Canadian HIV/AIDS Legal Network

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The criminalization of HIV transmission in England and Wales: questions of law and policy

In this article, Matthew Weait and Yusef Azad discuss the current law concerning the criminalization of HIV transmission in England and Wales,[1] and raise some issues about the wider implications of criminalization for those working in the HIV/AIDS sector. The authors look at the way the fault requirement of "recklessness" has been interpreted in the cases. They explore the courts' approach to consent – the defence which those who have appealed against conviction have sought to use. Then the authors raise some questions about the relevance of disclosure and the way the courts have dealt with knowledge about HIV status and the risks associated with unprotected sex. Finally, they discuss the relevance of the nature of the relationship between the accused person and the person to whom HIV has allegedly been transmitted, and touch on the potentially stigmatizing effects that criminalization may have on socio-economically marginalized groups. The authors conclude by discussing some more general policy-related issues.

Introduction

So far there have been four successful prosecutions in England and Wales for the transmission of HIV, two of which have resulted in appeals. Three of those who were convicted or who pleaded guilty were of black African origin, and one was Portuguese. All of the men had transmitted HIV to female sexual partners.

Mohammed Dica was convicted in 2003 and, after an appeal which resulted in two abortive retrials, was finally convicted in March 2005 and sentenced to four and a half years' imprisonment.[2] Kouassi Adaye plead-

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ed guilty in January 2004 and was sentenced to six years' imprisonment (which included time for unrelated offences). Feston Konzani was convicted in May 2004 and was sentenced to ten years' imprisonment. He lost his appeal against conviction and sentence in March 2005.[3] Paolo Matias pleaded guilty in April 2005 and was sentenced to three years' imprisonment.

All those prosecuted have been convicted under, or pleaded guilty to, section 20 of the *Offences Against the Person Act 1861*, a provision which requires that the prosecution prove that the defendant caused serious bodily harm to another and was aware of the risk of causing bodily harm.[4]

Recklessness

The fault requirement for section 20 is subjective recklessness. As a matter of general principle, a person is reckless in English law for the purposes of section 20 if s/he is aware of the risk of causing some degree of bodily harm and runs that risk.[5] In the present context, this means that the Prosecution must establish that, at the time HIV transmission occurred, the accused was aware of the risk of transmitting HIV to his partner.

Put like this, the fault requirement seems simple enough. However, the *Dica* decision suggests that the simplicity is more apparent than real. The underlying rationale for imposing criminal liability on those who are reckless is that they have advertently engaged in unjustified risk-taking.

Their fault lies in the objectively assessed unjustifiability of their actions, combined with the subjectively assessed mental state with which they were acting at the relevant time. Although it may be possible to characterize a risk run by a person who is aware of it as objectively justifiable, this is not an argument that has been advanced before the English courts. It is therefore of more immediate and practical relevance to explore the parameters of advertence.

There are a number of ways in which one might conceptualize advertence as far as the risk of transmission is concerned. The first is to think of it as requiring actual knowledge of one's HIV positive status: Such a model would mean that only those who had such knowledge, because they had tested positive, could be criminally liable if they transmit HIV.

The second, at the other end of the spectrum, is to think of advertence as merely requiring awareness that one *might* be HIV positive. Such a model would mean that those who had not tested HIV-positive, but who had previously engaged in activities which they knew carried the risk of transmission and were aware of the possible consequences of this, could be criminally liable if they were in fact HIV-positive and infected a partner.

People falling into either of these categories could, analytically, be defined as being reckless in the subjective sense. The judgment as to whether each person *should* be treated as such in law is, however, a different question that turns on one's views about the appropriate scope of liability. Some commentators, such as Professor John Spencer of Cambridge University, believe that those who fall into the second category ought as a matter of principle to be criminalized. In his words:

> To infect an unsuspecting person with a grave disease you know you have, *or may have*, by behaviour that you know involves a risk of transmission, and that you know you could easily modify to reduce or eliminate the risk, is to harm another in a way that is both needless and callous. For that reason, criminal liability is justified unless there are strong countervailing reasons. In my view there are not.[6]

For Spencer, and those sympathetic to his views, fault resides in an expansive definition of advertence – one that extends to people who, by virtue of prior conduct and knowledge of its implications, may justifiably be punished when they fail to adapt their sexual practices. This position is not one that found favour with the Court of Appeal in *Dica*. The Court stated that the effect of the judgment was:

> … to remove some of the outdated restrictions against the successful prosecution of those who, *knowing that they are suffering HIV or some other serious sexual disease*, recklessly transmit it through consensual intercourse …" [7] [Emphasis added.]

The Court of Appeal's narrower approach, of limiting criminalization to the case where a person knows s/he is HIV-positive, is one that we welcome. If the Court had adopted Spencer's more expansive definition, people who had ever had unprotected sex with a person about whose HIV or

sexually transmitted infection status they were uncertain, and who had not determined their own freedom from infection prior to unprotected sex with a new partner, would – absent a defence – be criminally liable under section 20 of the *Offences Against the Person Act*.

This would have resulted in a significant extension of criminal liability, one from which it is but a small step towards basing liability on membership of a high-prevalence group – on the grounds that gay men, injecting drug users or people from sub-Saharan Africa ought to assume by virtue of these criteria alone that they are, or may be, HIV-positive.

The Court of Appeal's approach of limiting criminalization to the case where a person knows s/he is HIV-positive is one that we welcome.

A further reason for welcoming the Court of Appeal's narrower definition of recklessness is that it at least goes some way towards acknowledging the UK Government's publicly stated view that only the *intentional* transmission of HIV should be criminalized. Although the Law Commission for England and Wales had, in 1993, recommended that there was no reason why the reckless transmission of disease should not be prosecuted,[8] the Government rejected this.

In a 1998 consultation document, the Home Office explained that although prosecuting intentional transmission was justifiable (because intention rendered incidents of transmission "evil acts"), the same argument could not be deployed where transmission was non-intentional.[9]

Had the Crown Prosecution Service (CPS) been sympathetic to, and heeded, the Government's position, there would have been no convictions for reckless HIV transmission. However, the CPS is an autonomous, statutory agency whose only concerns in pursuing a prosecution are (a) whether there is sufficient evidence to support the Crown's case and (b) whether such a prosecution is in the public interest. The CPS clearly felt these concerns were met in all three cases that have so far come to court. In the words of René Barclay, Director of Serious Casework, CPS London Area, writing after Mohammed Dica's original conviction:

> This was a ground-breaking prosecution, which was the result of a massive team effort. The implications are that in future people who are reckless in this way will be vigorously prosecuted.[10]

There exists a legitimate and lively debate about whether people should be held criminally liable for the reckless transmission of HIV during sex (assuming the first sense of recklessness described above, namely taking an unjustifiable risk of transmission with the knowledge that one is HIV-positive). Yet there is a strong principled and practical public health-based argument against extending the law to impose such liability.

Put simply, if a person may only be held criminally liable on the basis that he was in fact aware of his HIV positive status (as the decision in *Dica* confirms), this may provide a disincentive to testing: A person who does not know his HIV positive status cannot, legally, be reckless because he cannot, logically, be aware of the risk of transmitting HIV to his partner(s).

This somewhat paradoxical consequence of the subjective approach to fault adopted by the Court of Appeal is not one that it adverted to in its reasoning, since public health considerations – technically irrelevant to the issues being appealed – were not discussed. Although to our knowledge there exists no empirical data to confirm the disincentive hypothesis, there is none that refutes it either. On the assumption (a) that in matters of public health it is better to operate under a precautionary principle, and (b) that the alternative approach of imposing liability on those who are *not* aware of their HIV positive status would be even worse than the present position, there are strong reasons for rejecting liability for reckless transmission altogether.

Consent

The fact that people may be charged under section 20 of the *Offences Against the Person Act* for reckless HIV transmission is problematic enough. However, the question of consent, and the way this has been treated by the English courts, muddies the waters still further.

At Mohammed Dica's first trial in 2003, he sought in his defence to argue that the complainants had consented to the harm constituted by the transmission of HIV on the basis that they had agreed to have unprotected sex with him. The trial judge did not allow him to make this argument. The reason was simple. The judge believed that he was bound by the decision of the House of Lords in *R v Brown*.[11] That case (which concerned injuries sustained in the context of sado-masochistic sex) is authority for the proposition that a person may not

lawfully consent to the infliction of bodily harm by another, and it is not difficult to see why the judge treated it as authoritative in the context of HIV transmission.

The Court of Appeal, however, ruled that the trial judge's ruling had been wrong in law. While recognizing that there were strong public policy reasons for denying the defence of consent where physical injury was inflicted, albeit in the context of giving or receiving sexual pleasure, the Court held that the transmission of HIV in the context of sex was different.

In its view, the distinction lay in the fact that whereas the injuries in *Brown* were deliberately inflicted, the harm in HIV transmission cases is one more properly understood as the unfortunate consequence of risk-taking. Sex has always involved the taking of risks – whether those are the risks of disease, or those immanent in the physical processes of pregnancy and childbirth. If it were legally impossible to consent to risk-taking, in the Court's view this would amount to a significant and unjustifiable diminution of personal autonomy and was something that could only be sanctioned by primary legislation.[12]

There remain a number of important questions about the distinction the Court draws between consent to harm in the context of sado-masochistic sex and consent to harm in the present context.[13] For the purposes of this article, however, we want to concentrate on the way the Court interpreted its approach to consent in the subsequent case of *R v Konzani*. In *Konzani,* the appellant had admitted that by having unprotected sex while knowing his HIV-positive status, he was reckless. His appeal against conviction turned, therefore, on the direction that the trial judge had given the jury about consent – a defence he had been able to raise as a result of the earlier Court of Appeal decision in *Dica*.

The direction in that case had emphasized that in order to accept the defence of consent, the jury had to be satisfied that any consent to the risk of transmission was *consciously* given. This direction was objected to by counsel on the basis that it failed to explain to the jury that it could acquit if it considered that Mr Konzani had an honest belief in the complainants' consent (even if that belief were unreasonable). This was the argument before the Court on appeal.

It can be argued that a person who agrees to have unprotected sex with a person about whose HIV status they are uncertain consents to the risk of transmission.

The Court of Appeal declined to accept this argument. Although it recognized that it was normally the case that an honest belief in consent would provide a defence,[14] the Court said that in this context "the defendant's honest belief must be concomitant with the consent which provides a defence."[15] In the Court's view, there was a fundamental difference between running a risk (which the complainants' evidence suggested they were conscious of doing),[16] and *consenting* to a risk (which Mr Konzani's failure to disclose known HIV status prevented them from doing). As a result, there was no legally recognized consent in respect of which Mr Konzani could have had any belief, honest or otherwise.

With respect, this is neat logic but extremely problematic. In *Dica* the Court of Appeal had held simply that a person would have a defence if the complainant consented to the risk of transmission. It is at least arguable that a person who agrees to have unprotected sex with a person about whose HIV status they are uncertain consents to the risk of transmission by the very act of agreeing to have unprotected sex with that person. In *Konzani*, the Court of Appeal clearly recognized that there was a need to explain that this is *not* what it meant in *Dica*. It did this by reinforcing the connection between recklessness, consent and disclosure, and explaining that the allegation in *Dica* had been that the accused

> behaved recklessly on the basis that knowing that he was suffering from the HIV virus, and its consequences, and knowing the risks of its transmission to a sexual partner, he concealed his condition from the complainants, leaving them ignorant of it.[17]

This, it is suggested, is a radical interpretation of recklessness, one that extends the meaning of the concept beyond simply being aware of the risk of an event occurring. Instead, in this context at least,[18] the Court appears to be saying that recklessness involves not only foresight of risk, but also non-disclosure; and because non-disclosure results in ignorance, a person infected by the non-discloser cannot consciously or willingly consent to the risk of transmission. Therefore, according to the judicial logic, the defence is not available.[19]

There are those who will no doubt approve of the Court's approach on the basis that it prevents those who transmit HIV to others during unprotected sex from claiming that simply by agreeing to have such sex they are thereby consenting to the risk of harm. However, those who do approve should at least acknowledge the fact that they are in danger of reinforcing the idea, contrary to the philosophy behind most HIV prevention campaigns, that we are not responsible for our own health.

This is because by confirming that the defence is available only where there is consent to risk (or an honest belief in such consent), the Court is implicitly saying that those who do not willingly consent to the risk, but who willingly choose to *run* the risk, are not responsible for the consequences of doing so. Moreover, those who support the Court's reasoning need to recognize that this means agreeing that disclosure by a partner is the only relevant source of knowledge for the purposes of being able consciously to consent to the risk of transmission, despite the fact that there are other ways in which knowledge of risk can be gained. It is to this that we now turn.

Knowledge

It is no doubt true that a partner's disclosure that he is HIV-positive is the most immediate and direct way in which a person may be made aware of the risk of contracting HIV through unprotected sex; and it is, we suggest, wrong in principle that a person in receipt of this information should be able to assert that a criminal act has been committed if he is infected through consensual sex with that partner. But the question of whether a partner's *non*-disclosure ought automatically to mean that a criminal act has been committed is not so easy to sustain.

The reason for this is as follows. The Court of Appeal held in both *Dica* and *Konzani* that consent to the risk of transmission should provide the person who recklessly transmits HIV with a defence. In *Konzani* the Court made it clear that such consent had to be "willing" or "conscious" and that this was, in effect, not possible if the infecting partner had failed to disclose known HIV-positive status at the relevant time. In the Court's words:

> If an individual who knows that he is suffering from the HIV virus conceals this stark fact from his sexual partner, the principle of her personal autonomy is not enhanced if he is exculpated when he recklessly transmits the HIV virus to her through consensual sexual intercourse. On any view, the concealment of this fact from her almost inevitably means that she is deceived. Her consent is not properly informed, and she cannot give an informed consent to something of which she is ignorant.[20]

Using the language of deception, the Court is able to reinforce the link between (a) non-disclosure and fault (of the person who transmits HIV), and (b) non-disclosure and ignorance (of the person to whom HIV is transmitted). In so doing, it effectively denies the possibility that a person to whom disclosure is *not* made may still be sufficiently knowledgeable about the risk of transmission to warrant the conclusion that he or she did in fact consent to it.

We say "effectively" because the Court in *Konzani* did concede that there might arise situations in which a person may not have directly disclosed his HIV-positive status, but the circumstances are such that (a) the partner to whom he transmits HIV could give a legally recognized consent, or (b), they provide the basis for a claim that he honestly believed his partner to have consented. In the words of the Court:

> By way of an example, an individual with HIV may develop a sexual relationship with someone who knew him while he was in hospital, receiving treatment for the condition. If so, her informed consent, if it were indeed informed, would remain a defence, to be disproved by the prosecution, even if the defendant had not personally informed her of his condition. Even if she did not in fact consent, this example would illustrate the basis for an argument that he honestly believed in her informed consent. Alternatively, he may honestly believe that his new sexual partner was told of his condition by someone known to them both. Cases like these, not too remote to be fanciful, may arise.[21]

While this is indeed a concession, the Court, in its choice of examples, makes very clear its rejection of any argument based on *general* knowledge about the risks associated with unprotected sexual intercourse with a person about whose HIV status one is uncertain.[22] Both of the hypothetical scenarios are ones where there has, in effect, been disclosure – either through context (the hospital treatment setting) or through a third party.

As such, these concessions are extremely limited in their scope and suggest that even where a person adverts consciously to the possibility that a non-disclosing sexual partner may be HIV-positive (e.g., because that person is aware of the partner's unsafe sexual behaviour with others, or because of a prior history of injecting drug use), such conscious advertence should not provide the person

who transmits HIV to them with a defence.

Disclosure of known HIV-positive status to sexual partners may be the ethically defensible practice. Yet what is ethically warranted is not necessarily what the law mandates or ought to mandate. Legitimate criticism may be levelled at the criminalization of the individual who transmits HIV where those who have been infected are, despite non-disclosure, well aware of the potential harm to which they may be subjecting themselves by agreeing to have sex that carries the risk of transmission.

What is ethically warranted is not necessarily what the law mandates or ought to mandate.

Relationships and identities

We are very aware that the arguments advanced so far in this article are contentious. In the context of such a fraught and complex subject, this is hardly surprising. But even if, for the sake of argument, the criticisms that have been advanced against the law's response to the criminalization of transmission are accepted, there remains one key problem that admits of no easy resolution.

The criminal law is a blunt instrument that deploys general, universally applicable principles in determining liability. The neutral categories of harm, fault, causation and consent are ones that are ill-suited to judging conduct that takes place in the context of relationships characterized by infinitely various manifestations of intimacy, sexual desire, trust and honesty.

Similarly, the impartial criteria of evidential sufficiency and "the public interest" that inform the prosecution process are ones that may serve to conceal discriminatory effects, however unwitting and unintended those are. So far, in England and Wales only migrants have been prosecuted, of whom three have been men of black African origin, while in Scotland the only prosecution was against a man who had a history of injecting drug use.[23]

The questions that critics of the law must address, therefore, are these. First, is it possible to condemn the criminalization of people who recklessly transmit HIV to their sexual partners irrespective of the relationship in question? Second, is it possible to sustain criticism of prosecutions on the basis that those prosecuted are, and are more than likely to be in the future, members of communities who are already socially and/or economically marginalized, stigmatized and discriminated against?

Whether the kind of relationship the partners in a case of transmission have is, or should be, relevant to the question of criminal liability is a question that was referred to specifically by the Court of Appeal in the *Dica* case:

> At one extreme there is casual sex between complete strangers, sometimes protected, sometimes not, when the attendant risks are known to be higher, and at the other, there is sexual intercourse between couples in a long-term and loving and trusting relationship, which may from time to time also carry risks.[24]

Although this distinction may have an intuitive appeal, the Court held that it was irrelevant, as a matter of legal principle, to the availability of the defence of consent. Either there is consent (or an honest belief in it) or there is not.

The problem with such an approach to determining whether the defence of consent is available is that it fails to reflect the difficulties that may arise in the real world of criminal trials, difficulties which have been made greater as the result of the decision in *Konzani*. It will be recalled that in *Konzani* the Court emphasized that only a conscious or willing consent on the part of the person infected (or an honest belief in such consent) would provide a defence. It also suggested that consent of this kind would only exist, other than in the most exceptional of circumstances, where the person who transmits HIV discloses his known HIV-positive status in advance to a partner who subsequently becomes infected.

The problem, then, is this. Even though the Court in *Dica* said that the nature of the relationship between the parties was irrelevant to the question of consent, there is – we suggest – a very real danger that juries will treat it as profoundly relevant when determining whether there was consent to the risk of transmission, or an honest belief that consent to such risk existed.

For example, it is not unimaginable that a jury would be inclined to accept that a man infected as the result of consensual unprotected sex in a gay sauna with a stranger consented to the risk of transmission, or that the man who infected him honestly believed there was such consent. They would be able to do this because *Konzani* leaves open the possibility of the "exceptional" case where the context in which the parties involved meet can constitute disclosure and thereby

provide a basis for the jury accepting a defence based on honest belief. On the other hand, they might be less inclined to accept such a belief where an adulterous husband infects his wife.

What is more, this may be the case despite the fact that the Court of Appeal in *Konzani* has held consent may only be relied upon where it is (a) conscious or willing, and (b) the result of disclosure. So although it is difficult to see how – as a matter of law after *Konzani* – the man infected in the sauna should, absent disclosure, be entitled to any less protection than the wife, juries may be unwilling to treat the cases similarly.

The universally applicable rules of criminal law are singularly deficient when confronted by contexts that may suggest different moral or ethical considerations.

If they are unwilling to do so, based on a moral evaluation of the conduct or sexuality of the people in question, this will result in the law producing further discriminatory effects. If they are willing to treat them identically, this raises the question of whether the law ought properly to deny the responsibility of the informed gay man in the sauna for his own sexual health on the basis that, in law, he is no different from the wife who is unaware of the risks to which sex with her adulterous husband is putting her.[25]

Put another way, rules and principles of universal application may either have discriminatory effects in practice, or – if not – leave questions about the legitimacy of such principles unanswered. These issues, which are those that will no doubt arise in future cases, are ones that are not easily resolved and demonstrate, in our submission, that the universally applicable rules of criminal law are singularly deficient when confronted by contexts that may suggest different moral or ethical considerations.

