to draw down the rights and assert them as demands at the community level.

On the downside, a significant number of states continue to deny that HIV is a rights issue. Or they refuse to allow human rights to intrude into certain areas of HIV prevention on grounds of religion, custom, or law.<sup>8</sup> In Zimbabwe, Namibia, and many other countries in Africa and Asia, discrimination against men who have sex with men prevents HIV prevention strategies from targeting or reaching millions of vulnerable people.

States' refusal to distribute condoms to prisoners in most developing countries leaves huge numbers of people vulnerable to HIV, a vulnerability heightened by overcrowding and sexual violence. Similarly, sex work remains criminalized in most countries, including those with progressive constitutions, such as South Africa. In all these instances, the force of Justice Kirby's paradox remains: failure to protect or respect the rights of the most vulnerable fuels the epidemic.

One area where the human rights approach has had little tangible impact beyond offering an analysis relates to the vulnerability to HIV of poor women in developing countries, and to the inability or reluctance of states to challenge the serial violations of women's equality, autonomy, and bodily integrity. In 2004, a Regional Report of the Secretary General of the United Nations' Task Force on Women, Girls and HIV/AIDS in Southern Africa concluded that: "The Task Force has been left to believe that the problem [of women's vulnerability] is either so large that it forces this gender paralysis, or it is so accepted that it does not warrant significant attention from governments, donors and communities."<sup>9</sup> Belated recognition of this human rights crisis led to the formation of the Global Coalition on Women and AIDS in early 2004.

One area where the human rights approach risks not being successful in future is in relation to the rights of, and duties toward, children. This is an emerging human rights priority because the scale of AIDS-related death is now robbing millions of children of parents and relative security.<sup>10</sup> In relation to women and children, the barrier is not discrimination or prejudice toward the infected or marginalized groups, but the unwillingness of

societies to alter gender relations. The paradox here may be that despite the refusal to alter the status quo by empowering women, the status quo will eventually be undermined by the erosion of the social fabric of societies that depend on women's invisible labour.

Without being backed up by resources, many human rights will be universally recognized but not fulfilled.

But generally what we have learnt over the last 15 years is that:

- without being backed up by resources, many human rights will be universally recognized but not fulfilled;<sup>11</sup>
- human rights are most likely to impact on state policy or practice when they motivate social movements such as the Treatment Action Campaign (TAC) in South Africa and are integrated into their programs of actions and turned into demands; and
- bold and urgent action to demand progressive realization of the human rights to dignity, life, and the highest attainable standard of physical and mental health has to underpin all global public health strategies, in the same manner as is now taking place with 3 by 5. The right to treatment for HIV must be synchronized with advocacy that aims to reverse the gross inequalities in health spending and outcomes that are described for the umpteenth time in the 2003 World Health Report.<sup>12</sup>



In the post-treatment period of the HIV/AIDS pandemic, human rights advocacy must continue. The essence of the original AIDS paradox remains. Monitoring the rights of peoples vulnerable to discrimination and marginalization from access to health (and other) resources is vital. Local efforts to educate people about their rights and to redress violations must be ongoing. But on the basis of the accomplishments and failures of the last 15 years, new directions become necessary.

### Defining new approaches to the articulation of human rights

There have always been opponents of a human rights approach to HIV, but these are usually persons or governments with an a priori opposition to rights. However, in 2002 and 2003, a more theorized set of questions about the applicability of a human rights approach to HIV/AIDS in Africa was posed by De Cock and colleagues in two articles published in the *Lancet*.<sup>13</sup>

The authors' starting point is laudable. They explain that "[o]ur philosophical and technical approaches to HIV/AIDS prevention must interrupt HIV transmission, mitigate the epidemic's clinical and social effect, reduce stigma and vulnerability, and promote the rights and welfare of HIV-infected and uninfected people." But unfortunately, in their efforts to debunk "AIDS exceptionalism," De Cock et al mischaracterize Africa and the human rights approach to HIV in Africa. They also overlook the real factors that deter HIV testing and differentiate HIV from other infectious diseases. Below, I identify some of the flaws in their arguments.

One of the central points of their argument is that what the authors refer to as high awareness of HIV in

Africa (an assertion that contradicts their own call for appreciation of the "geographical and epidemiological heterogeneity of the pandemic"),<sup>14</sup> reduces the need for extensive pre-test counselling.

The emphasis on counselling around HIV diagnosis is unique in infectious diseases and merits discussion. Awareness of HIV/AIDS is now high in Africa, and evidence that more extensive pre-test counselling is necessary for HIV than for other infections is lacking.

On this basis, De Cock et al argue in favour of "routine testing" which, they argue, "should not require specific consent or pre-test counselling."<sup>15</sup> However, this argument fails to take into account the fact that awareness is not the same as knowledge and understanding. High levels of HIV/AIDS awareness are often accompanied by high levels of misunderstanding, myth, and denial. High awareness does not lead to health-seeking behaviour – and the deterrent is not the human rights approach. It is important to understand pre-test counselling as both a public health intervention intended to transfer knowledge about HIV to the patient and an ethical and human rights obligation compelling the health worker to respect patient autonomy.

For example, in South Africa, which has some of the continent's largest and most expensive HIV prevention campaigns, there is now evidence that these campaigns may create awareness of an ephemeral existence of HIV, but not of one's own risk. A recent survey carried out by the Reproductive Health Research Unit (RHRU) of the University of the Witwatersrand found that 85 percent of the nearly 12,000 young people surveyed were aware of HIV/AIDS. But:

Among sexually active young people 67% continue to think of themselves as being at low risk for HIV infection. 54% of young people who indicated never using a condom with their last sexual partner feel that they are at low risk of HIV infection... Despite the high prevalence of HIV in this young age group (10.2%), the vast majority of HIV positive youth do not know that they are infected as 67% reported that they had never been tested.<sup>16</sup>

The RHRU's findings beg the question why so-called at-risk populations are not seeking HIV testing – which brings us back to the issue of human rights and stigma! If anything, this emphasizes the importance of counselling rather than the opposite.

**De Cock and company create an artificial and unwarranted polarity between human rights, social justice, and public health.**

De Cock and company also create an artificial and unwarranted polarity between human rights, social justice, and public health. They claim to find a new AIDS paradox in their assertion that human rights advocates deter HIV testing by insisting on autonomy via informed consent, and they conclude that "failure to prevent HIV transmission constitutes an infringement of human rights that hampers Africa's human and social development."<sup>17</sup>

Contrary to what the authors suggest, human rights both encompass and demand social justice and public health. The problem is that bad or corrupt governance by First and Third World governments prioritizes neither

social justice nor public health in many developing countries. This is manifest in the fact that it is the lack of access to health-care services, including voluntary counselling and testing (VCT) and prophylactic or curative medicines, that is the greatest deterrent to health-seeking behaviour.<sup>18</sup> As recognized by the WHO, community mobilization around HIV/AIDS is necessary to demand the supply of VCT and other HIV-related services, as well as to create the demand in the community. Although De Cock would not believe it, the reality is that the human rights principles of confidentiality and informed consent are still widely ignored in health settings in Africa – and are therefore not the kind of obstacles they are claimed to be.

Nonetheless, in their second *Lancet* article, De Cock and his colleagues arrive by wrong means at a set of recommendations that should now be taken more seriously. These are itemized under the subheading “Messages for a serostatus approach to HIV/AIDS prevention and care in Africa.”<sup>19</sup> In essence, they recommend that we learn our HIV status, disclose it to our sexual partners, and seek medical care if we are positive.

De Cock’s approach is too formulaic and acontextual. For example, given the reality of unequal gender relations and sexual violence in a country like South Africa, there will be many women who cannot follow his advice to disclose, or to know the HIV status of, their sexual partner. Ironically, therefore, the success of a “serostatus-based approach” depends on the synergies it builds with the human rights approach. While we can agree with the “new” messages proposed by De Cock, and concur on the need to actively build them into a new generation of messages about

HIV/AIDS prevention and treatment, it is important to remain aware of the human rights issues they present.

Some suggestions about how this can be done are advanced below.

### **Confidentiality and openness**

*In addition to the right to confidentiality, we should emphasize the right to make choices about being open, and the duty of states to actively ensure that people are able to exercise this choice without fear.* This would require states to actively campaign against discrimination and to introduce laws that prohibit and penalize practices such as pre-employment HIV testing. Public messaging should promote openness and disclosure and stress that “people should not be penalized for being open,” rather than “people need not or should not be open for fear of being penalized.” This is not an argument for involuntary disclosure, but a proposal to more actively encourage openness, while still upholding the individual’s rights to autonomy and confidentiality.<sup>20</sup>

### **HIV testing**

*In the past, human rights advocates insisted on recognition of the right not to be tested for HIV because of stigma, discrimination, and the absence of therapy. This right remains, but in addition we should emphasize the right to have access to HIV testing and to know one’s HIV status.* Circumstances are sufficiently changed that HIV testing should be available and offered much more widely and routinely. As suggested in the Guidance Note on Scaling up HIV Testing produced by the UNAIDS Global Reference Group on HIV/AIDS and Human Rights,<sup>21</sup> UNAIDS and the WHO should not reject routine testing out of hand, but should insist that the routine offer of

HIV testing be accompanied by access to both pre-test counselling and therapy where clinically indicated.

It is important to appreciate that this is not what De Cock is arguing for. He argues for “a default policy of testing unless an individual specifically elects not to have it”<sup>22</sup> and an “emphasis on post-test counselling for those infected with HIV.”<sup>23</sup> Given that the problem of counselling is a systemic and structural one, rooted in government’s unwillingness to invest in this aspect of HIV care, De Cock’s formula is dangerous. It is likely that it will lead to large numbers of people being tested for HIV without even lip service being paid to the provision of pre- and post-test counselling.<sup>24</sup> Thus, as part of the 3 by 5 effort, there must be continued insistence on (a) absolute continued patient autonomy, (b) confidentiality, (c) non-discrimination, and (d) testing as an entry point to therapy where clinically indicated.

However, certain risks have to be admitted and undertaken. The risk to human rights of not scaling up HIV testing (missed opportunities for HIV prevention and treatment) must be weighed against the risks to human rights of an imperfect scaling up. Not all the key factors for the routine offer and encouragement of HIV testing, such as those set out in the Guidance Note, will be created by 2006. Therefore, UNAIDS and the WHO should work actively with governments that are committed to an ethical scale-up of voluntary testing, and encourage bodies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria to dedicate funds for this purpose.

Where governments lack this commitment, support should be given to civil society groups to demand more direct investment in counselling; and better and more visible public educa-

tion about HIV, in order that the level of public knowledge and understanding of HIV testing is much higher. Success in raising the quality of public knowledge about HIV would raise the quality of counselling (and facilitate informed decision-making) by taking away some of the burden that is presently placed on counsellors to convey information, provoke questions, etc, that should already be in the public domain.

We should emphasize the right to properly funded, managed, and planned health services, and governments' positive obligations in this regard.

### Health systems

*Finally, integral to the right to treatment, which has now been accepted on paper, we should emphasize the right to properly funded, managed, and planned health services, and governments' positive obligations in this regard.* In 2000-2001 the median per capita HIV/AIDS expenditure for six Southern African countries was US\$1. It ranged from \$29.67 in Botswana to US\$0.41 in Lesotho. The disparity in per capita spending on HIV within the same region is a travesty of the right to health. However, it reflects an unfortunate reality in which the extent of access to HIV-related care has become dependent on the foibles of government, colonial boundaries that cut across national groups, and donor decisions that favour one country over another.<sup>25</sup>

### The right to accountable governance and the obligation of states to take all necessary measures to prevent epidemics

However, the crux of the debate about the future focus and impact of human rights and public health arguments lies with issues of governance. What should have been learned from the last decade is that on almost every level HIV/AIDS is an expression of a crisis of politics and accountable and democratic governance that faces our world.

On the international level, a proper response to HIV/AIDS is threatened by the global impact on resource allocations of the prioritization of the "war on terrorism" over global human need by the United States, the United Kingdom, and other industrialized countries. In 2001, important recommendations were made by the WHO Commission on Macroeconomics and Health to "scale up access of the world's poor to essential health services, including a focus on specific interventions" such as HIV/AIDS. The report estimated that "by 2010 around 8 million lives per year, in principle, could be saved by essential interventions against infectious diseases and nutritional deficiencies."<sup>26</sup> But despite this there are still no serious or coordinated plans in place to check and reverse the emasculation of health services in developing countries. Instead there is pusillanimity with respect to governments whose violations of socioeconomic rights, and failures to meet duties to protect and promote health, have cost millions of people their health, dignity, and lives.

On the national level, a proper response to HIV is threatened by governments, such as those of China and

South Africa, that as a matter of politics and policy for years avoided taking the HIV/AIDS epidemic seriously. Explicit criticism of these governments, based on objective and demonstrable omissions in duties, has been left to local activists who, when they engage in such criticism, often risk persecution. Where civil society is weak or suppressed, as in many countries in Africa and Asia, governments continue to violate health (and many other) rights with impunity. A strong reason for human rights activists to develop a vigorous focus on the responsibilities of national government is that decisions and priorities decided at the national level affect government agendas and priorities both upstream (regional, international, and global) and downstream (provincial and/or municipal).

HIV/AIDS is still not an issue that is meaningfully on the agenda at international meetings of governments such as the G8, the G77, the African Union, or the Association of South East Asian Nations – as opposed to the agenda of the multilateral institutions of the United Nations. This is because except for special events like the 2001 United Nations General Assembly Special Session on HIV/AIDS, national governments have not yet made it so. Further, the problem of HIV/AIDS is still not one that is properly owned or admitted to by many governments of the worst-affected regions of the world.

At the level of local and municipal governance, in almost all high-HIV-prevalence countries, rudimentary services are not yet in place in communities, schools, municipalities, prisons, etc, that take account of the HIV epidemic. The absence of such services remains one of the major deterrents to HIV testing, disclosure, prevention, and treatment.

## Conclusion

Hopefully, this article has defended the ongoing relevance of the “AIDS paradox.” The converse of the paradox is that failure to protect the rights of the most marginalized and vulnerable to HIV increases the vulnerability of the whole population – to HIV infection, but also to its social consequences. The case of prisoners substantiates this point. Prisoners are mostly young and from high-HIV-risk groups. They bring high levels of HIV infection into prison. In environments where there is no access to information, condoms, or personal security, HIV becomes a threat to the whole prison population. Prisons have a high turnover, with many people returning to their communities – once again making HIV a threat to people whose “normal” risk is low.<sup>27</sup> Thus, the failure to protect human rights creates a vicious circle of HIV infection. Similar patterns could be deduced for sex workers and gay men.

Hopefully, the article has also illustrated how, despite the evolution of the human rights paradigm into explanatory notes, guidelines, and best practices, human rights violations continue. Organizations such as the Canadian HIV/AIDS Legal Network and the AIDS Law Project have done much to advocate for human rights at national and global levels. But they cannot create a *culture* of rights, or release the investment in health in developing countries that is needed to fight this epidemic.

The ongoing failure of governments to take the world’s health crisis seriously bodes ill for human rights in general and for 3 by 5 in particular. This has already been recognized by the UN Special Envoy for AIDS in Africa, Stephen Lewis. In March 2004, Lewis called a press conference at the United Nations to “sound the

alarm” about the lack of support for 3 by 5. He explained that the WHO “needs \$200 million, over 2004 and 2005, to put 3 by 5 in place. So far – and we are into the third month of 2004 – donor governments have been unwilling to contribute the money.” The failure to invest in 3 by 5 is a human rights violation committed by governments that have lost sight, or interest, in attaining the highest attainable standard of physical and mental health for the majority of the world’s citizens.

Arguably, therefore, the time for a more vociferous but all-encompassing human rights approach to HIV/AIDS – that affirms the original paradox – has arrived. A much more concentrated focus on the human rights obligations of national governments for the provision of health care is now critical. 3 by 5 may be a global aspiration, but it will only be achieved through successful national and regional health and HIV treatment plans. Consequently, the greatest threat to 3 by 5 – and thus to human rights – remains the unwillingness of national governments to meet their duties to their populations by instituting urgent measures to build health services, social services, and provide treatment.

– Mark J Heywood

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<sup>1</sup> The first international consultation on HIV/AIDS and human rights was held in 1989, the second in 1996, and the third in 2002. The International Guidelines on HIV/AIDS and Human Rights were published in 1998.

<sup>2</sup> M Kirby. *AIDS and the law*. *South African Journal on Human Rights* 1993; 9: 1.

<sup>3</sup> This is not to minimize the existence of epidemics in most industrialized countries and the danger of rising rates of infection in countries such as the US, UK, Australia, and Canada.

<sup>4</sup> See the Report of the Commission on Macro Economics and Health, WHO 2001.

<sup>5</sup> WHO, UNAIDS. *Treating 3 Million by 2005, Making it Happen; the WHO Strategy*, at 5.

<sup>6</sup> The right of access to treatment, as a part of the right to health care, is now supported by a range of UN General Comments, resolutions, Special Reports, and Declarations. An attempt to grapple with its meaning and the obligations it creates for States is found in the UNAIDS/OHCHR *International Guidelines on HIV/AIDS and Human Rights, Revised Guideline 6*, 2002.

<sup>7</sup> B Loff, M Heywood. Patents on drugs: manufacturing scarcity or advancing health? *Journal of Law, Medicine and Ethics* Winter 2002; vol 30:4: 621-631.

<sup>8</sup> This was evident in the compromises on the language that were made in the negotiations around the UNGASS Declaration of Commitment.

<sup>9</sup> Also: Human Rights Watch. *Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa*, 2003.

<sup>10</sup> *Africa’s Orphaned Generations*. UNICEF, November 2003.

<sup>11</sup> Lesotho, for example, has a model National AIDS Plan in its recognition of human rights, but there is no implementation, there are no resources, etc.

<sup>12</sup> Available at [www.who.int/whr/2003/en/](http://www.who.int/whr/2003/en/).

<sup>13</sup> K De Cock, E Marum, D Mbori-Ngacha. Shadow on the continent: public health and HIV/AIDS in the 21<sup>st</sup> century. *Lancet* 2002; 360: 67-72; De Cock, D Mbori-Ngacha, E Marum. A serostatus-based approach to HIV/AIDS prevention and care in Africa. *Lancet* 2003; 362: 1847-1849.

<sup>14</sup> De Cock et al. Shadow on the continent. *Ibid*.

<sup>15</sup> *Ibid*.

<sup>16</sup> HIV and Sexual Behaviour Among Young South Africans. A National Survey of 15-24 Year-Olds. 2004, at 56-57.

<sup>17</sup> De Cock et al. Shadow on the continent, *supra*, note 13.

<sup>18</sup> The degree of the scale-up envisaged for HIV testing by 3 by 5, and the need to create or improve 20,000 service points for VCT, is recognition of the paucity of these services on the ground at present.

<sup>19</sup> De Cock et al. A serostatus-based approach, *supra*, note 13.

<sup>20</sup> Anecdotally, in my experience in Southern Africa, the right to confidentiality has been translated in practice by many nurses and counsellors into discouragement of disclosure and the right to keep one’s HIV status secret. Responsibility for this rests with the failure of governments to properly train health workers, particularly about ethics and human rights. De Cock criticizes “professional organisations” for failing to respect patients’ rights to an accurate HIV diagnosis and to respond to the diagnosis. But this ignores the fact that, until recently,

the dilemma facing many physicians was the inability to respond to a diagnosis with appropriate treatments.

<sup>21</sup> Although the document in question has not yet been posted, other information about the Reference Group can be found at [www.unaids.org/en/in+focus/hiv\\_aids\\_human\\_rights/reference+group.asp](http://www.unaids.org/en/in+focus/hiv_aids_human_rights/reference+group.asp).

<sup>22</sup> De Cock et al. Shadow on the continent, *supra*, note 13.

<sup>23</sup> De Cock et al. A serostatus-based approach, *supra*, note 13.

<sup>24</sup> Effective 1 January 2004, routine testing of the wrong sort has been adopted as policy in Botswana, which has "become the first African country to implement routine opt-out testing on a national level, starting with health facilities." (*AIDS Analysis Africa* 2003/04; 14(4)). Following the lead of De Cock et al, the justification for this policy has been the low take-up of VCT and the notion that "public rights is more valid than human rights."

<sup>25</sup> See *A Comparative Analysis of the Financing of HIV/AIDS Programmes in Botswana, Lesotho, Mozambique, South*

*Africa, Swaziland and Zimbabwe*. HSRC Publishers, October 2003.

<sup>26</sup> *Macro-Economics and Health: Investing in Health for Economic Development*. Report of the Commission on Macroeconomics and Health, 2001, at 4.11.

<sup>27</sup> AIDS Law Project submission to the Jali Commission, 2004, available at [www.alp.org.za](http://www.alp.org.za).

## Harm-reduction activism: a case study of an unsanctioned user-run safe injection site

Due to the ongoing health crisis among injection drug users in Vancouver, Canada, there have been repeated calls for the establishment of safe injection sites (SISs) since the early 1990s. In April 2003, in response to a large-scale police crackdown and government inaction, a group of activists opened an unsanctioned SIS in Vancouver's Downtown Eastside (DTES). The 327 Carrall Street SIS operated for 181 days despite considerable police harassment and limited financial support. During the operation of the SIS, volunteers supervised over 3000 injections and demonstrated the feasibility of a user-run low-threshold SIS. The experience of the SIS provides valuable lessons for those seeking to advance the interests of injection drug users through community mobilization and direct action approaches. In this article, Thomas Kerr, Megan Oleson, and Evan Wood describe the events surrounding the establishment, operation, and closing of the unsanctioned SIS, and outline the lessons learned.

### Introduction

The Downtown Eastside of Vancouver, British Columbia has been the site of ongoing HIV and overdose epidemics.<sup>1</sup> The Vancouver HIV epidemic has been attributed to various factors, including over-investment in law-enforcement approaches, the high prevalence of cocaine injection, cuts to social housing and addiction treatment services, and difficulty accessing syringes among the city's injection drug users.<sup>2,3,4</sup> Since the early 1990s, various forms of activism have been initiated in the DTES to address the ongoing health crisis among injection

drug users, including actions aimed at promoting the establishment of safe injection facilities.<sup>5</sup> SISs, where users can inject pre-obtained illegal drugs,



The unsanctioned safe injection site at 327 Carrall Street, Vancouver.

have been implemented in several cities in order to reduce community and public health impacts of injection drug use.<sup>6</sup>

A significant development occurred in Vancouver in November 2002 when the former chief coroner of British Columbia, Larry Campbell, was elected as mayor of Vancouver. Campbell swept the election while running on a platform calling for harm reduction and the immediate establishment of SISs in the DTES.<sup>7</sup> In spite of these developments, the DTES was still without an SIS when the Vancouver Police Department

(VPD), on 7 April 2003, initiated a large-scale crackdown on the neighbourhood's drug market.<sup>8</sup> The crackdown, referred to as the City-Wide Enforcement Team initiative (CET), drew criticism from several local community groups, and drew international attention when observers from Human Rights Watch issued a report stating that the crackdown had resulted in numerous human rights violations<sup>9</sup> – a claim vigorously denied by police and local politicians.<sup>10</sup> On the night that the CET crackdown was initiated, local activists and drug users opened an unsanctioned “user-run” SIS to protest the crackdown and the government's failure to fulfill its promise to open an SIS.

Although several forms of activism have been initiated to address the ongoing health crisis in the DTES, little is known about them. Therefore, the present study was undertaken to describe a particular example of harm-reduction activism. In particular, we sought to describe the user-run unsanctioned site, including the events surrounding its opening, operation, and eventual closure on 7 October 2003.

## Methods

A case study methodology was selected as a means to obtain understanding of a particular instance of harm-reduction activism.<sup>11</sup> Individuals working at the SIS collaborated with external researchers in gathering data using various methods and sources.

*Site updates, meeting minutes, press releases, media stories.* All available historical documentation was compiled and systematically reviewed in order to derive information about the opening, operation, and closing of the SIS. Materials included updates disseminated by SIS volunteers, SIS

meeting minutes, related press releases, and media stories.

**Participant observation.** The authors also engaged in participant observation throughout the data collection period. The authors attended various SIS meetings and press events. Field notes were taken during or immediately following these activities. One author (Megan Oleson) worked as nurse at the SIS throughout its operation.

**Data analysis.** Historical documentation and field notes were sorted according to the central study objectives. Content analysis was used to examine patterns that emerged from the data. On the first pass an initial set of codes was used to denote key content areas. Subsequent reviews were used to assign data segments to categories and examine negative evidence.

## Results

### Opening of user-run unsanctioned safe site

The unsanctioned SIS officially opened on 7 April 2003; the same day VPD began its CET crackdown.<sup>12</sup> The group responsible for opening the SIS, the Coalition for Harm Reduction, had initially formed to organize a response to the police crackdown. The group described itself in a press release as follows:

The Coalition is made up of community groups who represent and stand in solidarity with poor people, drug users, sex workers, immigrants and refugees, aboriginal people and others who are marginalized. The member groups of this coalition share the philosophy of harm reduction and see the lack of a safe injection site and other life-saving initiatives combined with the increased levels of policing as creating an increasingly dangerous situation for poor residents of the DTES.<sup>13</sup>

The Coalition included several existing community groups, including the Vancouver Area Network of Drug Users (VANDU), the Anti-Poverty

The opening of the SIS was a direct community response to the reallocation of police officers to the DTES.

Committee, the Housing Action Committee (HAC), the Pivot Legal Society, and the Harm Reduction Action Society. The opening of the SIS was described as a direct community response to the reallocation of 44 VPD officers to the DTES and was also intended to protest the government's failure to open a sanctioned SIS. Comments made to the media by then VANDU President Robert Weppeler further describe the reasons behind the action:

We got tired of seeing deadline after deadline pass and still no safe injection site. We had an agreement with the city that they would bring in additional police after a safe injection site opened, but the police didn't wait. Instead they put 44 officers into the neighbourhood ... so a coalition of community groups pushed forward to force open a site.<sup>14</sup>

The SIS was located in the heart of the DTES open drug scene at 327 Carrall Street, and was built within a storefront space. The storefront had been rented by local activists who used the space primarily for community meetings. As an SIS, the space included a front room for drop-in visits as well as a small space in a back

room with two small tables, divided by a temporary wall, for injection, and one washroom. The SIS operated seven days a week, four hours a day from 10 pm to 2 am.

In order to ensure that the site was peer-driven, SIS volunteers at the site began organizing weekly “Council” meetings involving site volunteers and individuals using the site. The Council made decisions about operational issues, including decisions concerning evaluation, and also assumed responsibility for volunteer duties at the site. Members of the Council also attended meetings of the Coalition for Harm Reduction, which focused primarily on communication strategies, recruitment of non-drug-user volunteers, and fundraising. Although considerable efforts were made to recruit additional volunteers, few health-care professionals agreed to work at the site.

