

HIV/AIDS POLICY & LAW REVIEW

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Injection drug use, HIV/AIDS and incarceration: evidence from the Vancouver Injection Drug Users Study

The reliance on law enforcement as the dominant drug policy approach has resulted in record incarceration rates in many countries. Human rights advocates and public health researchers have argued that the risks of HIV transmission resulting from injection drug use within Canadian prisons must be addressed. Despite a decade of advocacy and some progress made, this remains an urgent public health crisis.¹ In light of these concerns, researchers working with the Vancouver Injection Drug Users Study (VIDUS) have undertaken a series of studies specific to injection drug use and HIV/AIDS in prisons. This article summarizes the body of evidence generated via VIDUS, discusses briefly the related human rights implications, and concludes with recommendations for action.

Throughout North America, policy-makers have primarily responded to the HIV epidemic among injection drug users by allocating resources to criminal justice interventions. In Canada, an Auditor General's report in 2001 estimated that of the \$454 million spent annually on illicit drug control efforts, \$426 million (93.8 percent) was devoted to police enforcement and incarceration.²

While it is known that inmates typically inject illicit drugs less frequently than drug users in the community,^{3,4} studies have demonstrated that injections occurring in prisons are often carried out in a high-risk

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

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

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Comments?

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

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Injection drug use, HIV/AIDS and incarceration: evidence from the Vancouver Injection Drug Users Study

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fashion.^{5,6} Risk behaviours, such as syringe sharing, are known to occur,^{7, 8, 9, 10, 11, 12} and have resulted in outbreaks of hepatitis C (HCV) and HIV infection among injecting inmates in Scotland, Australia, Lithuania and Russia.^{13, 14, 15, 16, 17, 18}

The Vancouver Injection Drug Users Study (VIDUS)

Vancouver, one of Canada's largest urban centres, gained international attention following the emergence of an HIV epidemic documented among local injection drug users in the mid-1990s.^{19, 20} VIDUS was initiated in response to this epidemic. VIDUS is an ongoing open prospective cohort that began in 1996 and that has enrolled over 1500 injection drug users.²¹ At baseline and semi-annually, participants provide blood samples for diagnostic testing and complete an interviewer-administered questionnaire.

Data is gathered on demographics, drug use, incarceration, health, sexual activity and risk behaviours. The majority of VIDUS research participants have been to prison. At the time of their baseline interview, over 1000 participants reported being incarcerated since they first began injecting drugs,²² representing approximately 76 percent of the cohort. Close to one-third of this group, 351 people, reported that they had injected drugs while incarcerated.

Incarceration and HIV infection

Some of the first evidence demonstrating an association between incarceration and HIV infection among VIDUS participants was revealed in a paper by Tyndall et al. published in 2003.²³ Although this study focused on the strong dose-dependent association between cocaine injection and HIV infection, incarceration was found to be associated with HIV infection in an analysis that considered the effect of other known risk factors for HIV infection. Specifically, the study found that individuals who had recently been incarcerated were 2.7 times more likely to become HIV-positive than those who had not been to jail or prison.²⁴ However, this association was not fully evaluated in the study.

The association between HIV infection and incarceration noted in the Tyndall et al. study did raise significant concern. In a subsequent editorial, Holly Hagan conducted an external evaluation of attributable risks, and concluded that 21 percent of the HIV infections among injection drug users in Vancouver were likely acquired in prison.²⁵ While these findings were of great concern, they do not conclusively connect rising rates of blood-borne diseases among inmates to HIV risk behaviour and subsequent blood-borne disease transmission occurring within prisons, because the selection of infected

individuals out of the community may be an alternate explanation.

Incarceration and high risk syringe sharing

In order to further explore the association between HIV infection and incarceration, Wood et al.,²⁶ using data obtained via VIDUS, conducted additional longitudinal analyses examining syringe sharing in prisons. Specifically, the authors performed analyses of syringe lending by HIV-infected injection drug users and syringe borrowing by HIV-negative users.