The second question – that of whether it is possible to criticize the prosecution process for reinforcing stigma against marginalized groups – is, if anything, even more complex. As a result of representations made by people living with HIV and AIDS, national and local AIDS organizations and others, the CPS in England and Wales is about to embark on a process of consultation about its prosecution policy in respect of HIV transmission cases. It is fair to say that empirical research demonstrates substantial concern among minority ethnic communities and asylum seekers in the UK, a fear that they are being targeted, and a worry that prosecutions will have an adverse effect on the health of their members. As one African woman commented:

> This [the Dica case] is just going to stop more people coming forward for testing. Dica has been used as a scapegoat and it is affecting other people like me. The judge and the jury do not know about HIV or what it is to be an African. The woman would have known to be careful and this just shows how little is understood about being African and the inter-dynamics.[26]

And as an African man stated, "When I see this article [about the Dica case] I feel belittled, as an African. What I think is that we are being associated with all these bad things."[27]

These concerns are real and important and how the criminal justice process responds to them will be of paramount importance. It is to this, and to more general issues, that we now turn in our concluding remarks.

Policy considerations and general remarks

Although the criminalization of HIV transmission is self-evidently a subject that demands a critical analysis of law and legal principles, it is also a subject which needs to be located within a broader policy context. It was explained above that in 1998 the UK Government rejected the recommendation of the Law Commission for England and Wales that there should be criminal liability for the reckless transmission of disease. One of its reasons for doing so was concern for the negative public health implications of such a recommendation. In the Government's own words:

> An issue of this importance has ramifications beyond the criminal law, into the wider considerations of social and public health policy. The Government is particularly concerned that the law should not seem to discriminate against those who are HIV positive, have AIDS or viral hepatitis or who carry any kind of disease. Nor do we want to discourage people from coming forward for diagnostic tests or treatment, in the interests of their health and that of others, because of an unfounded fear of criminal prosecution.[28]

When thinking about the recent convictions in England, and the law which they have generated, it is important to be aware of this background. What is striking is the

absence of any comment from the government generally or the Department of Health in particular on the prosecutions and their possible impact on public health and on the National Strategy for Sexual Health and HIV.[29]

Those HIV-sector organizations concerned about the criminalization of HIV transmission need to re-engage the government on this issue. A re-statement of the government's public health objections to criminalizing reckless transmission could well have an important influence on the police and the CPS. There might also be further consideration as to whether the government should press ahead with its proposed legislative provision to exclude reckless transmission of disease from the ambit of the criminal law – though there are obvious concerns that opening up the debate on possible legislative change could result in as bad or worse outcomes for HIV-positive people.

The proposed CPS consultation is one forum in which these concerns must be voiced and is an important next step in focusing the wide-ranging response to the prosecutions that has been expressed within the HIV sector. This response has included the production of policy positions;[30] the holding of roundtables and discussions at a number of HIV-related conferences, including an important session at the largest ever national conference of HIV-positive people; the initiation of a process to draft guidelines for clinicians on the issue; engagement with defence counsel at the various trials; and the sharing of information internationally.

There is a strong consensus in the HIV sector against the criminalizing of reckless transmission. Although there exists disagreement among HIV organizations and, it appears from discussions that have taken place, positive people about (a) whether intentional transmission should be prosecuted and (b) what to do with cases of deliberate deception, the united stand against prosecuting reckless transmission provides a firm foundation for future action.

The attendant issues arising from criminalization are no doubt familiar to those in jurisdictions with a longer history of such prosecutions. These include stigmatizing coverage in the media; incorrect understanding (demonstrated by the media, courts and police) both of the risks and routes of HIV transmission and of the effects of treatment; issues of confidentiality for clinicians and sexual health advisers; partner notification and advice to HIV-positive people; and the potential for further marginalization of communities (such as migrants and asylum seekers) which already experience discrimination and prejudice. All of these areas have been the focus of preliminary discussion, but there is an urgent need to agree on advice and information, and to develop campaigns, drawing in part on best practice from elsewhere.

More generally, criminalization in the UK should be seen in the broader policy context of a worrying interest in coercive responses to HIV. The Scottish Executive has recently published a consultation paper on their proposal for compulsory HIV tests following allegedly criminal incidents where there is a risk of infection.[31] There has been serious consideration in the Cabinet Office of mandatory HIV tests at borders for those wishing to reside in the UK – a policy advocated by the Conservative Party. The response to criminalization must be part of a wider effort to return the UK to its initial successful response to HIV, one grounded in public health and human rights.[32]

– Matthew Weait and Yusef Azad

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[1] See further MJ Weait. Criminal law and the sexual transmission of HIV: *R v Dica*. *Modern Law Review* 2005; 68(1): 121-134; MJ Weait. Dica: Knowledge, consent and the transmission of HIV. *New Law Journal* 21 May 2004: 826. There is a case comment in *Criminal Law Review* 2004 Nov.: 944-948. For a different perspective, see JR Spencer. Liability for reckless infection: part 1. *New Law Journal* 12 March 2004: 384; JR Spencer. Liability for reckless infection: part 2. *New Law Journal* 26 March 2004: 448.

[2] See www.hmcourts-service.gov.uk/judgmentsfiles/j2493/regina-v-dica.htm. The case is reported at [2004] 3 All ER 593 and (2004) Q.B. 1257.

[3] See www.hmcourts-service.gov.uk/judgmentsfiles/j3177/r-v-feston_konzani.htm. A significant proportion of the media coverage of these cases emphasized that the men involved were seeking asylum in the UK or, in Mr Dica's case, that he was a refugee. Therefore, it has been not just the men's ethnic origins that have been negatively implicated in the cases, but their political status as well.

[4] Section 20 provides: "[W]hosoever shall unlawfully and maliciously wound or inflict grievous bodily harm upon any person, either with or without any weapon or instrument, shall be guilty [of an offence]." The maximum sentence for conviction on indictment (i.e., in the Crown Court) is five years' imprisonment on each count.

[5] *R v Savage; R v Parmenter* [1992] 1 AC 699.

[6] JR Spencer. Liability for reckless infection: part 2, The emphasis is the authors'.

[7] *R v Dica*, para 59.

[8] Law Commission for England and Wales. *Offences against the person and general principles. 1993* (Law Com No. 218), paras 15.15-15.17.

[9] Home Office. *Violence: reforming the Offences Against the Person Act 1861*. 1998.

[10] R v Mohammed Dica. News release. London, The Crown Prosecution Service, 3 November 2003. Available at www.cps.gov.uk/news/pressreleases/archive/131_03.html.

[11] *R v Brown*, [1994] 1 AC 212. For more detailed discussions of the case, see N Bamforth. Sado-masochism and consent. *Criminal Law Review* 1994; 661; MJ Weait. Fleshing it out. In L Bently and L Flynn (eds). *Law and*

the Senses: Sensational Jurisprudence. London: Pluto Press, 1996.

[12] *R v Dica*, para 52.

[13] MJ Weait. Criminal law and the sexual transmission of HIV, pp 125-126.

[14] This is the case in the context of offences against the person. The law has now changed in the context of sexual offences so that belief in consent must now be reasonable if it is to provide a defence (*Sexual Offences Act 2004*).

[15] *R v Konzani*, para 45.

[16] See the extracts of the complainants' evidence in *R v Konzani*, paras 12-14, 19-20 and 25-28.

[17] *R v Konzani*, para 41.

[18] In most cases concerning non-fatal offences against the person, where recklessness is sufficient to establish liability, the presence or absence of disclosure is not an issue.

[19] This interpretation is supported by the Court's approval of the Lord Chief Justice's interpretation of *Dica* in the case of *R v Barnes* [2004] EWCA Crim. 3246 (a case involving reckless injury sustained in the context of sport). There he said, at para 10, "This Court held [in *Dica*] that the man would be guilty of an offence contrary to Section 20 of the 1861 Act if, being aware of his condition, he had sexual intercourse with [the complainants] without disclosing his condition. On the other hand, this Court considered that he would have a defence if he had made the women aware of his condition, but with this knowledge because they were still prepared to accept the risks involved and consented to having sexual intercourse with him." It is worth recording that the Lord Chief Justice sat on the panel that heard the appeal in *Dica*, and that Judge LJ, who delivered the judgment in *Dica*, also delivered the judgment in *Konzani*.

[20] *R v Konzani*, para 42.

[21] *R v Konzani*, para 44.

[22] For a more detailed discussion of this, see MJ Weait. Criminal law and the sexual transmission of HIV, pp 126-129.

[23] Stephen Kelly was convicted in Scotland in 2001 for the Scots law offence of "reckless injury."

[24] *R v Dica*, para 47.

[25] Even if she is aware of the risk, because she is aware that her husband has been having unprotected sex outside the marriage, there remains the very real question of whether she would necessarily be in a position (for socio-economic or physical safety reasons) to demand that he wear condoms during penetrative sex.

[26] C Dodds et al. *Outsider status: stigma and discrimination experienced by gay men and African people with HIV.* Sigma Research. December 2004, para 3.3.

[27] *Ibid.*

[28] Home Office. *Violence: reforming the Offences Against the Person Act 1861,* para. 3.16. The draft bill published by the government along with its response to the Law Commission report explicitly excluded from the definition of "injury" anything caused by disease except in cases of intentional serious injury (draft clause 15). The draft bill was never presented to Parliament for consideration and the government has not acted as yet on its 1998 proposals.

[29] Department of Health. *Better prevention, better services, better sexual health: the National Strategy for Sexual Health and HIV*. 2001. Available at www.dh.gov.uk/assetRoot/04/05/89/45/04058945.pdf.

[30] The position of the NAT may be found at www.nat.org.uk/natuk/policy.cfm?id=11.

[31] Scottish Executive. Blood testing following incidents where there is a risk of infection: proposals for legislation. 2005. Available at www.scotland.gov.uk/consultations/justice/btfci-00.asp.

[32] This would be consistent with UNAIDS best practice. See UNAIDS. *Criminal law, public health and HIV transmission: a policy options paper.* 2002. Available via www.unaids.org.

CANADIAN DEVELOPMENTS

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. Address correspondence to David Garmaise at dgarmaise@rogers.com. Glenn Betteridge can be reached at gbetteridge@aidslaw.ca.

HIV disclosure no longer required on application form for temporary resident visa

In May 2005, as a result of pressure from advocates, Citizenship and Immigration Canada (CIC) lifted the requirement that short-term visitors to Canada applying for a visa disclose their HIV status on the application form.

Canadian immigration policy requires nationals from many countries, including most developing countries, to apply for a temporary resident visa if they want to enter the country as short-term visitors. The law requires that a person be denied a visa or entry to Canada if they are "likely to be a danger to public health or safety" or if they "might reasonably be expected to cause excessive demand on health or social services." Generally, neither of these grounds applies to a person living with HIV/AIDS seeking to enter the country as a short-term visitor.

Nevertheless, prior to the change in policy, the visa application form asked whether the applicant (or any member of the applicant's family) had ever been treated for any communicable or chronic diseases and, if yes, to

provide details. The question was unnecessarily intrusive and overbroad, requiring people to disclose highly sensitive personal information (such as their HIV status) for no legitimate purpose. It presented a de facto barrier to people living with HIV/AIDS entering Canada, including for the 2006 International AIDS Conference in Toronto (AIDS2006).

The AIDS2006 Conference Organizing Committee expressed concerns to the Canadian government. The CIC undertook a review of the policy, working with other government departments, the AIDS2006 Toronto Local Host, the International AIDS Society, the Ministerial Council on HIV/AIDS, and the Canadian HIV/AIDS Legal Network. It is this review that led to the change in policy.

Canadian advocates stressed that it was necessary to secure a permanent change to the policy, and that an ad hoc exception for AIDS2006 would not suffice. The CIC agreed that the change would be a permanent one, and that it would affect not only people living with HIV/AIDS but also people with other health conditions.

As a result of the new policy, the CIC has changed the health-related questions on the visa application form. The new form no longer requires visitors to disclose details of their medical condition.

The CIC has also provided interim guidance on the changes to its visa offices worldwide. The government is in the process of amending the operational guidelines and operating manuals for visa offices to assist them in implementing the revised medical questions. The government has committed to further consultations with the AIDS2006 Local Host and others on the guidelines, which will be distributed to all visa offices for implementation.

Officials of the Canada Border Services Agency, which is responsible for border security, will also be provided with the guidelines to ensure information for ports of entry into Canada corresponds to the information sent to visa offices abroad.

Despite the change in policy, visa officers retain the discretion to order a medical examination for any visa applicant if they decide that the answers to the medical questions on the visa application form warrant one.

Currently, such an examination automatically includes an HIV test, regardless of the reason for requiring the exam. It is expected that this requirement will be reviewed in the near future, as part of ongoing efforts of AIDS2006 organizers and other advocates to work with the CIC to ensure that immigration policy and practice does not unjustifiably create barriers for people living with HIV/AIDS entering Canada as visitors.

Canada's current immigration policy in relation to visitors living with HIV/AIDS can be summarized as follows:

- Canada does *not* require people applying for a visa to enter Canada as a short-term visitor to disclose known HIV infection on the visa application form.
- Canada does *not* routinely impose mandatory HIV testing on short-term visitors, nor does it categorically bar visitors based on their HIV-positive status.
- HIV-positive status does *not* prevent a person from visiting Canada, nor should a diagnosis of AIDS, but for the rare and exceptional circumstance where the person's health condition is such that they are assessed as likely to require health and social services (such as hospitalization) during their stay in Canada that will create an excessive demand on Canada's public system. This is the same standard applicable to all persons.

– David Garmaise

For further information, see the update on this issue on the website of the Canadian HIV/AIDS Legal Network via www.aidslaw.ca/Maincontent/issues/immigration.htm. See also *Questions & Answers: Canada's immigration policy as it affects people living with HIV/AIDS*, prepared by the Legal Network, and available via the same website. A list of countries whose citizens require visas to enter Canada as tourists is available at www.cic.gc.ca/english/visit/visas.html.

Safer tattooing piloted in six federal prisons

In January of 2005, Correctional Service Canada (CSC) began implementing a safer tattooing pilot program in six federal prisons, one women's and five men's institutions. The pilot phase of the program is expected to last until 31 March 2006.

According to a CSC memo, "[i]mplementation of this important harm reduction measure is congruent with CSC's strategic outcome of 'providing a safe and healthy environment for those living and working in the correctional system' and contributes to the protection of society." [1]

Public health research has demonstrated that tattooing in prison is independently associated with hepatitis C infection. In a community setting, tattooing with non-sterile needles has also been associated with HIV transmission.[2]

Tattooing is a recognized part of Canadian prison culture, despite the risk of disease transmission and the fact that up until now it has been illegal in federal prisons. Under the pilot program, funded by the Public Health Agency of Canada, prisoner tattoo artists will be trained in infection prevention and control practices, and will have access to sterile tattooing equipment.

The CSC developed 128 pages of guidelines that cover tattooing in context, operations and availability of tattoo services, the set-up and take-down of the tattoo shop, the tattooist, the client, and blood borne disease training. The pilot program is based on education for the tattooist and for clients, and safer tattooing practices involving state-of-the-art tattooing equipment and infection control procedures.

The CSC will provide all of the equipment required and select the tattoo artists from among prisoners who apply. The CSC will also supervise the tattoo shop, approve tattoo designs, and institute forms to obtain consent to tattooing. Prisoners will pay CA$5 per tattoo session.

The pilot program will cost approximately CA$100,000 per pilot site. The pilot sites are in different regions of the country and include institutions of different security levels. The program will be evaluated at the end of one year. The evaluation will involve interviews with prisoners and staff at the pilot institutions, as well as the analysis of automated data (including data from the CSC's Infectious Disease Surveillance System) and documentation relevant to establishing the levels of efficiency and effectiveness of the pilot program.

In submissions commenting on an earlier draft of the guidelines, the Canadian HIV/AIDS Legal Network praised the CSC's initiative on the issue, but criticized the top-down model which animates the pilot programs. It appears that the CSC did not adequately consult with prisoners or staff in the development, design and implementation of the pilot programs. Moreover, prisoners have only a minimal decision-making role in the ongoing operation of the tattoo shops.

Under the *Corrections and Conditional Release Act*, the CSC is responsible for "the care and custody of inmates." In 1994, the CSC's Expert Committee on AIDS and Prisons recommended safer tattooing programs. This recommendation was repeated in reports by the Canadian HIV/AIDS Legal Network, the Prisoners' HIV/AIDS Support Action Network, and the Correctional Investigator of Canada.

– Glenn Betteridge

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[1] Copies of the memo, the *CSC Safer Tattooing Practices Initiative Draft Guidelines*, the training plan for pilot sites, and the evaluation framework are on file with the author.

[2] S Panda et al. Risk factors for HIV infection in injection drug users and evidence for onward transmission of HIV to their sexual partners in Chennai, India. *Journal of Acquired Immune Deficiency Syndrome* 2005; 39: 9-15.

Ottawa: City Council approves distribution of crack kits

After a divisive debate that pitted the Medical Officer of Health against the Chief of Police, Ottawa City Council voted in May 2005 to approve the distribution of crack kits to drug users. Similar programs already exist in Toronto, Montréal, Windsor, Guelph and Vancouver.[1]

The kits include glass stems that can be fitted on to pipes and mouthpieces, condoms, alcohol swabs and information on how to properly dispose of used materials.

Distribution of the kits in Ottawa had started on 1 April 2005, after having been approved by a committee of Council. However, objections from the police led to an extended debate at several committee and full Council meetings in April and May. Advocacy groups and community members participated in the debate.

During the debate,[2] Police Chief Vince Bevan said that there is no hard evidence to support the distribution of crack kits. He said that giving out free kits encourages drug use, and is not how the city should be approaching major drug problems.

Dr Robert Cushman, the city's Medical Officer of Health, countered that the program does not aid or abet drug use. He said that it is intended to curb the spread of diseases like HIV and hepatitis C by providing people with clean instruments when they use crack.

Rather than enabling drug use and encouraging people to try crack, giving out clean instruments may prevent diseases and could help some people get on the road to recovery, Cushman said. He added that distributing crack kits is a necessary extension of the existing needle exchange program, and illustrates the failure of law enforcement to curb the prevalence of crack and other serious drug problems in Ottawa.

The City of Ottawa has had a needle exchange program since 1991.

Cushman characterized the problem of drug abuse in Ottawa as an epidemic that needs city intervention. He said that there are believed to be between 3,000 and 5,000 injecting drug users (IDUs) in Ottawa. About 21 percent of Ottawa drug users have HIV, while 76 percent have hepatitis C. Those rates are higher than Toronto and Montreal, and second only to Vancouver.

The crack kits distribution program illustrates the failure of law enforcement to curb the prevalence of crack and other serious drug problems in Ottawa.

Bevan argued that the police should have more power to deal with addicts. He called on the province to adopt similar legislation to Alberta where the law permits police to force minors at risk into drug treatment through the courts.

However, others pointed out that there are insufficient drug treatment spaces. The Parkdale Avenue clinic, for example, has never been able to keep up with demand. Years ago, the clinic established a program for people on the treatment waiting list to ensure that they could get some help while they were waiting for treatment. Now, there are 30 people just waiting to get on the waiting list – making for at least a 60-day delay between the time that an addict wants to get help and the time when s/he is actually admitted to a program.

Except for one program in Thunder Bay, there are no residential treatment centres in Ontario for addicts under 16.

During the debate, questions were raised about the legality of the crack distribution program. The Canadian HIV/AIDS Legal Network sent a letter to Ottawa Mayor Bob Chiarelli supporting the city's decision to expand its harm reduction program to include the distribution of crack kits, and stating that the expansion is "permissible under Canadian law and is consistent with Canada's human rights obligations under international law."[3]

In a related development, Cushman said that the City of Ottawa's reluctance to give IDUs clean needles and syringes in the late 1980s is the main reason the city has more IDUs with HIV and hepatitis C than Toronto, which adopted needle exchange in 1989. Ottawa waited until 1991 to give out clean needles and syringes. Cushman said that early program lim-

itations – including strict rules and a limited number of needles for distribution – also contributed to the problem.[4]

Meanwhile, Ottawa City Council agreed to proceed with the development of an integrated drug strategy for the city. The idea of developing such a strategy was not new, but was given added impetus by the debate over the crack pipe distribution.