The drop-in space was overseen by local volunteer drug users who provided coffee and distributed and collected syringes. The injecting spaces were overseen by SIS volunteers and a registered nurse. All site volunteers received training in CPR, first aid, safer-injection education, and dealing with conflict. This training was provided by the nurse who worked at the SIS. Individuals accessing the injecting space were provided with sterile syringes, water, filters, and spoons. The on-site nurse supervised all injections, offered education related to safer injection and vein care, and provided first aid to those accessing the drop-in or the injecting spaces. The 327 SIS injecting room operated in a low-threshold format not commonly observed in most SISs.<sup>15</sup> For example, the site did not have rules requiring registration, or rules prohibiting either the sharing of drugs within the SIS or assisted injection. Throughout the operation of the SIS, site volunteers

also worked with local researchers to document the activities occurring at the SIS.

Approximately three weeks after the opening of the SIS, the Council decided to announce to the public that the SIS was in operation. The group decided to wait three weeks so that the feasibility of operating an SIS would already have been established even in the event that the police immediately shut down the site following the public announcement. On 4 May, the Coalition disseminated a press release stating that the SIS had been open for three weeks, and media were invited to attend a press conference at the site. The press release included the Coalition’s three demands that: (1) a sanctioned SIS be opened immediately; (2) the 44 police officers who had been reallocated to the DTES be removed immediately; and (3) the three pillars of treatment, prevention, and harm reduction described in the City of Vancouver’s “Four Pillar” Drug Strategy be implemented.

Throughout the operation of the SIS, the HAC also held meetings every Tuesday to plan direct action

**Demonstrations in the DTES helped to keep up morale and to maintain pressure on the police and City Council.**

approaches aimed at echoing the Coalition’s demands. Each week, members of the HAC would organize demonstrations in the DTES, which helped to keep up morale and to maintain pressure on the VPD and City Council. In addition, when SIS

volunteers were not working at the SIS, many would participate in “cop watch” activities organized by PIVOT and COPWATCH Vancouver. Cop watches typically involved two-hour shifts, during which volunteers would closely observe police officers patrolling the DTES, and take photos and videos of police activities, while also handing out PIVOT’s rights cards. The cards include a description of citizens’ rights in the event of police arrest or detainment and a statement that can be read aloud or handed to police by an injection drug user under police control or supervision.

Members of the HAC and the Coalition also attended every VPD board meeting that occurred between April and October of 2003. During these meetings activists would speak about the impact of the police presence in the DTES and would share experiences of police brutality. On more than one occasion, the 50 or more HAC and Coalition members attending the VPD board meetings shut down proceedings when activists were prohibited from speaking to agenda items.

### **The police respond**

Shortly after the Coalition announced to the public that the SIS was in operation, confrontations between SIS volunteers, participants, and police became increasingly common. Police opposition to the SIS was evident in early public comments made by police:

That an illegal safe injection site would be open is obviously a concern ... but it is not a high priority. Our focus is on the dealers, not addicts. We are very disappointed that groups did this now, because we are supporters of the official-supervised safe injection site application that has been forwarded to Health Canada.... We are monitoring

the situation, but we will not be taking any immediate action. (Police spokeswoman Anne Drennan)<sup>16</sup>

Despite these comments, there were 34 days (21 percent of all days of operation) involving police presence of some kind in or around the SIS.<sup>17</sup> According to field notes taken, the type of police activity varied considerably, from low-level surveillance of the site to uniformed officers entering the SIS. Among the more common types of activity recorded in the field notes included police parking their cars outside the SIS, and observing and questioning injection drug users entering and leaving the site:

Two officers parked from midnight to 2am outside 327 Carrall Street ... just hanging out outside the safe injection site. When asked to please respect the entrance and grant some space they refused and X told me this was his “community policing.” (6 July 2003)

Two officers searching people in the park, searched and detained a young Aboriginal man who regularly visits the safe injection site [and when] the police officers were questioned by staff, [one] officer replied that he had left the park too quickly and looked suspicious, and went on to say it was none of my business and that the safe injection site is illegal. (23 August 2003)

The SIS volunteers refused to close the SIS in the face of escalating police presence around the site. The position of the volunteers and their view of the police presence around the SIS was articulated by a local activist:

They have this idea that we’re supposed to be grateful they haven’t shut us down.... But no, we’re not grateful. They can’t shut us down. We didn’t ask their permission to open and we aren’t asking their permission to stay open. So what we get is this systematic harassment.<sup>18</sup> (Ann Livingston)

As interactions between police and the SIS volunteers became more frequent, SIS volunteers met with representatives of the City of Vancouver to

**The volunteers refused to close the SIS in the face of escalating police presence around the site.’**

secure an agreement concerning police conduct around the site. In June, after efforts to reduce the police presence around the SIS failed, members of the Coalition again demonstrated outside a local police board meeting. During the demonstration, members of the Coalition forced their way into the board meeting, despite a strong police presence, to demand that police stay away from the SIS and the injection drug users accessing it. Field notes indicate that police surveillance increased in the wake of these events, and according to SIS volunteers, the area around the site quickly became a “police zone.” The interactions between the SIS volunteers and police escalated in late July when three officers entered the SIS:

On July 20, 2003 at 1:24 am, three police officers forced their way into the safe injection site at 327 Carrall Street questioning and detaining people accessing the drop-in area of the site. The police officers attempted to access the injection room and were denied access by on-site volunteers, who demanded that the police present them with a warrant to search the premises. The officers involved had no warrant to enter the premises and declared no reasonable cause to enter the safe injection site and left.<sup>19</sup>

The increasing police presence around the SIS and the associated adverse impacts were noted in an update disseminated by SIS volunteers:

Already on a nightly basis the people who both access and volunteer at the safe injection site are subject to police harassment. They park their cruisers directly in front of the 327 safe injection site door, they walk their drug dogs in front of the safe injection site, the police harass and intimidate people who come in and out of the 327 safe injection site main door, the police drive their motorcycles on the sidewalk and through crowds of people in Pigeon Park and people standing in front of the 327 safe injection site, and harass the volunteers who open and close the safe injection site. This is blatant intimidation, and when the police intimidate anyone from using the safe injection site, the police are forcing them into the alternative: a dark alley, or fixing in their hotel room alone ... into riskier situations, with exposure to violence, untreated overdose, no access to medical attention.... (21 July 2003)

The final police action noted by the SIS volunteers occurred on 16 September 2003, the day after Vancouver’s sanctioned SIS officially opened. On this day, police changed the lock and nailed the door shut at 327 Carrall Street before the site opened at 10 pm. This action by the police prompted the first public disagreement between the mayor and police concerning the SIS, as indicated by comments made to the media:

With the site being opened, the legal site, we took the initiative and simply just shut it down.... The city council may have a different perspective .... But from our perspective, we believed it was time to shut down the facility, and we did that. (Police spokeswoman Sarah Bloor)



I'm disappointed. I'll admit that. I'm disappointed. It's going to have to close down, there's no question about that. We're going to have a meeting on Thursday with them and quite frankly, I'd like to have them become involved with the safe injection site. (Mayor Larry Campbell)<sup>20</sup>

Despite efforts by police to close the site, SIS volunteers managed to break the lock, kick open the door, and reopen the 327 SIS.

Prior to the closing of the SIS, the police denied reports that they had harassed participants accessing the site, and further stated that police activities had not deterred anyone from accessing the SIS:

I do not believe our officers are harassing people.... They conduct themselves in a professional manner. Officers in the area do street checks as part of routine patrol, and no one is prevented from accessing the site. (Police spokeswoman Sarah Bloor)<sup>21</sup>

The escalating police presence around 327 Carrall Street had a substantial impact on the operation of the SIS. Data collected during the operation of the SIS indicated that police presence around the SIS was associated with statistically detectable reductions in the number of drug users accessing the SIS injection room, including the number of Aboriginal users accessing the injection room, the number of visits to the drop-in area, as well as the number of syringes collected and distributed at the 327 SIS.<sup>22</sup>

### Closing the 327 SIS

The 327 Carrall Street SIS closed on 7 October 2003, 181 days after it opened, and approximately three weeks after Vancouver's official and sanctioned SIS opened a few blocks away. During the operation of the

unsanctioned user-run SIS, over 3000 injections were supervised, and there were almost 9000 visits to the site's drop-in area. The decision to close the site was made by the SIS Council. After six months of operating the SIS with little financial support, as well as little support from local health-care professionals, the small number of volunteers who staffed the site were exhausted, and yet confident that they had met several of their original goals. The new sanctioned SIS was open, and several of the drug users who volunteered at the 327 SIS were eventually employed there. The combined sense of fatigue and success surrounding the closure was described by a member of the site's Council:

The last six months have been a constant struggle against the City of Vancouver, the Vancouver Police department and various Business Associations, but we did what we said we would do, and we won. We are still fighting for the rights and dignity of injection drug users and people who live in poverty, and the group will continue to press for accessible supervised injection sites, community based injection sites, and an end to police targeting drug users and people who are poor. (Lisa Olm, 327 SIS volunteer)

As a final action, the 327 Carrall Street volunteers developed a set of recommendations for the operation of the sanctioned SIS. These included specific recommendations for the inclusion of peer workers within the SIS, which were submitted to representatives of the Vancouver Coastal Health Authority.

### Conclusion

In light of evidence indicating the harmful effects of police crackdowns within inner-city drug scenes,<sup>23, 24</sup> it is

clear that the 327 Carrall Street SIS performed an important public health function by providing an environment where users could inject safely and under supervision. However, the formation of the Coalition for Harm Reduction and the opening of the 327 Carrall Street SIS also showed that injection drug users are capable of organizing themselves and mounting resistance to policies and actions that pose threats to their safety and health. The injection drug users involved in this particular project organized themselves in the face of a police crackdown despite the health and legal risks associated with this type of action, and in doing so focused the attention of politicians and the public on the harmful effects of the police crackdown and the outstanding need for a sanctioned SIS within the DTES.

Injection drug users are capable of organizing themselves and mounting resistance to policies and actions that pose threats to their safety and health.

The experience at the 327 Carrall Street SIS also served to demonstrate the feasibility of involving users in the governance and operation of SISs. Previous studies have indicated that the involvement of injection drug users helps to increase the reach and effectiveness of harm-reduction interventions (eg, needle exchanges), and that user-driven interventions have been found to be more effective in terms of the coverage they provide

than traditional service-provider interventions.<sup>25, 26, 27, 28</sup> Given the success of the 327 Carrall Street SIS, it is clear that peers also have a role to play in the governance and operations of SISs. It is noteworthy that some of the peers who worked at the 327 Carrall Street SIS now hold peer-worker positions at the new sanctioned SIS in the DTES.

The 327 Carrall Street SIS also served to demonstrate the feasibility of a low-threshold SIS operational format. The SIS operated without rules preventing drug sharing and assisted injection, rules that have been previously shown to have potentially negative impacts on access to SISs by Vancouver injection drug users.<sup>29</sup> The format implemented at the 327 Carrall Street was successfully maintained throughout the operation of the SIS. This was possible because there were no disputes over drugs within the SIS, despite the fact that drug sharing was common; and because drug users performing or receiving assisted injections readily accepted all guidelines (eg, use of universal precautions) put in place by the SIS Council.

Many other lessons pertaining to community mobilization have been learned from the experience of the 327 Carrall Street SIS. First, the experience demonstrated the potency of coalition building. Second, this instance of harm-reduction activism showed that a multi-faceted approach can be highly effective, including one that involves: the establishment of participatory models of governance (eg, the SIS Council); the continuous application of direct-action methods (eg, protests); active participation in local meetings involving policymakers (eg, City Council meetings); the application of community-based research methods as a means of documentation; and extensive use of media.

Third, this experience shows that this form of activism requires considerable dedication, and relies extensively on the volunteer contributions of local community members who are willing to accept risks, such as arrest, that come with operating unsanctioned harm-reduction services for drug users.<sup>30</sup> Finally, the 327 Carrall Street SIS experience shows that this form of activism can prompt escalating police attention and harassment, indicating the need for: (a) a careful consideration of risks for those providing and accessing the harm-reduction service being operated; and (b) at times, legal support for activists.

Activism has long been central to advancing the interests of marginalized groups, including the establishment of harm-reduction programs for injection drug users. The 327 Carrall Street SIS volunteers succeeded in sustaining resistance to a police crackdown and government inaction, while providing a safe haven for users at heightened risk for drug-related harm and police violence. The site also demonstrated the feasibility of implementing a low-threshold SIS format that is culturally appropriate to the practice of injection drug users, as well as the feasibility of involving users in the governance and operation of SISs. Finally, the experience of the SIS provides valuable lessons for those seeking to advance the interests of injection drug users through community mobilization.

– Thomas Kerr, Megan Oleson,  
and Evan Wood

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<sup>1</sup> E Wood, T Kerr, PM Spittal, MW Tyndall, MV O'Shaughnessy, MT Schechter. The healthcare and fiscal costs of the illicit drug use epidemic: the impact of conventional drug control strategies and the impact of a comprehensive approach. *BC Medical Journal* 2003; 45(3): 130-136.

<sup>2</sup> MV O'Shaughnessy, JS Montaner, S Strathdee, MT Schechter. Deadly public policy. *International AIDS Conference*. 1998; 12: 982 (abstract no 44233).

<sup>3</sup> MW Tyndall, S Currie, P Spittal et al. Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic. *Aids* 2003; 17(6): 887-893.

<sup>4</sup> E Wood, MW Tyndall, PM Spittal et al. Unsafe injection practices in a cohort of injection drug users in Vancouver: could safer injecting rooms help? *Canadian Medical Association Journal* 2001; 165(4): 405-410.

<sup>5</sup> TH Kerr, E Wood, A Palepu, D Wilson, MT Schechter, MW Tyndall. Responding to explosive HIV epidemics driven by frequent cocaine injection: is there a role for safer injecting facilities? *Journal of Drug Issues* Summer 2003; 579-608.

<sup>6</sup> K Dolan, J Kimber, C Fry, J Fitzgerald, D McDonald, F Frautmann. Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia. *Drug and Alcohol Review* 2000; 19: 337-346.

<sup>7</sup> CBC. Real-life Da Vinci leads sweep in Vancouver elections. 18 Nov 2002.

<sup>8</sup> 90 arrested in drug sweep: the first five days of a major campaign has produced hundreds of trafficking charges. *Vancouver Sun*, 12 April 2003: A1.

<sup>9</sup> Human Rights Watch. Abusing the user: police misconduct, harm reduction and HIV/AIDS in Vancouver. Vol. 15, No. 2(B) – May 2003 (available at [www.hrw.org/reports/2003/canada/canada0503.pdf](http://www.hrw.org/reports/2003/canada/canada0503.pdf)).

<sup>10</sup> The City of Vancouver's response to the Human Rights Watch report on the health and human rights impacts of the Vancouver Police Department's City-wide Enforcement Team (CET) Initiative. 9 June 2003, available at [www.city.vancouver.bc.ca/fourpillars/pdf/HRW-response.pdf](http://www.city.vancouver.bc.ca/fourpillars/pdf/HRW-response.pdf).

<sup>11</sup> RE Stake (ed). *Case Study Methods in Educational Research: Seeking Sweet Water*. Washington: American Educational Research Association; 1988. RM Jaeger (ed). *Complementary methods for research in education*.

<sup>12</sup> Illegal safe injection site opens in Vancouver: CTV News, 2003.

<sup>13</sup> Safe Injection Site Needs Your Support. Coalition for Harm Reduction (2003). Media release, 13 May 2004.

<sup>14</sup> DRCNet. Vancouver: Unsanctioned safe injection site opens in midst of police crackdown on Downtown Eastside hard drug scene. *The Week Online with DRCNet*, 2003.

<sup>15</sup> RS Broadhead, TH Kerr, JP Grund, FL Altice. Safer injection facilities in North America: their place in public policy and health initiatives. *Journal of Drug Issues* 2002; 32(1): 329-355.

<sup>16</sup> *Supra*, note 14.

<sup>17</sup> T Kerr, M Oleson, M Tyndall, E Wood. A Case Study of

an Unsanctioned Peer-driven Safe Injection Site. Paper presented at the International Conference on the Reduction of Drug-related Harm, 2004, Sydney, Australia.

<sup>18</sup> DRCNet. Unapproved Vancouver safe injection site gets unwanted police attention. *The Week Online with DRCNet*, 25 July 2003.

<sup>19</sup> Columbia CNB. Police accused of raiding safe injection site. July 21, 2003.

<sup>20</sup> Safe injection site battle heating up. *CBC News British Columbia*. 1 October 2003.

<sup>21</sup> *Supra*, note 18.

<sup>22</sup> *Supra*, note 17.

<sup>23</sup> C Aitken, D Moore, P Higgs, J Kelsall, M Kerger. The impact of a police crackdown on a street drug scene: evi-

dence from the street. *International Journal of Drug Policy* 2002; 13(3): 189-198

<sup>24</sup> L Maher, D Dixon. Policing and public health: law enforcement and harm minimization in a street-level drug market. *British Journal of Criminology* 1999; 39(4): 488-512.

<sup>25</sup> CA Latkin. Outreach in natural settings: the use of peer leaders for HIV prevention among injecting drug users' networks. *Public Health Reports* 1998; 113 (Suppl 1): 151-159.

<sup>26</sup> RS Broadhead, DD Heckathorn, JC Grund, LS Stern, DL Anthony. Drug users versus outreach workers in combating AIDS: preliminary results of a peer-driven intervention. *Journal of Drug Issues* 1995; 25(3): 531-564.

<sup>27</sup> RS Broadhead, DD Heckathorn, DL Weakliem et al.

Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention. *Public Health Reports* 1998; 113 (Suppl 1): 42-57.

<sup>28</sup> JP Grund, P Blanken, NF Adriaans, CD Kaplan, C Barendregt, M Meeuwssen. Reaching the unreached: targeting hidden injection drug user populations with clean needles via known user groups. *Journal of Psychoactive Drugs* 1992; 24(1): 41-47.

<sup>29</sup> T Kerr, E Wood, D Small, A Palepu, MW Tyndall. Potential use of safer injecting facilities among injection drug users in Vancouver's Downtown Eastside. *Canadian Medical Association Journal* 2003; 169(8): 759-763.

<sup>30</sup> Canadian HIV/AIDS Legal Network. *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*. Montréal: Canadian HIV/AIDS Legal Network, 2002.

# 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](mailto:dgarmaise@rogers.com).

## Canada announces new funding for domestic and global fight against AIDS

In a flurry of announcements that came just weeks before it called a federal election, the federal government doubled the funding for its domestic HIV/AIDS strategy, doubled its contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and announced a significant contribution to the World Health Organization (WHO) 3 by 5 Initiative. AIDS organizations welcomed the announcements but were critical of the fact that the increased funding for the domestic strategy will take five years to implement. They also criticized the fact that funding for the global initiatives is not new money; it will come out of increases for development assistance previously announced.

### Canadian Strategy on HIV/AIDS

On 12 May 2004, Health Minister Pierre Pettigrew announced that annual funding for the Canadian HIV/AIDS Strategy (CSHA) would be doubled from the current \$42.2 million to \$84.4 million by 2008-2009. The additional \$42.2 million in funding will be phased in over a five-year period. The CSHA budget will grow by \$5 million in 2004-2005; \$8

million in each of 2005-2006, 2006-2007, and 2007-2008; and \$13.2 million in 2008-2009.

The \$5 million in additional funding for 2004-2005 is specifically earmarked for community-based organizations working with populations most at risk of HIV infection. None of the additional funding for subsequent years has been pre-allocated in this fashion.

Although the additional funding has been approved by the Cabinet,

Health Canada still has to obtain formal authorization from the Treasury Board Secretariat before the money can be spent. This means that Health Canada will have only five or six months in 2004-2005 to spend the additional \$5 million earmarked for that year.

The announcement of additional funding for the CSHA followed several years of intensive lobbying by community-based and other organizations involved in the fight against

HIV/AIDS. Annual funding had been frozen at \$42.4 million for over a decade. The organizations had been calling for the funding to be at least doubled. The House of Commons Standing Committee on Health had recommended an immediate increase to \$100 million.<sup>1</sup> While HIV/AIDS organizations welcomed the decision to double the CSHA funding, they were critical of the fact that it will take five years for it to happen. The Canadian Coalition of HIV/AIDS Stakeholder Organizations said that “this increase will result in most of the new money arriving at the frontlines too late for us to stop the next wave of infections and treatment failures that’s about to crash down on Canada.”<sup>2</sup>

## Global response

### WHO 3 by 5 Initiative

On 10 May 2004, Prime Minister Paul Martin announced that Canada will contribute \$100 million to the WHO 3 by 5 Initiative. The goal of the initiative is to ensure that three million people living with HIV/AIDS in developing countries are receiving antiretroviral therapy by the end of 2005. This contribution makes Canada the leading donor to the initiative.

The initiative was facing a revenue shortfall of US\$200 million in its first year or two of operation. The new

Canadian commitment covers nearly half that gap.

### Global Fund

On 12 May 2004, Minister for International Cooperation Aileen Carroll announced that Canada was increasing its contribution to the Global Fund to \$70 million for 2005, up from approximately \$35 million in 2004. The Global Fund’s target for 2005 is US\$3.5 billion, up from its 2004 target of US\$1.4 billion. The main reason for the sharp increase is that in 2005, the Fund needs to provide renewal funding for additional portions of grants approved in the early rounds of funding, as well as new funding for grants that will be approved in future rounds of funding.

According to the Equitable Contribution Framework, which is based on the premise that the bulk of Global Fund resources should come from the governments of relatively affluent countries, Canada is still not contributing its fair share. AidsSpan, a US-based NGO whose mission is to increase the effectiveness of the Global Fund, calculates that Canada’s contribution for 2005 should be US\$115 million.<sup>3</sup>

### Reaction

Canadian NGOs welcomed the announcement of new funding for the WHO 3 by 5 Initiative and for the Global Fund, but expressed concern

about the fact that the funding will eat up about half of the new funds allocated to the Canadian International Development Agency in the most recent federal budget. In a letter to Prime Minister Martin, Michael O’Connor, Executive Director of the Interagency Coalition on AIDS and Development, writing on behalf of a group of 23 NGOs that included the Canadian HIV/AIDS Legal Network, said that “the intention of the Global Fund was to tap *additional* resources to address the 3 diseases, not to take funds from already stretched official development assistance budgets.”<sup>4</sup>

The NGOs also renewed their call for Canada to increase its development aid to 0.7 percent of gross domestic product, a move they say is essential to meet the United Nation’s Millennium Development Goals.

– David Garmaise

<sup>1</sup> D Garmaise. Commons committee recommends significant increase in funding for AIDS strategy. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(2): 24-5.

<sup>2</sup> New AIDS money welcomed but needed now. News release, 14 May 2004. The Canadian Coalition of HIV/AIDS Stakeholder Organizations represents 16 major organizations engaged in prevention, treatment, and research across Canada, including the Canadian AIDS Society, the Canadian HIV/AIDS Legal Network, and the Coalition des organismes communautaires québécois de lutte contre le sida. The news release is available at [www.ctac.ca/english/pdf/mr\\_may14\\_2004\\_CoalitionRelease.pdf](http://www.ctac.ca/english/pdf/mr_may14_2004_CoalitionRelease.pdf).

<sup>3</sup> See “An updated analysis of the Equitable Contribution Framework” on the AidsSpan website at [www.aidsSpan.org/globalfund/index.htm](http://www.aidsSpan.org/globalfund/index.htm).

<sup>4</sup> Letter dated 21 May 2004. Available on the ICAD website at [www.icad-cisd.com/content/pub\\_details.cfm?ID=108&CAT=4&lang=e](http://www.icad-cisd.com/content/pub_details.cfm?ID=108&CAT=4&lang=e).

# Reports call for end to harms caused by Criminal Code prohibitions surrounding prostitution

The sale of sexual services between consenting adults is legal under Canadian law, yet the Criminal Code prohibits many activities related to prostitution and the sex trade. As a result, many people who work in the sex trade come into conflict with the law. In recent reports, two Canadian organizations have called for the repeal of the current Criminal Code prohibitions on activities related to the sex trade. Pivot Legal Society's report, "Voices for Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws," was released in March 2004.<sup>1</sup> The Conseil permanent de la jeunesse, a 15-member advisory panel to the Québec government, released "Prostitution de rue: avis" in April 2004.<sup>2</sup>

## Voices for Dignity

The backdrop of the Pivot report is the reality of over 60 missing (and numerous tortured) women sex trade workers in Vancouver, many of whom were from Vancouver's Downtown Eastside (DTES), home to Pivot. Voices for Dignity is based on affidavits from 91 current and former sex workers living and/or working in the DTES, 81 of whom were female and 10 male, ranging in age from 22 to 62. The report presents evidence of sex workers regarding their experiences, opinions, and beliefs with respect to the Criminal Code prohibitions of keeping a common bawdy house,<sup>3</sup> procuring,<sup>4</sup> and communicating for the purposes of prostitution.<sup>5</sup>

With one exception, the sex workers interviewed demanded that the bawdy-house law be repealed, so that sex workers who choose to work indoors, under safe and clean conditions, can do so. With one exception, those sex workers who addressed the communicating law demanded that it be repealed. They criticized it as ineffective and as creating dangerous working conditions as a result of enforcement. Overall, "the affidavits highlight many ways in which Canada's sex trade laws worsen the

already harmful conditions under which sex workers live, add to the stigma of their employment and social position, and support the inference that sex workers are less worthy of value than other members of society."<sup>6</sup>

Voices for Dignity describes the complex interplay among a host of factors, including poverty, housing, violence, health, addiction, and law enforcement. For example, the report cites how a Vancouver Police Department crackdown aimed at displacing the drug market from the DTES led to the arrests of sex workers, both those involved with drugs and those who were not; forced sex workers to work in unsafe locations; and likely exacerbated the health and social problems stemming from illicit drug use.<sup>7</sup> The report also highlights the interconnectedness of injection drug use, communicable diseases (such as HIV/AIDS and hepatitis C), and the lack of accessible health care among the sex workers who swore affidavits.