The study provided evidence to support the conclusion that HIV may be spreading among injection drug users within the prison setting.

Among 318 HIV-positive VIDUS participants, having been incarcerated in the six months prior to each interview remained associated with syringe lending during this period.²⁷ Similarly, among 1157 HIV-negative VIDUS participants, having been incarcerated in the six months prior to each interview remained associated with reporting syringe borrowing during this period.²⁸

This study suggested that the earlier finding of Tyndall et al. cannot be easily explained by selection biases. Further, it provided evidence to support the conclusion that HIV may be spreading among injection drug users within the prison setting, since it was found that behaviours that can directly contribute to HIV infection were strongly associated with reporting incarceration during follow-up.

Experiences injecting drugs in prisons: qualitative evidence

A qualitative study conducted by Small et al., through VIDUS, provides further indication that syringe sharing within prisons is a significant public health concern.²⁹ The HIV risks experienced by former inmates were explored through 26 in-depth interviews conducted with VIDUS participants recently released from provincial and federal institutions. This work provides an understanding of the social context of the correctional environment and the injection-related HIV risks that exist.

This study confirmed accounts from as early as 1994 that injection drug use in prisons routinely involves syringe sharing.^{30,31} It also confirmed the previous reports that injecting within the prison environment is characterized by a pattern of syringe sharing among large networks composed of numerous individuals:

I've known syringes that have gone through 30-40 people's hands. I swear to God. They have been used by that many different people.³²

Let's think about the diseases that go around. I mean, I'm watching 15 guys fix off of one syringe. How do you know out of 15 guys you're shar-

ing with, are you saying that none of them have it [HIV]?³³

Further, the comments by individuals involved in this study suggested that policies within prisons contribute to the risks related to injecting in prison, since inmates are denied access to sterile syringes by correctional policies, and face disciplinary action if found in possession of needles:

It's a nightmare. Equipment like syringes are in very, very short supply. You see syringes that have literally been around for months and months, if not years.... I am sure that many, many cases of HIV were transmitted because of those practices ... sharing. Everybody shares.³⁴

This study also found that that the scarcity of syringes may also prompt HIV-positive inmates to hide their HIV status because such disclosure could greatly limit their access to the small number of syringes circulating within prisons:

I picked it up in the institute. Guys don't say they're positive on the inside because they don't want the guys to say, "well you're not using the fuckin' rig because you're HIV positive." I've run into so many guys [outside] that have sat there and said, "well I've been positive for 6 years." And I look at them and say, "well you told me you were fuckin' [HIV] negative in '98!" But... if everybody knows the guys is positive, I mean... they're not gonna let him use the syringe, right?³⁵

This study indicated that policies that limit access to syringes in prison serve to drive syringe sharing among inmates and increase risks for HIV and HCV infection. It should also be noted that study participants asserted

that the distribution of bleach is an incomplete solution because injecting is a prohibited behaviour within prisons and, therefore, lengthy decontamination procedures involving bleach are generally not undertaken by inmates in this environment. Other studies and evaluations of bleach programs in prisons reached the same conclusion.^{36,37}

Policies that limit access to syringes in prison serve to drive syringe sharing among inmates and increase risks for HIV and HCV infection.

Incarceration and the discontinuation of HAART among injection drug users

VIDUS researchers have also sought to evaluate the provision of highly active antiretroviral therapy (HAART) in prisons. It is well known that HAART has produced reductions in both AIDS-related morbidity and mortality among HIV-positive individuals who receive treatment.^{38,39} However, the optimism generated by this new approach has been tempered by concerns about inequitable access to HAART and low levels of adherence to these complex regimens.^{40,41}

Among those known to have low rates of access and adherence to HAART, and consequently poor HIV/AIDS-related health outcomes, are injection drug users.⁴² HIV-positive injection drug users have been found

to have lower uptake of antiretroviral therapy compared to other HIV-positive persons in Canada, the United States and Europe,^{43, 44, 45, 46, 47} and consequently higher rates of AIDS-related morbidity and mortality.⁴⁸

