

Canadian HIV/AIDS Legal Network

HIV/AIDS POLICY & LAW REVIEW

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Still underground: searching for progress in realizing the human rights of women in prostitution

After more than 20 years of global consensus on the need to work respectfully with sex trade workers as a central anti-HIV/AIDS strategy, the abuse and demonization of women and others in sex work remain major impediments to progress in both defending human rights and fighting AIDS. In this article, Joanne Csete and Meena Saraswathi Seshu discuss the nature of human rights abuses faced by women in prostitution and describe impediments to reducing those abuses. The authors suggest measures that would help to advance the human rights of women in prostitution and to create an environment conducive to the realization of their crucial role in combating HIV/AIDS.

This article is based in part on “The Violence of Stigmatization,” an essay prepared by Ms Seshu, based on her experience working with women in prostitution in central India.¹ Ms Seshu is with SANGRAM (Sampada Grameen Mahila Sanstha), an organization based in Sangli, India, that works in six districts of Maharashtra and Karnataka states. Since 1993 SANGRAM has worked for the empowerment of women in prostitution, including mobilizing them for HIV-related peer education. Some 120 SANGRAM peer educators distribute 350,000 condoms to 5000 women every month. In 1996 this work broadened into the organization of a collective of women in prostitution called VAMP (Veshya AIDS Muqabla Parishad). Reflections from members of the VAMP collective are included in a box at the end of the article.

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Bangkok Supplement

Issues concerning the rights of women and of injection drug users figured prominently at the XV International AIDS Conference held in July 2004 in Bangkok, Thailand.

This issue of the *HIV/AIDS Policy & Law Review* includes a special section containing the most relevant presentations on legal, ethical, and human rights issues from the conference and its many satellite meetings. The section also contains selected abstracts.

See page 67.



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Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network is a national non-governmental organization dedicated to promoting laws and policies that respect and protect the human rights of people living with, and vulnerable to, HIV/AIDS through research, legal and policy analysis, education, advocacy, and community mobilization.

The Legal Network promotes responses to HIV/AIDS that implement the International Guidelines on HIV/AIDS and Human Rights; minimize the adverse impact of HIV/AIDS on individuals and communities; and address the social and economic factors that increase vulnerability to HIV/AIDS and to human rights abuses.

The activities of the Legal Network support its vision of a world in which the human rights and dignity of people living with HIV/AIDS and those affected by the disease are respected and fulfilled; and where laws and policies facilitate HIV prevention efforts, as well as care, treatment, and support for people living with HIV/AIDS.

For membership information, write to the address above or visit:
www.aidslaw.ca/AbouttheNetwork/membership.htm.

Comments?

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

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EDITORIAL

Note from the Managing Editor: On 1 November 2004, Ralf Jürgens left the staff of the Canadian HIV/AIDS Legal Network. Ralf was a founding member of the Legal Network (in 1992), was its first president (in 1993), and was its Executive Director since June 1998. Under Ralf's leadership, the Legal Network has become one of the leading advocates for human rights in the response to HIV/AIDS, both in Canada and internationally. While Ralf has moved on from his position at the head of the Network, his dedication to the struggle against the epidemic and for human rights will go on. He will continue to bring his passion and his insight to bear, including ongoing collaboration with the Legal Network. The Board, staff, and members of the Legal Network extend their heartfelt thanks to Ralf for his contributions, of which the HIV/AIDS Policy & Law Review is but one. We asked Ralf to write the editorial for this last issue of the Review produced under his leadership.

High time to vastly scale up action on human rights

When I last wrote an editorial for a special International AIDS Conference issue of the *HIV/AIDS Policy & Law Review* in 2000, after the conference in Durban, South Africa, I was full of new energy and optimism. At that conference, legal, ethical, and human rights issues related to HIV/AIDS had taken centre stage. Thanks to the efforts of treatment activists, particularly the members of the South African Treatment Action Campaign (TAC), the silence with regard to access to treatment in resource-poor countries had been broken. In one of the highlights of the conference, Justice Edwin Cameron, delivering the Jonathan Mann Memorial Lecture, made a passionate and compelling appeal, based on human rights and dignity, to make the future different and to make medical care and treatment accessible and affordable to people in resource-poor countries who face death from AIDS.¹

Without the worldwide mobilization that started at the Durban conference, that educated communities and governments, and that affirmed treatment as a human right, the current efforts to vastly scale up access to HIV treatments as part of the Treat 3 Million by 2005 (3 by 5) Initiative would have been unthinkable. In fact, before the conference, hardly anyone believed that life-saving HIV/AIDS treatments could ever be made accessible to people living with HIV/AIDS in resource-poor countries. After the conference, we knew that it had to be done.

Since then, in only four years, much has been achieved in making treatments more accessible. The number of people in resource-poor countries who currently benefit from treatments is still very low, but it is growing fast and we might still reach the target set for the end of 2005, or at least achieve partial success, with significant expansion

in access to treatment and enough momentum to continue scale up after 2005. Importantly, the 3 by 5 Initiative itself is driven by the conviction that access to health care and treatment is a human right. The fact that progress is finally being made in many countries in strengthening health systems and in providing treatment to those in need may be one of the greatest human rights achievements of the last decades. Human rights activists of all hues should rejoice and do everything they can to support the 3 by 5 campaign.

But a lot more needs to be done. As Mark Heywood pointed out in his excellent article on human rights and HIV/AIDS in the context of 3 by 5 in the last issue of the *Review*,² insofar as 3 by 5 may be an endorsement of a human rights approach to the epidemic, it could also be a threat to human rights if its implementation leads to shortcuts in core principles such as informed consent for HIV testing, or to a weakening of patient autonomy in decisions about disclosure. For example, in the wake of 3 by 5, many have suggested that HIV testing should become “routine,” meaning that everyone accessing health care would be tested for HIV unless they opt out from testing by explicitly refusing to be tested.

Such issues and their human rights implications were discussed at the Bangkok conference (as reflected in Gruskin’s article in this issue of the *Review* at page 99), but did not receive the attention they warrant. As Gruskin highlights, it is certainly true that access to HIV testing needs to be vastly scaled up in developing countries, and that it needs to be part of the effort to scale up access to treatment. It is also likely that stigma and discrimination will be reduced when more people are able to know their HIV status and benefit from treatment, thereby changing the perception that HIV is a death sentence for people in developing countries. However, we should know better than to think that stigma and discrimination will disappear, so we should scale up efforts against them with as much determination as we scale up access to (voluntary) HIV testing and to treatment. Unless we do so, the full potential of HIV testing and treatment will not be realized.

In addition, we need to overcome the failure thus far to see decisive action to protect or respect the rights of those most vulnerable to HIV. This lack of action, and the unwillingness to recognize that failure to protect and respect the rights of those vulnerable to HIV virtually guarantees that HIV will continue to spread rapidly, continues to fuel the epidemic. For example, over 20 years after the beginning of the HIV epidemic, and with

women bearing the brunt of the epidemic in many countries, who would dispute that, in order to address the vulnerability to HIV of poor women in developing countries, we need to empower women and alter gender relations?

At the conference, issues related to women and HIV/AIDS did finally receive more attention, as some of the presentations reproduced in this issue of the *Review* demonstrate. But governments, donors, and communities continue to fail to move from rhetoric to action on the issue of women and HIV/AIDS. All we seem to get are campaigns highlighting the importance of fighting stigma and discrimination or the rights of women and children, when we need development and implementation of large-scale, long-term, and well-funded plans of action, with specific targets and goals, aimed at fundamentally changing the conditions that put women at increased risk of HIV.

Another example is that of injection drug users. Few today (apart from those who are willing to distort or neglect the abundant available evidence for ideological or other reasons) would dispute that, in order to address the rapid spread of HIV among injection drug users in many parts of the world, we need to stop pushing them to the margins and depriving them of their rights and dignity, and instead recognize that people who use drugs have the same right to health as other citizens, including a right to treatment and to preventive measures that we know reduce the spread of HIV. A number of articles in this issue of the *Review* illustrate this point well, as does a report released by Human Rights Watch just before the conference, which clearly shows that governments’ infringements of the human rights of drug users lead to increased spread of HIV not only among those who use drugs, but ultimately among the general population.³

There was some debate about these important public health and human rights issues at the conference, but in contrast to the conference in Durban four years ago, few delegates left with new energy, commitment, passion, and hope. There were too many examples of abuses of human rights, failure of governments to take HIV/AIDS seriously, and empty talk, and generally a feeling that the international AIDS conference needs to get its act together in Toronto in 2006 to become relevant again. In one of the saddest moments of the conference, the only person living with HIV/AIDS (a Thai drug user) to speak at the opening ceremony addressed a nearly empty auditorium because the program had been changed at the last minute in a deliberate act to silence his voice.

Later in the conference, Thailand did announce that it would from now on “treat drug users as patients,” but few

believe that the country is serious about moving from its war on drug users, which has resulted in thousands of documented extrajudicial killings, to an approach that includes providing harm-reduction measures and acknowledging the rights and dignity of drug users. Despite this, high-profile speaker after high-profile speaker at the conference congratulated Thailand for being one of the few governments worldwide to have taken the HIV/AIDS epidemic seriously, but remained silent about the plight of drug users in the country. Explicit criticism of the Thai government was left to local activists (with some support from activists from other countries), many of whom risk persecution when they engage in such criticism.

As the next International AIDS Conference in Toronto in 2006 approaches, we finally need to move from rhetoric to action on HIV/AIDS and human rights, and vastly scale up efforts to promote and protect human rights as they relate to HIV/AIDS – in addition to continuing to scale up access to (voluntary) testing and treatment. At AIDS 2006, human rights and HIV/AIDS, with a focus on issues related to women and to injection drug users, need to be at the centre, rather than the margin, of the conference.

– Ralf Jürgens

Name change

Effective this issue, the name of this publication has been changed from the *Canadian HIV/AIDS Policy & Law Review* to the *HIV/AIDS Policy & Law Review*. The change reflects the fact that for some time now, the *Review* has been covering current issues and new developments not only in Canada but also around the world.

¹ E Cameron. The deafening silence of AIDS. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 79-86 (available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol5no42000/camerondurban.htm).

² M Heywood. Human rights and HIV/AIDS in the context of 3 by 5: time for new directions? *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 1, 7-13 (available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol9no22004/hr3x5.htm).

³ Not Enough Graves. The War on Drugs, HIV/AIDS, and Violations of Human Rights in Thailand. New York: Human Rights Watch, 2004 (available via www.hrw.org/campaigns/aids/2004/thai.htm).

Still underground: searching for progress in realizing the human rights of women in prostitution

cont'd from page 1

Introduction

In June 2004 the government of the Indian state of Goa forcibly displaced hundreds of women in prostitution from the Baina beach neighbourhood by destroying their 250 homes, making way for the commercial development of the beachfront property. Responding to a court order requiring them to offer livelihood alternatives to the Baina residents before any displacement could happen, state authorities offered the women the opportunity to be housed behind barbed wire in a former children's home to learn new commercial skills, including candle-making and embroidery. None of the women saw this as a viable alternative. The eviction occurred at the height of the monsoon season.²

Women in prostitution in Baina had worked effectively as a group to empower themselves to demand condom use of their clients, and they fought child trafficking into Goa. India is home to some of the world's most successful and internationally lauded collectives of women in prostitution who work together to prevent HIV and educate their clients and the larger community about AIDS. But the Goa authorities apparently had no regard for the impact on the women and the entire community of dispersing these HIV/AIDS activities, just as they had no regard for the property, rights, or well-being of these women.

In June 2003 the US Congress passed the Global AIDS Bill authorizing the White House initiative that has

come to be known as PEPFAR, the President's Emergency Program for AIDS Relief. It is well known that the Global AIDS Bill requires that one-third of PEPFAR funds allocated to prevention efforts must go to programs that promote sexual abstinence outside marriage as their key prevention strategy. What is perhaps less well known is that the bill also prohibits the granting of funds to "any group or organization that does not have a policy explicitly opposing prostitution."³ Chris Smith, a Republican from the state of New Jersey in the House of Representatives, who authored this provision, told the press that "it would simply be wrong for the United States to ... serve as an enabler for traffickers and pimps by providing money to combat AIDS to organizations who believe in the misguided approach [of] legalized prostitution and 'safe sex.'"⁴

The two developments noted above vividly illustrate the abuse and demonization of women and others involved in the sex trade.

Denying the capacity to consent

Sex work has featured in analyses of the AIDS epidemic from the beginning – for some, looming large as a problem; for others, understood for its potential as part of the solution. The latter group saw that the human rights of sex workers would have to be defended to protect them from HIV/AIDS and to combat the disease more broadly. While a few positive steps have been taken in recent years

to embody human rights of sex workers in national and local responses to AIDS, there has been an alarming shift recently against policy and programmatic support for interventions concerned with the rights and health of people engaged in sex work, even where such interventions have proven effective. The setbacks are due in part to the power of the anti-trafficking lobby in the US, which, as noted above, has effectively encouraged the demonization of both prostitution and trafficking and also, in the process, has systematically blurred the distinction between the two.

There has been an alarming shift against policy and programmatic support for interventions concerned with the rights and health of people engaged in sex work.

This confounding of trafficking with prostitution by political conservatives and religious fundamentalists in the US found fertile ground in a discourse on sex work already dominated by moral judgementalism, fear-mongering, and abolitionism. It is easy for those who confound sex work and trafficking to make the case that all sex work is the equivalent of trafficking when abolitionists, including some feminists, have long argued

that all sex workers have been forced into the institution of prostitution, and that making money from sex is synonymous with violent sexual exploitation. Complete abolition of prostitution is the logical solution for those who make this argument. But abolition in this case means criminalizing the manifestations of sex work such as soliciting, pimping, brothel-keeping, and trafficking, an approach likely to spill over into criminalizing the woman in prostitution.

There is no question that the motivations for sex work are complex and varied, and that some women enter prostitution because of poverty and because other livelihood alternatives are extremely limited. But to reduce prostitution to something involving no choice or agency on the part of the women practising it is as demeaning and as much a human rights violation as the violence and stigma that sex workers regularly face. Hilary Kinnell, of the UK Network of Sex Work Projects, notes that consent can be distinguished from coercion by applying clear criteria – such as whether a woman was subject to force or threats of force, was abducted or unlawfully detained, was unconscious, etc when she entered prostitution. Where coercion is not present, according to Kinnell,

to deny sex workers the right to consent to sex in exchange for money would put them in the same category as children under the age of thirteen and adults with severe learning disabilities or mental disorders – in other words, a return to the days when women could be sent to mental hospitals for having illegitimate children or acting in ways that embarrassed their adult male relatives.⁵

Framing women sex workers as hapless victims of exploitation is hardly a

step up from the more common historical view of them as “fallen women.” Depictions of prostitutes have long relied on images of wantonness, debauchery (making “valueless” money from sex), and moral weakness. The “whore” stigma emphasized the evil influence of these women on the “good” moral character of society, deeming them deviant and base. The concept of the fallen, debased, and deviant woman has always governed public opinion, policy, and law.

Criminalization and violence

Caught between their supposed victimhood and supposed wantonness, women in prostitution unsurprisingly face laws and policies in most countries that seek either to “protect” or to criminalize them, or both. Laws and policy on sex work have tended to reflect both the nearly universal social disdain of sex workers and the core beliefs about sex and sex work of policy-makers (mostly men). Even where national laws do not criminalize prostitution directly, they nearly always allow the police great latitude in

Social attitudes allow police a free hand for extortion, unlawful detention, and sexual abuse of women in prostitution.

detaining sex workers on charges such as vagrancy or loitering. Social attitudes add to that latitude and allow police a free hand for extortion, unlawful detention, and sexual abuse of women in prostitution, which are widely practised the world over.

Not only do police in many countries engage in such abuse with

impunity; they also turn a blind eye when criminal gangs, immigration and other officials, pimps, and clients abuse sex workers. Sex workers are in the impossible position in most countries of working essentially outside the law, but in a business in which police profit from prostitution – in the form of money or sex – and have no incentive to change the status quo. Police, government officials, and all of society drill into women in prostitution that their lives are illicit. The police’s selective use of the law and its trappings allows criminals and gangs – for example, the so-called goonda element in India – to use the site of sex work to practise their criminal activity, which relies on the vulnerability of the women. The result is an uneasy alliance between the state, criminals, and the women. No wonder it is impossible in so many countries for women in prostitution to escape the “protection” of a pimp or brothel owner or some criminal element.

A survey of sex workers in 13 districts in Tamil Nadu, India, in 2000 found that almost 70 percent of women in prostitution had been beaten by police and that over 80 percent had been arrested unlawfully.⁶ There is every reason to suppose that these patterns are representative of the situation in many countries where sex workers come from the lowest class or caste. It is obvious that when abused by the police, women in prostitution are unable to make an official complaint or prosecute that abuse. Unfortunately, this is true of sexual and other violent abuse against women in prostitution even when the police are not the perpetrators.

Women in prostitution, therefore, are frequently forced to accept conditions of abuse in their daily working lives. Madhuri Sawant, a woman in prostitution who had been trafficked

to Mumbai from elsewhere in India, related to the VAMP collective her experience of being caged in a small room without ventilation, not allowed to talk to her colleagues, and having to service clients that pimps brought to the room, without her having any power to choose whom to accept or reject. She felt she had relinquished her life to the trafficker and madam. After her escape, she said, “It is because Mumbai is so big and frightening that I felt alone and helpless. I thought that the dalal [pimp] from Mumbai would treat me like a human being, but he was ruthless. Even a woman like me who had 10 years’ experience in prostitution and sex work could not deal with the goondas in Mumbai. What must be happening to new, young girls? They must be really brutalized.”

The violence of stigma

Stigma, which has its roots in the standards set by patriarchal morality, is experienced by women in prostitution as perhaps the most important impediment to realizing their human rights. The impact of stigma on them is multi-faceted – denying them freedom from physical and mental abuse, and impeding their right to education and information, health care, housing, social security, and welfare services.

Being women in prostitution puts these women into a caste/class of their own. This caste/class occupies the lowest rung in the social hierarchy; it may even be considered outside the hierarchy as we know it. Mobility for these women is therefore almost impossible; when it is possible, it is only through deceit or money. The need to protect family members, especially children, from this stigma is an everyday struggle. As Bandawwa Makadwale from VAMP said, “All the money we have earned cannot help us

to live in peace. The outside world pushes us out and does not even accept our children who are not in the business of making money out of sex. Our health and our children suffer the most due to this stigma and discrimination.”

Stigma is perhaps the most important impediment to women in prostitution realizing their human rights.

The baseline survey of the sex worker community in Sangli conducted by SANGRAM in 1992 showed that less than two percent of the women have ever been to school of any kind, and that less than half of them reached high school. Though most of the children of these women were going to school, the survey showed a very high drop-out rate, especially after primary school. As one of their daughters said, “It is very painful to listen to your peers make snide remarks about your own mother. When my own teacher came to the community for sex, I ran and ran till I was breathless. I was so frightened. I never went back to school.” This stigma persists even when daughters of sex workers achieve prominence in other careers. A young woman whose mother worked in the sex trade was able to complete her studies and be awarded a master’s degree in business. She reported that she left her job in a local bank because the manager took to calling her in to ask questions about her mother and the other women in the community.

Stigma and discrimination against sex workers in access to health care are widespread. Women in prostitution reported to the National Commission of Women in India that

doctors and other medical staff at government hospitals treated them in a callous way, often asking irrelevant and humiliating questions about sexual positions and the like. There were reports of doctors assuming that the women were “AIDS carriers” and refusing to touch them, preferring to have attendants or nurses conduct physical examinations. Some women reported that doctors or social workers forced them to have sex.

The impact of HIV/AIDS

The HIV/AIDS epidemic should have provided an opportunity for a deeper understanding of the importance of respecting the rights of sex workers as an important end in and of itself, and as an essential step in the struggle against AIDS. Women in prostitution, after all, constitute a community that bears and will continue to bear the greatest impact of the HIV/AIDS epidemic in India and many countries, not least because HIV transmission is most efficient when sex is violent and abusive.

Instead, the lens of the HIV/AIDS epidemic has too often caused women in prostitution to be seen as “carriers,” “vectors,” and “core transmitters” of HIV. Portraying women in prostitution in this way reinforces the moral and judgmental attitudes of prostitution-bashers and the prejudice that AIDS is an “impure” disease that afflicts immoral persons. If these images are not countered, the result is to open the door wider to social stigma and violence against sex workers, decrease their ability to assert themselves, allow customers even more latitude to force unsafe sex upon them, and impede their access to health care and other services.

HIV/AIDS-related interventions and policies that target sex workers only as tools for reducing HIV trans-

mission may ignore the risks faced by sex workers that need to be addressed for their protection, and for anti-AIDS strategies to work. Fear of police and legal repression is a major reason why women shy away from outreach workers. In situations where a person has been trafficked or is an illegal migrant, it is almost impossible to expect that she, fearing repatriation (among other things), will seek prevention and treatment services for HIV simply because they are available. Likewise, it is almost impossible to conduct outreach to women who are under the “protection” of the criminal nexus and trafficking syndicates.

The 100 percent condom use strategy is rarely pursued in a way that respects the rights of sex workers.

One strategy for HIV prevention work among women in prostitution that has received international praise is the so-called “100 percent condom use” program, of which Thailand’s is probably the best known. In such programs, managers of commercial sex establishments agree to enforce condom use in the activities undertaken on their premises, and sex workers are instructed to refuse sex to any client refusing condom use. As UNAIDS notes, if all commercial sex venues abide by the rules of the program, clients will essentially be forced to use condoms.

While this strategy has undoubtedly increased condom use in many places where it has been pursued, it is rarely pursued in a way that respects the rights of sex workers. As Loff and others have noted, many 100 percent

programs have led to repressive surveillance of sex workers, compulsory HIV and sexually transmitted disease (STD) testing, and the arrests of women in prostitution when condoms are not used.⁷ In some cases, these programs have not ensured continuous availability of condoms, and sex workers have paid the price. Those prosecuted for not using condoms may end up having to work in more remote or hidden parts of the sex industry where they will be at increased risk of HIV and of abuse. In their worst forms, these programs are the antithesis of peer education efforts of organizations like SANGRAM, whose success has been based on the presence of sex workers themselves in decision-making roles in programs.

Contradictions and lacunae in the management of the HIV/AIDS programs in many countries also impede the realization of sex workers’ rights. Short project-oriented interventions cannot hope to achieve a sustained response to a problem as complex as abuse of sex workers. In situations where access to treatment services to the general population is difficult and sporadic, a service for vulnerable groups is an almost impossible dream. Programs that view women in sex work as a means to reaching the sexually active male population rather than the sex workers themselves are doomed from the start; they are likely to alienate women in prostitution rather than empower them to combat HIV.

In spite of the well-documented successes of sex worker-run collectives in controlling the spread of HIV in their communities, the crucial role of sex workers in HIV/AIDS prevention is too little recognized. It is clear from experiences in India and elsewhere that women in prostitution are the best educators of their male

clients. This has been recognized by “best practice” analyses of UNAIDS and by many experts, but still government and donor resources are most plentiful for top-down programs that effectively disempower sex workers.

A study of “targeted interventions” for HIV prevention among sex workers in India by the US-based NGO, CHANGE, found that these programs often reinforce stigma, particularly where there is no commitment by authorities to address human rights abuses against sex workers. The Indian government recognizes the importance of sex workers as peer educators and HIV/AIDS outreach workers, but has not been inclined to address the human rights violations that are so central to the vulnerability of sex workers to HIV.⁸

Even where the government supports peer education programs for sex workers, it has done nothing to address sex workers’ exposure to HIV through sexual violence at the hands of police, brothel owners, and criminals or, for that matter, the inability they share with many other women to negotiate safe sex with regular partners. Espousal of the rights of sex workers only goes as far as is needed to make programs run. As one NGO worker told CHANGE, “So [seeing to] the rights of women in prostitution is not because they as citizens have rights, but because from an HIV programmatic point of view, they have to have a few rights to enable them to use condoms.”⁹

Making rights meaningful

There is an urgent need to turn human rights discourse into a tangible reality where women in prostitution are concerned. Unfortunately, international human rights law is not extremely useful toward this end. The first international human rights instrument on

trafficking (the 1949 Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others) recognizes in a complicated way the theoretical right of adult women in prostitution to ply their trade, but is based on the premise that all sex work should end, and implicitly endorses the view that adult sex workers should be saved from themselves and rehabilitated.¹⁰ The convention prohibits prostitution of a person even when that person consents to prostitution.¹¹

The newer international law on trafficking, the so-called Trafficking Protocol of 2000 (Protocol to Suppress, Prevent and Punish the Trafficking in Persons, Especially Women and Children, Supplementing the U.N. Convention on Transnational Organized Crime) uses language similar to that of the earlier convention and certainly represents no advance on the matter of respecting the rights and agency of women in prostitution. As Loff observes, “The failure to recognise the distinction between forced and unforced prostitution [in international law] allows the claims of prostitutes’ rights groups to be ignored.”¹²

The Convention on the Elimination of All Forms of Discrimination Against Women of 1981 (CEDAW) condemns sexual exploitation and calls on governments to take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women. General Recommendation No 19 of the UN Committee on CEDAW enjoins states to ensure equal protection under the law for prostitutes and notes that prostitutes “are especially vulnerable to violence because their status, which may be unlawful, tends to marginalize them.”¹³ Jordan, in her extensive

analysis of the subject, suggests that the suggestion in the General Recommendation of the importance of legal protection for prostitutes is as close to an espousal of the human rights of women in prostitution as can be found in the current body of international law.¹⁴

Decriminalization and anti-discriminatory measures have been effective in improving health and work conditions of sex workers.

As a function of national law, prostitution in most countries is illegal. In addition, in some countries people engaged or assumed to be engaged in sex work are required to be tested for HIV; in others, sex workers may face detention and involuntary health and “rehabilitation” services, all of which may have the effect of pushing them further underground. Evidence exists that decriminalization and anti-discriminatory measures at the national level have been effective in improving health and work conditions of sex workers. Kinnell, for example, cites evidence from several countries that women in prostitution who vote and whose freedom to assemble and organize is not impeded are also more likely to report consistent condom use with clients.¹⁵

In India, the Immoral Trafficking Prevention Act, 1986 (ITPA) is meant to punish traffickers, but in practice ends up victimizing women in prostitution. Again, it portrays all sex workers as victims of exploitation.¹⁶ The ITPA has the further discriminatory twist of much harsher penalties for women convicted of “soliciting” (six months for a first offence and up to

one year for subsequent offences) compared to men (seven days to three months). Jordan notes that the effect of this law is to punish women in prostitution harshly and to give male pimps a slap on the wrist. She also asserts that in the way it authorizes states to establish red-light districts, the ITPA effectively requires women to make deals with exploitative pimps and madams.¹⁷

Recommendations

The most important and practicable way to make human rights meaningful for sex workers in the context of the AIDS epidemic is to show respect for their humanity, not only by listening to them and learning from their experience, but also by ensuring that they manage their own anti-AIDS efforts and have decision-making authority in programs that affect them. HIV/AIDS interventions “targeting” them should be of, by, and for them. Peer education and training programs among sex workers have an outstanding record when they are truly participatory; they have proven that the impossible is possible. Sex workers also do reach out to sympathetic social workers with the right attitude. The VAMP collective working in southern Maharashtra and Karnataka border areas exemplifies a human rights-based approach (see box on page 14).

An obvious key to empowering sex workers both to protect themselves from HIV and to help fight AIDS in their communities is to take formal, very public, and well-financed measures to address violence and other abuse against sex workers. Formal decriminalization of sex work is likely to be an important step toward this end in many countries. In addition, police need to be trained about HIV/AIDS and the unique capacities

that sex workers bring to combating AIDS, and they must be brought to accountability for their abuses against women in prostitution. All governments should have strategies for reducing social stigma against persons in sex work, including, as suggested by CHANGE,¹⁸ sensitizing mass media to portray sex workers in a humane manner and to report on incidents of violence and abuse against them, including cases of denial of access to services.

The track record of sex worker collectives fighting HIV/AIDS and other experiences lead to some particular recommendations for programs and other action, including the following:

- As also noted by CHANGE, sex workers called upon to educate their peers on HIV/AIDS – indeed all sex workers – should have the same access as everyone in the community to voluntary and confidential HIV testing, treatment, and care for HIV-related illness; condoms; and information on HIV/AIDS. Confidentiality is essential for the success of any medical services for women in prostitution.
- HIV/AIDS interventions for women in prostitution should be made available as part of comprehensive reproductive health services (including safe abortion).

Finally, it would be useful to have international law or declarations from key human rights bodies that call on states explicitly to protect and promote the human rights of women in prostitution and to respect their agency and capacity for consent. A declaration from one of the UN human rights bodies calling for decriminalization of sex work would be an important step forward. It is hard to imagine how women in prostitution will realize their right to work at an occupation of their choosing, their right to security and bodily integrity, their right to the highest attainable standard of health, and their right to be free of discrimination, without the decriminalization of their work. There is also an immediate need to clearly define the term trafficking in a way that would not only serve to enhance efforts to protect the rights of trafficked persons, but would also make a distinction between those coerced into sex trafficking and those working by choice in the sex trade.

– Joanne Csete and
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¹ Copies of the essay are available from the author.

² See, for example, Human Rights Watch. Eviction of sex workers boosts HIV risk. News release, 7 July 2004. Available at www.hrw.org/english/docs/2004/07/06/india9010.htm.

³ United States Congress. United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, (Public Law No: 108-25, 108th Congress, 117 Stat 711) s 301, inserting s 104A (Assistance to Combat HIV/AIDS) into Foreign Assistance Act of 1961 (22 USC 2151).

⁴ Office of US Representative Chris Smith. House committee passes AIDS bill with key Smith amendment on human trafficking and prostitution. News release, 2 April 2003.

⁵ H Kinnell. Why feminists should rethink on sex workers' rights. Paper prepared for the Beyond Contract Seminar Series, London, 16 December 2002.

⁶ SANGRAM. Fact File. *Of Veshyas, Vamps, Whores and Women* 2002; 1(3): 4.

⁷ B Loff, C Overs, P Longo. Can health programs lead to mistreatment of sex workers? *Lancet* 2003; 361(9373): 1982.

⁸ A Amin. Risk, morality and blame: a critical analysis of government and US donor responses to HIV infections among sex workers in India. Report by CHANGE, the Center for Health and Gender Equity, January 2004, at 20, 22. Available at www.genderhealth.org/pubs/AminHIVAmongSexWorkersinIndiaJan2004.pdf.

⁹ *Ibid* at 20.

¹⁰ AD Jordan. Commercial sex workers in Asia: a blind spot in human rights law. In Askin and Koenig (eds). *Women and International Human Rights Law*. Ardsley, New York (USA): Transnational, 2000, vol 2 at 548.

¹¹ B Loff, B Gaze, C Farley. Prostitution, public health and human rights law. *Lancet* 2000; 356(9243): 1764.

¹² *Ibid*.

¹³ United Nations Committee on the Elimination of All Forms of Discrimination Against Women. UN Doc No A/47/38, 1992, article 6(15). Available at www.dirittiu-mani.donne.aidos.it/bibl_2_testi/c_testi_interpr_ufficiali/c_comit_cedaw/racc19_violenza_engl.pdf.

¹⁴ *Supra*, note 10 at 550.

¹⁵ *Supra*, note 5 at 13.

¹⁶ *Supra*, note 10 at 556.

¹⁷ *Ibid*.

¹⁸ *Supra*, note 8 at 26.

The voices of VAMP: listening to women in prostitution

Activists of the VAMP collective of 5000 women in prostitution and sex work in central India have collected narratives from their members and their peers. Some of these are excerpted below. They are introduced by a joint statement from SANGRAM, the Sangli-based NGO from which VAMP grew, which addresses the transformation of mentality and of terminology that is required to create an environment of respect for the human rights of women in prostitution.

From SANGRAM and VAMP:

As our involvement with the women [in prostitution] deepened, our beliefs, ideas, and notions about prostitution and women in prostitution underwent a sea change. Our perception of prostitution as “exploitation, victimization, oppression, loose, immoral, illegal,” was shaken to the core. Indeed, not only did our ideas and beliefs have to be questioned and reformulated, but even the very use of language to describe the women had to be transformed. “Whore,” “harlot,” “veshya” – have been used as abuses for the “fallen woman” – the subject of much public discourse. We have tried to help reclaim some of the terminology, and assert identities with positive meaning. We revised our vocabulary to weed out words that reinforce the stigmatization and marginalization of women in prostitution.

Besides, we realized that the terminology used for generations by mainstream society to refer to “the fallen woman” was more often than not derogatory, within the moral space of sacredness. The need to reclaim womanhood also became necessary since this sanctified moral space refused to acknowledge the fact that the very identity (of being a woman) was obliterated by the “whore, harlot, veshya” image. Hence, the importance of the use of terminology like “women in prostitution” instead of the commonly used term “prostitute.”

Women who practise prostitution use the term “women in business” while referring to themselves. Now, after much discussion among ourselves, we have adopted the term “people in prostitution and sex work (PPS) to include all persons who “make money out of sex.”

From the VAMP collective:

- On the matter of the right to practise the business of making money from sex: “We protest against a society that deems us immoral and illegal mainly because we do not accept its mores, rules, and governance. We protest against the various forces of mainstream society that deny us the right to liberty, security, fair administration of justice, respect for our lives, discrimination, freedom of expression and association.”
- On the violence of stigma: “As people who experience violence as a part of our daily lives, we are being more and more penalized by increasing violence in a society that is trying to order and control our lifestyles. As women in prostitution we protest against a society that forces on us the violence of a judgmental attitude.”
- On women’s sexuality: “We believe that a woman’s sexuality is an integral part of her as a woman, as varied as her mothering, domestic, and such other skills. We do not believe that sex has a sacred space and women who have sex for reasons other than its reproductive importance are violating this space. Or if they choose to make money from the transaction they are immoral or debauched.”
- From VAMP activist Durga Pujari: “Over the years, we have become ‘commercial sex-workers’ from ‘common prostitutes.’ Debates are held about us and we are discussed in documents, covenants, and declarations. The problem, however, is that when we try to inform the arguments, our stories are disbelieved and we are treated as if we cannot comprehend our own lives. Thus we are either romanticized, victimized, or worse, and our reality gets buried and distorted.”

Steps forward, backward, and sideways: Canada's bill on exporting generic pharmaceuticals

In May 2004 Canada's Parliament passed **Bill C-9**, amending the Patent Act to provide for the compulsory licensing of patented pharmaceutical products. The bill allows generic manufacturers to make cheaper, generic versions of patented products and export them to countries that do not have sufficient capacity to produce their own. Canada thus became the first country to pass legislation implementing a World Trade Organization (WTO) Decision that relaxed WTO rules on pharmaceutical patents. Civil society organizations campaigned to enhance the bill before it passed, and succeeded in obtaining significant improvements. However, the final bill is marred by flaws that mean it falls short of being a "model" that should simply be replicated elsewhere.

This article is the second in a series tracing the evolution of Canada's legislation.¹ It reviews the developments leading up to the adoption of **Bill C-9** in its final form, and analyzes its positive and negative aspects. Hopefully, other advocates can learn from this experience and other countries can avoid replicating the negative aspects as they implement the WTO Decision.²

Background

The WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) sets out rules on patents, including for pharmaceuticals, which WTO members must follow. TRIPS allows countries to issue compulsory licences, which override exclusive patent rights and authorize someone other than the patent holder to also make a pharmaceutical product before the patent on it expires. In exchange, the recipient of the compulsory licence must pay "adequate remuneration" to the patent holder. Compulsory licensing introduces competition by generic pharmaceutical manufacturers and makes needed medicines more affordable.

But TRIPS Article 31(f) says that, ordinarily, compulsory licensing may only be used "predominantly" for the purpose of supplying the domestic market of the country where the licence is issued.³ This limits the use of compulsory licensing to produce

generic pharmaceuticals for export. For countries lacking sufficient capacity to make their own generic medicines, and therefore needing to import such medicines, Article 31(f) makes it difficult for them to use compulsory licensing to address their population's health needs.

On 30 August 2003 the WTO General Council unanimously adopted a Decision to address these difficulties, in response to demands for access to cheaper, generic medicines, particularly in the developing world.⁴ The Decision waives, on an interim basis, the provision in Article 31(f).

Canadian civil society advocacy: Bill C-56, then Bill C-9

In September 2003, Canadian civil society organizations and Stephen Lewis, the UN Special Envoy on HIV/AIDS in Africa, called on the government to change Canadian patent law to implement the WTO Decision. On 6 November 2003, after

two months of intense lobbying, a draft bill (Bill C-56) was introduced in Parliament. The bill was heavily criticized by civil society advocates for failing to implement the full flexibility in patent rules that had been agreed at the WTO. The bill was also

The draft bill was criticized for giving unwarranted, unnecessary privileges to patent-holding pharmaceutical companies that would undermine the entire initiative.

criticized for giving unwarranted, unnecessary privileges to patent-holding pharmaceutical companies that would undermine the entire initiative.⁵

In response, the government decided to refer the bill to committee for further public discussion. On 12

February 2004, after a change in government leadership, the bill was reintroduced (now re-numbered as Bill C-9) and hearings were held by the House of Commons Standing Committee on Industry, Science and Technology.

The Global Treatment Action Group (GTAG) coordinated advocacy efforts among numerous civil society organizations to improve Bill C-9 as it worked its way through the parliamentary process. GTAG engaged a wide range of organizations from across the country – from human rights advocates to development NGOs, from humanitarian organizations to faith-based groups, and from labour unions to student groups – as well as thousands of individual Canadians.

As a GTAG member, the Canadian HIV/AIDS Legal Network prepared an information package on the bill that was distributed to every Member of Parliament shortly before Committee hearings began, made a detailed oral presentation before the Committee, and made an extensive series of written submissions to the Committee. Numerous other civil society organizations, and some individual experts, also appeared before the Committee or made submissions. GTAG member groups met with many of the Committee members individually to identify needed amendments to the bill, issued numerous media releases, and hosted several press conferences.⁶

In addition, the Legal Network participated in a World Health Organization/Ford Foundation consultation on the implementation of the WTO Decision and conveyed the results of that consultation to the Standing Committee; presented an oral statement about Bill C-9 before the 60th Session of the UN

Commission on Human Rights; and met with the office of the Prime Minister and the offices of most of the ministers of the five federal departments involved in the drafting of the bill. (The office of the Minister of Industry, the department with lead responsibility, did not respond to requests for a meeting.)

The intensive, sustained efforts of civil society had a major impact in improving the bill from its original form.

On 20 April 2004, having heard from witnesses over several days, the Standing Committee began its clause-by-clause analysis of the draft bill.⁷ In response to pressure from civil society advocates (see below), the government said at Committee that it was prepared to remove the controversial, anticompetitive “right of first refusal” clause that would have allowed patent-holding companies to scoop contracts negotiated by a generic supplier with an importing country purchaser. Civil society advocates also spoke out against the introduction of several problematic “alternatives” to the right of first refusal proposed by the brand-name industry and the government. In the end, the Committee made several positive amendments to the bill, including the removal of the right of first refusal clause. But it also added some amendments that created new defects in the bill, which the governing Liberal Party allowed to stand in the final text.⁸

On 28 April 2004 the bill, as amended by the Standing Committee, was reported back to the House of

Commons. After further motions to introduce additional amendments (see below), on 4 May 2004 Bill C-9 was put to its third and final reading and adopted unanimously by the entire House and sent to the Senate. On 13 May 2004 it received third reading and unanimous approval in the Senate. On 14 May 2004 it received Royal Assent and thereby passed into law,⁹ making Canada the first country to enact such legislation.¹⁰

On 16 July 2004 the US and Canada adopted a Memorandum of Understanding, agreeing that the intellectual property provisions of the North American Free Trade Agreement (NAFTA) would not be applied so as to block the implementation of Canada's Bill C-9.¹¹

Commentary on Bill C-9: positive and negative features of Canada's legislation

In theory, this law makes it possible for a Canadian generic pharmaceutical producer to obtain a licence to manufacture a patented medicine for export to eligible countries. How it will play out in practice remains to be seen. The fact that a G-7 country has taken the step of passing such a law is significant, because it generates needed political momentum, from a developed country, behind the implementation of the WTO Decision.

Bill C-9 also represents a victory of sorts for civil society advocates, whose intensive, sustained efforts had a major impact in improving the bill from its original form. But in light of its several defects, the bill in its entirety falls short of providing a “model” that should simply be copied elsewhere. Rather, other countries should learn from the Canadian experience and avoid replicating these flaws in their own implementation of

the WTO Decision. The rest of this article identifies the positive and negative features of Canada's approach to implementing the WTO Decision.

Limited list of products

One of the most fundamental concerns with Bill C-9 is the government's insistence on maintaining a list of pharmaceutical products subject to compulsory licensing for export. The Canadian experience to date illustrates that such an approach should be avoided.