The report takes the sex workers' affidavits as evidence of harm suffered by sex trade workers as a result of the Criminal Code provisions related to prostitution, and argues that these provisions violate rights enshrined in the Canadian Charter of

Rights and Freedoms. According to the authors, sex workers' rights to freedom of expression, life, liberty, security of the person, and equality are all unjustifiably infringed by the relevant Criminal Code provisions, and so the provisions should be repealed. Voices of Dignity ends with a "call to action," a call that goes beyond the decriminalization of the sex trade to include: (a) consultations with sex workers on the reform of legislation, health and social services, and policing practices; and (b) the development of public education campaigns to promote sex workers' social citizenship and human rights. The

The Criminal Code provisions related to prostitution violate rights enshrined in the Canadian Charter of Rights and Freedoms.

report received national media attention,<sup>8</sup> and was the subject of favourable public comments by Irwin Cotler, Minister of Justice.<sup>9</sup>

## Prostitution de rue

The Conseil de la jeunesse's Prostitution de rue report has much in common with Voices of Dignity. The Conseil's report, grounded in extensive background research,<sup>10</sup> gives voice to those affected and focuses on the complex dynamics of stigmatization and vulnerability involved in street prostitution. Like the Pivot report, it received national media attention.<sup>11</sup> The Conseil consciously avoided the ideological issue of whether prostitution by young adults (over 18 years old) was employment or exploitation,<sup>12</sup> instead suggesting directions for improvement of the situation of youth street-based sex workers. The report's recommendations are presented in four sections: (1) preventing entry to street prostitution; (2) mechanisms to improve the situation of those who choose to engage in prostitution; (3) aid to those who want to leave street prostitution; and (4) further research related to specific themes.

Among other recommendations, the report calls on the Québec government to (a) launch an information campaign to draw attention to the discrimination, violence, and stigmatization faced by street-based sex workers;<sup>13</sup> and (b) encourage public services to adopt non-discrimination policies regarding marginalized peo-

ple.<sup>14</sup> Significantly, as a means to help people who inject drugs, and to decrease nuisance in communities, the report recommends that the government explore the possibility of a safe injection facility.<sup>15</sup>

Prostitution de rue points out the unsatisfactory results of the Criminal Code prohibitions, including the way in which police repression increases the vulnerability of street-based sex trade workers:

[TRANSLATION] In attempting to avoid the eye of the police, those involved in street prostitution are being exposed to less safe practices. They are more isolated, spend less time negotiating with customers, don't seek help when they are victims of criminal behaviour, etc. Nevertheless, like any other citizen, prostitutes are entitled to the protection of the police.<sup>16</sup>

The report calls on the government of Québec to lobby the federal government to decriminalize adult prostitution,<sup>17</sup> and to evaluate the implementation and impact of the decriminalization of prostitution.<sup>18</sup>

– Glenn Betteridge

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<sup>1</sup> Pivot Legal Society Sex Work Subcommittee. *Voices for Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws*. Pivot Legal Society: Vancouver, 2002, available via [www.pivotlegal.org](http://www.pivotlegal.org) [hereinafter *Voices for Dignity*.]

<sup>2</sup> Conseil permanent de la jeunesse. *Prostitution de rue: avis* April 2004, available in French via the Conseil's website, [www.cpj.gouv.qc.ca](http://www.cpj.gouv.qc.ca) [hereinafter *Prostitution de rue*.]

<sup>3</sup> Criminal Code, RSC 1985, c C-46, s 210 makes it a criminal offence to keep or be found in a common bawdy house. Section 211 makes it an offence to transport a person to a common bawdy house.

<sup>4</sup> *Ibid*, section 212 makes it a criminal offence to control or influence another person involved in prostitution, to live with or habitually be in the company of a prostitute, or live off of the avails of prostitution.

<sup>5</sup> *Ibid*, section 213 makes it a criminal offence to stop or attempt to stop any motor vehicle, impede the free flow of pedestrian or vehicular traffic, or to stop or to attempt to stop any person or in any manner attempt to communicate with any person, for the purposes of prostitution.

<sup>6</sup> *Voices for Dignity*, supra, note 1 at 2.

<sup>7</sup> *Ibid* at 24.

<sup>8</sup> J Armstrong. Repeal prostitution laws, report urges. *Globe and Mail*, A8, 2 March 2004.

<sup>9</sup> Press Release. Minister of Justice supports new Pivot report on sex trade. Pivot Legal Society, 2 March 2004; and personal communication with Katrina Pacey, co-Executive Director of Pivot and one of the report's authors.

<sup>10</sup> Conseil de la jeunesse. *Vue de la rue: Les jeunes adultes prostitué(e)s – Rapport de Recherche*. April 2004, available in French via the Conseil's website, [www.cpj.gouv.qc.ca](http://www.cpj.gouv.qc.ca).

<sup>11</sup> R Seguin. Sex trade laws must change, Quebec study says. *Globe and Mail*, A5, 27 April 2004.

<sup>12</sup> However, the Conseil is clear that prostitution for those under 18 years old raises the issue of sexual exploitation.

<sup>13</sup> *Prostitution de rue*, supra, note 2, recommendation 10.

<sup>14</sup> *Ibid* at recommendation 12.

<sup>15</sup> *Ibid* at recommendation 23.

<sup>16</sup> *Ibid* at 17.

<sup>17</sup> *Ibid* at recommendation 13.

<sup>18</sup> *Ibid* at recommendation 29.

# Nova Scotia renews its HIV/AIDS strategy

**On 1 December 2003, after a five-year process of consultation and planning, Nova Scotia embarked on a new HIV/AIDS strategy.<sup>1</sup> It replaces the first strategy, launched a decade earlier. The renewed strategy is meant to promote collaborative action on the determinants of vulnerability to HIV infection and on the capacity of people living with HIV/AIDS to achieve optimal health and quality of life.**

The strategy has four strategic directions: mobilize integrated action on HIV/AIDS; build a broad research and information-sharing strategy; build a coordinated approach to prevention and harm reduction; and build a coordinated approach to care, treatment, and support services.

For each strategic direction there are detailed recommendations on actions to be taken. They include recommendations regarding:

- community-based health services for people vulnerable to HIV infection;
- sufficient and stable funding for community-based HIV/AIDS programming;
- an HIV/AIDS research agenda for Nova Scotia;
- collecting HIV/AIDS surveillance data on African people, Aboriginal people, and new immigrant communities;
- safe, supportive educational environments for staff and students – especially for people living with HIV/AIDS, and gay, lesbian, bisexual, and transgendered people – in public schools, community colleges, and universities;
- a curriculum on HIV/AIDS, sexism, racism, and homophobia for public schools, and training and support for its implementation;
- a comprehensive prevention strate-

gy that incorporates a harm-reduction approach for different populations in a variety of service settings;<sup>2</sup>

- an awareness campaign to inform the public about HIV/AIDS;
- a seamless continuum of care, treatment, and support services for people living with HIV/AIDS;
- coordinated care for people living with HIV/AIDS who have mental health, substance use, or gambling issues;
- a multidisciplinary HIV/AIDS curriculum for all care providers in training or in professional development;
- a protocol for support and advocacy for people living with HIV/AIDS based on a patient-navigation model adapted from cancer care;
- the involvement of faith communities and spiritual organizations in supporting people living with HIV/AIDS;
- policies and programs to protect children diagnosed with HIV/AIDS;
- policies and practices relating to children in the care of the province;
- supportive workplace programs for people living with HIV/AIDS; and
- a review of guidelines for insurance coverage for people living with HIV/AIDS.

The recommendations focus on reducing discrimination, eliminating barriers to services, and meeting unmet needs through coordinated, targeted action. Specific attention is given to the needs of gay, lesbian, bisexual, and transgendered people; African Nova Scotians; Aboriginal people; women; youth; and children. While the language of human rights is not used, many of the recommendations are consistent with a rights-based approach to HIV/AIDS.

The Nova Scotia Advisory Commission on AIDS will coordinate the implementation of the strategy. It plans to form four intersectoral working groups to implement the recommended actions, one for each of the strategic directions.<sup>3</sup>

– Theodore de Bruyn

Theodore de Bruyn was a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network in 2003-2004.

<sup>1</sup> Provincial HIV/AIDS Strategy Steering Committee. *Nova Scotia's Strategy on HIV/AIDS*. Halifax, 2003. A summary report is available at [www.gov.ns.ca/health/downloads/HIVAids\\_summaryreport.pdf](http://www.gov.ns.ca/health/downloads/HIVAids_summaryreport.pdf).

<sup>2</sup> The proposed harm-reduction measures include access to barrier prevention methods, anonymous testing, needle exchange programs, and methadone services. There is no recommendation to establish safe injection facilities.

<sup>3</sup> For further information on the implementation on the strategy, contact the Commission by telephone at (902) 424-5730 or email at [proctom@gov.ns.ca](mailto:proctom@gov.ns.ca).



## Study highlights negative public health consequences of police crackdown on drug market

**A police crackdown in Vancouver's Downtown Eastside (DTES) displaced the drug scene to adjacent areas and may have exacerbated the health and social harms associated with injection drug use. This is the finding of a study published in the *Canadian Medical Association Journal* by Evan Wood and his colleagues at the British Columbia Centre for Excellence in HIV/AIDS.<sup>1</sup>**

This study is not the first to call into question the criminal law-based prohibitionist response to the public health problem of injection drug use.<sup>2</sup> It provides further evidence that heightened police enforcement contributes to the public health crisis among marginalized populations in the DTES.<sup>3</sup>

The study was based on data from people enrolled in the ongoing Vancouver Injection Drug Use Study. In April 2003, the Vancouver Police Department embarked on a large-scale crackdown on drug dealers and users in the DTES. Fifty additional police officers were deployed at an estimated cost of CAN\$2.3 million, with the goal of disrupting the open drug mar-

ket and interrupting the cycle of crime and drug use. The objective of the study was to rigorously evaluate the effects of the crackdown.

The study found that there was no overall reduction in frequency of drug use or change in drug price in the DTES. Although evidence suggests that the police presence made it more difficult to access drugs, this is likely explained by the fact that many drug dealers in the DTES moved to neighbouring areas. The study presents evidence that relocating the drug trade meant that drug users were moved away from the harm-reduction and addiction-treatment resources and services available in the DTES. As a result, the authors concluded, without

ready access to sterile syringes it is likely that unsafe injecting, and rates of bloodborne diseases like HIV and hepatitis C, will increase. The authors also said that the increased police presence may also decrease use of safe injection facilities and increase unsafe syringe disposal.

– Glenn Betteridge

<sup>1</sup> E Wood, P Spittal, W Small, T Kerr, K Li, R Hogg, M Tyndall, J Montaner, M Schechter. Displacement of Canada's largest public illicit drug market in response to a police crackdown. *Canadian Medical Association Journal* 2004; 170(1): 1551-1556. For a media report of the study, see F Bula. Crackdown hasn't cut drug use in Downtown Eastside: report. *Vancouver Sun*, 11 May 2004.

<sup>2</sup> See for example Human Rights Watch. Abusing the user: police misconduct, harm reduction and HIV/AIDS in Vancouver. *Human Rights Watch Report* 2003; 15(2B), reported in J Csete, J Cohen. Human rights in Vancouver: Do injection drug users have a friend in city hall? *Canadian HIV/AIDS Policy & Law Review* 2003; 8(2): 1; T Kerr, E Wood, D Small, A Palepu, M Tyndall. Potential use of safer injecting facilities among injection drug users in Vancouver's Downtown Eastside. *Canadian Medical Association Journal* 2003; 169(8): 759-763.

<sup>3</sup> The negative impacts of police enforcement on sex work, as reported recently, are examined in G Betteridge. Reports call for end to harms caused by Criminal Code prohibitions surrounding prostitution. *Canadian HIV/AIDS Policy & Law Review* in the Canadian News section of this issue.

## Health Canada considers dispensing medical marijuana through pharmacies

**Health Canada may be poised to emulate the Netherlands' system of distributing marijuana to HIV/AIDS and other patients through pharmacies. Meanwhile, revisions to the much-criticized medical marijuana regulatory system are under development.**

Health Canada is organizing a pilot project in British Columbia to distribute government-certified marijuana through pharmacies to persons who are authorized to use it for medical

purposes, according to a Canadian Press (CP) report.<sup>1</sup>

In July 2003, when Health Canada began distributing marijuana directly to medical patients in response to an Ontario Superior Court order, it stressed that the distribution scheme was an interim measure, pending more permanent solutions.<sup>2</sup> The CP report says that the pilot project will be modelled on a year-old program in the Netherlands that allows medical users to buy marijuana at their local drugstore. This would be the first time that drugstores in Canada could sell a controlled substance that is not an approved drug.

The CP report says that

the pilot project is slated for British Columbia because the province's college of pharmacists issued a groundbreaking statement last fall supporting the distribution of medical marijuana in pharmacies, unlike most health-care organizations which have opposed easier access.

According to CP, there are currently 78 people in Canada permitted to buy Health Canada marijuana, which is now sent by courier directly to patients or their doctors. Although the number of current approved users is

small, CP quotes Robin O'Brien, a consulting pharmacist who is organizing the pilot project for Health Canada, as saying that internal surveys for Health Canada have suggested that up to seven percent of British Columbia's population – about 290,000 people – use marijuana for medical purposes, albeit illegally. O'Brien said that easier availability of certified marijuana might encourage more medical users to register with the government. However, the CP report says, concerns about the poor quality of the Health Canada product may discourage potential users.

It is not clear whether the drug that will be distributed in pharmacies will be in a form that could be smoked by users. The CP report says that pharmacists would prefer that another method of ingestion be used.

The CP report says that if Health Canada's marijuana becomes more widely available, registered users could lose the option they currently have of growing their own marijuana or having someone grow it for them.

## Changes to the regulations

In response to the appeal court order that the Marijuana Medical Access Regulations (MMAR) be made less

restrictive,<sup>3</sup> in early 2004 Health Canada began a process of stakeholder consultations aimed at revising the existing MMAR. The department invited comments on the regulations,<sup>4</sup> promising that "a further opportunity to comment will be provided following publication of the proposed changes ... in the spring of 2004."<sup>5</sup> However, as of the end of June 2004, the proposed changes had not yet been published.

As well, a multi-stakeholder meeting was held in Ottawa in February 2004 to discuss possible changes to the MMAR. While the meeting was exploratory rather than conclusive, there were indications that many current restrictive aspects of the MMAR might be eased.

– Derek Thaczuk

<sup>1</sup> D Beeby. Certified marijuana may be made available in pharmacies. *Canadian Press*, 21 March 2004.

<sup>2</sup> See D Thaczuk. Health Canada makes marijuana available for medical use. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(1): 22-24.

<sup>3</sup> See G Cruess. Ontario court affirms that medical marijuana regulations are unconstitutional. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(2): 53-56.

<sup>4</sup> Notice: Health Canada invites comments on the Marijuana Medical Access Regulations (MMAR). Available at [www.hc-sc.gc.ca/hecs-sesc/ocma/archives.htm](http://www.hc-sc.gc.ca/hecs-sesc/ocma/archives.htm).

<sup>5</sup> *Ibid.*

## In brief

### Montréal: Probe requested into police hiring practices

The Canadian HIV/AIDS Legal Network and COCQ-Sida (the Québec coalition of community-based

AIDS organizations) have formally asked the Québec Human Rights Commission to launch an inquiry into the hiring practices of the Service de police de la ville de Montréal (SPVM) and the admission practices of the

École nationale de police du Québec (ENPQ), the training school for aspiring police recruits. The SPVM recruitment standards and the ENPQ's admission criteria explicitly stipulate that all candidates who test HIV-posi-

tive must automatically be rejected.<sup>1</sup>

The request was included in a letter sent to the Commission in June 2004.<sup>2</sup> The letter points out that admission and hiring criteria can only be used to measure aptitudes and qualities required by specific jobs or training programs, and that if they are used for other purposes they violate articles 10 and 20 of the Québec Charter of Human Rights and Freedoms (the Charter). The letter goes on to say that a candidate's HIV status does not in and of itself have an impact on her or his physical or mental ability to undergo police-patrol training or to work as a police officer.

COCQ-Sida and the Legal Network told the Commission that the ENPQ's admission criteria and the SPVM's hiring standards are flagrant examples of direct discrimination, of the kind formally prohibited both by the Charter and by the Supreme Court of Canada. The organizations pointed out that the medical conditions of people living with HIV vary widely from one person to the next; that many of them are in excellent physical shape; and that if they possess the aptitudes and qualities required for the job of police officer, they should not be denied access to it.

– David Garmaise

### Québec: College issues statement on HIV testing for physicians

The Collège des médecins du Québec (CMQ) says that mandatory HIV testing of its members is not necessary or appropriate, and that HIV-positive physicians should not be forced to reveal their status to their patients. The CMQ issued a position

statement<sup>3</sup> in response to the revelation in January 2004 that over 2600 patients had been operated on by an HIV-positive surgeon at Ste-Justine Hospital in Montréal.<sup>4</sup>

The CMQ said that mandatory HIV testing of physicians was not medically required and could be counterproductive. It said that coercive measures directed at physicians (or any other persons or group) encourage people to be more secretive and could increase, rather than decrease, the risk of transmission. The CMQ said that the primary responsibility to manage risks to patients rests with the physicians themselves. To meet this obligation, the CMQ position states:

- that physicians who may have been exposed to a bloodborne pathogen have a duty to know their status;
- that HIV-positive physicians should consult another doctor for treatment and follow-up;
- that HIV-positive physicians should inform their employers of their HIV status;
- that physicians who are HIV-positive and who are involved in procedures that could involve transference of blood or fluid should have their situation evaluated – initially and periodically thereafter – by a committee of experts; and
- that the infected physicians must follow the recommendations of the committee of experts.

Ste-Justine attempted to contact all 2600 patients to recommend that they undergo HIV testing, but was unable to contact about 15 percent of them. As of the end of April 2004, all those contacted who were tested for HIV had tested negative.<sup>5</sup>

The Québec Medical Association (QMA) issued a statement supporting the position taken by the CMQ. The QMA said that application of the recommendations proposed by the CMQ “constitute the best assurance for patients that they will have access to high quality and safe care, and that they can continue to have confidence in their physicians.”<sup>6</sup>

– Hari Subramaniam and David Garmaise

### Statistics Canada plans to use blood and other samples to measure health trends

Statistics Canada hopes to collect blood and urine samples – and possibly also saliva samples – from volunteers beginning in 2005, as part of a four-year project known as the Canada Health Measures Survey.<sup>7</sup> The \$20-million project would involve performing a battery of laboratory tests on the blood and urine of up to 10,000 Canadians in search of dozens of key health indicators. Researchers would look for HIV, diabetes, cholesterol levels, lead, pesticides, SARS, herpes, West Nile virus, and many other measures of the health of the general population.

The last such national survey in Canada was carried out in 1978-79. Statistics Canada says that many other countries have routinely collected bodily fluids for testing, including the US, the UK, New Zealand, Australia, and some European countries. In the US and Australia, these surveys revealed important trends that had not turned up through the use of questionnaires.

Statistics Canada says that the samples may also be stored for years so

that other tests not yet developed can be performed later.

Participants in the Canadian survey would be volunteers who are representative of the general population in terms of age, sex, and other demographic factors. Statistics Canada says that residents of Aboriginal reserves, members of the military, and people residing in institutions such as prisons would be excluded. The samples would be gathered in clinical settings, such as a mobile clinic, and participants would not receive payment, though they would be reimbursed for any out-of-pocket expenses such as travel.

Statistics Canada says that the Canadian Health Measures Survey will be conducted under the authority of the Statistics Act, which means that all information provided will be kept confidential. It says that no information that could identify participants or their families will be given to anyone without the participants' permission.<sup>8</sup>

A pilot project is planned for 2005, with full sampling expected in 2006, perhaps following the scheduled Canada-wide census that year. However, Statistics Canada says that planning is in the early stages, and that the project still needs the approval of Canada's privacy commissioner, as well as privacy officials in the provinces.

– David Garmaise

## Alberta: "Blood Samples" act passes third reading

The Alberta Legislative Assembly has adopted legislation that would force individuals to undergo tests for HIV, hepatitis, and other bloodborne diseases if their body fluids come into contact with those of a police officer, corrections officer, other emergency workers, or Good Samaritans. Bill 204, which was introduced as a private member's bill in February 2004,<sup>9</sup> passed third reading on 10 March.<sup>10</sup> It is now awaiting proclamation to become law.

The new legislation is being welcomed by emergency medical, fire, and police personnel around the province. "The safety and protection of firefighters and all emergency services personnel is of paramount importance," stated Calgary Fire Chief Wayne Morris. "When dealing with the various types of emergency incidents, even the best training and equipment cannot prevent situations beyond our control. Bill 204 will provide a fast track to a clean bill of health for all emergency services personnel."<sup>11</sup>

HIV/AIDS experts have argued, however, that "after the fact" mandatory testing does not protect workers from occupational exposures, and that other measures – such as education, training, and counselling – would be more effective. They also argue that

mandatory testing infringes on the rights of the individual being tested.<sup>12</sup>

– Rebecca Scheer

<sup>1</sup> See D Garmaise. Québec: An outbreak of HIV/AIDS-related stigma and discrimination. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(1): 15-20.

<sup>2</sup> See letter to Mr Pierre Marois, Président, Commission des droits de la personne, 7 June 2004. Available at [www.aidslaw.ca/Maincontent/issues/testing/letterpolice020604.pdf](http://www.aidslaw.ca/Maincontent/issues/testing/letterpolice020604.pdf). See also: Montréal police discriminate against people living with HIV/AIDS: community groups demand human rights commission inquiry. News release, 4 June 2004. Available at [www.aidslaw.ca/Maincontent/issues/testing/e-press-4june04.pdf](http://www.aidslaw.ca/Maincontent/issues/testing/e-press-4june04.pdf).

<sup>3</sup> Le médecin et les infections transmissibles par le sang. Énoncé de position du Collège des médecins du Québec. 27 April 2004. Available at [www.cmq.org/UploadedFiles/Position\\_infections\\_transmissibles\\_sang.pdf](http://www.cmq.org/UploadedFiles/Position_infections_transmissibles_sang.pdf).

<sup>4</sup> See Garmaise, supra, note 1.

<sup>5</sup> Quebec doctors won't be forced to tell patients if they have AIDS. Canadian Press, 27 April 2004.

<sup>6</sup> The QMA supports the report of the Collège des médecins. News release, 27 April 2004. Available on the QMA website at [www.amq.ca/ang/action.htm](http://www.amq.ca/ang/action.htm).

<sup>7</sup> Statistics Canada planning to collect blood, urine samples from Canadians. Canadian Press, 28 February 2004.

<sup>8</sup> See the Statistics Canada website at [www.statcan.ca/english/survey/household/measures/measures.htm](http://www.statcan.ca/english/survey/household/measures/measures.htm).

<sup>9</sup> See R Scheer. Alberta: New bill to allow for mandatory HIV testing in emergency situations. *Canadian HIV/AIDS Policy & Law Review* April 2004; 9(1): 20-21

<sup>10</sup> Full text and status of the Blood Samples Act is available at [www.assembly.ab.ca/pro/bills/ba-bill.asp?SelectBill=204](http://www.assembly.ab.ca/pro/bills/ba-bill.asp?SelectBill=204).

<sup>11</sup> Calgary's Emergency Services Applaud Passing of Bill 204 – Blood Samples Act. City of Calgary news release, 12 May 2004. Available at [www.gov.calgary.ab.ca/citybeat/public/2004/05/release.20040512\\_080819\\_20947\\_0](http://www.gov.calgary.ab.ca/citybeat/public/2004/05/release.20040512_080819_20947_0).

<sup>12</sup> 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; also, T de Bruyn. Occupational Exposure to HIV and Forced HIV Testing: Questions and Answers. Montréal: Canadian HIV/AIDS Legal Network, 2002. Available at [www.aidslaw.ca/Maincontent/issues/testing/testing-q&aE.pdf](http://www.aidslaw.ca/Maincontent/issues/testing/testing-q&aE.pdf).

# 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 Esther Amoako, Sam Avrett, Edgar Carrasco, Michaela Clayton, Jonathan Cohen, Victor Croquer, Esther Csernus, Joanne Csete, and Shaun Mellors. We welcome information about new developments for future issues of the *Review*. Address correspondence to David Garmaise, Managing Editor of the *Review*, at [dgarmaise@rogers.com](mailto:dgarmaise@rogers.com).

## International News – 10 years on

In the first issue of the *Canadian HIV/AIDS Legal Network Policy and Law Review* (then *Newsletter*) in 1994, David Patterson wrote about the emerging United Nations focus on ethics and law in the context of HIV/AIDS. In this issue he reviews the role of the *Review* in publicizing national and international legal and policy responses to HIV/AIDS over the last 10 years, and notes the need for greater attention to documenting and promoting rights-based approaches to law and policy reform.

In 1993 the United Nations Development Programme (UNDP) held a regional consultation in the Philippines to stimulate national networks of lawyers, people living with HIV/AIDS, and others working for legal reform, to fight discrimination and to create an enabling legal and social environment for responding to the epidemic. A similar consultation was held in Senegal in 1994, focusing on the countries of sub-Saharan Africa. Writing in 1991, Julie Hamblin, the “legal architect” of the UNDP approach, noted:

The challenge of HIV and AIDS policy during the 1990s is to recognize the need to address not only what might be called the “HIV-specific” issues, such as HIV education programmes and research into new barrier methods to prevent HIV transmission, but also the underlying social and economic factors that deprive individuals of the power to protect themselves against HIV infection.<sup>1</sup>

While the “underlying social and economic factors” differ across countries and cultures, in the late 1990s Jonathan Mann and others noted that

the international law of human rights provided universal standards for all national law and policy reform.<sup>2</sup>

For the last 10 years, the *Review* has documented and publicized national, regional, and international initiatives to promote such rights-based approaches to HIV/AIDS by publishing lead articles and encouraging contributions about even modest initiatives, with a focus on those countries and regions most affected by HIV/AIDS. In 1995 the *Review* reported on legal reforms in China and the United Kingdom, and in 1996

presented the first summary of presentations on law and ethics at an international AIDS conference. Since 1998, with UNAIDS support, the *Review* has carried special reports on legal, ethical, and human rights issues following the biennial international conferences on HIV/AIDS.

In 1999, the Legal Network formalized its partnership with the AIDS Law Project, South Africa, and starting in 2000 the *Review* increased its focus on HIV/AIDS and the law internationally, with a special section on HIV/AIDS and the law in different countries, and reports on rulings on discrimination in the airline industry (South Africa) and the military (Namibia). In 2001 the *Review* reported on the decision of 39 pharmaceutical companies to abandon their legal action against the government of South Africa, a case that demonstrated both the importance of combining legal action with community activism, and the relevance (if further evidence was needed) of legal and policy precedents in developing countries to the global response to HIV/AIDS.

However, while celebrating the victory in South Africa, the same issue of the *Review* reported on laws requiring the mandatory testing of sex workers, drug users, and people belonging to other so-called high-risk groups in China.