Also of concern are findings indicating that as many as 50 percent of injection drug users who initiate HAART discontinue therapy against medical advice.^{49, 50} These rates of discontinuation indicate potentially adverse outcomes for individual and public health due to the heightened risk for loss of virologic control and subsequent viral rebound,⁵¹ as well as the development of drug resistance and the transmission of resistant virus to others.^{52, 53}

In light of the ongoing problems associated with HAART discontinuation, Kerr et al. examined factors associated with discontinuation of HAART among 160 HIV-positive VIDUS participants.⁵⁴ In this analysis, incarceration was the strongest predictor of HAART discontinuation after consideration of all other competing factors, including intensity of drug use.⁵⁵

Among individuals who were taking HIV medications, those who had been incarcerated were 4.8 times more likely to discontinue HAART than those who had not been to prison. Although this study was limited by the fact that authors were unable to determine whether HAART had been discontinued prior to, during or following incarceration, it is important to note that 44 percent of participants who had discontinued HAART reported being in jail as the primary reason for discontinuing HAART.

Legal and human rights implications

Numerous international instruments address the rights of prisoners in the

context of the HIV epidemic, including the right to health.^{56, 57} Some of these instruments are laws, while others are international rules, standards or guidelines. It is important to distinguish between these types of instruments, since each has different implications for governments. International laws establish legal obligations binding on states that are signatories to an instrument, or on members of the body that enacted the instrument. Rules, standards and guidelines do not have the force of law and thus are not binding on governments.

Few international laws deal specifically or explicitly with the conditions of imprisonment, although both the *Universal Declaration of Human Rights* (1948)⁵⁸ and the *European Convention on Human Rights* (1950)⁵⁹ prohibit cruel, inhuman or degrading treatment or punishment. As well, the *International Covenant on Civil and Political Rights* (1966)⁶⁰ sets forth the right of persons deprived of their liberty to be treated with dignity and with respect for the inherent dignity of the human person (article 10[1]). Commenting on the effect of the *Covenant*, the Human Rights Committee (1989) stated that

the humane treatment and respect for the dignity of all persons deprived of their liberty is a basic standard of universal application which cannot depend entirely on material resources (Article 7)

and that

ultimate responsibility for the observance of this principle rests with the state as regards all institutions where persons are held against their will (prisons, hospitals, detention camps, correctional institutions).⁶¹

Although not legally binding on states, rules, guidelines and standards are nonetheless important because they express the moral and philosophical standards that should guide national administrators and courts, and often do so with a great deal of specificity. The international community has generally accepted that a set of minimum standards should apply to imprisonment, according to which prisoners retain all civil rights that are not taken away expressly or by necessary implication as a result of the loss of liberty flowing from imprisonment.

The right to health imposes a duty upon states to promote and protect the health of individuals and the community.

Access to HIV prevention, treatment and harm reduction programs implicates the right to health, given the evidence of their effectiveness at preventing severe harms associated with drug dependency, and injection drug use in particular. Numerous declarations and covenants provide that all people have a right to the highest attainable level of physical and mental health.⁶²

The right to health imposes a duty upon states to promote and protect the health of individuals and the community, including a duty to ensure quality health care. The right to health in international law should be understood in the context of the broad concept of health set forth in

the World Health Organization (WHO) constitution, which defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁶³

Like all other persons, prisoners are entitled to enjoy the highest attainable standard of health, as guaranteed under international law. Key international instruments reveal a general consensus that the standard of health care provided to prisoners must be comparable to that available in the general community. In the context of HIV/AIDS, comparable health services would include providing prisoners the means to protect themselves from exposure to HIV and other forms of drug-related harm.