The bill includes an initial list of 56 products to which it applies, derived principally from the World Health Organization (WHO) Model List of Essential Medicines. (In response to criticism, the government agreed to add to the original list in the bill all antiretrovirals [ARVs] for treating HIV/AIDS that are currently approved for sale in Canada.)

One of the most fundamental concerns with Bill C-9 is the government's insistence on maintaining a list of pharmaceutical products subject to compulsory licensing for export.

The bill also states that the federal Cabinet may, upon recommendation by the ministers of both Health and Industry, add other products to the list. A committee will be established to advise the ministers regarding which products should be added. Government officials have stated that civil society will be represented on this committee, along with people

who have expertise in delivering health care in resource-poor settings.

From the outset, civil society organizations were critical of the inclusion of any list, because it represented a step back from the international consensus achieved with the WTO Decision. In the negotiations leading up to the Decision, several developed countries proposed to limit its scope to just addressing specific diseases or just applying to specific pharmaceutical products. These efforts were roundly condemned by civil society activists as unethical and unsound health policy, and were firmly rejected by developing countries. Ultimately, all WTO members agreed that there would be no such limitations. By introducing a limited list of products in its implementing legislation, Canada has unilaterally undermined that consensus.

Canadian civil society groups repeatedly called on the government to abolish the list of products. They also warned that requiring a Cabinet decision to add new products would open the door to political lobbying by brand-name pharmaceutical companies to prevent the list from being expanded, thus creating further delays in the process. In the days leading up to the final vote on the bill in the House of Commons, the concerns of the civil society groups proved to be well founded.

At the Standing Committee stage, members discussed adding several medicines to the list in Bill C-9. The opposition New Democratic Party (NDP) had proposed that the added drugs include moxifloxacin and clarithromycin. Both are used to treat pneumonia. Clarithromycin is also used prophylactically to prevent mycobacterium avium complex (MAC), a life-threatening infection in people living with HIV/AIDS; a ver-

sion of the drug produced by an Indian generic manufacturer is among the HIV/AIDS medicines prequalified by the WHO. At the Committee, all political parties agreed that, absent any technical objections by Health Canada to a particular drug, the additional medicines would be added to the bill by motion when it came before the House of Commons for final reading and adoption.

Health Canada indicated that it had no objection to either of these two drugs being included in Bill C-9. But the NDP subsequently received calls from Bayer, the pharmaceutical company that holds the patent on the drug moxifloxacin in Canada, objecting to its inclusion in Bill C-9. At least one pharmaceutical company also contacted ministers' offices objecting to the addition of any medicines to the list,¹² and a minister's office subsequently contacted the opposition party to request that it withdraw some of its motions to add specific drugs that had already been agreed would be added.

Subsequently, during the consideration of these motions on the floor of the House of Commons, the governing Liberal Party argued against the addition of these medicines to the list of products covered by the bill, notwithstanding the government's previous assurances that including a list of products in Bill C-9 would not be used to limit the scope of the legislation in this fashion. Government representatives stated that moxifloxacin and clarithromycin were not on the WHO Model List of Essential Medicines, and claimed (incorrectly) that these medicines were not needed to treat HIV/AIDS, tuberculosis, or malaria.¹³

This experience illustrates the pitfalls of having a list of products, and calls into question the good faith of the government in promising that the list would not limit the scope of

Canada's initiative. This does not bode well for future efforts to add products to the list of products eligible for compulsory licensing and export.

Fixed-dose combination medicines

Of particular concern is how Canada's system will treat the case where a Canadian generic manufacturer seeks a compulsory licence to produce and export a "fixed-dose combination" (FDC) medicine, which combines more than one drug into a single dose. FDCs of ARVs simplify treatment regimens and are recognized by the WHO as being of critical importance in its efforts to dramatically scale up access to ARVs in the developing world.

The onus is on the government to ensure that the process is rapid, transparent, and not overly cumbersome.

Previously, Canadian law did not require that a drug manufactured solely for export undergo the regulatory approval process that applies to drugs marketed in Canada. Bill C-9 now imposes such a review on any pharmaceutical product manufactured under compulsory licence for export.

In the case of generic medicines being reviewed for Canadian marketing approval, standard practice is to base approval on data showing "bio-equivalence" of the generic product to an already approved brand-name product. But in the case of FDCs for treating HIV/AIDS, there are only three such products on the Canadian market. Two of these (Combivir® and Trizivir®) combine drugs patented by

GlaxoSmithKline; the third (Kaletra™) combines two drugs patented by Abbott. These combination products are important, but are not among those recommended as "first-line" therapy by the WHO for use in developing-country settings. The first-line products are currently only available from generic producers in countries such as India, where the drugs have not been patent protected and where it has therefore been possible to engineer their combination without infringing patents.

Now that Canada has insisted that any generic pharmaceutical produced for export under compulsory licence meet Canadian marketing approval standards, the onus is on the government to ensure that the process is rapid, transparent, and not overly cumbersome – particularly when it comes to enabling the production and export of products such as FDCs, which are a priority in the global effort to scale up treatment access. The issues described above will have to be dealt with via regulations, and via the policies and practices adopted by Canada's drug regulatory authority.

NGO procurement from generic suppliers

Originally, there was no provision in Bill C-9 that would allow an NGO to buy medicines from a Canadian generic producer. Under pressure, the government brought forward an amendment that would have solved this problem. Yet it allowed its own amendment to be largely gutted by one of its own party members at the Committee stage, and then it rejected requests that the amendment be reinstated.

As a result, under the final text of Bill C-9, any NGO in a developing country that wants to purchase medicines from a Canadian generic producer and import them must obtain the

"permission" of the government of that country. "Permission" is not defined.

This requirement applies even if the product is already approved for sale in the developing country by the health regulator, and even if there is no patent barrier to importing the product (either because it is not patented in the country or because the NGO has obtained a compulsory licence from the appropriate authority under the country's legislation that authorizes it to import the product). The requirement creates an additional hurdle that is not required by any WTO obligations, thus further delaying what is supposed to be a rapid response. It also exposes NGOs to political manipulation by governments.

Royalty payable to patent holder

On the positive side, Bill C-9 will likely set a reasonably good precedent in its approach to the royalties payable to a patent holder. The original bill had proposed a standard royalty rate of two percent of the value of the contract to be paid to the Canadian patent holder. The brand-name pharmaceutical companies objected, concerned that this would set a precedent they considered undesirable. Generic producers and civil society organizations found the rate acceptable, but were also agreeable to a sliding scale, as long as the rate in any given case was predictable, and as long as there was an overall cap on the royalty to keep the costs of using this system minimal.

While the details remain to be set out in regulations, the government has committed to establishing a sliding-scale formula linking the royalty rate in any given case to the ranking of the importing country on the UN Development Programme's Human Development Index. The effective cap

will be four percent of the value of the contract for the highest-ranking country. The majority of eligible importing countries rank well below this, meaning royalties in those instances will be significantly lower.

If enacted as promised, this will be a positive feature of Canada's law. Early drafts of the regulations conform, on this point, to what was promised by government representatives before the Parliamentary committee.

Exports to non-WTO developing countries

At the time of the WTO Decision, WTO member countries had been divided into various categories for the purposes of using the Decision to import generic pharmaceuticals.¹⁴

Twenty-three high-income countries agreed to opt out of using the Decision to import generic medicines produced under compulsory licences.¹⁵ Eleven middle-income countries stated that they would only use the Decision to import generic medicines produced under compulsory licence in situations of national emergency or other circumstances of extreme urgency.¹⁶ Ten Eastern European and Baltic countries made a similar statement, further indicating that they would opt out of importing entirely upon acceding to the European Union.¹⁷ This division of WTO members into different categories is reflected in the different country schedules attached to Canada's Bill C-9.

Civil society advocates argued that nothing in WTO law prohibited Canada from implementing the WTO Decision to authorize compulsory licensing of pharmaceuticals for export to *non*-WTO developing countries as well. As a result of that advocacy, the bill sets a positive precedent by affirming that countries implement-

ing the WTO Decision can authorize production of generics for export to non-WTO countries. However, the bill sets out certain conditions.

All the "least-developed countries" (LDCs) currently recognized as such by the UN were included under the bill from the outset, whether or not they belong to the WTO. However, under Bill C-9, a developing country that is neither a WTO member nor an LDC can procure cheaper medicines from Canadian generic producers *only* if:

- it is eligible for "official development assistance" according to the Organization for Economic Cooperation and Development (OECD);¹⁸
- it declares a "national emergency or other circumstances of extreme urgency;" *and*
- it specifies the name and quantity of a specific product needed for dealing with that emergency.

This approach creates an indefensible double standard between developing countries that belong to the WTO and those that do not.

Some provisions of Bill C-9 create an indefensible double standard between developing countries that belong to the WTO and those that do not.

In the negotiations leading to the WTO Decision, developing-country members firmly rejected efforts to limit their use of compulsory licensing to import generic medicines only in "emergency" situations. Health activists also rejected such proposals

as unsound and unethical. The final WTO Decision does not impose such a limitation. It respects members' sovereignty as set out in the TRIPS Agreement and reaffirms the statement in the November 2001 Doha Declaration to the effect that countries are free to determine for themselves the grounds upon which to use compulsory licensing.

For the most part, Bill C-9 does not limit the use of compulsory licensing of pharmaceuticals to only allow exports to countries facing "emergencies."¹⁹ Yet it does impose such a limit on the over 20 developing countries that are neither WTO members nor LDCs. This is at odds with the spirit of the consensus achieved in the WTO Decision and is an embarrassing demonstration of bad faith in the Canadian legislation.

In addition, if a non-WTO developing country or LDC is added in future to the relevant schedule of countries set out in Bill C-9, it must state that it undertakes to adopt the measures set out in the WTO Decision (paragraph 4) aimed at preventing diversion of the product. It must also agree that the product "will not be used for commercial purposes." If the country allows such use, then it may be struck off the list of countries eligible to import medicines from a Canadian generic supplier.

The term "commercial purposes" is undefined in the legislation, but is clearly aimed at limiting the possibility of commercial competition in the importing country's marketplace. This provision would hinder the longer-term benefit that competition could have in reducing medicine prices. It also raises questions about the distribution of imported generics via the private sector (eg, pharmacists) in the importing country. Will this be considered a "commercial purpose"? If so,

this provision fails to recognize the reality that many people in developing countries, as elsewhere, need to turn to private pharmacies when purchasing medicines, which are frequently paid for out of their own pocket rather than covered by a public scheme. This provision is unnecessary under TRIPS and the WTO Decision and should not have been included in the bill.

Price and profit caps

Under Bill C-9, the Canadian patent holder may apply for a court order terminating a compulsory licence or ordering a higher royalty (than what is specified by the sliding scale in the regulations) on the basis that a generic company's contract with a purchaser is "commercial" in nature. In its application to the court, the patent holder must allege that the generic producer is charging an average price for the product that exceeds 25 percent of the patent holder's average price in Canada. If the generic producer can demonstrate, through an audit, that its average price is less than 15 percent above its direct manufacturing costs, the court may not issue such an order.

Although this provision in Bill C-9 is ostensibly aimed at controlling prices charged by generic producers to developing-country purchasers, that objective could have been achieved through other means (such as through conditions imposed in the grant of the compulsory licence itself). This aspect of the law invites vexatious litigation by patent holders, is potentially a disincentive to generic producers using the system, and is not required under TRIPS or the WTO Decision. It should be avoided by other countries enacting similar legislation. Giving further privileges to patent holders to harass generic producers that are issued compulsory licences, and to interfere with production and export of

generic pharmaceuticals to developing countries, is a poor way to follow through on stated commitments to increasing access to medicines for all.

Two-year limit on compulsory licences

Finally, the new law states that a compulsory licence may only be issued for a maximum period of two years.²⁰

After two years, the generic company must apply for a new compulsory licence, based on a new contract, if it wants to be able to manufacture a patented product for export.

To impose this cap restricts the ability of a generic producer to enter into secure supply contracts with developing-country purchasers to a two-year period, even though negotiating longer-term contracts would provide more of an incentive for generic manufacturers to scale up production of a particular product, and would permit greater economies of scale.

This arbitrary cap on the term of a compulsory licence is a negative feature of Canada's law, and should be changed. At the very least, the term of a compulsory licence should be equivalent to the term of the contract that the generic manufacturer has negotiated with a purchaser and that is the basis for its application for a compulsory licence.

Conclusion

Overall, the chief defect of Canada's Bill C-9 is that it falls short of fully reflecting the "flexibilities" allowed under TRIPS and the WTO Decision. The Canadian initiative is an important one in the context of the overall global effort to improve access to medicines, but it can and should be improved. A parliamentary review of the law will occur in two years' time, at which point it may be further amended. In the interim, other coun-

tries moving to implement the WTO Decision should learn from the Canadian experience. Similarly, as the WTO Council for TRIPS discusses some sort of permanent solution to replace the interim waiver in the Decision, the positive and negative features of Canada's law need to be understood.²¹

— Richard Elliott

Richard Elliott is Director of Legal Research and Policy with the Canadian HIV/AIDS Legal Network, which is a founding member of the Global Treatment Access Group, an affiliation of Canadian civil society organizations collaborating to realize the human right to health.

The text of Bill C-9 and most of the additional materials referred to in the article above can be found at www.aidslaw.ca/Maincontent/issues/cts/patent-amend.htm.

¹ The first article in this series was R. Elliott, TRIPS from Doha to Cancún ... to Ottawa: global developments in access to treatment and Canada's Bill C-56, *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 1, 7-18.

² Portions of this article previously appeared, in abridged form, as: R. Elliott, Canada's new patent bill provides a basis for improvement, *BRIDGES Between Trade and Sustainable Development* 2004; 8(5): 19-20, available via www.ictsd.org/monthly/archive.htm.

³ There are some exceptions to this, such as in the case of anticompetitive practices by the patent holder: TRIPS Article 31(k).

⁴ Decision on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health, WTO Document IP/C/W/405.

⁵ For a detailed discussion, see Elliott, *supra*, note 1. See also: R. Elliott, Flirting with flawed patent law amendment, Canada may undermine welcome "Access to Medicines" initiative, *BRIDGES*, No 8, November 2003.

⁶ Most of these materials can be accessed online at www.aidslaw.ca/Maincontent/issues/cts/patent-amend.htm.

⁷ For the transcript of hearings and deliberations of the Committee, see the entry "Patent Act and Food and Drugs Act (amdt.) (Bill C-9)" in the index of the Committee's proceedings at www.parl.gc.ca/InfoComDoc/37/3/INST/Meetings/Evidence/INSTin-E.htm.

⁸ For the reaction of several civil society groups to the amended text, see: Canada proceeds with Bill C-9 on cheaper medicine exports: NGOs say initiative is important, and urge other countries avoid the flaws in the Canadian model. News release, 28 April 2004. Available at www.aidslaw.ca/Media/press-releases/

e-press-apr2804.pdf.; see also Médecins Sans Frontières. Bill C-9: How Canada failed the international community. News release, 28 April 2004.

⁹ An Act to amend the Patent Act and the Food and Drugs Act. SC 2004, c. 23. For a quick summary, see www.parl.gc.ca/37/3/parlbus/chambus/house/bills/summaries/c9-e.pdf.

¹⁰ On the same day, Norway promulgated changes to regulations under its Patent Act to implement the WTO Decision, although with far less detail. The regulations were scheduled to come into force on 1 June 2004. The text is available online at <http://lists.essential.org/pipermail/ip-health/2004-July/006812.html>.

¹¹ Letter from R Zoellick, US Trade Representative to Hon. J Peterson, Canadian Minister for International Trade, 16 July 2004. Available via www.aidslaw.ca/Maincontent/issues/cts/patent-amend.htm.

¹² G McGregor: Drug bill lets "Big Pharma" call the shots: government yields to pressure from Bayer to keep new drug off list of HIV/AIDS program. *Ottawa Citizen*, 4 May 2004.

¹³ For the transcript of House of Commons debates over Bill C-9, see the entry "Patent Act and Food and Drugs Act (amdt.);" in the index to Hansard, the record of chamber business, at www.parl.gc.ca/37/3/parlbus/chambus/house/debates/indexE/p-37-3_-e.htm.

¹⁴ This was reflected in a Chairperson's Statement placed on the record, at the request of the United States, in conjunction with the adoption by the WTO General Council of the Decision itself. The legal status of that Statement remains a matter of debate.

¹⁵ The countries are Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, and United States of America.

¹⁶ The countries are Hong Kong China, Israel, Korea, Kuwait, Macao China, Mexico, Qatar, Singapore, Chinese Taipei, Turkey, and United Arab Emirates.

¹⁷ The countries are Czech Republic, Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovak Republic,

and Slovenia. Accession occurred on 1 May 2004.

¹⁸ In the result, five countries have no option to procure medicines from a Canadian generic supplier while those products remain under patent in Canada: Russian Federation, Ukraine, Belarus, Bahamas, and Libya.

¹⁹ This had been the original intent of the government, but criticism from activists led to a change in the government position that was ultimately reflected in the legislation tabled in Parliament.

²⁰ If the full amount of the product specified in the licence has not been shipped during that period, the licence may be renewed once for up to another two years. However, only one renewal of a licence is permitted.

²¹ On 17 June 2004, WTO Council for TRIPS decided to push back its deadline for adopting a permanent solution to the TRIPS Article 31 (f) problem until March 2005. See: Quiet TRIPS Council focuses on health, biodiversity-related issues. *BRIDGES Weekly Trade News Digest* Vol 8(22): 23 June 2004.

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. Most of the articles for this section were written by David Garmaise, the editor of Canadian News, and Glenn Betteridge, Senior Policy Analyst at the Canadian HIV/AIDS Legal Network. Information about occasional correspondents is provided with their contribution. Address correspondence to David Garmaise at dgarmaise@rogers.com. Glenn Betteridge can be reached at gbetteridge@aidslaw.ca.

Ontario: Police disclose HIV status of accused under Police Services Act

In Ontario, people suspected of or charged with aggravated assault for exposing another person to HIV through unprotected sexual intercourse risk not only a criminal conviction but also having their names, dates of birth, descriptions, photographs, addresses, sexual history, employment information, and HIV status made public. This disclosure without the consent of the person suspected or charged has usually taken the form of a “public safety advisory.” To date, at least five such advisories have been released by police services across Ontario.¹

All five advisories concern males who had been criminally charged as a result of not disclosing their HIV-positive status before having unprotected sexual intercourse with females. Each advisory identified the person charged as HIV-positive, and included at least his name, age, and a photo. In each case the photo, along with other personal information, was published by the media. In some advisories, sexual partners are advised to seek HIV test-

ing. In others, the police are encouraging people who had sexual relations with the person charged to contact police.

Authority under Police Services Act and regulations

Prior to 1997 amendments to the Police Services Act (PSA)² made by the former Progressive Conservative government, there was no authority to

release this kind of identifying information about people who had been charged with, but not yet convicted of, a crime.

Since that time, the PSA and regulations have authorized the police chief to disclose personal information about a person charged with a crime as long as the disclosure is made for one or more of the purposes listed in the PSA.³ These purposes include protection of the public; protection of

victims of crime; law enforcement; enforcement of, and compliance with, any federal or provincial law or program; and keeping the public informed of the law enforcement, judicial, or correctional processes respecting any individual.⁴

Under section 3 of the regulation, where someone is charged, convicted, or found guilty of an offence but does not have a previous conviction and does not pose a significant risk of harm, the police chief may disclose only the person's name, date of birth, and address, and may release information about the charges laid and the judicial proceedings that followed.⁵

However, where an individual has previously been convicted or found guilty under any federal or provincial act, and the police chief reasonably believes both that the individual poses a significant risk of harm to other persons or property and that disclosure will reduce that risk, under section 2 a police chief can release *any* information about that individual.⁶ Under this section, the police chief can release information even if the person has not been charged with an offence. Advisories released under this section have included photos, details of employment, and private health information such as HIV status.

Legal issues for people living with HIV/AIDS

The disclosure of *any* personal information authorized under section 2 of the regulation raises a number of significant legal issues for people living with HIV/AIDS. First, section 2 arguably offends the constitutional guarantee of the presumption of innocence when applied to a person who is being investigated for or charged with, but not found guilty of, an offence. The publication of photos of, and other personal information on,

people subject to criminal investigation or charges can have devastating effects on the lives of individuals that effectively amount to punishment.

For example, people living with HIV/AIDS have lost housing, employment, and personal relationships, and have even been subject to violence when their HIV status becomes known. Under the PSA the police chief is required to consider, among other factors, "what is reasonable in the circumstances, what is consistent with the law and the public interest and what is necessary to ensure the resolution of criminal proceedings is not delayed."⁷ The chief is not required to consider the potential negative consequences to the person accused of the crime when determining whether or not to release the information.

The publication of photos of, and other personal information on, people who have been charged can have devastating effects on their lives.

While there may be occasions where the threat to the public safety warrants the release of personal health information such as HIV status before a criminal trial, the decision to release such information should only be made by a court that has considered the available evidence and balance the likelihood of harm to the public with the likelihood of harm to the individual.

Indeed, in two cases where the police sought search warrants to seize medical records, Ontario courts have held that in determining whether or not to grant the warrant, a court must

adequately balance the competing public and private interests.⁸ In *Serendip Physiotherapy* the court held that "all health information should be presumptively protected" and that the onus should be on the police to prove to a judicial officer the necessity of the information.⁹ The analysis of the privacy interests at stake in *Serendip Physiotherapy* is applicable to the health information released by the police in public safety advisories.

The Ontario cases highlight the important supervisory role of courts, which are accustomed to balancing individual constitutional rights (in this case, the right to privacy and the presumption of innocence) with public safety concerns. Police, who are charged with investigating crimes and arresting accused, lack the legal knowledge and training to make important decisions involving fundamental rights.

A second and related issue is the over-inclusiveness of the disclosure provisions of the PSA and regulations. The power to release any personal information, including health information, depends in part upon the person having been previously convicted or found guilty under *any* federal or provincial act. (The police chief must also believe that the person poses a significant risk of harm to another person or property, and that the disclosure would reduce the risk of harm.)

Thus, people who have been convicted of ticket scalping (under the Ticket Speculation Act¹⁰) or of attempting to approach a motor vehicle to solicit business (under the Highway Traffic Act¹¹) and who are subsequently suspected of aggravated assault for having unprotected sexual intercourse without disclosing their HIV status, could find their name, picture, and health information revealed in a police advisory.

The threshold of “any conviction” is too low, given the sensitive personal information that can be disclosed, and is not rationally connected insofar as the past conviction need not be related to the current investigation or charges that underpin the disclosure.

Third, advisories under section 2 are being used for purposes other than those permitted by that section. The regulation authorizes the disclosure of personal information only if the chief

Police lack the legal knowledge and training to make important decisions involving fundamental rights.

of police reasonably believes that the disclosure will reduce a significant risk of harm to other persons or property. It follows that the police chief’s power should be exercised only to limit the risk to individuals or property.

However, some of the advisories indicate that the police are looking for assistance in building the case against the accused and ask for sexual partners and witnesses to contact the police. Indeed, one advisory was published while the individual charged was in custody and presumably no longer a danger to members of the public.

Perpetuating and promoting stigma and discrimination?

Arguably, the publication by Ontario police of these advisories contributes to the climate of stigma and discrimination experienced by people living with HIV/AIDS by contributing to assumptions about the “threat” that people with HIV/AIDS present to the community at large. The public warnings may fuel the perception among the population at large that people living with HIV/AIDS act in a deviant and criminal manner and in doing so expose others to HIV infection.

These perceptions may serve to increase the feeling of alienation among a community of people, many of whom are already marginalized on the basis of other socially determined identities. As a result, people with HIV/AIDS may be extremely reluctant to disclose their HIV status to family or friends, thus potentially losing the benefit of their support. Or they may be reluctant to access health-care benefits and services, or other supports.

The potential adverse consequences of the advisories, including the potential for violence against the person who was a subject of an advisory, has not been lost on at least one police service. One advisory concludes with the following paragraph: “Although Mr [X] poses a risk to members of our community he is still

a citizen of Canada and has guaranteed rights under the Charter. As such the North Bay Police Service will also act to protect these rights if infringed.”

– Tamara Katz and Glenn Betteridge

Tamara Katz is a student at New York University School of Law who spent the summer of 2004 as an intern at the HIV & AIDS Legal Clinic (Ontario). She can be reached at tk570@nyu.edu.

¹ HIV-positive London, Ont man charged for not telling partners of disease. Canadian Press Newswire, 17 April 2003; North Bay Police Service. Public Advisory, 23 February 2004; S McKeown. Police fear man with HIV has “a lot of victims.” *National Post*, 11 March 2004; K Patrick. HIV alert sent to police worldwide. *Windsor Star*, 11 June 2004; TO police seek victims of HIV-positive man. CTV.ca, 31 August 2004. The advisories are often posted on the website of a police service, but may not be archived or otherwise available for future reference.

² RSO 1990, c P15 [hereinafter PSA].

³ See generally O Reg 265/98 (Disclosure of Personal Information).

⁴ PSA at para 41(1.1).

⁵ O Reg. 265/98 at ss 3(1), 3(2).

⁶ *Ibid* at s 2(1).

⁷ *Ibid* at s 6.

⁸ See *R v JO*, [1996] OJ No 4799 (SC)(QL) at para. 6; *R v Serendip Physiotherapy Clinic*, [2003] OJ No 2407 (SC)(QL) at para. 41.

⁹ *Serendip Physiotherapy*, *ibid* at para 60.

¹⁰ RSO 1990, c T7.

¹¹ RSO 1990, c H.8, s 177.

BC: Campaign launched to protect personal health information

A diverse group of rights, health, union, and HIV/AIDS organizations has launched a province-wide campaign to demand that the British Columbia government cease contracting out the administration of its medical plans to a private US company. The Right to Privacy Campaign (RPC) believes that the government's contract with Maximus Inc. places British Columbians' confidential health and related information within easy reach of US government agencies as a result of provisions in the USA PATRIOT Act and other US legislation.¹

In March 2004 the BC government announced that it had selected Maximus to handle the administration of its Medical Services Plan (the public general medical insurance plan) and Pharmacare (the public drug insurance plan).

The USA PATRIOT Act provides US intelligence and law enforcement agencies with extraordinary surveillance and police powers in order to combat terrorism. The Act contains provisions that allow the Federal Bureau of Investigation (FBI) to force the disclosure of medical and health records.²

Organizations participating in the RPC include the BC Persons with AIDS Society, the Victoria AIDS Respite Care Association, the BC Civil Liberties Association, the BC Coalition of People with Disabilities, the BC Federation of Labour, the BC Freedom of Information and Privacy Association, and the BC Health Coalition.

The Maximus agreement is of special concern to people living with HIV/AIDS. "American law bans HIV-positive people," said Glen Bradford, then Chairperson of the British Columbia Persons with AIDS Society, in June 2004. "We can't legally go there for work or business purposes. If the BC government

turns our health records over to Maximus, it would be a simple matter for the FBI to identify HIV-positive British Columbians and, under the provisions of the [US] Homeland Security Act, turn that information over to US Customs and Immigration authorities."³

BC Health Coalition Coordinator Terrie Hendrickson said that the Maximus deal affects "not only ... one of the most important rights Canadians hold, which is the confidentiality between patients and doctors but also ... the ability of governments to protect the rights of [its] citizens and to ... make public policy decisions without the influence of other governments ... or private companies."⁴

In October 2004 the RPC presented a petition with over 50,000 names to opposition members of the BC Legislature, opposing the contracting out of medical plan administration to private companies. The petition included both paper and online signatures.⁵

Also in October 2004, a report issued by the BC Office of the Information and Privacy Commissioner concluded that while the outsourcing of private services is not prohibited by BC legislation, because there is a "reasonable possi-

bility" of unauthorized disclosure of British Columbians' personal information under the USA PATRIOT Act, "rigorous other measures must be put into place to mitigate against illegal and surreptitious access." The report contained 16 recommendations designed to protect British Columbians' personal information in the possession of private contractors from being disclosed to the FBI.⁶

In November 2004 the RPC endorsed the 16 recommendations of the Privacy Commissioner and called on the government to suspend all further contracting out of management services to US-linked companies until all of the recommendations are implemented.⁷

BC Health Minister Colin Hansen told the media that the contract with Maximus addresses all of the recommendations of the Privacy Commissioner.⁸ In a news release issued on 4 November 2004, BCPWA Chairperson Paul Lewand said that the Minister's contention was "simply wrong" and called on the government to cancel its contract with Maximus.⁹

– David Garmaise

¹ Right to Privacy Campaign launched to protect individuals' privacy by stopping Maximus deal. News

release, Right to Privacy Campaign, 21 June 2004. Available at www.righttoprivacycampaign.com/NewsRel/NewsReleases/RPC/NewsRelease%2004-06-21.pdf.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Privacy Campaign presents 50,000-name petition opposing contracting out of Medicare and Pharmacare

administration. News release, Right to Privacy Campaign, 25 October 2004.

⁶ Report on privacy implications of the USA PATRIOT Act released. News Release, Office of the Information and Privacy Commissioner for British Columbia, 29 October 2004. Available at [www.oipcbc.org/news/rtsngen/Patriot%20Act%20\(FINAL\)%20OCT2904.pdf](http://www.oipcbc.org/news/rtsngen/Patriot%20Act%20(FINAL)%20OCT2904.pdf). The full report is available at www.oipc.bc.ca/sector_public/usa_patriot_act/pdfs/report/privacy-final.pdf.

⁷ Statement by the Right to Privacy Campaign. Undated. Available at www.righttoprivacycampaign.com/endorsementLetter.pdf.

⁸ Health Minister says medical information safe. CTV News (online), 4 November 2004.

⁹ AIDS group calls MAXIMUS deal "a betrayal." News release, British Columbia Persons With AIDS Society, 4 November 2004. Available at www.bcpwa.org/pdf/news_maximus.pdf.

Nova Scotia: "Blood samples" legislation passed

On 18 October 2004 the Nova Scotia legislature passed the Mandatory Testing and Disclosure Act,¹ thus becoming the third Canadian province or territory to pass similar legislation.²

The Nova Scotia Act, which originated as a private member's bill, sets out a procedure under which certain people (including victims of crime, Good Samaritans, firefighters, peace officers, police officers, and persons employed in correctional services) who have come into contact with the bodily substances of another person, and as a result may have been exposed to an agent that causes a communicable disease, may apply to the Supreme Court of Nova Scotia for an order that the other person submit to medical testing. (Under the Ontario and Alberta legislation, an application is made to a medical officer of health.)

The application must set out the circumstances of the exposure, be accompanied by a physician report, and meet other specified conditions. Before issuing an order, a court must be satisfied of a number of conditions, including that there are reasonable

grounds to believe that the person making the application might have become infected, and that the testing order is necessary to decrease or eliminate the risk to the health of that person.

The Act provides a limited right to appeal a court-ordered test, and the possibility of halting the order until the appeal can be heard by the Court of Appeal. The Act also contains privacy protections for the health information of both the person who has applied for the order and the person who is ordered to provide a sample. The Nova Scotia statute is the first legislation based on model legislation developed by the Uniform Law Conference of Canada.³

The communicable diseases covered by the Act will be specified in regulations, and will likely include HIV/AIDS and various types of hepatitis.

The Nova Scotia Advisory Commission on AIDS presented a

brief to the legislative committee responsible for reviewing the legislation, suggesting a number of amendments. Only minor changes were made to the bill as a result of the committee's review. Throughout the legislative debate, no members of the assembly spoke against the legislation, which had the support of all parties. The Act will come into force on a day determined by the cabinet, presumably after regulations have been developed.

— Glenn Betteridge

¹ Bill 125: Mandatory Testing and Disclosure Act. 59th General Assembly, 1st Session (2004); SNS c 29.

² See R. Carey, Ontario: People can now apply for forced HIV testing in certain situations. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 25-27; R. Scheer, Alberta: "Blood Samples" act passes third reading. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 28.

³ For more information about the Uniform Law Conference of Canada, see www.ulcc.ca/en/home/.

British Columbia: Studies show positive public impacts of harm-reduction measures for drug users

Two recent studies from the BC Centre for Excellence in HIV/AIDS show that HIV prevention measures for IV drug users increase public order, and can potentially save substantial public resources.

In the first study, researchers concluded that the provision of harm-reduction and treatment measures aimed at reducing HIV transmission in Vancouver's Downtown Eastside (DTES) could save up to \$133 million in treatment costs.¹ The second study, the first evaluation report of Insite, North America's only medically supervised safe injection site for illicit drug users, showed that the opening of the site has been independently associated with increases in public order, including fewer publicly discarded syringes.²

Cost of treatment and costs of inaction

The DTES is home to an estimated 5000 people who inject illicit drugs. The estimated HIV prevalence rate among this group of people is 31 percent. In other cities with more mature HIV epidemics driven by injection drug use, HIV prevalence rates are as high as 50 percent.

The researchers used a mathematical model to estimate the costs associated with treating HIV-infected drug users in the DTES at the current HIV prevalence rate and at the "mature" rate. Based on an estimated lifetime cost of \$150,000 to treat a person

with HIV, the researchers estimated a cost of \$216 million to treat people already infected, and of \$349 million to treat people if the infection rate rises to 50 percent, a difference of \$133 million.

The researchers stated that "it is likely that expanding effective interventions, such as addiction treatment, supervised injection facilities and syringe exchange programs, to reduce the further spread of HIV would likely be highly cost effective."

The researchers concluded that the results of their study should be seen as a "caution to health policy makers" against inaction, and that a failure to act would lead to "enormous medical expenditures [being] required to treat the HIV epidemic among injection drug users" in Vancouver.

Safe injection site leads to improvements in public order

On 22 September 2003 the first supervised safe injection site was opened in Vancouver's DTES. Since that time, on average more than 500 people have used the site each day to inject illicit drugs obtained elsewhere. The research team studied measures of public disorder for three weeks before

and 12 weeks after the opening of the facility.

The researchers found significant reductions in public injection drug use, publicly discarded syringes, and injection-related litter (syringe wrapper and caps, sterile water containers and cookers) associated with the operation of the facility. They report that these findings are consistent with anecdotal reports of improved public order by police and other agencies in the neighbourhood.

The researchers conclude that the study findings should have "substantial relevance to many urban areas where public injection drug use has been associated with substantial public health risks and adverse community impacts."

— Glenn Betteridge

¹ L. Kuyper, R. Hogg, J. Montaner, M. Schechter, E. Wood. The costs of inaction on HIV transmission among injection drug users and the potential for effective interventions. *Journal of Urban Health* 2004; 81(4): 655-660.

² E. Wood, T. Kerr, W. Small, K. Li, D. March, J. Montaner, M. Tyndall. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Canadian Medical Association Journal* 2004; 171(1): 731-734.

Nurse, legal society receive human rights award

The 2004 Canadian Awards for Action on HIV/AIDS and Human Rights have been presented to Megan Oleson, a Vancouver nurse who set up a temporary, unauthorized safe injection site (SIS) for intravenous drug users in the Downtown Eastside; and to the Pivot Legal Society (PLS), also of Vancouver. The PLS worked with Oleson to set up the temporary site while Canada's first legal SIS was still under construction.

The awards were established in 2002 by the Canadian HIV/AIDS Legal Network and Human Rights Watch to highlight outstanding contributions that decrease vulnerability to HIV/AIDS and protect the rights and dignity of those infected and affected.¹

Oleson worked tirelessly to protect and promote the health and human rights of the most vulnerable residents of Vancouver's Downtown Eastside. As a member of the Anti-Poverty Committee and the Vancouver Area Network of Drug Users (VANDU), Oleson spearheaded various actions to address the issues that continue to

plague the Downtown Eastside: lack of access to harm-reduction measures, lack of appropriate housing, poverty, and police brutality.

During the large-scale police crackdown on local drug users in the spring of 2003, Oleson acted quickly to organize local activists and drug users to establish the unauthorized SIS at 327 Carrall Street. The site would not have been possible without Oleson, who supervised injections, taught drug users about safe injection practices, and referred individuals to available health and social services.

The PLS is a non-profit organiza-

tion that uses law reform, legal education, and strategic legal action to advance the interests and improve the lives of marginalized people in new and innovative ways. Formed in the fall of 2000, Pivot works with few resources, but with great vision and dedication, to address the legal and human rights challenges faced by sex workers, drug users, and the homeless in Vancouver's Downtown Eastside.

For further information, see www.aidslaw.ca/Maincontent/awards.htm.

¹ See also "Thai Drug Users' Network receives human rights award" in the International News section of this issue.

Proposed amendments to medical marijuana regulations released for comment

On 23 October 2004, Health Canada released proposed amendments to the **Marihuana Medical Access Regulations (MMAR)** for public comment.¹ The amendments are intended to respond to consumer concerns about the onerous bureaucratic requirements for obtaining legal permission to possess and cultivate marijuana for medical purposes, and to address the need for a safe, reliable, legal source of medical marijuana. Under the proposed amendments, police forces throughout Canada will be able to access limited information about people authorized to possess marijuana, people licensed to produce marijuana, and legal grow operations.

According to Health Canada, as of September 2004, 757 persons were authorized to possess marijuana, and

553 persons were licensed to produce marijuana, for medical purposes.² However, evidence brought forward

in a number of high-profile court cases has pointed to serious problems with the federal government's system

that permits people to legally obtain and possess marijuana for medical purposes.

As recently as October 2003, the Ontario Court of Appeal ruled that certain of the MMAR's eligibility requirements and the MMAR's limits on legal sources of marijuana were unconstitutional and struck down those provisions.³ In response, Health Canada amended the MMAR in December 2003.

The amendments released for consultation on 23 October of this year are a "second phase ... based on a broader review of the MMAR to address issues expressed by Health Canada's stakeholders in the medical marijuana program and involved in a comprehensive consultative process."⁴ Stakeholders included groups and individuals representing patients, physicians, pharmacists, nurses, and law enforcement agents.

The proposed amendments:

- reduce the categories of symptoms under which a person may

apply to use marijuana for medical purposes from three to two;

- reduce the gatekeeping role of physicians and eliminate the requirement of specialist physician approval;
- streamline the application and reapplication process by reducing the documents required;
- give authority to Health Canada to communicate limited information to police, but do not permit the disclosure of medical information; and
- provide the framework to set a pilot project for the distribution of marijuana through pharmacies.

While the proposed amendments move the distribution of medical marijuana toward a more traditional health-care model, the issue of cost to the consumer has not moved in that direction. Consumers of medical marijuana remain solely responsible for the cost of their marijuana, without consideration of their ability to pay, and without federal or provincial pharmacare for medical marijuana.

People who wished to make comments on the regulatory amendments had 30 days to do so. However, in light of the extensive consultation and drafting that went into developing the amendments, it is likely that they will be brought into force without any significant amendments.

– Glenn Betteridge

¹ Regulations Amending the Marihuana Medical Access Regulations, Canada Gazette Part I (23 October 2004) at 2930-2951. Available via <http://canadagazette.gc.ca/partI/2004/20041023/pdf/g1-13843.pdf>. The Marihuana Medical Access Regulations came into force on 14 June 2001 (SOR/2001-227) and were amended for the first time on 3 December 2003 (SOR/2003-387).

² See Office of Cannabis Medical Access website at www.hc-sc.gc.ca/hecs-sesc/ocma/stats/2004/sept/stats_sept-04.htm.

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

⁴ Canada Gazette Part I, supra, note 1 at 2932.

In brief

MP calls for review of solicitation laws

There is an urgent need to review Canada's solicitation laws, according to Libby Davies, Member of Parliament for Vancouver East, and the New Democratic Party's House Leader and Social Policy critic.

Davies wrote to Minister of Justice Irwin Cotler in September 2004 ask-

ing him to re-strike the House of Commons Sub-Committee on Solicitation Laws. The sub-committee met briefly in 2003, but was automatically dissolved when Parliament was prorogued in November 2003.

In her letter to Cotler, Davies said that "sex trade workers across Canada face grave danger and often death," and that "the current criminalization of sex trade workers ... dis-

courages or prevents women from contacting the police when their safety is in jeopardy." In the meantime, Davies said, the federal government should place a moratorium on the enforcement of the communicating and solicitation laws under the Criminal Code.

– David Garmaise

Vancouver: Gay posters banned by billboard company

In June 2004 the CBC reported that Pattison Outdoor, a billboard company owned by Vancouver businessman Jimmy Pattison, refused to run advertisements prepared by Health Canada targeting gay men. The posters, which depict gay men in suggestive poses, are aimed at reducing the rate of unprotected sex in the gay community.¹

According to an AIDS Vancouver worker, a representative of Pattison Outdoor said that the messages and visuals were inappropriate for its environment. The CBC story adds that Pattison is well known for his conservative political and religious views.

Despite the ban imposed by Pattison, the ads were scheduled to run all summer on billboards owned by another company, Viacom, in six Canadian cities.