In 2002 the international coverage became even more extensive, following the creation of the Network's international program and the appointment of the first Director of this pro-

gram in June 2001. From March 2002 the *Review* included a separate section on "HIV in the Courts – International," while the International News section continued to document international developments such as the UN General Assembly Special Session on HIV/AIDS and national initiatives such as judicial training, legal education, and law reform.

### **National initiatives to promote rights-based law and policy reform**

National initiatives are typically under-documented and under-reported, yet are of great value, and even inspiration, to advocates in other countries and regions. In many cases, these activities have been supported by a range of international donors and organizations, including the World Bank, UNDP, UNAIDS, the United States Agency for International Development, the Canadian International Development Agency and, more recently, the Global Fund to Fight AIDS, Tuberculosis and Malaria. As rights-based approaches to development generally, and to HIV/AIDS in particular, become more concretized, there is a corresponding need to document and publicize them more rigorously to stimulate the harmonization of approaches based on international law, expert guidance, and best practice.

This issue of the *Review* contains articles and notes on developments in the Andean and Caribbean regions,

Ghana, Namibia, Hungary, the Philippines, Latin America, South Africa, Russia, and the US. As always, the common theme is the rights of people living with and most vulnerable to HIV/AIDS, and the national, regional, and international initiatives to respect, protect, and fulfill these rights.

Ten years after the first paragraphs on the emerging role of the law in responding to the global HIV/AIDS epidemic appeared in this periodical, rights-based approaches are far better understood and articulated.<sup>3</sup> A key challenge is to further strengthen the linkages between national laws, policies, and programs on HIV/AIDS and the international law of human rights, and to better document, publicize, and harmonize these efforts.

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<sup>1</sup> J Hamblin. The role of the law in HIV and AIDS policy. AIDS Supplement 1991 (ref). Available online as UNDP Issues Paper No. 11 at [www.undp.org/hiv/publications/issues/english/issue11e.htm](http://www.undp.org/hiv/publications/issues/english/issue11e.htm).

<sup>2</sup> See, eg, J Mann. Human rights and AIDS: the future of the pandemic. *Health and Human Rights: A Reader*. New York: Routledge, 1999; 3(1): 216-226.

<sup>3</sup> In 2002-2003 the Canadian International Development Agency supported the Canadian HIV/AIDS Legal Network in developing a rights-based programming tool on HIV/AIDS for development officers. See D Patterson. Programming HIV/AIDS: a human rights approach. Available at [www.aidslaw.ca/Maincontent/issues/discrimination/rights\\_approach/international.htm](http://www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach/international.htm).

# Ghana: Capacity-building workshops for lawyers and judges

**In 2004, AIDS Alert Ghana (an Accra-based NGO) commenced a series of two-day workshops to enhance the capacity of lawyers and judges to respond to HIV/AIDS. The workshops are organized by the AIDS Alert Law Project (AALP).**

Ghana has no AIDS-specific laws, and some have argued that there is no need for AIDS-specific laws because existing laws can effectively address emerging issues of relevance to HIV/AIDS. But what are these existing laws? Are they dealing adequately with the issues? Is there a need for law reform? Issues addressed in the workshops include law reform, reproductive rights, gender and gender-based violence, harmful customary and traditional practices, rights and obligations of patients and doctors, confidentiality and disclosure, and stigma and discrimination. The role of men as partners and the implications of their behaviour for women, families, and communities is also examined.

As of June 2004, judges and lawyers from the following institutions have participated in the workshops:

- the Ministry of Justice, specifically lawyers from both the Civil and Prosecutions Department of the Attorney General's department
- Ghana Legal Aid Board
- Ghana Legal Literacy Resource Foundation
- the Legal Departments of the Ghana Police Service
- Legal Department of the Ghana Armed Forces
- Legal Department of the Ghana Immigration Service
- Legal Department of Customs Excise and Preventive Services
- Ghana Law Reform Commission
- Commission on Human Rights and Administrative Justice

- the Judicial Service
- the Ghana Bar Association
- Land Registry
- the Registrar General's Department
- Masters (LLM) students (Law Faculty, University of Ghana)
- Council for Law Reporting
- African Women Lawyers Association
- Federation of Women Lawyers (FIDA) Ghana

A Network of Lawyers Against AIDS is also planned, to build on the knowledge shared at the workshops.

## The AIDS Alert Law Project

The AALP was launched in 2002 by the Deputy Minister for Justice, Gloria Akuffo.<sup>1</sup> The project is managed by a Board, a full-time Executive Director, staff, and volunteers. The AALP aims to:

- provide legal advice to people living with HIV/AIDS;
- promote advocacy to highlight the needs and rights of people living with HIV/AIDS;
- monitor legal developments in the HIV/AIDS area;
- undertake community-based HIV/AIDS research;
- undertake activities to promote awareness and understanding of legal and ethical policy issues raised by HIV/AIDS; and
- conduct a survey of the results of the cases from 1985 to the present

and the impact on reducing HIV infection in Ghana.

Ghana's HIV/AIDS policy is premised on the 1992 Constitution of Ghana and based on principles of social justice and equity. The main issues addressed by the policy include stigmatization and discrimination, decentralization of preventive efforts, review of laws, implementation of guidelines and related policies.

A key feature of the policy is the introduction of policies that respect and promote fundamental human rights. Legal and regulatory issues considered by the policy include reducing vulnerability to infection, reducing stigmatization and discrimination, ensuring that adequate attention is paid to women and children; and ensuring that access to social and economic opportunities remain open to infected persons.

However, in 2002 the Ghana AIDS Commission reported that efforts to create a supportive legal, ethical, and policy environment fell short of what was required.<sup>2</sup> The AALP training workshops were developed in response to this need.

For further information, contact Esther Baah Amoako (ebamoako@hotmail.com) at AALP.

<sup>1</sup> Acting Commissioner for the Commission on Human Rights and Administrative Justice, National Vice-President of the Ghana Bar Association, and Director General of the Ghana AIDS Commission.

<sup>2</sup> A situational appraisal of HIV/AIDS activities in Ghana. Accra: Ghana AIDS Commission, 2002.

## Comparative study of HIV/AIDS and human rights in Andean nations

**A comparative study of five nations of the Andean community has revealed serious gaps in meeting international commitments to address HIV/AIDS-related human rights.<sup>1</sup>**

The study, originally published in Spanish by the Latin American and Caribbean Council of AIDS Service Organizations (LACCASO) in 2003, covers Bolivia, Colombia, Ecuador, Peru, and Venezuela. The original research was undertaken by non-governmental organizations addressing human rights and/or HIV/AIDS in each country. The study sets out the epidemiological, constitutional, and human rights context in each country and then assesses compliance with the 12 principles set out in the United Nations International Guidelines on HIV/AIDS and Human Rights.<sup>2</sup>

This is possibly the first time a regional comparative approach has been used to assess compliance with international legal obligations relating to HIV/AIDS.<sup>3</sup> It makes useful reference to sub-regional agreements such as the Andean Letter for Human Rights Promotion and Protection, signed by the five Community

Presidents in July 2002, as well as regional and international agreements to protect human rights. The study reveals wide variability across the five countries in both the formal protection afforded by the law and in its implementation. The study also examines the institutional frameworks established to respond to HIV/AIDS in the five countries, as well as the relationships between governments and non-governmental organizations, and the situation of groups most vulnerable to HIV/AIDS. It concludes with recommendations and an extensive bibliography for each country.

Follow-up to the study has so far included three national consultations (Quito, Caracas, and Lima) for representatives of government, non-governmental organizations, and the media. Material from the report has also been provided to national human rights NGOs for use in their reporting and advocacy on HIV/AIDS.

A sub-regional comparative study of this type undertaken by non-governmental organizations has several advantages over isolated country studies, including strengthened relationships between the organizations and enhanced capacity to engage with national governments on law and policy reform with reference to other countries in the region.

For more information contact Victor Croquer (vcroquer@accsi.org.ve) at LACCASO.

<sup>1</sup> Comparative Report on HIV/AIDS and Human Rights Situation in the Andean Community (2003). The study is available in Spanish (with an unofficial translation in English) on the LACCASO website, along with the five country reports at [www.laccaso.org](http://www.laccaso.org).

<sup>2</sup> International Guidelines on HIV/AIDS and Human Rights. Geneva: UNAIDS and OHCHR, 1998 (amended 2002).

<sup>3</sup> See also H Watchirs. Measuring legal implementation of the International Guidelines on HIV/AIDS and Human Rights. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 29-31.

## Report documents human rights abuses of drug users in Thailand

**A violent, state-sponsored “war on drugs” is jeopardizing Thailand’s long struggle to become one of Southeast Asia’s leading rights-respected democracies. This is one of the findings of a report released by Human Rights Watch (HRW) on the eve of the XV International AIDS Conference in Bangkok, Thailand in July 2004.<sup>1</sup>**

Thailand has been a widely praised model of success in the fight against AIDS, based on the country’s promotion of condom use and its efforts to work in a non-judgmental way with



sex workers and their clients to change long-standing behaviours. However, an estimated 30 percent of new HIV transmission in Thailand is among drug users, and the Thai authorities have never seen the value of working with drug users or ensuring any level of HIV prevention or AIDS care services for them. As a result, 40 to 50 percent of injection drug users in Thailand are HIV-positive.

Prime Minister Thaksin Shinawatra made matters worse for this already marginalized population in early 2003 when he launched a brutal crackdown on drug offenders, officially targeting drug traffickers. Within three months of the start of the crackdown, over 2200 alleged drug offenders had been killed, and another 500 deaths followed in subsequent weeks. It is clear

that not all these persons, nor the thousands arrested without due process, were drug traffickers; many were small-scale drug users who were more easily apprehended by the police. The government attributed most of the deaths to drug gangs turning on each other, claiming that only a handful of the killings were carried out by the police “in self-defense.”

The HRW report described the ruthless tactics used by the government, which gave local officials the authority to blacklist and target a wide range of “enemies,” and showed that the government seemed able to turn the killings on and off, all the while denying responsibility for them. Many outside observers have called for an independent investigation of these deaths.

Whatever the circumstances of the fatalities of the drug war, one result of the crackdown is clear: drug users were terrorized and driven into hiding, even further beyond the reach of HIV prevention and other services than they were before. Service providers with long experience in Thailand told HRW that many drug users had disappeared from view during the crackdown and had not reappeared. Thousands of drug users, and even some people with no connection to drugs, were also reported to have turned themselves in to military-style drug “treatment” camps to avoid arrest or murder.

<sup>1</sup> Not enough graves: the war on drugs, HIV/AIDS, and violations of human rights. Human Rights Watch. June 2004. Available at [www.hrw.org/campaigns/aids/2004/thai.htm](http://www.hrw.org/campaigns/aids/2004/thai.htm).

## The Philippines: HIV/AIDS, condoms, and human rights

**Influential leaders are increasingly attacking condoms through HIV-prevention programs that focus on sexual abstinence and marital fidelity.<sup>1</sup> In May 2004 Human Rights Watch (HRW) released a report that examines the impact of these policies in the Philippines, the largest Roman Catholic country in Asia and a major recipient of US HIV/AIDS funding.<sup>2</sup>**

The right to health is noted in international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; and the Convention on the Rights of the Child. Treaty-monitoring bodies have interpreted the right to health as forbidding states from

restricting access to contraceptives and health-related information,<sup>3</sup> as well as from “censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information” from children and youth.<sup>4</sup>

Although the Philippines has ratified the relevant treaties, HRW notes that the Philippines is violating its

commitments in numerous ways. The national government refuses to purchase condoms with national funds, leaving the poorest people without an effective method of HIV prevention. Some local governments, Manila’s in particular, prohibit the distribution of condoms and other contraceptives in state health facilities. Police routinely confiscate condoms from sex workers

and use them as evidence to prosecute for prostitution.<sup>5</sup>

School-based HIV-prevention programs, which are often the only source of information for children and youth, often omit information about condoms and, by law, are forbidden from using HIV prevention to promote birth control. The AIDS Prevention and Control Act (1998) provides that HIV/AIDS education in schools “not be used as an excuse

to propagate birth control or the sale or distribution of birth control devices” and “not utilize sexually explicit materials.”<sup>6</sup>

For further information, contact Jonathan Cohen (cohenj@hrw.org) at HRW.

<sup>1</sup> US international AIDS funding will also advance a moral agenda. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(2): 30-31.

<sup>2</sup> Unprotected: Sex, Condoms, and the Human Right to

Health. New York: Human Rights Watch, 2004. Available at <http://hrw.org/reports/2004/philippines0504>.

<sup>3</sup> Committee on Economic, Social and Cultural Rights. The right to the highest attainable standard of health: CESCR General comment 14 (22<sup>nd</sup> Session, 2000), paras 34-35.

<sup>4</sup> Committee on the Rights of the Child. HIV/AIDS and the rights of the child: CRC General comment 3 (32<sup>nd</sup> Session, 2003), para 16.

<sup>5</sup> Citing possession of condoms as evidence for prostitution-related offences impedes HIV prevention and is specifically prohibited in some jurisdictions. See *Handbook for Legislators on HIV/AIDS, Law and Human Rights*. Geneva: UNAIDS, 1999, at 57.

<sup>6</sup> Republic Act 8504, Philippine AIDS Prevention and Control Act of 1998, art 1 (“Education and Information”), implemented by rule 2.

## Russian Federation: Battle not over in drug-law changes

As reported in the last issue of the *Review*, in late 2003 the Russian Parliament amended the national drug law to allow for the possibility of less harsh penalties for small-scale drug users.<sup>1</sup> The Parliament left the development of accompanying regulations to the federal drug-control authorities and the Ministry of Health. These two entities were meant to recommend new levels of minimum dosages that would qualify users for criminal penalties if those amounts were found in their possession. Rather than acting in the spirit of the Parliament’s amendment, in March 2004 the drug-control authorities circulated a proposal for minimum dosages so tiny that virtually any level of possession would incur a long prison sentence.

AIDS and harm-reduction NGOs protested this retrogression. They were joined in their protest by Ella Pamfilova, chairperson of the Commission on Human Rights under the President of the Russian Federation. In May 2004 the government announced new minimum dosages that are still low by international standards but that are much higher than those proposed by the drug-control police. This is an important repudiation of the most repressive tendencies in Russian drug law, but

the battle is far from over. No sooner were the new regulations announced than the drug-control police and some of their allies in the Parliament said they would still fight for harsher rules.

In April 2004 Human Rights Watch (HRW) released a report documenting human rights abuses against drug users, some of which are directly related to the draconian provisions of federal drug law.<sup>2</sup> Russian police find drug users to be easy targets for extortion, unlawful arrest and detention, coercion to extract confessions,

and a wide range of other due-process violations.

The demonization of drug users is compounded by widespread misinformation about HIV transmission – a result of the state’s neglect of HIV prevention programs. Drug users and people living with HIV/AIDS are stigmatized partly because so many Russians still believe that HIV is spread through casual contact. In drug policy and AIDS policy, the Russian state must begin embracing the lessons of the global struggle against AIDS if it is to have any hope of slowing the burgeoning epidemic.

For further information, contact Joanne Csete (csetej@hrw.org) at HRW.

<sup>1</sup> Russian Federation: Penalties eased for possession of illegal drugs. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(1): 32-33. See also W Butler: HIV/AIDS and Drug Misuse in Russia: Harm Reduction Programmes and the Russian Legal System. London: International Family Health, 2003.

<sup>2</sup> Lessons not learned: human rights abuses and HIV/AIDS in the Russian Federation. New York: Human Rights Watch, 2004. Available at <http://hrw.org/reports/2004/russia0404>.

# Hungary: A fight every step of the way for voluntary, anonymous, and free tests

**Voluntary, anonymous, and free HIV tests must be addressed in developing any effective policy in the fight against HIV/AIDS. There are heated discussions about the first two criteria, particularly anonymous testing, but free testing can also become contentious, as the following story shows.**

Since January 2003, Hungarian health legislation has stipulated that any person who does not belong to any of the groups that may be required to undergo a mandatory HIV test, and who wants to remain anonymous, must have anonymous access.

In order to write an article on examinations, checkups, and screening tests recommended to the public, such as dental checkups and mammographies, a journalist from the biggest-circulation women's magazine in Hungary decided to be tested for HIV.<sup>1</sup> She went to the nearest health establishment equipped to carry out the test.

Despite the fact that pre-test counselling took place within the hearing of everyone in the waiting room (the nurse having forgotten to close the door), the journalist was surprised to have to present her social security card in order to be tested. When she objected that she had asked for an anonymous test, she was told that to get an anonymous test she would have to pay HUF5000 (Hungarian forints)

– the minimum monthly salary in Hungary being HUF55,000. Stung by this news, the journalist decided to present her card and give up her anonymity. Then, in order to find out her test result, she had to present her identity card.

The fear and stigmatization that HIV/AIDS still inspire make the right to confidentiality of information more important than ever. The point of anonymous testing, which these Hungarian health authorities did not understand, is to reach out to and create confidence in a greater number of people, some of whom are among both the most vulnerable to infection and the most disadvantaged. If such a test is not free of charge, the policy fails to meet its epidemiological objective; it is completely counterproductive – and illegal – to have to buy one's anonymity.

The budget for anonymous HIV testing was included in the health authority's budget several years ago, when the National AIDS Council was

abolished. Whether or not one has a social security card, therefore, should not determine whether the test is free of charge. Public health protection and respect for human rights point in the same direction, and the violation of these rights greatly undermines the goal pursued.

After the journalist's article was published, the privacy-of-information ombudsman initiated an inquiry, pending at the time of writing. The Hungarian Civil Liberties Union reported the abuses it knew about to the ombudsman and is assisting in the inquiry.

For more information, contact Eszter Csernus (csernuse@tasz.hu) at the Hungarian Civil Liberties Union.

<sup>1</sup> S Dobray, É Fejos, Cs Miholics, BR Kövér, H Szigeti. „Szurovizsgálatok Kálváriaja – Anonim AIDS szűrés csak személyi igazolvánnyal!” – in: *Nők Lapja*, 3 March 2004 ([translation] “Ordeal of medical checkups – anonymous HIV test only with identity card”).

## USA: Cirque du Soleil pays US\$600,000 to end HIV discrimination complaint

**In April 2004 Lambda Legal, a US-based civil rights organization, announced that the travelling circus Cirque du Soleil would pay a record US\$600,000 to end an HIV discrimination complaint filed by one of its former employees who was dismissed because he has HIV.<sup>1</sup>**

The settlement ends a nationwide campaign and a federal disability complaint filed by Lambda Legal on behalf of its client, Matthew Cusick. Part of the settlement covers future earnings, since Cirque's public hostility toward Cusick over the period preceding the settlement led him to decide not to return to work for the company.

In 2003 Lambda Legal and community leaders launched a nationwide

campaign against Cirque du Soleil, which intensified over several months with protests outside Cirque shows in San Francisco, Los Angeles, and Orange County, California. Several thousand people signed petitions and sent letters to Cirque du Soleil to complain about Cusick's dismissal, and some of the United States' most accomplished performers, artists, and celebrities joined the campaign.

Under the settlement agreement, Cirque du Soleil will host annual anti-discrimination training for all its employees worldwide and will adopt a zero-tolerance policy toward discrimination based on HIV and other disabilities. For two years Cirque will have its records open to the US Equal Employment Opportunity Commission, ensuring that the company complies with the agreement.

<sup>1</sup> The full text of the conciliation agreement is available on the Lambda Legal website at [www.lambdalegal.org/cgi-bin/iowa/documents/record?record=1478](http://www.lambdalegal.org/cgi-bin/iowa/documents/record?record=1478).

## Namibia: Policy adopted on HIV/AIDS and the education sector

**The Namibian National Policy on HIV/AIDS for the Education Sector, adopted in 2003, provides a framework for prevention, care, and support for both learners and employees in the education sector and for the mitigation of the impact of HIV/AIDS on learners and employees, as well as on the education sector itself.**

Since its adoption, the policy has been widely distributed to all schools and other educational institutions in Namibia. The Ministry of Basic Education and the Ministry of Higher Education, Training and Employment Creation have established a joint HIV/AIDS Management Unit that is responsible for coordinating and ensuring the overall implementation of the policy in both primary and secondary schools.

This exemplifies the commitment to implement the policy and to address the HIV and AIDS pandemic

through research, curriculum development, after-school activities, school-based counselling, the training of staff and learners, workplace support, and the provision of information, education, and communication materials.

The policy addresses the particular factors that increase vulnerability to HIV infection on the part of both learners and employees, and seeks to ensure that no learner or employee faces discrimination on the basis of his or her HIV status. HIV testing for the purpose of employment, enrolment, or continued attendance is pro-

hibited. Confidentiality with regard to information relating to HIV status voluntarily shared by either employees or learners is to be respected. The particular needs of orphans and vulnerable children in respect of access to education are to be addressed. Education on HIV/AIDS and sexuality in educational institutions is identified as an integral part of the curriculum.

The process of developing the policy was overseen by a joint working group comprising representatives from both the ministries of Basic and of Higher Education as well as from

the National Association of Namibian Students (NANSO), the University of Namibia, the Polytechnic of Namibia, and teachers' trade unions.

The consultative process was led by the AIDS Law Unit of the Legal Assistance Centre. An initial meeting was held with government and NGO stakeholders in the education sector to

explain the policy development process and to gain input from stakeholders on the issues they would like to see covered in the policy. A questionnaire was then designed for use by school heads for focus group meetings with teachers, learners, and parents.

A draft policy was then compiled and circulated widely. After further

consultation at a national conference in June 2002, the policy was adopted by Cabinet and formally launched by the Minister of Basic Education in April 2003.

For further information, contact Michaela Clayton (mclayton@lac.org.na) at the AIDS Law Unit (www.lac.org.na).

## Global: HIV/AIDS-related travel restrictions – UNAIDS/IOM statement and revision of International Health Regulations

**In June 2004 UNAIDS and the International Organization for Migration (IOM) issued a joint statement on HIV/AIDS-related travel restrictions. While acknowledging that the regulation of immigration matters is widely recognized as falling within the sovereign power of the individual state concerned, the statement distinguishes between short-term (one month or less) and long-term travel.**

In both cases the statement notes that restrictions cannot be justified on public health grounds and, where restrictions are based on economic grounds (eg, cost of health care and social assistance) for long-term visitors or migrants, restrictions on entry or stay “should be implemented in such a way that human rights obligations are met, including the principle of non-discrimination, *non-refoulement* of refugees, the right to privacy, protection of the family, protection of the rights of migrants, and protection of the best interests of the child. Compelling humanitarian interests should also be given due weight.”<sup>1</sup>

Recognizing the importance of leadership on this issue, in 1993 the UN system imposed a global ban on the UN sponsorship of conferences or meetings on HIV/AIDS in countries with short-term travel restrictions

on people with HIV/AIDS. For example, because the US generally prohibits the entry of aliens (visitors) with HIV infection, UN-sponsored international AIDS conferences and meetings cannot presently be held there. During the UN General Assembly Special Session on HIV/AIDS in 2001, the US issued a temporary waiver of the ban to allow HIV-positive delegates to attend the UN headquarters in New York.<sup>2</sup>

The International Health Regulations aim to harmonize the protection of public health with the need to avoid unnecessary disruption of trade and travel, and are legally binding on WHO member states.<sup>3</sup> Under the Regulations (being revised), states cannot refuse entry to a person who cannot provide a certificate stating that he or she is not “carrying the AIDS virus.”<sup>4</sup> The revised

Regulations are expected to be submitted for consideration by the 58<sup>th</sup> World Health Assembly in 2005.

<sup>1</sup> UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions (2004). Available via [www.unaids.org](http://www.unaids.org) or [www.iom.int](http://www.iom.int). For a list of country HIV testing requirements, see the website of the US State Department <http://travel.state.gov/HIVtestingreqs.html>. See also *HIV/AIDS and Immigration: Final Report*. Montréal: Canadian HIV/AIDS Legal Network, 2001; *Canada's Immigration Policies as They Affect People Living with HIV/AIDS: Questions and Answers*. Montréal: Canadian HIV/AIDS Legal Network, 2003. Both documents are available at [www.aidslaw.ca/Maincontent/issues/immigration.htm](http://www.aidslaw.ca/Maincontent/issues/immigration.htm).

<sup>2</sup> For further information on the UN system policy and the 2001 US government waiver, see “Canadian HIV/AIDS Legal Network – UNGASS accreditation” at [www.aidslaw.ca/Maincontent/events/UNGASS.htm#ac](http://www.aidslaw.ca/Maincontent/events/UNGASS.htm#ac).

<sup>3</sup> See [www.who.int/csr/ihr/en/](http://www.who.int/csr/ihr/en/). See also *Global Crisis-Global Solutions: Managing public health emergencies of international concern through the revised International Health Regulations*. Geneva: WHO, 2002 (WHO/CDS/GAR/2002.4). Available at [www.who.int/csr/resources/publications/ihr/en/](http://www.who.int/csr/resources/publications/ihr/en/).

<sup>4</sup> *Weekly Epidemiological Record* 1985; 60: 311. Personal communication, Dr David Lehman, WHO (29 May 2002); *International Health Regulations* (1969), Article 81 and Appendix 2.

## In brief

**December 2003:** The World Health Organization published a cartoon booklet for young people called “HIV/AIDS: Stand up for Human Rights.”<sup>1</sup> The cartoon is part of a global campaign to tackle HIV/AIDS-related stigma and discrimination and other human rights violations.

**January 2004:** The International Labour Office published a report entitled “Guidelines on addressing HIV/AIDS in the workplace through employment and labour law.”<sup>2</sup> The report provides an excellent reference for preparing or evaluating legislation relating to HIV/AIDS in the workplace, and covers definitions, non-discrimination, prohibited grounds of discrimination, terms and conditions of employment, training and vocational guidance, care and support, and enforcement.

**February 2004:** The 8th Annual Convention of the Indian Network of NGOs Working on HIV/AIDS (INN) convened more than 300 participants in Lucknow, India, for three days of discussion on topics related to HIV/AIDS and vulnerability, stigma, and discrimination. The 9th Annual INN Convention will be hosted by a coalition of Indian HIV/AIDS human rights organizations in early 2005. For further information, contact Sushil Huidrom (sushilhuidrom@Rediffmail.com).

**March 2004:** The Pan-African Treatment Access Movement met in Harare, Zimbabwe, on 3-5 March and created six working groups, including a working group on Governance, Health and Human Rights. For further information, contact the Acting Convenor, Tapiwanashe Kujinga (tapiwa68@hotmail.com).