The purpose of the integrated drug strategy is to bring city officials, the police, public health and other community leaders together to combat the problem with a unified approach.[5]

– David Garmaise

[1] See D Garmaise. Groups distribute harm reduction kits to crack users. *HIV/AIDS Policy and Law Review* 2004; 9(3): 30.

[2] The description of the debate over the distribution of crack kits is taken from two newspaper articles: C Weeks. Council keeps crack pipe program: Bevan's protests go up in smoke after showdown with health officer. *Ottawa Citizen*, 22 April 2005; J Steinbachs. Drug woes plague all in Ottawa: crack pipe issue, funding to help addicts critical issues for city. *Ottawa Sun*, 10 May 2005.

[3] The text of the letter is available via www.aidslaw.ca/Maincontent/issues/druglaws.htm.

[4] C Weeks. Ottawa needle exchange came too late: HIV, hepatitis C cases linked to hesitancy to confront drug problem. *Ottawa Citizen*, 16 May 2005.

[5] Ibid.

Bill to export generic drugs comes into force

The *Jean Chrétien Pledge to Africa Act* (the *Act*), the Canadian legislation aimed at allowing the export of lower-cost medicines to developing countries, came into force on 14 May 2005, exactly one year after it received Royal Assent.

The *Act* amends the *Patent Act* and the *Food and Drugs Act* to facilitate the export of lower-cost generic medicines to developing countries confronting public health problems but lacking their own capacity to manufacture pharmaceutical products. The law makes it possible, at least in theory, for generic drug manufacturers to obtain compulsory licences that override the patents on particular drugs so they can make generic versions for export to eligible developing countries.

The *Act* was passed unanimously in the last Parliament.[1] Finalizing the accompanying regulations and passing some technical amendments through Parliament have delayed implementation for the last year.

The Canadian HIV/AIDS Legal Network welcomed the fact that the legislation has now been proclaimed, hailing it as "one important initiative in the larger struggle to increase access to more affordable medicines in the many parts of the developing world where they are desperately needed."[2]

The Legal Network remains concerned about various provisions in the legislation that create unnecessary and unjustified hurdles to using it, and that could undermine it. Nevertheless, it called on generic manufacturers to take advantage of the new law, and on the federal government to take an active role in cooperating with generic manufacturers to get their products through the approvals system so they can be exported.

The Legal Network also called on the government to be pro-active in making sure developing countries know of this option to source cheaper medicines, and to assist them in taking advantage of Canadian sources.

Accompanying *Regulations* were proclaimed on the same day and were published in the Canada Gazette in June 2005.[3]

– David Garmaise

[1] See R Elliott. Steps forward, backward and sideways: Canada's bill on exporting generic pharmaceuticals. *HIV/AIDS Policy & Law Review*, 2004; 9(3): 15-21.

[2] Affordable medicines for developing countries: Human rights advocacy group welcomes Canadian law coming into force, urges generic companies and government to follow through with lower-cost medicines. News release. Montréal, Canadian HIV/AIDS Legal Network, 13 May 2005. Available via www.aidslaw.ca/Media/archivedreleases.htm#pr.

[3] See SOR/2005-141 and SOR/2005-142. Canada Gazette, Vol. 139, No.11. 1 June 2005. Available via http://canadagazette.gc.ca.

Recommendations published concerning non-disclosure of HIV status

The conclusions from an expert working group on persons who fail to disclose their HIV status were published in the 1 March 2005 edition of the Public Health Agency of Canada's *Communicable Disease Report*.[1] The recommendations recognize that legal and ethical considerations must inform and guide both policy and practice as they relate to non-disclosure of HIV/AIDS. The expert working group favoured a graduated response model based on a public health approached to the issue rather than a criminal law approach.

In 2002 and 2003, the Federal-Provincial-Territorial Advisory Committee on HIV/AIDS (FPT AIDS) convened a groups of experts in HIV/AIDS from diverse backgrounds, including public health, medicine, law, psychiatry and psychology, and persons living with HIV/AIDS who worked in the community. The purpose of the working group was to discuss the risk of HIV transmission associated with particular behaviours, and to assess different strategies to address the issue of non-disclosure of HIV/AIDS.

The working group agreed on the need for a public health approach to the issue of HIV-positive people who risk transmitting HIV to others and who are unwilling or unable to disclose their HIV status. HIV prevention is the primary objective of the approach. Under the public health approach, official action is linked to the potential for transmission.

The working group suggested that the *HIV Transmission Guidelines for Assessing Risk,* developed by the Canadian AIDS Society, should be expanded and used as a model for assessing the risk associated with specific activities in particular circumstances. The *Guidelines* group activities into four categories of risk: high, low, negligible and none.

The working group endorsed, subject to a number of recommendations, a model for response developed by the Calgary Health Region. The Calgary model sets out a graduated response. The first level focuses on counselling and education. The second level consists of assisting the HIV-positive person to access support services. The third level involves issuing public health orders to regulate the person's behaviour. The fourth level involves issuing apprehension and isolation orders under public health law, while the final level involves criminal prosecution.

Although the Calgary model calls for a graduated response, it says that "[l]egal intervention can occur concurrently with other levels of intervention." Some members of the working group were critical of provincial and territorial public health legislation, such as that in Alberta, that requires physicians to report risk behaviours to authorities.

The working group recommended that the Calgary model be used in concert with the *HIV Transmission Guidelines*. Specifically, the working group recommended that where there is no risk or negligible risk, no intervention other than counselling and education is warranted; and that interventions under public health legislation should be limited to situations of high risk and non-disclosure.

Other factors important to the determination of the level of intervention include the vulnerability of the person at risk of HIV transmission, and the vulnerability of the HIV-positive person if there is disclosure (in situations of domestic abuse, for example).

The working group identified a number of advantages of a public health approach, as opposed to a criminal law approach:

- there is greater scope for prevention and more opportunities for surveillance of HIV;
- confidentiality is maintained to a greater extent;
- there is less stigmatization of persons with HIV; and
- HIV is less likely to be driven underground.

The recommendations encourage public health officials to consult additional sources for fuller examination of the legal and ethical context relating to this issue before adopting or adapting specific response models.

– Glenn Betteridge

[1] Persons who fail to disclose their HIV status: Conclusions reached by an expert working group. *Canada Communicable Disease Report* 2005; 31(5): 53-61. Available at www.phac-aspc.gc.ca/publicat/ccdr-rmtc/05pdf/cdr3105.pdf.

Criminal charges laid in three new situations

Recently, three people living with HIV have been charged with criminal offences related to exposing someone to HIV. Each case is a first under Canadian law.

In February 2005, an HIV-positive man in Hamilton, Ontario was charged with two counts of first-degree murder in the deaths of two female sexual partners he is alleged to have infected with HIV.[1] The women died of complications related to HIV infection. The man had originally been charged with multiple counts of aggravated sexual assault for failing to disclose his status to the two women (and to eleven other women) prior to engaging in unprotected sexual intercourse.

The two women's deaths were classified as first-degree murders because they are alleged to have resulted from sexual assaults, which automatically elevates the type of murder offence. First degree murder carries a maximum sentence upon conviction of life imprisonment without eligibility for parole until the person has served twenty-five years.

On 23 March 2005, an HIV-positive woman appeared in a Barrie, Ontario court to answer to two charges of aggravated assault.[2] While numerous men have been charged with aggravated assault for failing to disclosure their HIV status prior to unprotected sexual intercourse, this is the first known case of such charges being laid against a woman. The woman was arrested and charged by Canadian military police, after allegedly having protected and unprotected sexual intercourse with military personnel stationed at CFB Borden.

On 27 May 2005, the Hamilton Police Service announced charges against an HIV-positive woman – one count of failing to provide the necessaries of life, and one count of criminal negligence causing bodily harm.[3] The charges relate to the woman's failure to disclose her HIV-positive status to hospital staff during and after the birth of her child, thus depriving the child of standard medical care. The child has tested HIV-positive.

It is standard practice to administer a short course of HIV antiretroviral medication to a child born to an HIV-positive woman with the goal of preventing the child from becoming HIV-positive. Police allege that the woman lied when specifically asked about her HIV status and stopped taking her HIV antiretroviral medication at some point during her pregnancy. They also allege that the woman was diagnosed with HIV during a previous pregnancy, at which time she followed medical advice and the child was HIV-negative.

The Canadian HIV/AIDS Legal Network issued a press release warning about the inappropriateness of using criminal prosecutions to stem HIV transmission.[4] The Network said that

> [p]rosecuting a mother for not disclosing her HIV status to health care workers is just the kind of action that would drive others in her situation underground and away from the assistance they need. If women face criminal charges in these situations, it's a reason to avoid HIV testing and prenatal care, which harms both them and their babies. Do we really think that throwing this woman in jail is going to help either her or her children?
>
> *– Glenn Betteridge*

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[1] B Brown, W Hemsworth. HIV infection draws first murder charge. *Toronto Star* (online edition), 25 February 2005.

[2] M Henry. Woman's lovers warned or risk. *The Barrie Examiner* (online edition), 19 March 2005; B Fenlon, S Pazzano; Twist in HIV arrest. *Toronto Sun* (online edition), 24 March 2005.

[3] HIV mother charged after baby infected. *Toronto Star* (online edition), 28 May 2005.

[4] Criminal charges against HIV-positive mother inappropriate response, says Canadian HIV/AIDS Legal Network. News release. Montreal, Canadian HIV/AIDS Legal Network, 27 May 2005. Available at www.aidslaw.ca/Media/press-releases/e-press-HamiltonMother_may2705.pdf.

In brief

Buprenorphine now approved for the treatment of opiate addiction

For the first time since 1961, a new drug will be available in Canada for the treatment of addiction to opiates such as heroin and prescription pain medications. Buprenorphine (trade name: Subutex) was approved by Health Canada in February 2005. Up to now, the only substitution treatment approved in Canada for the treatment of opiate addiction has been methadone.

Schering-Plough, the drug's manufacturer, says that buprenorphine diminishes drug cravings, reduces withdrawal symptoms and blocks the effects of subsequent drug abuse.[1]

According to public health officials in Montréal, the pharmacological characteristics of buprenorphine are such that there is a plateau dose beyond which its effect is prolonged rather than augmented. This plateau effect reduces the risk of overdose, which makes the prescription of buprenorphine safer than methadone. The drug is administered sublingually every day, in front of the pharmacist.[2]

Schering Canada Inc. plans to organize educational sessions for physicians who wish to prescribe buprenorphine. It expects these sessions to be completed by the end of 2005, by which time the drug will be commercially available.

Each province and territory will need to decide whether special authorization is required before a physician can prescribe buprenorphine (as is the case now with methadone in most or all jurisdictions).

– David Garmaise

Saskatchewan: Mandatory "bodily substances" testing legislation passed

On May 24, 2005, the *Mandatory Testing and Disclosure (Bodily Substances) Act* passed its third reading in the Saskatchewan legislature, making Saskatchewan the fourth Canadian province to pass such a law. The bill was introduced on 12 April 2005, following consultation with police and emergency service providers.[3] No other stakeholders were consulted.[4]

The *Act* sets out a procedure for obtaining and testing samples of bodily substances in cases where certain people – such as emergency service personnel, victims of crime, and Good Samaritans – have come into contact with the bodily substances of another person. The bill also provides for limited disclosure of personal health information resulting from the testing.

Court orders for testing would only be available where a physician believes there is a significant risk of transmission of a communicable disease, and where the test meets the medical needs of the applicant. [5]

The Act is based on model legislation drafted by the Uniform Law Conference of Canada, a group of jurists from across the country that aims to promote the harmonization of Canadian laws.[6] Similar legislation was previously introduced in Nova Scotia, Alberta and Ontario.[7]

– Sarom Bahk

Sarom Bahk is a student at the McGill Faculty of Law, and a summer intern with the Canadian HIV/AIDS Legal Network.

First evaluation of Vancouver safe injection facility

In September 2003, Canada's first and only safe injection facility was opened in Vancouver. In a recent article, a team of researchers from the B.C. Centre for Excellence in HIV/AIDS analyzed the facility's use by injection drug users.[8]

The researchers conclude that "use of a medically supervised safer injection facility was independently associated with reduced syringe sharing in a community-recruited sample of injection drug users who had similar rates of syringe sharing before the facility's opening."

The study was based on interviews with 431 injection drug users during the six-month period from 1 December 2003 to 1 June 2004. The researchers compared injection drug users who reported undertaking all, most or some of their injections at the facility with injection drug users who reported few or no injections at the facility. The rates of syringe sharing was similar in these two groups prior to the opening of the facility.

Due to limits in the study design, the researchers caution against drawing the conclusion that the safe injection facility has caused a decrease in syringe sharing among injection drug users. However, the findings do help inform discussion about the potential public health benefits of safe injection facilities.

– Glenn Betteridge

Officials in two Canadian cities express support for safe injection sites

Officials in Toronto and Victoria have spoken publicly about the need for safe injection sites (SISs) in their communities.

After touring five SISs in Bern, Switzerland and Frankfurt, Germany, Victoria Mayor Alan Lowe said that his city needs an SIS to help addicts. He said that the SIS should have housing and a drop-in centre with medical treatment.[9]

David McKeown, Toronto's Medical Officer of Health, said that Toronto should consider opening a centre where drug addicts can openly shoot up heroin and smoke. McKeown said that SISs can reduce the open use of drugs on the street and drug overdose.[10]

Canada's first and only officially-sanctioned SIS opened in Vancouver in 2003 as a three-year pilot project.

– David Garmaise

New Brunswick: Sex education curriculum adds abstinence statement

As reported previously, the sexual education component of New Brunswick's health education curriculum recently faced opposition from parents advocating for an abstinence focus.[11] The revised curricula for grades six, seven and eight were released in March 2005.[12] Each curriculum contains the following new "abstinence statement":

> The Growth and Development strand of the New Brunswick Health Education Curriculum emphasizes that abstinence from all sexual activity that involves risk is the best and only truly safe health choice for adolescents. Students who do decide to become sexually active now or in the future need information about the effective use of protection against pregnancy and sexually transmitted infections. Classes do not encourage students to become sexually active nor do they include teaching about sexual techniques.

Overall, the curricula retain a comprehensive sex education focus. However, parents are given the option of removing their children from class when the "growth and development" sections of the curricula are taught. In grades six and seven, these sections include information on puberty, the male and female reproductive systems, relationships, and sexuality and gender stereotypes.

The grade eight curriculum examines influences on sexuality and relationships, and choices and consequences related to becoming sexually active, including information on pregnancy and sexually transmitted infections. It also includes a discussion of sexual orientation issues.

– Glenn Betteridge

New medical marijuana regulations approved

In June 2005, Health Canada formally adopted new *Medical Marihuana Medical Access Regulations*.[13] The new *Regulations* were proposed in October 2004 and public comments were solicited.[14]

The major changes are as follows:

- It is no longer necessary to obtain the signature of a specialist on application forms for authorization to use medical marijuana. The signature of a family physician or general practitioner will now suffice.
- Changes to the wording of the forms should make it easier to for physicians to support the program. The responsibility of choosing marijuana as a therapy now rests more with the individual than the physician.
- The authorization renewal process has been considerably simplified.

– David Garmaise

Minister announces new drug approval initiatives

Health Minister Ujjal Dosanjh says that he wants to revamp Canada's drug approval system. His plans include a more open and transparent approach to drug approvals, and conditional licensing for some drugs.[15]

In an interview with the *Canadian Medical Association Journal*, Dosanjh said that his plans will require not only legislative change, but also a wholesale shift in Health Canada's culture.

Health Canada has announced that it will launch a new database in the summer of 2005 to provide health care professionals and the public with information on all drugs approved in Canada since 1994. The searchable, bilingual database will list the licences (Notices of Compliances) issued as well as summaries of the basis for Health Canada's approval of the drugs.[16]

Dosanjh has also announced:

- that a permanent Drug Safety Board will be created to permit

Canadians and health care practitioners to provide input into drugs both before and after they are approved;
- that an ombudsman's office will be created to assist in resolving disputes about the way Health Canada fulfils its responsibilities under the *Food and Drugs Act*; and
- that a new Office of Paediatric Initiatives will be established to coordinate dialogue among experts interested in nutrition and in the safety of food, drugs, medical devices and vaccines for children.[17]

– David Garmaise

Many HIV-positive people do not get enough to eat

One in five persons living with HIV/AIDS go hungry because they do not have enough food to eat, according to a survey conducted in Vancouver by people from the Canadian HIV Trials Network, the B.C. Centre for Excellence in HIV/AIDS, and the University of British Columbia.[18] The finding has important consequences for the health of people living with HIV/AIDS for several reasons.

First, because of what HIV does to the body's metabolism, HIV-positive people need extra amounts of high-quality protein and other nutrients. Second, weight loss is a feature of HIV disease. Finally, a lack of food can affect the ability of people living with HIV/AIDS to adhere to taking medications, since some medications are best taken with food.

The researchers hope that their findings will provide the foundation for the development of nutritional and social strategies to address the problems that give rise to food insecurity and hunger among this population.

– David Garmaise

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[1] First new opiate addiction treatment in over 40 years: Subutex changes landscape for opiate addiction treatment. News release. Montréal, Scherling Canada Inc., 11 February 2004. Available at www.newswire.ca/en/releases/archive/February2005/11/c3086.html.

[2] Direction de santé public de Montréal and Association des médecins omnipracticiens de Montréal. *Prévention en practique médicale*. April 2005. Available via www.santepub-mtl.qc.ca.

[3] Saskatchewan. Legislative Assembly. Hansard, 90A (12 April 2005) at 2480-81; Saskatchewan. Legislative Assembly. Hansard, 94A (19 April 2005) at 2569-71; Saskatchewan. Legislative Assembly. Hansard, 115A (24 May 2005) at 3130.

[4] Saskatchewan. Standing Committee on Human Services. Hansard, 20 (17 May 2005) at 279-83.

[5] Bill 102: *Mandatory Testing and Disclosure (Bodily Substances) Act*. 25th Legislative Assembly, 1st Session (2005). See also New legislation will protect police and emergency personnel. News release. Regina, Saskatchewan Justice, 19 April 2005.

[6] Uniform Law Conference of Canada. *Uniform Mandatory Testing and Disclosure Act*. 2004. Available via www.ulcc.ca.

[7] See G Betteridge. Nova Scotia: "Blood samples" legislation passed. *HIV/AIDS Policy & Law Review* 2004; 9(3): 26; R Scheer. Alberta: "Blood Samples" act passes third reading. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 28; 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.

[8] T Kerr et al. Safer injection facility use and syringe sharing in injection drug users. *The Lancet* (forthcoming). Published online 18 March 2005 on the website of *The Lancet* at http://image.thelancet.com/extras/04let9110web.pdf.

[9] L Dickson. Lowe sees drug remedy in Europe. *Victoria Times Colonist*, 15 May 2005.

[10] C Porter. Safe injection site proposed. *Toronto Star*, 1 April 2005.

[11] G Betteridge. New Brunswick: New sex education curriculum stirs debate. *HIV/AIDS Policy& Law Review* 2005; 10(1): 38.

[12] The curricula are available via www.gnb.ca/education/.

[13] The *Regulations* were published in the Canada Gazette (Part II) on 29 June 2005. Available via http://canadagazette.gc.ca.

[14] See G Betteridge. Proposed amendments to medical marijuana regulations released for comment. *HIV/AIDS Policy & Law Review* 2004; 9(3): 28-29.

[15] L Eggertson. "New approach" as Health Canada seeks conditional licences for drugs, new pediatric office. *Canadian Medical Association Journal* 2005; 172(7): 863.

[16] L Eggerton. Health Canada to publish reasons for drug approval. *Canadian Medical Association Journal* 2005; 172(11): 1431.

[17] Ibid.

[18] L Normén et al. Food insecurity and hunger are prevalent among HIV-positive individuals in British Columbia, Canada. *Journal of Nutrition* 2005; 135(4): 820-825.

INTERNATIONAL DEVELOPMENTS

This section provides brief reports on developments in HIV/AIDS-related law and policy outside Canada. (Cases before the courts or human rights tribunals are covered in the section on HIV in the Courts – International.) We welcome information about new developments for future issues of the *Review*. Readers are invited to bring cases to the attention of Richard Pearshouse, editor of this section at rpearshouse@aidslaw.ca.