Groups distribute harm-reduction kits to crack users

Organizations in several Canadian cities have begun distributing harm-reduction kits for crack users.

The *Winnipeg Free Press* reported in September 2004 that the group Street Connections has been distributing kits consisting of glass tube pipes, cleaners, alcohol swabs, matches, lip balm, and an instruction pamphlet, as well as chewing gum to prevent teeth grinding. The Winnipeg program is modeled on a similar one in operation in Toronto.

The *Vancouver Sun* reported in November 2004 that the Rock Users

Group (RUG), which is affiliated with the Vancouver Area Network of Drug Users (VANDU), began distributing similar kits to smokers in the Downtown Eastside.

Many people who do crack use very poor equipment, which can lead to burns, cuts, and sores on their lips. This, in turn, can increase the chances of acquiring HIV and hepatitis C, and other harms.²

VANDU, RUG, and other organizations have called for the creation of a safe inhalation room for crack users within Insite, the safe injection facility established in the Downtown Eastside in September 2003. A spokesperson for the Vancouver Coastal Health Authority, which operates the site, said that there is currently no legal provision that would permit a safe inhalation site, and that the federal government would have to provide an exemption to allow one to operate.

– David Garmaise

The reports in the *Winnipeg Free Press* and *Vancouver Sun* are cited on the website the Drug War Chronicle at <http://stophthdrugwar.org>.

British Columbia study finds high levels of poverty and disability among HIV-positive

A survey of people living with HIV/AIDS in British Columbia has found that nearly 50 percent of them are living below the poverty line.³ The survey also revealed that people living with HIV experience a wide array of impairments that limit their ability to participate in daily activities and function in various roles, including social, student, sexual, and cultural roles.

The results of the survey, which was conducted in 2002, were released in August 2004 by the British Columbia Persons with AIDS Society (BCPWA) and the British Columbia Centre for Excellence in HIV/AIDS. The study is the largest undertaken to date in Canada assessing the impact of HIV, and the medications used to treat HIV infection, on a person's ability to function and level of disability.

The study results are based on an anonymous questionnaire mailed out to 1508 BCPWA members, 762 of whom completed and returned the questionnaire. Respondents were predominantly male (90 percent) and white (86 percent). Eighty percent reported being unemployed at the time of the survey.

Nine out of ten people surveyed reported one or more symptoms associated with impairment, and one or more participation restrictions, while 58 percent reported being diagnosed with depression by their doctor. The report calls for "innovative programs that help people living with HIV to adapt to their illness and keep them engaged in life."

– Glenn Betteridge

Health Canada approves rapid HIV test for sale in Canada

On 12 October 2004 the Medical Devices Bureau of the Therapeutic Products Directorate, Health Canada approved for sale in Canada a rapid test for HIV antibodies.⁴ The test detects HIV antibodies in blood plasma or serum in under three minutes, and is intended for use in clinical settings. It is the only rapid HIV-antibody test currently approved for sale in Canada.

MedMira is the Nova Scotia-based producer of the test.⁵ The US Food and Drug Administration and the State Food and Drug Administration in the People's Republic of China have approved similar rapid HIV test products by MedMira.

MedMira's is not the first rapid HIV-antibody test approved for use in Canada. In 2002, Health Canada issued a Product Advisory in relation to another manufacturer's rapid HIV test, BioChem ImmunoSystems' Fast-Check HIV-1/2 tests due to the potential for false negative results.⁶ The manufacturer agreed to stop offering the test for sale in Canada.

The introduction of rapid testing technology raises numerous legal and ethical concerns. The Canadian HIV/AIDS Legal Network has analyzed these concerns and made recommendations for the appropriate use of rapid HIV-antibody testing.⁷

– Glenn Betteridge

¹ Pattison company rejects AIDS ads. CBC (online), 15 June 2004.

² Fact Sheet: Health Issues Affecting Crack Smokers. Safer Crack Use Coalition. Available at www.canadianharmreduction.com/readmore/FShealthissues-revised.doc.

³ *HIV associated disability among people living with HIV in British Columbia*. Vancouver: British Columbia Centre for Excellence in HIV/AIDS and British Columbia Persons with AIDS Society, 2004. For more information on the study, please contact Lisa Gallo, Director of Communications and Education at 604.893.2209 or 604.612.0222 or email info@bcpwa.org.

⁴ Health Canada maintains a Medical Devices Active Licence Listing (MDALL). The MDALL contains product-specific information on medical devices that are licensed in Canada, including the date of issue of the licence. To access the MDALL, see www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/mdlic_e.html.

⁵ To see MedMira's press release regarding the Health Canada approval, see www.medmira.com/prs/2004/20042110.pdf.

⁶ See www.hc-sc.gc.ca/english/protection/warnings/2002/2002_31e.htm. See also: D Garmaise. Inaccurate results lead to removal of rapid HIV tests. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1): 40.

⁷ R Elliott, R Jürgens. *Rapid HIV Screening at the Point of Care*. Montréal: Canadian HIV/AIDS Legal Network, 2000. Available at www.aidslaw.ca/Maincontent/issues/testing/finalreports/tofc.htm.

INTERNATIONAL NEWS

This section provides brief reports on developments in HIV/AIDS-related law and policy outside Canada. 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.

HIV/AIDS, law, and discrimination in Guyana

In June 2004 the Guyanese National AIDS Committee completed a comprehensive national assessment on HIV/AIDS, law, ethics, and human rights – the first to be completed under the Pan-Caribbean Partnership against HIV/AIDS (PANCAP) Project on Law, Ethics and Human Rights.¹ In this article the author of the report, Arif Bulkan, reviews the application of Guyanese law to HIV/AIDS-related discrimination, and notes the considerable gap between law and practice.

There is a substantial body of anti-discrimination law in Guyana, contained in both the Constitution and in statutes that seek to address specific equality issues. At the highest tier, the Constitution prohibits both discriminatory laws and discriminatory treatment by the state and its agents. This provision was modeled on a similar one in the European Convention on Human Rights and is replicated throughout the Commonwealth Caribbean (with the notable exception of Trinidad and Tobago), though recent amendments to our Bill of Rights have involved significant changes to this article.

Under the Constitution, merely different treatment is not prohibited. Rather, what is made unlawful is different treatment motivated by certain forbidden grounds. These grounds were expanded in 2003 and include the following: race, place of origin, political opinion, colour, creed, age, disability, marital status, sex, gender, language, birth, social class, pregnancy, religion, conscience, belief, and culture. Notably, this list does not include HIV/AIDS (though that is possibly captured by “disability”) or sexual orientation. The constitutional provision addresses state action, not private actors.

The coverage of the provision is unrestricted, in the sense that it renders unlawful discriminatory laws and treatment in any area, including the provision of health care, social security, employment, and access to goods and services. The guarantee is subject to a number of exceptions relating to non-Guyanese citizens, matters of personal law, and standards regarding employment. There are also exceptions that are unrestricted in scope, such as, for example, different treatment authorized due to the “special circumstances” of an unspecified class. In the absence of guidelines and standards regarding the

operation of this provision, it confers immense discretion upon legislators.

In 2003 the Bill of Rights was amended to include a number of other equality rights. This was all part of the constitutional reform process, which was initiated after events that had severely disrupted the country following the 1997 general elections. On a superficial reading, it would seem that these new rights strengthen the non-discrimination regime in Guyana, but in reality their impact is likely to be negligible. However, rights guaranteeing free choice of employment, equality of all persons before the law, equality of birth status, and equality for women could prove useful in the context of HIV/AIDS-related discrimination.

Other statutes in Guyana address equality issues, and these are important as they apply to both state and private actors. The Equal Rights Act (1990) guarantees equality for women. The Prevention of Discrimination Act (1997) prohibits discrimination in employment-related matters. The Occupational Safety and Health Act (1997) imposes substantial duties on employers regarding the provision of information, infection controls, and occupational health services for workers.

In addition to these laws, Guyana initiated a National Policy on HIV/AIDS in 1995 that was adopted by Parliament in 1998. This policy subscribes to a progressive, rights-based approach to HIV/AIDS issues, and was the fruit of the advocacy of many individuals and organizations such as the Guyana Human Rights Association. The policy emphasizes the right of all people living with HIV/AIDS to the best quality of health care available without discrimination on a number of grounds, including that of sexual orientation. The

policy also articulates a number of rights of persons living with HIV/AIDS in the area of employment, their social and employment environment, health and educational facilities, housing, and access to goods and services.

The policy articulates a number of rights of persons living with HIV/AIDS in the area of employment, health and educational facilities, housing, and access to goods and services.

Application of Guyanese laws prohibiting HIV/AIDS-related discrimination

There are a number of positive features in the response to HIV/AIDS in Guyana. Most notable is the availability of free antiretroviral (ARV) medication to all people living with HIV/AIDS, without discrimination. This program began in Georgetown in April 2002; as of the end of 2003, 260 people were receiving treatment.

In 2003 the National AIDS Programme Secretariat (NAPS) conducted training of doctors from other regions of Guyana; the program has since expanded to cover some of these regions. In this sense Guyana certainly stands out from many countries in the Commonwealth Caribbean, where in some instances persons living with HIV/AIDS have had to resort to the courts in order to access treatment.

Another crucial element in the response to the HIV/AIDS epidemic in Guyana is the existence of the National AIDS Committee (NAC), which is buttressed around the coun-

try by local groups called Regional AIDS Committees (RACs). The NAC, which was formed to promote HIV/AIDS policy and advocacy issues, has been instrumental in spearheading the entire national assessment process. Other useful functions of the NAC and RACs are monitoring government efforts, strategizing, raising HIV/AIDS awareness in far-flung communities, and helping overall in containing the spread of the disease.

All is not positive, however. In the first place, there is an overwhelming *perception* of discrimination harboured by persons living with HIV/AIDS. The result of this has been as damaging as if such discrimination actually existed, for it has led to a climate of secrecy and silence around the disease. In several instances encountered, people do not even access treatment services (even though these are free) or other support services for fear of being identified as HIV-positive.

HIV/AIDS counsellors identify the most common area of discrimination as being in relation to employment. There is, for instance, a significant amount of HIV screening in practice – among fast-food places and in other professions. Also, some major companies require an HIV test as part of their medical examination, but it remains unclear for what purpose and how results are treated.

Discrimination in relation to private insurance is practised openly. Where policies are sought above a certain level, an HIV test must be taken, and the market practice across the board is to refuse coverage if the applicant tests positive.

Instances of discrimination in the delivery of health care were also recounted during the assessment. Some health-care workers remain reluctant to interact with patients with

HIV/AIDS. Further studies are needed to establish the extent of such discrimination, but counsellors related many incidents which suggest that although attitudes may be changing, considerable ignorance and prejudice still surround the disease.

Stigma is still widespread. Although the situation is improving, it still manifests itself in communities and even within families, and this is most obvious in the tremendous silence that still surrounds an HIV diagnosis.

Among groups popularly associated with HIV, stigma and discrimination are rampant. One counsellor staffing an HIV hotline for the past four years stated that HIV and homosexuality are a “double jeopardy,” and said that over the years many stories were recounted to him of discrimina-

tion on the grounds of both homosexuality and HIV.

Again, it is difficult to assess the true extent of this problem in the absence of focused studies, and also because of the reluctance of victims to publicize their status. But that this is a significant problem is undeniable. This is most evident in the fact of the utter absence of any support groups for homosexuals, the lack of any programs targeting homosexuals, and the reality that these activities exist on the margins of the society.

Conclusion

There are many laws that guarantee non-discrimination in Guyana and the country subscribes to many progressive policies. However, the reality is quite different and there remain many

areas in which discrimination flourishes. The silence that accompanies HIV status must be broken so that issues of stigma and discrimination can be confronted, and so that persons living with HIV/AIDS can access the best available level of treatment and care.

– Arif Bulkan

Arif Bulkan (abulkan@yorku.ca) is an attorney-at-law in Guyana and a doctoral student at Osgoode Hall Law School, York University, Canada.

¹ A Bulkan, National Assessment on HIV/AIDS, Law, Ethics and Human Rights. National AIDS Committee (Georgetown, 2004). Available on the CARICOM website in the PANCAP section (www.caricom.org); see also the Legal Network website (www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach/international.htm).

Policy and environment assessment on illicit drug use and HIV risk in Cambodia

Research on the extent of illicit drug use and its consequences for HIV risk in Cambodia has revealed that government, NGO, and health-care systems in that country are unequipped to deal with HIV/AIDS epidemics among injecting drug users.

The availability of amphetamine-type stimulants (ATS) has risen dramatically in Cambodia in the past five years, and injecting heroin use has increased in its capital city, Phnom Penh. There is little detailed information about drug use and HIV risk in Cambodia, but surveys of street children and middle-class youth show an increase in illicit drug use, primarily ATS,

throughout the country.

In late 2003 the POLICY Project undertook a research project. Legal, policy, and programmatic environments were assessed, as were barriers to overcoming illicit drug-related HIV risk. A two-day national workshop was held with participants from government and NGOs working on HIV/AIDS and drugs, with partici-

pants assessing policy options for priority and feasibility.

This research found that government drugs and HIV structures had no joint policy or planning processes and that the risk and transmission of HIV related to drug use were not systematically addressed under existing structures, strategies, and activities.

The policy assessment recommended the following actions:

- Government structures dealing with HIV/AIDS and people dealing with illicit drug use should hold regular joint meetings.
- Aspects of the legal and policy environment, such as the status of needle and syringe programs, should be clarified. Laws, policies, and programs addressing HIV/AIDS should incorporate the issue of illicit drug-related HIV risk, and those addressing illicit drug use should also address HIV risk.
- HIV/AIDS organizations need access to technical assistance and capacity-building resources on drugs.
- A pilot needle and syringe program is needed, as one element of a comprehensive harm-reduction strategy for illicit drug use, to assess the effectiveness of such programs in reducing drug-related HIV transmission and other drug-

related harms in Cambodia.

- Access to appropriate detoxification, treatment, and rehabilitation services that incorporate international best practice for users of ATS, inhalants, and opiates need to be expanded.
- In-country research and epidemiological surveillance need to be expanded.

Some progress has been made in implementing these actions. For example, joint meetings involving government and people dealing with illicit drug use began in January 2004 and are now occurring on a regular basis to develop and implement a joint workplan. As well, a pilot needle and syringe program has been started by a local NGO, Mith Samlanh/Friends, with approval from the National Authority for Combating Drugs. There was agreement by the Ministry of the Interior and researchers that a pilot needle and syringe program was needed.

These steps represent a rapid

change in the way that Cambodia addresses drug use and related HIV/AIDS risk, but substantial investment is required by the donor community to ensure that appropriate interventions are scaled up to a level that will prevent drug-related HIV transmission.

– David Burrows and Chris Ward

Dave Burrows is Director, AIDS Projects Management Group and a consultant to the POLICY Project on its work on drugs policy and programming in Cambodia. Chris Ward is a Senior Technical Advisor for HIV/AIDS and Human Rights with the POLICY Project Cambodia.

Electronic copies of the report on the research (entitled “Policy and Environment Assessment: Illicit Drug Use, the Burden of Drug-related Harm, and HIV Vulnerability in Cambodia”) are available from the Futures Group website at www.futuresgroup.com. Hard copies are available from the POLICY Project Cambodia; contact Ms Muth Seineada, POLICY Project Cambodia, at mseineada@online.com.kh.

Southern Africa: Reports document legal responses to HIV/AIDS

A series of reports have been issued on the legal response to HIV/AIDS in eight member states of the Southern African Development Community (SADC). The states are Botswana, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe.

The eight reports were prepared by the AIDS and Human Rights Research Unit, a unit recently established by the Centre for the Study of

AIDS (CSA) and the Centre for Human Rights (CHR) at the University of Pretoria.¹

Even though sub-Saharan Africa,

and particularly Southern Africa, has experienced the brunt of the AIDS epidemic, until recently relatively little research had been done about the

AIDS responses of governments in this region.

Each report discusses the legal framework of the SADC and the particular country, and then addresses the following topics: the health sector (eg, HIV notification and the regulation of medical trials); equality and non-discrimination; labour rights (eg, HIV/AIDS in the workplace); gender rights (eg, the impact of the legal status of women); children's rights; criminal law; and HIV/AIDS and prisons.

The reports, which are mainly descriptive in nature, attempt to chart the legal response in each country, based on constitutional norms, legislation, policy frameworks, and case law. The reports are in the process of being extended to the other SADC countries and to other African countries such as Nigeria and Uganda, to facilitate legal comparison.

For more information, contact Prof Frans Viljoen, AIDS and Human Rights Research

Unit, Centre for Study of AIDS / Centre for Human Rights, University of Pretoria, at fviljoen@hakuna.up.ac.za.

¹ HIV/AIDS and Human Rights. Available online at www.csa.za.org/filemanager/list/10, and may be ordered from: The Centre for the Study of AIDS, University of Pretoria, Pretoria, 0002, South Africa.

NGO Code of Practice released

***Renewing Our Voice: Code of Good Practice for NGOs Responding to HIV/AIDS* was launched on World AIDS Day 2004, with the endorsement of over 150 NGOs from around the world. Eleven NGOs collaborated on the project.**

Background

The multi-faceted impact of HIV/AIDS and the rising trends in the rates of infection have led to an increase in the number and range of NGOs responding to the challenge. These include NGOs undertaking HIV/AIDS prevention and care and support work; NGOs integrating HIV/AIDS-specific interventions with other health programming, such as sexual and reproductive health, and child and maternal health programs; and NGOs mainstreaming HIV/AIDS within development, human rights, and humanitarian programming.

Simultaneously, there have also been significant changes in the global funding environment, particularly in

ensuring that the lessons learned over the past 20 years are used to guide the allocation of resources in scaling up responses to HIV/AIDS.

These changes both support and complicate the process of urgently needed scaling up of successful approaches. At the same time, this proliferation of NGOs and rapid scaling up of programs has, at times, occurred at the expense of accountability and quality programming and has led to fragmentation of the NGO advocacy voice.

While there is an urgent need to scale up program interventions, it is also critical to continue to advocate for law and policy reform as an essential part of an effective response. Laws, policies, social norms, and community attitudes and perceptions

shape the environment in which we respond to HIV/AIDS. Advancing the human rights of people living with HIV/AIDS and affected communities must remain central to an effective response.

These challenges have informed the development of the Code of Good Practice. The Code provides a shared vision of principles for good practice in programming and advocacy that can guide the work of NGOs, and to which NGOs can commit and be held accountable.

Objectives

The Code aims to:

- outline and build wider commitment to the principles, practices, and evidence base that underscore

successful HIV/AIDS work by NGOs;

- assist NGOs to improve the quality and cohesiveness of their work on HIV/AIDS, and strengthen their accountability to NGO partners, communities, and constituencies;
- foster greater collaboration between the wide variety of NGOs now involved in responding to HIV/AIDS; and
- renew the voice of NGOs by enabling them to commit to a shared vision of good practice in their programming and advocacy.

A draft of the Code was the subject of wide ranging consultation during 2004, culminating in a high-profile satellite meeting at the XV International AIDS Conference in Bangkok, Thailand.

In late 2004 the Steering Committee that has guided this project commenced work to secure the necessary resources to establish the project's second phase, designed to support the effective implementation of the Code. There will also be a further process to allow more NGOs to sign on to the Code. An update concerning this process will be provided on the

website of the International Federation of Red Cross and Red Crescent Societies via www.ifrc.org.

– *Julia Cabassi*

Julia Cabassi is the manager of the Code project. The text of the Code is available at www.ifrc.org/what/health/hiv/aids/code/. Hard copies of the Code are also available from Oxfam Publishing at publish@oxfam.org.uk and www.oxfam.org.uk/publications. Further information on the Code can be obtained from Bernard Gardiner at Bernard.gardiner@ifrc.org.

Thai Drug Users' Network receives human rights award

The 2004 International Award for Action on HIV/AIDS and Human Rights has gone to the Thai Drug Users' Network (TDN).

The awards were established in 2002 by the Canadian HIV/AIDS Legal Network and Human Rights Watch to highlight outstanding contributions that decrease vulnerability to HIV/AIDS and protect the rights and dignity of those infected and affected.

TDN was formed in 2002 by a few drug users who were moved to act by having seen so many of their peers die

of AIDS and other drug-related harms. They began by documenting and analyzing the human rights abuses that not only impeded drug users' access to HIV prevention services and AIDS care but also forced them to live on the margins of society. Since then, TDN has advocated for the rights of drug users and acted to draw Thai and international attention to the

lack of a compassionate and scientific response to the challenges of injecting drug use in Thailand.

In 2004 TDN won a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria to continue its work.

For further information, see www.aidslaw.ca/Maincontent/awards/internationalrecipient2004.htm.

Nigeria addresses HIV/AIDS in the workplace

In 2004 Nigeria undertook several important steps to address issues related to HIV/AIDS and the workplace.

National Workplace Policy

In June 2004 the Federal Ministry of Labour organized a workshop with the Nigerian Labour Congress, the National Employers Consultative Association, and other important stakeholders to review and adopt a National Workplace Policy. The overall goal of the policy is to provide guidelines to government, employers, and workers on their roles and responsibilities regarding HIV prevention, the elimination of stigma and discrimination, the promotion and protection of human rights, and the care and support of workers infected and affected by HIV/AIDS. The policy has been sent to the Federal Executive Council for consideration and final approval.

Educational sector

In September 2004 a national HIV/AIDS workplace policy for the education sector, designed to complement the National Workplace Policy, was reviewed and adopted at a national stakeholders meeting. It contains various provisions protecting the rights of students and employees of the Federal Ministry of Education and its affiliates.

In addition to prohibiting mandatory testing and discrimination, the policy

states that staff with HIV-related illness shall continue working, if they so wish, as long as they are fit for available and appropriate work, and that employers should provide them with reasonable alternative working arrangements that suit the stage of their illness. Arrangements may include flexible working hours, time off for counselling and medical appointments, extended sick leave, transfer to lighter duties, and part-time work.

The policy also provides for HIV/AIDS education programs and contains a section dealing with access to education and socio-economic security of orphans and vulnerable children (defined as children within the age bracket 0-18 who have lost one or both parents or are made vulnerable by HIV and AIDS).

The policy was subsequently submitted to the Joint Consultative Committee on Education and the National Council of Education for final approval.

Labour legislation reform

Finally, comprehensive labour legislation reform – supported by an International Labour Organization (ILO) Project to Promote Democracy through Fundamental Principles and Rights at Work and Tripartism (known as NIDEC) – is expected to

culminate in the adoption of five new bills. The new bills (Collective Labour Relations Bill, Labour Standards Bill, Labour Institutions Bill, Bill to amend the National Labour Studies Institute Act, and an Occupational Safety and Health Bill) will be discussed in a forthcoming meeting of the tripartite National Labour Advisory Council.

Nigeria has ratified several ILO conventions that can help fight the effects of HIV/AIDS in the world of work. Domesticating these international obligations will give Nigerian men and women vital channels for exercising their rights in this area.

The draft Labour Standards Bill deals with HIV/AIDS in the workplace, including the prohibition of HIV testing and discrimination, and the application of universal precautions in workplaces where there is an occupational risk of HIV infection. This bill will reinforce the policies mentioned above and represent a crucial step in the efforts aimed at HIV prevention and the protection of workers affected by the epidemic.

For more information contact Marie-Claude Chartier (chartier@ilo.org) or Jane Hodges (hodges@ilo.org) at the International Labour Office.

New report on the impact of HIV/AIDS on the world of work

A new report presents global estimates of the impact of HIV/AIDS on the labour force, on men and women of working age, on children, and on the economy in 50 countries, and traces its possible future impact in projections to 2015.

“HIV/AIDS and work: global estimates, impact and response – 2004,” which was issued by the International Labour Organization Programme on HIV/AIDS and the World of Work, is designed to inform awareness-raising, information and education programs, advocacy activities, and workplace and national policy-making.

The report includes examples of a range of responses to HIV/AIDS in the world of work. It outlines policy implications and describes the supportive environment policies can provide. It also contains a section showing a variety of legal initiatives that have been used to respond to HIV/AIDS in the world of work,

including AIDS-specific laws, labour legislation, anti-discrimination and human rights legislation, disability laws, and insurance laws.

The report is available at www.ilo.org/aids. For further information, contact Odile Frank at Frank@ilo.org.

UK: Developments on HIV/AIDS, stigma, and discrimination

“Are YOU HIV Prejudiced?”

As part of its ongoing “Are YOU HIV Prejudiced?” campaign, the National AIDS Trust (NAT), a UK-based HIV/AIDS policy development and advocacy organization, has published two resource packs that target employers and primary-care workers respectively.

In 2003 the campaign was aimed at the general public. The objective was to maintain or increase knowledge among the general population and to create a society that is HIV- and AIDS-aware. While NAT continues its general education work via the

campaign’s website, in 2004 the focus was extended to employment and health care.

The packs have been carefully designed to be practical as well as informative and educational. They attempt to raise awareness and promote actions to address HIV-related stigma and discrimination in specific settings by providing a better understanding of what HIV stigma and discrimination means, why it is an issue in employment and health care, why it occurs, and what can be done to challenge it.

The packs contain a wide range of fact files that provide key information on the medical aspects of HIV and AIDS, explain HIV stigma and dis-

crimination, and give practical advice on the management of HIV-positive employees (for the employer’s pack) or the treatment of HIV-positive patients (for the health-care pack). They also include scenarios, case studies, and practical tools on using the materials in different situations.

NAT has also launched two micro-sites as part of its general campaign’s website www.areyouhivprejudiced.org. The micro-sites promote and complement the packs and include interactive features and a comprehensive resource section. For more information about the campaign, contact Keith Winestein, NAT’s Campaigns Manager, at keith.winestein@nat.org.uk. To order the resource packs, go to www.nat.org.uk.

Disability Discrimination Bill

In December 2003 the government introduced a draft Disability Discrimination Bill that sought to address some of the gaps and deficiencies of the Disability Discrimination Act (1995) (DDA 1995), especially in relation to the definition of disability. The DDA 1995 does not protect people living with HIV who are asymptomatic. The draft bill extends the scope of the DDA 1995 to include people with HIV from the moment of diagnosis. However, it does not prohibit discrimination on grounds of perceived disability, or on grounds of association with a disabled person.

The draft bill went through pre-legislative scrutiny, which enabled organizations and individuals to make comments. Numerous submissions criticized the fact that the bill failed to include both a medical and social definition of disability. HIV-related discrimination often affects people who are not living with the virus but are stigmatized and discriminated against because they belong to groups most affected by HIV (discrimination on grounds of perceived HIV status), or because they are associated with HIV by virtue of their job or personal relationships.

Yet, with around 50,000 people currently living with HIV in the UK, the extension of the scope of the Act to cover HIV-positive people from the moment of diagnosis is welcome. The bill is currently before Parliament. Should it pass, the changes to the definition of disability are expected to come into force in December 2005.

The text of the bill is available at www.parliament.uk. For more information about HIV and disability law in the UK, contact Delphine Valette at delphine.valette@nat.org.uk.

HIV-related stigma and discrimination against gay men and black Africans

Two UK agencies, SIGMA Research and NAT, have published a report on HIV-related stigma and discrimination against gay men and black Africans in the UK. The research attempted to develop an evidence base on HIV-related stigma and discrimination and to explain how it is interrelated with racism, homophobia, and sexism.

The focus of the research was on institutional discrimination, including access to health care and housing. But the research also examined patterns of disclosure to family, friends, and the wider community to establish the

ways in which HIV stigma mediates informal social support.

The research was conducted through focus groups of HIV-positive gay and bisexual men, HIV-positive African women, and HIV-positive African men, themed by both target and subject. The report provides key findings on the difference of experiences of African migrants and gay and bisexual men in relation to stigma and discrimination.

In particular, the research shows that the conditions that give rise to HIV stigma toward black Africans are entrenched, structural, and virulent. On the other hand, the research found, gay and bisexual men have strengths (eg, pre-existing rights accorded to all citizens and permanent residents of the UK and a history of AIDS activism) that significantly counter the negative effects of stigma.

The report also makes key recommendations for government, profession associations, and HIV/AIDS organizations.

The report (entitled "Outsider status – Stigma and discrimination experienced by gay men and African people with HIV") is available via the web at www.areyouhivprejudiced.org. For more information about the research, contact Peter Weatherburn at peter.weatherburn@sigmaresearch.org.uk or Delphine Valette at delphine.valette@nat.org.uk.

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 the release of two important documents: the first comprehensive review of prison needle exchange programs worldwide, and a policy document by the Ontario Medical Association recommending implementation of such programs. In light of the evidence presented in these documents, and of the public health and human rights imperatives to act, prison systems that continue to oppose introduction of measures aimed at reducing the spread of HIV and hepatitis C in prisons will find it very difficult to justify their continued inaction. We then present a short summary of some of the presentations on issues related to HIV/AIDS in prisons at the XV International AIDS Conference. This is followed by an article on a pilot study conducted in a federal prison in Manitoba, Canada, to assess risk factors for hepatitis C and HIV transmission. We report on three court cases concerning the care and treatment of prisoners. Finally, we provide information on a few additional recent developments in prisons worldwide, and on new or updated resources on issues related to HIV/AIDS in prisons. With the exception of those on the court cases, all the articles in this issue were written by Ralf Jürgens.

This section is dedicated to the memory of Michael Linhart, a former prisoner with AIDS and hepatitis C, Board member of the Canadian HIV/AIDS Legal Network, and formidable advocate for the rights of prisoners to prevention and care. Michael died in October 2004 on the eve of the release of the Legal Network's report on prison needle exchange programs.

Prison needle exchange programs work

On 27 October 2004 the Canadian HIV/AIDS Legal Network and the Ontario Medical Association (OMA) released reports recommending that needle exchange programs (NEPs) be implemented in prisons, based on evidence that such programs promote and protect the health of both prisoners and prison staff. At the same time, the Scottish Prison Service announced that it was looking at providing such programs, and an Iranian physician reported on a pilot project in his country.

The Legal Network's report¹

The Network's report is particularly important because it represents the first comprehensive review of prison NEPs worldwide.² The authors under-

took a literature review, visited prisons in four countries, and corresponded with people responsible for administering prison needle exchange programs. The report concludes that the experience and evidence from the six countries where prison needle exchange programs existed as of April 2004 (Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus) have demonstrated that such programs:

- reduce risk behaviour and disease (including HIV and HCV) transmission;
- have other positive outcomes for the health of prisoners;
- do not endanger staff or prisoner safety, and in fact make prisons safer places to live and work;
- do not increase drug consumption or injecting;
- have been effective in a wide range of prisons; and
- have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons.

In light of this evidence, the report recommends that prison systems that have not yet done so take immediate steps to implement NEPs. At the press conference that marked the release of the report, the authors highlighted that this

does not condone drug use. Rather, it is a pragmatic public health measure that should accompany other efforts to reduce harms related to drug use, such as drug treatment programs, including methadone maintenance.³

The report also analyzes the legal obligation of governments to respect, protect, and fulfill prisoners' right to health, including the right to preventive health measures. It points out that the failure to provide access to essential HIV and hepatitis C prevention

measures to prisoners is a violation of prisoners' right to health in international law; and inconsistent with international instruments that deal with the rights of prisoners, prison health services, and HIV/AIDS in prisons, including the United Nations' Basic Principles for the Treatment of Prisoners, the World Health Organization's Guidelines on HIV Infection and AIDS in Prisons, and UNAIDS documents.⁴

The OMA report⁵

The OMA report is largely based on the Legal Network's report and comes to the same conclusions and recommendations: NEPs in prisons work, and they should be implemented quickly. The report is important, however, because it clearly demonstrates that issues related to HIV/AIDS in prisons are public health issues, and that the medical community is concerned about the lack of attention devoted to health care and prevention in prisons. According to the report, "[m]any physicians in Ontario who are involved in the provision of medical care within the prison system have expressed concerns that the quality of care available in prisons is often far below that which is available to the general population. The absence of NEPs in Canadian prisons is a prime example of this gap."⁶ The report continues by saying:

Issues concerning prisoners do not seem to be of high concern to the public. People should be concerned, not only because the health of prisoners is at stake but also, because prisoners do return to the community. There is a high rate of turnover in prisons, especially provincial prisons. Prisoners returning to the community, if infected with HIV or hepatitis C (HCV), can and do infect others. The OMA believes that not only is this happening

now but that it will continue to happen. This situation constitutes a clear and present health crisis.⁷

It further concludes:

The OMA believes that the many radical changes that have occurred since the beginning of the HIV/AIDS epidemic, including the fact that what was once an untreatable terminal disease can now be treated thus prolonging life, have resulted in the need to change how people living with HIV/AIDS in prisons receive care, and how people in prisons access prevention measures.

The report calls for an "urgent response," stating that "[w]here political will is combined with a solid implementation plan, NEPs in prisons can quickly become a reality."⁸ It follows a February 1996 Position Statement on Blood Borne and Sexually Transmitted Viral Infections by the Australian Medical Association, which stated that "[e]ffective prevention among prison populations requires the establishment of preventative education programs, needle exchange programs for intravenous drug users and safe sex programs for those involved in high risk sexual behaviour."⁹

Other developments related to NEPs

In related developments, Dr Akbar Bayabzadah from the Tehran Psychiatric Institute reported that a NEP pilot project had started in an Iranian prison.¹⁰ According to several news reports,¹¹ the Scottish Prison Service is also considering distributing harm-reduction kits, including sterile injection equipment, to prisoners. Dr Andrew Fraser, head of health care for the Service, was quoted as saying that "we have got to acknowl-

edge that drugs come into prisons. The clean needles would be given out by health workers, and other prison staff would have to respect that they have a job to do.”¹²

¹ R Lines, R Jürgens, G Betteridge, H Stöver; D Laticevski, J Nelles. *Prison Needle Exchange: Lessons from a comprehensive review of international evidence and experience*. Montréal: Canadian HIV/AIDS Legal Network, 2004. Available via www.aidslaw.ca/Maincontent/issues/prisons.htm.

² Previous reviews were less ambitious in scope: K Dolan et al. Prison-based syringe-exchange programmes: a review of international research and development. *Addiction* 2003; 72(1): 59-65; H Stöver, J Nelles. Ten years of experience with needle and syringe exchange programmes in European prisons. *International Journal of Drug Policy* 2003; 14: 437-444.

³ See the press release and other press materials, available via www.aidslaw.ca/Maincontent/issues/prisons.htm.

⁴ For more details and references to these documents, see the report at pages 14 to 18.

⁵ Ontario Medical Association. *Improving Our Health: Why is Canada lagging behind in establishing needle exchange programs in prisons?* Toronto: The Association, 2004. Available via www.oma.org/phealth/health.htm.

⁶ *Ibid* at 3.

⁷ *Ibid* at 2.

⁸ *Ibid* at 17.

⁹ Australian Medical Association calls for needle exchange programs for prisoners. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(4): 25.

¹⁰ CBC Radio 1. The Current, 20 October 2004 (www.cbc.ca/thecurrent/2004/200410/20041020.html).

¹¹ K Foster. Heroin kits on demand for Scots prisoners (<http://scotlandonsunday.scotsman.com/index.cfm?id=1207582004>); Scotland gives clean syringes to prisoners. *Washington Times*, 17 October 2004 (<http://washingtontimes.com/upi-breaking/20041017-013018-6484r.htm>); Addicted inmates may get needles (http://news.bbc.co.uk/2/hi/uk_news/scotland/3751140.stm).

¹² *Ibid*.

Is the world finally waking up to HIV/AIDS in prisons? A report from the XV International AIDS Conference

Issues related to HIV/AIDS in prisons have traditionally received little attention at the International AIDS Conference, despite the fact that levels of HIV prevalence within prison populations tend to be much higher than in the general population. However, the conference in Bangkok may represent a turning point. This article highlights some of the relevant findings presented at the conference. A longer version of this article, including background information about HIV/AIDS in prisons worldwide, has been published in the September 2004 issue of *Infectious Diseases in Corrections Report*.¹

Overview

Even before the official conference started, a one-day satellite conference debated issues related to HIV/AIDS in prisons in great depth (see the article entitled “Prisoners’ health and human rights in the HIV/AIDS epidemic” in the Bangkok 2004 section of this issue of the *Review*).

At the conference itself, two oral sessions and a large number of poster presentations were dedicated to HIV/AIDS in prisons. Most activities focused on HIV prevention, although

delegates also debated the question of how HIV treatment, including anti-retrovirals, can best be made available to prisoners. This was particularly important in light of current efforts spearheaded by the World Health Organization to make effective treatments available to three million people in developing countries by 2005.²

At the end, delegates expressed satisfaction that issues related to HIV/AIDS in prisons are starting to receive the attention they deserve. They expressed the hope that by the

time of the next International AIDS Conference in Toronto in 2006 the world will have woken up to the reality of HIV/AIDS in prisons.

Major oral sessions on HIV/AIDS in prisons

The first of two major oral sessions on HIV/AIDS in prisons was entitled “Not hard-to-reach, but still hard-to-serve? What works in HIV prevention and care in prisons.” It included presentations from prison officials from Indonesia,³ Thailand,⁴ and Iran,⁵ as well as a presentation on the first

comprehensive survey of prison-based needle exchange programs (reviewed above).⁶

The presenter from Thailand focused on his country's efforts to deal with the problem of TB and HIV co-infection in prisons. Both the officials from Indonesia and Iran admitted that sexual activity and injection drug use occur in their prison systems, and talked about the measures, including condoms, bleach, and methadone maintenance treatment, that they have introduced in their countries to respond to HIV/AIDS in prisons.

At a time when many Western countries have not introduced such measures, it was striking to hear senior officials of these countries speak openly about heavily stigmatized and prohibited behaviours such as injection drug use and homosexual activity, and about the necessity not to close our eyes to the reality, and instead respond pragmatically to prevent the greater evil: the spread of HIV among prisoners and ultimately to the general public.

The second oral session was entitled "Preventing HIV spread in prisons" and included two presentations from the United States, two from Canada, and one each from Pakistan and Thailand:

- Barry Zack from California presented on the role of non-governmental organizations (NGOs) as partners of prison systems in the fight against HIV/AIDS.⁷ He emphasized that a unique opportunity for collaboration exists between prisons and NGOs when it comes to the provision of pre-

vention, social support, and transitional HIV services for prisoners, and concluded that "prison officials who have worked with NGOs have shown that the collaboration can work for the prison, the NGO, the prisoner and the community."

- Richard Wolitski presented the results of "Project START," funded by the US Centers for Disease Control and Prevention, to develop an HIV, STD, and hepatitis prevention program for young men aged 18 to 29 who are leaving prison and to test the effectiveness of a number of interventions in reducing sexual risk after leaving prison. Results presented showed that those prisoners who received enhanced interventions consisting of two pre-release, four post-release, and optional sessions based on participant need were less likely to engage in unprotected sex than prisoners who received only a single pre-release session intervention.⁸
- The first of the two Canadian studies 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."⁹ The study was reviewed in a previous issue of the *Review*.¹⁰
- Another Canadian presentation reported about a project aimed at establishing prison-based harm-reduction policies and programs in Eastern Europe and the former

Soviet Union, where rates of HIV among injection drug users and in prisons are particularly high,¹¹ and where the response to HIV must be vastly scaled up to prevent the further spread of HIV in prisons and to the general population.

- Two presentations from Pakistan¹² and Thailand¹³ focused on the growing population of children and juveniles in prisons, and emphasized the need for programs aimed at reducing their vulnerability to HIV/AIDS.

¹ Available at www.idcronline.org/archives.html.

² For more information, see www.who.int/hiv/en/.

³ D Soejoto. First things first: Overcoming policy challenges to HIV programming in prisons. XV International AIDS Conference, 2004, Abstract no WeCs211, *Medscape General Medicine* 2004; 6(3) 11 July [eJournal of the International AIDS Society 2004; 1(1) 11 July].

⁴ P Akarasevi. TB and HIV coinfection: Implications for prophylaxis and treatment. Abstract no WeCs213.

⁵ P Afshar. Going national: Experiences in developing nationwide harm reduction in Iran's prisons. Abstract no WeCs214.

⁶ R Jürgens et al. Prison needle exchange: A review of international evidence and experience. Abstract no ThPeC7472.

⁷ B Zack. Control of HIV/AIDS in prisons/jails: The international experience and role of non-governmental organizations as collaborative partners. Abstract no WeOrE1295.

⁸ RJ Wolitski et al. Project START reduces HIV risk among prisoners after release. Abstract no WeOrC1296.

⁹ E Wood et al. Incarceration is independently associated with syringe lending and borrowing among a Canadian cohort of injection drug users. Abstract no WeOrC1297.

¹⁰ See: HIV/AIDS in prisons: other developments. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 49.

¹¹ T Kerr et al. Establishing prison-based harm reduction policies & programs in Eastern Europe & the former Soviet Union. Abstract no WeOrE1298.