**March 2004:** The US-based Center on AIDS & Community Health at the Academy for Educational Development (AED) has created a website focusing on HIV/AIDS-related stigma and discrimination ([www.hivaidsstigma.org](http://www.hivaidsstigma.org)). The website offers definitions of stigma and discrimination, a literature review, and a tool kit for NGOs, community groups, and educators.

**April 2004:** The Latin American and Caribbean Council of AIDS Service Organizations (LACCASO) and the Inter American Regional Workers Organization, with the support of the International Labor Organization, held a regional consultation to discuss country studies of HIV/AIDS-related discrimination and exclusion in the workplace in Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Dominican Republic, and Haiti (San Jose, Costa Rica, 26-29 April 2004). The Consultation was attended by representatives of unions, workers’ agencies, and NGOs. Outcomes include a statement affirming the centrality of human rights and a commitment to work together to address the issues identified. The country studies and the full report of the meeting are available on the LACCASO website (in Spanish) at [www.laccaso.org](http://www.laccaso.org). For further information, contact Victor Croquer (vcroquer@accesi.org.ve) at LACCASO.

**June 2004:** The Canadian International Development Agency extended until March 2005 funding for the Canadian HIV/AIDS Legal Network’s technical support to AIDS-law organizations in Kenya and Zambia. Legal Network members will continue to provide training and advice pro bono to the Kenya Ethical and Legal Issues Network (KELIN) and the Zambia

AIDS Law Research and Advocacy Network (ZARAN).<sup>3</sup> For further information, contact David Patterson ([david.patterson@videotron.ca](mailto:david.patterson@videotron.ca)).

**June 2004:** Following the international consultation of HIV treatment, microbicide, and vaccine advocates in Montréal in November 2003,<sup>4</sup> a trilateral community consultation of advocates from South Africa, India, and Brazil was held in Durban, South Africa. For further information contact Shaun Mellors (s-mellors@mweb.co.za).

**June 2004:** The Caribbean Community and Common Market (CARICOM) and the Pan Caribbean Partnership on HIV/AIDS (PANCAP) hosted a regional workshop on HIV/AIDS, law, ethics, and human rights in Georgetown, Guyana.<sup>5</sup> The meeting discussed HIV/AIDS-related stigma and discrimination in the region, the preparation of regional guidelines, and opportunities to seek high-level political commitment to addressing the issues. Technical assistance was provided by the Canadian HIV/AIDS Legal Network. For further information, contact Alicia Sands ([asands@caricom.org](mailto:asands@caricom.org)) at PANCAP.

<sup>1</sup> Available at [www.who.int/hhr/activities/publications/en/](http://www.who.int/hhr/activities/publications/en/) (English only).

<sup>2</sup> J-Hodges. Guidelines on addressing HIV/AIDS in the workplace through employment and labour law. Geneva: ILO, 2004. Available at [www.ilo.org/public/english/dialogue/ifpdial/downloads/papers/hivaid.pdf](http://www.ilo.org/public/english/dialogue/ifpdial/downloads/papers/hivaid.pdf).

<sup>3</sup> For project information and reports for 2002-2003, see “Promoting a rights-based approach to HIV/AIDS internationally” at [www.aidslaw.ca/Maincontent/issues/discrimination/rights\\_approach/international.htm](http://www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach/international.htm).

<sup>4</sup> See J Godwin. HIV treatments, vaccines, and microbicides: toward coordinated advocacy. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(1): 1, 7-14.

<sup>5</sup> For related activities, see Caribbean: Regional support for HIV/AIDS law and policy reform. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(1): 29-31.

# GLOBAL ACCESS TO TREATMENT, VACCINES, AND MICROBICIDES

With this issue of the *Review*, we expand this section to include not only issues concerning access to treatment, but also issues related to obtaining access to vaccines and microbicides. This is in keeping with recent efforts to promote collaborative advocacy between the three fields, within an overarching human rights framework. In this issue, we report on a paper from the Canadian AIDS Society on legal and ethical issues in microbicides research and development in Canada. We also report on the call issued by some consumer groups for a ban on internet pharmacies. Finally, we cover the announcement of the first ever therapeutic HIV vaccine trial in Canada. This section is edited by Richard Elliott, Director, Policy & Research, Canadian HIV/AIDS Legal Network. He can be reached at [relliott@aidslaw.ca](mailto:relliott@aidslaw.ca).

## Legal and ethical issues in microbicides research and development in Canada

The Canadian AIDS Society (CAS) recently completed a report entitled *Microbicides Development and Delivery in Canada: Legal, Ethical and Human Rights Issues*. The report builds on Canadian and international experience and was written in consultation with Canadian community and international experts. It is available on the CAS website ([www.cdnaids.ca](http://www.cdnaids.ca)) and from the Canadian HIV/AIDS Information Centre ([www.aidssida.cpha.ca](http://www.aidssida.cpha.ca)) as of September 2004. In this article the report's author, Anna Alexandrova, argues that Canada needs to develop a microbicides development and delivery strategy that addresses research and development issues, outlines possible roles for meaningful community participation, and provides guidelines on funding, promotion, licensing, and distribution.

### Introduction

From a global perspective, HIV prevalence in Canada is relatively low. Yet despite evidence that Canadians

generally have a good understanding of modes of HIV transmission, risk factors, and prevention options, HIV

transmission continues. For many people, this indicates that available prevention options are lacking.

This is especially true in the case of women, who represent an increasing proportion of reported HIV cases in Canada.<sup>1</sup>

Many HIV prevention strategies focus on individual behaviour change, neglecting the broader factors that influence individual and community behaviours. But many women have limited or no control over whether their partners choose to use condoms. Neither do they have control over the broader factors that have direct influence on their risk of HIV infection. Recent Canadian research has found that socioeconomic factors, gender, cultural and religious values, and beliefs and practices play an important role in women's ability to protect themselves from HIV infection.<sup>2</sup> HIV-related stigma and other types of discrimination further compound the issue by increasing the inability of women to protect themselves.

Therefore, women need to be provided with effective HIV prevention options they can control – options such as microbicides. Such an option is particularly important for women who are marginalized in Canadian society. Microbicides are also a potentially significant prevention tool for men who have sex with men, who risk HIV transmission through unprotected anal sex.

### What are microbicides?

A “microbicide” is any substance that can substantially reduce the transmission of sexually transmitted infections (STIs), including HIV, when applied either in the vagina or rectum. Microbicides can be delivered in a gel, cream, suppository, film, sponge, or vaginal ring. Many scientists and practitioners agree that microbicides may offer one of the most promising preventative interventions, given that they could be safe, effective, inexpen-

sive, readily available, and widely acceptable.<sup>3</sup> Mathematical modelling comparing how different combinations of condom and microbicide use affect individual risk of HIV and other STIs has demonstrated that the use of microbicides will not lead to an increased risk of HIV if people abandon condoms in favour of microbicides.<sup>4</sup>

Many women have limited or no control over whether their partners choose to use condoms.

Recognizing these benefits, in June 2001 all member states of the UN General Assembly Special Session on HIV/AIDS unanimously adopted the UN Declaration of Commitment on HIV/AIDS, in which they committed, among other things, to “encourage increased investment in HIV/AIDS-related research nationally, regionally and internationally, in particular for the development of sustainable and affordable prevention technologies, such as vaccines and microbicides.”<sup>5</sup>

### Human rights-based approach to microbicide development and delivery

A “rights-based approach” to microbicide development and delivery uses human rights as a point of reference for policy development in order to assess and address the human rights implications of any related policy or law. Furthermore, this approach positions human rights as an integral part of the design, implementation, monitoring, and evaluation of microbicide development and delivery.<sup>6</sup>

A global perspective and international human rights instruments have played an important role in shaping Canada's response to HIV/AIDS. Canada has ratified numerous human rights instruments that recognize and define the right to health in law. Under these instruments, people are entitled to the conditions that would allow them to exercise their right to health to the fullest, and governments are obliged to ensure a system of health protection that provides equal opportunities to enjoy the highest attainable level of health, including access to information, and the prevention, treatment, and control of epidemic diseases. The development and delivery of microbicides would promote the health of many Canadians by keeping them from being infected with HIV.

### A role for Canadian community-based organizations

Canada has committed to the importance of ensuring greater participation of people infected or affected by HIV/AIDS in all national and global HIV responses (the GIPA principle).<sup>7</sup> Microbicides are a part of these responses. Therefore, in keeping with its commitment, Canada should create the conditions to strengthen the participation of people living with HIV/AIDS and community-based organizations in microbicide development and delivery. This will mean, for example, providing funding to AIDS organizations to raise awareness of microbicides in their community or to fund community-based research initiatives that would look into the acceptability of microbicides within various communities in Canada (eg, among Aboriginal women who are statistically among the groups at highest risk for HIV infection).



In order for communities to meaningfully participate in the design and implementation of microbicide trials, in disseminating their results, and in preparing for eventual microbicide delivery, community representatives need to gain and disseminate information about the scientific, legal, and ethical issues related to microbicide research, the clinical trials process, the regulatory approval process, and the marketing and delivery of microbicides in Canada. To this end, the government should encourage national, regional, and local community-based organizations who serve people living with or affected by HIV/AIDS to learn more about microbicides, disseminate this knowledge, and participate in decision-making.

### Law and ethics in clinical trials

One potential microbicide is in clinical trials in Canada. The Invisible Condom™ is a combination of both physical and chemical barriers, a non-toxic polymer-based liquid that becomes a semi-solid gel at body temperature and guards against HIV/STI infection. Phase I of the trial was conducted in Canada, where 70 healthy volunteers (47 women and 23 male partners) were recruited. Future phases of the trial will take place outside of Canada in a country with high HIV prevalence.

Future trials in Canada should follow sound legal and ethical principles. Existing federal regulations require that generally acceptable principles of “good clinical practice” must guide the design and conduct of a clinical trial.<sup>8</sup> The term “good clinical practice” is quite broadly defined, and includes requirements such as prior approval by a Research Ethics Board before the clinical trial begins, as well as a variety of conditions to be met in

the actual implementation of the research.<sup>9</sup>

In addition to the legal requirement of approval by a Research Ethics Board, clinical trials should be designed and carried out with input from local Community Advisory Boards (CABs). CABs include key stakeholders and representatives of the community who work with the research team to identify and resolve community-related issues. For example, CABs were established in each of the three Canadian sites for the AIDS VAX trial (Vancouver, Toronto, and Montréal), the first trial in Canada of a preventive HIV vaccine. Among other things, the CABs helped researchers understand target communities, and recruit and retain trial participants; disseminated information in the community; participated in the design of the informed-consent process; and worked to ensure good working relationships between trial organizers, researchers, and local health services.

### Legal status of microbicides in Canada

Microbicides possess characteristics that present special regulatory and licensing challenges. In Canada, manufacturers must receive a licence to sell health products defined as a “medical device” under the Food and Drugs Act.<sup>10</sup> Condoms are an example of a medical device. Similarly, all drugs are reviewed to assess their safety, efficacy, and quality before being authorized for sale. To ensure that quick and comprehensive licensing and review protocols exist for microbicides, it is important to identify whether a microbicide will be considered a medical device or a drug under the Food and Drugs Act.

This determination will depend on the components in the microbicides.

The decision on whether microbicides will be considered a drug or a device will likely determine whether first-generation microbicides will be available by prescription only or whether they will be sold over the counter as well. If a microbicide includes anti-retroviral agents (like those currently used in medications to treat HIV infection), it will probably have to be considered a drug and be available by prescription only.

UNAIDS suggests that microbicides would be most effective if available without prescription.<sup>11</sup> Ideally, microbicides should be made available at low or no cost through needle exchange outlets, methadone maintenance treatment programs, women’s crisis centres, reproductive and sexual health clinics, outreach workers, community-based organizations, and other venues traditionally used for safer-sex education and HIV prevention in Canada.

### Taking action on microbicides

In Canada, civil society organizations have taken the initiative on microbi-

There has been only one clinical trial of a microbicide in Canada, and there is no dedicated funding for microbicide development and delivery.

cide issues. The Microbicides Advocacy Group Network (MAG-Net) is a coalition of about 30 Canadian AIDS service organizations, sexual and reproductive health organizations, international development NGOs, and researchers. It is coordi-

nated by the Canadian AIDS Society (CAS) and serves as the Canadian arm of the Global Campaign for Microbicides. The goals of MAG-Net are to share ideas and resources on raising awareness of microbicides with other CAS members and partners, and to share ideas and provide input into coordinated advocacy efforts at local, national, and global levels.

But the response of the Canadian government and the private sector has been less robust. There has been only one clinical trial of a microbicide in Canada, and there is no dedicated funding for microbicide development and delivery. A Canadian strategy on the development and delivery of microbicides is needed. It also flows from Canada's international obligations and commitments in the areas of health and HIV/AIDS, as described above.

Such a strategy should address research and development issues, outline possible roles for meaningful community participation, and provide guidelines on funding, promotion, licensing, and distribution. A model exists for developing such a strategy. Canada is the first and only industrialized country to begin developing an HIV Vaccines Plan with support from Canadian researchers, coalitions of community-based organizations, government departments, and internation-

al partners. The key components of the Plan include:

- ensuring Canada's commitment to the development of HIV vaccines;
- ensuring public engagement;
- ensuring integrated strategic plans for HIV vaccine research and development;
- ensuring equitable vaccine access and delivery; and
- ensuring accountability, monitoring, and evaluation.

However, no specific resources have been allocated for the development of the HIV Vaccines Plan, or for its eventual implementation.

Canadian community-based organizations and people living with HIV/AIDS should continue to promote microbicides on the national and international agenda. They need sufficient funding so that their work can be made fully effective. With political and financial commitment to microbicide research and delivery, an effective microbicide could be on the market within five to seven years. It is up to Canadian advocates, and to private sector and government stakeholders, to make sure we contribute to this critical global effort.

— Anna Alexandrova

Anna Alexandrova has worked as a consultant to CAS and to the International Harm

Reduction Development Program, Open Society Institute, New York. She holds a Master of Laws degree from the University of Toronto and a Bachelor of Laws from the International University of Moscow. She can be reached at AnnaAlexandrova@aol.com.

<sup>1</sup> In 2002, women accounted for nearly 26 percent of all positive HIV test reports. See *HIV and AIDS in Canada, Surveillance Report to December 31, 2002*. Ottawa: Minister of Public Works and Government Services, April 2003, at 12.

<sup>2</sup> E Tharao, from *Women's Health in Women's Hands*, presented findings from E Tharao, N Massaquoi, M Brown, *Silent Voices of the AIDS Epidemic: African and Caribbean Women, their Understanding of the Various Dimensions of HIV/AIDS and Factors that Contribute to their Silence* at the Microbicides Symposium, held in Ottawa, Ontario (30 October 2003).

<sup>3</sup> Office of AIDS Research, National Institutes of Health. Some studies suggest that in the absence of an ideal microbicide, participants would use a messy and unpleasant microbicide product if its efficacy against HIV were proven. See UNAIDS, *Microbicides for HIV Prevention*. Geneva: UNAIDS, April 1998, at 3.

<sup>4</sup> A Foss, P Vickerman, L Heise, C Watts. Shifts in condom use following microbicide introduction: should we be concerned? *AIDS* 2003; 17(8): 1227-1237.

<sup>5</sup> Declaration of Commitment on HIV/AIDS. GA Res/S-26/2, 27 June 2001, para 89.

<sup>6</sup> For a definition of a "rights-based approach to health," please see *Questions and Answers on Health and Human Rights* (Health & Human Rights Publication Series, Issue No 1). Geneva: World Health Organization, 2002 (available via [www.who.int](http://www.who.int)).

<sup>7</sup> See *From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA)*. Geneva: UNAIDS, 1999. Contains the Paris Declaration of 1 December 1994.

<sup>8</sup> See, generally, Food and Drug Regulations, CRC, c 870, as amended, Division 5, Drugs for Clinical Trials Involving Human Subjects.

<sup>9</sup> *Ibid* at s C.05.010 (d).

<sup>10</sup> Food and Drugs Act, RSC 1985, F-27.

<sup>11</sup> UNAIDS, *Microbicides for HIV Prevention: UNAIDS Technical Update*. Geneva: UNAIDS, April 1998.

## Consumer groups call for ban on internet pharmacies

**A number of consumer groups have called on the Canadian government to ban internet pharmacies, claiming that the industry is putting the health of Canadians at risk. The groups say that the impact will escalate if the problem is not addressed.**

Internet pharmacies are online pharmacies set up primarily in Canada to sell brand-name drugs to US customers; many of these pharmacies are located in Manitoba. Brand-name drugs are often significantly cheaper in Canada than they are in the US. Internet pharmacies now sell about US\$1 billion worth of prescription drugs annually to uninsured Americans.<sup>1</sup>

In March 2004, eight consumer groups, including the Canadian Treatment Action Council (CTAC) and the British Columbia Persons With AIDS Society, said that internet pharmacies are causing drug shortages in Canada, as drugs are diverted to US customers.<sup>2</sup> The groups said that because of the internet pharmacies, brand-name pharmaceutical companies are seeking and implementing price increases for the drugs they sell in Canada; and that these price increases are stretching the budgets of provincial drug reimbursement programs.

The consumer groups said that the brand-name pharmaceutical companies are using the internet-pharmacy issue to step up their pressure on the Canadian government to deregulate drug pricing, a long-standing goal of the industry. (Prices for brand-name drugs are currently regulated by the Patent Medicine Prices Review Board.) Consumer groups have called on the government to defend Canada's existing system of price regulation in the face of this pressure.

In addition, the consumer groups said that some of the drugs being

shipped to the US may not have gone through Canada's drug review processes. They expressed concern that these drugs could eventually get into the Canadian drug supply.

The consumer groups said that the growth of the internet pharmacy industry is impeding access to pharmacists and physicians by Canadians. The groups said that 30 percent of pharmacists in Manitoba have left the public domain to work for internet pharmacies; that pharmacies serving the public are closing or shortening their hours of operation; and that many physicians are spending a lot of time co-signing US prescriptions rather than serving Canadian patients.

Finally, the groups questioned whether it is ethical for physicians to prescribe medicine to a patient with whom the physician has had no face-to-face contact, and to whom the physician will not be providing follow-up care.

In May 2004, the Manitoba Society of Seniors Inc. also called on the federal government to ban the diversion of Canadian drugs to the US. Citing various sources, the Society said that 40 percent of the provincial drug supply was diverted to the US in 2003; that more than 20 percent of Manitoba community pharmacists are now engaged in cross-border selling; and that more than 80 percent of community pharmacists report increasing drug shortages.<sup>3</sup>

Health Canada says that it is monitoring the industry but has not yet found any evidence that Canadians

are facing drug shortages because of online pharmacies.<sup>4</sup>

The brand-name drug companies don't like internet pharmacies either because they eat into their profit margins in the US market (although cross-border shipments still represent a tiny portion of that market). Some drug companies, including Pfizer Canada, have blacklisted Canadian wholesalers who supply internet pharmacies.

– David Garmaise

In July 2004, the Canadian HIV/AIDS Legal network released a report and a series of info sheets on the issue of the federal regulation of pharmaceutical prices in Canada. While the report does not analyze the complex issues raised by internet pharmacies, it does provide a detailed analysis of the evolution of Canada's approach to controlling medicine prices for Canadians and offers several recommendations to the federal government aimed at strengthening Canada's price regulation system. The report and the info sheets are available on the Legal network's website via [www.aidslaw.ca](http://www.aidslaw.ca) by clicking on "What's New."

<sup>1</sup> Health groups call on Martin to ban Internet pharmacies. Canadian Press, 30 March 2004.

<sup>2</sup> Position Statement: Cross-border Internet Pharmacy. Available on the CTAC website via [www.ctac.ca](http://www.ctac.ca). The other six consumer groups are: the Best Medicine Coalition, the Canadian Arthritis Patient Alliance, the Canadian Organization for Rare Disorders, the Consumer Advocare Network, Epilepsy Manitoba, and the Hepatitis C Network.

<sup>3</sup> Manitoba seniors ask Prime Minister to ban cross-border drugs. News release. 4 May 2004. Available via the website of the Manitoba Society of Seniors Inc. at [www.msos.mb.ca](http://www.msos.mb.ca).

<sup>4</sup> Supra, note 1.

## Therapeutic HIV vaccine trial launched in Canada

**The first-ever clinical trial of a therapeutic HIV vaccine in Canada is currently underway. The trial is being run by the Canadian Network for Vaccines and Immunotherapeutics (CANVAC) in cooperation with Aventis Pasteur, of France, and the Immune Response Corporation (IRC), of the United States.**

The vaccine being tested contains two ingredients – Remune (from IRC) and ALVAC (from Aventis Pasteur). The Phase I trial started in April 2004 and is scheduled to run for 18 months. The first several months were spent recruiting 60 trial participants from Ottawa and Montréal.<sup>1</sup> The trial is designed to explore whether Remune and ALVAC together will produce a synergistic effect that is greater than either product has so far demonstrated

on its own or in other combinations.

Unlike a preventive vaccine, the target audience for a therapeutic vaccine are people who are already infected with HIV. The goal of the research is to find a product that can replace antiretroviral drug cocktails, or at least reduce dependence on these cocktails.

Having an HIV vaccine trial in Canada is a welcome development. However, there does not appear to

have been much communication with HIV/AIDS organizations in Ottawa or Montréal about the design of the trial, or about the potential impact of the trial on existing prevention programs.

– David Garmaise

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<sup>1</sup> Canadian researchers start new trials for anti-AIDS vaccine. Agence France Presse, 30 March 2004.

# HIV/AIDS IN PRISONS

This section of the *Review* addresses issues related to HIV/AIDS in prisons. The editor of this section is Ralf Jürgens, former Executive Director of the Canadian HIV/AIDS Legal Network.

In this issue, we report on two developments at the Correctional Service of Canada – the decision to establish safer tattooing pilot projects in six federal prisons, and the release of a comprehensive profile of the health needs of federal prisoners in Canada. We then report on the release by three United Nations agencies of a policy brief on reduction of HIV transmission in prisons. This is followed by an article on a court case in the United States where a federal judge determined that by not providing adequate medical care Alabama prison officials violated the constitutional rights of HIV-positive prisoners. Finally, we report on a few additional recent developments in prisons in Canada and elsewhere, and on new or updated resources on issues related to HIV/AIDS in prisons. All of the articles in this issue were written by Ralf Jürgens.

## Correctional Service Canada to undertake Safer Tattooing Practices Initiative

In 1994, the Expert Committee on AIDS and Prisons recommended that tattooing equipment and supplies be authorized for use in federal correctional institutions, and that prisoners who would offer tattooing services to other prisoners be instructed on how to use tattooing equipment safely.<sup>1</sup> Ten years later, Correctional Service Canada (CSC) has finally announced that, as part of a Safer Tattooing Practices Initiative, it will set up safer tattooing pilot projects in six federal prisons in 2004, and evaluate the initiative.

There has been concern about the potential spread of infectious diseases, particularly hepatitis C, but also HIV, through the sharing of tattooing equipment in prisons. Forty-five percent of respondents to CSC's 1995 Inmate Survey said they had had a tattoo done in prison.<sup>2</sup>

Under the Safer Tattooing Practices Initiative, tattoo parlours will be set up in federal prisons in all regions, including in one institution for women. These parlours will be administered by prisoners themselves, under the supervision of CSC staff.

The union representing the 5700 federal correctional officers made its opposition to the initiative public in a press release on 22 May 2004, suggesting that the “initiative is a misguided response to increasing rates of infectious disease, does not respond to CSC’s mandate, and poses unacceptable risks to security for its members, inmates, and the community at

large.”<sup>3</sup> Once again, the union is thus opposing measures aimed at reducing the spread of infection in prisons, and at protecting the health of prisoners, staff, and the public.

In contrast, community advocates expressed support for CSC’s initiative, although they suggested that CSC is doing too little, too late. They are concerned that many prisoners may not access the tattoo parlours that will be set up because too many rules and regulations may deter prisoners. They pointed to a comprehensive policy document on tattooing developed in consultation with prisoners that suggests alternative approaches to regu-

lating tattooing in prisons.<sup>4</sup> Finally, they also called upon CSC to implement pilot needle exchange programs.

<sup>1</sup> *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Correctional Service Canada, 1994, at 80 (recommendation 6.4).

<sup>2</sup> CSC. 1995 National Inmate Survey: Final Report. Ottawa: The Service (Correctional Research and Development), 1996 No SR-02.

<sup>3</sup> UCCO-SACC-CSN opposes prison tattoo initiative. Press release of 22 May 2004. Available at [www.newswire.ca/en/releases/archive/May2004/22/c6783.html](http://www.newswire.ca/en/releases/archive/May2004/22/c6783.html).

<sup>4</sup> P Collins et al. Driving the point home: a strategy for safer tattooing in prisons. Toronto: PASAN, Canadian HIV/AIDS Legal Network, HIV/AIDS Regional Services, 2003. Available via [www.pasan.org](http://www.pasan.org).

## Health-care-needs assessment of federal prisoners in Canada released

**On 7 April 2004, Correctional Services Canada (CSC) released a comprehensive profile of the health needs of federal prisoners in Canada, published in a special supplement to the *Canadian Journal of Public Health*.<sup>1</sup>**

The study begins with an overview of health services provided by the CSC and a description of the prisoner population, including sociodemographic indicators. Other sections address inmate mortality, physical health conditions, infectious diseases, and mental health issues. The final section provides a summary, the key findings, and some conclusions.

The study found that prisoners have consistently poorer health status when compared with the general Canadian population, regardless of the indicator chosen. With respect to socioeconomic indicators, the study

found that prisoners are twice as likely not to have finished high school, and nine times more likely to have been unemployed.

With respect to health behaviours, the study found that prisoners are more than twice as likely to smoke, 30 times more likely to inject drugs, and two to 10 times more likely to have an alcohol or substance abuse disorder.

Concerning chronic conditions, the study found that prisoners are 40 percent more likely to be treated for diabetes in males and three times more likely in females; 68 percent more likely to be treated for cardiovascular

conditions in males and more than two times more likely in females; 43 percent more likely to be treated for asthma in males and almost three times more likely in females; and 50 percent more likely to need the use of mechanical aids.

With respect to infectious diseases, the study found that prisoners are more than twice as likely to have been infected with HBV, more than 20 times more likely to have been infected with HCV, more than 10 times more likely to have been infected with HIV, and much more likely to be infected with TB.

As far as mental health disorders are concerned, the study found that prisoners are more than twice as likely to have had any mental disorder, three times more likely to have schizophrenia in males and 20 times more likely in females, and four times more likely to have a mood disorder.

The study also found that prisoners are at a 45 percent increased risk of death, are eight times more likely to die of homicide, and are almost four times more likely to die of suicide.