ABC in Uganda: success or subterfuge?

Since the enactment of the US President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, US officials have repeatedly pointed to Uganda as an example of the effectiveness of the "ABC" (Abstain, Be faithful, use Condoms) approach to HIV prevention. Uganda is one of few African countries to have experienced a decline in national HIV prevalence, from approximately 15 percent in the early 1990s to an estimated six percent today. While scholars continue to debate the reasons for this, the US government has attributed the decline to increased abstinence, faithfulness and condom use among Ugandans, and thus has made ABC the centerpiece of its global HIV prevention strategy.

There is growing concern, however, that ABC is simply a mask for "abstinence-*only*" approaches currently receiving significant government funding throughout the US. By definition, abstinence-only programs cannot promote the use of condoms against HIV. They teach sexual abstinence until marriage as the "exclusive" method of HIV-prevention and often exaggerate condom failure rates in an attempt to scare young people into abstaining.[1] These approaches stand in direct contrast to comprehensive sex education, which promotes abstinence as a healthy choice for young people but provides factual information about condoms and safer sex as well.

In a recent investigation,[2] Human Rights Watch found that, consistent with abstinence-only approaches, the Ugandan government had removed information about condoms and safer sex from US-funded primary school HIV/AIDS materials. Draft secondary school materials, now under revision, contained the myth that

condoms have microscopic pores that can be permeated by HIV.

US funds were also being used to support the Uganda Youth Forum, an organization led by Ugandan First Lady Janet Museveni, that denigrates condoms and encourages young people to sign "True Love Waits" cards whereby they pledge to abstain until marriage. Virginity pledges have been shown to be not only ineffective, but potentially harmful because they decrease the chances that young people will practice condom use and seek treatment for sexually transmitted diseases when they do have sex.[3]

US and Ugandan officials reacted angrily to Human Rights Watch's findings, claiming that their approach to HIV-prevention has always been "ABC," not abstinence-only. At the same time, officials in both governments continued to promote the view that increased abstinence and faithfulness, not condom use, was the main reason behind Uganda's HIV decline.

The best available evidence suggests this is not so. As Helen Epstein and Sam Okuonzi argue in a recent article, the main reason behind Uganda's HIV decline was not abstinence, but "pragmatic safe sex."[4]

In response to rising HIV rates and a concerted government effort to instil fear of HIV infection, Ugandans reduced their number of casual sexual encounters (but did not abstain) in the late 1980s and early 1990s. Beginning in the early 1990s, condom use in casual relationships increased sharply. In the late 1990s, when rates of casual sex increased, high levels of condom use prevented HIV rates from rising again.

Whether the current approach in Uganda is "ABC" or "abstinence-only," one thing is clear – in Uganda, US government-funded condom programs are restricted to "high-risk" areas such as bars and discos and banned from locations, such as schools and universities, where they would serve the general population.[5] At the same time, Uganda is facing an unprecedented condom shortage due to a nationwide recall of Engabu condoms, the country's most popular brand.

These developments are cause for great concern. Throughout the 1990s, the US and other donors achieved great success in increasing rates of condom use in the general population in Uganda through aggressive social marketing campaigns and widespread availability of free condoms. This success is now beginning to unravel as anti-condom conservatives in the US Congress exert more and more power over US global AIDS policy, and as Ugandan officials play along.

– Jonathan Cohen

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[1] See, for example, United States House of Representatives Committee on Government Reform – Minority Staff Special Investigations Division. *The content of federally funded abstinence-only education programs.* Report prepared for Rep. Henry A. Waxman, December 2004; also, Human Rights Watch. *Ignorance only: HIV/AIDS, human rights and federally funded abstinence-only programs in the United States: Texas: a case study.* Vol. 14, No. 5(G), September 2002; also, ME Kempner. *Toward a sexually healthy America: abstinence-only-until-marriage programs that try to keep our youth "scared chaste."* New York: Sexuality Information and Education Council of the United States, 2001.

[2] Human Rights Watch. *The less they know, the better: abstinence-only HIV/AIDS programs in Uganda.* Vol. 17, no. 4(A), March 2005.

[3] P Bearman, H Brückner. Promising the future: virginity pledges as they affect transition to first intercourse. *American Journal of Sociology,* 2001; 106(4): 859-912; P Bearman, H Brückner. After the promise: the STD consequences of adolescent virginity pledges. *Journal of Adolescent Health* 2005; 36: 271-278.

[4] S Okuonzi, H Epstein. Pragmatic safe sex, not abstinence or faithfulness, was key to Uganda's HIV decline. *Health Policy and Development* 2005; 3(1): ii-iii.

[5] The strategy document that guides the implementation of PEPFAR states that condoms are only to be promoted to "high-risk populations" such as sex workers, sero-discordant couples and substance users. See Office of the United States Global AIDS Coordinator (OGAC). *The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy.* Washington, D.C.: United States Department of State, 2004: p 29.

UN leadership and harm reduction: a rough road

An unprecedented coalition of over 300 harm reduction, human rights and HIV/AIDS-focused NGOs from around the world worked together in support of harm reduction in the lead-up to the annual session of the UN Commission on Narcotic Drugs (CND) in March 2005.

The coalition, which included 26 organizations in Asia and 31 in eastern and central Europe, wrote letters to all CND delegations and to Antonio

Maria Costa, head of the UN Office on Drugs and Crime, urging support for harm reduction in the session. The letters helped to spur editorials in support of harm reduction in major newspapers.[1]

What occasioned this extraordinary advocacy? The CND had scheduled a debate on HIV/AIDS, one of its first, for the annual session. In the lead-up to the session, the United States signalled that it wanted that debate to result in an anti-harm reduction consensus. In February 2005, the US House of Representatives held public hearings entitled "Harm reduction or harm maintenance?" in which members of Congress accused syringe exchange advocates of being "drug promoters."

A high-level US State Department official also exacted a pledge from Costa that the UNODC would review all of its documents for references to harm reduction and would be "even more vigilant" in the future in excluding references to the term.[2] Costa had previously expressed some support for harm reduction, but it seemed to evaporate under US pressure. Significantly, in the face of these unusually public US actions, there was no statement of any kind from UNAIDS, which has a mandate for global leadership on HIV prevention.

In the CND debate, the European Union, numerous European countries and Brazil stood up explicitly for harm reduction as a central element of HIV prevention; other countries were supportive but less explicit. Canada centred its remarks on stigma faced by people who use drugs, without an explicit endorsement of harm reduction. The representative of the World Health Organization highlighted the indispensability of syringe exchange.

Only two countries, the US and Japan, spoke explicitly against syringe exchange and harm reduction. Unfortunately, in his summary of the debate, UNAIDS director Peter Piot emphasized the absence of consensus on harm reduction. Someone who saw himself as a global advocate for HIV prevention might have chosen rather to note that in the 52-member body, only two countries spoke explicitly against harm reduction.

Although the US did not offer a resolution to eliminate all reference to syringe exchange in UN documents, as had been feared, it systematically excised useful language on HIV prevention in other CND resolutions. For example, a resolution brought by Nigeria called for attention to HIV prevention in national drug control strategies. The US insisted that the resolution call for prevention of drug use in national drug control strategies, a very different idea.

Since the CND works on a consensus system, any one country can block a resolution. The US used this privilege with little resistance. The delegation from Brazil decided not to pursue its resolution on the importance of harm reduction, seeing that it would be killed, but vowed to raise the issue again in the future.

On the heels of the CND meeting, the ministers of health of the Commonwealth of Independent States met in Moscow in late March. According to NGO participants, Piot and Costa stood by as a call for urgently needed opiate substitution therapy was dropped from the meeting's declaration. In addition, though the UNAIDS-UNODC press statement on the meeting reconfirmed the UN's "strong conviction that civil society organizations must play a central role at all levels,"[3] NGO representatives at the meeting said that the UN leaders did nothing to prevent the exclusion of civil society representatives from key sessions in Moscow.

At the June 2001 UN General Assembly Special Session on HIV/AIDS, Piot did not mention harm reduction in his speech in the plenary session, and UN representatives said nothing about harm reduction in the round-table on prevention. Canada was the only country delegation in that round-table to speak of harm reduction as part of HIV prevention.

All of this raises the question of whether UN leadership will be anywhere to be found as the member states gather in late June to consider a new global HIV prevention strategy at the UNAIDS governing board meeting. The draft prevention strategy paper includes brief references to harm reduction and the importance of furnishing sterile syringes to drug users. At this writing, NGOs and a few members states are strategizing and advocating to preserve that language against further backward movement. Whether UN officials will show leadership before the member states on this occasion remains to be seen.

– Joanne Csete

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[1] See, for example, Editorial: Ideology and AIDS. *New York Times*, 26 February 2005.

[2] Costa's letter to Robert Charles of the US Department of State is available via www.tni.org.

[3] UNODC and UNAIDS. CCO Statement on the CIS Ministerial Meeting (press statement), 2 April 2005. Available at www.unodc.org/pdf/event_2005-03-31_statement.pdf.

United States: Funding restrictions threaten sex workers' rights

Recent developments concerning the US government's restrictive policies on HIV/AIDS funding have drawn attention to how the government's mandatory "anti-prostitution pledge" endangers the lives of sex workers and trafficking victims.

US law requires that foreign organizations receiving US global HIV/AIDS and anti-trafficking funding have policies explicitly opposing prostitution.[1] US law also bars the use of global anti-AIDS and anti-trafficking funds to "promote, support, or advocate the legalization or practice of prostitution."[2]

In September 2004, the US Department of Justice issued an opinion letter supporting the application of these restrictions to US-based organizations, reversing its initial position that it would be unconstitutional to do so.[3] In June 2005, despite an international outcry that these restrictions violate fundamental rights to freedom of speech and information and threaten sex workers' human right to health, the US government formally amended its policy to extend these restrictions to US-based organizations receiving global HIV/AIDS funds.[4]

The US law specifically exempts certain multinational organizations receiving anti-AIDS funds (including the Global Fund to Fight AIDS, Tuberculosis and Malaria, and UN agencies) from the "anti-prostitution pledge" requirement.[5] The US government recently proposed a new policy that would have extended the anti-prostitution policy requirement to grantees of exempt organizations.

This proposal would have effectively gutted the exemption because thousands of groups worldwide receive money from Global Fund grants and from other exempted organizations.[6] However, in May 2005, following a public outcry by sex worker, public health, human rights and faith-based organizations in the US and abroad, the US government backed down on this new policy.[7]

In May 2005, Brazil rejected US$40 million in US anti-HIV/AIDS grants because the Bush administration made the funding conditional on the recipient organizations adopting a pledge opposing commercial sex work. Dr. Pedro Chequer, head of Brazil's national AIDS programs, criticized the restrictions, noting that they could undermine the very programs responsible for Brazil's landmark success in reducing the spread of HIV.[8]

Sex worker organizations, joined by a diverse coalition of public health, human rights and faith-based organizations, have continued to challenge the restrictions as threatening the fundamental rights of sex workers to receive life-saving information about HIV/AIDS and as threatening their human right to health.[9]

Sex workers play a crucial role in HIV/AIDS prevention. As UNAIDS and other experts have recognized, sex workers who are trained and informed about HIV/AIDS are the most effective HIV/AIDS educators for their peers.[10] Sex worker-run organizations have had remarkable success in providing HIV/AIDS education and services and in empowering marginalized women to participate in public life and to challenge some of the rights abuses that impede their struggle against HIV/AIDS in countries as diverse as India, the Dominican Republic, Brazil and Senegal.[11]

US restrictions on working with sex workers threaten to undermine this exemplary work and to exacerbate stigma and discrimination against already marginalized groups. Public statements against prostitution are likely to alienate sex workers, and to fuel public opprobrium against them, further driving sex workers underground and away from life-saving services. The broad language of the restrictions is already chilling work in the field. In Cambodia, for example, NGOs discontinued plans to provide English language classes for sex workers for fear that such programs would be seen as "promoting prostitution."[12]

– Rebecca Schleifer

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[1] *United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003*, 22 U.S.C. § 7631(f) (2003); and *Trafficking Victims Protection Reauthorization Act of 2003*, 22 U.S.C. § 7110(g) (2) (2003).

[2] Ibid.

[3] Letter from Acting Assistant US Attorney General Daniel Levin, US Department of Justice, to Alex M. Azar II, General Counsel, US Department of Health and Human Services, 20 September 2004 (on file with the author).

[4] See United States Agency for International Development. *Acquisition & Assistance Policy Directive 05-04,* 9 June 2005; see also the letter from Congressman Henry Waxman to US Attorney General Alberto Gonzales, US Department of Justice, 13 April 2005, contesting the constitutionality of provisions as applied to U.S. based organizations (on file with the author); and the letter from sex worker, public health, human rights and faith-based organizations to US President George Bush, 17 May 2005, challenging the constitutionality of provisions as applied to US and foreign organizations, and as threatening fundamental human rights to health and to receive lifesaving information about HIV/AIDS (online at http://hrw.org/campaigns/hivaids/hiv-aids-letter/).

[5] *Consolidated Appropriations Act, 2004,* Pub. L. 108-199, s 595(3) (2004).

[6] See Expansion and Support of HIV/AIDS/STI/TB Information, Education, and Communication and Behavioral Change Communication Activities in Ethiopia – Amendment 70 Fed. Reg. 29759-01. May 2005.

[7] D Brown. US backs off stipulation on AIDS funds: plan had called for overseas groups to publicly denounce sex trafficking. *Washington Post,* 18 May 2005.

[8] MM Phillips, M Moffett. Brazil refuses US AIDS funds, rejects conditions. *Wall Street Journal*, 2 May 2005:A3.

[9] See, for example, the letter from sex worker, public health, human rights, and faith-based organizations to US President George Bush.

[10] See, for example, UNAIDS. *Female sex worker HIV prevention projects: lessons learnt from Papua New Guinea, India and Bangladesh*. UNAIDS Best Practice Collection. November 2000.

[11] See ibid.; also, K Kempadoo, J Doezema. *Global Sex Workers: Rights, Resistance, Rebellion.* London: Routledge, 1998, pp 227-266.

[12] Interview by Alice Miller, Columbia Univ. Law School, with Elaine Pearson, Anti-Slavery International, Bangkok, Thailand. July 2004 (on file with the author).

Russian Federation: Going backwards on drug policy

On 6 April 2005, the Russian government submitted a bill to the Duma (the national parliament) which, if passed, would turn back many of the recent reforms of Russia's drug policy.

In December 2003, the provisions of the Criminal Code of the Russian Federation relating to drug policy were reformed.[1] Those reforms, proposed by the President of the Russian Federation, resulted in a humanization and rationalization of Russian drug policy and the introduction of a distinction between drug consumers and drug dealers.

The reforms introduced the concept of the "average one-time dose" to the Criminal Code as the basis for estimation of large and especially large quantities of drugs. The average one-time dose is a concept that exists solely for the purpose of definition of liability within the use of the Criminal Code. The reforms determined that a large quantity for the purposes of the criminal law "shall be considered a quantity of narcological, psychotropic substances or their prototypes exceeding the average one-time dose by 10 or more times, while an especially large quantity shall be considered a quantity exceeding the average one-time consumption dose by 50 or more times."

The 2003 reforms changed the criminal liability for distribution of illegal substances: Sanctions for selling drugs in quantities of less than 10 doses became milder, while punishment for selling drugs in especially large quantities, offering them to underage individuals, and involving law enforcement bodies in drug dealing, became more severe.

These legal reforms, which came into effect in 2004, had a dramatic impact on anti-drug practices: Criminal prosecution for buying, possessing, transiting, processing and preparing substances for personal use, became impossible. Following the reforms, about 35,000 prisoners convicted of the drug-related activities were set free.

The reforms to the Criminal Code were supported by the Ministry of Justice, the General Prosecutor's Office, the Ministry of Interior and many other Russian and international experts. President Vladimir Putin has spoken out in favour of the reforms. In his recent annual address to the nation, Putin referred to methods of controlling alcoholism and drug addiction, and stated that the problem "cannot be solved by prohibition methods."

Despite all of this, the Russian government has now submitted a bill that would remove from the Criminal Code the concept of using an "average one-time dose" for narcological and psychotropic substances as the basis for estimation of large and especially large quantities of drugs. Removing this concept would remove the basis for differentiating between drug use for personal consumption and drug use for drug dealing when it comes to determining punishment.

The turn-around by the government is a result of the lobbying efforts of the Federal Drug Control Services (FSKN), the government's counternarcotics agency. The FSKN put forward populist arguments that the use of an average one-time dose meant that the Criminal Code approved drug use and amounted to the "legalization of drugs." Established in 2003, and having a staff of 40,000 operational and investigational workers, this agency needs to arrest people for drug use to justify its existence. The FSKN was put in a difficult situation when the 2003 reforms dramatically reduced the possibility of prosecuting drug users.

The first reading of the bill proposed by the government was scheduled to take place in the second half of June 2005. Considering the negative attitude of the government deputies to the concept of average one-time dose, there is a good chance it will pass.

There is still hope that the President of the Russian Federation has not changed his position from that which he explicitly declared at the enactment of the 2003 reforms. Activists are hoping that state human rights officials will continue the struggle for preserving the 2003 reforms. Ella Panfilova, head of the Council for Assistance to the Development of Civil Society Institutes under the President of Russian Federation, and Vladimir Lukin, Human Rights Commissary of the Russian Federation, have both put a lot of effort into the adoption of the reforms. Their support, and the support of the President, will be crucial to the success of efforts to prevent a roll-back of the reforms.

– Lev Levinson

Lev Levison is Head of the New Drug Policy Program at the Human Rights Institute in Russia.

[1] The Review has previously covered developments on the process of reforming the Russian Federation's drug laws. See A Alexandrova. Russian Federation: Penalties eased for possession of illegal drugs. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(1): 32-33; and J Csete. Russian Federation: Battle not over in drug-law changes. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 34.

India: New patent law may restrict access to HIV/AIDS treatments

On 4 April 2005, India's *Patents (Amendment) Act, 2005*[1] (the *Act*) received presidential assent. The *Act*, which represents a major shift in Indian patent policy, raises serious concerns that the supply of generic drugs to developing countries could decline.

The *Act* was passed in order to make India's patent law compliant with the World Trade Organization's (WTO's) *Agreement on Trade-Related Aspects of Intellectual Property Rights* (*TRIPS*).[2] Prior to the Act coming into force, India's patent law regime had spurred the development and commercialization of generic pharmaceuticals, such as antiretroviral HIV/AIDS drugs, which are usually considerably cheaper than brand-name, patented drugs. As a result, Indian generic manufacturers have become a major source of lower-cost medicines in many developing countries.

The previous patent law regime, in place since 1970, was a process-ori-

ented system which only recognized "process patents." This meant that only the process of producing a drug could be patented, leaving it open to generic companies to produce the medicine as long as they could come up with a different, non-patented process (often known as "reverse engineering").

The *Act* changes India's patent regime to now also recognize "product patents," meaning that the drug itself can now be patented, instead of just a particular process. This blocks generic manufacturers from making their own versions of the medicine even if they use a different process.

Product-oriented patent regimes, typical of developed countries, do not allow for the level of generic drug production witnessed in India. In these regimes, the focus is on protecting inventors' rights to exploit their inventions, including against competitors that can produce those inventions via alternative methods.

Workings of the *Act*

Under the *Act*, generic versions of drugs discovered prior to 1995 can continue to be produced, because these are not covered by patents. At present, these drugs represent the overwhelming majority of generic antiretrovirals being produced in India.

However, as required by *TRIPS*,[3] for drugs discovered on or after 1 January 1995 and before 1 January 2005, the Indian government created, prior to the passage of the *Act,* a so-called "mailbox" for patent applications. These applications sat in the mailbox until 2005 when the Indian law was changed to comply with *TRIPS* by recognizing patents on pharmaceutical products.

Now that 2005 has arrived, and India has introduced product patents, it will begin reviewing the applications in the mailbox. In other words, patents on these drugs could eventually be granted for whatever portion of the TRIPS-standard 20 year patent term remains, provided the brand-name manufacturer filed a patent application before 1 January 2005, the day the Act is deemed to come into force.