¹² AYB Ayub. Prevention of HIV/AIDS and STDs among juvenile prisoners in north west frontier province, Pakistan. Abstract no WeOrC1299.

¹³ E Ireland, N Chaipech. Reducing children's vulnerability to HIV/AIDS and drugs in detention facilities in Thailand. Abstract no WeOrC1300.

Canada: Study provides further evidence of risk of hepatitis C and HIV transmission in prisons

In 2002, as part of a larger injection drug use social network study undertaken in Winnipeg,¹ a study was undertaken at Stony Mountain Institution to obtain data on the social network interactions in the prison and the potential role these interactions have on facilitating or inhibiting the spread of bloodborne pathogens among injection drug users.² The study, although small in size and largely exploratory, provides further evidence of the risk of HCV and HIV transmission in prisons and its potential public health implications.

The Winnipeg study

The study was undertaken as a sub-project within the Winnipeg Injection Drug Use Social Network Study, which was funded by Health Canada, carried out in Winnipeg in 2001/2002, and which aimed to provide pilot data on the social network interactions of Winnipeg injection drug users (IDU) and the potential role these interactions have on facilitating or inhibiting the spread of bloodborne pathogens among IDU.

During the course of the study, the investigators entered into discussions with staff at Stony Mountain Institution to discuss the possibility of doing a similar study within a correctional facility. Health Canada eventually gave approval to undertake this study. Because of the nature of the prison environment, where discussions of the behaviours of third parties can have serious safety implications, extensive modifications to the study questionnaire were required, and the types of questions about networks that were asked in prison were much more generic than those that could be asked in the community.

The study at Stony Mountain

Forty of the 420 prisoners at Stony Mountain participated in the study. A mechanism was developed to allow individuals who had participated in

injection drug use to present for the study in as confidential a manner as possible. Because it was generally known that the study was focusing on drug use, most individuals presenting for study enrollment were current or former IDU. Therefore, as the authors point out, the sample is not representative of the general prison population, and should not be interpreted as such.

Participants provided background demographic data, as well as information on their knowledge with respect to risk factors for transmission of HCV and HIV and on their injection drug behaviours both within the prison and in the community immediately before their current prison term.

Ninety-seven percent of participants reported that they had ever injected drugs. Approximately half of them had injected during their present prison term, with seven reporting that they had stopped prior to entering prison, and 11 reporting that they had stopped as a result of being arrested or imprisoned. Smyth noted that the reasons for stopping injection drug use in prison have been insufficiently examined, and speculated that the lack of clean needles could be a component of this decision.³ Therefore, the investigators asked individuals an open-ended question on why they had stopped injecting in prison. Reasons typically centered on a concern for their health and a desire to change their lives, or on problems associated with injecting in a

prison environment (eg, limited opportunities to inject, or drug availability and quality). Only one individual specifically reported he had stopped due to his inability to get clean injection equipment in prison and his resulting concern over HIV infection. Two participants reported that they had started injecting during a prison sentence, saying that they needed to be accepted or form a bond with others, or simply that "everyone else was using."

Frequency of injection in prison varied greatly. Slightly more than half of the 21 prison injectors reported relatively few injections (less than 30 times) during the previous six months, while others reported injecting more than 100 times. Drug injection frequency in the community was higher than in prison, but over half of participants said that outside they had never used someone else's needle. This is consistent with other studies in which many individuals who practised safer injection in the community started sharing needles in prison.

When asked about the number of individuals who were usually present when an individual injects drugs, respondents most commonly said three or more. Slightly less than half of individuals currently injecting in prison indicated they inject with more than one group or network of people in prison, with the numbers ranging from two to as many as six. This provides evidence of the numerous trans-

mission opportunities. The study investigators write:

With respect to drug use and transmission, the picture that emerges from the data is of a highly interconnected network of people. Many individuals frequently interact with different groups of inmates for injection purposes....

The movement of individuals (or needles) between different groups of people creates numerous “bridge” opportunities for pathogens to move between networks, resulting in a very high risk environment for transmission. In a community setting, it is known that pathogen transmission is most efficient within highly interconnected networks.”⁴

Conclusions

Despite the small sample size of the study and its limitations, the study does provide yet more evidence of the potential for transmission of HIV and HCV in prisons. From a public health

perspective, it is particularly worrisome that the movement of individuals between different networks of people essentially creates either one or a few large, highly interconnected networks through which bloodborne viruses can be readily transmitted.

The study also explores the issue of whether making clean needles available in prisons could potentially lead to increased injection drug use. One of the prisoners interviewed reported that the lack of access to clean injection equipment was a factor in his decision to stop injecting. However, for the other prisoners who stopped injecting, their decision to stop was influenced by other factors. The authors conclude that “there is potential for some increase in the number of injectors as a result of the introduction of needle exchange,” but that “the reduction in the potential for transmission created by the availability of clean needles would likely out-

weigh any increased transmission potential created by increased injection drug use.”⁵ It should be noted that the evaluations of existing prison needle exchange programs have found no evidence of increased drug use or increased drug injection.⁶

¹ JL Wylie et al. The Winnipeg social network injection drug use study: Project overview and analysis of gender- and ethnic-based differences in individual and social network drug use behaviours. Presented at CAHR 2002, abstract no 333P (www.pulsus.com/cahr2002/abs/abs333P.htm).

² JL Wylie. A pilot study assessing risk factors for hepatitis C and HIV transmission within a federal correctional institution. On file with author.

³ BP Smyth. Many injectors stop injecting while imprisoned. *British Medical Journal* 2000; 321(7253): 1406.

⁴ Wylie, supra, at 2 at 6, with reference to SR Friedman et al. Sociometric risk networks and risk for HIV infection. *American Journal of Public Health* 1997; 87(8): 1289-1296.

⁵ Wylie, supra, note 2 at 10.

⁶ See the reports by the Canadian HIV/AIDS Legal Network and the Ontario Medical Association, summarized above in the article entitled “Prison needle exchange programs work.”

Canadian court orders remand centre to provide prescribed medication and permit consultation with outside physician

In two applications brought by Geary, a provincial prisoner, the Alberta Court of Queen’s Bench ordered the Edmonton Remand Centre to provide Geary with prescribed medication and to permit him to consult an outside physician.¹ In each application, Geary was asking the court on an urgent basis to order interim measures until such time as the court could hear his full application for release from custody. This decision has important implications for prisoners living with HIV/AIDS, some of whom report receiving medical treatment that does not meet professionally accepted standards. It is also significant that, in finding for the prisoner, the court refers to the Charter, the United Nations Standard Minimum Rules for the Treatment of Prisoners, and American constitutional case law.

Application for access to pain medication

In 2000, Geary suffered serious burns to 60 to 70 per cent of his body. In 2002 his physician prescribed Dilaudid for pain, and a number of other medications. Geary was detained at the remand centre awaiting trial on a range of relatively minor charges. The institution’s physicians refused Geary’s requests for his pain

medication, believing that he did not have a prescription for Dilaudid. Despite the fact that an institutional physician confirmed with Geary's family physician that he had prescribed the pain medication, the institutional physician refused to provide it based on the belief that Geary had prescriptions from multiple doctors for the same medication.

Over the course of his stay in remand, the prisoner's physical and mental health deteriorated, but his requests for Dilaudid were repeatedly denied. Geary brought an application for an order for access to the medication, and for access to skin cream and permission to wear personal clothing. His application was based on sections 12 (right not to be subjected to any cruel and unusual treatment or punishment) and 15 (equality rights) of the Canadian Charter.²

Veit J allowed in part Geary's application. Geary's claims for personal clothing and skin cream were refused because they did not meet the test for granting relief until the issues could be fully argued before the court. However, Veit J held that Geary's request for medication reached the necessary threshold to grant: there was a serious issue to be decided; Geary's pain caused him irreparable damage; and the balance of convenience between the remand centre and Geary favoured the latter.

Veit J adopted the reasoning in the American case of *Newson*,³ which found that allegations of unnecessary and wanton infliction of pain involve "allegations of deliberate indifference to serious medical needs which engages [sic] constitutional considerations."⁴ In determining the balance of convenience, Veit J examined the following factors: the likelihood for success in the main application; the effects of granting the relief; and the

non-interference with the institutional physicians who were named as defendants.

The judge held that the applicant has "at the least, a possibility of success in his main application," that granting access to his prescribed medication will neither have major implications for the institution nor is pointless, and that there would be no undue interference with the professional standards of the defendants, who are physicians, since "they are not asked to prescribe something which they think is inappropriate or to supervise what they consider to be an inappropriate course of conduct."⁵

Application for consultation with outside physician

Veit J granted Geary's application for a consultation with an outside, licensed physician for the purposes of assessing his pain. Veit J held that the since Geary had not abused his independent right to request consultation with an outside physician and since "the institution's existing policy, international standards concerning the treatment of prisoners on remand, and the ethical standards of the medical profession all support that right,"⁶ the application must be granted.

The judge denied the remand centre director's application to impose a condition on his right of consultation, that is, that the director be allowed to undertake an independent medical examination. Veit J held that given the facts of this case, the institution had had adequate opportunity to examine the applicant and is not entitled to an additional medical examination at this time. Additionally, given the "personally intrusive" nature of medical examinations, "the defendant's right to a medical examination of the plaintiff [under the Rules of Court] should

be sparingly, rather than broadly, interpreted."⁷

Comment

After the hearings, Geary and his counsel negotiated an agreement with the administration of the remand centre on the appropriate course of medical treatment. As a result, the merits of his main application were not heard by the court. As part of that treatment, Geary entered into methadone maintenance therapy.⁸

Although there is no mention of Geary's HIV or hepatitis C status, the decisions are significant for prisoners living with HIV/AIDS and hepatitis C. There is anecdotal evidence that prisoners in Canada experience problems accessing pain and other medications, including the medications used to treat HIV infection.

During a 12-month period, community-based service providers recorded 373 contacts with prisoners in federal and provincial correctional systems, during which the prisoners provided: 12 reports of medications prescribed by an outside physician being changed by the prison physician without consultation; 59 reports of pain medication being cut off or reduced; 14 reports of HIV antiretroviral medications being cut off; three reports of HIV antiretroviral medications being administered improperly; 11 reports of missing doses of HIV antiretroviral medications; and seven reports of being released from custody without HIV antiretroviral medications.⁹

The decisions in the Geary cases are welcome in light of this evidence of the failure of prison authorities to provide prisoners with medical care that meets professional standards. Especially significant was the judge's reference to documents that establish legal and ethical standards such as the

Canadian Charter, the United Nations Standard Minimum Rules for the Treatment of Prisoners,¹⁰ and the Canadian Medical Association Code of Ethics, as well as case law addressing prisoners' rights under the American constitution. American constitutional case law on the right of prisoners is much better developed than Canadian case law in this area.

The judge was very critical of a number of practices of the remand centre, not the least of which was, without reasonable grounds, failing to provide Geary with prescribed medication and refusing him access to an outside specialist. He was also critical of the practice of reducing prisoners' medication without further inquiry when they do not attend health services to receive doses, commenting that "[i]t also appears that the failure of a

detention facility to determine why an inmate is not showing up for prescribed drugs is a matter for legitimate concern, and that where there is knowledge on the part of the institution that the inmate is withdrawing from drugs, special responsibilities may apply."¹¹

These cases represent a positive development for prisoners' right to the highest standard of physical and mental health, as guaranteed by international laws that Canada has ratified.

— Arryn Ketter and Glenn Betteridge

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¹ *Geary v Alberta (Edmonton Remand Centre)*, [2004] AJ No 22 (Alta QB) (QL); *Geary v Alberta (Edmonton Remand Centre)*, [2004] AJ No 24 (Alta QB) (QL).

² Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, (UK) 1982, c 11.

³ *Newson v Peterson*, 2003 U.S. App. Lexis 9134 (6th Circ.).

⁴ *Geary v Alberta (Edmonton Remand Centre)*, [2004] AJ No 22 at para 44.

⁵ *Ibid* at para 46.

⁶ *Geary v Alberta (Edmonton Remand Centre)*, [2004] AJ No 24 at para 1.

⁷ *Ibid* at para 21.

⁸ Personal correspondence with counsel in the case.

⁹ M Linhart. Initiative to Monitor Prison AIDS Care & Treatment (IMPACT): Data analysis and evaluation (June 2001), on file with the Canadian HIV/AIDS Legal Network.

¹⁰ Standard Minimum Rules for the Treatment of Prisoners. Adopted 30 August 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders. UN Doc A/CONF/6/11, annex I, ESC res 663C, 24 UN ESCOR Supp (No 1) at 11, UN Doc E/3048 (1957), amended ESC res 2076, 62 UN ESCOR Supp (No 1) at 35, UN Doc E/5988 (1977).

¹¹ *Geary v Alberta (Edmonton Remand Centre)*, [2004] AJ No 22 at para 46.

Canadian court denies prisoner access to anti-anxiety medication

In a judgment released on 22 September 2004, the Federal Court refused to order a federal correctional institution to provide a prisoner with the anti-anxiety medication clonazepam, one among a class of medications known as benzodiazepines.¹ Benzodiazepines are available for prescription by Correctional Service Canada (CSC) physicians and psychiatrists. However, the CSC formulary provides for a discontinuation schedule for inmates who come from the provincial penitentiary system where the continued use of benzodiazepines is not indicated.

Thomas Powell, the applicant, had suffered from acute anxiety and panic disorder for 13 years prior to this application and had been regularly prescribed clonazepam. A CSC physician who had treated Powell alleged that he had a history of abuse of clon-

azepam and alcohol, and that he committed the offences for which he is incarcerated while on clonazepam. The physician alleged that Powell desired to be sedated.

The Commissioner of Correctional Services issues health directives in

relation to the Corrections and Conditional Release Act (CCRA)² that require the provision of essential health care to incarcerated individuals. The Commissioner's Directive (CD) at issue in this case was CD 805, which declares that "[m]edications

shall be prescribed only when clinically indicated” and that “hypnotic or sedative medication [shall] only [be prescribed] when there is evidence that the inmate’s sleep is disturbed and only in exceptional circumstances.” The applicant challenged this policy, claiming that the effective prohibition on clonazepam under CD 805 violated his rights under sections 85 to 87 of the CCRA, and sections 7 and 9 of the Canadian Charter.³

The court reviewed the CSC formula and determined that neither it nor CD 805 prohibit physicians from prescribing benzodiazepines. Physicians are free to prescribe them if, in their professional judgment, they are clinically indicated.⁴ However, the court found that there was “no legal foundation for an order compelling the CSC to treat the Applicant with

benzodiazepines”⁵ based on a number of factual findings, not the least of which was that “there is no evidence that any physician, whether employed by the CSC or engaged exclusively in private clinical practice, would today prescribe Clonazepam for the Applicant.”⁶ The court also dismissed the alleged Charter violations.

Comment

Of interest to HIV advocates and HIV-positive inmates is the fact that although the court decided that there was no blanket prohibition on access to sedatives under the policies in effect, in practice there appears to be a de facto prohibition of benzodiazepines. There are anecdotal reports that HIV-positive prisoners who have regularly taken benzodiazepines are unable or unwilling to take antiretro-

viral medication without also taking such anti-anxiety medications. Perhaps on another situation of fact the courts would be better able to address the issue of an apparent blanket prohibition.

– Joanna Wells

Joanna Wells is a student at Dalhousie Law School.

¹ *Powell v Canada (Attorney General)* [2004] FCJ No 1566 (FC) (QL).

² Corrections and Conditional Release Act, SC 1992 c20.

³ Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, (UK) 1982, c 11.

⁴ *Powell*, supra, note 1 at paras 118 to 132.

⁵ *Ibid* at para 145.

⁶ *Ibid* at para 137.

Prisoner denied access to medical marijuana

In a case that has recently come to the attention of the editors, the Federal Court refused to order Health Canada to provide a federal prisoner with medical marijuana, even though he possessed legal authorization to possess marijuana.¹

On 21 August 2001, Michael Patriquen was granted an exemption under the Controlled Drugs and Substances Act² to use marijuana to treat medical conditions. In August 2002 he was convicted of possession of marijuana for the purposes of trafficking and sentenced to six years’ imprisonment. While incarcerated, Patriquen consistently requested that he have access to marijuana under his

lawful exemption. Those requests have been denied. Patriquen applied for judicial review of the decision, and requested an interim order from the court that Health Canada supply him with marijuana until the court could hear his full judicial review application. As an alternative, he asked the court to order Health Canada to approve a compassion club as a licensed dealer of marijuana so

that it could provide him with marijuana.

In deciding whether to issue an interim order, a court must determine whether there is a serious issue to be tried; whether the applicant would suffer irreparable harm if the injunction was not granted; and whether the balance of convenience favours the applicant. The court is not required to decide the merits of the issues to be

raised in the full judicial review application.

The court agreed that this was a serious issue to be tried, namely whether or not access to marijuana constituted “essential health care.” Correctional Service Canada (CSC) is required to provide “essential health care” to prisoners, and reasonable access to non-essential mental health care under sections 89 and 86 of the Corrections and Conditional Release Act.³ However, after assessing the relevant medical evidence, the court did not find that Patriquen had demonstrated that he would suffer irreparable harm if he was not provided with marijuana. Finally, regarding the balance of convenience, the court determined that it would be inappropriate to breach the CSC prohibition on marijuana based on evidence that suggested that “allowing marijuana

into the Institution for distribution to inmates would pose an unreasonable risk to the safety of staff members, inmates and visitors, as well as the overall security of the institution.”⁴

Comment

If this case proceeds to a full hearing on the merits, the outcome will be significant for prisoners living with HIV/AIDS who require medical marijuana. The Ontario Court of Appeal has decided that certain limits placed by government on the ability of those who need marijuana for medical purposes to obtain it are unjustified and thus unconstitutional.⁵ Given that CSC has a statutory obligation to provide prisoners with essential health care according to professionally accepted standards and equivalent to that available in the community, it

may be difficult for the government to justify its refusal to provide prisoners with access to medical marijuana. Moreover, in a full hearing CSC may have difficulty proving that providing marijuana to prisoners poses an unreasonable safety risk. Health services in institutions already prescribe medications that are much more potent, addictive, and sought after.

– Joanna Wells

¹ *Patriquen v Canada (Correctional Service)*, [2003] FCJ No 1186 (FC) (QL).

² SC 1996, c 19.

³ Corrections and Conditional Release Act, SC 1992 c 20.

⁴ *Patriquen*, supra, note 1 at para 33.

⁵ *R v Parker* (2000), 29 OR (3d) 481 (CA); *Hitzig v Canada*, [2003] OJ No 3873 (CA) (QL).

Other developments

US: Study links incarceration and HIV rates in black communities

Many studies have documented the prevalence of HIV in prisons, but researchers have now established a link between rates of imprisonment among African-Americans in the United States and the high HIV/AIDS rates in African-American communities outside of prison.

A study conducted by University of North Carolina epidemiologist James Thomas found a “robust corre-

lation” between incarceration rates and rates of HIV and sexually transmitted diseases. Researchers noted that in North Carolina, African-Americans comprise more than 70 percent of HIV/AIDS cases and about 60 percent of the state’s 35,000 prisoners. Nationwide, more than half of all new HIV infections in the US occur among African-Americans, and African-American women comprise 72 percent of new HIV cases among all women. Of the 2.1 million people currently incarcerated in the US, 40 percent are African-American.¹

Canada: Revised guidelines on management of infectious diseases and on bleach distribution issued

On 4 November 2004, Correctional Service Canada issued revised guidelines on management of infectious diseases and on bleach distribution.

Commissioner’s Directive 821 – Management of Infectious Diseases, provides comprehensive policy direction on the management of infectious diseases in Canadian federal prisons, “reflects public health principles, and

incorporates a full range of infectious disease program elements.”² Its objective is to “contribute to public health and a safe and healthy environment through a comprehensive infectious diseases program.”³ Among other things, the Directive states that:

A full range of infectious diseases program elements, including but not limited to screening/testing, immunization, education and training, harm reduction measures, care and treatment, surveillance activities, and partnerships, shall be implemented based on best evidence and public health expertise. (Paragraph 9)

Approved harm reduction items shall be readily and discreetly accessible to inmates in CSC operational units so that no inmate is required to make a request to a staff member for any item. (Paragraph 11)

Inmates living with infectious diseases shall be provided with human treatment and support, in an environment free of discrimination. (Paragraph 13)

The Institutional Head shall ensure that non-lubricated, non-spermicidal condoms, water-based lubricants, dental dams and bleach are discreetly available to inmates at a minimum of three locations, as well as in all private family visiting units. (Paragraph 21)

CSC’s Health Services shall ensure that partnerships are established nationally, regionally and locally with other federal departments, provincial and municipal governments, service agencies and stakeholder groups, in order to ensure the sharing of information, best practices, and expertise. (Paragraph 35).

Guidelines 821-2 – Bleach Distribution,⁴ provide additional detail on how bleach shall be made accessi-

ble to prisoners. Bleach has been available in federal (and many provincial) prisons in Canada for many years,⁵ but it was felt that clearer guidelines were needed to ensure effective and safe distribution. Among other things, the guidelines state that:

Full-strength (between 5.25% and 7%) household bleach shall be utilized as the disinfecting agent. (Paragraph 6)

[Bleach kits] shall consist of:

- a. one 1-ounce opaque plastic bottle of bleach, labelled with a notice reading “Bleach, Do Not Drink or Inject;”
- b. one 1-ounce empty opaque plastic bottle for water; and
- c. instructions on the proper cleaning of syringes and needles. (Paragraph 7)

Every newly-admitted inmate shall be issued one bleach kit following reception into federal custody and shall be offered a kit on each occasion of reception upon transfer to another institution. (Paragraph 9)

There will be a minimum of three designated locations in each institution where inmates can refill an empty bottle with bleach or obtain a bottle of bleach. Appropriate locations are those affording the inmate privacy to the extent possible. In no instance shall an inmate be required to approach a staff member in order to obtain refills. (Paragraph 11)

An inmate in possession of quantities of bleach in excess of the one-ounce bottle is considered to be in possession of contraband unless prior authorization has been obtained. (Paragraph 14)

The possession of a one-ounce bottle of bleach is not in itself sufficient evidence of drug usage or other activity constituting a disciplinary offence. (Paragraph 15)

Canada: Prison networking and research & advocacy groups founded

The Canadian HIV/AIDS Legal Network and the Canadian AIDS Society recently announced the formation of two new groups to better address HIV/AIDS and hepatitis C in Canadian prisons: the Prisons HIV/AIDS and Hepatitis C Networking Group and the Prison HIV/AIDS & Hepatitis C Research & Advocacy Consortium.

For a number of years now, Canadian community-based HIV/AIDS organizations and hepatitis C organizations have been working together through a so-called Prisons Networking Group to bring about reforms to the way prison systems throughout Canada address HIV/AIDS and hepatitis C, and to meet the needs of individual prisoners infected and affected by HIV and hepatitis C. In 2004 the Prisons Networking Group decided that the time had come to split into two groups – one focused on networking for frontline service providers and organizations who work with prisoners, the other focused on systemic research and advocacy issues.

The Canadian AIDS Society facilitates the new Prisons HIV/AIDS and Hepatitis C Networking Group, which provides community groups and frontline workers an opportunity to voice their concerns, exchange information, stay informed on the latest initiatives, and bring forward issues that need to be addressed by the advocacy group.

The Canadian HIV/AIDS Legal Network facilitates the Prison HIV/AIDS & Hepatitis C Research & Advocacy Consortium, which advocates for the implementation of prison health policies, programs, and servic-

es that reflect best practice and meet national and international human rights standards.

For more information, see the Legal Network's website at www.aidslaw.ca/Maincontent/issues/prisons.htm#adv.

New resources

Fighting for prison health

The Fall 2004 issue of *Harm Reduction News* focuses on prison issues. It includes, among many other articles, updates on harm-reduction initiatives in prisons in Moldova, Russia, Kyrgyzstan, Mexico, and Iran, as well as articles about women prisoners, tuberculosis, policy reform, and states' obligation to promote and protect the health of prisoners. The issue can be downloaded from the website of the Harm Reduction Development Program of the Open Society Institute at www.soros.org/initiatives/ihrd.

The May 2004 issue of *Connections* (the newsletter of the European Network on Drug Services in Prison & Central and Eastern European Network of Drug Services in Prison) contains an article about the

implementation of the first methadone programs in prisons in Poland, as well as a summary of a study of substitution treatment in European prisons. Back issues of *Connections* are available via www.ceendsp.net.

Women and HIV/AIDS in prisons and jails

The US-based National Minority AIDS Council (NMAC) released a 20-page booklet, entitled *Women & HIV/AIDS in Prisons and Jails*, that addresses issues and challenges confronting incarcerated women living with HIV. For copies, see www.nmac.org or call NMAC at 1-202-483-6622.

Articles on HIV and HCV in Canadian prisons

A recent study investigated rates of testing and seropositivity for HIV and HCV among prisoners in all 53 Canadian federal penitentiaries.⁶ It found that of 7670 new admissions during 2002, 30 percent were tested for HIV and HCV: 0.7 percent tested positive for HIV and 10 percent tested positive for HCV. Overall seroprevalence rates at year-end for 2002 were

two percent for HIV and 26 percent for HCV, and were substantially higher among women.

A paper published in the August 2004 issue of *Canada Communicable Disease Report*⁷ reviews the literature on the risk factors and behaviours that place the prison population at greater risk of HCV infection and the factors that lead to the transmission of HCV in prisons.

¹ Study links incarceration and HIV rates in black communities. *AIDS Policy & Law* 2004; 19(6): 5.

² Correctional Service Canada. Policy Bulletin 181: Commissioner's Directive 821 – Management of Infectious Diseases, and Guidelines 821-2 – Bleach Distribution. Ottawa: CSC, 4 November 2004 (www.csc-scc.gc.ca/text/plcy/cdshtm/b181-821_e.shtml).

³ CSC. Commissioner's Directive 821 – Management of Infectious Diseases. 4 November 2004, paragraph 1 (www.csc-scc.gc.ca/text/plcy/cdshtm/821-cde_e.shtml).

⁴ CSC. Guidelines 821-2 – Bleach Distribution. 4 November 2004 (www.csc-scc.gc.ca/text/plcy/cdshtm/821-2-gl_e.shtml).

⁵ See R Lines. *Action on HIV/AIDS in Prisons: Too Little, Too Late - A Report Card*. Montréal: Canadian HIV/AIDS Legal Network, 2002 (www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm).

⁶ P De, N Connor, F Bouchard, D Sutherland. HIV and hepatitis C virus testing and seropositivity rates in Canadian federal penitentiaries: A critical opportunity for care and prevention. *Canadian Journal of Infectious Diseases & Medical Microbiology* 2004; 15(4): 221-225 (www.pulsus.com/Infdis/15_04/de_ed.htm).

⁷ Hepatitis C virus transmission in the prison/inmate population. *Canada Communicable Disease Report* 2004; 30(16): 141-148 (available via Health Canada's website at www.hc-sc.gc.ca).

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.

Court orders Immigration and Refugee Board to take into account evidence of HIV-related discrimination

On 31 August 2004, the Federal Court granted an HIV-positive woman's application for judicial review of a decision by the Immigration and Refugee Board (IRB).¹ The issue before the court was whether the Board erred by ignoring documentary evidence before it with respect to the treatment of people living with HIV/AIDS in Nigeria. The court ordered that a newly constituted panel redetermine the claim in light of evidence of the discrimination faced by HIV-positive people in Nigeria.

JO is a 33-year-old citizen of Nigeria who claimed Convention Refugee status based on a well-founded fear of persecution in her country of origin. She made her claim as a woman enduring domestic abuse and as an HIV-positive person subject to discrimination in her country.

JO also claimed that if she did not

meet the test for a Convention Refugee under the Immigration and Refugee Protection Act (IRPA), she should nonetheless be permitted to remain in Canada and apply for permanent residence as a "person in need of protection" under the Act. She alleged that she was systemically raped and beaten by a chief, a man to

whom she was promised to marry.

Since entering Canada, she learned that she was HIV-positive. She argued that her fear of persecution is exacerbated by her HIV status, the discrimination against HIV-positive people in Nigeria, and the inaccessibility of treatment in Nigeria. JO's lawyer placed before the Board evidence of

systemic discrimination against people living with HIV/AIDS in Nigeria.

The IRB found that inconsistencies in JO's documentary evidence impugned her credibility. According to the IRB, there was no "credible or trustworthy" evidence that she would be denied medical care, that the care would be inadequate, or that she would be ostracized by family and community, and face discrimination in employment and other systemic discrimination.²

However, the court found that the IRB ignored salient documentary evidence before it.³ Shore J stated that the IRB is obliged to communicate how it came to its conclusions based on the evidence as a whole. The court also found that the IRB contradicted itself by citing evidence of widespread discrimination against HIV-positive Nigerians, but then ruling out the possibility of systemic discrimination. There was no evidence before

the IRB that demonstrated that discrimination and stigma did not exist in Nigeria.⁴

Comment

This ruling is especially significant in light of previously reported Federal Court – Trial Division decisions relating to Convention Refugee claims of HIV-positive people under the since-repealed Immigration Act.

On 9 May 2001, the Federal Court rejected an HIV-positive man's application for judicial review of the IRB's rejection of his claim for refugee status.⁵ In that case, Rouleau J stated that no link was established between poverty, inaccessibility of treatment, and the usual grounds of persecution.

In *Tchiegang*, the refugee claim of a person living with HIV was refused on the basis that she did not provide the Board with evidence that she would be denied medical treatment on a Convention ground.⁶

Future decisions of the IRB and Federal Court will determine whether the category of "person in need of protection" found in the IRPA will offer people living with HIV/AIDS greater protection than the strict Convention Refugee criteria.

– Barbara Mysko

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¹ *JO v Canada (Minister of Citizenship and Immigration)* [2004] FCJ No 1426 (FC) (QL).

² *Ibid* at para 20.

³ *Ibid* at para 26.

⁴ *Ibid* at para 29.

⁵ *Mare v Canada (Minister of Citizenship and Immigration)*, 2001 FCT 450, [2001] FCJ No 712 (QL). See R Elliott. Federal Court denies asylum, rejects claim that lack of adequate medical care is persecution. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2): 15-16.

⁶ See G Betteridge. Fear of lack of adequate medical care not well-founded fear of persecution. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(2): 44-45.

Appeal board overturns decision denying Zambian admission to Canada

The Immigration and Refugee Board, Appeal Division (IRB) has granted the appeal related to an HIV-positive Zambian citizen refused admission to Canada based on "excessive demand" criteria found in the Immigration and Refugee Protection Act (IRPA).¹ The woman had made two applications for admission to Canada. At the time of the woman's initial application, she had not been diagnosed with HIV. The appeal was granted based on humanitarian and compassionate considerations existing at the time of the first application.

Mona Chanda Tompwe's sister made a family-class application to sponsor her to come to Canada. In a reassess-

ment of an earlier denial, the visa officer rejected the application, finding Tompwe inadmissible on health

grounds on the basis that her HIV-positive status would cause excessive demand on Canadian health and social services. The IRPA prohibits the admission of some potential immigrants where the applicants will place an excessive demand on health and social services.² Excessive demand occurs where an individual is expected to place a greater financial burden on government services than the average Canadian.³ At the time of the reassessment, Tompwe was a 22-

year-old orphan living alone in Zambia. The visa officer also refused to approve the application on humanitarian and compassionate grounds, but did not indicate his reasons for doing so.

In granting the appeal, the IRB stated that there were sufficient humanitarian and compassionate reasons for admission as far back as July 2001, at the time of the visa officer's initial refusal. The IRB found that the humanitarian and compassionate considerations had increased in importance in light of Tompwe's recent discovery of her HIV-positive status and the fact that she was now living alone in Zambia.

Tompwe's lawyer submitted a letter from Oasis to the visa officer attesting to the adequacy of its facilities for treatment purposes.⁴ Oasis is an Ottawa-based medical clinic working in the area of HIV prevention and treatment. The letter indicated the

clinic's willingness to provide medical care to Tompwe and to enroll her in a clinical trial through which she would be provided with antiretroviral medication free of charge. The letter also noted that her prognosis would not be very good if she was left in Zambia with no support system. While the IRB did not cite this letter as a ground for granting the appeal, it did mention its existence in its reasons.⁵

Comment

The excessive-demand criteria have been severely criticized for discriminating against immigrants seeking admission to Canada.⁶ While this case was not decided based on the excessive-demand criteria, the letter submitted by Oasis signals an innovative approach that might be fruitfully used by HIV-positive immigrants to circumvent the criteria. Evidence demonstrating that an applicant would not

require the Canadian health system to provide her with expensive antiretroviral medications is clearly relevant to the issue of excessive demand.

— Barbara Mysko

¹ *Kamba v Canada (Minister of Citizenship and Immigration)* [2004] IADD No 290 (QL).

² See Immigration and Refugee Protection Act, SC 2001, c 27, s 38; Immigration and Refugee Protection Regulations, SOR/2002-227, s 1(1) definition of "excessive demand" and s 34. The Act came into force on 28 June 2002.

³ *Ibid.*

⁴ *Supra*, note 1 at para 8.

⁵ *Ibid.*

⁶ See, for example, the Canadian HIV/AIDS Legal Network's Submission to the Standing Committee on Citizenship and Immigration on the Regulations Made under the Immigration and Refugee Protection Act (5 February 2002), available via www.aidslaw.ca/Maincontent/issues/immigration.htm.

Severance provisions of old Ontario employment standards legislation infringe Charter equality rights of persons with disabilities

On 19 January 2004, the Divisional Court of the Ontario Superior Court of Justice decided that s 58(5)(c) of the Ontario Employment Standards Act (ESA)¹ infringed the equality rights of people living with disabilities.² Section 58 provides an employee "with general entitlement to severance pay upon termination of his or her employment," but subsection (5)(c) "operates to deny severance pay to employees who are terminated in circumstances in which their contract of employment has 'become impossible of performance or frustrated' by illness or injury."³

In an application for a judicial review of an award of the Board of Arbitration, the plaintiffs claimed that s 58(5)(c) discriminated against the

disabled, contrary to equality guarantees enshrined in section 15(1) of the Canadian Charter of Rights and Freedoms. The case was brought on

behalf of a nurse who, after 10 years of work for a hospital, was unable to continue work due to illness.

The board had decided that it had

jurisdiction to determine the constitutionality of s 58(5)(c). It found that the benefit was denied “based on the non-viability of the contract as opposed to the disability of the employee.”⁷⁴ This observation, combined with the board’s finding that “there was no accommodation possible that would permit the grievor to perform the essential duties of her job without imposing undue hardship on the hospital,”⁷⁵ led it to conclude that the subsection did not infringe Charter s 15(1).

The board found that the denial of severance pay did not stereotype or devalue persons with severe and prolonged disabilities, since the purpose of the severance pay provision was to compensate an employee for the investment she had made in her employer’s business.

The Divisional Court disagreed with the board. The court found that the central question was “whether the severe disability distinction drawn by s. 58(5)(c) of the ESA imposes a disadvantage upon [the plaintiff] as a disabled person in a manner that constitutes discrimination under s. 15(1) of the Charter” and held that the question must be answered in the affirmative.

The court found that while less-disabled employees are not deprived of the benefit, “the group of disabled employees that the legislation excludes from receiving the benefit is the very group that is the most disadvantaged, since it consists exclusively of those employees who are so seriously disabled that they are not able to continue in their current employment.”⁷⁶ Indeed, the court felt that denying a benefit to past employees who are unable to continue their

employment due to their disability “cannot help but send the message that the contributions of those employees were not as valuable as the contributions of able-bodied employees.”⁷⁷

The court held that “denying severance pay to those with severe disabilities does not accord with the needs, capacities and circumstances of individuals with prolonged and serious disabilities” and that this factor “weighs in favour of a finding of discrimination.”⁷⁸

Finally, the court considered the values contemplated in Charter s 15(1), determining that the denial of severance pay based on severe disability goes to the core of these values. The court found that s 58(5) “singles out the severely disabled to deny them an employment benefit to which they would have been entitled but for their disability.”⁷⁹ In so doing, the court said, s 58(5)(c) violates Charter s 15(1), since the dignity of the severely disabled is violated by denying them severance pay.

Since the court found that the violation of Charter s 15(1) could not be saved by Charter s 1 – ie, that there is no pressing or substantial social need to justify the denial of the benefit – it held that s 58(5)(c) is unconstitutional and of no force and effect. The court quashed the board’s award and ruled that the employee was entitled to receive severance pay.

The Divisional Court’s decision has been appealed to the Ontario Court of Appeal.¹⁰

Comment

The ESA was repealed effective 4 September 2001, and replaced with the Employment Standards Act, 2000 (ESA 2000).¹¹ Severance pay entitle-

ment is dealt with in s 64 of the ESA 2000, and the equivalent provision to s 58(5)(c) is now found in the regulations enacted under the ESA 2000.¹² The wording of the provisions under the ESA 2000 differs from the old ESA in important respects. Therefore, the court’s reasoning likely does not apply to the severance pay provisions that have been in force since 4 September 2001.

While the nature of the employee’s disability was not stated in the judgment, this case is potentially significant for persons living with HIV/AIDS whose employment was terminated due to severe disability prior to 4 September 2001 and who did not receive severance pay. Whether or not such people will have claims against previous employers will depend, at least in part, upon the outcome of the appeal(s) in this case.

– Arryn Ketter

Arryn Ketter is a student at the Faculty of Law, McGill University.

¹ RSO 1990, c E 14.

² *Ontario Nurses’ Association v Mount Sinai Hospital*, [2004] 69 OR (3d) 267 (OCJ- Div Ct).

³ *Ibid* at para 1.

⁴ *Ontario Nurses’ Association*, *supra*, note 2 at para 28.

⁵ *Ibid*.

⁶ *Ibid* at para 40.

⁷ *Ibid* at para 41.

⁸ *Ibid* at para 43.

⁹ *Ibid* at para 49.

¹⁰ *Ontario Nurses’ Association v Mount Sinai Hospital*, [2004] OJ No 1900 (OCA) (QL).

¹¹ SO 2000, c 41 [ESA 2000].

¹² Section 9 of O Reg 288/01.

Criminal charges against marijuana compassion club members stayed

As reported in a newspaper article, a British Columbia Provincial Court judge has stayed charges of possession of marijuana for the purpose of trafficking.¹ Smith and Budda were charged after a January 2002 police raid on a business operating as a “compassion club.”

In her reasons, Judge Chaperon expressed satisfaction that the men imposed restrictions on the distribution of the drug. On this basis, she confirmed that they “operated a compassion club to provide persons with a medical need with a safe, reliable supply of marijuana.”² Judge Chaperon also raised questions about the constitutionality of the law under which the accused had been charged.

Comment

This is not the first time that compassion club volunteers have successfully avoided criminal liability for distributing marijuana to people who use it for medical purposes. In one significant

case, the Ontario Court of Appeal upheld the Superior Court of Justice’s *Hitzig* decision finding the Marijuana Medical Access Regulations (MMAR)³ represented an unconstitutional barrier to accessing a legal supply of marijuana for persons with a recognized medical need.⁴

The regulations challenged in *Hitzig* were in effect in January 2002 when the accused were arrested and charged. Subsequently, the MMAR have been amended to allow authorized individuals to obtain marijuana for medical purposes from a supplier contracted by the federal government.⁵

— Barbara Mysko

¹ J Bell. Compassion club operator sees pot charges stayed by judge. *Victoria Times-Colonist*, 9 September 2004.

² *Ibid.*

³ SOR/2001-227.

⁴ *Hitzig v Canada*, [2003] OJ No 12 (CA) (QL). For a full summary of the decision and its implications for people living with HIV/AIDS, see G Cruess. Ontario court affirms that medical marijuana regulations are unconstitutional. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 53-56. For further case references concerning the application of the MMAR to compassion clubs, see G Betteridge. Criminal charges against marijuana compassion club volunteers stayed on constitutional grounds. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(1): 63.

⁵ See D Garmaise. Health Canada makes marijuana available for medical use. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(1): 22-24.

Federal Court permits contaminated-blood litigation to proceed

In ongoing legal proceedings involving people infected with HIV through contaminated blood products, on 3 June 2004 Campbell J of the Federal Court permitted the plaintiffs to refile an amended statement of claim, thus allowing the litigation to proceed. As reported in a previous issue of the *Review*, the court had struck out their original statement of claim, ruling (among other things) that it disclosed no reasonable cause of action and constituted an abuse of process.¹

In a case filed in an Ontario court, the plaintiffs had alleged that certain government officials were negligent

because they delayed in taking steps to protect the plaintiffs from contracting HIV through blood products. The

plaintiffs were unsuccessful in that case. The plaintiffs believed that they were unsuccessful because of a lack

of evidence, the evidence having been destroyed when certain records were destroyed. So the plaintiffs then brought a Federal Court case against the people alleged to be responsible for destroying the records, namely members of Canadian Blood Committee (CBC).