The study emphasizes that

[t]here is little doubt that the burden of health conditions in the inmate population is substantial. From a health perspective, inmates represent an incredibly high-risk population. They have a web of negative health determinants, including low education, unemployment, unstable living conditions, unhealthy behaviours, and poor social supports. These contribute to high rates of chronic diseases, injuries and death. High rates of mental disorders further complicate the situation.<sup>2</sup>

The study points out that health services in the CSC have traditionally been “individual care-based and therefore reactive,” and that a “much greater population health focus is required.”<sup>3</sup> It acknowledges that the range of public health services that exist in Canadian communities is underdeveloped in prisons, and that there is a need for a public health infrastructure to fulfill the core functions of public health services within prisons – ie, to assess the health status of prisoners; have an effective surveillance system for infectious and chronic diseases; fulfill the CSC Health Services’ mandate in health promotion; have coordinated actions to prevent diseases and injuries; protect the health of prisoners; and evaluate the effectiveness, accessibility, and quality of health services.

The study continues by saying that

a functioning prison public health system is required to ensure the appropriate management and control of

infectious diseases. CSC has a distinct interest in ensuring the prevention of transmission among inmates and from inmates to prison staff. Canadians have a vested interest in ensuring that the pool of individuals infected with HIV, HCV, TB, and STDs is not amplified through the country’s prison system.<sup>4</sup>

The study concludes by pointing out that prisoners “have the same right to health services as other Canadians” and that prisoners “come from the community and return to the community.”<sup>5</sup> Therefore, “addressing their health needs will contribute to the inmate’s rehabilitation and successful reintegration into the community.”<sup>6</sup>

<sup>1</sup> A health care needs assessment of federal inmates in Canada. *Canadian Journal of Public Health* 2004; 95(Suppl 1).

<sup>2</sup> Ibid at S49.

<sup>3</sup> Ibid at S51.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid at S52.

<sup>6</sup> Ibid.

## United Nations agencies release policy brief on reduction of HIV transmission in prisons

**Three United Nations agencies – the World Health Organization, UNAIDS, and the UN Office on Drugs and Crime – recently released a policy brief on reduction of HIV transmission in prisons.<sup>1</sup> The document calls upon governments to step up HIV prevention measures in prisons by adopting comprehensive programs that include all the measures against HIV transmission that are carried out in the community, including needle exchange.**

The document briefly reviews “four elements of prevention programmes in prisons [that] have been studied extensively: the provision of bleach for cleaning needles and syringes; needle and syringe programmes; methadone maintenance treatment;

and the provision of condoms.” It concludes with the following statement concerning “policy and programming implications”:

The prevention of HIV transmission in prisons is mostly hampered by the denial of governments of the existence of injection drug use and sexual intercourse in prisons, rather than by a lack of evidence that key interventions work. There is ample evidence that drug use in general, injecting drug use in particular and sexual intercourse between inmates are widespread in such institutions. Furthermore, there are data indicating that the risk of HIV

infection in prisons is usually higher than in the general community: prisons are a high-risk environment for HIV infection. Once this has been accepted, governments have a wide range of programme options for preventing HIV transmission in prisons.

The evidence shows that such programs should include all the measures against HIV transmission that are carried out in the community outside prisons, including HIV/AIDS education; testing and counselling performed on a voluntary basis; the distribution of clean needles, syringes, and condoms; and drug-dependence

treatment, including substitution treatment. All these interventions have proved effective in reducing the risk of HIV transmission in prisons. They have also been shown to have no unintended negative consequences. The available scientific evidence suggests that such interventions can be reliably expanded from pilot projects to nationwide programs.<sup>2</sup>

<sup>1</sup> World Health Organization. Evidence for action on HIV/AIDS and injection drug use – Policy brief: Reduction of HIV transmission in prisons. Geneva: WHO, 2004 (WHO/HIV/2004.05). Available via [www.who.int/en/](http://www.who.int/en/).

<sup>2</sup> *Ibid.*

## US judge: Inadequate medical care for HIV-positive prisoners is a violation of rights

**A federal judge in the United States has determined that Alabama prison officials violated HIV-positive prisoners’ constitutional rights and that poor medical care caused HIV-positive prisoners to die early.**

In September 2003, Human Rights Watch had expressed serious concerns about the appalling conditions endured by prisoners living with HIV/AIDS at Limestone Correctional Facility in Alabama.<sup>1</sup> The conditions were documented by Dr Stephen Tabet in a report on health conditions at Limestone. In the report, Dr Tabet expressed concern about the number of preventable deaths among HIV-positive prisoners at the facility.

In March 2004, Dr Tabet issued a second report, saying that “one of the most egregious medical failures at

Limestone is the number of preventable deaths. Patients continue to die because of the failure of the medical system.”<sup>2</sup>

Thirty-eight HIV-positive prisoners died between 1999 and 2002 at Limestone, and five died between October 2003 and March 2004. In his first report, Dr Tabet addressed the 38 deaths that occurred between 1999 and 2002 and alleged that nearly all of the deaths were preceded by a failure to provide proper medical care or treatment. He concluded that all of the deaths were caused by preventable illnesses. In his second report, Dr Tabet

detailed the deaths of the five prisoners who died between October 2003 and March 2004. He found, for example, that one prisoner literally suffocated in front of medical staff without treatment, while another lost more than 170 pounds without medication and a proper diet. A third HIV-positive prisoner with TB was placed in a dormitory with other prisoners with HIV, exposing more than 200 prisoners with compromised immune systems to TB before he died.

The Alabama Department of Corrections mandatorily tests prison-



ers for HIV, housing HIV-positive male prisoners at the Limestone Correctional Facility.

In a report issued in June 2004, US Magistrate Judge John Ott determined that Alabama prison officials violated sick prisoners' constitutional rights. The report was issued after the Department of Corrections agreed to numerous improvements in care and treatment to settle a federal lawsuit brought by HIV-positive prisoners housed at Limestone. The settlement requires the Department of Corrections' medical provider to hire a full-time nurse to serve as an HIV

coordinator charged with directing an infection-control program and arranging medical care for HIV-positive prisoners, including monitoring treatment progress and educating prisoners on HIV/AIDS and STDs. The settlement also prohibits the Department from housing HIV-positive prisoners in dormitories and it mandates that the Department clean the prisoners' cells.<sup>3</sup>

In his report, Ott wrote that because of "disregard of human life," the prisoners likely would have prevailed at trial, and added that the settlement was the best way to stop pain and suffering and ensure that medical

care would improve.<sup>4</sup> He added that "it is evident that lives were lost due to preventable lapses in the medical treatment" and that "HIV prisoners died without necessary intervention by the Limestone medical staff or Alabama Department of Corrections."

<sup>1</sup> See, Human Rights Watch. Case study: Alabama, a system in crisis. October 2003. Available at [www.hrw.org/reports/2003/usa1003/16.htm](http://www.hrw.org/reports/2003/usa1003/16.htm).

<sup>2</sup> New report blames inadequate HIV medical care for HIV inmate deaths at Limestone Correctional Facility. *Positive Populations* 2004; 5(6): 6.

<sup>3</sup> See *AIDS Policy & Law* 2004; 19(11): 12 (18 June 2004).

<sup>4</sup> C Crowder. Judge: prison's care violated rights of HIV-infected inmates. *Birmingham News*, 8 June 2004.

## Other developments

### Québec: High rates of HIV and HCV in prisons

A recent study, presented at the 13<sup>th</sup> Annual Canadian Conference on HIV/AIDS Research in May 2004, revealed high rates of HIV and HCV infection among prisoners in provincial prisons in Québec.<sup>1</sup>

The study was undertaken in seven provincial institutions. HIV prevalence was 2.3 percent among men (32 of 1357) and 8.8 percent among women (22 of 250). HCV prevalence was 16.6 percent and 29.2 percent respectively. Of the male prisoners, 27.7 percent admitted having injected drugs on the outside, and 7.2 percent tested HIV-positive. All HIV-positive women had injected drugs on the outside.

### Canada: Study shows that incarceration is independently associated with syringe lending and borrowing

Another study presented at the 13<sup>th</sup> Annual Canadian Conference on HIV/AIDS Research showed that of the 1475 injection drug users enrolled in the Vancouver Injection Drug Users Study (VIDUS), 1123 (76 percent) reported a history of incarceration since they first began injecting drugs. Of these, 351 (31 percent) reported ever injecting in prison. Among the 318 HIV-infected injection drug users, having been incarcerated in the six months prior to each interview was independently associated with syringe lending during this period.

Similarly, among the 1157 HIV negative injection drug users, having been incarcerated in the six months prior to each interview was independently associated with reporting syringe borrowing during this period. The researchers concluded that "incarceration was independently associated with risky needle sharing for HIV-infected and HIV-negative IDU," and that the "strong evidence of HIV risk behaviour should reinforce public health concerns about blood-borne diseases transmission in prisons."<sup>2</sup>

### Canada: Does incarceration result in HIV treatment interruptions?

There is increasing and disturbing evidence that despite major efforts

undertaken by prison systems, prisoners with HIV/AIDS continue to have problems accessing treatment equivalent to that available outside. In particular, there is evidence suggesting that a significant number of prisoners discontinue antiretroviral treatment while in prison.<sup>3</sup>

A study presented at the 13<sup>th</sup> Annual Canadian Conference on HIV/AIDS Research examined interruptions of highly active antiretroviral therapy (HAART) among 160 HIV-positive participants in the Vancouver Injection Drug Users Study (VIDUS).<sup>4</sup> It found that 71 of the study participants (44 percent) discontinued HAART during the study period. Factors independently associated with discontinuation of HAART included recent incarceration. Indeed, the most frequently cited reasons provided for discontinuing HAART were being in prison (44 percent) and medication side effects (41 percent). The study concluded that “programmatic changes may be needed to promote optimal retention on HAART among incarcerated HIV-infected IDUs.”

Information collected by HIV/AIDS organizations that provide front-line services to prisoners also support the evidence from scientific studies. A paper entitled “Initiative to Monitor Prison AIDS Care & Treatment (IMPACT): Data Analysis and Evaluation”<sup>5</sup> reports on 373 contacts filed by frontline workers based on information given by prisoners in federal and provincial correctional systems. During an approximately 12-month period:

- 45 reports involved HIV medications;
- 14 prisoners reported being cut off HIV antiretroviral medications;
- three prisoners reported that their HIV antiretroviral medications had

- been administered improperly;
- 11 prisoners reported missing doses of HIV antiretroviral medications; and
- seven prisoners reported being released from custody without HIV antiretroviral medications.<sup>6</sup>

High rates of discontinuation indicate potentially adverse outcomes for individual and public health due to the heightened risk for loss of virologic control and subsequent viral rebound,<sup>7</sup> and the development of drug resistance and the transmission of resistant virus to others.<sup>8</sup>

In October 2004, the Canadian HIV/AIDS Legal Network will start research for a short paper reviewing the problem of HAART discontinuation in prisons and its implications, and make recommendations, based on an analysis of the legal, ethical, and human rights issues raised, about how the problem can be addressed by the provincial/territorial and federal prison systems. The research will include consultation with prisoners as well as with prison medical staff and public health officials.

### **United States: Revised standards for health services in correctional institutions published**

The American Public Health Association has published the third edition of its “Standards for Health Services in Correctional Institutions.”<sup>9</sup> The Standards were first published in 1976, the year in which the United States Supreme Court ruled that “deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain ... proscribed by the Eighth

Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoners’ needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed.”<sup>10</sup>

Since then, prisons in the US have become larger, more violent and more crowded. New forms of maximum-security prisons and punitive segregation encourage routine violence against prisoners and subject them to new and terrible forms of social isolation and psychological torture. Increasing numbers of children and adolescents are being incarcerated in more and more punitive settings.<sup>11</sup>

Against this background, the third edition sets standards of health care that are respectful of prisoner patients and require prison-based health-care workers to view themselves as independent health-care workers first and foremost. The “Standards” point out that when “health care professionals identify too strongly with the security staff in the institution, they become entangled in a conflict of identity that injures them, their prisoner patients, and the institution.”<sup>12</sup>

### **Ireland: Report reviews harm-reduction interventions**

On 28 May 2004, the Irish National Advisory Committee on Drugs released a report entitled “A Review of Harm Reduction Approaches in Ireland and Evidence from the International Literature.”<sup>13</sup> The report includes a review of the Irish and international evidence regarding injection drug use in prisons, as well as of harm-reduction interventions such as

prison needle exchange programs (PNEPs). In an interview with the *Irish Times* following the launch of the report, its author Gerard Moore of Dublin City University called for the introduction of PNEPs in Ireland.<sup>14</sup>

### **Russia: Study recommends improved and additional harm-reduction strategies, including prison needle exchange programs**

In a study published in June 2004 in the *International Journal for Equity in Health*, Kate Dolan et al evaluated the effectiveness of an HIV peer training program conducted in a colony for drug-dependent male prisoners in Siberia.<sup>15</sup>

In 2002, there were 34,000 HIV-positive prisoners in Russia, 95 percent of whom were injection drug users.<sup>16</sup> In 2000, Médecins Sans Frontières (MSF) implemented an HIV educational program in some Russian prisons, including in a colony for male drug dependent prisoners in Siberia. The aim of the study was to evaluate the impact of the program.

Virtually all respondents (95 percent) had a history of injection drug use. Approximately 13 percent reported having injected in their current prison, and 10 percent (in 2000) and 12 percent (in 2001) reported having had sex in prison.

The study found that prisoners' knowledge of HIV transmission improved and that "provision of educational materials and training peer educators can be an inexpensive way to reach a population that is difficult to access outside prison." However, it concluded that "much more will be needed to prevent an HIV epidemic in

Russian prisons," including provision of methadone maintenance treatment and needle exchange programs, which have been found to be effective in other countries.

### **Indonesia: Working committee on HIV/AIDS in prisons formed**

Alarmed by the rising number of prisoners testing positive for HIV, the government and non-governmental organizations have formed a national working committee to help curb the spread of HIV in prisons in Indonesia. Data from the Ministry of Health and the National Narcotics Agency show that in the Salemba penitentiary in Central Jakarta, only 0.2 percent of 497 blood samples taken anonymously in 1998 were HIV-positive. In 2001, however, 22 percent of the 250 prisoners tested were found to be HIV-positive.<sup>17</sup> In addition to HIV education and provision of voluntary testing and counselling, condoms and bleach will be provided. Needle exchange and methadone maintenance treatment pilot projects are also being considered.

For additional information, contact Palani Narayanan at [pnarayanan@ihpcp.or.id](mailto:pnarayanan@ihpcp.or.id).

### **United States: Jail to offer methadone treatment**

Worldwide, an increasing number of prison systems are offering methadone maintenance treatment (MMT) to prisoners, including most Western European systems (with the exception of Greece, Sweden, and two jurisdictions in Germany). Programs also exist in Australia and in Canada.

Finally, an increasing number of Eastern European systems are starting MMT programs or planning to do so in the next few years.<sup>18</sup>

In the United States, however, only a few prisons have offered such treatment. In a first-of-its-kind program for a county jail, the Metropolitan Detention Center in Albuquerque, New Mexico, recently began offering "preventive" health care to prisoners. A methadone maintenance treatment pilot program at the jail is set to begin shortly. County officials say that "preventive" health care will curb the spread of HIV and hepatitis, save medical costs, and help reduce the rate at which prisoners return to jail, thereby saving taxpayers thousands of dollars in medical and correctional costs. However, contrary to the practice in many Canadian prisons, the methadone program will only be offered to prisoners who are enrolled in a methadone program at the time of their arrest.<sup>19</sup>

### **United States: "Ex-prisoners are family too"**

A new social marketing ad campaign, "Ex-prisoners are family too," was launched in San Francisco on 29 June 2004. The campaign is designed to help parolees, their families, and the general public improve the reintegration of people coming out of prison. To view the campaign ads, go to [www.centerforce.org/exprisonersarefamilytoo](http://www.centerforce.org/exprisonersarefamilytoo).

### **New resources**

In June 2004, the Canadian HIV/AIDS Legal Network published three new or updated resources on

issues related to HIV/AIDS in prisons:

- Syringe Exchange Programs in Prisons: Reviewing the Evidence;
- Methadone Maintenance Therapy in Prisons: Reviewing the Evidence; and
- the third version of a series of 13 info sheets on HIV/AIDS in prisons.

These resources are available on the Network's website via [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm).

A report by the American Civil Liberties Union on HIV/AIDS and civil rights contains a section on HIV in prisons and jails. Among other things, it states:

All over the country, prisoners and jail inmates are deprived of their HIV medications when they are first incarcerated and are denied a transitional supply of medication when they are released. We are interested in bringing lawsuits that would highlight the obli-

gation of all jails and prisons to provide medication upon release and to provide prompt access to medication upon admission.<sup>20</sup>

<sup>1</sup> S Landry, M Alary, G Godin, G Lambert, H Gagnon. Étude de prévalence du VIH et du VHC chez les personnes incarcérées au Québec et pistes pour l'intervention. *Canadian Journal of Infectious Diseases* 2004; 15 (Suppl A): 50A (abstract 306).

<sup>2</sup> E Wood et al. Incarceration is independently associated with syringe lending and borrowing among a cohort of injection drug users. *Canadian Journal of Infectious Diseases* 2004; 15 (Suppl A): 57A (abstract 327).

<sup>3</sup> A Palepu, MW Tyndall, K Li, B Yip, RS Hogg, MV O'Shaughnessy, J Montaner, M Schechter. Access and sustainability of antiretroviral therapy among injection drug users in Vancouver. *Canadian Journal of Infectious Diseases* 2001; Suppl B:32B; FL Altice, F Mostashari, GH Friedland. Trust and the acceptance of and adherence to antiretroviral therapy. *Journal of Acquired Immune Deficiency Syndromes* 2001; 28(1): 47-58.

<sup>4</sup> T Kerr, A Marshall, J Walsh, A Palepu, MW Tyndall, RS Hogg, J Montaner, E Wood. Determinants of highly active antiretroviral discontinuation among injection drug users. *Canadian Journal of Infectious Diseases* 2004; 15 (Suppl A): 86A (abstract 458P).

<sup>5</sup> The paper was prepared by M Linhart, BC Persons With AIDS Society, in 2001. On file with author.

<sup>6</sup> Ibid.

<sup>7</sup> PR Harrigan, M Whaley, JS Montaner. Rate of HIV-1 RNA rebound upon stopping antiretroviral therapy. *AIDS* 1999; 13(8): F59-62.

<sup>8</sup> SG Deeks. International perspectives on antiretroviral resistance. Nonnucleoside reverse transcriptase inhibitor

resistance. *Journal of Acquired Immune Deficiency Syndromes* 2001; 1(26): S25-33; DR Bangsberg, FM Hecht, ED Charlebois et al. Adherence to protease inhibitors, HIV-1 viral load, and development of drug resistance in an indigent population. *AIDS* 2000; 14 (4): 357-366.

<sup>9</sup> American Public Health Association. *Standards for Health Services in Correctional Institutions*. Washington, DC: The Association, 2003.

<sup>10</sup> Ibid at xvii.

<sup>11</sup> Ibid at xviii.

<sup>12</sup> Ibid.

<sup>13</sup> Available at [www.nacdie/publications/prevention\\_hr.html](http://www.nacdie/publications/prevention_hr.html).

<sup>14</sup> Reported in Voices Rising (the eBulletin of the Irish Penal Reform Trust) 2004; 2(6) (14 June 2004).

<sup>15</sup> KA Dolan, M Bijl, B White. HIV education in a Siberian prison colony for drug dependent males. *International Journal for Equity in Health* 2004; 3:7 (21 June 2004). See [www.equityhealthj.com/articles/browse.asp](http://www.equityhealthj.com/articles/browse.asp).

<sup>16</sup> A Kononets. Some facts about HIV in prisons. *Prison Health Care News* 2002; 2. International Centre for Prison Studies and Kings College London.

<sup>17</sup> L Aurora. Working committee on HIV/AIDS in jails formed. *Jakarta Post*, 13 April 2004; Indonesia sets up first prison HIV eradication committee. *AHRN Newsletter* 2004; 34 (April 2004).

<sup>18</sup> See, for more information, HIV/AIDS in Prisons. Info sheet 7: Prevention and treatment: Methadone. Montréal: Canadian HIV/AIDS Legal Network, 3<sup>rd</sup> edition, 2004. Available via [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm).

<sup>19</sup> Albuquerque jail to offer methadone treatment to inmates. At [www.drugpolicy.org/news/03\\_02\\_04nm.cfm](http://www.drugpolicy.org/news/03_02_04nm.cfm).

<sup>20</sup> T Lange. HIV & Civil Rights. A Report from the Frontlines of the HIV/AIDS Epidemic. ACLU AIDS Project, November 2003. Available via [www.aclu.org/HIV/AIDS/](http://www.aclu.org/HIV/AIDS/).

# 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](mailto:gbetteridge@aidslaw.ca).

## Criminal law and HIV transmission/exposure: three new cases

In ongoing coverage, we review new developments in the area of criminal prosecutions for HIV transmission or exposure. Since issue 8(1) of the *Review*, three new Canadian cases have come to our attention. They are reported below. A related, significant development in the UK is reported in *HIV/AIDS in the Courts – International*.

### Closure in *R v Williams*: ten-year sentence for withholding HIV status from three sexual partners

The *Review* has extensively covered the *Williams* cases on their journey through various levels of courts.<sup>1</sup> The cases all arise from a number of charges of aggravated assault and

common nuisance against Mr Williams for failing to disclose his HIV status to three sexual partners prior to engaging in unprotected intercourse. This article reports on the appeal to the Newfoundland Court of Appeal<sup>2</sup> of the sentences handed down by the Newfoundland Supreme Court.<sup>3</sup>

### Background

Mr Williams pleaded guilty to a single count of aggravated assault against each of the two partners he had sex with after being informed of his HIV-positive status. One of the relationships involved two instances of unprotected sexual intercourse, while the other relationship continued for over a year. Neither partner tested positive for HIV.

Mr Williams had unprotected sexual intercourse with a third partner both before and after he had been informed of his HIV status. In this instance, he was charged with common nuisance and aggravated assault. He pleaded

not guilty, but was subsequently convicted on both charges. On appeal to the Newfoundland Court of Appeal, the court substituted the trial judge's conviction on the charge of aggravated assault with a conviction for *attempted* aggravated assault. This result was affirmed by the Supreme Court of Canada.

On the basis of the Supreme Court's decision, Williams appealed the trial judge's sentence for the convictions relating to all three sexual partners to the Newfoundland Court of Appeal.

### **Trial judges' original sentences**

Sentencing involved two separate hearings – one hearing related to the charges to which Williams pleaded guilty, the other to the guilty verdict from the trial. On 23 May 2000, the Newfoundland Supreme Court determined the appropriate sentence for the conviction for aggravated assault (five-and-a-half years) and common nuisance (18 months) relating to the third partner.<sup>4</sup>

On 19 June 2001, a different judge of the Newfoundland Supreme Court determined that the conviction relating to the first complainant, with whom Williams had a short-term relationship, warranted three years' imprisonment.<sup>5</sup> The judge determined that the convictions relating to the second complainant, with whom Williams was involved in a longer relationship, warranted four years' imprisonment.

Then the judge applied the principle of totality. The principle operates to reduce the total sentence where the addition of separate sentences would result in a period of imprisonment that would be inappropriately lengthy. Taking into account the existing conviction on the first charge of aggravated assault, the judge reduced the sentences for the other two aggravated assault charges – from three years to

two years and from four years to three years. In total, Williams received 10-and-a-half years' imprisonment.

### **Court of Appeal decision**

Both trial judges' sentencing decisions were appealed to the Newfoundland Court of Appeal by the prosecution and Mr Williams. The Crown submitted that the trial judge erred by taking the principle of totality into account, while counsel for Mr Williams argued that the sentences were unduly harsh and should be reduced. The Court of Appeal found appropriate the sentences imposed by the second trial judge before he applied the totality principle. Reviewing the first judge's sentence, in light of the substitution by the Supreme Court of a conviction for attempted aggravated assault, the court reduced the sentence from five-and-a-half years to three years, stating that the maximum sentence for aggravated assault was seven years. The sentence of 18 months concurrent for common nuisance was affirmed.

The court went on to state that the principle of totality was not applicable in reducing the sentences because they fell within the appropriate range of sentences. The court relied upon the principles of general and specific deterrence and the protection of the public to find that a cumulative 10-year sentence was appropriate. Welsh JA specifically commented that “Williams, and others in a similar situation, must understand that a serious penalty will result from such callous and selfish disregard for the safety of others' lives.”<sup>6</sup>

### **17-month sentence after surprise guilty plea**

On 18 May 2004 an HIV-positive man, Mr Bernard, from Winnipeg, was sentenced to 17 months in prison after he cut his preliminary hearing

short by entering a guilty plea to one count of aggravated assault.<sup>7</sup> The complainant in the case has tested HIV-negative to date.

“Some segments of the population have a harder time disclosing their HIV-positive status.”

Bernard's defence counsel argued that “some segments of the population have a harder time disclosing their HIV-positive status, citing shame and a lack of education about the disease as contributing factors.”<sup>8</sup> Elliot J of the Court of Queen's Bench concurred with counsel's joint recommendation of a two-year jail term, which was reduced to 17 months taking into account pre-custody time already served. This sentence will be followed by three years' probation. The judge's reasons-for-sentencing decision, including the terms of probation, have not been reported.

### **Multiple assault convictions result in seven-year prison term**

Various media reported that a Québec court had handed down a seven-year prison sentence to 47-year-old Navrumbwa Djamali for failing to disclose his HIV-positive status to three women he had unprotected sexual intercourse with.<sup>9</sup> One of the women was involved with Djamali for 18 months. Another woman, a Japanese exchange student, claimed sex was forced upon her. None of the women have since tested positive for HIV.

Djamali was convicted of two

counts of aggravated sexual assault, one count of sexual assault, one of forcible confinement, and one of aggravated assault. Garneau J found Djamali's claim that he didn't know HIV could be spread by bodily fluids lacking in credibility. Defence counsel has indicated Mr Djamali's desire to appeal what he deemed a harsh sentence. The sentencing decision has not been reported.

– Glenn Betteridge and Hari Subramaniam

Hari Subramaniam is a legal intern at the Canadian HIV/AIDS Legal Network and is a student at the Faculty of Law, McGill University.

<sup>1</sup> For a report of the trial and sentencing decisions, see R Elliott. Criminal law and HIV/AIDS: update III. *Canadian HIV/AIDS Policy & Law Newsletter* 2000; 5(2/3): 33-35; and Criminal law and HIV/AIDS: update V. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 17-23 at 21. For analysis of the decision of the Newfoundland Court of Appeal, see R Elliott. Criminal law and HIV transmission/exposure: three new cases. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 64-66. For an analysis of the Supreme Court of Canada decision, see R Elliott, G Betteridge. HIV-positive person who did not disclose status convict-

ed of attempted aggravated assault. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 50-52.