If a generic formulation of an unpatented mailboxed drug is on the market, its manufacturer can continue production unless and until a patent is granted. If and when the patent on the mailboxed drug is granted, however, generic producers will have to pay a "reasonable" royalty to the inventor. Roughly 9000 patent applications have been filed in the mailbox in India, the vast majority by non-Indian applicants.

Finally, patent applications for drugs made after 1 January 2005 will, if granted, convey to the inventor a 20-year monopoly on the right to make, use, sell and import the drug. This protection is subject to potential qualifications, such as parallel importing (the right of the government to import a drug from another country where it is being sold at a cheaper price than that offered in India) and compulsory licensing (giving the government or another company the right to produce a patented product without the patent holder's authorization).

Criticisms of the *Act*

Generic drug producers in India, along with several civil society organizations, have expressed concern that the new law will restrict access to medicines for people living with HIV/AIDS, not only in India but also elsewhere in the developing world. Indian drug companies are credited with playing a major part in driving treatment costs from about US$15,000 ten years ago to their current levels of about US$200 in some African countries. Indian companies provide antiretroviral medications to up to half of the one million people in the developing world receiving such medications.[4]

Concerns have been expressed that the new law will restrict access to medicines, not only in India but also elsewhere in the developing world.

Attempting to address fears that the new law gives primacy to the interests of multinational pharmaceuticals, the *Act*'s proponents point to the sweeping discretionary powers that the *Act* reserves for the government to ensure the availability of medicines. However, it is reasonable to be sceptical about whether certain of these powers, like those dealing with emergencies, will ever be invoked, given that India has been notoriously silent for years about the severity of the AIDS epidemic within its borders, and that there is considerable domestic and external pressure by the pharmaceutical industry and some other countries to not take any measures that would limit patent rights.

As well, the issue of what might constitute reasonable royalties for the continued marketing of mailboxed drugs that become patented, or for new patented drugs on which compulsory licences may be issued, is likely to generate disagreement between patent holders and generic distributors or activists. This could easily lead to

protracted and expensive litigation that would pose an additional barrier to generic manufacturers pursuing marketing permission or compulsory licences.

Activists have argued that the Indian government should quickly specify "reasonable" royalties as conforming to international norms of 3-4 percent.[5] If multinationals are allowed too much influence in this pricing issue, the supply of generic drugs currently on the market to the developing world is very likely to decline in future.

Conclusion

While the long-term consequences of the law are as yet undetermined, its passage cannot be seen as a positive step toward access to treatment. While some flexibilities have theoretically been maintained, on balance Indian law that used to facilitate the production and export of cheaper generic medicines has now been restricted in line with WTO requirements.

Although India is not the only country that produces generic AIDS medicines, Indian companies have until this point been a global leader in the export of these drugs. As the latest treatments come to market, it will be increasingly difficult for these companies to keep pace, because – depending on when drugs are invented – patent protection will prevent them from competing, and as yet undetermined royalty rates may price them out of competition.

Furthermore, it is "unclear whether makers of generic drugs in other countries…will fill any increasing demand for cheaper medicines."[6] As a result, cheap generic versions of newly created medicines may not be received in the developing world in a timely fashion.

– Gord Cruess

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[1] *The Patents (Amendment) Act*, No. 15 of 2005. Available at www.patentoffice.nic.in/ipr/patent/patent_2005.pdf.

[2] For background on the *TRIPS* agreement and patent law, see R Elliott et al. *Patents, international trade law and access to essential medicines – 3rd ed.* Canadian HIV/AIDS Legal Network and Médicins sans frontières. March 2003. Available at www.aidslaw.ca/Maincontent/issues/cts/Patents-international-trade-law-and-access.pdf.

[3] *TRIPS* agreement, Article 70(8)-(9).

[4] DG McNeil. India alters law on drug patents. *New York Times* (online edition), 24 March 2005. Available via www.nytimes.com.

[5] The beginning of the end of affordable generics. News release. Médicins sans frontières, 22 March 2005. Available via www.msf.org.

[6] DG McNeil.

Taiwan: AIDS NGOs fight to keep human rights law

Thirty-seven government deputies, all members of the ruling Democratic Progress Party (DPP), have recently proposed a bill to eliminate Article 6-1 of Taiwan's *AIDS Prevention and Control Act* (1997).[1]

Article 6(1) currently states that

> HIV-infected individuals shall not be discriminated against, and the rights of such individuals shall not be deprived. For example, such individuals shall not be treated in the areas of schooling, medical care, employment, etc. in a discriminatory or unjust manner. Without explicit consent or approval from an HIV-infected individual, he or she may not be filmed, his or her photo may not be taken, and his or her words may not be recorded.

For Taiwanese living with HIV/AIDS, the importance of Article 6(1) cannot be underestimated. Article 6(1) is the only regulation that protects the human rights to medical care, work, education and privacy for people living with HIV/AIDS. Article 6(1) also

provides the legal basis for prohibiting discrimination against people living with HIV/AIDS.

For example, Article 6(1) was the basis of an important case in June 2003, when Mr. Chen, a medical employee infected with HIV while on duty in the hospital he worked for, brought a formal lawsuit against his employer for violating his privacy and for unjust dismissal. The case created a precedent for people with HIV/AIDS to protect the right to work against unfair dismissal by employers.

However, the DPP deputies consider that Article 6(1) disregards the health and safety of people without HIV infection. The draft bill that they have introduced says that

> [e]xtinguishing HIV has been a vital goal around the globe, but Article 6(1) allows the *AIDS Prevention and Control Act* to be a law "to protect" HIV, ignoring the health and safety of the public. In order to maintain the health and safety of people, and to prevent the innocent from getting infected, Article 6(1) should be eliminated.

HIV/AIDS NGOs in Taiwan consider this a groundless statement that wrongly suggests that allowing people with HIV/AIDS to work, study, access medical care or live with dignity will fuel the spread of HIV/AIDS. This false logic, which often forms the root of collective panic, not only reflects the lawmakers' ignorance of modes of HIV transmission, but also deepens the already-widening discrimination against those with HIV/AIDS.

The Persons with HIV/AIDS Rights Advocacy Association of Taiwan (PRAA), together with 38 scholars and over 40 local NGOs, held a news conference on 12 April 2005 to protest against this policy. At the news conference, scholars and NGO spokespersons took turns criticizing and condemning the government deputies for proposing a bill that would seriously violate the human rights of people living with HIV/AIDS.

The press conference received significant coverage favourable to the arguments raised by PRAA. However, subsequently, the bill passed its first reading in the legislative assembly. The PRAA continues to lobby in the legislative assembly to prevent the bill passing second and third readings.

– Pan Chung-Li

Pan Chung-Li is a graduate student at the Department of English in National Central University, and a volunteer reviewer for the PRAA and Positive Development Family, Taiwan. Expressions of support for efforts to prevent the elimination of Article 6(1) should be sent to the PRAA at praatw@yahoo.com.tw.

[1] Details on Taiwan's *AIDS Prevention and Control Act* (in both Chinese and English) can be found at www.cdc.gov.tw. The draft of the Bill to eliminate Article 6(1) can be found (in Chinese) at www.praatw.org.

Tenofovir trials raise ethical issues

The development of safe, effective and accessible prevention methods has become one of the most urgent global public health needs.[1] Whether the antiretroviral drug tenofovir (Viread), a nucleotide reverse transcriptase inhibitor, is appropriate for use as pre-exposure prophylaxis (PREP) for the prevention of HIV infection is currently being studied in a number of clinical trials. However, recent controversies over perceived defects in trial design and implementation, and inadequate consultation with the communities involved, threaten to prevent ongoing research unless closer collaboration between researchers and activists can be established.

Consistent concerns by activists and commercial sex worker advocacy groups have emerged across the trials.[2] The overarching complaint has been the lack of involvement of stakeholder groups in the planning of the trial.[3] Activists also argued that there has been a lack of safety data supporting the long term use of teno-

fovir in healthy participants.[4] They stated that participants of the trial are not fully informed of the risks involved and are not provided with adequate counselling or tools, such as condoms or clean needles, to prevent infection.

In addition, activists decried the lack of long-term insurance for adverse events related to the trial drug,[5] and argued that participants who seroconvert during the trial are not provided with an adequate standard of care that includes early access to antiretrovirals.

Even within the academic community, there is no consensus on several of the ethical issues identified, such as standard of care, access to proven prophylaxis and access to treatment for seroconverters.[6]

There are currently six ongoing or planned human clinical trials testing PREP tenofovir (in Ghana, Malawi, Botswana, Thailand, the US and Peru). In early 2005, opposition halted two PREP trials, in Cambodia and Cameroon, and threatened the stability of planned and recruiting PREP trials in other developing nations. A planned PREP tenofovir study in Nigeria was halted because of it inability to meet research protocol requirements.

The trial closures have received worldwide media attention, thus demonstrating the ability of activists to engage the media and bring about important consequences for the conduct of trials. In order to prevent further trial closures and to prevent this occurrence in future prevention trials, efforts have been undertaken to develop a strategy to engage activists, trial participants and researchers to resolve differences.

Identifying concerns and barriers to the trial before they become a media spectacle may be considered as preventative ethics – an approach whereby investigators proactively engage activist and advocacy groups working within the target community to address concerns before the issues become deepened opinions and the divide widens.[7]

On 19 May 2005, the International AIDS Society convened a meeting of stakeholders representing activists, advocates and trialists to address the above concerns. The four challenges identified at that meeting were providing treatment and care to trial participants, establishing the standard of care for prevention interventions offered to participants, ensuring research literacy for potential participants, and strengthening mechanisms for community involvement. The meeting focused on those countries where the trials are still ongoing or have yet to be definitively cancelled: Botswana, Thailand, Cameroon, Malawi and Ghana.

Throughout the discussions, it remained clear that early involvement of stakeholder groups is necessary to prevent dissent within the affected communities and to create systems to respond effectively to concerns raised during the course of the trial. Because the issues of standard of care, best proven prophylaxis and access to care post-trial are widely varied and not established in a uniformly accepted international guideline,[8] a number of participants identified the need for national guidelines on treatment and care to be established.

Certain issues were not resolved over the course of the meeting, including the questions of how to provide treatment to trial participants who seroconvert during clinical trials in settings with minimal health infrastructure; and how to provide clean needles to trial participants who are injection drug users, in settings where drug use is highly stigmatized and harm reduction is considered illegal.

The meeting established a Pre-Exposure Prophylaxis Stakeholders Group to provide a mechanism for raising and addressing issues around the PREP tenofovir studies on an ongoing basis.

– Edward Mills

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[8] Schuklenk; Lie.

US: Developments in the treatment of HIV-positive prisoners in two states

Legal actions have been launched in Alabama and Mississippi to address living conditions and medical care of HIV-positive prisoners in state prisons.[1] These were the only two states to allow complete segregation of HIV-positive prisoners in state prisons into the 1990s. The two cases highlight the ways in which the courts have been involved in supervising prison conditions in the United States.

Alabama

On 17 February 2005, 240 HIV-positive Alabama prisoners filed a contempt motion in United States District Court alleging that the state was in violation of an April 2004 settlement agreement of an earlier legal case.[2]

The 2004 agreement was intended to ameliorate sub-standard medical care in the Limestone Correctional Facility. The agreement required the Department of Corrections' medical provider to hire a full-time nurse to direct an infection-control and education program and to arrange medical care for HIV-positive prisoners, including monitoring treatment progress. It also prohibited the Department from housing HIV-positive prisoners in dormitories and it mandated that the Department clean the prisoners' cells daily.[3]

The complaint process established by the settlement agreement required the plaintiffs to submit written notices of non-compliance; the defendants then had 15 days to settle the issue. The current contempt motion notes that prison officials failed to respond to four complaint letters sent between December 2004 and February 2005.

These letters described numerous violations providing the substance of the contempt motion: the absence of an HIV specialist, the absence of a full-time physician, the failure to treat inmates co-infected with hepatitis C, gaps in the provision of medication, inadequate access to outside specialist care, and a shortage of nurses.[4] Of particular concern was the resignation of two doctors at the facility, including the HIV specialist.

When the contempt motion was filed, there was no HIV specialist at the prison, and the one remaining doctor was treating more than 2200 Limestone prisoners, including those in the unit where HIV-positive prisoners remained segregated.[5] The case is ongoing.

Mississippi

On 31 March 2005, a United States Magistrate Judge for Mississippi ended a long-standing case over the treatment of HIV-positive prisoners, deciding that conditions had improved enough to make further court supervision unnecessary.[6]

This concluded a 15-year dispute between the American Civil Liberties Union and the Mississippi Department of Corrections (MDOC). During that time, the court had ordered the MDOC to give HIV-positive inmates drug combination treatment and to allow them to participate in community work programs, thus ending total segregation.

Both cases underscore the need for vigilance and long-term commitment by human rights and civil liberties groups advocating for prisoners' rights.

– Katie Gibson

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[1] For past coverage of this issue in the Review, see R Jürgens. US judge: Inadequate medical care for HIV-positive prisoners a violation of rights. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 48-49; R Jurgens. Mississippi: Judge says prison must obey treatment guidelines. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(4): 63-64.

[2] HIV inmates' attorneys file contempt motion against state. Associated Press, 19 February 2005.

[3] The Alabama Department of Corrections settled *Leatherwood v Campbell et al* (2004) under a consent order, enforceable in Federal District Court. Documents from the case are available via www.schr.org.

[4] The text of the motion is available via www.schr.org.

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In brief

Holland: Companies to offer life insurance to people living with HIV/AIDS

On 9 March 2005, the Dutch Association of Insurers (DAI) announced that from now on it will recommend to Dutch insurance companies that they provide individual life insurance plans to some people living with HIV/AIDS. The DAI's recommendations reflect improvements in HIV treatment and corresponding increases in life expectancy. The DAI has recommended to its members that HIV-positive people responding well to antiretroviral treatment who have no other medical complications, and who are not injection drug users, should be eligible for life insurance. However, each insurance company is free to determine its own terms of approval.[1]

In general, personal insurance for people living with HIV is hard to obtain and premiums tend to be very high. Guarantee Trust Life Insurance, the only company that underwrites life insurance policies for HIV-positive people in the US, would set premiums on a US$250,000 policy at US$1631 per month for a 35-year-old non-smoking HIV-positive man, while a non-smoking man of the same age with cancer would pay US$635.[2]

According to the DAI, Dutch insurance companies will determine policy prices on an individual client basis, but costs will be reasonable. A 20-year policy for unexpected death worth US$260,000 would likely cost people living with HIV/AIDS US$105-130 per month, a little more than twice the price of the same policy for people who are not HIV-positive.[3]

UK: Guidelines for liver transplants for HIV-positive people issued

In April 2005, liver transplant guidelines for people living with HIV in Britain were released. The guidelines were authored by the British HIV Association and The UK and Ireland Transplantation Centres, and were endorsed by the British Tranplantation Society Standards Committee.[4]

The UK guidelines state that HIV infection should no longer be an absolute bar to liver transplantation because of the positive effect of antiretroviral treatment on the long-term health of people living with HIV/AIDS.

According to the guidelines, candidates must be responding well to antiretroviral treatment in order to be considered for transplantion. Unfortunately, this requirement represents a "catch-22" situation for many HIV-positive people who require a liver transplant in order to be able to respond to antiretroviral therapy.

The guidelines also state that candidates should have CD4 cell counts above 200 cells per cubic millimeter of blood, no detectable viral load, an absence of AIDS-defining illness after immune reconstitution, and long-term antiretroviral treatment options if the HIV reactivates. They should have a medical diagnosis which gives them at least a 50 percent chance of living five years beyond the operation.

The guidelines state that if alcohol is a contributing cause of the liver disease, candidates must have abstained from drinking during the six months prior to the transplant operation (although some centres will put patients on a waiting list during this period so as to avoid excessive wait times.) These candidates must also commit to total abstinence from alcohol after the operation.

Injection drug users are categorically excluded from consideration, though candidates who are stable on methadone are not.

UK: House Committee urges universal free HIV treatment

On 21 March 2005, the UK House of Commons Health Select Committee published a report condemning the UK government's recent decision to deny free HIV treatment to failed asylum seekers, illegal immigrants, visa overstayers and others who are in the UK without proper authority.[5] The Committee recommended that free HIV treatment be made available to all people living in the UK, regardless of their immigration status.

Prior to 2004, anyone who had spent 12 months in the UK prior to commencing HIV treatment received the treatment for free. The regulations were changed in 2004 in order to limit perceived "health tourism." However, the Committee's report stressed that there was no evidence to

suggest that this was happening in the UK, or that the regulations limiting free HIV treatment have served as a disincentive to illegal entry and residency.

The Committee noted that since HIV treatment reduces the risk of transmission, the exclusion of persons targeted by the regulations could drive up rates of infection. It also argued that the exclusion would likely deter people from getting tested. The Committee was particularly critical of the government's willingness to treat tuberculosis for free, but not HIV. Many people in the UK living with HIV/AIDS are coinfected with TB; the Committee found that not treating the underlying HIV infection in this class of patients could result in some people not seeking treatment for either HIV or TB.

The Committee concluded that the new government policy could not be justified on economic or public health grounds and that it would have a disproportionately negative effect on people coming from countries where HIV is endemic. There has been no response by the UK government to the Committee's recommendations, either prior to, or following, Britain's general election on 5 May 2005.

Nepal: Sexual minorities group facing possible ban

The Blue Diamond Society, Nepal's only organization that advocates for the rights of sexual minorities, has been fighting a proposed ban on both the society and homosexuality. The case to ban the Blue Diamond Society was filed with Nepal's Supreme Court by a private lawyer. The motion requests the Court to hold that the society be outlawed on the basis that it violates the Nepalese criminal code's prohibition on "unnatural sex."[6]

Hearings were held on 18 January 2005 and 18 March 2005, but were inconclusive. The case is ongoing.

Sexual minorities are the subject of routine police harassment and repression in Nepal. On 13 April 2005, police attacked and beat a group of transgendered people going to a festival in Kathmandu on Nepal's New Year's Eve.

On 9 August 2004, in an episode that received widespread media attention, 39 transgendered people (members of the Blue Diamond Society) were picked up in police raids in the capital and held for over two weeks without adequate food and water. Human Rights Watch reports that several people were beaten and raped while in policy custody.[7]

China: Alleged quarantine of HIV positive people in several provinces

Local authorities in parts of China most seriously affected by the HIV epidemic are constructing homes for people living with HIV/AIDS, alledgedly in order to contain the disease.[8] Dubbed "green harbours," these homes appear to be emerging in a number of different provinces. Some critics fear that they actually serve as quarantine wards and that people are being sent to them against their will.[9]

Such concerns are consistent with other reports on the human rights of people living with HIV/AIDS in China. In 2003, a Human Rights Watch report noted that unconfirmed stories of detention of people living with HIV/AIDS have circulated since the 1980s.[10] The report also documented features of Chinese law – national and local – that permit the quarantine of HIV-positive people during HIV testing or treatment.

Kenya: Free antiretrovirals distributed in prison

In May 2005, a pilot project commenced which will provide free HIV and tuberculosis drugs to inmates at Kodiaga prison in Kenya. The project is the result of a partnership between the US Center for Disease Control (CDC) and Kenyan prison and health authorities. HIV and TB are the leading causes of preventable deaths amongst inmates in Kenyan prisons.[11] According to the CDC, this project could eventually include all Kenyan prisons.[12]

In a separate project, the US and British governments are also in the process of establishing voluntary counselling centres for people living with HIV/AIDS in Kenyan prisons. To date, 10 of these centres have been established. They are intended to be used by prison inmates, prison officials and surrounding communities.

South Africa: Prison oversight body recommends permitting consensual sex between inmates

In March 2005, controversy erupted over prison policy prohibiting consensual sex in South African jails. The Judicial Inspectorate of Prisons (JIP), the office that oversees and reports on

prison conditions in the country, issued a report recommending that the Department of Correctional Services permit consensual sex between inmates. The report followed an appeal made to the JIP by two inmates who were charged with misconduct by prison authorities for engaging in consensual sex. The JIP ruled in their favour.