Recommendations on HIV/AIDS in prisons developed by the international community and national governments consistently support “equivalence of treatment” of prisoners,^{64, 65} stress the importance of prevention of transmission of HIV in prisons, and suggest that prevention measures – including sterile syringes – be provided to prisoners. For example, Principle 9 of the *Basic Principles for the Treatment of Prisoners* states that “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”⁶⁶ As well, the 1993 *WHO Guidelines on HIV Infection and AIDS in Prisons* state that “[i]n countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release.”⁶⁷

Discussion

A growing body of research derived from VIDUS points to risks associ-

ated with injection drug use within prisons in British Columbia. In particular, these studies suggest that incarceration is associated with an increased likelihood of becoming HIV-positive, high-risk syringe sharing, and sub-optimal treatment of HIV-infection.

This body of evidence reinforces conclusions from elsewhere that there is a pressing need to implement and evaluate additional HIV prevention measures, such as prison-based needle exchange, in Canadian prisons, and points to the need for additional research and programs that seek to ensure optimal treatment of HIV among incarcerated injection drug users. Obviously, with respect to the latter, community diversion programs for non-violent drug offenders, rather than prison sentences, must be urgently evaluated for both HIV-negative and -positive users.

In recent years, public health researchers have increasingly recognized the role of environmental factors in influencing HIV risks among injection drug users.^{68, 69} The risks experienced by users are influenced by many factors including: the legality and availability of sterile injection equipment, law enforcement practices, drug market dynamics, the type of drugs consumed, specific injection practices employed and the availability of adequate addiction treatment.^{70, 71, 72}

The risk environment that exists within correctional institutions is far different than that experienced in the wider community, because it is characterized by policies that completely restrict access to sterile syringes and serve to promote high syringe sharing within large social networks. Recognizing the impact of law and policy upon the health of inmates highlights the potential of structural

interventions, such as policy reform, to modify these environmental conditions.⁷³ For example, the introduction of prison-based needle exchange would impact the risk environment within prisons by increasing the availability of sterile injection equipment and improving the ability of injection drug users to protect themselves from HIV.

This approach is consistent with the best available evidence, as well as international and national laws and guidelines. Numerous expert opinions have recommended that prison-based needle exchange be implemented in Canada, and evidence pertaining to syringe distribution programs among inmates has demonstrated positive impacts of these programs.^{74, 75, 76}

Evaluations of prison-based needle exchanges show a decline in syringe sharing, as well as no new cases of HIV or HCV among individuals participating in the programs.

Evaluations of prison-based needle exchanges have shown a decline in syringe sharing, as well as an absence of new cases of HIV or HCV among individuals participating in the programs. Staff attitudes towards prison-based needle exchange were reported to be positive, and needles were not used as weapons against guards or fellow inmates as originally feared.^{77, 78}

The negative impact of incarceration on HIV treatment for injection drug users has also been documented in other Canadian studies.⁷⁹ Although further study is needed to better understand the association between incarceration and discontinuation of HIV treatment, existing studies nevertheless indicate that renewed efforts are needed to enhance the quality of care for HIV-positive injection drug users who become incarcerated.

A rights-based analysis indicates that governments have an obligation to honour the principle of equivalence, which states that prisoners are entitled to same level of health care that is provided in the community. Further, prison administrators are obligated to honour international human rights laws and guidelines which require that the health of prisoners be fully protected. Access to HIV prevention, treatment and harm reduction programs implicates the right to health, given the evidence of their effectiveness in promoting health and preventing severe harms associated with injection drug use. The failure to provide these measures, as well as the practice of punishing those addicted to drugs, perpetuates the discrimination and stigmatization of a group of highly vulnerable members of society.

Conclusion

A growing body of research derived from VIDUS reveals the ongoing and unaddressed problems related to injection drug use and HIV/AIDS in Canadian prisons. These studies have demonstrated a strong connection between incarceration, syringe sharing, HIV infection and sub-optimal treatment of HIV/AIDS. This body of evidence reinforces previous calls for renewed efforts to modify

the conditions existing in prison environments in order to address the problems of injection drug use and HIV/AIDS among incarcerated injection drug users. In addition, community diversion programs for non-violent drug offenders, rather than ineffective prison sentences, must be urgently evaluated for both HIV-negative and positive users.