The issue before Campbell J was whether the claims brought in the plaintiff's amended statement of claim should be struck out. The amended statement of claim included a claim for loss of chance related to the Ontario case, misfeasance in public office, and breach of fiduciary duty.

The plaintiffs claim for damages for "the destruction of the CBC audiotapes and transcripts, which they argue caused a 'loss of chance of success at the Ontario Court of Appeal,'"² is based on the argument that "the spoiled records could have made a difference ... if the content was known."³ In dismissing the original statement of claim, the Federal Court found that the plaintiffs were prevented from challenging the findings on causation made by the Ontario Court of Appeal in a legal action arising out of the same facts. Campbell J

relied on this earlier decision of the Federal Court to find that the paragraphs relating to loss of chance should be struck from the amended statement of claim.

As for misfeasance in public office, the plaintiffs claim that the three individual defendants, who were members of the Secretariat of the CBC, engaged in "deliberate and unlawful conduct in their capacity as public officers when they destroyed the audiotapes and transcripts."⁴ Campbell J found that the plaintiffs may be successful in their argument, since "it is enough that the breach [of the duty owed in a tort claim of misfeasance in public office] is of a kind that is part of the general duty imposed by Parliament and owed to the Crown or to the public by a federal employee." Further, he noted that this claim was not raised or adjudicated in the Ontario action and, therefore, that the plaintiffs were not prevented from making the claim in an action in the Federal Court.

As to the claim of breach of fiduciary duty, the plaintiffs alleged that the CBC owed a fiduciary duty to preserve the records of its operations so

that its performance as a fiduciary could be reviewed. Additionally, they argued that since the Canadian government was a member of the CBC, it could also be directly, as well as vicariously, liable. Campbell J held that it was "not plain and obvious that a properly framed claim for damages [including punitive damages] arising from a fiduciary duty has no chance of success."⁵

Campbell J ordered that the plaintiffs be permitted to refile the amended statement of claim, striking the claim of loss of chance, but allowing the claims of misfeasance in public office and breach of fiduciary duty to proceed.

— Arryn Ketter

¹ See *Leblanc v Canada*, [2003] FCJ No 1005 (FCTD) (QL). For further information, see C Smith and G Holly, Court strikes out latest action in contaminated blood litigation, *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 56-57.

² *Leblanc v Canada*, [2004] FCJ No 984 (FC) (QL) at para 18.

³ *Ibid* at para 20.

⁴ *Ibid* at para 23.

⁵ *Ibid* at para 28.

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.

India: Court finds government has constitutional obligation to provide ARVs to released prisoner

On 5 May 2004 the High Court of Delhi upheld an HIV-positive person's fundamental right to access treatment and medicines.¹ This is a significant decision, given the number of people in India estimated to be infected with HIV. The decision will have implications for the government's rollout of antiretroviral (ARV) therapy.

The case involves LX, a man who was diagnosed as HIV-positive while incarcerated at Tihar jail in Delhi. Upon diagnosis, the hospital prescribed a combination of ARVs. When LX was granted bail in May 2000, the jail authorities informed him that they would discontinue his ARV medicines upon his release.

In December 2000 the ex-prisoner

filed a writ before the High Court of Delhi. He argued that there is a positive obligation on the state to ensure the continuation of the ARVs even after bail, and that a failure to fulfill this obligation would constitute an infringement of the constitutional right to life and health. In January 2001 the court issued an interim order directing the jail hospital to

supply the ARVs. As a result of administrative difficulties, the order was modified a year later, ordering the All India Institute of Medical Sciences (AIIMS) to provide the ARVs instead.

In January 2004, after further arguments by the parties, the court directed LX to present himself at Lok Nayak hospital, one of the hospitals

designated for the government rollout plan under the National AIDS Control Programme (NACP). At the hospital, LX was told that he did not qualify for the plan and that his drug prescription was not provided for under the scheme.

The parties returned to court. On 5 May 2004 the court ordered the AIIMS to continue providing ARVs to LX until 30 June 2004, and ordered that in the meantime LX was to be examined by a physician for the purposes of providing him with medica-

tions under the NACP. The court specified that in the event that a switch in medications was ordered under the NACP, the physician was to confirm the efficacy of the medications such that LX would “continue to enjoy the benefits of the medicines as in the past.”² Finally, the court ordered that if the medications available under the NACP were not suitable, LX was to be provided with the medications he was already taking.³

– Barbara Mysko

Barbara Mysko is a student at the Faculty of Law, McGill University.

¹ *LX v Union of India & Ors*, WP (Civil) 7330/2000 (HC). See also: Delhi, India High Court decision upholds HIV positive person’s fundamental right to ARV treatment. Lawyers’ Collective HIV/AIDS Unit, press release, 17 May 2004.

² *LX v Union of India & Ors*, supra, note 1 at para 4.

³ *Ibid* at para 5.

India: Challenge to constitutionality of criminal law banning homosexual acts dismissed

On 1 September 2004 the Delhi High Court dismissed litigation seeking to quash a law making homosexual acts a punishable offence.¹ Section 377 of the Indian Penal Code dates back to the 1860s, during the period of British colonialism. Two NGOs, one of which was an AIDS organization involved in prevention work, challenged the law after being criminally charged.

In June 2001 police raided the offices of Naz Foundation and the National AIDS Control Organization (NACO), resulting in the arrest of four workers.² The workers were charged with conspiracy to commit “unnatural sexual acts” under section 377 of the Indian Penal Code, which provides that “Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with 152 [imprisonment for life], or with imprisonment of either description for a term which may extend to ten years, and

shall also be liable to fine.” The workers were also charged with at least four other counts of obscenity related to safer-sex educational materials found on their premises. The workers were imprisoned for 45 days, until granted bail on their third application.

The original petition to the Delhi High Court was filed in December 2001 by the Lawyers Collective and Naz Foundation. Lawyers for the organizations argued that section 377 sanctions discrimination against sexual minorities and runs counter to laws guaranteeing the right to liberty and

privacy enshrined in the Indian Constitution. The Lawyers Collective argued that the Section is often used to harass lesbian, gay, bisexual, and transgender persons. Ironically, the Joint Action Council (JAC), a prominent group promoting the rights of HIV-positive people, filed a petition indicating that there was no evidence section 377 had ever been used against gay people.

The High Court dismissed the litigation on technical grounds, stating that there was “no cause of action” and that a petition cannot be filed

“just for the sake of testing the legislation.”³ It cited a prior decision that it could not give “advisory opinions or declaratory judgments” on whether a valid law is constitutional “apart from some concrete injury or controversy.”⁴ The court refused to express an opinion where nobody was “aggrieved” and where it was being asked to examine the legislation “academically.”⁵

The Lawyers Collective plans to seek alternative legal avenues to decriminalize sex between consenting adults of the same sex. They will ask for a review of the dismissal by the High Court or take their case to the Supreme Court.

– Barbara Mysko

¹ *Naz Foundation v Govt. of NCT, Delhi & Ors*, WP (Civil) No 7455/2001 (HC). See also: R. Devraj. Fight to decriminalize gay sex is pressed by activists. Inter Press Service, 16 September 2004.

² Indian High Court dismisses sodomy law challenge. International Gay and Lesbian Human Rights Commission, press release, 3 September 2004.

³ *Naz Foundation*, supra, note 1.

⁴ *Ibid.*

⁵ *Ibid.*

Libya: Foreign health-care workers sentenced to death for deliberate infection

On 6 May 2004, five Bulgarian nurses and a Palestinian doctor accused of deliberately infecting 426 children with HIV were sentenced to death by the Benghazi Criminal Court in Libya.¹ The execution is to be carried out by firing squad. The panel of five judges also sentenced a sixth Bulgarian, a doctor, to four years' imprisonment. The doctor originally faced the same charges as the others, but instead was convicted of illegally changing foreign currency. The court did not explain the modification of charges.

The case began when members of the medical staff of al-Fateh Children's Hospital in Benghazi, Libya, were arrested in January 1999. Children being treated at the hospital were infected with the virus between April 1997 and March 1999. By the date the decision was rendered, over 40 children had died.

Libyan leader Moammar Gadhafi initially accused the workers of being involved in a CIA- and Israeli-led conspiracy, but later backed away from this accusation.² After the charges were laid, some representatives of European governments and human rights groups blamed the Libyan health ministry for the infections. They alleged that the ministry failed to properly screen blood products and permitted inadequate sterilization

practices.³ A professor testified at the trial that poor hygiene and “the re-use of infected medical equipment” were the probable causes of infection.⁴

Throughout the trial, European Union spokesman Diego de Ojeda and Amnesty International (AI) representatives reported serious violations of the rights of the accused.

Interviews with the defendants conducted by AI uncovered stories of torture in order to extract confessions.⁵ Defendants complained of electric shocks, sexual abuse, and beatings.

In response to these allegations, eight members of the Libyan security forces and two civilian employees were charged with torturing the defendants. They were tried in the same proceedings as the medical staff. In its judgment, the court stated that it was

“not competent” to consider the torture charges.⁶ The court did not explain if it was dropping the charges or referring them to another court.

Under Libyan law, death sentences lead to an automatic appeal. If the appeal fails, the Supreme Council of Judicial Bodies of Libya must consent to the discharge of the death sentence.

– Barbara Mysko

¹ B. Whitaker. Medics face Libyan firing squad for giving HIV to children. *The Guardian*, 7 May 2004; Libya: Quash death sentences against foreign medical professionals. Amnesty International: News Release, 6 May 2004, online at www.amnesty.ca/resource_centre/news.

² Whitaker, supra, note 1.

³ EU asks Libyan leader Kadafi to release Bulgarian health care workers on trial for allegedly infecting children with HIV. Kaiser Daily HIV/AIDS Report, 29 April 2004.

⁴ *Ibid.*

⁵ Amnesty, supra, note 1.

⁶ Whitaker, supra, note 1.

UK: Court grants asylum to pregnant claimant, citing European Convention

An HIV-positive Ghanaian woman who applied for asylum in the United Kingdom has been granted permission to remain on the grounds that returning her to Ghana would violate the rights of her unborn child pursuant to Article 3 of the European Convention on Human Rights.¹ Article 3 states that “no one shall be subjected to torture or to inhuman or degrading treatment or punishment.”²

The applicant applied for asylum for the first time in 1999 on the ground that had she remained in Ghana her life would be at risk. Her claim was refused. When she appealed the decision, she was pregnant. Thus, she contended that not only her Article 3 rights, but also those of her unborn child, would be violated if an order was issued to return her to Ghana. She argued that if she were forced to return to Ghana, she would have no alternative but to breastfeed, which would put the unborn child at risk of contracting HIV.

The adjudicator rejected the Article 3 claim as to the mother, but accepted it with regard to the unborn child. The Secretary of State appealed the decision to the Immigration Appeal Tribunal (IAT). The IAT held that the

decision of the adjudicator had been “perverse” and accordingly reinstated the decision of the Secretary of State to refuse her claim for asylum. The applicant appealed the decision of the IAT to the Court of Appeal, arguing that the IAT had overturned the ruling based on the facts. Appeal tribunals are not permitted to overturn administrative tribunal decisions based on the facts; they may do so only on errors of law.

The Court of Appeal held that the IAT “had plainly erred in finding the decision of the adjudicator to have been perverse.” Setting aside the decision of the IAT, the court wrote that “although the foetus had no right to life, the position of the unborn child was rightly a determinative issue. It was *an obvious matter of humanity* that where a mother had to witness

her own child contracting and then dying from HIV/AIDS, that would constitute inhumane treatment far in excess of her experience in personally contracting the infection and suffering accordingly.”

– Arryn Ketter

Arryn Ketter is a student at the Faculty of Law, McGill University.

¹ *CA v Secretary of State for the Home Department*, [2004] All ER(D) 354 (CA).

² [European] Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No 5) 213 UNTS 222, entered into force 3 September 1953, as amended, at Article 3.

UK: House of Lords recognizes that privacy rights include protection of mental health

Razgar, an Iraqi national, had claimed asylum in the United Kingdom. He was not HIV-positive. He suffered from a psychiatric disability and was challenging an order that he be removed to a third country on the basis that it would detrimentally affect his mental health.

The House of Lords was asked to consider whether the rights protected by article 8 of the European Convention on Human Rights were engaged by

the foreseeable consequences for health or welfare of removal from the United Kingdom in the case where the removal would not constitute a violation of article 3.¹ Article 8 provides that “everyone has the right to respect for his private and family life, his home and his correspondence.”² Article 3 states that “no one shall be subjected to torture or to inhuman or degrading treatment or punishment.”³

The House of Lords cited *Henao v Netherlands*,⁴ which held that “removal cannot be resisted merely on the ground that medical treatment or facilities are better or more accessible in the removing country than in that to which the applicant is to be removed.”⁵ In *Henao*, the HIV-positive applicant was from Columbia and was seeking asylum in the Netherlands based on the rights guaranteed under article 3 of the European Convention on Human Rights.

The House of Lords agreed with the decision of the European Court of Human Rights in *Henao*, writing that it would “frustrate the proper and necessary object of immigration control in the more advanced member states of

the Council of Europe if illegal entrants requiring medical treatment could not, save in exceptional cases, be removed to the less developed countries of the world where comparable medical facilities were not available.”⁶

The House of Lords also proposed to adopt the same approach to the application made on the grounds of article 8, asserting that “the Convention is directed to the protection of fundamental human rights, not the conferment of individual advantages or benefits.”⁷ However, the rights in article 8 also protect the preservation of mental stability and mental health as a crucial part of one’s private life.⁸

Therefore, the House of Lords held that “the rights protected by article 8 can be engaged by the foreseeable consequences for health of removal from the United Kingdom pursuant to an immigration decision, even where such removal does not violate article 3, if the facts relied on by the applicant are sufficiently strong.”⁹

In the case of the applicant, the House of Lords found that the facts he relied on were sufficiently strong to

make out a case for a violation of his article 8 rights, and that the Secretary of State was in error to hold that the applicant’s claim was manifestly unfounded.

This case is significant for HIV-positive asylum seekers, as it may provide a ground upon which to challenge deportation orders where the mental health of the asylum seekers might be endangered by deportation.

– Arryn Ketter

¹ *R (on the application of Razgar) v Secretary of State for the Home Department*, [2004] UKHL 27 (HL).

² [European] Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No 5) 213 UNTS 222, entered into force 3 September 1953, as amended, at article 8.

³ *Ibid* at article 3.

⁴ European Court of Human Rights, 24 June 2003, unreported.

⁵ *R (on the application of Razgar)*, *supra*, note 1 at para 4.

⁶ *Ibid*.

⁷ *Ibid*.

⁸ *Ibid* at para 8.

⁹ *Ibid* at para 10.

Criminal law and HIV transmission or exposure: four new cases

New Zealand: Six years for non-disclosure to four women

A New Zealand court has sentenced a man to six years’ imprisonment for having sex with four women without

disclosing his HIV-positive status.¹ According to news reports, Shingirayi Nyarirangwe is a refugee from Zimbabwe living in Auckland since 2001.

Hubble J of the Auckland District Court sentenced the man to three

years in jail after he pleaded guilty to four charges of criminal nuisance and three charges of assault. The terms were cumulative, consisting of six months on each of the criminal nuisance convictions and four months on each of the assault convictions.

The judge said the number of victims involved and their anguish in waiting for their HIV results were aggravating factors. Nyarirangwe has been held in custody since August of last year and could soon be considered for parole because he has already served a third of his sentence.

Australia: Ten-year sentence for infecting three women

In Australia, a 28-year-old man has been sentenced to 10 years' imprisonment for infecting three women with HIV.² Feston Konzani is an African asylum seeker living in Middlesbrough.

In 2000, Konzani was diagnosed as HIV-positive and was told to warn any future partners of his HIV status. The accused had sex with the women between November 2000 and August 2003, and failed to disclose that he was HIV-positive. Konzani was charged with four counts of causing grievous bodily harm, but he was later cleared of one of the charges.³ It took the jury less than three hours to convict Konzani on the three remaining charges.

Fox J of the Teesside Crown Court sentenced Konzani to one four-year sentence and two three-year sentences to run consecutively. The court was informed that Konzani will be deported to Malawi after serving his prison sentence.

Australia: Man convicted on retrial

In another Australian case, a 37-year-old man was convicted for the second

time of causing grievous bodily harm to a teenage woman by infecting her with HIV.⁴ Ronald Houghton was diagnosed as HIV-positive in 1990.

The pair had sex over a four-month period in 1999, during which time Houghton failed to disclose his status. The woman found out she was HIV-positive after donating blood in January 2000. Although she confronted Houghton, he denied having the virus and produced false test results as evidence.

On 3 October 2002, Houghton became the first person in West Australia convicted and jailed for infecting a sexual partner with HIV. The trial court sentenced Houghton to seven years. On appeal, Houghton raised 15 arguments as to why the conviction should not stand. The Court of Appeal quashed his conviction and granted him a retrial.⁵

At the retrial this September, the District Court jury deliberated for about two hours before finding Houghton guilty of causing grievous bodily harm. Sentencing is scheduled for late October. The maximum penalty for the charge is 10 years' imprisonment.

France: First conviction for non-disclosure and transmission

For the first time in France, an HIV-positive person has been convicted for engaging in sexual intercourse leading to HIV infection, and not disclosing his HIV-positive status.⁶ A Strasbourg court sentenced Christophe Morat to six years in prison for "voluntary transmission of a harmful substance leading to bodily harm or permanent illness."⁷

Morat was diagnosed with HIV in 1998. The two complainants engaged in unprotected sex with Morat and were infected in 1999 and 2000. One of the women claimed to be allergic to latex condoms. The court first decided against Morat in May 2004. The decision was rendered in Morat's absence and without the presence of legal representation. Because he was not present or represented by a lawyer, Morat had the option of opposing the decision and being retried. Morat entered his opposition to the judgment in June.

He was convicted after a rehearing, and the court took into consideration in determining a sentence the demands of public order and the need to prevent the further spread of the disease. The court decided that six years' imprisonment constituted a "proportionate" sentence in the circumstances.⁸

— Barbara Mysko

¹ HIV-positive man pleads guilty to unprotected sex charges. *New Zealand Herald*, 31 August 2004; HIV convict up for parole soon. *New Zealand Herald*, 11 September 2004.

² HIV man is jailed for 10 years. BBC News: UK Edition, 14 May 2004.

³ HIV accused cleared of one charge. BBC News: UK Edition, 12 May 2004.

⁴ D Darragh. Man who gave woman HIV guilty again. *West Australian* [Perth], 11 September 2004.

⁵ *Houghton v The Queen*, [2004] WASCA 20.

⁶ Six ans de prison pour avoir sciemment contaminé par le VIH ses partenaires. *Le Monde*, 28 June 2004.

⁷ Author's translation of "administration volontaire d'une substance nuisible ayant suivie de mutilation ou infirmité permanente."

⁸ *Le Monde*, supra, note 6 at 8.

In brief

Mexico: Discharge of HIV-positive soldiers discriminatory and unconstitutional

The Cuarto Tribunal Colegiado en Materia Administrativa has ruled that the provision of the Social Security Institute Law for Mexico's armed forces that allows for discharge based on HIV infection constitutes discriminatory treatment and is unconstitutional.¹ The law was passed by Congress last year. The ruling raises

the possibility that the law, which also allows those in the military with tuberculosis or diabetes to be discharged, may be repealed.

The court reasoned that the armed forces are governed by the Mexican constitution, six international treaties, and several federal laws that prohibit discrimination and dismissal of people living with HIV. In May 2004 the Party of the Democratic Revolution presented an amendment that would eliminate HIV as a ground for discharge, since HIV infection does not

entail a person's inability to work. The court's verdict cannot be appealed.

– *Arryn Ketter*

¹ D Cevallos. Court rules army cannot discharge HIV-positive soldier: Inter Press Service, 1 June 2004.



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BANGKOK 2004: LAW, ETHICS, AND HUMAN RIGHTS

In this special section of the *HIV/AIDS Policy & Law Review*, made possible by funding received from the Joint United Nations Programme on HIV/AIDS (UNAIDS), we reproduce the most relevant presentations on legal, ethical, and human rights issues related to HIV/AIDS given at the XV International AIDS Conference in Bangkok, Thailand, in July 2004, and at the many satellite meetings. We also provide selected abstracts. We did the same for Geneva98,¹ Durban 2000,² and Barcelona 2002.³ With funding from UNAIDS, this issue will be mailed to over 500 people and organizations with an interest in HIV/AIDS and human rights, particularly in developing countries, in addition to the Review's regular distribution list. This issue will also be distributed via the UNAIDS Information Centre to thousands of additional recipients. The goal is to increase access to materials on human rights, legal, and ethical issues related to HIV/AIDS for individuals and organizations worldwide; to facilitate networking among individuals and groups active in the area; and to promote policy and legal responses to HIV/AIDS that respect human rights.

Issues concerning the rights of women and of injection drug users figured prominently in Bangkok, and this is reflected in the choice of articles and abstracts for this special section.

¹ Geneva98: Law, Ethics, and Human Rights. Canadian HIV/AIDS Policy & Law Newsletter 1999; 4(2/3): 78-117, available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/geneva98.htm.

² Durban 2000: Law, Ethics and Human Rights. Canadian HIV/AIDS Policy & Law Review 2000; 5(4): 54-117, available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol5no42000/durbanintro.htm.

³ Barcelona 2002: Law, Ethics, and Human Rights. Canadian HIV/AIDS Policy & Law Review 2002; 7(2/3): 77-122, available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol7no2-32003/barcelona02.htm.

Not as simple as ABC: making real progress on women's rights and AIDS

In a world where the subordination and abuse of women and girls is driving the HIV/AIDS epidemic, significant resources must be invested in programs that will offer women real protection against human rights abuses. This was a central theme of Joanne Csete's presentation at "Acting on rights: women, HIV/AIDS and the Barcelona Bill of Rights," a satellite meeting held on 11 July 2004 and organized by Health Canada. This article, which is based on the presentation, discusses the limitations of the ABC approach to HIV prevention; lists some of the contextual factors that feed the subordination of women; and describes some of the violations of women and girls linked to HIV/AIDS. The author calls for the establishment of large-scale, intersectoral programs addressing the structural factors that constrain the behavioural choices of women.

One would think that with a phenomenon as socially and behaviourally complex as the AIDS epidemic, there would be a lot of competing theories about how best to understand and address the social factors related to the disease. There is some of that, but I am struck by the continued prominence in powerful policy circles of a single idea about the social and behavioural underpinnings of AIDS that has been dominant from the beginning of the epidemic – that is, that AIDS is a disease that comes mostly to people who have uncontrollably bad behaviour. According to this view, people who are infected with HIV are sexually promiscuous, they have sex with the wrong people, they take drugs, they sell sex – in other words, they can't master themselves and their urges.

We witnessed a particularly vile version of this in the early years of the North American epidemic from a range of people that included religious fundamentalists and some prominent US politicians. The same paradigm that condemned people with AIDS in the US as deserving what they got became a ready base from which to cast judgments on what was happening in Africa. In the

late 1980s the dominant analysis in some Western circles was that the main determinant of health problems in Africa was overpopulation. There were whispered theories in some halls of power to the effect that Africans, with their burgeoning population and uncontrolled sexual behaviour, were also bringing this disease upon themselves. With rare and courageous exceptions, the not-very-veiled policy line was "Why should this disease matter? The people who get it are just junkies, just homosexuals, just prostitutes, just Africans."

Although today people don't say these things in quite the same way, has the underlying analysis really changed? Instead of using the language of blame, the more common practice now is to focus on the flip side of the coin and talk about the "innocent victims" of AIDS – the babies born with HIV, the people infected through blood transfusion – in contrast to those who are guilty of bad behaviour and of not being able to control their urges. To this day in the US, for example, the main legislation that appropriates funds for domestic AIDS programs is named after Ryan White, an "innocent vic-

tim" who died of AIDS at age 19 after being infected through a blood transfusion.

The limitations of ABC

It is the natural corollary of all this thinking that the best way to prevent HIV transmission is to get these people with bad behaviour to master themselves and correct their behaviour. Hence ABC – abstinence, be faithful, condoms – the ultimate expression of getting people to straighten themselves out. Many supposed ABC-based programs are thinly disguised A-only or AB-only programs. In addition, the version of ABC that is so heavily underwritten by the US is dangerous because it violates people's right to basic information. The message is not "Here's information about how to protect yourself from HIV and other STDs, but you should think about sexual abstinence as a possibility" – but rather "It's better for you to be ignorant about the basics of HIV transmission than to be led down the path of immorality by sex education." In the worst versions of ABC, young people are given misinformation about the supposed ineffectiveness of condoms. But then, proper sex edu-

cation does not correspond well to the vision of goodness, womanhood, and femininity held by people who tend to preach sexual abstinence – good women (or men, for that matter) shouldn't think too much or know too much about sex.

The version of ABC that is so heavily underwritten by the US is dangerous because it violates people's right to basic information.

No matter how you cut it, the simplistic framework of blame that is embodied in ABC adds up to an appalling ignorance of the structural factors of violence, abuse, sexual stereotyping, and subordination – an ignorance that constrains the choices and behaviour of women and others at high risk of HIV.

The situation of women

The subordination and abuse of women and girls drives the HIV/AIDS epidemic in every part of the world. Some of the contextual factors that feed this are:

- society's double standard for sexual conduct: men, even in long-term unions, may "graze" while women may not question or defy this;
- stereotypes and social norms of both femininity and masculinity that victimize men as well as women;
- the disparate impact of poverty on women and girls, which too often leads to situations in which they are constrained to trade sex for survival;
- the economic dependence of

women and girls on men, which limits the ability of women to leave dangerous marriages and other unions; and

- a global deterioration in reproductive rights.

In a relatively short time, Human Rights Watch (HRW) has documented numerous violations of the human rights of women and girls linked to HIV/AIDS. These include the following:

- **Domestic violence and marital rape.** In Uganda, about 40 percent of women report having been beaten in their homes. To our dismay, the National AIDS Program doesn't seem to see this as a central concern. Many women there told us they would not think of telling their friends or relatives about this abuse, let alone the police.
- **Sexual violence, abuse, and coercion.** There are epidemic levels of rape and sexual abuse in country after country. In South Africa in 2000, a survey of 37,000 young men found that by age 18, one-quarter of them had forced a woman or girl to have sex, and 20 percent of them thought that a girl being raped enjoyed it.
- **Inadequate prosecution of sex crime offenders.** HRW has observed trials of alleged sex offenders around the world, and has seen the winks and nods of judges and prosecutors and sometimes the complete dismissal of women's and girls' testimonies as rape survivors.
- **Discrimination against women in the law** – especially property, inheritance, and divorce law, which, among other things, exacerbate women's economic dependence on men.
- **Abuses faced by girls orphaned and otherwise affected by AIDS.** The combination of AIDS-related stigma, poverty, and lack of parental care makes for horrific abuses against girls affected by AIDS. HRW has heard many times from girls who lost their parents, moved in with a relative or foster family, and had the man meant to be their "guardian" say to them, "Your parents died of that disease. No one else will take you in, so how can you refuse me?"
- **Infringement (disparate) of the right to education.** Many times, people around the world have said to us "Well, you wouldn't pull a boy out of school to take care of a sick person; who would do that?"
- **Elements of some traditional practices** – not just female genital mutilation, which carries its own HIV risks, but also widow inheritance, cleansing of widows through sex with a stranger, and other practices.
- **Gender discrimination in access to health services and health information** – exacerbated by "abstinence until marriage" approaches and infringement of reproductive rights.
- **A wide range of abuses faced by sex workers** – not just women but also men and transgendered persons. If we think that it's hard for any woman to report a rape and be taken seriously in some places, imagine how much harder it is for sex workers who, by definition, under the law in some countries, cannot be raped.

These issues are starting to get more attention. But the sad truth is that there are very few resources funding very few programs to provide real protections of the human rights that are being so consistently violated in these areas. By contrast, the strategy of preaching morality has many millions of dollars behind it. It is politically easy. It appeals to the worst and easiest-to-reach impulses in people who are important political constituents of certain powerful governments.

There are very few resources funding very few programs to provide real protections of the human rights that are being violated.

Going beyond ABC

Even in its best variation, ABC, whether aimed at women or men, is clearly far too narrow as a formula for HIV prevention. If we insist on alphabetic mnemonic devices, I would like to propose an extension – a “DEF” – that would force a deeper view of the structural factors that constrain behavioural choices (with a focus on the legal framework):

D: Defend against sexual and domestic violence, improve prosecution of offenders, and ensure the availability of post-exposure prophylaxis to all survivors of rape. There is well-documented experience from South Africa and numerous other countries that special training for police, prosecutors, judges, social workers, and other service providers – as well as offering certain protec-

tions for witnesses and rape survivors – can dramatically improve prosecution of sex offenders.

E: Ensure girls’ education (legally) as a step to economic equality. Ensure that schools are safe and that curricula give real information on HIV/AIDS and related issues.

F: Fix gender inequality in property, inheritance, and divorce laws. Among other things, this means that there is a presumption in the law that marital property is held jointly and is equally divided upon termination of marriage; that there is consent from both spouses on decisions of transfer of land and housing; and that dowry payment is not a legal requirement for marriage of any kind.

The law will not help with everything – a good legal framework is a necessary but not sufficient condition for the kind of change we seek – but it *is* necessary, and it is feasible. If legal change happens, of course, we will then have to fight like hell to be sure that good laws are implemented.

The UN’s World AIDS Campaign for 2004-2005 is called “Women, Girls, HIV and AIDS.” We have to do everything possible to ensure that it is effective in measurable ways. It would be wonderful if the UN could broker a real program of protection of women from AIDS-related human rights abuses. And if the UN could find a willing government at national or subnational levels and some willing donors – not just a pilot but a large-scale intersectoral program, generously funded, rigorously evaluated – that would demonstrate:

- that you can work with men and women together to change patterns of violence;

- that you can train police and justice officials so that prosecution of sexual offenders is not a joke;
- that you can keep girls in school and keep schools safe;
- that you can get traditional and religious leaders and even some married men behind the idea that marital property is jointly held;
- that women can be allowed to initiate fair divorces without society falling apart;
- that women can be informed of their rights and organize around that information; and
- that when marital rape is treated as a crime, AIDS has a new enemy.

There is another vision of AIDS – other than as the disease of bad behaviour – that seems to attract nearly as much attention these days. It is AIDS as a security threat –

When will we recognize the terror in the fact that violence against women is seen by policy-makers the world over as an unfortunate reality of life that one can’t do much about?

which, as UN Special Envoy for HIV/AIDS in Africa Stephen Lewis says, is somehow always instantly riveting. If we are forced to link AIDS to security and terror, my question is this: When will we recognize the terror in the fact that in all countries where studies have been done, between 20 and 50 percent of young women report that

their first sexual encounter was forced? Or that there are more countries than not where more than one woman in three has been beaten in the home? Or that violence against women is seen by policy-makers the world over as an unfortunate reality of life that one can't do much about?

That there are hundreds of millions of dollars behind ABC and almost nothing for real protection of the human rights of women linked to AIDS constitutes a blatant disregard for women and for the real terror of violence against, and subordination of, women. Public health policy-making in circles of great power has been taken over by forces that are far from being concerned about the human rights or the best interests of those most affected

by AIDS. When did it become acceptable for policy on a problem as complicated as this to be dominated by simplistic, sanctimonious slogans about abstinence and fidelity? How long will we continue to watch AIDS policy and programs reflect the worst of the world's misogyny, homophobia, denial of humanity of sex workers and drug users, and self-righteousness?

It is time for our own anti-terrorism campaign, which, unlike the one that dominates headlines in today's world, will not be about addressing human rights violations by committing more of them. There is no mystery about how to protect women's rights in the ways that are most relevant to reducing their HIV risk and improving their access to AIDS care.

Thousands of women's organizations and other civil society actors, and a few governments, are doing this work and are desperate for support. The cost of policies that reduce AIDS to "bad behaviour" is high and has been borne too long and too disproportionately by women and girls. It is time to shift the analysis of the determinants of AIDS, and to shift how resources are allocated so that we can bring about the real changes in women's lives that are the true hope of stopping AIDS.

– Joanne Csete

At the time of writing, Joanne Csete was the Director of the HIV/AIDS and Human Rights Program at Human Rights Watch.

Making prevention work

In her plenary address on 14 July 2004 at the XV International AIDS Conference in Bangkok, Thoraya Ahmed Obaid, Executive Director of the United Nations Population Fund, also addressed issues related to women and HIV/AIDS. The following are a few extracts from her presentation:

- The women and girls who are more vulnerable to HIV/AIDS are the same women and girls who are coerced into early marriage; who die in labour after too many closely-spaced births; who suffer from sexually transmitted infections and unwanted pregnancies; who have unequal access to education and health care; who are told that if they get married they will be safe from HIV and AIDS; who suffer in silence from violence and abuse; and who are infected by their unfaithful husbands.
- It is a sad commentary and an indictment of our inaction that in some places women themselves can be inherited, yet they cannot inherit land and property.
- It is time to dispel the myth that child marriages protect girls from HIV; we need to expose this practice for the dangerous risk that it is.
- To make prevention work, we must confront the widespread poverty and gender discrimination and violence that help the epidemic to spread.... To make prevention work for women and girls[, w]e must work within cultures to challenge the social norms that contribute to the lower status of women and girls and that condone violence against them.
- To make prevention work, stopping violence against women and girls must be a priority. Laws must be strengthened and enforced. Perpetrators must be brought to justice. From the time they are on their mother's knee, boys should be taught that this kind of behaviour is unacceptable.
- Leaders at all levels – including political leaders, traditional leaders, religious leaders, and community leaders – must carry the message of zero tolerance of violence against women and girls forward.

– Thoraya Ahmed Obaid

Young women living with HIV/AIDS have rights too: a personal testimonial

Many women living with HIV/AIDS continue to be treated as second-class citizens. In this presentation prepared for “Acting on rights: women, HIV/AIDS and the Barcelona Bill of Rights,” a satellite meeting held on 11 July 2004, Promise Mthembu poignantly describes the stigma, discrimination, and abuse that she has faced as a young HIV-positive woman in Africa. The presentation discusses the issues of violence, disclosure, power imbalances in relationships, reproductive rights, safer sex, and access to health care. The presentation concludes with a series of specific recommendations for helping women living with HIV/AIDS realize their rights. Because Ms Mthembu was unable to attend the meeting in person, her presentation was read by Kanjoo Mbaindikua, who told the delegates at the meeting that she shares many of Ms Mthembu’s circumstances and experiences.¹

HIV/AIDS is a growing problem among women globally. At the end of 2003, women accounted for more than half of new HIV infections. These are women in the productive and reproductive years of their lives. I am one of these women. I want to share with you some of my experience of living as an HIV-positive woman, and to highlight the stigma, discrimination, and hardship that women living with HIV/AIDS face.

My story

I learned about my HIV status in 1995 when I went for my tuberculosis check-up. I was 20 years old at the time. (I think that I was infected when I was 15 years old because my child, who is now 12, is also living with HIV/AIDS. The doctors speculate that the child was infected at birth.)

I was pregnant. I happily agreed to have an HIV test at the time, never thinking that the result would be positive. When I received my result, I was shocked and angry. I had been part of an HIV/AIDS project while at school. I knew about AIDS, but I just didn’t think it would happen to me. I had one sexual partner, was from a religious family, and was not sleeping around.

I found it very difficult to disclose my HIV status. After much soul-searching, I came to terms with the fact that I was HIV-positive and that I could do nothing to change the situation. I accepted myself as a woman living with HIV/AIDS. I told my partner and my family. My partner was shocked and found it hard to believe. My family was supportive.

Anger led me to attend AIDS meetings. I wanted to change the way AIDS work was being done. After all, if AIDS prevention were working, I would not have been infected. Five months after learning I was HIV-positive, I began to speak openly about living with HIV/AIDS in an effort to prevent others from becoming infected.

My parents were not happy about my speaking openly about living with HIV/AIDS. They are staunch Catholics and felt that my openness would impact negatively on the family in the eyes of the Church.

At eight months, the baby I was carrying died in utero. Three days after I discovered that my baby was no longer breathing, I was induced and I gave birth to a stillborn child. This was a horrifying experience for me. One day later my partner lost

another child that he had with another woman. This child was also stillborn and the cause was also an infection in utero. I began to realize that HIV was really in my body and was causing slow damage.

Losing two babies also made my partner worried. Up to that point, he had been denying that he might be infected. He started to question how he could be HIV-positive, and he began to blame me for bringing HIV into his life. It did not stop there. My husband went to his family and told them about my HIV status, but neglected to tell them that he was HIV-positive too. He told them that if anything happened to him, I would be responsible.

The abuse began growing daily. He beat me because he was HIV-positive and frustrated. I had to accept the way he was treating me – if I challenged his actions, it meant that I did not care for him. He demanded that I support him despite his abuse of me. It was at this time that I married him. We’d been living together for a while; he had paid *lobola* (bride wealth) to my parents. Although I knew the relationship was abusive, I felt I had no choice but to marry him.

Marriage changed nothing. He became more and more angry with me for attending AIDS meetings and giving talks about my personal story. He was jealous of my meeting other people who are HIV-positive, saying that I cared for and supported other people at his expense.

Although we were both receiving counselling and information about the necessity of practising safer sex in

Although I knew the relationship was abusive, I felt I had no choice but to marry him.

order not to reinfect each other, he forced me into unprotected sex because I was his wife and he had paid *lobola* for me. My life became an endless circle of beatings and unprotected sex, especially if he was drunk. I could not take it any longer and I left him, despite the cultural disgrace and shame that it caused.

Three months after leaving him, I became sick. The doctors diagnosed a cervical cyst. I was hospitalized so that the cyst could be removed. However, the doctors also found out that I was pregnant. I did not want to have a child at this stage and requested that the pregnancy be terminated. The doctors agreed to the termination only on condition that I consent to being sterilized. I had no option. Because of the attitude of the nursing sisters, it took three days for my termination to be performed. I had to put up with the judgmental attitude of the health-care staff, including their disbelief that a woman with HIV would get pregnant.

My story highlights some of the negative aspects and issues of being a

woman living with HIV/AIDS. However, things are not all negative. It is possible to live a positive life with HIV and its stigma and discrimination; the obstacles can be overcome.

Disclosure and relationships

The issue of disclosure has long been debated among AIDS activists, health-care workers, and people living with HIV/AIDS. It has been stated that disclosure is a double-edged sword. On the one hand, it may be constructive; it may help people living with HIV/AIDS to get the support and services they need. On the other, it can be quite destructive. Some women living with HIV/AIDS are chased out of their homes when they disclose their HIV status; others lose their jobs; many are denied medical care after telling the health-care workers they are HIV-positive. People have different reasons for promoting disclosure. For some people, it is the reduction in transmission of the virus; for others, it is support and care.

If we are to promote disclosure, we need to create a culture of human rights that enables people living with HIV/AIDS to disclose their HIV status without fear of negative consequences. We need to create strong support structures and services before we embark on mass disclosure campaigns.

Confidentiality is a basic right that all human beings enjoy. People living with HIV/AIDS should be able to expect the same rights as anyone else. We must start by giving people skills to disclose and by encouraging voluntary disclosure. People should not be pressured to disclose. Rather, they should be trained how to disclose, to make sure it is the right time for them. Health-care workers and others promoting disclosure should listen to people living with HIV/AIDS. If a woman

says she cannot disclose her HIV status due to fear of her partner, she should be supported in this decision.

HIV can take away your health, but it cannot take love away. As a woman living with HIV/AIDS, I still have relationships with friends, family, and colleagues. However, sometimes these relationships are destroyed because of fear and lack of knowledge about HIV/AIDS.

Due to testing at antenatal clinics, women are often the first in the partnership to receive an HIV-positive result. They are then faced with the responsibility to disclose and ensure that safer-sex practices are followed. Sex is a difficult issue for women living with HIV/AIDS. Many of us lack condom-negotiating skills. Like most women, women living with HIV/AIDS don't have the power to control their sexual lives. Moreover, women living with HIV/AIDS are expected to practise safe sex at all

We need to create a culture of human rights that enables people living with HIV/AIDS to disclose their HIV status without fear of negative consequences.

times. This is extremely difficult because "safe" means disclosure of HIV status. Many women fear the consequences of such disclosure.

The impact of having unsafe sex and worrying about reinfection is very traumatic and leaves women in the circle of powerlessness and fear. Some women decide not to have sex, but face abuse instead. They may even be raped and blamed. One young

woman living with HIV/AIDS whom I know did not want to have sex and was raped by a man who did not know her HIV status. After discovering her status, her family and that of the rapist blamed her for transmitting HIV to the rapist.

Reproductive rights

In my experience, there is an assumption that all women living with HIV/AIDS practise safer sex. The reality is that as much as we want to, we may not be in a position to do so.