The JIP report stated that unless consensual sex constitutes a threat to prison order, inmates retain a right to sexual intercourse upon incarceration. The report argued that denying consensual sex is inconsistent with principles of human dignity.[13] It added that allowing inmates to engage in sex could reduce incidents of rape and could promote safer sex.[14]

The Department of Correctional Services has publicly disagreed with the JIP recommendation. A spokesperson for the Department stated that prisoners forfeit the right to sexual intercourse.[15] Sexual violence in South African prisons is widespread, and is a major factor contributing to the spread of HIV in prison populations.[16]

Australia: New free trade agreement with US targets drug prices

On 1 January 2005, a new bilateral free trade agreement (FTA) between Australia and the United States came into force. One of the subjects of the FTA is the Australian government's program to subsidize certain pharmaceutical drugs, the pharmaceutical benefits scheme (PBS).

In order to be listed on the PBS, a drug must be recommended by the Pharmaceutical Benefits Advisory Committee (PBAC), an independent statutory body that advises the Australian government. In making its recommendations, the PBAC considers a drug's overall effectiveness and cost and chooses the most affordable version of a drug unless more costly formulations are significantly more effective.

During the negotiation of the free trade agreement, the US demanded the creation of an independent body to review the PBAC's decisions to list or reject drugs for subsidies. Under Annex 2-C(2)(f) of the FTA, Australia must now provide an independent review process that can be invoked at the request of a pharmaceutical company whose drug the PBAC recommends not listing for subsidy.[17] The details of how this process will work are as yet undetermined, and some fear that the process will undermine the PBAC, which is famous for its "tough stance...concerning the cost effectiveness and prices of pharmaceutical products."[18]

If what constitutes an "independent review" is agreed upon, potential dissenting views of PBAC decisions that might emanate from such a review could be supported by industry lobbying.[19] However, because the FTA leaves the term undefined, appeals of PBAC decisions might end up before a trade panel. If Australia were not to comply with the judgment of the trade panel, the US could retaliate with trade sanctions.[20]

The provision on reviewing PBAC decisions in the US-Australia FTA illustrates concerns that public health advocates have with US bilateral FTAs generally – i.e., that the leverage these agreements cede to brand name pharmaceutical companies will influence subsidization and pricing decisions on potentially all medications – including those that treat HIV/AIDS – in the countries that sign them.

On 29 January 2005, the British Journal of Medicine reported that pharmaceutical companies were secretly arguing before the PBAC that it should recommend higher pricing for a new hypertension drug than the Australian government had been willing to pay.[21] Depending on how the PBAC rules, the industry could attempt to invoke the review mechanism under the new FTA.

Scotland: Executive proposes mandatory HIV testing for criminal suspects

In February 2005, the Scottish Executive (the devolved government for Scotland) released legislative proposals that would allow police officers, health care workers, victims of crime and other persons at risk of infection to apply for compulsory HIV, hepatitis B and hepatitis C testing of criminal suspects.

The proposals were made in response to a petition by the Scottish Police Federation (SPF). The SPF argued that the police are at special risk of contracting bloodborne diseases in the course of duty and that officers should have the right to request mandatory testing of suspects of crime in situations of possible exposure. The SPF submitted that mandatory testing would reduce the anxiety felt by officers and their families.

The Scottish Executive stated that because mandatory testing is a serious invasion of privacy, it should only be allowed to go forward where it is jus-

tifiable based on the circumstances of the incident and the nature of the risk faced by the injured party. Furthermore, a sheriff – an officer of a regional civil court – must make the decision to allow testing after hearing submissions from the person requesting testing and the person who might be subject to the mandatory testing order.[22]

HIV Scotland, which represents a number of voluntary sector and community-based organizations, raised a number of concerns about the proposed legislation that rely in part on past advocacy of the Canadian HIV/AIDS Legal Network on the issue of mandatory testing.[23] HIV Scotland argued that the risk of occupational exposure to HIV is extremely low,[24] and that mandatory testing is not the best way to assuage anxiety arising from occupational hazards. Rather, HIV Scotland said, police – and the public in general – require education about the risk of various forms of transmission and access to counselling where necessary.

Pointing to recent Canadian experience, the organization observed that mandatory testing is very rarely necessary, since circumstances in which there is a real risk of transmission are uncommon and voluntary testing is usually agreed to. For example, between 1 September 2003 and November 2004, legislation in Ontario, Nova Scotia and Alberta that resembles the Scottish proposals resulted in just one mandatory blood test. HIV Scotland suggested that the proposals are therefore excessive and, if implemented, may increase public fear and stigmatization of HIV.

Finally, HIV Scotland contended that law reform would likely undermine the privacy of those tested, since once someone who has initiated testing of a suspect is informed of his/her HIV status, it is impossible to guarantee the confidentiality of that information.

Scottish Prison Service to halt mandatory drug testing

In April 2005, it was reported that the Scottish Prison Service (SPS), the agency responsible for administrating prisons, would end mandatory drug testing in Scotland's penal institutions.[25]

Mandatory testing in Scottish prisons was introduced in 1994 in order to identify drug users and discourage drug use. Under that policy, testing positive to illegal drugs could result in the loss of various prison privileges. Under the new policy, the SPS intends to move away from punitive measures toward encouraging drug users to enter treatment programs.[26]

Prison officials have admitted that mandatory drug testing has been a failure. A 2004 SPS survey indicated that 50 percent of prisoners had taken illegal drugs in the month prior to the completion of the survey, and that 76 percent of prisoners reported that mandatory drug testing had not influenced the amount of illegal drugs they used in jail.[27]

Mandatory testing appears to encourage a shift to drugs that are only detectable by testing for a short period of time after they are consumed, such as heroin. Because needles are scarce in Scottish prisons, people who inject drugs must share injection equipment, which involves a high risk of HIV and hepatitis C transmission.[28]

The SPS is reportedly considering distributing clean needles and injection kits to Scottish prisoners.[29]

All of the "In brief" articles were written by Gord Cruess, a student at the McGill Faculty of Law, and a summer intern with the Canadian HIV/AIDS Legal Network.

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[18] P Drahos, D Henry. The free trade agreement between Australia and the United States: undermines Australian public health and protects US interests in pharmaceuticals. *British Medical Journal* 2004; 328: 1271-72 at 1271. Available via www.bmj.com.

[19] Ibid. at 1271.

[20] Ibid. at 1272.

[21] R Moynihan. New free trade agreement sparks fight over drug pricing. *British Medical Journal* 2005; 330: 213.

[22] Scottish Executive. Blood testing following criminal incidents where there is a risk of infection: proposals for legislation. February 2005. Available at www.scotland.gov.uk/consultations/justice/btfci-00.asp.

[23] These concerns are outlined in HIV Scotland's response to the Scottish Executive's consultation on the proposals. Available via www.hivscotland.com. Other responses to the consultation will be made available via the Scottish Executive's website: www.scotland.gov.uk/Home.

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[25] M Howie. Prison drug tests "failing to have impact." *The Scotsman* (online), 22 April 2005. Available via http://thescotsman.scotsman.com.

[26] Ibid.

[27] Scottish Prison Service. *Seventh prison survey*. 2004. Available via www.sps.gov.uk.

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HIV/AIDS IN THE COURTS – CANADA

This section presents a summary of Canadian court cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on criminal and civil cases. The coverage aims to be as complete as possible, and is based on searches of Canadian electronic legal databases and on reports in Canadian media. Readers are invited to bring cases to the attention of Glenn Betteridge, editor of this section, at gbetteridge@aidslaw.ca. All the articles in this section were written by Sarom Bahk, a student at the Faculty of Law, McGill University.

Federal Court overturns negative Pre-Removal Risk Assessment of HIV-positive failed refugee claimant

An HIV-positive failed refugee claimant from Mexico has successfully challenged a Pre-Removal Risk Assessment (PRRA) decision by a Canadian immigration officer.[1]

In October 2002, Jose Luis Garcia Mendez arrived in Canada and submitted a refugee claim. In the course of his immigration medical examination, he was diagnosed as HIV-positive. The basis of his refugee claim before the Immigration and Refugee Board (IRB) was that he had suffered discrimination in Mexico as a homosexual male and, as a result, would be unable to receive treatment for his HIV infection.

Mendez's refugee claim was rejected by the IRB in a decision rendered on 29 April 2003, based on a negative finding of credibility. The IRB considered whether the claimant would receive "proper" treatment for his HIV condition if he were to return to Mexico. It concluded that Mendez would not suffer discrimination on

medical grounds, and that in any case, the *Immigration and Refugee Protection Act* (*IRPA*) precludes a successful claim for protection based on a state's failure to provide health or medical care.[2]

Mendez did not challenge his failed refugee claim; however, he applied for a PRRA in February 2004. A failed refugee claimant subject to a removal order may apply for a PRRA, the ultimate purpose of which is to prevent deportation to a country where the person would be at risk.

In his PRAA application, Mendez put forward two pieces of new evidence. First, he testified that he had entered into a gay relationship with a Canadian citizen in May 2003, and that they were married in February 2004. Second, he included evidence from the case of his HIV-positive Mexican friend, Sergio Luis Pineda Flores, whose claim for refugee status had already been accepted.

The evidence related to the Flores case consisted of documents in support of Flores's claim; the Board's 3 January 2002 decision granting refugee status to Flores; and a letter signed by Flores describing his own experience of discrimination within the Mexican health care system. This evidence called into question the Board's conclusion that there is no discrimination by health care professionals in Mexico against homosexual males with HIV/AIDS.

However, the PRRA Officer found the evidence inadmissible on the basis that under the *IRPA*, "an applicant whose claim to refugee protection has been rejected may present only new evidence that arose after the rejection or was not reasonably available … at the time of the rejection."[3]

In addition, the officer found that Mendez was merely speculating that his experience would be similar to that of Flores if he were to return to Mexico. The officer claimed that Mendez was alleging a risk of persecution "based on the general knowledge of mistreatment of homosexuals in Mexico and a specific individual's personal experiences."[4] The officer further noted that Mendez's initial claim was based on problems relating to his employment, and that according to his own statement, "he did not suffer physically because of his sexual orientation."[5] The officer examined general country conditions in Mexico to see if there had been a significant change since the Board's decision that would require Mendez to be in need of protection. The officer concluded that "protection is available towards sexual minorities if the applicant were to experience harassment and discrimination upon his return to Mexico."[6]

Campbell J of the Federal Court – Trial Division found that the PRRA Officer had erred in disregarding the new evidence. In particular, the Court said, the letter written by Flores was dated 17 March 2004 – four months after Mendez's Board hearing – and thus could be accepted as new evidence.

Campbell J cited passages from Flores' letter which describe Flores' humiliation and suffering as he attempted for five years to obtain adequate HIV treatment in Mexico. The judge found the letter to be cogent evidence in support of Mendez's claim. This oversight on the part of the officer was found to be an error of law, and Mendez's case was referred to a different PRAA Officer for re-determination.

Mendez further argued that the new evidence rule under the *IRPA* offends his fundamental rights under section 7 of the Canadian *Charter of Rights and Freedoms*. Because Campbell J had ruled in his favour on non-constitutional grounds, however, the judge refrained from making a decision on the *Charter* argument.

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[1] *Mendez v Canada (Minister of Citizenship and Immigration)*, [2005] FCJ No 115, 2005 FC 111 (QL).

[2] *Immigration and Refugee Protection Act*. SC 2001, c 27, s 97(1)(b)(iv).

[3] Ibid. at s 113(a).

[4] Mendez at para 16.

[5] Ibid.

[6] Ibid.

Argentinean couple living with HIV denied Convention refugee status

On 25 January 2005, the Federal Court of Canada upheld an Immigration and Refugee Board (IRB) decision refusing to grant refugee status to an HIV-positive man and his same-sex partner.[1] Pablo Sergio Gonzalez and his partner, Nelson Horacio De-Robles, feared persecution by the government of Argentina because of Gonzalez's past political activity.

Gonzalez and De-Robles left Argentina for Canada on 27 October 2002 and made a claim for refugee status on 7 November 2002, based on their sexual orientation and political activities. Gonzalez provided evidence that in August of 2002 he began receiving death threats from paramilitaries, who threatened to kill him and his partner. In addition to his fear of political persecution, Gonzalez testified that after losing his job as a journalist in September 2001, he was unable to find another position due to discrimination stemming from his HIV-positive status

The IRB's decision to reject the claim was based on the perceived lack of credibility in Gonzalez's oral testimony. In recounting the details of his reasons for fleeing Argentina, Gonzalez often hesitated or made contradictory statements, particularly about the dates of events.

The applicants had argued that Gonzalez had suffered systemic discrimination in the workforce because he was HIV-positive. The IRB rejected this argument, pointing out that Gonzalez had managed to find a job as a bartender even though he could not find work in journalism. Further, the IRB held that even if the testimony had been credible, the Argentinean state was capable of protecting the applicants from persecution .

In their appeal, Gonzalez and De-Robles claimed that the IRB had erred in failing to consider Gonzalez's HIV-positive status in analyzing the risk of persecution, and had made an error when assessing Gonzalez's credibility. Gonzalez claimed that hesitations in his testimony could be attributed to the side effects of his HIV medication, which include memory loss and drowsiness, and that the IRB did not consider this factor in evaluating his testimony.

Shore J of the Federal Court upheld the IRB's decision. He found that the Board had correctly concluded that the applicants had not demonstrated that Argentina was incapable of protecting them, as was required by the legal test for proving refugee status, and that this was determinative of the appeal. However, Shore J went on to consider the arguments put forward by Gonzales and De-Robles.

Shore J upheld the IRB's finding that Gonzalez had suffered systemic discrimination in the workforce because of his HIV status. He also upheld the IRB's findings with respect to credibility. In Shore's view, the failure to take the effects of the medication into account was not an error sufficient to overturn the decision.

He pointed out that Gonzalez had testified clearly throughout his entire hearing, except with regard to the discrepancies seized upon by the IRB. He also noted that the IRB is given great latitude in assessing an applicant's credibility, based on its observations at the hearing.

[1] *De-Robles v Canada (Minister of Citizenship and Immigration)*, [2005] ACF no 135, 2005 FC 108 (QL).

Landlord found to have discriminated based on HIV status

The British Columbia Human Rights Tribunal (the Tribunal) has allowed a claim for discrimination against a Vancouver landlord who refused to rent an apartment to a couple, both of whom were living with HIV/AIDS.[1]

Bruce McDonald and his partner Ron Sabey were seeking an apartment in the city's West End. When McDonald telephoned Peter Dobrovich-Schuster, president of Schuster Real Estate Co. and owner of the rental suite, the landlord asked McDonald what he and his partner did for a living.

Upon being told they were on disability pensions, the landlord asked what the disability was, and before McDonald could answer, said that he "hoped it was not AIDS because he had no intention of running a hostel."[2] McDonald testified that he was taken aback by this statement, but nonetheless made arrangements to meet with Dobrovich-Schuster and examine the apartment.

The meeting was conducted in the landlord's office. He sat behind a desk, and directed McDonald and Sabey to sit on a couch off to the side, despite the fact that there were two chairs directly in front of the desk. McDonald testified that he had the impression that the landlord was afraid of catching something from them. Sabey testified that that the landlord's attitude toward them "made him feel like they were pariahs or lepers."[3]

McDonald assured the landlord during the meeting that they would be able to pay the rent through a provincial subsidy that Sabey received. The landlord said that he would get back to them, but did not call and had no further contact with either McDonald or Sabey.

McDonald filed a complaint with the Human Rights Tribunal on 6 January 2003, under section 10 of the B.C. *Human Rights Code* (the *Code*). Section 10 of the *Code* provides that: "[A] person must not … deny to a person or class of persons the right to occupy, as a tenant, space that is represented as being available for occupancy by a tenant … because of the ... physical or mental disability ... of that person or class of persons."[4]

The Tribunal had decided in a previous case that being HIV-positive or having AIDS was a physical disability for the purposes of the *Code*.[5] McDonald provided medical evidence that he suffered from HIV/AIDS. Having done so, in order to prove discrimination under the *Code* he only needed to establish that his disability was one of the factors in the landlord's decision to refuse to rent the apartment to McDonald.

In his written response to McDonald's complaint, the landlord stated that he did not rent to McDonald and Sabey because they were "unkempt" and he was afraid of losing existing tenants in the building. He also wrote that he found them dubious potential tenants because of their willingness to rent the suite despite the fact that it was dirty and in need of repairs. The couple testified that landlord's comments on their appearance were groundless, and that they had never indicated an intention to rent the suite "as is." A neighbouring building manager testified that the building was generally in poor condition and that many of its tenants were noisy and disorderly.

The Tribunal did not accept the landlord's version of events, finding no evidence disputing the couple's account of the landlord's comment about not wanting to rent to persons with AIDS, or of his conduct at the meeting with them. The Tribunal concluded that the landlord did not want to rent to McDonald and Sabey because he believed they were HIV-positive. Tribunal member Junker further stated:

> [I]f I am required to assess …whether Schuster's conduct was demeaning of Mr. McDonald's dignity, I have no difficulty concluding that this is the case. The refusal to rent to a person because they have AIDS is the kind of discriminatory conduct that the Code aims to eradicate.[6]

The Tribunal awarded CA$2,500 in damages to the claimant for injury to dignity, feelings and self-respect. Further, the Tribunal ordered the real estate company to cease its contravention of the *Code*, and to refrain from committing the same or similar contravention(s).

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[1] *McDonald v Schuster Real Estate Co.*, [2005] BCHRTD No. 177, 2005 BCHRT 177 (QL).

[2] Ibid. at para 6.

[3] Ibid. at para 9.

[4] *Human Rights Code*. RSCB 1996, c 210, s 10.

[5] *Trudeau v Chung*, (1991) 16 CHRR D/25 (BC Human Rights Council).

[6] *McDonald* at para 27.

Supreme Court finds settlement money attributable to past disability benefits taxable

The Supreme Court of Canada recently held that the portion of a lump sum settlement from a lawsuit attributable to past disability insurance benefits should be included as taxable income.[1]

Vasiliki Tsiaprailis was receiving long-term disability benefits through her employer's insurance policy. When the insurance company terminated her benefits, Tsiaprailis sued for a continuation of these benefits. The parties reached a settlement. Tsiaprailis received a lump sum payment of CA$105,000. This amount represented her entitlement to past benefits under the insurance plan, 75 percent of the present value of her future benefits, and an amount for costs, disbursements and GST. For the 1996 taxation year, Revenue Canada assessed these monies as taxable income.

Tsiaprailis appealed the assessment in the Tax Court of Canada in 2002, arguing that the settlement payment did not meet the criteria of "amounts received by the taxpayer in the year that were payable to the taxpayer on a periodic basis in respect of the loss of … the taxpayer's income from an office or employment, pursuant to … a disability insurance plan" under the *Income Tax Act* (the *Act*).[2] The trial judge found that a lump sum payment stemming from a lawsuit could not be described as an amount "payable to the taxpayer on a periodic basis."[3]

The majority of the Federal Court of Appeal disagreed, deeming the portion of the settlement that was attributed to past disability benefits to be taxable. The Court said that although the arrears were in the form of a lump sum payment, they were "payable … on a periodic basis" because the insurance policy defined them as such.[4]

The Supreme Court of Canada upheld the Federal Court decision. Charron J, writing for the majority found that tax treatment is dependent on the nature and purpose of the payment. The determinative factors were what the payment was intended to replace, and whether the amount, had it been paid under the policy, would have been taxable in the recipient's hands. In this case, part of the settlement monies were intended to replace past disability payments, and such payments – had they been paid to Tsiaprailis – would have been taxable under the *Act*.

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[1] *Tsiaprailis v Canada*, [2005] SCJ No 9, 2005 SCC 8 (QL).

[2] *Income Tax Act*. RSC 1985, c 1 (5th Supp), s 6(1)(f)(ii).

[3] *Tsiaprailis* at para 33.

[4] Ibid. at para 35.