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Legal Network report calls for decriminalization of prostitution in Canada

In December 2005 the Canadian HIV/AIDS Legal Network released *Sex, work, rights: reforming Canadian criminal laws on prostitution*.¹ The report examines the ways in which the prostitution-related provisions of the Criminal Code, and their enforcement, have criminalized many aspects of sex workers' lives and have promoted their social marginalization. Evidence indicates that the criminal law has contributed to health and safety risks, including the risk of HIV infection, faced by sex workers. The Legal Network calls for the decriminalization of prostitution in Canada, and for other legal and policy reforms that respect the human rights and promote the health of sex workers. Despite the report's Canadian focus, its human rights analysis is relevant to the situation of sex workers in other countries where prostitution is illegal and sex workers face rights abuses. In this article, Glenn Betteridge, the principal author of the report, briefly sets out the case for law reform.

Criminal Code and foundations for reform

Prostitution, the exchange of sex for money and other valuable consideration, is legal in Canada. However, it is difficult for sex workers and their clients to engage legally in prostitution. Four sections of the *Criminal Code* (sections 210 to 213) make illegal virtually every activity related to prostitution and prohibit prostitution in almost every conceivable public or private place.²

Sections 210 and 211 respectively make it illegal for a person to keep a "bawdy-house" – i.e., a place regularly used for prostitution – or to transport a person to such a place. Section 212 makes it illegal to encourage or force people to participate in prostitution (also known as "procuring"), or to live on the money earned from prostitution by someone else (also known as "living on the avails of prostitution"). Section 213 makes it illegal for sex workers and customers to communicate in public for the purposes of prostitution.

In its report, the Legal Network puts forward three foundations that

should guide the review and reform of the prostitution-related provisions of the *Criminal Code*:

- evidence from credible research and from sex workers themselves;
- Canada's obligations under international human rights law; and
- the *Canadian Charter of Rights and Freedoms* ("Charter").³

Enforcing marginalization, undermining safety⁴

The relationship between criminal law and sex workers' health and safety, including the risk of HIV infection, is complex. The criminal law reflects and reinforces the stigmatization and marginalization of sex workers. This marginalization has a concrete dimension and predictable outcomes. The *Criminal Code*, and its enforcement, often force sex workers to work on the margins of society and in circumstances where they are vulnerable to violence, exploitation and other threats to their health and safety, including potential exposure to HIV.

Section 213, the communicating section, has resulted in the most pronounced risks for sex workers. Research and sex workers' experience has shown that the enforcement of that section has:

- displaced street-based prostitution from centrally located residential or commercial neighbourhoods to industrial or remote neighbourhoods where sex workers have few people to turn to for help if prospective clients or predators become aggressive or violent;
- resulted in more tense working conditions and fewer clients, which means that some sex workers may be less cautious about accepting potentially dangerous clients; and
- meant that sex workers have less time to negotiate their services and safer sex with potential clients.

Canadian researchers have identified multiple dimensions to the relationship between the Canadian criminal law and sex workers' health and safety. The *Criminal Code*:

- contributes to legal structures that tend to make sex workers responsible for their own victimization, whereby sex workers “deserve what they get”;
- makes prostitution part of an illicit market, and creates an environment in which brutal forms of manager-exploitation can take root;
- encourages the convergence of prostitution with other illicit markets, such as the drug market; and
- alienates sex workers from the protective service of police by institutionalizing an adversarial relationship between sex workers and police.

The *Criminal Code*, and its enforcement, often force sex workers to work on the margins of society.

Sex workers’ human rights under Canadian and international law

Sex workers are entitled to human rights and freedoms under the Canadian *Charter* and international human rights law. Recognition of such rights by policy and decision makers is essential to realizing the human dignity of sex workers.