<sup>2</sup> *R v Williams*, [2004] NJ No 140 (CA) (QL).

<sup>3</sup> *R v Williams*, [2000] NJ No 166 (NFLD SC-TD) (QL) and *R v Williams*, [2001] NJ No 169 (NFLD SC-TD) (QL).

<sup>4</sup> *R v Williams*, [2000] NJ No 166 (NFLD SC-TD) (QL).

<sup>5</sup> *R v Williams*, [2001] NJ No 169 (NFLD SC-TD) (QL).

<sup>6</sup> *Williams*, supra, note 2 at para 61.

<sup>7</sup> Man jailed for unprotected HIV sex. *Edmonton Sun*, 18 May 2004.

<sup>8</sup> *Ibid.*

<sup>9</sup> HIV-positive man gets 7 more years after unprotected sex. *Canadian Press*, 12 April 2004.

## Fear of persecution not adequate to claim refugee status

**In *Delgadillo v Canada*,<sup>1</sup> the Federal Court of Canada upheld an Immigration and Refugee Board (IRB) decision to refuse refugee status to a Mexican gay male refugee claimant because he had an Internal Flight Alternative (IFA). Although the court reached this conclusion, it nevertheless agreed that Mr Delgadillo had a legitimate fear of persecution. As well, the court made an important finding – that people in Mexico who are living with HIV/AIDS do not have an IFA.**

Mr Delgadillo based his claim for refugee status and the need for protection on the fact that he is a gay man. Due to two previous homophobic incidents involving the police in his hometown, he moved to Puerto Vallarta where he secured employment at the public safety department, of which the police services formed a branch. After three years on the job, Mr Delgadillo noticed that the atmosphere in the workplace turned anti-gay and -lesbian. He testified that after a lesbian police officer was fired, co-workers began to suspect that Mr Delgadillo was gay. He further testified

that he was threatened by two police officers to the effect that if he did not pay them, they would inform Mr Delgadillo's boss of his sexual orientation. On a separate occasion, one of these police officers forced Mr Delgadillo to give him US\$100. Mr Delgadillo entered Canada shortly thereafter.

The IRB accepted that Mr Delgadillo had a fear of persecution by the two police officers but rejected his claim for refugee status on the basis that he had an IFA – ie, Mexico City. Under the Immigration and Refugee Protection Act, a person can

only be conferred refugee protection if he would face a risk to his life or a risk of cruel and unusual treatment in every part of the country.

Therefore, if a so-called IFA exists, a person's application for refugee protection cannot be granted.

Documentary evidence before the IRB established that Mexico City was not an IFA for only three groups: effeminate men, HIV-positive men, and political activists and whistleblowers. The IRB rejected Mr Delgadillo's claim because he did not fit any of the established criteria. The IRB rejected the effeminacy criteria

on the basis of Mr Delgadillo's "apparent" mannerisms and his ability to secure and retain a job in the "macho" public safety department.

In determining that Mexico City is an IFA, the IRB cited the presence of gay politicians, legislative changes favouring gay persons, 17 years of gay pride celebrations, and 400 highly publicized gay marriages in 2002. Further, the IRB determined that deporting Mr Delgadillo to Mexico would be neither unduly harsh to him nor pose a risk of harm to him. The Immigration and Refugee Protection Act requires that the board make these assessments.<sup>3</sup>

The Federal Court followed the standard of review for IRB decisions relating to an IFA, that of patent unreasonableness, and ruled that the IRB's findings were reasonable and that no material issue was overlooked.

### Comment

The IRB's decision shows depth and thoroughness, especially in the amount of evidence reviewed. However, the court's decision points to the need for more objective criteria for assessing risk based on sexual orientation. "Effeminacy" is an extremely vague, culturally specific, and subjective criterion.

The case has significant implications for Mexican citizens who face persecution based on their HIV status because the IRB clearly stated that there is no IFA for those individuals. As such, this ruling increases the chances of their refugee claims being successful in Canada.

— Hari Subramaniam

<sup>1</sup> *Delgadillo v Canada (Minister of Citizenship and Immigration)*, [2004] FCJ No 651 (FC).

<sup>2</sup> Immigration and Refugee Protection Act SC 2001, c 27 at ss 95, 97.

<sup>3</sup> *Ibid* at s 97, which sets out legislative criteria for a person in need of protection.



# 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](mailto:gbetteridge@aidslaw.ca).

## US: Immigration court allows Zambian woman's asylum claim based on HIV infection

On 9 February 2004, the federal Immigration Court ruled that a Zambian woman can stay in the US because her HIV-positive status gives her a well-founded fear of persecution in Zambia.<sup>1</sup> The court found that she would face severe and lethal discrimination in the public health clinics and in the employment sector and that the Zambian government is unwilling or unable to control this persecution.

The woman, a Zambian citizen, arrived in the US in 1998 on a temporary visa to take a course related to the hotel industry. While in the US she was diagnosed with AIDS and overstayed her visa because she was too ill to travel home. She was not aware of her HIV status before this diagnosis. She testified that she feared returning to Zambia because she

would not be able to continue the antiretroviral (ARV) therapy that she had started in the US, and also that she would face severe discrimination in health care, employment, housing, and the general community.

Her testimony was supported by the testimony of a medical doctor who had spent time practising in Zambian public medical clinics. He stated that

the medical facilities in Zambia were extremely limited, especially for people living with HIV/AIDS, and that ARV therapy was available in Zambia only for the rich.

The tribunal found that the woman was not time-barred from filing a claim because although she was supposed to have filed within one year of her arrival in the US, her HIV/AIDS diagnosis was a changed circumstance that "materially affected her eligibility for asylum."<sup>2</sup>

Under section 208(a) of the Immigration and Nationality Act, in order to be granted asylum the person must meet the statutory definition of a

refugee. Accordingly, the woman had to prove that she was unable or unwilling to return to her native country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. The woman had to meet both the test of being in a particular social group and of facing a well-founded fear of persecution.

There is a three-part test for obtaining asylum based on membership in a particular social group. The individual must: (1) identify a group that constitutes a particular social group; (2) establish that he or she is a member of that group; and (3) show that he or she would be persecuted or has a well-founded fear of persecution based on that membership.

The court did find that the woman faced a well-founded fear of persecution on account of her membership in the particular social group, namely women in Zambia infected with HIV/AIDS. Because of the discrimi-

nation perpetuated by health officials in public clinics and the absence of codified laws to protect HIV-positive people in the health, employment, and housing spheres, the court decided that the woman had a subjectively genuine and objectively reasonable fear of persecution.

The court did not accept the argument that the lack of ARV therapy in Zambia was a reason in itself to accept the woman's application. They found that the lack of ARV therapy in Zambia was due to a lack of resources and not because of the woman's group membership. This is consistent with other immigration court decisions in the US.<sup>3</sup>

### Comment

This is an important decision for asylum seekers from countries where there is extensive discrimination against people living with HIV/AIDS. The UN Convention Relating to the Status of Refugees forms the basis of domestic immigration laws in all signatory countries. Therefore, this deci-

sion is relevant to people from countries with similar circumstances as Zambia seeking asylum in countries that are signatories to the refugee convention. The acceptance of discrimination against people living with HIV as persecution is laudable. The court's decision may be relied upon to extend the level of protection offered to HIV-positive asylum seekers and refugee claimants in other jurisdictions.

— Joanna Wells

Joanna Wells is a second year student at Dalhousie Law School and a summer intern at the Canadian HIV/AIDS Legal Network.

<sup>1</sup> To preserve the anonymity of the woman and her daughter, their names were removed from the decision. The decision is dated 9 February 2004. Judge O John Brahos presided over the Immigration Court, Chicago, Illinois, sitting in Kansas City, Missouri.

<sup>2</sup> Page 7.

<sup>3</sup> See, for example, E Marceau. US: Court rules deportation of HIV-positive Dominican does not violate convention against torture. *Canadian HIV/AIDS Policy & Law Review* 2003; (8)2: 52.

## Australia: Migration Review Tribunal waives medical inadmissibility criteria for two HIV-positive visa applicants

**In two recent cases, Australia's Migration Review Tribunal (MRT) overturned government decisions to refuse the visa applications of HIV-positive candidates for Partner (Temporary) (Class UK) visas on the basis of medical inadmissibility. In doing so, the MRT questioned the opinion of the government medical officer concerning the costs to the Australian community, and took into account the applicants' potential contributions.**

Under the Australian Migration Act 1958 and associated regulations, a Partner (Temporary) visa applicant must demonstrate that he or she does not have a disease or condition that would result in significant health-care or community-service costs to the

Australian community, or prejudice the access of an Australian citizen or permanent resident to health care or community services. The applicant must meet these criteria regardless of whether the applicant will actually use such services.

The enabling legislation requires the MRT to consider the opinion of the Medical Officer of the Commonwealth (MOC) regarding the medical criteria as correct. The Minister may waive the medical admissibility criteria where (1) granting the visa would be unlikely to result in undue cost to the Australian community or undue prejudice to the access of Australian citizens or permanent residents to health care and social services, and (2) the applicant satisfies all other criteria for the visa. This waiver is set out in clause 4007(2) of schedule 4 of the Migration Regulations 1994.

In the first case, the applicant, a gay male citizen of Singapore, applied for a visa in November 1999 based on his same-sex relationship with an Australian citizen.<sup>1</sup> The MOC's opinion of March 2001 was that the applicant's medical condition was such that the "provision of the health care or community services relating to the disease or condition would be likely to ... result in significant cost to the Australian community in the areas of health care and community services" and thus the applicant failed to meet the required criteria.<sup>2</sup> The MOC estimated that the applicant's cost to the community would be nearly AUS\$250,000.

The MRT, noting that the applicant was well educated and financially

independent, observed that he was "in a position to make a substantial contribution to the Australian community."<sup>3</sup> The MRT also found that, after considering the applicant's positive response to antiretroviral therapy, the MOC's AUS\$250,000 estimate was inflated. The ruling dwelt at length on the hostile environment faced by homosexuals in Singapore and the fact that the applicant fulfilled most other requirements of the visa. The MRT remitted the application made by the visa applicant to the Department of Immigration, Multicultural and Indigenous Affairs for reconsideration with the direction that the health criteria be waived pursuant to clause 4007(2).

In a similar case, the applicant applied for a visa based on a spousal relationship with an Australian citizen.<sup>4</sup> The MOC estimated that the lifetime cost of treating the applicant's HIV infection would amount to AUS\$250,000, and refused the visa application.

In finding that the ministerial discretion should be granted and the medical requirement waived, the MRT explicitly addressed what constitutes "undue cost."<sup>5</sup> The MRT noted that the MOC was *required* to consider the applicant's education, factors preventing the sponsor from joining the sponsor in his or her own country, the lack of care and treatment for HIV-positive people in the country of origin, as well as other surrounding circumstances that merited leniency on compassionate grounds. While acknowledging that the applicant's medical costs would amount to AUS\$10-15,000 per annum, the MTR

ruled that this did not, in and of itself, reach the level of "undue cost to the Australian community."<sup>6</sup> The MRT remitted the application to the department for reconsideration with the direction that the health criteria be waived pursuant to clause 4007(2).

## Comment

These cases highlight the MRT's willingness to look beyond the Migration Act and associated legislation to the assessment factors for a waiver, which are set out in ministry policy. As the MOC's refusal to issue a waiver in each of the above cases indicates, strictly applying the phrase "undue cost to the Australian health care system" effectively prevents persons infected with HIV from immigrating or temporarily residing in Australia. The willingness of the MRT to take other personal characteristics and factors into consideration does justice to the whole person, rather than seeing someone as the sum cost of his or her illness.

— Hari Subramaniam

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<sup>1</sup> Case ABCDECG, MRTA 683, 9 February 2004, Australian Migration Review Tribunal.

<sup>2</sup> *Ibid.*

<sup>3</sup> *Ibid.*

<sup>4</sup> Case ABCDECR, MRTA 737, 11 February 2004, Australian Migration Review Tribunal.

<sup>5</sup> *Ibid.* at para 37.

<sup>6</sup> *Ibid.* at para 44.

# Botswana: Industrial Court tackles HIV testing in the workplace

**The Botswana Industrial Court<sup>1</sup> recently decided two cases regarding mandatory HIV testing in the workplace. One case addressed constitutional rights of HIV-infected people, expanding the reach of the Bill of Rights to the private sphere and potentially offering wide protection to people living with HIV/AIDS. Both cases highlight the glaring need for HIV-related legislation in Botswana.**

## Dismissal where employee tested HIV-positive

The first case involved an HIV-positive man who was forced to undergo an HIV test by his employer 19 days after he finished his pre-employment medical exam.<sup>2</sup> The doctor who performed the test sent the results directly to the employer. The complainant received his test results through the mail, enclosed with a letter of termination.

Legwalia J of the Industrial Court found that the man's dismissal was procedurally and substantively unfair. He determined that because the company had requested the man undergo the HIV test 19 days after his pre-employment medical exam, the test could not be considered part of that exam. The judge stated that the HIV test constituted "compulsory post-employment HIV testing" and therefore violated the employment contract.

The judge also found that the man's HIV-positive status did not constitute just cause for dismissal under the law because the applicant had already passed the required pre-employment medical exam, which the judge found did not include HIV testing. He declared the man could only be dismissed due to poor performance or misconduct.

Legwalia J awarded the man the highest compensation under the law: six months' wages. He expressed his

concern about the shocking manner in which the applicant had received the HIV results, especially considering that the National Policy on HIV/AIDS requires that all results be delivered with post-testing counselling.

Although on the facts of the case, Legwalia J determined that the applicant had been subject to post-employment testing, he went on to consider the legality of pre-employment HIV testing. He expressed concern regarding the lack of legislation in Botswana governing issues of HIV and recognized that the only instrument available to him in this regard was the National Policy on HIV/AIDS, which is not a binding instrument.

The employer appealed the judge's finding that the HIV test was a post-employment requirement. The appellant claimed that Legwalia J was not entitled to find the HIV test was post-employment testing because the two parties had agreed in their factual submissions that the HIV test was part of the medical examination. The Court of Appeal agreed with this submission and subsequently overruled the award of six months' salary.<sup>3</sup> The man finally received the equivalent of one month's salary and was reimbursed for the cost of the HIV test.

## Refusal to submit to HIV test

The second case involved a woman who was offered a position as a secu-

rity assistant, coincidentally with the same employer as in the previous case. Six months after she started work she was required to undergo an HIV test. She refused and was terminated. Her employer gave no reasons for her dismissal.

Dingake J found that her dismissal was both substantively and procedurally unfair because she was dismissed after her probationary period had expired. He declared that at that point she could not be terminated without a valid reason. He further indicated that "the instruction to undergo an HIV test was irrational and unreasonable to the extent that such a test could not be said to have been related to the inherent requirements of the job. The applicant was

**"The instruction to undergo an HIV test was irrational and unreasonable [and not] related to the inherent requirements of the job."**

entitled to disobey the order and/or instruction."<sup>4</sup>

He went on to determine whether or not the company had violated her constitutional rights even though he had already determined that her dismissal was unfair under the

Employment Act.<sup>5</sup> He first discussed whether or not the Bill of Rights, which is found in sections 3 to 16 of the Constitution,<sup>6</sup> applies to private corporations. He determined that “under exceptional circumstances” the Constitution can apply to private entities and that it did apply in this case because the company in question operates in the public domain and relies on public patronage for its business.<sup>7</sup>

Dingake J then considered which of the applicant’s constitutional rights were violated by her dismissal. He determined that her right to privacy had not been violated because she had not actually undergone an HIV test, but he said that it had been “undermined.”<sup>8</sup>

He further determined that her right to be free from discrimination had also not been violated because there was no evidence to suggest that she had been treated differently because of her perceived HIV status. In making this determination Dingake J declared that HIV status should be added to the list of unlawful grounds of discrimination even though the distinction did not apply in this case.<sup>9</sup>

However, he did find that her right to liberty had been violated. “Choosing whether to test or not is a private decision striking at the heart of

personal and individual autonomy and no entity, the state or any employer ought to be permitted to interfere.”<sup>10</sup> He found that the employer’s requirement that the woman undergo an HIV test was an irrational demand unrelated to the inherent requirements of her position as a security assistant. The employer did not appeal the Industrial Court’s decision.

### Comment

Both cases are important to the development of HIV/AIDS jurisprudence in Botswana. The first case highlights the reluctance of the judiciary to find pre-employment testing illegal in the absence of legislation specifically prohibiting the practice. Although Legwalia J condemned the practice, he felt powerless to do anything beyond condemning it.

The second case has potentially wider-reaching effects because Dingake J’s expansive interpretation of the Constitution has the potential to protect individuals from a broad array of HIV-based human rights violations in the workplace and increases the reach of the judiciary’s influence in this area. His finding that the Bill of Rights applies to private conduct is a path-breaking decision that could have effects that go

beyond the employment context to cover a variety of private relations.

Nevertheless, other judges are not bound to follow the same constitutional reasoning and may reach different conclusions when faced with a similar set of facts. The call for legislation in the area of HIV/AIDS must be heeded in order to offer consistent and systematic protection of employees and other people infected and affected by HIV/AIDS.

— Elizabeth Maxwell

Elizabeth Maxwell is a graduate of Yale Law School and is a Fulbright Scholar. She is a volunteer with the Botswana Network on Ethics, Law and HIV/AIDS (BONELA). For more information about BONELA or the cases reported, contact bonela@botsnet.bw.

<sup>1</sup>The Industrial Court was established in 1994 and charged with settling trade disputes.

<sup>2</sup>Industrial Court Case No 35 of 2003, at 12.

<sup>3</sup>Court of Appeal Case No. 37 of 2003.

<sup>4</sup>Industrial Court Case No 50 of 2003, at 4.

<sup>5</sup>The Employment Act, 1984, c. 47:01 of the Laws of Botswana.

<sup>6</sup>Constitution of Botswana 1967, ss 3-16.

<sup>7</sup>Case No 50, supra, note 4 at 27.

<sup>8</sup>Ibid at 56.

<sup>9</sup>Unlawful grounds listed in Section 15(3) of the Constitution are race, tribe, place of origin, political opinions, colour, and creed.

<sup>10</sup>Case No 35, supra, note 2 at 77.

## India: Constitutional protection from discrimination in employment on the basis of HIV status affirmed in three cases

In the 1997 landmark decision in *MX of Bombay Indian Inhabitant v M/s ZY*, Tipnis J observed that “den[ying] employment to the HIV-infected person merely on the ground of his HIV

status irrespective of his ability to perform the job requirements and prospective of the fact that he does not pose any threat to others at the work place is clearly arbitrary and

unreasonable and infringes the wholesome requirement of Art 14 as well as Art 21 of the Constitution of India.”<sup>1</sup> In three judgments released in 2004, the High Court of Judicature at Bombay

reaffirmed its commitment to the progressive aspirations of the Constitution.

In *Mrs G v New India Assurance Company Ltd.*,<sup>2</sup> the court ruled that an HIV-positive widow could not be denied employment on compassionate grounds at her deceased husband's workplace solely because of her HIV-positive status if she was otherwise fit for the position.

In *Mr S Indian v Director General of Police & Ors.*,<sup>3</sup> the Central Industrial Security Force had denied employment on compassionate grounds to the HIV-positive widow of a deceased employee under the supposed basis that there were no vacancies. The court insisted that a vacancy be created.

Finally, in *Mr X v State Bank of India*,<sup>4</sup> a sweeper who had worked for the State Bank of India for nine years

on a contract basis was denied a permanent position after testing HIV-positive. The court held that the ruling in *M/s ZY* prohibited employment discrimination based on HIV status alone and insisted that Mr X be absorbed into a permanent position. The tone of the judgment is noteworthy. Shah J stressed the need for an inclusive, supportive approach to those suffering from HIV, observing that "Most people with HIV/AIDS continue working which enhances their physical and mental well being and they should be entitled to do so. They should be enabled to contribute their creativity and productivity in a supportive occupational setting. HIV positive persons may have years of constructive, healthy service ahead of them. To exclude them lacks a rational founda-

tion and is unfair. HIV infected persons need maximum understanding and help wherever possible."<sup>5</sup>

These three cases indicate the willingness of the Indian judiciary to protect people living with HIV/AIDS from discrimination in employment due to their HIV status.

— Hari Subramaniam

<sup>1</sup> *MX of Bombay Indian Inhabitant v M/s ZY and another*, Division Bench High Court at Bombay, AIR 1997 (Bombay) 406. For a brief discussion of this case, see M Dhalwal. Creation of an enabling and gender-just legal environment as a prevention strategy for HIV/AIDS among women in India. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 86-89.

<sup>2</sup> *Mrs G v New India Assurance Company Ltd.* High Court at Bombay. Writ petition No 1563 of 1999, heard 2004.

<sup>3</sup> *Mr S Indian v Director General of Police & Ors.* High Court at Bombay. Writ petition No 202 of 1999, heard 2004.

<sup>4</sup> *Mr X v State Bank of India.* High Court at Bombay. Writ petition No 1856 of 2002, heard 2004.

<sup>5</sup> *Ibid* at para 8.

## UK: Court of Appeal orders retrial in UK's first HIV criminal transmission case

**On 5 May 2004, the UK Court of Appeal, Criminal Division, granted Mohammed Dica's appeal against his October 2003 conviction on two counts of causing grievous bodily harm for reckless transmission of HIV.<sup>1</sup> The court ordered a retrial after determining that the trial judge was wrong to not allow the defendant to present information that the victims had known about his condition and had consented to the risk.<sup>2</sup>**

### The trial

Dica was convicted on 14 October 2003 of recklessly causing grievous bodily harm for having unprotected sex with two women without informing them of his HIV-positive status.<sup>3</sup> He was charged in July 2002 with inflicting grievous bodily harm. It was not alleged that he raped or intentionally infected the women, but that he was reckless as to whether or

not they would become infected.

At the end of the prosecution's case the trial judge made two critical rulings, which had resounding effects on cases involving intentional transmission of HIV and other sexually transmitted diseases.

The trial judge overruled *R v Clarence*,<sup>4</sup> declaring the 116-year old precedent no longer authoritative in English law. *Clarence* has generally precluded conviction for reckless

transmission of STDs by stating that consent to sexual intercourse also included consent to risk of all consequent disease.

The trial judge also ruled that the jury could not hear evidence from the accused that the two women had known of his status and consented to the risk of becoming infected. He decided that the women had no legal capacity to consent to unprotected sex with an infected man because of the

serious potential of the consequences. He relied on the precedent in *R v Brown* that declared that there could be no consent to sadomasochist sex because of the seriousness of the harm that would result.<sup>5</sup> This was the ground on which Dica appealed.

### The appeal

The Court of Appeal overturned the conviction and sent the case back for a retrial. The Court of Appeal disagreed with the trial judge's reasoning that the consent of the complainant to the risk of infection cannot be a defence to the charge of reckless transmission. The Court of Appeal noted "consensual acts of sexual intercourse are [not] unlawful merely because there may be a known risk to the health of one or the other participant."<sup>6</sup> The court emphasized, however, that it was important that the complainant be consenting to the risk of infection and not merely knowing

that the accused was infected. The court commented that this is a high bar to reach and requires full disclosure on the part of the infected individual.

There was also some indication in the decision that the use of a condom could be a defence to reckless transmission, on the basis that the accused could not be said to have acted recklessly, "if protective measures have been taken by the appellant that would have provided material relevant to the jury's decision [as to] whether ... recklessness was proved."<sup>7</sup>

### Comment

By overruling *Clarence*, the trial court effectively broadened the scope of the criminal law to include reckless transmission, a move that has been strongly criticized by many advocates in the field of HIV/AIDS.<sup>8</sup> In overturning the decision, the Court of Appeal did not disagree with the trial judge that *Clarence* was no longer authoritative.

The Court of Appeal, in fact, affirmed that the reckless transmission of HIV could be a criminal offence, which is a departure from much previous case law both in the UK and in the Commonwealth.<sup>9</sup>

— Joanna Wells

<sup>1</sup> *R v Dica* [2004] All ER (D) 45 (May).

<sup>2</sup> *Ibid.*

<sup>3</sup> See G Holly, UK: Precedent-setting criminal conviction for grievous bodily harm. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 62.

<sup>4</sup> (1888), 22 QBD 23.

<sup>5</sup> *R v Brown (Anthony)* [1994] 1 AC 212.

<sup>6</sup> *Dica*, supra, note 1 at para 47.

<sup>7</sup> *Ibid* at para 11.

<sup>8</sup> Terrence Higgins Trust. Response to Home Office Consultation Paper: "Violence: Reforming the Offences Against the Person Act 1861." London: The Trust, 1998; M Weait. The criminalization of HIV transmission in the UK. 12th International Conference on AIDS 1998; 12: 961 (Abstract No 44117).

<sup>9</sup> See for example *HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 46-47; *R v Harms* (1944) 81 CCC 4 (Sask CA); *R v Bolduc* [1967] SCR 677; *R v Maurantonio* (1968), 65 DLR (2d) 674 (Ont CA); *R v Papadimitropoulos* (1957), 98 CLR 249 (HC Australia).

## Australia: Supreme Court of Western Australia orders retrial in case of man convicted of infecting girlfriend with HIV<sup>1</sup>

**On 3 October 2002, the District Court convicted an HIV-positive man, Houghton, of unlawfully causing grievous bodily harm to his girlfriend for having unprotected vaginal and anal intercourse with her. Houghton had not told her of his HIV status prior to intercourse. He had been aware of his status for some years before meeting the woman, but testified at his trial that he believed that he could not transmit HIV if he did not ejaculate inside the woman. The woman became HIV-positive as a result of the sexual intercourse. The question put before the jury was twofold: whether there had been bodily injury caused by the applicant to the complainant; and whether that injury was of sufficient severity to constitute grievous bodily harm. The jury found Houghton guilty and in doing so made a finding that the transmission of HIV constitutes grievous bodily harm.**

Under the Criminal Code of Western Australia, the offence with which Houghton was convicted is committed by a person who "unlawfully does grievous bodily harm to another." The Code was amended in 1992 to add that "a reference to causing or doing grievous bodily harm to a person includes a reference to causing a person to have a serious disease."

“Serious disease” means a disease of such a nature as to endanger, or be likely to endanger, life; or cause, or be likely to cause, permanent injury to health.

Houghton appealed his conviction, raising 15 arguments as to why the conviction should not stand. The Supreme Court of Western Australia heard the appeal. The majority of the court overturned his conviction and ordered a retrial.