Criminal law and HIV transmission or exposure: one new case

HIV-positive man receives three years in prison for unprotected sex

The Ontario Court of Justice has sentenced a man to three years in prison for engaging in unprotected sex after being alerted by health authorities that he was HIV-positive.[1] Donald Scott DeBlois pleaded guilty to attempted aggravated assault for having unprotected sex with a woman on two occasions without disclosing his HIV-positive status. The woman has since tested positive for HIV.[2]

Getliffe J of the Ontario Court of Justice stressed the importance of sending a message of deterrence

through sentencing in HIV transmission and exposure cases. He pointed out that the victim's life "has essentially been ruined" and that the seriousness of DeBlois' actions in ignoring the advice of health authorities must be considered.[3] An additional aggravating factor was DeBlois' past criminal record, which included counts of break and enter, robbery and breach of court orders.[4]

Mitigating factors in the sentence were DeBlois' guilty plea, which allowed the victim to avoid testifying at trial, his obvious remorse, and the fact he had started performing community work educating others about the dangers of unprotected sex.[5]

[1] *R v DeBlois*, [2005] O.J. No. 2267 (QL)

[2] P Geigen-Miller. Sex nets HIV carrier three-year jail term. *London Free Press*, 17 February 2005.

[3] *DeBlois* at para 8.

[4] P Geigen-Miller.

[5] *DeBlois* at paras 4, 10.

Court affirms that severance exclusion for workers with disabilities violates Charter

The Ontario Court of Appeal has upheld a lower court decision declaring a severance provision of the provincial *Employment Standards Act* (the *Act*)[1] to be unconstitutional.[2] Section 58(5)(c) of the *Act*, which denies severance pay to employees whose jobs are terminated due to illness or injury, was found to be of no force and effect by the Ontario Divisional Court in January 2004.[3] On 4 May 2005, the Court of Appeal affirmed that the provision contravenes section 15(1) of the *Canadian Charter of Rights and Freedoms*.

The case arose when the Ontario Nurses' Association filed a grievance on behalf of its member, Christine Tilley, a nurse who was unable to continue work due to illness. The labour arbitration board found that the denial of severance benefits to Tilley was based on the non-viability of her employment contract rather than her disability, and thus did not contravene her equality rights.

On judicial review, the Divisional Court disagreed with the board's ruling and held that the severance provision imposed a disadvantage upon disabled persons and constituted unjustifiable discrimination under the *Charter*.

At the Court of Appeal, the employer argued that the dominant purpose of severance pay is to compensate terminated employees who remain in the workforce, which accords with the denial of severance pay to employees whose work is terminated because of illness or injury.

However, the Court did not accept these arguments, finding that the assumption that employees whose contracts have been frustrated due to disability will never work again is "based on an impermissible stereotype that disabled persons cannot fully participate in the workforce."[4] The Court pointed out that Tilley was able to find new employment following her termination by the hospital.

The discriminatory impact of the severance provision could not be justified under section 1 of the *Charter*, as its objective was not found to be sufficiently compelling to override the right of disabled persons to equal treatment in employment. Nor was there a rational connection between the objective of granting severance pay to employees who will rejoin the workforce, and a law denying such benefits to employees with disabilities.

[1] *Employment Standards Act*. RSO 1990, c E14, s 58(5)(c).

[2] *Ontario Nurses' Association v Mount Sinai Hospital*, [2005] OJ No 1739 (QL).

[3] *Ontario Nurses' Association v Mount Sinai Hospital*, (2004) 69 OR (3d) 267. For further information, see A Ketter. Severance provisions of old Ontario employment standards legislation infringe Charter equality rights of persons with disabilities. *HIV/AIDS Policy & Law Review* 2004; 9(3): 55-56.

[4] *Ontario Nurses' Association* [2005] at para 26.

In brief

Tribunal finds Québec ministry's refusal to cover HIV medication "not a serious question"

A person living with HIV has unsuccessfully challenged a decision by the Régie de l'assurance maladie du Québec (RAMQ) denying him coverage for an HIV medication.[1] BB was seeking reimbursement for Tenofovir, which he was taking because a different drug, Combivir, had caused him to experience side effects such as vomiting, diarrhea, insomnia, loss of appetite, fatigue, weight loss and depression. Combivir contains two nucleoside reverse transcriptase inhibitors (NRTIs): AZT and lamivudine. BB's physician indicated that her patient had experienced intolerance to AZT, one of the medications in Combivir.

On 24 December 2004, BB was informed that under the regulations he could not be reimbursed for Tenofovir unless he could demonstrate that he was intolerant to two different NRTIs or that two different NRTIs he was taking had proven to be ineffective. Since BB had only demonstrated intolerance toward AZT, he was told he did not qualify to receive coverage for Tenofovir.

On 6 January 2005, BB applied for a stay of the RAMQ's decision to the Tribunal administratif du Québec – Section des affaires sociales (the Tribunal). He also requested coverage for Tenofovir until such time as his appeal of the decision would be heard. The RAMQ responded to the application in writing, reiterating that the claimant's request could not be granted under their regulations.

The Tribunal stated that a RAMQ decision is effective unless a Tribunal member orders otherwise by reason of urgency, or due to the risk of serious and irreparable harm.[2] To grant interim relief, a court or tribunal must be satisfied that there is "a serious question to be tried as opposed to a frivolous or vexatious claim."[3] Given the evidence of BB's physician that he had only had difficulty with one NRTI, the Tribunal found that there was not a "serious question," and rejected the application for interim relief.

Red Cross pleads guilty to distributing tainted blood

On 30 May 2005, the Canadian Red Cross Society pleaded guilty to distributing blood infected with HIV and hepatitis C during the 1980s.[4] The organization was fined CA$5000 – the maximum penalty for violating the *Food and Drugs Act*.[5] In addition, the Red Cross will set aside US$1.2 million for a medical research project and for scholarships for family members of the patients.

Dr Pierre Duplessis, Secretary-General of the Red Cross, accepted responsibility on behalf of the agency for the distribution of the tainted blood, stating that the Canadian Red Cross was "deeply sorry… for the suffering caused to families and loved ones of those who were harmed."[6]

The Red Cross, which once managed the Canadian blood system, had also been charged with criminal negligence and common nuisance in failing to properly screen blood donors, failing to test blood properly, and failing to warn the public that there were risks associated with blood products. These criminal charges were dropped in exchange for the guilty plea under the *Food and Drugs Act* and the public apology.

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[1] *BB v Régie de l'assurance maladie du Québec*, 2005 QC Trib 1354 (Tribunal administratif du Québec).

[2] *An Act respecting the administration of justice*. RSQ, c J-3, s 107.

[3] *Manitoba (AG) v Metropolitan Stores*, [1987] 1 SCR 110, at para 32.

[4] Canadian Red Cross pleads guilty in tainted-blood scandal that infected thousands. Associated Press, 30 May 2005.

[5] Tainted blood scandal. *CBC News* (online), 30 May 2005.

[6] Canadian Red Cross.

HIV/AIDS IN THE COURTS – INTERNATIONAL

This section presents a summary of important international cases relating to HIV/AIDS or of significance to people living with HIV/AIDS. It reports on civil and criminal cases. Coverage is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the *Review*. Coverage of US cases is very selective, as reports of US cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of Glenn Betteridge, editor of this section, at gbetteridge@aidslaw.ca.

Australia: HIV-positive visa applicants successfully appeal refusals based on medical inadmissibility

Two visa applicants have successfully appealed decisions to refuse their applications on the basis of medical inadmissibility, claiming that their HIV status does not present significant costs to the Australian health care system.[1]

Australia's Migration Regulations provide that in order to be granted visas, applicants must be free from a disease or condition that will "result in a significant cost to the Australian community in the areas of health care and community services."[2] However, the Minister for Immigration and Multicultural Affairs may waive these requirements if he or she is "satisfied that the granting of the visa would be unlikely to result in … undue cost to the Australian community."[3]

In the first case, the applicant had applied for an Extended Eligibility

(Temporary) (Class TK) visa on the basis of his marriage to an Australian woman. The Medical Officer of the Commonwealth (MOC) had given an opinion estimating that the visa applicant's lifetime costs for treating HIV infection would be nearly AUS$250,000 (approximately US$190,000) and argued on this basis that the applicant was inadmissible.

On the basis of the MOC's decision, the application was denied. The applicant contested the decision before Australia's Migration Review Tribunal (the Tribunal). He submitted reports from his doctor stating that his health was stable, that he was responding well to antiretroviral treatment, and that he was able to work full-time. He also argued that the cost of HIV is rapidly declining and that treatment is extending people's lives.

The Tribunal found that the term "undue cost" may incorporate consideration of compassionate factors and compelling circumstances. Reference was made to the discrimination and lack of access to treatment faced by people living with HIV/AIDS in the applicant's home country.

The Tribunal also considered the interests of the applicant's step-daughter, and found that they would be best served by her continuing to live with the visa applicant , with whom the child had developed a strong father-daughter relationship. The applicant's case was further bolstered by written declarations by family and friends that he was "well regarded in the community," and that he contributed to the Australian economy by working two jobs.[4]

The second applicant was a Zambian doctoral candidate who appealed his student visa refusal to the Federal Court of Australia. The MOC's opinion stated that management of the applicant's condition entailed a significant ongoing cost.[5]

The applicant submitted that the MOC's opinion was invalid because it failed to identify how the MOC had reached the conclusion, and because the MOC had assessed the situation of a hypothetical HIV patient rather than that of the applicant himself. The applicant argued that due to its invalidity, the Tribunal was not bound to apply the MOC's opinion.[6]

Finkelstein J emphasized that the regulation does not require the MOC to assess anything beyond "a hypothetical person who suffers from HIV."[7] However, the MOC's assessment was deemed invalid because it overlooked the fact that the applicant was paying for and self-administering his medication. Thus, the only cost borne by the Australian health care system was the quarterly monitoring of the applicant's immune function and viral load: an estimated AUS$4279 (approximately US$3255) over four years, which falls within the lower range of costs incurred by the average citizen.

Comment

The Australian tribunal's willingness to incorporate humanitarian and compassionate considerations into the notion of "undue cost" is significant. Balancing costs against contributions is fair and just. For many people, HIV infection can be managed with medical care and treatment, allowing them to continue to participate in the community. The applicant's expected contributions to domestic and household work (including caring for dependents), expected contributions to community services, and expected contributions to educational, scientific or cultural life should all be taken into account.[8]

However, even under Australian law, these humanitarian and compassionate considerations are an exception to the general rule of medical inadmissibility of HIV-positive applicants. The positive contributions are only taken into account in deciding whether to issue a *discretionary* waiver *after* an HIV-positive individual has been determined to be medically inadmissible. Australia (and other jurisdictions with similar medical inadmissibility legislation, such as Canada) should reform immigration law to incorporate positive contributions into the legislative test for determining medical inadmissibility.[9]

– Sarom Bahk

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[1] *Amanda MacDonald (Member)*, [2005] MRTA 103 (9 February 2005) (Australian Migration Tribunal); *v Minister for Immigration and Multicultural and Indigenous Affairs*, [2005] FCA 429 (Federal Court of Australia).

[2] *Migration Regulations* 1994 (Cth), sch 4, cl 4005(c)(ii)(a) and cl 4007(1)(c)(ii)(a).

[3] *Migration Regulations* 1994 (Cth), sch 4, cl 4007(2)(b).

[4] at para 48.

[5] Ibid. at para 3.

[6] Ibid. at para 6.

[7] Ibid. at para 14.

[8] See Canadian HIV/AIDS Legal Network. *Brief to the Standing Committee on Citizenship and Immigration: Immigration and Refugee Protection Regulations.* January 2002. Available via www.aidslaw.ca/Maincontent/issues/Immigration/BriefonImmigrationRegulations.htm.

[9] For example, see Canada's *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. See also B Mysko. Appeal board overturns decision denying Zambian admission to Canada. *HIV/AIDS Policy & Law Review* 2004; 9(3): 54-55.

UK: House of Lords upholds deportation order

On 5 May 2005, the House of Lords rejected a 30-year old HIV-positive woman's appeal of her deportation order. The woman had argued that expelling her to Uganda, a country where access to HIV medication and medical care was uncertain, constituted a violation of guarantees against inhuman treatment in the *European Convention* (the *Convention*). The House of Lords ruled that deporting an HIV-positive asylum seeker is not a violation of *the Convention* absent "exceptional circumstances."[1]

The appellant traveled to the United Kingdom in 1998 and was diagnosed as HIV-positive with an AIDS-defining illness upon arrival. Thanks to ongoing medical care and medication, her condition stabilized over several years. The appellant's claim for asylum was based on her experience being kidnapped and raped by members of both the rebel Lords Resistance Army and a faction of the Ugandan security forces.

The Secretary of State refused the application for asylum. An adjudicator allowed an appeal, holding that her expulsion would be a breach of article 3 of the *Convention* which states, "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."[2] After several levels of appeal, the case was heard by the House of Lords.

The House of Lords identified the question before it as whether expelling the appellant would constitute inhuman treatment within article 3 given the uncertainties in accessing necessary drugs and medical care in Uganda.[3] Domestic law required the Court to interpret European Court of Human Rights (the European Court) jurisprudence; the Lords noted, "We must take its case law as we find it, not as we would like it to be."[4]

The Lords focused their analysis on the decision in *D v United Kingdom*, where the European Court relied on article 3 to overturn an order to deport a person living with HIV/AIDS to St. Kitts.[5] According to the Lords, this case enunciated two fundamental principles. First, states have the right to control the entry, residence and expulsion of aliens. Second, aliens facing deportation cannot claim an entitlement to remain in the state in order to benefit from continuing medical or other assistance.

However, in exercising the right to expel an alien, a state must not violate article 3. The original scope of this article embraces both illegal activities in the deporting country and action in the receiving country undertaken or implicitly supported by public authorities. In *D v United Kingdom*, the European Court held that the scope of article 3 could be extended to address other medical or humanitarian concerns only in "exceptional circumstances." The central question was whether the appellant's circumstances qualified as exceptional using the European Court's jurisprudence.

While the Lords agreed that the imminence of death constituted the exceptional circumstance in *D v United Kingdom* and subsequent cases, each relied on somewhat different reasoning. Lord Hope articulated the test for an exceptional circumstance in terms of preventing suffering in death:

> It would need to be shown that the applicant's medical condition had reached such a critical stage that there were compelling humanitarian grounds for not removing him to a place which lacked the medical and social services which he would need to prevent acute suffering while he is dying.[6]

Baroness Hale emphasized dignity over suffering, asking

> whether the applicant's illness has reached such a critical stage (i.e. he is dying) that it would be inhuman treatment to deprive him of the care which he is currently receiving and send him home to an early death unless there is care available there to enable him to meet that fate with dignity.[7]

Finally, Lord Nicholls reframed the issue to conform to the principle that aliens facing deportation cannot claim an entitlement to remain in order to benefit from medical assistance: The imminence of an applicant's death is an exception because letting him or

her stay imposes few additional burdens on the health system.[8]

In this case, the court found the appellant to be healthy. Since her death was not imminent, her situation was not deemed exceptional. The Court denied the appeal, but noted that the Home Secretary could exercise discretion and not deport her.

Comment

The House of Lords' ruling represents a significant obstacle for failed HIV-positive asylum seekers who come from countries where access to HIV antiretroviral medication and treatment is poor and who wish to remain in the UK.

Three points from the ruling stand out. First, the availability of treatment and health care in the applicant's country of origin are virtually irrelevant to the *European Convention* article 3 rights. While Lord Nicholls recognized that the problem was rooted in the disparity of access to medical care in different countries in the world, this is not an issue under article 3.[9] Lord Hope concluded simply that "the fact that the treatment may be beyond the reach of the applicant in the receiving state is not to be treated as an exceptional circumstance."[10]

Second, only those applicants who are gravely ill despite medical care will be able to take advantage of article 3. While recognizing that apparently healthy individuals may rapidly deteriorate upon deportation, the Lords held that a deportation will only violate *European Convention* article 3 rights where the applicant is in the final stages of a terminal illness.

Lord Hope noted that the only reason why the appellant was not near death, as required under the "test," was because she was receiving antiretroviral medication in the UK. Once this "life support machine" was turned off, she would face suffering and early death. He resolved the problem by focusing narrowly on the principle that aliens facing expulsion may not claim any entitlement to medical or other assistance in the UK.[11]

Third, domestic resource considerations trump larger humanitarian policy concerns. The Lords' decision is firmly grounded in narrow domestic policy and economic rationales. Lord Brown described the choice as deporting the appellant to early death versus allowing her to stay

> at the expense of that state – an expense both in terms of the cost of continuing treatment … and any associated welfare benefits, and also in terms of immigration control and the likely impact of such a ruling upon other foreign AIDS sufferers aspiring to these benefits.[12]

Lord Nicholls concluded, "[A]rticle 3 cannot be interpreted as requiring contracting states to admit and treat AIDS sufferers from all over the world for the rest of their lives."[13]

– Katie Gibson

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[1] *N (FC) v Secretary of State for the Home Department* (2005), UKHL 31.

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

[3] *N (FC)* at para 8 (Lord Nicholls), para 23 (Lord Hope), para 59 (Baroness Hale), and para 74 (Lord Brown).

[4] Ibid. at para 25 (Lord Hope).

[5] *D v United Kingdom* (1997), 24 EHRR 425.

[6] *N (FC)* at para 50. Lord Brown concurred on this test.

[7] Ibid. at para 69.

[8] Ibid. at para 15.

[9] Ibid. at para 18.

[10] Ibid. at para 50.

[11] Ibid.

[12] Ibid. at para 92.

[13] Ibid. at para 17.

Sweden's compulsory confinement order declared a violation of liberty guarantee

On 25 January 2005, the European Court of Human Rights unanimously held that the Swedish government violated an HIV-positive man's right to liberty when it placed him under a detention order for several years.[1]

In 1994, Eie Enhorn was diagnosed with HIV and it was determined that he had infected another man with the

virus. Sweden's 1988 *Infectious Diseases Act* empowers county medical officers to mandate restrictions on the activities of individuals with certain diseases who are deemed a danger to society. Swedish authorities mandated that Enhorn always disclose his status to sexual partners, use condoms and limit his alcohol intake to avoid impairing his judgment.

Several months later, the county medical officer petitioned the County Administrative Court for an order for compulsory isolation, arguing that

> [t]he applicant may not presently be sexually active, but history has shown that when the opportunity arises he is likely to have sexual relationships…. he does not want to change his conduct and he distorts reality in such a way that he is never to blame for anything.[2]

The Court ordered Enhorn to be confined, and prolonged its confinement order in subsequent judgments. One such judgment was upheld by the Administrative Court of Appeal. Overall, the detention orders were in effect for almost seven years, during which time Enhorn was confined in hospital for a total of one and a half years and lived in hiding for the remainder of the time.

Enhorn challenged the confinement orders in an application to the European Court of Human Rights. He claimed that the compulsory isolation and confinement orders unlawfully deprived him of his liberty within the meaning of Article 5 § 1 of the *European Convention on Human Rights*.[3] Both parties agreed that the orders amounted to a "deprivation of liberty" and that such a deprivation was provided for in Article 5 § 1 (e) which allows "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants." The issue before the Court was whether Enhorn's detention was "lawful."

The Court acknowledged having "only to a very limited extent decided cases where a person has been detained 'for the prevention of the spreading of infectious diseases.'"[4] Therefore, it established new criteria to assess whether a detention was lawful, asserting that a detention is lawful where the spread of the disease is dangerous for public health and safety and where detention is used as a last resort. According to the Court, these criteria ensure that the law complies with the principle of proportionality and is free from arbitrariness.

In this case, the Court held that HIV does indeed constitute a danger to public health. However, the Court said that it was not possible to conclude that the repeated confinement orders were employed "as a last resort" because the Swedish government did not provide "any examples of less severe measures which might have been considered for the applicant in the period from 16 February 1995 until 12 December 2001, but were apparently found to be insufficient to safeguard the public interest."[5] In addition, the overall duration of the confinement orders showed that "the authorities failed to strike a fair balance between the need to ensure that the HIV virus did not spread and the applicant's right to liberty."[6] Enhorn was awarded non-pecuniary damages of _12,000 (approximately US$14,400), costs and expenses.

Comment

This is the first time that the European Court of Human Rights has examined in detail a deprivation of liberty for the purposes of preventing HIV transmission. The case sets a precedent for using human rights guarantees of liberty to scale back wide-ranging isolation and confinement regimes, limiting the power of public health authorities. Moreover, the Court's approach demonstrates the need to balance private freedoms against public health benefits.