Ironically, the non-prostitution-related conventions to which Canada is a party offer sex workers the potential for greater human rights protection than prostitution-specific instruments. As a party to both the *International Covenant on Civil and*

Political Rights and the *International Covenant on Economic, Social and Cultural Rights*, Canada has an obligation to respect, protect and fulfill the rights set out in these covenants for all people within its territory, including sex workers.

Many of the rights set out in these international treaties are reflected in the Canadian *Charter*. Five *Charter* rights are especially relevant when considering the effect of the prostitution-related offences in the *Criminal Code* on the rights of sex workers in Canada:

- Section 2(b) guarantees everyone freedom of expression.
- Section 2(d) guarantees everyone freedom of association.
- Section 7 protects everyone from violations of “life, liberty and security of the person,” except where the violation is “in accordance with the principles of fundamental justice.”
- Section 11(d) guarantees any person charged with an offence the right to be presumed innocent until proven guilty according to law in a fair and public hearing by an independent and impartial tribunal.
- Section 15 guarantees everyone equality before and under the law, and equal protection and benefit of the law.

Arguably, the prostitution-related offences in the *Criminal Code* violate these *Charter* rights. This conclusion is based on the *Charter* rights as they have been interpreted by the Supreme Court of Canada, and evidence that the prostitution-related offences in the *Criminal Code* contribute to sex workers’ risk of experiencing violence and other threats to their health and safety.

Take the example of the *Charter* section 7 rights to security of the person. Supreme Court decisions have confirmed that the constitutional right to security of the person protects “both the physical and psychological integrity of the individual.”⁵ Physical integrity includes protection from state interference with a person’s bodily integrity.⁶ The Supreme Court has further clarified that action by the state may be an unconstitutional violation of security of the person if it has a “serious and profound effect on a person’s psychological integrity.” In order to find a violation of psychological integrity, the effect of the state’s action must be “greater than ordinary stress or anxiety,” but it does not need to be so serious as to cause “nervous shock or psychiatric illness.”⁷

There is considerable evidence that sex workers, specifically women sex workers engaged in street-based prostitution, face high rates of violence and murder, in addition to other health and safety threats, including increased risk of HIV infection. Moreover, there is compelling evidence that points to a complex causal relationship between the prostitution-related offences in the *Criminal Code* and health and safety risks (and negative outcomes) for sex workers. There are affidavits from sex workers, qualitative studies based on in-depth interviews with sex workers and sex worker advocates, and expert evidence from Canadian researchers who have studied the working conditions and health and safety of sex workers.

Human rights and legal standards developed in the context of HIV/AIDS recognize the harms associated with the criminalization of sex work and the need for decriminalization.

The UN's *International Guidelines on HIV/AIDS and Human Rights* suggest that criminal laws that raise the risk of HIV/AIDS or that otherwise contribute, directly or indirectly, to threats to the health and safety of sex workers should be repealed.⁸

Treating prostitution as a personal service industry is much more likely to achieve public health objectives than a criminal law approach.

The Inter-Parliamentary Union (IPU) recognizes that criminal regulation impedes the provision of HIV/AIDS prevention and care by driving people engaged in prostitution underground, and suggests that positive public health outcomes are more likely to be achieved where prostitution is treated as a personal service industry.⁹ For the IPU, treating prostitution as a personal service industry which is neither condemned nor condoned is much more likely to achieve public health objectives than a criminal law approach. The IPU calls on parliamentarians to engage in a productive dialogue with the sex industry to these ends.

Reform beyond the criminal law needed

The available evidence indicates that Canada is not respecting, protecting and fulfilling sex workers' right to health or other human rights. Sex

workers have historically been subject to stigma and discrimination, based on stereotype and prejudice and on attitudes about sexual expression. As a consequence, the public debate regarding prostitution has been shaped by moralizing, rather than thoughtful consideration of the issues based on thorough research, study and consultation with those most affected.