The decision of the majority focused on the meaning of the word “unlawfully,” which, in their view, should be given its ordinary meaning of “prohibited by law” or “contrary to law and not excused.” The majority went on to consider – without deciding – which pre-existing law Houghton may have contravened by having unprotected sexual intercourse

with the woman. They canvassed the possibility that he may have breached the duty imposed under section 266 of the Code on all persons to take reasonable precautions to avoid harms resulting from a dangerous thing within his charge and control. HIV was identified as the “dangerous thing” under Houghton’s control.

The majority decided that “it seems to us to be strongly arguable that the doing of grievous bodily harm to the complainant in this case was unlawful in that it was done in breach of the duty imposed by s 266 of the *Code* ... the question whether or not the appellant’s conduct was unlawful was one for the jury.” Since the District Court judge had not placed this issue before the jury, the Court of Appeal overturned that court’s decision and ordered a new trial.

## Comment

Most of the relevant comments regarding HIV/AIDS and the law come from the minority judgment, although the rest of the court agreed with this part of the judgment. Murray J affirmed that the transmission of HIV could be considered grievous bodily harm and that the infected individual did not need to develop AIDS or become gravely ill for grievous bodily harm to be done. The transmission of the virus was sufficient to be convicted of the offence, even in the absence of a breach of some other law.<sup>2</sup>

– Joanna Wells

<sup>1</sup> *Houghton v The Queen* [2004] WASCA 20.

<sup>2</sup> For a discussion of Canadian criminal law on unlawfully causing grievous bodily harm, see R. Elliott, *Criminal Law and HIV/AIDS: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and the Canadian AIDS Society, 1997: 69-71.

## In brief

### Spanish court rules that national HIV registry should be abolished

The Spanish National Court ruled that the Information System on New HIV Infections (SINVIH) makes it possible for HIV-positive people to be identified and “does not fulfill adequate measures to preserve ... privacy.”<sup>1</sup>

The registry had been in place since December 2000 and has long been criticized by HIV advocates as not doing enough to ensure patients’ privacy. The registry keeps track of patients’ initials, the health centre where they were diagnosed, and patients’ date of birth, town of resi-

dence, nationality, and clinical and laboratory data.<sup>2</sup>

The government has indicated that it will appeal the decision. However, the Minister of Health, Elena Salgado, indicated that she was willing to meet with stakeholders to discuss how to improve the registry to ensure privacy and efficacy.

– Joanna Wells

### China: Damages awarded to husband of woman infected with HIV through blood transfusion

On 29 April 2004, the Hebei Provincial Higher People’s Court ordered the Kantai Hospital in Shahe City, Hebei province, to pay

US\$43,700 to the husband of a woman who died after contracting HIV during a blood transfusion at the hospital.<sup>3</sup> The woman received the blood transfusion during the delivery of her daughter, now seven, who has also tested positive for HIV. The court found that the hospital had collected the transfused blood in violation of safety regulations and was therefore responsible for the woman’s death and the child’s infection.

– Joanna Wells

<sup>1</sup> Spanish HIV registry should be abolished, court rules. *Lancet* 2004; 363(9421).

<sup>2</sup> *Ibid.*

<sup>3</sup> Chinese farmer wins “AIDS blood” case. *China Daily*, available on the *China Daily* website via [www.chinadaily.com.cn/en/home/index.html](http://www.chinadaily.com.cn/en/home/index.html) (accessed 12 May 2004).



# LAW ESSAY CONTEST

In 2002/2003, the Canadian HIV/AIDS Legal Network held its first-ever nationwide essay contest for law students.<sup>1</sup> There were two topic areas: one Canadian issue, and one international issue as it relates to Canada. This year, all the entries were on the international topic – a case comment on the 2001 ruling of the High Court of South Africa that the government was in breach of its constitutional obligations to provide a comprehensive national program to prevent mother-to-child transmission of HIV, including making antiretroviral drugs available for this purpose. Contest entrants were asked to discuss the implications this ruling might have regarding the right to health in Canada. In this issue, we are publishing an edited version of the second-place essay. The winning essay was published in volume 8(3) of the *Review*.

## **Treatment Action Campaign (TAC) v South Africa (Minister of Health):<sup>2</sup> reflections on the right to health care in Canada**

In this article, Showkat Yazdanian examines the potential impact of the South African Constitutional court's decision in *TAC v Minister of Health* on the right to health care in Canada. Showkat first focuses on the potential utility of international treaties and precedents as a means to uphold the right to preventative health care in Canada. She then examines the Canadian Constitution's bearing on a right to health care, including an analysis of the current division of federal and provincial health powers.

Worldwide, mother-to-child transmission (MTCT) of HIV is responsible for over 90 percent of HIV infections among children under the age of 15.<sup>3</sup> The tragedy of this figure is compounded by the fact that the prudent administration of antiretroviral therapies such as nevirapine could save the lives of an estimated 300,000 children each year.<sup>4</sup> The responsibility of states

to prevent MTCT of HIV and other diseases may be easily declared, but wadding the moral obligation into a legal straitjacket may prove more difficult. It was successfully done in the *TAC v Minister of Health* ruling, in which the South African government was compelled by the Constitutional Court to institute an MTCT treatment program.

Fortunately, Canada does not suffer from an HIV epidemic like that of the Republic of South Africa, nor does it have the benefit of a constitution as sensitive to health-related matters as that of South Africa. The South African Constitution<sup>5</sup> came into effect in 1996 and was designed to accommodate the concerns of post-apartheid Africa, including racial integration

and the AIDS epidemic.<sup>6</sup> The effect of *TAC v Minister of Health* was to substantially buttress the right of South Africans to proactive, preventative health care. If this is to be replicated in Canada, where the Constitution is littered with artefacts of its 1867 inception, the instruments of legal change will necessarily have to be more inventive.<sup>7</sup> Given the division of powers between the provinces and the federal government enshrined in the Canadian Constitution, the recognition of a right to health care in Canada will likely take more than a ruling of the Supreme Court.

*TAC v Minister of Health* substantially buttressed the right of South Africans to proactive, preventative health care.

One possible instrument of change might be international law. The 1999 Supreme Court decision in *Baker v Canada (Minister of Citizenship and Immigration)* set an important precedent for the recognition of international law obligations within domestic Canadian law.<sup>8</sup> *Baker* held that Canada's ratification of the UN Convention on the Rights of the Child<sup>9</sup> obliged courts to consider the values inherent in the Convention (as well as in the Charter) during immigration proceedings. *Baker* could be relied upon to argue that Canada's ratification of treaties such as the Universal Declaration of Human Rights,<sup>10</sup> the Convention on the Rights of the Child, and the International Covenant on Economic, Social and Cultural Rights<sup>11</sup> commits

Canada to consistently provide preventative health care.

An alternative approach to realizing the effects of *TAC v Minister of Health* in Canada might be to find a means of interpreting regular statutes in accordance with the Canadian Charter of Rights and Freedoms<sup>12</sup> and the values it reflects. The issue at stake transcends the prevention of MTCT of HIV. MTCT of HIV in Canada is rare. However, the rarity of MTCT and other prenatal diseases in Canada cannot be attributed to unequivocal domestic legal safeguards of the right to health. The protections currently afforded by the government could be curtailed with the turn of an election. In the absence of a strong constitutional guarantee, the right to receive proactive health care remains precarious.

### Health care, international law, and domestic law

Although international conventions and the decisions of foreign courts are not binding in Canada, they enjoy a persuasive value in Canadian courts. As stated by Claydon, "the search for wisdom is not to be circumscribed by national boundaries."<sup>13</sup> It seems, however, that the arms-length relationship between national and international law may be beginning to contract in several jurisdictions, including Canada. Positive duties have been fashioned from what could be construed as mere human rights rhetoric.

In reaching its decision in *TAC v Minister of Health*, for instance, both the lower court and the Constitutional Court relied on *Government of the Republic of South Africa v Grootboom and Others*,<sup>14</sup> a case in which the South African government was ordered to devise a program to provide housing and basic sanitation for a group of destitute squatters. The

court in *Grootboom* relied upon a seemingly innocuous and abstract Constitutional clause about "human dignity ... and the advancement of human rights and freedoms"<sup>15</sup> to find that the government had a practical duty to "act positively to ameliorate ... the desperation of hundreds of thousands of people living in deplorable conditions."<sup>16</sup>

Although international conventions and the decisions of foreign courts are not binding in Canada, they enjoy a persuasive value in Canadian courts.

Another striking example of the courts creating a positive, legally enforceable duty where none existed before is the Australian immigration case of *Minister of State for Immigration and Ethnic Affairs v Teoh*.<sup>17</sup> In *Teoh*, a Malaysian immigrant with three children was denied Australian residency status on the basis of "bad character" related to his criminal record. The High Court struck down the decision, effectively deciding that the state had failed to address *Teoh's* legitimate expectation that the tribunal would take into account the rights of his children under the Convention on the Rights of the Child in determining his claim for residency.

The reasoning employed by L'Heureux-Dubé J in *Baker* bears some resemblance to that of the *Teoh* case. *Baker*, like *Teoh*, grounds significant aspects of the analysis in the Convention on the Rights of the

Child. Mavis Baker had been ordered deported from Canada despite the fact that she had four Canadian-born children, two of whom required a caregiver because of disability. The effect of the Supreme Court's decision was an order for reassessment in which the best interests of Ms Baker's children were given greater consideration.

The *Baker* judgment changed the way immigration cases are handled in Canada; immigration officers are now required as a matter of routine to consider "the best interests of children" when determining applications for residency on humanitarian and compassionate grounds, a process that reflects the rights set out in the Convention on the Rights of the Child. The decision is important not only for its result but also because one of the legal instruments that the Supreme Court relied upon to reach its decision was an international convention that had not been implemented by Parliament and had no direct application within Canadian law.

Decisions like *Baker* and *Teoh* may potentially be used to support a more widespread use of international convention provisions in domestic rulings. After all, the legal issues in *Teoh*, *Baker*, *Grootboom*, and *TAC v Minister of Health* were similar. In all four cases, federal governments were ordered by judges to honour splendid but rather vague commitments to uphold human rights.

However, *Baker* provides a strong precedent to press domestic decision-makers (and even legislators) to take into account international human rights obligations recognized by Canada when fulfilling their statutory (public and parliamentary) duties. As recognized in *Baker*, interpreting domestic law in light of the "values reflected in international human rights law may help inform the contextual

approach to statutory interpretation and judicial review."<sup>18</sup> For example, Article 6 of the Convention on the Rights of the Child reads:

1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Ostensibly, the endorsement of these provisions committed Canada to more than a promise to abstain from killing children. The clear and imperative wording of the phrase "ensure to the maximum extent possible" implies a positive and proactive duty to use every available means of enriching the quality of the life of the child.

*Teoh* and *TAC v Minister of Health* are not the only domestic court decisions to import into domestic law a positive duty based on an international human rights treaty. As early as 1985, Canadian courts were attempting to breathe life into the quixotic clauses of international agreements. In *Singh v Canada (Minister of Employment and Immigration)*, Wilson J wrote:

I believe therefore that a Convention refugee who does not have a safe haven elsewhere is entitled to rely on this country's willingness to live up to the obligations it has undertaken as a signatory to the United Nations Convention Relating to the Status of Refugees.<sup>19</sup>

*Singh*, like *Baker*, fundamentally altered immigration law in Canada. Canada's global vow to protect political expatriates from a "well-founded fear of persecution"<sup>20</sup> was transformed into a positive duty to grant a hearing and provide reasons to every refugee claimant physically present in Canada.

Yet international, bilateral, and multilateral treaties may not always be allies in the domain of health-care

rights. In recent years there has been increasing concern over the impact that international trade agreements may have on the Canadian health-care system. According to a report produced for the Commission on the Future of Health Care in Canada:

If Medicare did not already exist today, the full force of Canada's current international trade and investment obligations would now almost certainly make creating it far more difficult, if not impossible. The prospect of compensating well-entrenched foreign commercial interests for lost investment opportunities would probably be enough to tip the balance in favour of Medicare's foes.<sup>21</sup>

Two of the most controversial agreements are the General Agreement on Trade in Services (GATS)<sup>22</sup> and the North American Free Trade Agreement (NAFTA).<sup>23</sup> Although both contain limited provisions to exempt health services from the application of the respective agreements, neither includes an explicit guarantee for the protection of Canada's current system of socialized medicine, commonly referred to as Medicare. The trend toward the increased commercialization of health care – through private financing and for-profit delivery of services – raises some alarming policy issues related to the universality of health care. Unfortunately, an in-depth analysis of these issues exceeds the scope and length constraints of this essay. The point was made to underscore the observation that Canada is not inured from the effects of international agreements – whether friend or foe to its health-care system.

The practical consequences of the *TAC v Minister of Health* decision and international treaties for the right to health in Canada are presently ambiguous. *TAC v Minister of Health* is a powerful precedent. It required

the government not only to abstain from encumbering access to preventative health care, but also to actively provide it, necessitating the substantial expenditure of financial resources. Even more remarkably, it compelled the government to protect those not even recognized as legal persons in Canada.<sup>24</sup>

The rapid advancement of expensive prenatal fetal treatments<sup>25</sup> may give rise to a whole new class of health rights. For example, the expectant parents of a potentially disabled child might cite *TAC v Minister of Health* or the Convention on the Rights of the Child as precedent or justification for enforcing a governmental duty to fund preventative fetal surgery. If international conventions are to have any tangible benefit to the citizens of a country that ratifies the convention, it will likely be as a result of court decisions that impose positive obligations on government.

## Health care and the Canadian Constitution

The *TAC v Minister of Health* ruling invoked sections 7(2) and 8(1) of the South African Constitution, chapter 2 of which contains the South African Bill of Rights. Section 27(1) of the South African Bill of Rights states:

- a) Everyone has the right to have access to health care services, including reproductive health care.
- b) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.<sup>26</sup>

It seems astonishing that these clauses have no constitutional equivalent in Canada, where access to health care is considered a birthright and a keystone of the national identity. The conven-

tional explanation for the apparent indifference of the Fathers of Confederation to health care is that in 1867 health was assumed to be a private matter.<sup>27</sup>

The only explicit references to health in the Constitution are paragraphs 91(11) and 92(7) of the Constitution Act, 1867. Paragraph 91(11) gives to Parliament the power to legislate with respect to “quarantine and the establishment of marine hospitals.” Paragraph 92(7) assigns to legislatures the power to make laws with respect to “the establishment, maintenance and management of hospitals.” The ambiguity of the phrasing has led some to draw the conclusion that health should be treated as an aggregate of matters, the responsibility for which should be divided between federal and provincial jurisdictions. For instance, Justice Estey in *Schneider v The Queen* wrote:

Health is not a subject specifically dealt with in the Constitution ... or by way of subsequent amendment.... In sum, “health” is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation.<sup>28</sup>

The conventional explanation for the apparent indifference of the Fathers of Confederation to health care is that in 1867 health was assumed to be a private matter.

Sections 92(7), 92(16), and 92(13) are invoked to justify the general jurisdiction of the provinces over health matters, despite the fact that health law often touches upon aspects of human well-being that extend beyond the traditional powers of property, civil rights, and “matters of a local nature.”<sup>29</sup> The problems caused by HIV/AIDS are not easily amenable to solutions based on the jurisdictional categories found in the Canadian Constitution.

The Court in *TAC v Minister of Health* quoted a South Africa Department of Health publication that referred to the country’s AIDS pandemic as a “scourge ... afflicting millions of lives ... causing fear and uncertainty, and threatening the economy.” If an AIDS epidemic were to erupt in Canada on a similar scale, provincial governments would be ill equipped to deal with the ensuing national and international ramifications in imports, exports, general trade, and immigration matters. As Estey J wrote in *Schneider*:

Federal legislation in relation to health can be supported where the dimension of the problem is national rather than local in nature ... or where the health concern arises in the context of a public wrong and response is a criminal prohibition.<sup>30</sup>

This passage by Estey J was quoted approvingly by La Forest J in *RJR-Macdonald v Canada (Attorney General)*.<sup>31</sup> However, this view does not represent what is generally considered to be the accurate description of the allocation of legislative powers with respect to health. The opinion of Justice Beetz in *Bell Canada v Quebec (CSST)* remains the prevalent approach, whereby “General legislative jurisdiction over health belongs to the provinces, subject to the limited

jurisdiction of Parliament ancillary to the powers expressly conferred by s. 91 of the Constitution Act.”<sup>32</sup>

Litigants seeking to establish a comprehensive legal guarantee of a right to health care, including the protection of preventative health rights, would do well to rely on the reasoning of Estey J in *Schneider*. The *TAC v Minister of Health* action succeeded because health care was regarded as the ineluctable obligation of the state. Preventative health care is unlikely to be recognized by courts and the public as a legal right as long as the provinces are discordant in their understanding of what such a right entails.

The primary purpose of the Canada Health Act<sup>33</sup> is to provide financial incentives to the provinces to administer a universally available health-care system. Effectively, it codified the existing federal government control over health through the spending power.<sup>34</sup> Tax money is granted conditionally to health-care programs where federal regulations are imposed on an area widely regarded as a provincial responsibility. An amendment to the Canada Health Act requiring the provinces to provide certain types of preventative health care in order to receive tax funding would likely have the desired effect. Unfortunately, the gravity of the *TAC v Minister of Health* ruling, which unconditionally recognized the government’s responsibility to fund and administer MTCT programs, could not be reproduced in this fashion.

In the absence of a constitutional or Charter-based remedy, specifically enacted legislation would appear to be the only alternative. However, in order to ensure that health care is accorded the status of a right, the legislation itself would have to be of a distinct or elevated nature – much like the

Canadian Bill of Rights.<sup>35</sup> The Bill of Rights lay dormant for years until the plaintiffs in *Authorson v Canada (Attorney General)* employed it to

An amendment to the Constitution would be the ideal solution, since it would entrench the right to health in the Canadian identity.

supplement the failure of the Charter to address property rights.<sup>36</sup> The case was successfully argued before the Ontario Court of Appeal on this basis despite the fact that the power over property rights is consigned to the provinces under s 92(13).<sup>37</sup>

New health-care legislation enacted in the manner of the Bill of Rights might address such issues as civil and criminal liability for transmission of fatal diseases like AIDS and the state’s responsibility to protect children from prenatal transmission of HIV, thus at least partially rectifying the omissions of the Constitution. This would be an unconventional act, but it has two advantages. First, it would provide a definitive statement of Canada’s commitment to preventative health care. Second, it would contribute to dispelling the myth that health care is the exclusive domain of the provinces.<sup>38</sup>

## Conclusion

Two approaches to securing the right to preventative health care in Canada have been described in this essay: interpreting Canadian common law and statutes in a manner consistent with international conventions; and

fortifying the federal government’s role in protecting the health of Canadians. Both are predicated on the implausibility of a constitutional amendment to achieve a similar end. An amendment to the Constitution would be the ideal solution, since it would entrench the right to health in the Canadian identity. This is not as fantastic a step as it may sound. For one thing, Canada would not be the first country to make health care a constitutional guarantee. The constitutions of countries such as South Africa, Switzerland,<sup>39</sup> and Sweden<sup>40</sup> all contain sections empowering courts to strike down any law inconsistent with the country’s obligation to provide universal health care. Perhaps even more compelling, however, is the extent to which health care has come to be recognized as a right in Canada.<sup>41</sup> The generally optimistic response to last year’s Romanow Report suggests that universal health care is a value that should continue to be nurtured in this country.

– Showkat Yazdanian

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<sup>1</sup> Details of the contest can be found at [www.aidslaw.ca/Maincontent/lawessaycontest.htm](http://www.aidslaw.ca/Maincontent/lawessaycontest.htm).

<sup>2</sup> Case No 21182/2001, 14 December 2001, High Court of South Africa (Transvaal Provincial Division). Reported in 2002(4) BCLR 356 (T), 2001 SACLR LEXIS 123, and available via [www.tac.org.za](http://www.tac.org.za) (hereinafter *TAC v Minister of Health*), cited to LEXIS, which has its own internal page numbering for the judgment, which numbering is used in the following notes. The Order of the High Court was varied on appeal to the Constitutional Court of South Africa, Case CCT 8/02, 5 July 2002, available at [www.concourt.gov.za/files/tac/tac.pdf](http://www.concourt.gov.za/files/tac/tac.pdf). The Constitutional Court generally ordered the South African and state government to devise and implement within its available resources a comprehensive and coordinated program to progressively realize the rights of pregnant women and their newborn children to have access to health services to combat MTCT of HIV. For the full Order of the Court, see the decision at para 135.

<sup>3</sup> See information on the website of AVERT, an international HIV and AIDS charity based in the United Kingdom at [www.avert.org/motherchild.htm](http://www.avert.org/motherchild.htm).

<sup>4</sup> Ibid.

<sup>5</sup> Constitution of the Republic of South Africa, 1996, Act 108 of 1996.

<sup>6</sup> See KYigen. Enforcing social justice: economic and social rights in South Africa. *International Journal of Human Rights* 2000; 4(2); 13 at 21.

<sup>7</sup> See specifically the Constitution Act, 1867 (UK), 30 & 31 Vict, c 3.

<sup>8</sup> [1999] 2 SCR 817 (hereinafter *Baker*).

<sup>9</sup> GA res 44/25, annex, 44 UN GAOR Suppl (No. 49) at 167, UN Doc A/44/49 (1989), entered into force 2 September 1990.

<sup>10</sup> GA res 217A (III), UN Doc A/810 at 71 (1948).

<sup>11</sup> GA res 2200A (XXI), 21 UN GAOR Suppl (No. 16) at 49, UN Doc A/6316 (1966), 993 UNTS 3, entered into force 3 January 1976.

<sup>12</sup> Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 (hereinafter Charter).

<sup>13</sup> J Claydon. International human rights law and the interpretation of the Canadian Charter of Rights and Freedoms. *Supreme Court Law Review* 1982; 4: 287.

<sup>14</sup> 2001(1) SA 46 (CC) (hereinafter *Grootboom*).

<sup>15</sup> Constitution of the Republic of South Africa, supra, note 5 at s 1(a).

<sup>16</sup> Ibid at para 93.

<sup>17</sup> (1995) 183 CLR 273 (Aust HC) (hereinafter *Teoh*).

<sup>18</sup> *Baker*, supra, note 8 at para 70.

<sup>19</sup> [1985] 1 SCR 177 at para 20 (hereinafter *Singh*). Although the Court was unanimous, the judges split 3-3 in their reasons for judgment. Half the court, led by Chief Justice Dickson, relied upon the Charter; Justices Beetz, Estey, and McIntyre employed the Bill of Rights.

<sup>20</sup> Immigration Act, s 2(1), repealed, 2001, c 27, s 274;

Immigration and Refugee Protection Act, 2001, c 27; Convention relating to the Status of Refugees, 189 UNTS 150, entered into force 22 April 1954.

<sup>21</sup> The Canadian Centre for Policy Alternatives Consortium on Globalization and Health. *Putting Health First: Canadian Health Care Reform, Trade Treaties and Foreign Policy*. Ottawa: Commission on the Future of Health Care in Canada, October 2002 ([www.policyalternatives.ca/publications/putting-health-first.pdf](http://www.policyalternatives.ca/publications/putting-health-first.pdf)).

<sup>22</sup> General Agreement on Trade in Services. 15 April 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1B, Results of the Uruguay Round of Multilateral Trade Negotiations. The Legal Texts 25, 33 ILM 1168 (1994).

<sup>23</sup> North American Free Trade Agreement Implementation Act, SC 1993, c 44.

<sup>24</sup> *R v Morgentaler* (No 2) [1988] 1 SCR 30.

<sup>25</sup> On Wednesday, 29 October 1999, the BBC reported that an operation was performed on a 23-week-old fetus to prevent the debilitating disease spina bifida; see <http://news.bbc.co.uk/1/hi/health/479416.stm>.

<sup>26</sup> *TAC*, supra, note 2 at para 4.

<sup>27</sup> The 1859 Consolidated Statutes of United Canada listed only three health statutes: the Public Health Act, c 38 (measures to prevent, mitigate and control epidemics and contagious diseases and creation of a Central Board of Health), the Inoculation and Vaccination Act, c 39 (controls on inoculation and vaccination), and the Emigrants and Quarantine Act, c 40 (duties on immigrants, medical inspection of immigrants and passengers arriving by ship, and quarantine measures).

<sup>28</sup> [1982] SCR 112 at 136 (hereinafter *Schneider*).

<sup>29</sup> H Leeson. *Constitutional Jurisdiction Over Health and Health Care Services In Canada*, August 2002; retrieved from <http://dsp-psd.communication.gc.ca/Collection/CP32-79-12-2002E.pdf> on 17 February 2002.

<sup>30</sup> Supra, note 28 at 141.

<sup>31</sup> [1995] 3 SCR 199 at 245-246.

<sup>32</sup> [1988] 1 SCR 749 at 761.

<sup>33</sup> RSC 1985, c C-6.

<sup>34</sup> The spending power is traditionally inferred under s 91(3) of the Constitution.

<sup>35</sup> RSC 1985, Appendix III.

<sup>36</sup> [2000] 53 OR (3d) 221 (OCA). The pertinent provision of the Bill of Rights is section 1(a), which protects "the enjoyment of property."

<sup>37</sup> Since this article was written, the Ontario Court of Appeal's decision was reversed by the Supreme Court, which found that the Bill of Rights does not protect against the expropriation of property by the passage of unambiguous legislation. See *Authorson v Canada (Attorney General)*, [2003] SCJ No 40.

<sup>38</sup> For instance, through the spending power, the federal government negotiated the most important terms of both the Medicare and hospital insurance programs and defrays approximately one-half of each province's costs. See P Hogg. *Constitutional Law of Canada*. Scarborough: Carswell, 2001, section 28.

<sup>39</sup> Constitution of Switzerland; adopted by public referendum on 18 April 1999 and in force since 1 January 2000. See Article 41(b), available at [www.oefre.unibe.ch/law/icl/sz00000\\_.html](http://www.oefre.unibe.ch/law/icl/sz00000_.html).

<sup>40</sup> Constitution of Sweden; adopted on 1 January 1975. See Article 7(1), available at [www.oefre.unibe.ch/law/icl/sw00000\\_.html](http://www.oefre.unibe.ch/law/icl/sw00000_.html).

<sup>41</sup> As stated in R Romanow. *Building on Values: The Future of Health Care in Canada*. Ottawa: Commission on the Future of Health Care in Canada, November 2002 (hereinafter Romanow Report): "Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth." Full documentation of the Romanow Commission's work is available via [www.hc-sc.gc.ca/english/care/romanow/index1.html](http://www.hc-sc.gc.ca/english/care/romanow/index1.html).