– Katie Gibson

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[1] *Enhorn v Sweden* (2005), Strasbourg Application no. 56529/00.

[2] Ibid. at para 11.

[3] *[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 5.

[4] *Enhorn* at para 41.

[5] Ibid. at para 49.

[6] Ibid. at para 55.

UK: Legal action on needle exchange programs in prisons dismissed

In April 2005, a judicial review application against the UK Home Secretary for his failure to introduce needle exchange programs in prisons in England and Wales was dismissed by a judge at the Royal Courts of Justice (Administrative Court Division).[1]

The legal proceedings were initiated in November 2004 by prisoner John Shelley, who was detained at HMP Long Lartin (near Evesham). Shelley claimed that prisoners who injected drugs were at high risk of becoming infected with blood-borne viruses, especially HIV and hepatitis B and C, by having to share dirty needles with other prisoners.

It was argued in the application for judicial review that the failure to provide prisoners with clean needles violates articles 2, 3 and 8 of the *European Convention on Human Rights*. These articles deal, respectively, with the right to life, the prohibition of inhuman or degrading treatment, and the right to privacy. The prisoner's application followed the introduction of Prison Service Instruction 53/2003, which provided that disinfecting tablets were to be made available to prisoners as of 1 April 2004.

The issues raised by the application for review were:

- whether the failure to provide needle exchange programs represents a failure to take reasonable steps to prevent a real and immediate risk to life;
- whether the failure to provide needle exchange programs represents a failure to provide adequate health care to address the risk of transmission of blood-borne viruses (especially HIV and hepatitis C); and
- whether adequate justification has been provided for the failure to provide needle exchange programs.

The application relied on:

- the UK Department of Health's commitment to the principle of equity that prisoners should receive the same range and quality of services as the general public (this commitment was acknowledged by the Department of Health when it took over the administration of health care in prisons);
- evidence that disinfecting tablets are not are not as effective as clean needles to protect against the transmission of blood borne viruses (a view shared by the UK Department of Health);[2]
- the availability of needle exchange programs in nearly all health authorities in England and Wales, which have proved to reduce the risk of cross-infection of blood borne viruses such as HIV and hepatitis B and C among injecting drug users; and
- evidence that needle exchange programs in prisons have been effective in reducing risk behaviour and disease transmission, do not endanger staff or prisoner safety (needles were not being used as weapons), and do not increase drug consumption or injecting.[3]

Despite these arguments, the application for judicial review of the policy was dismissed. The judge was satisfied that the Home Office had showed that they had considered the issues and that it was within their discretion to consider that needle exchanges should not be introduced.

The judge placed significant weight on security concerns (i.e., the risk that inmates would use needles to assault other inmates or prison officers) despite the fact that the Home Office produced no evidence for this and did not really refer to the matter in its arguments.

Due to funding issues, it is uncertain whether the case will be brought to the Court of Appeal. If leave to appeal were allowed, a judgment in favour of the prisoner would require the Home Office to take harm reduction in prisons a step further, by at least introducing a trial program of needle exchanges.

– Delphine Valette

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[1] *John Shelley v The Secretary of State for the Home Department* (2005), Case No. CO/5613/2004.

[2] E Allison. Health officials and Prison Service clash over HIV-prevention scheme. *The Guardian*, 1 March 2004.

[3] R Lines et al. *Prison needle exchange: lessons from a comprehensive review of international evidence and experience.* Canadian HIV/AIDS Legal Network. 2004. Available at www.aidslaw.ca/Maincontent/issues/prisons/pnep/toc.htm.

Europe: Court declares admissible complaint about lack of medical assistance in Russian detention facility

On 3 March 2005, the European Court of Human Rights found admissible an application by Viktor Vasilyevich Khudobin,[1] a Russian national, who claimed that his arrest and detention by Russian authorities had violated several provisions of the *European Convention on Human Rights* (the *Convention*).[2]

In particular, the Court declared admissible Khudobin's claim that the inadequacy of medical treatment and inhuman conditions in the detention facility violated article 3 of the *Convention* which states, "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." Khudobin complained that authorities denied him assistance during an epileptic seizure, moved him from cell to cell, made him sleep on the floor, forcibly took a blood sample, and housed him with contagious patients with no regard for his particular vulnerability due to HIV.

Khudobin was arrested in an undercover operation, charged with drug trafficking on 30 October 1998, and transferred to a pre-trial detention facility. Over the course of the following year, Khudobin's family and lawyers made numerous requests on his behalf for a medical examination and submitted multiple applications for his release, citing his poor health.

Khudobin suffered from several diseases, including epilepsy, pancreatitis, pneumonia, viral hepatitis B and C, HIV and mental illness. He remained in detention until 11 November 1999, when the Butyrskiy District Court ended the criminal proceedings, ruling that he was criminally insane when he was alleged to have committed the crime.

While still in custody, on 29 October 1999, Khudobin filed an application with the European Court of Human Rights containing several claims. The Court declared admissible Khudobin's complaints about the inadequate medical treatment and inhuman conditions of detention, the length of his pre-trial detention, the slow review of his requests for release, and the reliance on evidence obtained as a result of police incitement.

The Court rejected other claims, finding them "manifestly ill-founded." Of particular interest is Khudobin's complaint that he had been infected with HIV in the pre-trial detention facility resulting in an infringement of *Convention* article 2, which states, "Everyone's right to life shall be protected by law."

The Court declared this part of the claim inadmissible since he had tested HIV-positive on the first day after his arrest. It also rejected Khudobin's allegations of ill-treatment on the day of his arrest, unlawful detention, impermissibly long criminal proceedings, and a violation of his right to prepare his defence.

The Court will schedule a hearing of those complaints it declared admissible.

– Katie Gibson

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[1] *Khudobin v Russia* (2005), Strasbourg Application no. 59696/00.

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

South Africa: Book publisher ordered to pay damages for disclosing women's HIV status

The High Court of South Africa has found that a book publisher violated the constitutional rights of three HIV-positive women by publishing their names and HIV-positive status.[1] In their claim, the women named as defendants the book's author, a prominent journalist, the book's subject, politician Patricia de Lille, and the publisher, New Africa Book Publishers.

The three women had participated in a clinical drug trial at Kalefong Hospital. They disclosed their names and HIV status during an investigation by an internal ethics committee at the University of Pretoria and a subsequent independent enquiry into whether the trial had violated the rules of informed consent. De Lille, a politician who has supported various HIV/AIDS advocacy efforts, assisted the trial participants in raising concerns about informed consent and subsequently received the ethics committee's report.

While the report was intended for limited circulation, nowhere did it indicate that its contents were confidential. When de Lille hired Charlene Smith, a prominent journalist, to write her biography, she provided her with a copy of the report. Smith included some of its contents in the book, including the names and HIV status of the three women.

The three women argued that de Lille, Smith and the publisher intentionally or negligently invaded their rights to privacy, dignity, psychological integrity and mental and intellectual well-being. The defendants argued that the women consented to their names being included in the report or that it was reasonable for any reader to assume such.

The Court's reasons for the decision are based on two principles of South African law. First, the right to privacy includes the entitlement to decide when and under what conditions private facts may be made public. Second, the intention to injure (*animus injurandi*) was presumed upon the book's publication in 2000.

The Court asked whether each defendant had acted reasonably in disclosing the private information, thereby rebutting the inference of the intent to injure. The Court found that each had acted reasonably:

> The decisive factors in this part of the inquiry are that the disclosure of the Plaintiffs [sic] names and status was contained in what was to all intents and purposes the report of an official inquiry, commissioned by a public body into a matter of public interest. The author of the report is an eminent person. There is nothing in the report, or the covering letter enclosing a copy of it, to suggest that any part of it, and particularly the Plaintiffs names and status, was confidential.[2]

On the facts, the Court further found that none of the defendants had acted negligently at the moment that the book was published. Thus, the claims against the de Lille and Smith were dismissed and the plaintiffs were ordered to pay costs.

The Court noted, however, that the plaintiffs had a continuing right to privacy that permitted them to "determine the destiny of private facts."[3] Thus, they had a valid claim against the publisher for damages subsequent to the book's publication. In assessing damages, the Court concluded that "the Plaintiffs fears of a likelihood that the disclosure of their status in the book will lead to this fact becoming well known is more imagined than real."[4]

The Court took into account the facts that nobody had yet confronted them because of the disclosure and that the readership of political biographies is limited and "unlikely to include people with whom the Plaintiffs come into regular contact or may come into contact."[5] The publisher was ordered to delete the unauthorized references in the unsold copies of the book and pay each plaintiff damages of 15,000 rand (approximately US$2230) and costs.

– Katie Gibson

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[1] *NM, SM and LV v Charlene Smith, Patricia de Lille and New Africa Books* (2005) 02/24948 (High Court of South Africa, Witwatersrand Local Division). Full text of the judgment is available via www.alp.org.za.

[2] Ibid. at para 40.2.

[3] Ibid. at para 42.

[4] Ibid. at para 51.

[5] Ibid. at para 51.3.

Criminal law and HIV transmission or exposure: four new cases

UK: Man sentenced to prison term; conviction of second man upheld

On 23 March 2005, Mohammed Dica was sentenced to four and a half years in prison on a charge of recklessly causing grievous bodily harm. Dica, an HIV-positive man from south-west London, was charged after a partner alleged that Dica had convinced her to have unprotected sex with him without informing her of his HIV status.

This was Dica's second trial on the charge; at the first, he was accused of committing grievous bodily harm against two women. In an appeal of his original conviction of October 2003, he was granted a new trial because the judge at first instance failed to consider the consent of the complainant to the risk of sexually transmitted infection as a valid defence. Dica's conviction represents the latest chapter in the first criminal case for HIV transmission in the UK.[1]

On 17 March 2005, the English Court of Appeal (Criminal Division) upheld the conviction of Feston Konzani for grievous bodily harm against three women.[2] Konzani failed to disclose to each of the three women his HIV positive status. Each consented to unprotected sex with him, and each contracted HIV. Konzani was sentenced to a total of ten years in prison for his convictions on each of the charges.

One of the grounds of appeal in this case was Konzani's contention that consent to unprotected sex with him amounted, by implication, to consent to all the risks associated with sexual intercourse. The Court rejected this proposition, clarifying that where one sexual partner knows of his or her HIV infection, his or her sexual partner must know of that infection for that partner's consent to be "informed." the Court said that concealment of the fact of being HIV positive in a sexual relationship amounts to deception.[3] The Court further held that such concealment is also reckless, which, if proved by the Crown, satisfies the intent requirement for the charge of grievous bodily harm in circumstances of HIV transmission via sexual intercourse.

Following *R v Dica*,[4] there is now no doubt that in the UK there is a positive duty on HIV-positive people to disclose their status to sexual partners prior to unprotected sex. While both *Konzani* and *Dica* address HIV transmission in these circumstances, the discussion of consent in *Konzani* does not mention whether the defence of consent could be valid in situations of HIV transmission where an HIV-positive individual does not disclose his or her status but uses a condom.

It is important to note, however, that Judge LJ emphasized that recklessness is fact-specific, meaning that all the relevant circumstances must be considered in each case.[5] Furthermore, in *Dica*, the Court held that "protective measures…taken by the appellant"[6] could be a defence to reckless transmission.

– Gord Cruess

Gord Cruess is a student at the McGill Faculty of Law, and a summer intern with the Canadian HIV/AIDS Legal Network.

See also the feature article in this issue on "The criminalization of HIV transmission in England and Wales: questions of law and policy."

France: Conviction upheld

On 4 January 2005, the Court of Appeal for Colmar upheld the conviction of Christophe Morat, France's first person to be found criminally liable for HIV transmission.[7] Morat had appealed two separate judgments against him for infecting two women with HIV without disclosing to them that he was HIV-positive.

Morat had engaged in unprotected sex with both women. One of these women committed suicide in November of 2004. In addition to his jail sentence, Morat was found civilly liable to each of the women for _230,000 (approximately US$285,000).

– Gord Cruess

Netherlands: Supreme Court overturns HIV-positive man's sentence

On 18 January 2005, the Supreme Court of the Netherlands ruled that an HIV-positive man had not committed attempted grievous bodily harm when he engaged in unprotected oral and anal without disclosing his HIV status.[8]

In 2003, the Court of Appeal in Arnhem sentenced the man to two years and three months for the grievous bodily harm offence, but acquitted him of attempted manslaughter.[9] Under Dutch law, proof of "conditional intent" is required to secure a conviction for grievous bodily harm. Intent exists where the accused person accepts that there was a "substantial possibility" that the harm would result from the act.

The Supreme Court found that although the accused created a risk of infection, the evidence did not prove that infection was a "substantial possibility." The Court cited expert medical evidence that the chance of HIV transmission where an HIV-positive male anally penetrates another person without a condom, as occurred in this case, is one in 500; the chance of infection from unprotected oral sex was much less.

The Court noted that "[i]t could be a different matter under unusual circumstances involving increased risk."[10] The Court emphasized that legislators, not courts, must consider the question of whether HIV-positive people who engage in unprotected sex should be punished without regard for the actual risk of transmission in the circumstances of a particular case, referred to by the Court as an "abstract endangerment offence."[11]

The Supreme Court quashed the sentence and referred the case to the Court of Appeal in Den Bosch for further consideration.

– Katie Gibson

[1] HIV man guilty of infecting lover. *BBC News*, 23 March 2005. For further information, see J Wells. UK: Court of Appeal orders retrial in UK's first HIV criminal transmission case. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 62-63; and G Holly. UK: Precedent-setting criminal conviction for grievous bodily harm. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 62.

[2] *R v Feston Konzani* [2005], EWCA Crim 706.

[3] Ibid. at para 42.

[4] *R v Dica* [2004], EWCA Crim 1103.

[5] Ibid. at para 43.

[6] Ibid. at para 11.

[7] P Benkimoun. La pénalisation de la transmission du sida fait à nouveau débat. *Le Monde* (online edition), 1 April 2005. For more on this decision, see B Mysko. France: First conviction for non-disclosure and transmission. *HIV/AIDS Policy & Law Review* 2004; 9(3): 64.

[8] *Prosecution Services v AA* (18 January 2005), The Hague AR1860 02659/03 (Supreme Court of the Netherlands).

[9] *Prosecution Services v AA* (30 June 2003), Arnhem 21/001435-03 (Arnhem Court of Appeal).

[10] *Prosecution Services v AA* (2005) at para 3.6.

[11] *Prosecution Services v AA* (2005) at para 3.7.

In brief

Australia: Refusal to provide tattooing services found not discriminatory

The Victorian Civil and Administrative Tribunal (the Tribunal) rejected a claim that a tattoo artist's refusal to provide service to a man living with HIV and hepatitis C violated Australia's 1995 *Equal Opportunity Act* (the *Act*). [1]

Geoffry Hay disclosed his HIV-positive and hepatitis C-positive status to Melbourne tattoo artist Danny Dubbeld when requesting a tattoo. Dubbeld refused to tattoo Hay. Hay complained that Dubbeld's denial of service violated the *Act*, which makes it unlawful to refuse to provide a service to another person because that individual has an infectious disease.

An exception in the *Act* allows a denial of service to protect the health or safety of any person. The Tribunal noted that the individual claiming the exception has the burden of proving that it was "reasonably necessary." Accordingly, "[t]he tribunal must ask itself whether a reasonable person *in the respondent's position* would have regarded it as necessary to refuse to provide the service in order to protect the health or safety of any person or the public generally."[2]

The Tribunal examined the concept of universal precautions from the health care field. That concept is based on the assumption that all patients carry infectious diseases and that their blood and bodily fluids should only be handled in accordance with precautions used to reduce the thereat of infection. A physician gave evidence before the Tribunal that universal precautions are an accepted practice in health care settings.

The Tribunal found that while "it would be wise for tattooists to take

universal precautions in the same way as the medical profession,"[3] tattooists do not have the same training as medical professionals and cannot be expected to meet this standard. Thus, "the analogy with health professions, whilst relevant, is not decisive when it comes to the circumstances that might make it reasonably necessary for a tattooist to refuse to provide a tattooing service."[4]

Balancing the rights and interests involved, the Tribunal determined that Dubbeld's refusal was reasonably necessary to prevent the risk of HIV infection. While the risk to Dubbeld of infection was low, the effect of infection on his health would be high. Moreover, the social utility of tattooing is low, especially when contrasted with the provision of medical services.

– Katie Gibson

Japan: High Court upholds health official's conviction on one charge, dismisses another

On 25 March 2005, the Tokyo High Court upheld a professional negligence conviction against Akihito Matsumura, former head of the biologics division of Japan's Health and Welfare Ministry.[5]

The Tokyo District Court had convicted Matsumura in the death of a patient who in 1986 was infected with HIV as a result of having been given a tainted blood product.[6] The original trial focused on whether Matsumura could have anticipated that unheated coagulants would cause HIV infection and whether he had authority to prevent their use.

The District Court ruled that he should have foreseen the consequences because he knew that at least five haemophiliacs had become infected by the end of 1985. The High Court agreed with this conclusion and upheld his suspended one-year prison sentence.

The High Court acquitted Matsumura on another professional negligence charge stemming from an infection that took place between May and June 1985. The Court ruled that only limited information was available on the transmission of HIV through blood products at that time.

In Japan in the 1980s more than 1,300 patients were infected with HIV through contaminated blood products, including one-third of the country's haemophiliacs. Matsumura has filed an appeal of his conviction with the Supreme Court. While Matsumura is the first central government bureaucrat to be convicted for a decision made in his professional capacity, a case against former presidents of a blood company is currently before the Supreme Court.

– Katie Gibson

New Zealand: Woman denied compensation for exposure to HIV

A New Zealand woman is appealing to the country's High Court two decisions that denied her Accident Compensation Corporation (ACC) payments.[7] Her claim was based on alleged mental injuries that arose after she found out her sexual partner was HIV-positive.

The ACC administers New Zealand's accident compensation scheme, which provides no-fault personal injury coverage for all citizens, residents and temporary visitors to New Zealand. The ACC defines personal injury as a physical injury, or a mental injury caused by a physical injury. A personal injury may be caused by an accident, a work-related gradual disease or infection, medical error or rare and severe complications from an operation, or mental injuries resulting from sexual assault or abuse.[8]

The woman did not contract HIV, but was diagnosed with post traumatic stress disorder resulting from the episode. Her partner was convicted of criminal nuisance in 1999 for failing to disclose to her his HIV status, presumably in the context of a sexual relationship. Criminal nuisance is not listed as a compensable crime under the ACC's schedule for compensation.

The woman lost her first appeal against the ACC's denial of compensation. In that appeal, her lawyer argued that the woman's partner was guilty of indecent assault, on the basis that consent to sexual intercourse is nullified when a sexual partner fails to disclose that he is infected with HIV, a life threatening disease. If this argument were to be accepted in her appeal to the High Court, the woman would be eligible for ACC compensation, and the case would set a precedent in New Zealand.

– Gord Cruess

China: Public health officials convicted of malpractice

In February 2005, two public health officials of the Inner Mongolia Autonomous Region were convicted

of malpractice for turning a blind eye to a hospital's illegal blood collection activities.[9] The hospital had been banned from carrying out blood tests because it lacked adequate infectious disease screening procedures. It nonetheless collected blood and provided blood transfusions to 30 patients. Eleven of them contracted HIV and two infected their spouses.

Li Zhanping, former director of the Qingshuihe County Public Health Bureau, received a three-year prison sentence, suspended for five years. His former deputy was sentenced to three years, suspended for four years. They were convicted under article 397 of China's criminal law, dealing with malpractice.

– Katie Gibson

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[1] *Hay v Dubbeld* (2005), VCAT Reference Number A286/2004.

[2] Ibid. at para 6.

[3] Ibid. at para 12.

[4] Ibid. at para 24.

[5] Court upholds tainted-blood conviction. *The Japan Times*, 26 March 2005.

[6] Ex-health official guilty in patient's AIDS death. *The Japan Times*, 29 September 2001.

[7] L Haines. HIV claim heads to High Court. *The New Zealand Herald* (online edition), 1 May 2005. Available via www.nzherald.co.nz.

[8] More information on New Zealand's accident compensation scheme and the ACC is available via www.acc.co.nz.

[9] D Fang. Officials sentenced, removed for dereliction. *China Daily*, 2 February 2005.