Repeal of the prostitution-related offences of the Canadian *Criminal Code* is a necessary prerequisite for improving conditions so that sex workers can work free from violence and other health and safety risks, including HIV infection. However, it is unrealistic to think that decriminalization will put an end to the violence, stigma and discrimination sex workers currently experience.

In consultations with the Legal Network, sex workers articulated forcefully that law and policy reform should also focus on improving health services and working conditions for sex workers. In particular, such reforms should assess sex workers' needs for primary health care and comprehensive sexual health programs. Reforms should examine ways to afford sex workers the protections accorded to workers under occupational health and safety and workers' compensation legislation.

Respect for the human rights of sex workers must be grounded in the experiences, choices and agency of the men, women and transgendered people involved in prostitution. As a matter of both principle and pragmatism, legal and policy reform must include meaningful participation of sex workers in decisions that affect

them. In the absence of meaningful sex worker participation, legal and policy reforms risk perpetuating the very health risks and human rights abuses such reforms were intended to address.

– Glenn Betteridge

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Recently, the STAR (Sex Trade Advocacy and Research) project submitted a report to a Canadian House of Commons subcommittee regarding the prostitution-related sections of the *Criminal Code*. See "Report calls for changes to the law to improve safety, security and well-being of sex workers" in the Canadian Developments section of this issue.

¹ *Sex, work, rights: reforming the Canadian criminal laws on prostitution*. Canadian HIV/AIDS Legal Network, 2005. Available via www.aidslaw.ca/Maincontent/issues/sexwork.htm.

² *Criminal Code*, RSC 1985, C-46.

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

⁴ This section of the article is drawn from chapter 4 of the Legal Network's report. The chapter is entitled "Effects of criminalization on sex workers' health and safety, including vulnerability to HIV/AIDS." Please see the chapter for complete references.

⁵ *New Brunswick (Minister of Health and Community Services) v G(J)*, [1999] 3 SCR 46.

⁶ *R v Morgentaler*, [1988] 1 SCR 30.

⁷ *New Brunswick (Minister of Health and Community Services) v G(J)*.

⁸ *HIV/AIDS and Human Rights: International Guidelines*. UN High Commissioner for Human Rights and UNAIDS, 1998: Guideline 4 (para. 29c). Available via www.ohchr.org/english/issues/hiv/guidelines.htm.

⁹ Joint United Nations Program on HIV/AIDS and the Inter-Parliamentary Union. *Handbook for Legislators on HIV/AIDS, Law and Human Rights*. Geneva, 1999, pp 56-59. Available via www.ipu.org/PDF/publications/aids_en.pdf.

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. All of the articles for this section were written by David Garmaise, the editor of Canadian Developments, 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.

Report calls for changes to the law to improve safety, security and well-being of sex workers

In June of 2005, the STAR (Sex Trade Advocacy and Research) project submitted a report to the House of Commons subcommittee regarding the prostitution-related sections of the Criminal Code.¹ The report calls for the repeal of these Criminal Code sections, the recognition of prostitution as work under provincial laws, changes to municipal by-laws and increased funding for sex worker organizations to engage in education, support and advocacy.

Collaborative research partnership

STAR was a collaborative research partnership between academics, sex work organizations and one public

health unit. The partnership conducted case studies between 2001 and 2004 in Montréal and Toronto. The case studies focused on prostitution and explored “how public policies influence the working lives, condi-

tions of work, and the health, safety and well-being of sex workers operating in diverse venues.”² In-depth interviews were conducted with 120 sex workers and numerous key informants from municipal government

and the community, and a review of laws and policies was undertaken.

Lack of safety and security

The report notes at the outset that safety and security are “essential prerequisites to health.”³ The authors used the phrase “safety and security” to refer to physical safety on the job; securing a safe work environment; rights to protection, health and well-being; and economic security.