Given that assumption, health workers get angry when we get pregnant. They personalize the issue and start abusing our rights. They have no empathy: the fact is that some women living with HIV/AIDS may choose to have a child for many reasons. All women have the right to reproduce. This includes women living with HIV/AIDS. It is a serious problem that we are made to forego our right in order to access services – for example, being able to terminate a pregnancy only upon agreeing to sterilization, as happened to me.

Health care

Health care is still a problem for women living with HIV/AIDS. Despite numerous calls for comprehensive HIV and AIDS care policies – including antiretroviral drugs, treatments for opportunistic infections, and prophylactic treatments – to date these have not been put in place in many developing nations.

Treatment advocacy and rollout initiatives are gender-blind and leave women living with HIV/AIDS without access to care and medication. This has to change.

There are international policy guidelines on access to care by women living with HIV/AIDS. However, they are not enforceable. Some governments who adopt these guidelines add the phrase “subject to availability of resources.” If this is the way it is going to be, there will be no gender-equitable access to treatment.

International human rights documents and the constitutions of many countries list health as one of the fundamental human rights. However, in practice, for people living with HIV/AIDS health care is not a right but a privilege. This is unacceptable.

Specific recommendations

As a woman living with HIV/AIDS who has undergone the trauma of initial disclosure and the pain and prejudice following disclosure, who has bargained her rights to access health services, and who continues to be treated generally as a second-class citizen – I recommend the following for the recognition of my rights and humanity in thought as well as in deed:

- Women living with HIV/AIDS must be made aware of their rights. To enforce these rights, and to ensure that they are real (and not just on paper), accessible legal services must be provided.
- Services must be provided to support women who experience negative results due to disclosure.
- Human rights abuses in health-care settings should be challenged, and legal proceedings should be publicized.
- We must make a greater effort to challenge negative attitudes

toward women living with HIV/AIDS in organizations, communities, and society.

- Specific women’s treatment issues should be researched and the information disseminated.
- Sexual and reproductive health concerns of HIV-positive women should form part of the mainstream treatment agenda.
- We need to advocate for comprehensive HIV and AIDS treatment plans that take the specific needs of women into account.
- Voluntary disclosure of HIV status backed with relevant support should be encouraged.
- Through education, we must challenge power imbalances in relationships, which often place women in vulnerable positions.
- More emphasis should be put on increasing prevention options for women, including female condoms and microbicides.

Let us all work toward helping women living with HIV/AIDS realize their rights.

– Promise Mthembu

Promise Mthembu is a Global Advocacy Officer, Sexual and Reproductive Rights, with the International Community of Women Living with HIV and AIDS.

¹ Kanjoo Mbaindjikua has been involved in the development of the the International Community of Women’s Vision Paper on HIV Positive Young Women. She was also a participant at the young women’s dialogue held in Durban, South Africa, in 2004.

A human rights crisis in need of a human rights response

Although HIV/AIDS is a human rights crisis, in many countries the protection of human rights is still not a vital component of the response. By protecting human rights, it is possible to help prevent HIV and to mitigate the personal and societal impact of the epidemic. In her presentation to a plenary session of the XV International AIDS Conference in Bangkok on 16 July 2004, Irene Khan describes how discrimination and inequality fuel HIV/AIDS, and how gender inequalities and violence render women and girls particularly vulnerable. The presentation concludes by outlining a series of measures that need to be implemented to protect human rights.

A few days prior to the start of the Bangkok conference, four people, all HIV-positive, were detained in Shangqiu city, Henan province, China, after they tried to protest inadequate health care and other services for those infected with HIV/AIDS in the city. Two of them were parents who were protesting the closure of their children's school. The school had been set up by Li Dan for children whose parents were HIV-positive or had died of AIDS, but the school was shut down after Li told the authorities that he was going to attend the conference.

This case shows very clearly why HIV/AIDS is a human rights crisis. The need for comprehensive human rights-based approaches to HIV/AIDS has possibly never been so critical. This is largely because AIDS-related threats to human rights have never been so significant.

Despite increased funding, political commitment, and progress in responding to HIV/AIDS, the scale and impact of the crisis continue to grow and to outpace both global and local responses to the pandemic.

The failure to protect the rights and dignity of people is fuelling the epidemic. Although activists have long

realized that protection of human rights must be central to any strategy to address HIV/AIDS, human rights are still far from becoming a vital component of the response in many countries.

Too many governments are still looking for a quick fix to HIV/AIDS. They fail to recognize that human rights violations increase people's vulnerability to infection, that people living with HIV/AIDS often face grave human rights abuses, and that governments must tackle the causes and consequences of these abuses if the fight against HIV/AIDS is to be successful.

Even where there is recognition that human rights violations increase people's vulnerability to HIV infection, changes in the nature of the epidemic are challenging us to reconceptualize the human rights-based approaches to the crisis.

In relatively low-prevalence countries, a "human rights approach" to the epidemic has historically been associated with harm-minimization policies and practices, legal protection from discrimination and, in some cases, criminalization of "at risk" groups such as commercial sex workers, injecting drug users, gay men, men who have sex with men, and, increasingly, women.

However, the emergence of a very different epidemic in high-prevalence countries calls for a more sophisticated understanding of the epidemic and its relationship to human rights – one that goes beyond prevention and harm minimization, and respects and promotes the dignity and equal worth of people living with HIV/AIDS.

Fighting discrimination

Discrimination increases vulnerability to infection and can lead to human rights abuses for those who are already infected. Non-discrimination is a fundamental principle of human rights. Under international law, governments have the responsibility to ensure that everyone is treated equally and has equal access to public goods and services.

The principle of non-discrimination is critical because disease, death, and disability are never evenly distributed. They are determined by the differing capacities of individuals to access information, to understand the risks, to reduce the risks, and to access preventive and care services. They are determined by different levels of income, education, and purchasing power.

Discrimination and inequality are driving the epidemic. Wherever it strikes, HIV/AIDS exacerbates existing inequalities and creates a fatal combination of stigma and neglect.

When people are denied the right to health, those who suffer most are the ones with the greatest needs. Vulnerability to HIV increases when people are denied the right to information; when restrictions are put on freedom of expression; when people are forced to flee their homes and become displaced; and when people are denied adequate support and services.

When communities or workers are deprived of their right to organize and mobilize, it makes them less able to respond appropriately to HIV/AIDS and more vulnerable to it.

In Thailand, for example, state-sanctioned discrimination and harassment of injecting drug users is driving them underground and impeding their access to the services and support they need. Thailand, which is widely acknowledged to have been a leader in the fight against AIDS, risks being

Wherever it strikes, HIV/AIDS exacerbates existing inequalities and creates a fatal combination of stigma and neglect.

compromised by its approach to drugs and injecting drugs users.

As a result of discrimination, people living with HIV/AIDS face significant and ongoing violations of their rights. Positive people risk being sacked from their jobs, ostracized by their communities, and excluded from the protection of the law. Positive

children or children of positive parents may be excluded from schools or may be segregated.

Women and HIV/AIDS

It is not surprising, therefore, that HIV/AIDS is finding new victims among those with unequal status in society. The relationship between human rights violations, vulnerability, and HIV/AIDS is compellingly clear when one looks at the impact on women.

More than ever before, gender inequality and gender violence are driving new infections among women and girls. Globally, women comprise half of the people living with HIV/AIDS. But in sub-Saharan Africa, 57 percent of those living with HIV/AIDS are female. In the same region, young women aged 15-24 are two-and-a-half times more likely to be infected than men. In South Africa, one in four women is HIV-positive by the age of 24 – twice the infection rate among men.

The unequal political, economic, and social status of many women means that they are more prone to violence and less able to negotiate safer sex. Research shows that women who are beaten or dominated by their partners are nearly 50 percent more likely to become infected with HIV, compared with women who live in non-violent households.

The rape of women, whether in the battlefield, backstreet, or bedroom, greatly exposes them to the risk of HIV infection. In the war that rages in the Democratic Republic of Congo, hundreds of women have become HIV-positive after being raped and abused as part of a deliberate strategy to terrorize and displace the civilian population. Many of these women are abandoned by their husbands because they have been “tainted” by the enemy.

Upon disclosure of their HIV-positive status, many women face abandonment, greater risk of abuse from their partner, family, and community, and even death. In Cape Town, South Africa, Lorna Mlofana, a community educator for the Treatment Action Campaign, was raped by a group of

An HIV-positive woman often bears a double burden of infection, abuse, abandonment, social marginalization, and poverty.

men who then beat her to death when she told them she was HIV-positive.

Also in South Africa, when a woman named Nombulelo found out that she was HIV-positive, she confronted her husband with the truth and asked him to go for testing. He walked out, leaving her to care for Nombulelo’s four children as well as eight children belonging to her brother and sister, both of whom had died of AIDS. While for many men HIV/AIDS is a distant threat that will kill them in 10 years’ time, for women like these it is an everyday danger that shapes their lives.

Research into the link between domestic violence and HIV/AIDS in Uganda has shown that men prefer to beat their wives rather than confront reality and agree to be tested, or allow their wives to seek testing and counselling.

The same social and economic factors that make women vulnerable to HIV infection shape their experiences once they are infected. An HIV-positive woman often bears a double burden of infection, abuse, abandonment, social marginalization, and poverty. She has to care for the sick, worry

about passing on the virus to her children, and worry about who will take care of the children when she is gone.

HIV/AIDS leaves a legacy beyond one generation. Girls in poor households affected by AIDS frequently find their education curtailed because they have to care for their family. Their choices and possibilities may be so diminished that they have to turn for survival to the sex trade or to work that exposes them to sexual abuse and violence, increasing the risk that they themselves will die of AIDS. Many AIDS orphans are at risk of physical abuse, sexual violence, trafficking, and hazardous labour. But girls are more likely to suffer the worst consequences of these abuses, especially sexual and physical violence.

Migrant workers, displaced persons and refugees, minority ethnic communities and indigenous people, young people and the disabled, prisoners, sex workers, injecting drug users, and sexual minorities all face similar challenges.

The way forward

By protecting human rights, it is possible to help prevent HIV; safeguard the dignity of people living with, and affected by, the virus; and mitigate the personal and societal impact of the epidemic.

How can we best protect human rights? First, governments must recog-

nize that they are primarily responsible for respecting, protecting, and fulfilling human rights. They must establish clear institutional mechanisms for discharging that responsibility.

Second, concrete steps must be taken to ensure equal access and non-discrimination. Laws, policies, and practices should be urgently reviewed and overhauled where necessary. This should involve reforming public health, criminal, and correctional laws, as well as legislating to protect people from discrimination, with a particular focus on “at risk” groups and people living with HIV. Laws regulating public goods and services, including medical and social services, should also be reviewed to ensure that they facilitate the best and most effective delivery of goods and services to those who need them most.

Third, a supportive environment should be created for people at risk or living with the virus. A vital component of such an environment is the commitment to engage actively and meaningfully with people living with, and affected by, HIV/AIDS. They must be provided with legal and support services that will educate them about their rights, and allow them to seek advice and help to enforce those rights. This means practical support to groups representing positive people and affected communities. It also means recognizing the right of these groups to express views that are

sometimes different from those of governments, and to provide advice to governments without fear or favour.

Fourth, we must be ready to listen to positive people – whatever the differences of view. We must also be ready to support them in a pragmatic and non-judgmental manner. The prohibition imposed by the US government on providing funding to organizations that take a human rights-based approach to sex work will make matters worse, impeding the delivery of information and support to women in the sex industry who desperately need it.

Finally, we must work to build a healthy and vital civil society that will support efforts to advance human rights in the context of HIV.

There may not be a quick fix for AIDS, but there is an effective way forward. It requires a sustained commitment by governments, corporate actors, international organizations, and civil society groups to work together to put human rights and human dignity at the centre of our response. The fight against AIDS, if it is to be successful, must be a fight for the rights and interests of the world’s most marginalized people.

– Irene Khan

Irene Khan is the Secretary-General of Amnesty International. She can be reached at secgen@amnesty.org.

Sex workers and law reform in South Africa

The Sisonke movement in South Africa aims to galvanize sex workers to fight for equal rights and for improvements in their living and working conditions. This article, based on Jayne Arnott's presentation to a plenary session at the XV International AIDS Conference in Bangkok on 14 July 2004, outlines the legislation that governs the sex trade in South Africa; reviews related legal and policy developments since the end of apartheid in 1994; describes the present environment; and outlines the contribution that sex workers themselves are making to the fight for reform.

Ten years after the end of apartheid and the advent of democracy in South Africa, sex workers still experience harassment. Listen to the voices of sex workers in Cape Town in 2004:

Some women are not arrested if they give sex for free.

They sprayed me with a spray gun, at the same time kicking me all over my body.

They sprayed tear gas in the van and took us to the cells.

The police arrest me about four or five times a month.

We are kept in the cell overnight and released after 11 the next day; we never see a magistrate.

We get picked up even when we are not working.

Background

The Sexual Offences Act,¹ formerly the Immorality Act, penalizes the keeping of brothels, procurement of women as prostitutes, soliciting by prostitutes, and living off the earnings of prostitution. In 1988 a new section was added to the Act;² this section criminalizes engaging in sexual intercourse or performing indecent acts for reward.

It is very difficult to achieve successful prosecution under the Act, so the authorities regularly resort to municipal by-laws to police sex work. The by-laws are used to target, harass, and arrest sex workers, particularly those based on the street. There are general by-laws that are used selectively to target sex workers, and by-laws specifically aimed at sex workers – such as “loitering for purposes of prostitution.”

South Africa has a constitution that is considered to be one of the most progressive in the world. It includes a Bill of Rights that ensures protections for all. Initially, in the post-1994 period, there was a climate of toleration of sex work, and minimal policing. The policing that was done was mainly in response to public complaints. On a government-policy level, there was some movement toward reviewing the legislation around sex work. In 1995, for example, the Department of Health commissioned a draft bill on sex work. In 1996 a task team appointed by the Gauteng Provincial Ministry of Safety and Security produced a draft policy document on sex work that recommended decriminalization. This received some support from the African National Congress (the governing party) in 1997, but lost

momentum in 1998. None of these initiatives moved beyond an internal discussion arena.

In the period after 2000, despite a lack of legislative review, a de facto decriminalized environment existed in which sex work was tolerated. Most arrests and harassment of sex workers was largely directed at street-based sex work, the most visible and vulnerable, and largely in response to community complaints. The Sexual Offences Act was rarely used to charge sex workers. During this period, members of the Sex Worker Education and Advocacy Task Force (SWEAT), a not-for-profit organization based in Cape Town that has been working with sex workers around health and human rights issues since 1994, were mainly dealing with arrests and rights-based infringements related to municipal by-laws.

SWEAT was able to engage sex workers in collective actions around harassment and incorrect arrest procedures. The climate was conducive to engaging with community-based forums, such as Community Policing Forums, in different areas of the Cape Metropole. It was clear that there was some room for negotiating, despite the power imbalances and criminalized environment.

Legal and other developments in 2002

1. Jordan versus the State: March 2002

In 2002 a challenge was brought against the constitutionality of the Sexual Offences Act by a brothel owner, Ellen Jordan.³ The challenge was against the sections criminalizing sex workers and brothel keeping. The High Court judges found the section criminalizing sex workers to be unconstitutional. The judgment was then referred to the Constitutional Court (see below).⁴

2. Paper on adult sex work: August 2002

Next the South African Law Reform Commission (SALRC) released an issue paper in August 2002 on the Sexual Offences Act as it relates to adult sex work. Although the paper did not put forward any recommendations for legislative change, it was a comprehensive and fair representation of the context of sex work in South Africa. The issue paper set out the

SWEAT engaged sex workers in collective actions around harassment and incorrect arrest procedures.

three legal models for addressing sex work, namely criminalization, decriminalization, and legalization. SWEAT's submission supported decriminalization.

As a result of the issue paper, SWEAT was optimistic about the possibilities of legislative review.

SWEAT embarked on an intensive intervention to summarize the paper and to alert sex workers and the sex work industry to this opportunity to input into the legislative process. This culminated in a first National Meeting of Sex Workers in mid October 2002, at which nine independent submissions from groups of sex workers were generated.

A second paper from the SALRC, which is expected to contain recommendations for legal changes, has been considerably delayed. As of September 2004, it had not yet been released.

3. Constitutional Court judgment in the Jordan case: October 2002

Then came the verdict of the Constitutional Court in the Jordan case.⁵ By a 6-5 margin, the judges ruled that the Sexual Offences Act withstood constitutional scrutiny, so they reversed the High Court judgment of March 2002. The judges emphasized that although the section of the legislation that was challenged was found to be constitutional, this did not necessarily mean that the legislation itself was as effective as it could be. They added that the SALRC should review the legislation.

The judgment was a great setback for legal-reform initiatives. It created considerable negative publicity around sex work, which resulted in increasing levels of police activity, targeting mostly street-based sex workers across the country. Local governments were influenced by the judgment and used it to justify an increase in policing and in controlling local legislation. Public opinion was swayed by the judgment, and the result was an immediate and sustained backlash against sex workers and the sex work industry.

Present environment

We are faced with increasing levels of policing by local authorities as a result of their "zero tolerance" approach. This is coupled with calls to clear the streets of "crime and grime," calls that are supported by a Moral Regeneration Campaign led by the South African government. Sex workers are vulnerable targets for this kind of approach; they become valuable arrest statistics to show that the authorities are acting on "criminal elements."

The judgment led to an immediate and sustained backlash against sex workers and the sex work industry.

Sex workers and legal reform

At a national meeting called by SWEAT in October 2002, sex workers from across South Africa met to respond to the first paper by the SALRC. With respect to HIV/AIDS, collectively the sex workers made the following assertions:

- We feel that HIV/AIDS is a killing disease. It is the responsibility of individuals to protect themselves.
- We don't think that there should be laws to control sex workers from spreading HIV/AIDS, because such laws can end up suppressing us. For example, it is your right to know your HIV status and you should not be forced to disclose this without your permission.
- Our rights to health services

should be respected and realized.

- We require health information and education.
- We would like to be treated the same as other workers, and not to be given special treatment.

With respect to law reform, collectively the sex workers declared that:

- Prostitution should be decriminalized because it is not a crime. The 1957 Sexual Offences Act should be reviewed in order to decriminalize sex work.
- All regulations implemented should have as their guiding principle the Bill of Rights.
- Fees for sexual services should be standardized.
- Police should stop harassing us, and should be available when we need them to protect us from violent crimes.

- Health facilities should be accessible, and health-care providers should be educated to provide a service rather than intimidate us.

At a second national meeting in 2003, the movement Sisonke was launched. The mission statement of Sisonke reads: "At Sisonke our aim is to unite sex workers to improve our living and working conditions and to fight for equal access to rights."

In 2004 SWEAT supported national meetings of representatives of groups of sex workers from across the country with a view to developing leadership and preparing for participation in further legislative review.

Conclusion

Before law reform at the national level can proceed, the SALRC has to produce its second paper (with recommendations for changes to the law).

SWEAT will be active in lobbying parliamentarians regarding legislative reform. SWEAT will also support the growth of Sisonke nationally to promote self-representation in legal-reform processes. In the meantime, on a local government level, SWEAT maintains an active role in challenging human rights infringements and promoting health and safety within the sex work industry.

– Jayne Arnott

Jayne Arnott is the Director of SWEAT. She can be reached at sweat@iafrica.com.

¹ The Sexual Offences Act 23 of 1957.

² Section 20 [1] [aA].

³ *S v Jordan and Others* 2002 [1] SA 797 [T].

⁴ *S v Jordan and Others* 2002 [6] SA 642 [CC].

⁵ *S v Jordan and Others* 2002 [11] BCLR 1117 [CC].

Youth: too often missing from the response

Responses to HIV/AIDS need to recognize the diversity of youth and need to be inclusive of youth. In his presentation to a plenary session of the XV International AIDS Conference in Bangkok on 14 July 2004, Raoul Fransen explains why it is important to involve youth in policy-making and at all stages of program development and implementation. The presentation emphasizes the need to ensure that young people are able to make choices concerning their sexuality, and are provided with the information and support necessary to enable them to make intelligent choices.

I am constantly told that youth are the future. UN Secretary-General Kofi Annan says that young people are the key in the fight against AIDS. We may be the future and we may be the key, but we are not one single group. Young people do not all live in the

same box and do not appreciate being constantly lumped together.

Strategies that are developed to address youth as a homogenous group are inefficient. They do not take into account differences in gender, culture, norms, values, sexuality,

etc. Not all youth face the same HIV vulnerabilities. The vulnerability of impoverished young women living in a rural village in Africa is different from the vulnerability of emerging gay youth in the favelas of Rio.

Young people may find themselves

in specific situations that make them vulnerable, such as choosing an education or career, discovering their sexuality, and finding a (first) partner. But the vulnerability young people encounter is not so much defined by their age but rather by the situation and circumstances they find themselves in.

For youth, then, building and shaping their lives is always going to be a difficult process.

When a young person is HIV-positive, this can be even more challenging.

When I tested HIV-positive at age 15, there was no specific support for young people. It was hard to find someone whom I could really relate to. Besides the emotional aspects, I had unique things to deal with, such as school and getting health insurance. None of the older people with HIV I knew had any experience with this. I don't think much has changed for HIV-positive young people.

Youth may be the future, but we are also the present, and the present reveals that:

- 50 percent of the 15,000 new infections each day are among persons aged 15 to 24, of whom 75 percent are girls;

- more than a third of all people now living with HIV/AIDS are young people between the ages of 15 and 24, and almost two-thirds of them are girls; and
- in sub-Saharan Africa more than half the population of people living with HIV/AIDS is estimated to be under 18 years of age.

Yet, at the International AIDS Conference in Barcelona two years ago, of the 15,000 participants only 200 were under 30. So it is high time that a conference such as this puts youth high on the agenda, and we compliment the organizers of the Bangkok Conference for having done so.

Involvement of youth

However, if we expect young people to participate fully, we need to confront the belief and practice that organizations and "real" issues are for adults only. We need to show that youth can contribute at all levels, from activism to policy to advocacy, and we need to give them the opportunity to do so. Otherwise, youth will not come forward.

Youth are viable and absolutely necessary partners, but are often miss-

ing from the response. Too many youth programs and projects are headed by people who – while skilled – are quite clearly not young.

Young people are not just a target group to reach, but a resource to reach it with.

There are many reasons why young people need to be included. In most regions, they are the group worst affected by this epidemic. Youth are part of the solution, not the problem.

Young people are not asking for understanding; they want to participate. Young people are not just a target group to reach, but a resource to reach it with.

The involvement of young people can and does improve the effectiveness of an intervention. By adapting interventions to our needs and aspirations, the interventions become ours and we make sure they work. The empowerment of youth builds self-esteem, skills, knowledge, and confi-

Developing-country perspective

At the plenary session on 14 July 2004, Ricky Tonbing, of the Delhi Network of Positive People, in India, also spoke briefly about issues of concern to youth. The following are edited extracts from his presentation:

- Just as governments call on young people in times of war, so should governments summon young people to fight the war against HIV/AIDS.
- Because approximately 50 percent of new infections occur in the 15 to 24 age group, half of all resources should be used for programming that will benefit the young people of today.

- Young people should be meaningfully involved in the response to HIV/AIDS. Involvement means more than employment in menial jobs. It means contributing to the development of policies that affect young people.
- Young people living with HIV/AIDS have an important role to play in HIV prevention.
- Many young people learn of their HIV status from Voluntary Counselling and Testing programs that have poor standards of counselling and poor referral systems.

– Ricky Tonbing

dence. Involving youth creates real future opportunities for them, which benefit the organization, school, or community in question.

How should youth be involved? It should not be done in a tokenistic way, where youth are given a platform but in reality have little say. Real participation doesn't only take place at the level of implementation, but also at the level of determining the route to follow and the destination at which to arrive. This means that young people have to be involved in determining policies, and in the planning, implementation, and evaluation of activities. If young people are not involved in all these steps, it will be a story about youth in which the ideas of young people themselves are not heard. When young people are involved, the story will be from, with, and for youth.

In February 2004, at a European Union Ministerial Conference on "Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia," a group of young people recommended:

- that young people be placed on national AIDS committees and other bodies with decision-making power in terms of policy-making;
- that the power of organizations of young people be harnessed in program implementation at all levels;
- that young people be included as equal partners at future conferences and discussions;
- that organizations of young people be invited to the table when key policy documents, such as national and regional declarations, are discussed; and
- that organizations should be transparent with respect to how they try to involve young people and

how successful they are. As youth, we often have limitations that need to be acknowledged. Older people may have more of a certain type of information and skill. What we need is true partnership between young people – with their specific knowledge, experiences, enthusiasm, and ability to reach out to peers – and professionals who recognize and respect our input.

The ABC approach simply does not fit into the world view or life experiences of so many young people.

Most young people do not have much money and need to be resourced. There is the perception that young people will not have a problem with serving as unpaid volunteers. While that may be true to a degree, young people still have to support themselves financially.

Because young people don't stay young forever, leadership needs to be sustainable. We need a system to ensure that knowledge and expertise is passed on to the young leaders of tomorrow. This requires a unique institutional memory and additional resources.

Youth and prevention

Young people are often seen simply as a target for prevention. Prevention is often seen as something that is done to youth, rather than as something that each new generation has to develop and work through for itself. No wonder prevention continues to fail us all.

Many young people are AIDS-fatigued from prevention campaign messages that are outdated or unrealistic, or both. The ABC approach, for example, simply does not fit into the world view or life experiences of so many young people. It does not recognize youth's sexual and reproductive rights. ABC is a really good example of one generation's dishonest morality being delivered upon another.

Young people, who may not have experienced the events of the first decades of the epidemic, are often faced with new and different forms of misconception, prejudice, and discrimination. Even in Western Europe – where few people are dying of AIDS and where many taboos have been broken – stigma and discrimination are still very much part of the daily lives of people living with HIV/AIDS.

In the developed world, relatively easy access to antiretrovirals has changed the image of AIDS from a fatal disease to "just a sexually transmitted infection." AIDS has fallen off the public agenda. This has resulted in a new wave of infections among youth.

Recently, people living with HIV/AIDS are being persecuted for not disclosing their status when having unprotected sex. This undermines prevention efforts because it makes it safer not to know one's status and because it fuels a false sense of security among people who assume that HIV-positive persons will always disclose their status when having sex.

When I learned I was HIV-positive, I thought that I would never have sex again, mainly out of fear of infecting others. It took a while before I was ready to experience intimacy again. If there had been specific support, this might have been easier or I might even have made different choices.

One of the obvious omissions in our international response is Positive Prevention. I know of only a few programs and institutions that are looking at the sexual and reproductive health needs of HIV-positive young people.

Everyone must be able to decide freely whether or not he or she wants to have sex, and with whom. Rather than being taught *not* to have sex, young people – whether or not they have HIV – should be empowered to make the *choice* that is right for them – be this abstinence, or partner reduction, or using condoms. They need to be given a choice, not an ideology.

Young people should be supported in discovering their sexuality. This support should include basic information about sexuality and life skills–based education; access to commodities such as condoms, other contraceptives, and clean needles; and access to a range of support services.

We need to equip young people with the tools necessary to make safe and healthy decisions. But they have to be our decisions.

I challenge all people, young people and older generations, civil society and other sectors, to implement the strategies that we know work, and

change those that do not, and to challenge policies that exclude the reality of young people.

– Raoul Fransen

Raoul Fransen, 26, was diagnosed HIV-positive at age 15 and is co-founder of Young Positives, an international network of Young People Living with HIV&AIDS, which supports organizations for and by young people living with HIV, and is affiliated with the Global Network of People Living with HIV/AIDS (GNP+). He can be reached at RFransen@StopAidsNow.nl.

Double discrimination: drug users living with HIV/AIDS

Drug users in Russia living with HIV/AIDS are often denied basic medical and social services and are systematically excluded from antiretroviral therapy programs. In this presentation to “HIV Treatment for Drug Users – A Realistic Goal,” a satellite meeting of the XIV International AIDS Conference held on 15 July 2004, Dmitry Samoilov describes the discrimination faced by people living with HIV/AIDS in general, and HIV-positive drug users in particular. The presentation includes powerful personal testimonials from people living with HIV/AIDS. The author describes the obstacles to drug users’ accessing health care, and concludes with suggestions for actions that should be taken to address the problem.

According to international experts, Russia now has one of the fastest-growing HIV epidemics in the world. There are already about one million people in Russia living with HIV/AIDS. About 75 percent of these are injection drug users who contracted the virus through non-sterile needles and syringes. The virus is now spreading faster in Russia than in Africa.

The World Health Organization estimates that around 50,000 people in Russia need antiretroviral (ARV) therapy. Currently, fewer than 1000 people are receiving this treatment.

One of the most problematic aspects of the epidemic in Russia is discrimination against people living with HIV/AIDS. We are denied medical treatment, jobs, and places at uni-

versity. Because of the intolerance and ignorance about our community’s problems and way of life among doctors, psychologists, and social workers, as well as the general public, many of us simply go underground. We become inaccessible to medical workers and other public services, and we stop seeking information about personal health. This prevents people

with HIV from being well informed and renders them helpless.

Drug users living with HIV are subject to double discrimination. Many people in Russia consider drug users to be second-class citizens who don't deserve any help. Therefore, they are often denied basic social services, including medical assistance. The following personal testimonials illustrate the problem:

(Mikhail) I called an ambulance because I needed to be taken to the hospital right away. After telling the doctors that I had HIV, as I was required to do according to Russian law, the doctors told me that they weren't a "taxi" and refused to give me any medical assistance.

"They told me I'd end up in prison anyway, so what's the point in treating you?"

(Olga) At the women's clinic, where I found out about my diagnosis, all of the doctors who worked there came to have a look at me. I was like a social freak for them – a pregnant drug addict with HIV. Everyone in the clinic felt it was their duty to the Motherland to explain to me how hopeless my situation was and how I shouldn't even consider becoming a mother since society had no need for infected mothers, not to mention infected children.

(Yekaterina) They told me I'd end up in prison anyway, so what's the point in treating you? They said they'd rather treat other people – people who weren't taking drugs and never had. I can't understand it. We're all people,

after all. After that I started shooting up again. I had big plans for the future, but I just couldn't cope.

(Andrey) At the AIDS Centre you have to prove that you are a "benefit to society" in order to get any treatment, even palliative care.

Access to treatment

Since drug users were particularly hard hit by HIV during the initial phase of the AIDS epidemic in Russia, they now make up the biggest group of people who need antiretroviral treatment, yet they are systematically excluded from ARV therapy programs.

According to Elana Vinogradova, chief doctor at the AIDS centre in St Petersburg, in February 2004 there were a few former drug users among the 150 or so people who received treatment using funding from the city government. However, she said, those who still use drugs were not considered a worthy candidates. "Treatment is expensive, and it's not provided to active drug users. People have to sign a contract that they will continue to come every month; if they don't they know they can be taken out of the program. We know all of the people on treatment. We know who can be trusted and who not."¹

Andrey Seltsovskiy, Director of the Department of Health for the City of Moscow, has said that drug addicts must be persuaded to seek treatment, that they are uncontrollable and do not wish to undergo treatment, and that they have other priorities.²

In an interview with Human Rights Watch, however, the director of the Federal AIDS Centre, Vadim Pokrovsky, noted that, based on the data available to him, active drug

users were quite capable of sticking to a course of treatment.³ Consequently, at the federal level there is no categorical ban on treating such individuals, although the Centre recognizes that municipal and regional AIDS clinics with inadequate resources may deny them treatment due to financial considerations. The Centre's stance is constantly reinforced by myriad new studies showing that active drug users adhere to treatment as well as anyone else.

Discrimination against people living with HIV/AIDS or those who are merely suspected of having the virus is a clear violation of human rights. Under Russian legislation, every Russian citizen has an equal right to receive medical care, whether or not they take drugs.

As the following testimonials show, many people with HIV are denied treatment whether or not they are known to be drug users:

(Fedor) They say that if you don't live with your parents you're "unstable," and you won't get any treatment.

(Pavel) I got a blood clot from a bad injection. I was shivering and my head hurt. I called an ambulance. These two guys came and asked me what was the matter. They made it clear that I would have to pay for some medicines. And then they told me it was high time I dropped dead.

(Anton) I was in a car crash. I broke my leg, and the bone came through the skin. When the ambulance arrived, I told the doctors that I had HIV, and they spent a long time discussing how to get me to the hospital, since they were afraid of touching me. This discussion lasted about 40 minutes, and only then did they put on their rubber gloves, place me on the stretcher and

take me to the hospital, where they gave me my food through a little window.

Drug users' access to health care is complicated by a number of factors. First, injection drug users are often unregistered and have no passport or insurance policy, which is now compulsory. Second, some doctors don't understand in principle why users should be supported. Third, if users go to drug treatment clinics they will officially be registered as drug

Every Russian citizen has an equal right to receive medical care, whether or not they take drugs.

addicts. Fearing the stigmatization that can result from such an official diagnosis, drug users avoid turning to medical institutions for treatment.

Fourth, there is a serious lack of access to substitution therapy, which enhances health in general as well as adherence to ARV therapy. People

who receive substitution therapy can experience significant improvements in their physical and emotional state, and can improve their relationships with other people. Supportive substitution therapy should be linked to preventive interventions and services as well as efforts to provide treatment to people living with HIV/AIDS.

What needs to be done

To change the situation it is necessary to develop harm-reduction programs; to make a connection between harm-reduction programs and the health-care system, particularly the structures responsible for providing ARV therapy; and to ensure interaction with human rights organizations on the national and international level.

It is also necessary to organize and develop associations of drug users and people living with HIV in order to defend the community's rights and protect its interests at all levels of decision-making. This is why we created the Community of People Living with HIV/AIDS in Russia, with the aim of bringing people together to combat discrimination and stigmatization and fight

for access to treatment.

By altering the attitudes of society, we can create a more tolerant atmosphere for ourselves, our relatives, and friends. It is also essential to change the state's policies, including funding for treatment. There is no point in waiting for someone else to lobby for the interests of people living with HIV/AIDS, including those who use drugs. We must unite and fight for ourselves and others. If we do not make a collective effort, nothing will change.

– *Dmitry Samoilov*

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¹ Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation. Human Rights Watch. April 2004, at 47. Available at <http://hrw.org/reports/2004/russia0404/russia0404.pdf>.

² Statement made during a media conference on "Additional measures for the prevention of HIV infection in Moscow in 2003, and the city anti-AIDS program for 2004-2006" held on 18 June 2003 in Moscow. Available in Russian on the website of the Information Centre of the Moscow government at www.mosinform.ru/full_conf.shtml?sub=stenogram&myid=53&submenu=2.

³ *Supra*, note 1 at 47.

Drug control, human rights, and harm reduction in the age of AIDS

In many countries, HIV prevalence among people who use illicit drugs is high. Yet many governments resist implementing effective HIV prevention measures, and drug users often lack access to care, treatment, and support, including for HIV/AIDS. Growing evidence indicates the dominant prohibitionist approach to illicit drugs is ineffective – and even counterproductive, blocking or undermining measures shown to reduce harms to drug users and to communities affected by open drug scenes. The growing debate over global drug control policy could shift us collectively away from the current, failed prescriptions to a more rational, pragmatic, and health-promoting framework of harm reduction. This article by Richard Elliott is an abridged version of a paper prepared for “Human Rights at the Margins: HIV/AIDS, Prisoners, Drug Users and the Law,” a satellite meeting held in Bangkok on 9 July 2004, and organized by the Canadian HIV/AIDS Legal Network and the Lawyers Collective HIV/AIDS Unit (India).¹ The article briefly outlines the impact of these two different policy approaches, examines international law on drug control, discusses how harm reduction reflects a human rights-based approach to drugs, and assesses some strategies for reforming global policy on illicit drugs.

Injection drug use and HIV/AIDS: global health challenges

Injection drug use is pervasive throughout the world and is associated with severe health and social impacts. Injection drug users (IDUs) suffer from disproportionately high levels of HIV/AIDS and other infectious diseases, as well as overdose, and police violence. Overall, the evidence suggests that while IDUs do not enjoy adequate access to antiretroviral therapy and face additional difficulties in adhering to treatment, these challenges can be overcome with appropriate support.

Prohibition versus harm reduction

The enforcement of drug prohibition continues to dominate national and international responses to drug use. The available evidence demonstrates numerous deficiencies with this approach. In some cases, prohibition

actually fuels risky injection and drug-storage practices. Policing can impede drug users’ access to health services and to programs such as syringe exchanges. Enforcement policies have prompted transition to drug injection among previously non-injecting drug users, as a more efficient, less detectable method. Enforcement has failed to achieve its stated goals of decreasing drug use and improving public order.

Allocating significant resources to such ineffectual, and even harmful, approaches is inefficient and carries the opportunity cost of lost investment in more beneficial police services.

In addition, the “war on drugs” has taken a terrible toll from a human rights perspective. Documented violations of human rights by state agents include: harassment, illegal searches, extortion, beatings, and torture (including the use of drug users’ addiction as a means to elicit false confessions).² Thailand offers one of

the more extreme examples: a nationally declared drug war has been associated with the extrajudicial execution of over 2200 suspected drug dealers, many of them likely addicted drug users.³ Other documented abuses include forced detoxification, forced HIV testing, and forced labour during detention.⁴ The war on drugs is also marked by racial discrimination.⁵ In contrast to prohibition,

Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use, especially the risk of HIV infection. It seeks to lessen the problems associated with drug use through methodologies that safeguard the dignity, humanity and human rights of people who use drugs.⁶

Harm reduction does not preclude abstinence as a goal, but rather accepts that illicit drug use has been, and will continue to be, a feature of cultures throughout the world, and

that efforts should be made to reduce harms among individuals who continue illicit drug use. In practice, interventions include outreach programs, peer-driven interventions and drug user organizations, needle exchange programs, substitution therapy (eg, methadone maintenance), and safer injection facilities.

Evidence indicates that harm-reduction measures can have a positive impact in preventing HIV infection among people who use illicit drugs and their sexual and drug-sharing partners, can improve their access to health and other services, and are more respectful of their dignity and rights.⁷ Yet such approaches are blocked or hampered in many jurisdictions by the lack of political and financial support.

Harm reduction approaches are blocked or hampered in many jurisdictions by the lack of political and financial support.

Drug control and harm reduction in international law

The global system for drug control rests upon three UN conventions requiring signatory states to take various measures to criminalize drug-related activities: the 1961 Single Convention on Narcotic Drugs; the 1971 Convention on Psychotropic Substances; and the 1988 Convention against Illegal Traffic in Narcotic Drugs and Psychotropic Substances.

Three international bodies administer the treaties:

- The UN Commission on Narcotic Drugs (CND) consists of 53 UN member states and is the central policy-making body within the UN system in relation to drug control, with the authority to bring forward amendments to existing treaties or propose new treaties. The CND currently operates by consensus, meaning any single country can block a resolution or other initiative.
- The UN Office on Drugs and Crime (UNODC) “assist[s] UN member states in their struggle against illicit drugs, crime and terrorism.” The UNODC is a recent co-sponsor of the Joint UN Programme on HIV/AIDS (UNAIDS) and has shown some support for harm-reduction measures, at least insofar as they relate to preventing HIV.⁸ However, the UNODC leadership has criticized harm-reduction advocates as undermining “multilateralism.”⁹ The contradictions internal to the UNODC, and between the UNODC and other “core values” of the UN, remain to be resolved.¹⁰
- The International Narcotics Control Board (INCB) consists of 13 individuals and describes itself as “the independent and quasi-judicial control organ for the implementation of the United Nations drug conventions.” Members critical of harm reduction dominate the INCB, and the Board continues to decry “drug injection rooms,” denying that they serve “medical and scientific purposes” and asserting that any government that allows safer

injection sites “facilitates drug trafficking,” in contravention of the treaties.¹¹ The INCB interpretations are not legally binding, but help shape the political climate in which decision-makers determine national policies.

Criminalization and penalties for drug-related activities are the focus of the conventions. But they also contain important qualifications that can, if interpreted and implemented courageously by policy-makers, make some space for harm-reduction initiatives, even if this “room for manoeuvre” is limited.¹²

In particular, the 1961 and 1971 treaties allow for the production, distribution, or possession of controlled substances for “medical and scientific purposes.” They also allow states to provide measures of treatment, rehabilitation, and social reintegration as alternatives, or in addition, to criminal penalties. While the 1988 convention requires each state to criminalize possession of a controlled substance even if only for personal consumption, it also acknowledges that this obligation is “subject to the constitutional principles and the basic concepts of its legal system.” Various harm-reduction measures can be implemented if states are willing to use such provisions to defend more flexible, health-friendly interpretations.

Harm reduction and human rights

In one of the first articles to make a case for harm reduction based on human rights norms, Alex Wodak explored how prohibition leads to infringements of various rights and contributes to the harms suffered by drug users:

Reliance on criminal sanctions as the major response to illicit drug use inevitably results in the denial of human rights of the IDU population as drug use remains defined as a law enforcement rather than a health problem. Poor health outcomes in this population then follow, because health promotion and health care services are more difficult to provide to a now stigmatized and underground population. Protection of human rights is an essential precondition to improving the health of individual drug users and improving the public health of the communities where they live.¹³

Despite the importance of human rights to harm-reduction efforts, Andrew Hathaway argues that the harm-reduction movement adopted a too strictly empirical focus and claimed to occupy the “middle-ground” on drug issues, articulating its principles as emerging from a “scientific public health model” and “unduly overlooking the deeper morality of the movement with its basis in concern for human rights.”¹⁴ Sam Friedman et al have pointed out that the harm-reduction movement formed during a period marked by a “political economy of scapegoating” that targeted drug users, among others, as responsible for social ills. They suggest that “this climate shaped and limited the perspectives, strategies, and tactics of harm reductionists almost everywhere.”¹⁵ In an environment hostile to the notion that drug users are entitled to universal human rights, a pragmatic response to the immediate harms caused by prohibitionist excesses is to cast the problem in the language and data of public health – recognizing, of course, that the need to defend human rights is even greater in such circumstances.

Hathaway’s concern is expressed with a traditional libertarian emphasis on civil and political rights that governments should not infringe. Nadine Ezzard outlines the need to also address underlying “vulnerabilities,” including various factors that “constrain choices and limit agency,” thereby increasing the risks of drug-related harm.¹⁶ As such, her call for linking harm reduction with human rights flags that governments must take positive measures to address economic, social, and cultural human rights in responding to drug use.

In responding to drug use, governments must take positive measures to address economic, social, and cultural human rights.

How should we conceive of the relationship between human rights and harm reduction? There are at least four interconnected ways in which these concepts are, or can be, linked:

- The harm-reduction movement inherently reflects human rights principles, by insisting on the dignity of people who are often marginalized and vulnerable to the denial of human rights.
- From a purely pragmatic perspective, respect for human rights is necessary for harm-reduction interventions to be feasible and effective.
- Human rights norms point toward harm reduction, rather than prohibition, in our policy responses to drug use.

- Harm-reduction advocates can and should deploy human rights norms in making the case for drug-policy reform.

This last proposition warrants further explanation: What is the human rights-based case for harm reduction?

Harm reduction: a human rights-based approach to drug policy

An approach to drug policy based on human rights principles allows for – and indeed actively supports – harm-reduction measures. By way of brief example, consider two international sources of guidance.

First, states that are parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR) “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹⁷ Furthermore, states are legally bound to take steps to realize this right over time, including steps “necessary for ... the prevention, treatment and control of epidemic ... diseases; [and] the creation of conditions which would assure to all medical service and medical attention in the event of sickness.”¹⁸ The UN committee tasked with monitoring state compliance with the ICESCR has clarified that states are obliged to *respect, protect, and fulfill* this right.¹⁹ States are in breach of their obligation to respect the right to health through any actions, policies, or laws that “are likely to result in ... unnecessary morbidity and preventable mortality.”²⁰ Given the mounting evidence, when will a figure or body, with sufficient stature to have political impact, acknowledge that prohibition, at least as an isolated policy approach, amounts to a violation of

states' obligations with regard to the right to health?

Second, the International Guidelines on HIV/AIDS and Human Rights “translate international human rights norms into practical observance in the context of HIV/AIDS” and identify measures governments can take “to protect human rights and achieve HIV-related public health goals.”²¹ These should inform national policy on illicit drug control. For example, the Guidelines recommend that “Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users.”²²

Regime change: strategies for reforming global drug policy

How might the global drug-control regime be reformed to shift decisively away from prohibition as the dominant policy approach?

It has now been generally accepted that substitution therapy and needle exchange programs are permissible under international drug-control treaties. But other measures such as safer injection facilities remain contested, and the overall prohibitionist climate engendered by this legal regime creates a “chill” in relation to various measures. Furthermore, the 1988 Convention's requirement that states criminalize even possession for personal consumption – thereby rendering all drug users criminal offenders – leaves little interpretive wiggle room.

Even if states have some leeway in interpretation, and the political will can be mustered domestically to

forge ahead with harm-reduction initiatives, the amount of “policy space” they can open up is limited by the larger political environment. The structural inertia of the CND, the internal division of the UNODC, and the ideological opposition of the INCB hardly make for a supportive global framework. Add to this the power of countries committed to the prohibitionist agenda, including the United States, and it becomes apparent that it is as much a question of politics as of law. As Robin Room puts it: “The impact of the system comes instead from the implementation of the treaties, and with the international politics that surrounds that.” He describes “an international environment where states have been reluctant to break openly with a governing orthodoxy describing drug control in terms of a war on drugs.”²³

An increasing number of countries are shifting away from criminalization as their dominant approach to illicit drugs.

It would appear, however, that “cracks in the consensus”²⁴ are emerging. An increasing number of countries are shifting away from, or at least tempering, criminalization as their dominant approach to illicit drugs. The UN General Assembly is expected to next debate global drug policy in 2008, meaning the next few years are a window of opportunity for pursuing strategies that could reform the current regime. What are the options?

In general, the chances of actual *amendments* to the existing conven-

tions are slim at best, given the need for consensus. The long-term project of adopting a *new convention* on harm reduction faces the same challenge. The process could gradually shift political consciousness, but these options do not respond with adequate urgency to current health crises.

In theory, some states might be convinced to *denounce* (ie, withdraw from) one or more of the conventions, but this is unlikely. Aside from domestic political considerations, any single state taking such a step would be condemned as a “pariah narcostate” and “would have to be prepared to face not only US–UN condemnation but also the threat or application of some form of US sanctions.”²⁵

A more feasible approach might be to promote a strategy of *collective withdrawal*: a critical mass of like-minded states jointly stating, in some instrument introduced in relevant UN bodies, their interpretation as to which harm-reduction measures are permissible under the conventions and, if necessary, identifying those aspects of the treaties from which they are withdrawing, as well as proposing reforms. This would confer safety in numbers, and would be most likely to succeed if such a “coalition of the willing” included both developed and developing countries.

Such a step is unlikely without coordinated, transnational advocacy by civil society organizations. Laying some groundwork with documented support from relevant UN bodies would also be advisable.²⁶ For example:

- The governing boards of UNAIDS and the WHO could adopt policy encouraging states

to implement harm-reduction measures.

- The six UN human rights committees, the Office of the High Commissioner for Human Rights, and the special rapporteurs could incorporate concerns about the human rights impact of the “war on drugs” and the human rights benefits of harm-reduction measures into their work.
- Resolutions could be brought before the UN Commission on Human Rights and the World Health Assembly affirming the human rights of drug users and recognizing the right of sovereign states to implement harm-reduction measures.
- Several UN agencies could jointly submit a report to the CND for its “thematic debate” at its 2005 session, indicating strong support for harm-reduction measures on both public health and human rights grounds.
- Civil society advocates can directly or indirectly intervene in these various processes with evidence, arguments, and documentation that make the case for a more rational, human rights–friendly approach to drug policy.

Conclusion

The global drug-control regime must be of concern to all those who witness the human and economic devastation wreaked by the “war on drugs.” Advocates must pursue more health-friendly interpretations and implementation of the existing drug-control treaties, as well as strategies for reforming them. The harm reduction and human rights movements

enjoy a close kinship; each would benefit from exploring the relationship more fully. Collaboration will increase our chances of successfully seizing those opportunities to effect “regime change.”

– Richard Elliott

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¹ The paper is entitled “Regime Change?: Drug Control, Human Rights and Harm Reduction in the Age of AIDS.” It is available on the Legal Network’s website (www.aidslaw.ca) in the section dealing with drug law and policy. This abridged version omits most references; the full paper includes extensive notes and a bibliography.

² *To Serve and Protect: A report on policing in Vancouver’s Downtown Eastside*. Vancouver: Pivot Legal Society, 2003; *Abusing the User: Police misconduct, harm reduction and HIV/AIDS in Vancouver*. New York: Human Rights Watch, May 2003.

³ *Not Enough Graves: The war on drugs, HIV/AIDS, and violations of human rights in Thailand*. New York: Human Rights Watch, 2004.

⁴ *Fanning the Flames: How human rights abuses are fueling the AIDS epidemic in Kazakhstan*. New York: Human Rights Watch, 2003; B Adams, J Csete: *Locked Doors: The human rights of people living with AIDS in China*. New York: Human Rights Watch, 2003.

⁵ E Drucker: Drug prohibition and public health: 25 years of evidence. *Public Health Reports* 1999; 114(1): 14-29.

⁶ *What Is Harm Reduction?* New York: International Harm Reduction Development Program, 2004.

⁷ For more details regarding the benefits of each of these interventions, see the paper on which this article is based, via www.aidslaw.ca.

⁸ Eg, see WHO/UNODC/UNAIDS Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. Geneva, 2004.

⁹ UNODC. *World Drug Report 2004*. Vienna, 25 June 2004.

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¹⁴ AD Hathaway. Shortcomings of harm reduction: toward a morally invested drug reform strategy. *International Journal of Drug Policy* 2001; 12: 125-37 at 125.

¹⁵ SR Friedman et al. Harm reduction – a historical view from the left. *International Journal of Drug Policy* 2001; 12: 3-14.

¹⁶ N Ezzard. Public health, human rights and the harm reduction paradigm: from risk reduction to vulnerability reduction. *International Journal of Drug Policy* 2001; 12: 207-19 at 213.

¹⁷ ICESR, Article 12.

¹⁸ *Ibid*.

¹⁹ UN Committee on Economic, Social and Cultural Rights. General Comment No 14: The right to the highest attainable standard of health, UN Doc E/C.12/2000/4 (2000).

²⁰ *Ibid* at para 50.

²¹ *HIV/AIDS and Human Rights: International Guidelines*. Geneva: UNAIDS and OHCHR, 1998, para 10.

²² *Ibid*, Guideline 4 (“Criminal laws and correctional systems”), para 29(d).

²³ R Room. Impact and implications of the international drug control treaties on IDU and HIV/AIDS prevention and policy. Paper prepared for 2nd International Policy Dialogue on HIV/AIDS, Warsaw, Poland, 12-14 November 2003.

²⁴ M Jelsma, P Metaal. Cracks in the Vienna Consensus: The UN drug control debate. *Drug War: A WOLA Briefing Series*, January 2004. Washington, DC: Washington Office on Latin America, 2004.

²⁵ R Bewley-Taylor: Challenging the UN drug control conventions: problems and possibilities. *International Journal of Drug Policy* 2003; 14: 171 at 176-177.

²⁶ For more discussion of such a proposal, see: D Spivack. Conclusions from Workshop III: International cooperation on drug policy, forming part of the 2002 Lisbon International Symposium on Drug Policy, 23-26 October 2003, available at www.senliscouncil.net/documents/Spivack_paper.

In Thailand, drug users have to fight for their rights

Injection drug users have been overlooked in the Thai government's response to HIV/AIDS, but not in its war on drugs. They experience constant police harassment and ineffective services, and face stigma and discrimination in society and in the health-care setting. Paisan Suwannawong, of the Thai Drug Users' Network, was scheduled to speak at the Opening Ceremonies of the XV International AIDS Conference in Bangkok on 11 July 2004. But he was placed last on a very long agenda that included Thai Prime Minister Thaksin Shinawatra, United Nations Secretary-General Kofi Annan, and Miss Universe. By the time he spoke, all the dignitaries and almost all the delegates had left the hall. In this edited version of his address, Paisan provides a personal testimonial about what it is like to be a drug user living with HIV/AIDS in Thailand, outlines the problems with the government's response, and describes other obstacles to delivering treatment and other services to drug users.

It means a lot to me to speak from the perspective of a drug user living with HIV.

I grew up in one of Bangkok's biggest slums, not far from here. I saw many people using drugs, but never imagined that I would become a drug user myself. The first time I smoked marijuana, it felt like a challenge because all the public campaigns said drugs were "bad" and "dangerous." I discovered that this wasn't true, so I continued to smoke it.

Then I started smoking heroin, and became addicted without realizing it. I didn't have any money, I was feeling withdrawal symptoms, and my friend offered to share his heroin and inject me. Yes, it was scary the first time.

I got arrested at least 20 times. Most of the time I did not have any drugs on me. The police would plant drugs on me and force me to confess, and beat me if I did not sign their document.

I could not carry a needle around, because if the police arrested me the charge would be more serious. I heard about the risk of getting HIV from sharing needles, but when you are craving heroin, you don't think about

anything else. You just want to inject.

I was in prison twice. The conditions were terrible and we had to stay in our cells for more than 15 hours a day. For me, there is nothing worse than losing your rights and your freedom. I am not surprised that people use drugs and inject in prison, even if they never used or injected before. I believe that I got HIV in prison because I injected almost every day there.

Getting off drugs is not easy. Many times, I went into drug treatment not because I wanted to quit but rather to please my family, get away from the police, or take a break because the amount of drugs I needed was getting expensive. The attitudes of treatment staff only made me feel worse.

Other times, I really did want to quit. But can you imagine how it feels to leave a treatment program and go back home, with nothing to do? How difficult it is to look for a job and explain where you've been? My own family would watch my every move. I could see in their eyes they did not trust me. I was too embarrassed to see my friends, whose lives seemed so successful. It was so

lonely. I felt I had nothing at those times. The only thing I could think of was to go back to using drugs.

Finally I got off drugs 13 years ago. I knew I really needed help. I decided to go to a "TC," or "therapeutic community." This is how I found out that I was HIV-positive. The test was (and still is) a requirement for entering the TC. There was no pre- or post-test counselling. In fact, my results were given to my sister, not to me.

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Current situation for drug users

Today, not much has changed. Drug users are still seen as morally weak and bad people. We face stigma and discrimination in society and in the health-care setting. We experience constant police harassment and ineffective services.

In Thailand, injecting drug users are the only group whose HIV prevalence rate, which is at 50 percent, has not changed in 15 years. One-third of all new HIV infections are IDU-related, and this number is increasing. Yet there has been no effective response from the government.

In the recent war on drugs in Thailand, over 2200 people were killed extrajudicially in the first three months of the campaign. More than 50,000 people were arrested, hundreds of thousands were forced into military-run rehabilitation centres, and drug users were forced underground and away from services that were already difficult to access.¹

Last year, the Thai Drug Users' Network developed a proposal for a peer-driven HIV prevention, care, and support intervention for injectors, and submitted it to the Global Fund to Fight AIDS, Tuberculosis and Malaria. We had to bypass the Country Coordinating Mechanism (the standard process for submitting a Global Fund proposal) and, with the help of international AIDS activists, lobby to get political support for our proposal. In October 2003 we were awarded a US\$1.3 million grant, but we still haven't received the money.

Even though the Thai government says its current policy is to treat drug users as "patients," not "criminals," it is still illegal to be a drug user. We continue to be arrested and offered the choice of prison or military-run rehabilitation centres. Is this harm reduction or harm production?

Every minute, a person is infected with HIV by using a dirty needle. Globally, one in three of all new HIV infections outside Africa is IDU-related. In fact, contaminated needles account for the largest share of new infections in Eastern Europe and Asia.

The World Health Organization (WHO) says that drug users have an equal right to all levels of care, but in practice we are denied access to anti-retroviral (ARV) treatment as well as basic prevention interventions like clean needles. Methadone is still illegal in many countries and is not even on the WHO Essential Drug List.

There are many harm-reduction interventions that have been proven to help injection drug users stay free of HIV, including clean needles and methadone. We need these means of prevention in place now! And we need access to treatment now!

Drug users are offered the choice of prison or military-run rehabilitation centres. Is this harm reduction or harm production?

Drug users, like other politically, socially, or economically marginalized groups, are easily abused by the government and others, who exploit them for money or services. We often do not enjoy even the most basic human rights. In Thailand this is also true for sex workers, men who have sex with men, migrant workers, and undocumented citizens.

The global environment

The world we live in today is not a world of sharing but of advantage-taking, profit-seeking, and competition to "get ahead." It is a world motivated by greed and controlled by corporations, which do not recognize the value of a human being. While an elite few amass enormous wealth, basic needs are denied to many millions.

Today, many of our governments are run by these elites, who are more interested in protecting their personal investments than promoting public welfare. They invest public resources in projects whose profits go into the pockets of their friends instead of providing for the welfare of society. Governments privatize our public utilities, as well as our education and health-care systems.

Social welfare programs and other forms of assistance become issues of charity, not rights or entitlement. As a result, our public hospitals are overloaded and underfunded, severely compromising the availability and quality of treatment and care offered.

Of course, tackling AIDS isn't just about health care and ARVs. Prevention, harm reduction, poverty reduction, and decent living standards are all part of the process. But governments like that in the United States, and international bodies like the World Trade Organization, make the task much more difficult.

Market-driven policies and the emphasis on "abstinence only" have already proved to be, at best, totally useless and, at worst, harmful. It is outrageous that today, conservative groups, especially in the US, are advancing a moralistic ideology that contradicts scientific evidence about HIV prevention. Although condoms and clean needles are the most effective tools we have to prevent the transmission of HIV, programs that promote them are not funded, or are defunded.

Evidence shows that widespread access to ARVs leads to huge improvements in health and quality of life, with significant reductions in health-care and other costs, because of improved health and productivity among people living with HIV/AIDS and their families. The most painful

experience I can think of, after living with HIV for 13 years, is being poor and HIV-positive. I watched many friends die in front of me from terrible opportunistic infections, simply because they were poor and could not afford treatment.

I watched many friends die in front of me from terrible opportunistic infections, simply because they were poor and could not afford treatment.

What kills us is not AIDS, but greed. Multinational pharmaceutical companies inflate the prices of their drugs without thinking about poor people. They use their wealth to influence US and European government policy to ensure that intellectual property rights are weighted in their favour.

Other governments say they are too worried about adherence and drug resistance to offer treatment, when the truth is they don't want to pay, or they don't want to suffer repercussions from their trading partners by breaking patents.

Four years ago, Thai people with HIV/AIDS asked the government to use a compulsory licence for ddI, but the government was too afraid of trade and other sanctions from the US. Ultimately, we took Bristol Myers-Squibb to court and won the right to produce tablet-form ddI locally. The Thai court ruled that, because patents can lead to high prices and limit access to medicines, patients have the right to sue the patent holder.

This was a very important battle that we won. But the war is not over. Recently, the Thai government entered free-trade negotiations with the United States. We know that the US unilaterally pushes for intellectual property protection that is stricter than what is agreed internationally.

A free trade agreement with the US would mean that Thailand, now producing generic ARVs for most who need it, would no longer be able to sustain this important program. We are demanding that the Thai government refuse to trade away the health of its people by negotiating intellectual property protections for medicines.

The US government and its policies affect the ability of people all over the world to enjoy their basic rights and needs. Many poor countries cannot provide basic services like health care because they have to pay back enormous debts to the US and Western banks.

While thousands die of AIDS every day from lack of funds, there is unlimited funding for war. While the Global Fund is out of money, billions of dollars are freely available for killing and destruction in Iraq. The Global Fund shortfall is due to broken promises of rich donor countries that refuse to pay their fair share.

The role of activists

Four years ago, at UNGASS, after activists demanded an urgent response to the global AIDS treatment crisis, Kofi Annan called on all the world's governments to develop what he described as a "war chest." This became the Global Fund. At the last international AIDS conference, the WHO launched its "3 by 5" initiative. Yet, today, six million people are still waiting for their drugs.

AIDS doesn't wait and neither do we. Faced with the abuse of power

and greed of corporations, we cannot wait for our governments to act. Governments and corporations hate activists because we know what they are up to, and we are pulling the masks of fake concern from their face to reveal their true nature.

But I think that activists should be honoured. Activists are my true friends. They stand by my side when I face discrimination and injustice. They have the courage to stand up to those in power who use their positions for their own benefit. They are the ones who can help provide a way forward to fight AIDS and injustice in this world.

Access for all is the theme of the Bangkok Conference and the dream of many who attended. Yes, it's not easy to achieve in the world we live in today, but the world belongs to all of us to change.

Five years ago, doctors, nurses, and many other people told me and my friends that ARVs were an impossible dream. Recently, Thailand announced that it would provide ARVs to all those who need them, starting with 50,000 people by the end of 2004. I urge all of us to dream of a day when our world will be filled with love, sharing, and peace. And I believe that when we dream together, our dreams come true.

— Paisan Suwannawong

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¹ See: Report documents human rights abuses of drug users in Thailand. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 32-33. See also: 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.

The spread of harm-reduction programs in Brazil

A harm-reduction law implemented in the state of São Paulo in 1998 paved the way for Brazil to implement an extensive network of harm-reduction programs across the country. In his plenary address to the XV International AIDS Conference in Bangkok on 16 July 2004, Luiz Paulo Teixeira outlined the history of harm reduction in São Paulo, described how the Brazilian government adopted harm reduction as a national policy, and put forward some recommendations for extending harm-reduction policies and addressing key issues in drug-law reform. Mr Teixeira explained that leadership from both the political sector and civil society is necessary for harm reduction to be successfully implemented.

Changing the law is not easy, but it is possible. As we often say, if there is a will there is a way.

Drug users are at risk for, and vulnerable to, HIV infection. The practical solution is harm reduction. Harm reduction is a comprehensive package of activities that reduce the harms from drugs, particularly with respect to HIV/AIDS and hepatitis. They do so by providing services that are effective, human, and friendly to users. These services include syringe exchange, condoms, education about drugs and HIV, peer outreach, drug substitution therapy, and other treatments.

Harm reduction in São Paulo

In Brazil, the first harm-reduction program was formally introduced in 1989 in the city of Santos, in the state of São Paulo, where almost 60 percent of the drug users were infected with HIV. When the municipality introduced the harm-reduction program, the justice authorities prosecuted public health officials because they believed that syringe exchange would be a stimulus to drug users. The program was closed by order of the courts in 1995 and the health

officials were charged under existing drug laws.

In order to overcome the obstacles presented by this situation, I tabled a harm-reduction bill in the state Parliament. The rationale for the bill was based on legal, health, financial, and political arguments. First, we argued that the bill was not designed to increase drug use, but rather to help change the risk behaviour of drug users. There was evidence to show that harm reduction helped to reduce HIV infection and increase access to health services, including drug treatment.

Second, we pointed out that the cost of prevention programs was extremely low compared to the cost of treating AIDS and hepatitis. Finally, we said that drug users are citizens too, and have the right to health and to be free of discrimination.

Three years later, in 1998, the law was approved by the Parliament. Several factors contributed to our success. First, civil society had demanded prevention and access to antiretroviral treatment for all. Second, harm reduction had already been implemented (illegally), so the foundation existed and we already had experience with this approach.

Finally, the media played a role. They continued to draw attention to the spread of HIV and hepatitis, and to the link between the spread of these diseases and unsafe injecting drug use. The media were also publishing the successful experiences of other countries. This increased public pressure on political leaders.

The new law in São Paulo allowed for the legalization of harm-reduction programs, including syringe exchange. It also allowed for the use of government budgets for harm reduction, which meant that the program was funded and sustained. Thanks to this law, drug users and service providers are no longer arrested when taking part in harm-reduction programs.

National rollout

Pilot and small-scale projects were wonderful, but could not in themselves curb the epidemic. Brazil saw this clearly. So, after 1998, the law on harm reduction was approved in other Brazilian states at the national level. As a result, HIV infection among drug users in the country was reduced, and there was improvement in health indicators and in the dignity of these vulnerable citizens.

There are now 125 harm-reduction programs in Brazil, serving 65,000 drug users, as compared with only five programs in 1998. As well, from 1988 to 2003, a total of 631 projects were supported by the government. Seventeen states are covered by 17 harm-reduction associations. Harm reduction has been implemented in prisons. In 2003 a national drug law and policy was approved, which means that harm reduction is now a national strategy.

When the new drug law and policy was approved in 2003, harm reduction became a national strategy in Brazil.

Community response is key. A supportive policy and legal environment allows communities to organize, to involve drug users, and to strengthen the exceptional response to HIV in this population. Three networks were established: the Brazilian Outreach on Harm Reduction Association (ABORDA), the Brazilian Harm Reduction Network (REDUC), and the Latin American Harm Reduction Association Network (RELARD). RELARD was built together with other Latin American countries. Finally, a Brazilian drug users network was formed in 2004.

Further action needed

Yet we need to do more and to do better. It is still crucial to fight for a

progressive policy focused on health and human rights, and based on advanced and successful experiences in a number of countries. To make this happen will require the engagement of the health systems and the proactive involvement of drug users.

Brazil needs to do a number of things. First, Brazil needs to develop programs that allow for safe injecting rooms, as has been done in Australia, Holland, Switzerland, and other countries. This may reduce risk at strategic locations in drug injecting networks and thereby reduce HIV and hepatitis transmission.

Second, Brazil needs to implement trials on various drug substitution treatments. Third, it needs to enact legislation that decriminalizes drug users, as has been done in many countries. Fourth, Brazil needs to develop a strategy to coordinate harm-reduction programs and basic health care. Fifth, there needs to be closer partnerships between harm-reduction programs and mental health programs. Finally, the educational system in Brazil must have more effective prevention programs with respect to drug use and misuse, and harm reduction.

It is also critical to have a broader and longer-term strategy to reduce vulnerability and social exclusion, by combining programs for drug users, sex workers, and other marginalized groups. These programs should include education, harm reduction, income generation and micro credit, protection of the rights of citizens, empowerment of women and youth, and community involvement in programs.

We have evidence to show that harm-reduction projects work. We must implement harm-reduction programs nationwide, with sufficient resources and with the full involvement of drug users, the authorities, and health officials. But this can only be done in a supportive policy and legal environment. This means not stigmatizing, marginalizing, and criminalizing drug users.

AIDS is a global problem. Working at the country level alone is not enough. We need a new international policy on drugs that will provide a supportive framework for comprehensive harm-reduction policies and programs. We have to just say no to the war on drugs.

We have to eliminate stigma and discrimination. We must ensure equitable access to HIV/AIDS prevention, treatment, and care. Let us fight the disease and fight discrimination together, even if it requires changing the law.

We leaders have to ask ourselves, "Have we done enough?" If we can do it in our country, others can do it also.

– Luiz Paulo Teixeira

Luiz Paulo Teixeira was a member of the state Parliament in São Paulo for eight years. He is also the former Secretary of Housing and Urban Development in São Paulo. Since 2001, Mr Teixeira has headed up the sector of Urban Development and Housing in the City of São Paulo. He can be reached at agenda@pauloteixeira13.com.br.

Prisoners' health and human rights in the HIV/AIDS epidemic

Prisoners exist on the margins of society, often without access to HIV prevention, care, treatment, or support. Depriving prisoners of the means to protect themselves from HIV infection, and failing to provide prisoners living with HIV with care, treatment, and support equivalent to that available in the community, offend international human rights norms. This article by Glenn Betteridge provides a summary of a draft paper prepared for Human Rights at the Margins: HIV/AIDS, Prisoners, Drug Users and the Law, a satellite meeting held in Bangkok on 9 July 2004, and organized by the Canadian HIV/AIDS Legal Network and the Lawyers Collective HIV/AIDS Unit (India). The full text of the final paper, including references, is available on the Legal Network's website.¹ The article reviews some of the international laws and instruments that protect the rights of prisoners and that set out minimum standards for treatment of prisoners; outlines activities in the prison setting that place prisoners at risk for HIV; describes some of the policies and societal factors that fuel the HIV/AIDS epidemic in prisons; and proposes a series of specific actions that should be taken now to respond to this epidemic.

HIV/AIDS in prisons

Worldwide, levels of HIV prevalence within inmate populations tend to be much higher than in the general population. Several countries have reported HIV prevalence rates ranging from 10 to 25 percent. Many of the data regarding HIV/AIDS in prisons are from high-income countries; relatively little information is available for developing countries and countries in transition.

Violence, sexual activity, and injection drug use in prison all carry the potential for HIV transmission. Forced sexual intercourse (rape) is common in prisons, and often involves a high risk of HIV transmission because of the unavailability of condoms and the violent nature of forced sex. Unprotected coerced and consensual sexual intercourse also occur in prisons. In countries other than those with large heterosexual HIV epidemics, the areas with the highest HIV prevalence in prisons are those where HIV infection is epidemic among IV drug users in the general population. Incarceration is a common event among injection drug

users, and injection of illicit drugs is common within prisons. While users typically inject less frequently in prisons, studies have demonstrated that the injections that occur tend to be carried out in a more "high-risk" fashion than injections in community settings. For example, a single syringe will often be shared among a large group of prisoners.

Other communicable diseases disproportionately affect prisoners. Of particular concern are the elevated prevalence rates of hepatitis B and C, and tuberculosis.

International human rights law and related norms

Under international norms, prisoners enjoy all human rights except those they are necessarily deprived of as a fact of incarceration. There are two general categories of instruments that protect human rights. Each poses different obligations on governments. International human rights *law* is binding on governments. International *rules, standards, and guidelines* are not law, and are therefore not binding on governments.

International human rights laws

International human rights laws (for example, the International Covenant on Civil and Political Rights, the African Charter on Human and Peoples' Rights, and the European Social Charter), while general in nature, are relevant to the rights of prisoners in the context of the HIV/AIDS epidemic.² States that have ratified or acceded to these international laws are legally bound to respect, protect, and fulfill the right of prisoners to equality and non-discrimination, life, security of the person, the enjoyment of the highest attainable standard of physical and mental health, privacy, and an effective remedy for violations of human rights; and the right not be subjected to torture or to cruel, inhuman, or degrading treatment or punishment.

International rules, standards, and guidelines

Specific rules, standards, and guidelines apply to the situation of prisoners, and impose both negative and positive obligations on states regard-

ing prison conditions and the treatment of prisoners. The most important of these instruments are:

- Basic Principles for the Treatment of Prisoners
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment
- Standard Minimum Rules for the Treatment of Prisoners
- Recommendation No R (98)7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison

Two additional international instruments that are relevant to the situation of prisoners in the context of HIV/AIDS are the World Health Organization (WHO) Guidelines on HIV Infection and AIDS in Prisons (1993), and the International Guidelines on HIV/AIDS and Human Rights.

The WHO Guidelines “provide standards – from a public health perspective – which prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by HIV/AIDS.” The WHO Guidelines outline general principles and cover areas such as HIV testing; prevention measures; management of HIV-infected prisoners; confidentiality; care and support of HIV-infected prisoners; women prisoners; juvenile detention; semi-liberty, release, and early release; community contacts; resources; and evaluation and research.

The International Guidelines identify the following specific action in relation to prisons:

Prison authorities should take all necessary measures, including adequate

staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.³

When governments fulfill their human rights obligations to prisoners they also promote positive public health outcomes.

In the context of the HIV/AIDS epidemic, when governments fulfill their human rights obligations to prisoners they also promote positive public health outcomes. Measures undertaken to prevent the spread of HIV and other infections will benefit prisoners, staff, and the public. Prisoners should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. Lowering the prevalence of infections in prisons means that the risk of exposure to these infections among staff will also be lowered. Most inmates are in prison only for short periods of time and are then released into their communities. In order to protect the general population, pre-

vention measures need to be available in prisons, as they are outside.

Factors that fuel HIV/AIDS in prisons

Prohibitionist policies have proven ineffective at stopping or even decreasing drug use, and have resulted in widespread human rights abuses and incarceration of drug users. Domestic laws and international conventions that render drugs illegal are used by governments as a rationale to justify the failure to provide the full range of harm-reduction measures to people who inject drugs, including prisoners.

Homophobia and the stigmatization of same-sex sexual relations present a significant barrier to the introduction of condoms and lubricant (and dental dams) in prisons. Prison authorities often justify the refusal to provide condoms and lubricant by claiming that same-sex sexual relations and intercourse do not take place in prison. Or they argue that because sexual relations among prisoners are illegal, providing condoms to prisoners would be seen as condoning illegal behaviour.

In many countries prisons operate under military or security forces, or are part of the ministries or departments responsible for these areas. Even in countries where prisons are not associated with military or security forces, an unquestioning, rule-bound inflexibility is the normal stance of decision-makers responsible for prisons. This discourages openness to change, innovation, and links with the community within which the prison operates. Paradoxically, within prisons, the premium placed on respect for rules often means respect for unwritten rules and shared codes of conduct that violate domestic laws and poli-

cies applicable to prisons, to say nothing of international human rights norms and standards.

In many countries, the predominant purpose underlying imprisonment is punishment, if not in law then in popular and political discourse. In this context substandard, deplorable prison conditions are deemed to be acceptable. For those people living with HIV at the time of incarceration, a prison sentence may shorten their lifespan or even result in death, due to the lack of adequate health care, overcrowding and inadequate nutrition, and the presence of infections, in particular tuberculosis.

In the vast majority of prison systems in the world, health care is provided by the same ministry or department responsible for prison administration, not by the ministry or department responsible for health care in the community. Prisons were not designed, and are generally not equipped, to deal with prisoners infected with chronic, potentially fatal diseases such as HIV/AIDS, hepatitis, and tuberculosis. They do not have adequate staffing levels, staff training, or equipment to meet the health needs of prisoners suffering from these diseases. When health services for prisoners are “captured” within, or subservient to, the prison administration, it is unlikely that prisoners will trust or have confidence in the health-care providers. This lack of trust contributes to substandard health care for prisoners.

The public, and by extension politicians, are generally not supportive of prisoners or of the rights of prisoners. There is a lack of information and understanding of the realities of prison life and prison conditions. Furthermore, there is a lack of knowledge among the public about the international human rights

Prisoners and former prisoners rarely coalesce into a constituency capable of influencing public opinion or public policy, or of effecting political change.

and other norms that apply to prisons and prisoners. Prisoners and former prisoners rarely coalesce into a constituency capable of influencing public opinion or public policy, or of effecting political change. This is likely because of the marginalization of prisoners and former prisoners, as well as the underlying marginalization of the groups of people who have high rates of incarceration.

With few exceptions, elected and other decision-makers have been slow to respond to the HIV/AIDS epidemic in prisons, or have failed to address the epidemic within prisons at all. For the majority of developing countries and countries in transition, there are no reliable estimates of HIV prevalence in prisons. This lack of information allows decision-makers in these countries to persist in their inaction. In other countries, even in the face of HIV prevalence rates that are many times higher than in the general population, and of evidence of HIV transmission in prisons, often decision-makers have failed to take action. With very few exceptions, there have been no consequences for inaction on the part of elected officials or decision-makers responsible for prisons.

Priority initiatives for 2004-2006

In addition to longer-term advocacy (such as law reform and legal

action), immediate action is needed to address the HIV/AIDS epidemic in prisons. Non-governmental organizations, international organizations (such as the WHO and UNAIDS), and other funders should consider prioritizing the following initiatives leading up to the International AIDS Conference in Toronto, Canada, in 2006 (AIDS 2006):

Building a movement based on human rights, prisoners’ rights, and HIV/AIDS. There are numerous, long-standing organizations that advocate for human rights, and organizations that advocate for prisoners’ rights. In the last 20 years, many organizations that advocate on behalf of people living with or vulnerable to HIV/AIDS have been created at national, regional, and international levels. At all these levels, human rights, prisoners’ rights, and HIV/AIDS organizations should explore alliances and find ways to work together.

Review of the WHO Guidelines.

The WHO Guidelines have not been adequately promoted and are in need of an update. The WHO, working in partnership with UNAIDS, the United Nations Office on Drugs and Crime, and NGOs, should revise the guidelines and develop and implement a promotion plan.

The WHO “3 by 5” initiative and other access-to-treatment initiatives.

To ensure that prisoners with HIV/AIDS who need treatment benefit from access to treatment initiatives, the initiatives need to include a prison-specific component.

High-level policy dialogues on

HIV/AIDS in prisons. High-level dialogues involving NGOs, domestic

and international governments can play a role in advancing public policy. Consideration should be given to organizing a dialogue on HIV/AIDS in prisons.

AIDS 2006 and regional AIDS conferences. An effort should be made to work with the organizers of AIDS 2006 and the regional AIDS conferences to ensure greater attention to HIV/AIDS in prisons.

Report cards and human rights audits. Report cards and human rights audits of prison systems can form the basis of cooperation among all stakeholders to bring about positive changes. Where violations and their root causes are identified, solutions can be formulated, and resources can be more easily obtained to implement these solutions.

Prison study tours and technical assistance. Experiences of successful responses to HIV/AIDS, including successful implementation of harm-reduction programs, need to be shared. International funders as well as governments in high-income countries have an obligation to facilitate the sharing of expertise and experiences by funding and facilitating prison study tours and the provision of technical assistance.

NGO declarations. Declarations can provide an NGO platform for the reforms and programs required to respect, protect, and fulfill the human rights of prisoners in the context of the HIV/AIDS epidemic. Consideration should be given to working with the drafters of existing declarations, such as the Dublin Declaration, to expand its scope to

include the other regions of the world, and to promote the Declaration worldwide.

– Glenn Betteridge

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¹ The paper is entitled "Prisoners' Health and Human Rights in the HIV/AIDS Epidemic." It is available via www.aidslaw.ca/Maincontent/issues/prisons.htm

² Note also that there is strong agreement that the Universal Declaration of Human Rights – UN GA res 217A (III), UN Doc A/810 at 71 (1948) – is legally binding on all United Nations member states on the grounds that it is customary international law.

³ International Guidelines on HIV/AIDS and Human Rights. UNCHR res 1997/33, UN Doc E/CN.4/1997/150 (1997) at para 29(e).

Current issues and concerns in HIV testing: a health and human rights approach

In the rush to scale up HIV testing, partially justified by the fact that treatment is becoming more widely available, the long-held view that testing must be voluntary, and that it must be accompanied by pre- and post-test counselling, is being increasingly questioned. However, as long as stigma, discrimination, and unequal access to care and treatment continue, the individual informed decision to take an HIV test must remain an integral step in medical practice. In this article, based on her presentation at an oral abstract session of the XV International AIDS Conference in Bangkok on 14 July 2004, Sofia Gruskin describes the developments that have led some people to question voluntary testing and counselling (VTC); outlines the factors that need to be considered in analyzing whether a proposed HIV testing strategy is effective in both health and human rights terms; calls for clarity in the use of terms such as "routine testing," "opting in," and "opting out"; and provides a list of considerations that must be addressed for any scaling up of HIV testing to be successful.

Introduction

From the perspectives of both public health and human rights, concerns

exist as to how and why HIV testing is carried out, and whether people understand the behavioural, service,

and other implications of a positive test result. In the early years of HIV, members of affected communities and

human rights advocates recognized that HIV testing must be voluntary, and that informed choice was central to creating a climate of confidence and trust between the person being tested and service providers. The mounting pressure that existed at the time to make HIV testing mandatory was curbed as most public health professionals came to understand this simple truth. VTC was a necessary and central component of the response to HIV/AIDS and has remained so to this day.

Today few would dare claim mandatory HIV testing in the health-care setting as an acceptable option. It seems, however, that the recent and justifiable interest in scaling up HIV testing has resulted in a discourse that is highly politicized and that once again appears to be pitting public health goals against human rights norms. We must not allow public health and human rights to be framed as diverging concepts in the approach to HIV/AIDS. We need a scale-up effort that embodies sound public health and human rights practice.

Historically, VTC was understood to include both pre- and post-test counselling. Over time, primarily because of their costs in financial and human resources, the need for both pre- and post-test counselling has been increasingly questioned. Strategies are currently being proposed that range from understandable attempts to minimize costs by trying different models of group pre-test counselling, to more problematic suggestions that people should be tested automatically when they enter a health service unless they know enough to ask that it not be done.

There are also increasing claims in both the professional and the general media that seem to suggest that HIV testing itself is what matters

most. The implication is that the other elements, including the counselling and the voluntariness, are less important, if not irrelevant, if not actual obstacles.

Hand in hand with this, in a number of countries there have been moves toward more stringent forms of testing that are increasingly being lumped together under the general heading of “routine testing.” Unfortunately, the vagueness of this term obscures whether HIV tests are being routinely offered or routinely imposed and whether, in either case, the individual has a true informed choice to opt in or opt out of being tested. We must ensure that the language of routine testing, which is increasingly permeating discussions of HIV/AIDS, is not or does not just become mandatory testing under another name.

We must ensure that the language of routine testing does not just become mandatory testing under another name.

Where are we now?

The momentum behind this change in approach to VTC can be attributed to a range of factors and frustrations. VTC has not been sufficiently emphasized in many national responses to AIDS, and even when VTC services do exist there is generally low demand for, and use of, them. It is important to recall, however, that successful efforts have not been sufficiently replicated. Evidence has shown that low demand can to a large degree be attributed to the lack

of treatment options, and to HIV/AIDS-related stigma and discrimination resulting in people being concerned about coming forward to learn their HIV status.

Further, only a fraction – perhaps five percent – of people living with HIV/AIDS in developing countries are currently aware of their serostatus. Now that treatment is finally starting to become more readily available, testing has to be significantly scaled up, since people generally need to know their status in order to access treatment.

Finally, some actors engaged in the response to HIV/AIDS appear to genuinely believe that more than 20 years into the epidemic, this move toward “routinization” of HIV testing is part of an increasing normalization of HIV, which – so the logic goes – can gradually help to reduce stigma and discrimination.

The public health goals of scaling up testing in the current context have been pretty well defined, but the methods that are to be applied to achieve these goals have not. Both public health and human rights considerations require that HIV testing be scaled up in ways that can most effectively ensure that people can get the services they need and stay connected to those services.

In human rights terms, strategies that impinge on rights such as privacy might be acceptable if such restrictions were provided for in law, and if there was *evidence* to show that this particular approach was strictly necessary and the least restrictive alternative by which this clear and legitimate objective could be met. In this scenario, the public health gains of removing the voluntary nature of HIV testing, including imposing testing on people without ensuring their consent, might in

themselves justify some limitations on rights. However, the case has not been made.

The obligation and the burden of proof to provide this evidence is on those who would suggest a need to restrict human rights in any way, and requires evaluating:

- the perceived and actual benefits, as well as the risks over time, of the chosen approach;
- the strength of the evidence on which the decision is being made; and
- the actual care and treatment offered through this chosen strategy for particular individuals or populations, in specified locations, over time.

These criteria have not been met by any of the advocates for a move away from VTC as the preferred approach to HIV testing. In addition, in the past year, the basic tenets of VTC have been severely scrutinized by a number of actors to determine whether this strategy is still the most effective, given current realities. Most notably, UNAIDS and the WHO have come out with a revised policy on HIV testing that provides some specificity in relation to the health-care setting, and that affirms the internationally recommended strategies for HIV testing. Further, opponents to the routine imposition of HIV testing have noted that as long as stigma, discrimination, and unequal access to care and treatment continue, the individual, informed decision to take an HIV test must remain an integral step in medical practice – because otherwise there could be severe adverse effects, not only at the individual level, but with regard to participation with the health-care system more generally.

The who, what, where, and why of HIV testing

While current discussions of HIV testing are often formulated in general terms, a health and human rights analysis requires determining in any particular situation whether a proposed strategy is the most effective in both health and human rights terms.

The individual, informed decision to take an HIV test must remain an integral step in medical practice.

This means that we need to pay attention to a range of factors, including why and how HIV testing is being done, as well as the implications of a positive test result that flow within different legal and policy contexts.

First, why is testing occurring in a particular place? What is the purpose of the testing strategy? Leaving aside surveillance, testing for individual diagnosis occurs for many different reasons, including:

Because people voluntarily want to know their HIV status. This has traditionally been the heart of HIV testing strategies. It is because of informed decision-making that people seek to know their status. Informed consent and pre- and post-test counselling remain key to this strategy.

Because it is part of “routine” screening in health services. This is where the biggest confusion lies. The major issue here is whether HIV testing in this context is actually routinely imposed or routinely offered by the provider.

To reduce mother-to-child transmission. A large concern arises when HIV testing occurs around delivery. Issues that need to be addressed include ensuring consent to be tested, how pre- and post-test counselling will be provided, how and when the woman will be informed of a positive test result, and how confidentiality of that test result will be protected. In addition, far more attention needs to be paid to what links to services and treatment exist for both mother and child, not only at the point of delivery, but also over time.

Because of societal attitudes and prejudices toward certain individuals and population groups. Even when testing is ostensibly voluntary and accessible to the population as a whole, there may be legal or community norms that limit access to the test for some people, for example on the basis of age or gender. There is also a danger that the rush to scale up HIV testing may end up serving as a justification to mandatorily test populations, such as injection drug users or sex workers, whose actions fall outside the law, without ensuring that the testing that is done is linked to treatment and that people receive the benefits of scale-up efforts, whether or not the testing occurs inside the health-care setting.

To determine eligibility for activities, services, and goods. The use of the term “routine” is increasingly also creeping into discussions about testing for access to services and goods such as university entrance.

Second, where is testing being done? Testing often occurs in primary-care clinics or in specialized services such as antenatal clinics, but testing also

occurs in non-health care settings such as the workplace, universities, immigration offices, police stations, and prisons. How testing is done in each of these places must be considered, particularly in relation to informed consent, confidentiality, and the consequences to a person of a positive result, including ensuring that treatment is made available to them over time.

Third, a critical aspect of HIV testing with significant implications for the promotion and protection of human rights is what happens with a positive test result. Attention must be given to whether and how positive results are conveyed to the person, but also to whether consent to disclose this information is explicit, implicit, or irrelevant, and to whether and how these results are given to care providers, partners, family members, employers, and the state.

Some suggestions for a way forward

Unfortunately, the definition and interpretation of “routine” varies widely, and discussions continue at a level of generality that is not conducive to systematic analysis or implementation and that could lead to abuse. Clarity is needed as to whether HIV testing is routinely offered or routinely imposed; whether there is pre- and post-test counselling; and whether there is a potential to opt in or to opt out and, in either case, whether there are negative consequences on the person’s ability to access care, support, and treatment over time.

Some definitions are suggested below that may be useful in helping to clarify the many different strategies captured under the rubric of “routine testing”:

- Routinely offered test: provider-initiated, and requires individual pre- and post- test counselling enabling the person to make an informed decision.
- Routinely imposed test: performed at the discretion of the care provider without necessarily ensuring individual consent.
- Opting-in: informed consent by the person to undergo the test being offered.
- Opting in by default: systematically imposed test, unless the person spontaneously requests the test not to be performed.
- Opting out: stated refusal by the person to undergo the test being offered.

Strategies should move toward the routine offer of an HIV test in health-care settings.

Any routine or systematic practice of HIV testing where the person’s informed decision to be tested is not specifically solicited, including opting in by default, must be explicitly rejected. Rather, strategies should move toward the *routine offer* of an HIV test in health-care settings. Any scale-up of HIV testing requires systematic attention not only to the logistics of scaling up, but also to ensuring the conditions necessary for people to access testing and to stay connected to the health system once they receive their test results.

All efforts to scale up HIV testing must ensure the *voluntary* nature of the test, and that health-care services move toward the *routine offer* of an HIV test. Based on the work of the

UNAIDS Reference Group on HIV/AIDS and Human Rights, several key factors can be identified that must be addressed simultaneously and in a comprehensive fashion in order for any scaling up of HIV testing to be successful over the long term. These include:

- the testing process itself, including the purpose and the practice of it, and the implications of a positive test result;
- the degree of access to sustainable treatment and care that exists for people once they learn their status;
- whether the existing health-care infrastructure is sufficient to handle increased demand if more people learn of their status;
- the levels of HIV/AIDS-related stigma and discrimination within the area and the efforts that are being made to reduce them; and
- the legal and policy context within which the scale-up effort is occurring, including whether the laws and policies in relation to HIV specifically and in relation to vulnerable populations such as sex workers and drug users are in conflict or share a similar harm-reduction approach.

Conclusion

Scaling up must occur in each of these categories simultaneously. Considering any one of these areas in isolation will not be sufficient to ensure that HIV testing will result in more people not only knowing their HIV status, but also getting the care and support they need. Isolated or haphazard attempts to increase HIV testing may have significant negative consequences for HIV/AIDS and for use of the health-care and social systems more generally.

The concept of voluntariness must remain at the heart of all testing strategies not only to be consistent with human rights principles, but also to ensure their public health benefit. Public health workers have a legal obligation not to undercut human rights unless there is established evidence of significant public health gains; in relation to HIV testing, no such evidence exists. While

on the surface it may seem reasonable to use the word “routine” to describe a procedure that is done systematically within a health-care setting, the unqualified use of the term “routine testing” is dangerous and must be stopped.

– Sofia Gruskin

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Sexual minorities, violence, and AIDS in Africa

In most low-income countries, the occurrence of sex between men and between women has usually been ignored or denied by public opinion, governments, and the international community. This has led to systematic violations of the human rights of sexual minorities, a high level of violence against them, and the neglect of the spread of HIV/AIDS among men who have sex with men (MSM) and women who have sex with women (WSW). In this article, which is based on his presentation during an oral abstract session of the XV International Conference on AIDS in Bangkok on 14 July 2004, Ronald Lwabaayi discusses the double epidemic of violence and AIDS faced by MSM and WSW in low-income countries, with special reference to Africa, and offers recommendations on how to address these issues within a human rights and poverty-reduction framework.¹

In low-income countries in general, and in Africa in particular, few people who have sexual relationships with members of the same sex identify themselves as lesbian, gay, bisexual, or transgender (LGBT). Within this group, two further categories can be distinguished: those who socialize and engage in sexual relationships with LGBT-identified persons, and those who do not. The latter include students in boarding schools, migrant workers, men in worker camps (such as miners), men enrolled in military service, street boys, and the inmates of correctional institutions. The MSM and WSW population in low-income

countries is, therefore, highly heterogeneous.

Violence and other social risks

The United Nations Human Rights Committee has interpreted the Universal Declaration of Human Rights and the International Convention on Civil and Political Rights to include the protection of the rights of sexual minorities to equality and non-discrimination before the law; to liberty and security of the person; to not be subjected to cruel, inhuman, or degrading treatment or punishment; and to not to be subject-

ed to arbitrary arrest, detention, or exile.² Several other UN commissions have commented on the special vulnerabilities of sexual minorities, and on the extremely adverse impact of laws that criminalize same-sex sexual behaviour. Yet, continuing the criminalization of same-sex behaviour enacted by the colonial powers during the 20th century, more than two-thirds of African countries still criminalize same-sex behaviour and deny MSM and WSW their basic human rights.³

Furthering this hostile environment, African politicians and (especially) religious leaders across Africa have actively condemned gays

and lesbians and same-sex sexual relationships, and have allowed people to persecute, cast out, or abuse sexual minorities with impunity.⁴ Even where politicians have not attacked homosexuality, the level of intolerance and violence against sexual minorities can be frighteningly high.⁵

Particularly distressing is that MSM and WSW, especially those who identify as gay or lesbian, or who cannot hide it, are frequently sexually victimized.⁶ Sexual assaults against MSM are frequent and take place in homes, schools, on the street, in the military, during wars, in prison, and at police stations. Lesbians' risk of rape may be higher than that of heterosexual women because they may become special targets of rape once their sexual identity is known.⁷

In Africa, lesbians risk becoming special targets of rape once their sexual identity is known.

Moreover, intolerance and stigma lead to a variety of other social risks for MSM and WSW who either declare their sexual preference or cannot hide it. These include loss of employment or livelihood, being thrown out of their homes, eviction from housing, and the loss of a social safety net typically provided by their families and wider social and religious groups. Social isolation, in turn, makes MSM and WSW highly vulnerable to adversities such as unemployment or sickness, which can often lead to destitution, disability, poverty, or loss of life. These

social risks increase the possibility of prostitution, with its associated risks of violence, sexually transmitted infections, and AIDS.

HIV/AIDS

The fact that sexual identity and behaviour are not the same implies that there is a significant "bridge" of HIV transmission between MSM and the general population.⁸ In order to hide their sexual identity, a significant portion of LGBT people have sexual partners of the opposite sex, marry a person of the opposite sex, or have children.⁹ The same applies to MSM who do not consider themselves as LGBT and who naturally seek opposite-sex partnerships. Therefore, HIV acquired by MSM as a consequence of intercourse with other men is frequently transmitted to the women with whom they have sex, and from there to their children during pregnancy, at birth, or during breastfeeding.¹⁰

Moreover, given the special risks involved with anal intercourse, HIV/AIDS prevalence among MSM is likely to be significantly worse than among the general population. The probability of HIV transmission through anal intercourse is at least five times as high as through vaginal sex.¹¹

A recent assessment conducted in eight anglophone African countries showed a high prevalence of AIDS among MSM, and revealed that the risk of dying from AIDS for MSM is medium to high in all locations, irrespective of the legal or political situation.¹² The group most seriously affected by HIV/AIDS are male sex workers, for whom the risk of dying from AIDS is high in all locations. For gay men other than sex workers, the risk is medium to high in most

locations. For lesbians, surprisingly, the risk is high in more than half of the locations and medium for most of the remaining locations. Contrary to WSW in the developed world, most WSW in Africa marry men or have male sexual partners, and are therefore exposed to the same risks of contracting the disease as heterosexual women. Another factor is their very high risk of rape, as mentioned above.

Finally, HIV prevention messages aimed at MSM/WSW generally cannot be obtained from sources other than LGBT associations. Similarly, AIDS care and treatment generally neither reaches nor targets the LGBT population, even in cities where these services are offered to the general public. Thus, even in the public health sector there is discrimination.

Toward an inclusive strategy against violence and AIDS

Rather than trying to deal with the issues of sexual minorities as a separate agenda, embedding these issues into the broader agendas of organizations dealing with gender, violence, human rights, and HIV/AIDS would be more likely to lead to progress. This approach would capitalize on a broad set of alliances, and reduce the likely negative reaction of policymakers, religious groups, and the population at large that a single-issue program could provoke. From an even broader perspective, these issues should be integrated into existing frameworks of poverty reduction and human rights.

Key actors in improving the conditions of sexual minorities are states, civil society, LGBT people and associations, and the donor community. LGBT people and associa-

tions should be at the core of targeted advocacy and prevention efforts. Non-LGBT civil society organizations should also be encouraged to provide HIV/AIDS prevention, care, and treatment services to specific MSM populations, such as migrants, inmates of correctional institutions, and young street people.

States and civil society should proactively advocate for and protect the human rights of sexual minorities. States should be encouraged to

States and civil society should advocate for and protect the human rights of sexual minorities.

provide sexual minorities with equitable access to economic opportunities, the protection of legal systems,¹³ and service delivery, especially in health, education, and HIV/AIDS prevention, care, and treatment. At this time, in most of Africa, it is nearly impossible for LGBT groups to meet or organize because of oppressive laws, official campaigns against them, lack of information, negative media, deep cultural and religious disapproval, the absence of safe meeting places, the lack of financial support, and the risks of violence, loss of livelihood, and social isolation.¹⁴

Finally, the donor community and international organizations need to become much more active in advo-

cating for improvements in the lives of sexual minorities. Donors and governments need to develop an enabling environment for working on MSM and WSW issues at the international and national levels. The donor community also needs to help finance an aggressive response to AIDS among MSM, including the provision of targeted service-delivery programs.

There is also a need for academic institutions, civil society organizations, and the international community to undertake intensive research on the conditions and problems of sexual minorities. The current capacity of all these actors to implement research, policies, and programs for sexual minorities is almost non-existent. What is needed is a combination of formal training, learning by doing, and empowerment, especially for LGBT groups, which are typically poorly organized and cannot sustain themselves.

Conclusion

Up to now, African states, civil society organizations, international organizations, and donors have not responded to the needs of sexual minorities. Yet the high vulnerability of MSM and WSW to violence and AIDS is a problem throughout Africa that calls for urgent action. The marginalization of MSM and WSW increases their disease burden and exposes them to an increased risk of loss of livelihood and loss of life. Finally, the likely high HIV prevalence within the MSM population

and the significant spillover of the HIV epidemic to women and children require that HIV/AIDS among MSM be urgently addressed.

— Ronald Lwabaayi

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¹ Both this article and the presentation at the Bangkok Conference are based on a paper written by Mr Lwabaayi, H Binswanger, C Anyamele, and T Van Nguyen, entitled "Sexual Minorities, Violence and AIDS in Africa." Copies of this paper can be obtained from Mr Lwabaayi.

² Human Rights Watch and the International Gay and Lesbian Human Rights Commission. *More than a Name: State-Sponsored Homophobia and Its Consequences in Southern Africa*. Human Rights Watch, USA, 2003.

³ Afrol News, at www.afrol.com/Categories/Gay/index_legal.htm, May 2004.

⁴ Supra, note 2.

⁵ All Africa HIV/AIDS and Human Rights Symposium. *LGBT Risk Assessment for Eight Selected African Countries*. February 2004. South Africa (in print).

⁶ WHO World Report on Violence and Health, 2002.

⁷ Supra, note 5.

⁸ UNAIDS. *AIDS and Men Who Have Sex with Men: UNAIDS Point of View*, July 1998. Also, CI Niang et al. *Meeting the Sexual Health Needs of Men Who Have Sex With Men in Senegal*. Horizons Program, USAID. The Population Council Inc, New York, 2002. Also, All Africa, supra, note 5. Also, J Robertson. *The Black Swans of Africa: AIDS and Sex Between Men in Sub-Saharan Africa*. The Harvard School of Public Health, Harvard University. In press. 2003.

⁹ Niang et al, supra, note 8. Also, S Brody, J Potterat. Assessing the role of anal intercourse in the epidemiology of AIDS in Africa. *International Journal of STD and AIDS* 2003; 14: 431-436.

¹⁰ UNAIDS, supra, note 8.

¹¹ Robertson, supra, note 8.

¹² Supra, note 5.

¹³ Supra, note 2.

¹⁴ Supra, note 5.

Bangkok 2004: Abstracts on legal, ethical, and human rights issues

There were over 175 abstracts at the XV International Conference on AIDS touching on legal, ethical, and human rights issues. The topics addressed in these abstracts ranged from strategies to reduce HIV/AIDS stigma and discrimination to the impact of the Thai war on drugs, and from privacy protection and the disclosure of health information to advocating for the rights of HIV-positive women. Only a small number of abstracts can be included in this special issue of the *Review*. The following abstracts have been chosen because, together with the other articles in this special issue, they provide a representative sample of the many legal, ethical, and human rights topics addressed at the Conference.

Three of the abstracts deal with reducing the vulnerability, and advocating for the rights, of women and girls. Another is about harm reduction for women prisoners. One abstract is on the topic of using advocacy to promote the rights of injection drug users and people living with HIV/AIDS. Another illustrates the value and importance of advocacy undertaken by people living with HIV/AIDS themselves. Two abstracts describe the use of a rights-based approach, one in the context of prevention programming, and the other in relation to providing care and support services. Two abstracts deal with the use of the law and legal services to advance the response to HIV/AIDS. Finally, there are individual abstracts on access to anti-retroviral therapy, post-exposure prophylaxis for the survivors of sexual violence, ethical issues in HIV vaccine research and development, and mandatory HIV testing of migrant workers. Of the 14 abstracts presented here, 10 relate specifically to developing countries; another three describe global issues. Other abstracts from the Bangkok Conference are available on the Conference website via www.AIDS2004.com.

Abstract E4040: Advocating for HIV-positive women's rights to reproductive health care in Ukraine

Issues: HIV-positive women face barriers when accessing health care in Ukraine. They do not always receive full and accurate information to make informed reproductive health decisions, they face stigma and discrimination, and they have their confidentiality breached.

Description: The project sought to develop a process to remove operational policy barriers, thereby promoting an improved enabling environment for HIV-positive women

seeking health care. The framework provided an advocacy model that engaged a community advisory board (CAB), including persons living with HIV/AIDS, and used a human rights approach. The initiative included five interrelated activities: (1) a human rights orientation workshop about internationally endorsed human and reproductive rights; (2) a qualitative survey of HIV-positive women and providers to document violations of the rights of positive women and barriers to accessing reproductive health services; (3) a targeted review of Ukrainian laws; (4) a comparison of Ukrainian laws with regional and international treaties to which Ukraine is a signatory; and (5) policy dialogue and advocacy.

Lessons learned: (1) Involving people affected by HIV/AIDS from the beginning in the implementation of a project, along with other key stakeholders, is vital. (2) Going beyond the anecdotal evidence to document problems that persons living with HIV/AIDS face is critical as a first step toward policy change. (3) It is also necessary for policy-makers to become involved as early as possible so that they become invested in improving the situation. (4) To be accepted as equal partners, persons living with HIV/AIDS need skills and knowledge to address some issues.

Recommendations: This pilot process recommends initiating advo-

cacy, engaging a CAB, and using a human rights approach to address complex policy change issues. It allows for meaningful participation by persons living with HIV/AIDS in policy development, while sensitizing stakeholders to human rights and health issues.

Presented by: O Semerik, M Medrek, A Eckman, L Porter, POLICY Project.

Abstract E4088: Demanding universal antiretroviral treatment for persons living with HIV/AIDS in Guatemala

Issues: Guatemala, with an estimated HIV prevalence rate of nearly two percent, is one of the last countries in Latin America to officially recognize the nearly 100,000 persons living with HIV/AIDS within its borders. Since 2001 the Department of Public Health in Guatemala has ignored numerous written requests and petitions to give an audience to persons living with HIV/AIDS who are requesting universal coverage for antiretroviral treatment.

Description: Tired of witnessing an average of 10 deaths per day due to AIDS in Guatemala without any significant public response, persons living with HIV/AIDS organized themselves, with the support of the Fernando Iturbide Foundation for the Prevention of AIDS and the Association for Integrated Health. They sent a petition directly to the then president of Guatemala, Alfonso Portillo, demanding the urgent treatment of 26 HIV-positive persons and a commitment to universal access to drug therapies within 30 days. The Human Rights Committee of Guatemala fully supported the peti-

tion, but the President did not reply. In response to his non-action, a lawsuit was launched against the President. Thanks to the efforts of the NGO community, the President was convinced to hear the complaints, and agreed to sign Decree 27-2000, which provided US\$62,500 for treatment of a limited number of persons living with HIV/AIDS. In January 2003 the Constitutional Court of Guatemala annulled the lawsuit on the ground that it had no legal precedent. In August 2003 the National Alliance for Persons Living with HIV/AIDS and other NGOs filed a case with the International Commission for Human Rights, claiming that the government of Guatemala was not providing adequate attention to its HIV-positive citizens. This case is still pending.

Lessons learned: When working with reluctant government institutions, tenacity is the only way to produce results.

Recommendations: The legal precedents for supporting universal coverage of antiretroviral treatment to all persons living with HIV/AIDS should be considered a universal human right and therefore not dependent on slow-moving national legal procedures.

Presented by: FJ Cabrera, Fundación Fernando Iturbide, Guatemala City, Guatemala.

Abstract E4180: Advocating for the rights of injection drug users and people living with HIV/AIDS

Issues: The Ukrainian legislation that regulates the issues of non-med-

ical drug use and HIV/AIDS is rather progressive. But in actual practice, implementation is a serious problem. Systematic violations of the rights of IDUs and persons living with HIV/AIDS often take place.

Description: In April 2003 the Ukrainian Harm Reduction Association (UHRA) started an advocacy project, with 22 NGOs participating. The first goal of the project is to set up a network of operational services that will provide IDUs and persons living with HIV/AIDS with legal aid through harm-reduction projects. Research among IDUs, persons living with HIV/AIDS, social workers, medical personnel, and lawyers was conducted in order to identify rights violations and appropriate methods for organization of the legal aid. Specific informational materials were developed for all involved target groups. A training workshop on advocacy will be conducted. The second goal of the project is to improve existing legislation and policy in the field of non-medical drug use and HIV/AIDS in Ukraine. International human rights standards and the laws of Ukraine in the field of HIV/AIDS were analyzed to determine compliance of Ukrainian national laws and policies with the international human rights standards. Rapid Policy Assessment Research was conducted to identify the reasons for violations of the existing laws. Public and parliamentary hearings were held. Recommendations on improving the existing legislation and legal practice were developed. Draft laws will be elaborated.

Lessons learned: Violations of the rights of IDUs and persons living with HIV/AIDS are caused by deficiencies and contradictions in the

criminal and public health legislation and regulations. There is an absence of real mechanisms to implement the laws.

Recommendations: Multi-level strategies to lobby for changes in the legislation should be developed in order to implement the recommendations from this project.

Prepared by: OV Kucheruk, UHRA, Kiev, Ukraine.

Abstract E4187: Grassroots and direct lobbying organized by HIV-positive advocates

Issues: Government responses to HIV are often inadequate to address unmet needs. Obtaining resources and prioritizing interventions require multiple advocacy tactics. Key among effective tactics are those that result in government officials hearing from community stakeholders who share their experiences and provide feedback about policy decisions.

Description: The National Association of People with AIDS (NAPWA-US) produces AIDSWatch, the largest US HIV-focused in-person congressional lobbying campaign. More than 500 people, the majority of whom are HIV-positive, gather in Washington, DC for a three-day event, consisting of lobby-skills training and HIV policy briefings, prior to meetings with members of Congress. HIV-positive constituents lead the meeting delegations, focusing meetings on demonstrating how policy decisions will affect their health, safety, and well-being. AIDSWatch increases advocacy capacity by providing civil

society groups the opportunity to identify willing and effective trained advocates for further advocacy efforts, encouraging confidence among HIV-positive people, and modeling lobbying campaign tactics that can be adapted for state and local efforts.

Lessons learned: Persistent increased grassroots lobbying capacity is more likely when recruitment and training assert the right of all citizens to meet with elected officials and bureaucrats. Officials are more likely to address unmet needs and ask for follow-up information and advice when they understand how policy decisions affect the lives of constituents. Advocacy skills learned at AIDSWatch are transferable to other advocacy campaigns and result in increased capacities at local and state levels.

Recommendation: Widespread adoption of constituent-based legislative advocacy efforts in both high-income and developing nations is indicated to better educate decision-makers about how action or inaction around HIV issues affects their constituents and nations.

Prepared by: P Feldman, T Anderson, NAPWA-US, Washington, United States.

Abstract E4201: Legislation on HIV/AIDS for India – a participatory process with civil society

Issues: Democratic law-making processes must reflect the concerns of civil society in order to be a constructive means of social change and effective in practice. This is particularly so in the HIV/AIDS context

wherein multifarious, often competing issues have emerged that have brought into stark relief the inequalities of society, extreme prejudice and bigotry, and weaknesses in the public health system. With the wide variety of issues that need to be addressed in the area of HIV/AIDS, it is imperative that a consultative, participatory process involving experts from the field be implemented when drafting omnibus legislation on HIV/AIDS.

Description: This paper explains the unique process undertaken by the Lawyers Collective HIV/AIDS Unit in 2002-2003 to draft legislation on HIV/AIDS for India, at the behest of the government of India. The process was undertaken in three stages. Firstly, background research on key legal issues around HIV/AIDS and their treatment in legal regimes similar to India was undertaken. Then the process of drafting a rights-based law began, followed by nationwide consultations with various stakeholders to obtain their feedback, comments, concerns, and critiques on the draft law. This process of consultations, in the form of workshops with persons living with HIV/AIDS, members of vulnerable communities and targeted interventions, health-care workers, trade unions and employers, women's organizations, children's groups and others, was done with the clear aim of being inclusive, holistic, participatory, and open.

Lessons learned: It is vital that in order for a law to be meaningful and implementable, input must be obtained from the people who are going to be impacted most and those who are likely to use it. A participatory process also engenders support for, and ownership in, the draft legislation.

Recommendations: In order to be efficacious, laws that address social concerns such as HIV/AIDS must be grounded in social realities that are best reflected through real field experiences.

Prepared by: V Divan, Lawyers Collective HIV/AIDS Unit, Mumbai, India.

Abstract E4208: Ethical and legal issues in HIV vaccine research and development in Kenya

Justification: While Kenya has developed broad policies and guidelines on the conduct of biomedical research involving human subjects, with the object of addressing the incidental legal, ethical, and human rights issues, it has not yet put in place a clear law or policy on HIV vaccine trials. Researchers have embarked upon vaccine trials using commercial sex workers in Nairobi as participants. There is a need, therefore, to examine whether the research being undertaken on a population whose practices are considered illegal under Kenyan law complies with the legal and ethical norms relating to HIV vaccine research.

Issues: The issues addressed include the value of the research to Kenya, its scientific validity, fairness of subject selection, consideration of the risk-benefit ratio to the participant, review of the research protocol, informed consent and respect for the subjects, compensation, and the use of vulnerable groups.

Method: Examination of the protocol used as a basis for the study was carried out, following which personal

interviews involving researchers and research participants were undertaken. Relevant existing legislation, policies, and guidelines were studied with a view to determining their adequacy for the country's research needs.

Lessons learned: (1) The legislative coverage on research generally and HIV vaccine research in particular is incomprehensive and inadequate. (2) The protection afforded to the vulnerable and stigmatized group of commercial sex workers is inadequate. (3) Monitoring and evaluation was left to the goodwill of the researchers.

Recommendations: There is need (1) to ensure that law reform incorporates the legal and ethical rules on HIV vaccine research as enunciated in various international instruments; (2) to reconsider the legal position of commercial sex workers in Kenya; and (3) to provide mechanisms for post-review monitoring and evaluation of research to ensure compliance with legal and ethical rules.

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Abstract D5081: HIV-related harm reduction among women in the Canadian prison system: the need for best practices in action

Background: Despite the considerable social and economic costs associated with HIV to the individual, community, and government, access to appropriate HIV prevention among women in prison remains controversial and marginalized. This study was undertaken to explore

access to harm reduction among a sample of women in Canada's national prison system.

Methods: In-depth interviews took place with a sample of 156 female prisoners incarcerated in nine of the 11 national prisons, accounting for approximately 40 percent of the total population of federally incarcerated women in Canada. Interviews explored women's lived experiences in accessing harm-reduction initiatives in prison. Data from the interviews were transcribed verbatim and analyzed thematically.

Results: Access to harm-reduction measures such as condoms, lubricants, and bleach were not uniformly available to all women in the various facilities. Seventy percent of women using injection drugs reported problems in accessing bleach. Sixty-nine percent of sexually active women reported dissatisfaction with the current provision and accessibility of safer-sex measures. Tattooing and body piercing were among the most common risk behaviours reported among participants, but little harm-reduction education was provided.

Conclusions: Access to harm-reduction initiatives in the national prison system for women must be consistent across facilities. Harm-reduction measures such as syringe exchanges, safer tattooing, and information on slashing/cutting are urgently required. The current bleach program must be improved, and the piloting of needle exchanges in Canadian prisons must include women's prisons and must reflect the elements of best practices. Standards of care within the prison system, including the provision of harm-reduction

measures and best practices, should not be any different from those accessible to women outside the prison system.

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Abstract D523 I: Using a rights-based framework to explore care and support for people living with HIV/AIDS

Issues: HIV/AIDS is associated with a range of rights, with the right to health foremost. International law and commitments such as the Declaration of Commitment on HIV/AIDS promote and provide protection of these rights. A rights approach recognizes states' obligations in respecting, promoting, and fulfilling human rights, but also the roles of other actors in supporting that relationship or holding states accountable.

Description: In 2003 a study was conducted to explore factors that affect care and support for mobile and mobility-affected people living with HIV/AIDS in three Greater Mekong countries, Cambodia, Viet Nam, and Lao PDR, with a view to learning lessons about acceptable, accessible, and appropriate care and support services. The study utilized qualitative and participatory methods and was conducted using a definition of care and support adapted from UNAIDS and the World Health Organization. A rights framework provided an overarching structure for the study, guided the research, and acted as a basis for analysis. It focused on eight key rights –

right to health, participation, confidentiality, dignity, freedom from discrimination, information, privacy, and autonomy. The study recognized that these rights were indivisible and that other rights could also arise. The views of service providers, gatekeepers, caregivers, and persons living with HIV/AIDS were explored using common themes of inquiry. Underlying this was an analysis of power relations between persons living with HIV/AIDS and those with whom they interact to receive care and support.

Lessons learned: A rights framework was appropriate for conducting and analyzing this study. The rights of mobility-affected persons living with HIV/AIDS to health, participation, confidentiality, dignity, freedom from discrimination, information, privacy, and autonomy were neither respected nor fulfilled. Marginalization exacerbated mobility.

Recommendations: Mobile people's vulnerability to rights abuses must be addressed.

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Abstract D5244: Mandatory testing of migrant workers: a violation of rights

Issues: Currently 60 countries impose mandatory HIV testing for migrants. Mandatory testing is often

accompanied by notification and deportation. It is discriminatory in nature, and often undertaken in violation of the migrant's rights to privacy, confidentiality, consent, and a livelihood. The use of mandatory testing as a strategy to manage the HIV epidemic as well as its ethics and rationale are questionable. Mandatory testing and deportation denies migrants access to treatment.

Description: CARAM is a network of community-based organizations in 11 countries in Asia doing participatory action research with migrants and their families. Given the increasing numbers of migrants who were returning home HIV-positive, CARAM embarked on research focusing on the concerns and problems of HIV-positive migrants, and reviewing related policy on mandatory testing, notification, and deportation.

Results: CARAM's research and interventions on the issue show that migrants have little or no knowledge that they are being tested for HIV; pre- and post-test counselling is nil or poor; provision of information on HIV to departing migrants by recruiting agencies in sending countries is minimal; notification is followed by deportation (immediately in some countries) without counselling, referral, or care; and even when migrants come in with a clean bill of health through pre-employment medical tests, a disabling environment in destination countries can result in HIV infection and, with it, stigma and discrimination.

Recommendations: (1) Mandatory testing and deportation for migrants should be abolished. (2) Voluntary testing and pre- and post-counselling should be offered to migrants in line

with internationally recognized standards. (3) Migrants should be allowed to continue working. (4) Migrants should be given access to treatment and health information. (5) Pre-departure and post-arrival orientation, including on health and HIV, should be offered to migrants.

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Abstract E5433: Understanding the dynamics of a community-led rights- based approach in the prevention of HIV/AIDS

Issues: Karagwe district is one of the rural districts in Kagera region. In 1994, hundreds of thousands of Rwandese refugees crossed the border to Karagwe following the genocide in Rwanda. This contributed to the increased HIV/AIDS infections in the district.

Description: The work of the Agency for Cooperation in Research and Development (ACORD) is aimed at promoting the rights of the poorest and marginalized communities in sub-Saharan Africa. ACORD realizes that for effective peer education, rights-based approaches are important in promoting sustainable behavioural change against the spread of HIV/AIDS. ACORD started working in Karagwe district in 1996 when it introduced a peer health education system. The system has enabled different groups in the community to protect themselves and reduce stigma and discrimination against those infected by HIV/AIDS. Community-

led advocacy and Information, Education and Communications (IEC) programs were used to increase awareness of HIV/AIDS and to create behavioural change.

Lessons learned: The impact of a community-led rights-based approach in the prevention of further HIV/AIDS infections and stigma has played significant role in community-based peer health education. The lessons learned are as follows: (1) a rights-based approach reaches many people through community-led advocacy and IEC; (2) a rights-based approach is an important mechanism for reducing transmission of HIV/AIDS and sexually transmitted infections; and (3) a rights-based approach helps community members to understand and protect their rights.

Recommendations: Peer health education can be replicated to other communities; consistent retraining of peer health educators and community involvement using a rights-based approach is advisable.

Prepared by: C Magere, ACORD, Mwanza, Tanzania.

Abstract D6448: Barefoot lawyers extending services to rural people living with HIV/AIDS

Issues: Widows and orphans are vulnerable to property grabbing, disinheritance, divorce, social rejection, marginalization, and adverse cultural practices. This is exacerbated because of a lack of awareness regarding rights, inadequate support services, and a lack of legal knowledge. Traditionally, when a man died, a relative would marry his wife,

assume responsibility for his children, and manage the assets of his household. HIV/AIDS has complicated this tradition. The increasing number of people infected and dying has overstretched the capabilities of families to care for widows and orphans, who are often left without any will. Will writing is a taboo in our society, viewed as a prediction of death. Widows rarely inherited their husband's property.

Methodology: (1) Succession planning – ie, assisting families affected by HIV/AIDS to make clear plans to provide for their children's basic needs after the parents die. This involves writing wills and memory books. (2) Legal aid for persons living with HIV/AIDS, which includes organizing legal awareness sessions; training community volunteers to provide basic legal information and to assist members of the community in writing wills and preparing memory books; distributing simplified legal documents and booklets that have been published in the local languages; conducting mobile legal clinics; and representing people in court or helping to resolve conflicts amicably.

Results: Persons living with HIV/AIDS have been helped to reclaim their property. Children and their mothers have regained their shelter, food security, and livelihood. Fathers have been persuaded to provide for their children's care and school fees. Children have taken the initiative to approach the lawyers for assistance with cases.

Conclusion: This project has empowered the most vulnerable groups in society to achieve social justice and equitable recognition under the law. It has also widened

the accessibility of legal knowledge to rural communities and reduced the taboo against will writing. Voluntary HIV testing has increased because people now know they can receive free legal services if they have been tested.

Prepared by: R Oketch, Plan Uganda.

Abstract D6479: A gender issue: reducing the vulnerability of Maasai girls to HIV/AIDS

Issues: Gender roles and relations influence the course and impact of the HIV/AIDS epidemic. Culturally conceived roles and identities of males and females characterize the substructure of communities that propagate exploitive traditions, and limit access to factors that reduce vulnerability. In particular, females in “traditionally based communities” that uphold patriarchal ideologies face a greater vulnerability as a result of the sexual roles and identity they adopt, and structural factors that distribute power unequally.

Description: This paper outlines a project funded by the Canadian International Development Agency, “A Gender Issue: Reducing the Vulnerability of Girls to HIV/AIDS,” which was conducted over a five-month period among the pastoral Maasai in Northern Tanzania. It presents an analysis of the traditional and cultural beliefs and mores, as well as the structural factors, that place women and girls at greater risk of HIV infection. It also presents the challenges and proposed strategies of prevention programming among traditionally based communities.

Lessons learned: Among traditionally based communities, the vulnerability of females is embedded in tradition; they face a “sacred order” of social, economic, and political dimensions that compounds their vulnerability. Conventional approaches to HIV prevention that propose foreign values relating to behaviour and social organization are often ineffective.

Recommendations: Conventional approaches of raising awareness and promoting positive behavioural change are interim strategies, and empowering women and girls is quintessential. However, sustainable interventions must include extensive collaboration with, and is ultimately facilitated by, male traditional leaders who are the “gatekeepers” of tradition and of the ideological substructure of the community. Interventions must avoid the “social planning” nature of many contemporary interventions and, instead, must be characterized by “locality development” principles – ie, broad-based participation, cooperation, voluntarism, education, and community-determined initiatives and goals.

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Abstract E6863: Sexual violence survivors’ right to post-exposure prophylaxis: South Africa, a case study

Issues: In the context of South Africa’s explosive HIV/AIDS epidemic, sexual violence can be a death sentence. The government’s

2002 pledge to provide HIV post-exposure prophylaxis (PEP) to sexual violence survivors could become a model for other states to meet human rights obligations to protect rape survivors, but significant obstacles to obtaining PEP remain.

Description: A 2003 investigation by Human Rights Watch found that government failure to provide adequate PEP information or training left police, health professionals, counselors, and rape survivors without basic information about it. Government opposition to antiretroviral drugs (ARVs) continued after the program launch, influencing some service providers not to offer PEP in the belief that it was against government policy. Children under 14 cannot give consent to PEP treatment or prerequisite HIV testing, posing problems for children unaccompanied by a parent or guardian. The failure of police and health professionals to follow national instructions for sexual violence investigation and treatment also interfered with PEP services.

Lessons learned: Documenting barriers to PEP implementation and analyzing them against international human rights norms suggest legal and policy solutions for countries developing PEP programs. These lessons also apply to similar challenges in the provision of ARV treatment for people living with HIV/AIDS.

Recommendations: South Africa’s obligations to ensure the right to the highest attainable standard of health and to protect individuals against violence and its consequences require that it urgently implement its PEP program. It must launch a public education campaign on PEP services

for sexual violence survivors, including clear statements supporting ARV treatment; provide training on PEP and sexual violence to police, health professionals, and other service providers; put procedures in place to obtain prompt consent to PEP treatment and HIV testing for children; and strengthen the response of the criminal justice system to sexual violence.

Prepared by: RA Schleifer, Human Rights Watch, New York, United States.

**Abstract E8142:
HIV/AIDS and gender-based violence: linking advocacy at the grass-roots level**

Issues: At the global policy level, there is increasing recognition of the connections between HIV/AIDS and violence against women. It has been observed that gender-based violence can increase vulnerability to HIV infection, and that HIV infection can

increase the risk of interpersonal violence. There are many initiatives that focus on women and HIV/AIDS, and even more that focus on ending violence against women and providing services to survivors. However, very few programs address the linkages between the two in an integrated and sustained fashion. There is a need to translate the growing theoretical and policy discussions on these intersections to enhance programming on HIV/AIDS and to end gender-based violence.

Description: This paper reviews the evidence on the connections between HIV/AIDS and gender-based violence and examines programs that address the connections between the two. It then presents a number of recommendations to promote policy and program development that effectively link the two issues.

Lessons learned: Advocacy, service provision, and health promotion efforts can be strengthened in the

areas of HIV/AIDS and gender-based violence by recognizing, identifying, and building upon the linkages between these issues and the stakeholders involved.

Recommendations: Cross-training and increased communications between HIV/AIDS workers and those working on gender-based violence will lead to enhanced and more efficient interventions. Attention should be drawn to the existing tools and materials in each area that can be useful to the other area, and to tools and materials that can simultaneously address HIV/AIDS and gender-based violence, emphasizing how they complement each other, and how their effectiveness can be improved.

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