The report also notes that a small proportion of prostitution is street-based (10 to 20 percent), while the vast majority takes place in locations such as brothels, massage parlours, homes, and hotels. The report’s key findings in relation to safety and security were that:

- sex workers working in street-based prostitution face the greatest risk;
- sex workers’ perception of risk varies depending on the venue where prostitution takes place; and
- a range of risks exists within and across work locations.⁴

While street-based sex workers have developed multiple strategies to reduce potential risks, these strategies often increase the risk of arrest given the existence and enforcement of the criminal prohibitions on activities related to prostitution. Furthermore, some sex workers reported that the police were a direct obstacle to their safety and security: the “marginalized and quasi-criminal status of sex work undermined their ability to seek protection” from the police.⁵

The report also documents other challenges faced by sex workers attempting to maintain their safety

and security, including lack of access to health care, and economic insecurity. Sex workers and organizations of sex workers identified a lack of respectful non-judgmental health care services, and difficulty finding providers knowledgeable about the specific and unique health care needs of sex workers.

The criminal law, and provincial and municipal laws were identified as having potential negative impacts on sex workers’ economic security. Enforcement of the criminal prohibitions on sex work can result in fines, lost income while in detention and the costs of legal defence. Workers who wish to avoid such problems can work indoors through escort agencies or massage parlours or as independent operators. However, such work choices often involve significant costs associated with licensing, advertising and fees paid to business owners, and may result in sex workers being forced to pay income taxes.

Recommendations

The report’s recommendations are based upon a number of guiding principles for change, principles that highlight the need to recognize the rights of sex workers and to include sex workers in law and policy reform. As the authors succinctly state:

Given the close relationship between human rights and health and the struggles that sex workers have had in ensuring their human rights are protected, much of our focus within this project has, necessarily, turned to human rights.⁶

The report recommends decriminalization of prostitution which, in the authors’ view, is a pre-requisite for the recognition of prostitution as work and the protection of sex work-

ers’ rights as workers. The report recommends that steps should be taken to ensure that sex workers who are victims of criminal acts are protected by the police and the criminal law.

The report takes the position that provincial labour and workplace legislation has limited application to sex work and workers because many sex workers are self-employed or work as independent contractors and, principally, because activities involved in prostitution are illegal. The report points to New Zealand’s prostitution law reform as a model of legislation that recognizes sex workers’ right to occupational health and safety under existing workplace law.

At a municipal law level, the report calls for a review of by-laws to ensure that they do not (a) undermine sex workers’ efforts to minimize the risks they face, or (b) effectively create a system of quasi-criminal fines and penalties. Finally, the report recommends that all levels of government make funding available to sex worker organizations to educate, support and advocate for sex workers and their rights.

In concluding, the report cautions against reforms narrowly focussed on legislative change in the absence of efforts to improve the safety and security of sex workers.

Legislative change in and of itself, however, will not be sufficient to improve the situation for sex workers. Such changes must be combined with social policy changes, including education, support and advocacy, as other factors (e.g., public attitudes and opinion; the stigma attached to sex work) also have a negative impact on sex workers’ lives.⁷

– Glenn Betteridge

The Canadian HIV/AIDS Legal Network has issued a report calling, among other things, for the decriminalization of prostitution in Canada. See feature article elsewhere in this issue.

¹ Sex Trade Advocacy and Research (STAR). *Safety, security and the well-being of sex workers: a report submitted to the House of Commons Subcommittee on Solicitation Laws*. June 2005. Available via www.uwindsor.ca/star.

² *Ibid.* at p 6.

³ *Ibid.* at p 4.

⁴ *Ibid.*, p 21.

⁵ *Ibid.* at p 26.

⁶ *Ibid.* at p 33.

⁷ *Ibid.* at p 39.

Toronto: Report calls for more harm reduction measures for drug users

The City of Toronto should expand its harm reduction outreach strategies to reach marginalized drug users, in particular people who use crack cocaine. This is one of 66 recommendations contained in a report on a proposed Toronto Drug Strategy.¹ The report also calls for increased emphasis on prevention, the decriminalization of cannabis possession, and consideration of a safe injection facility for hard drug users similar to the one already in operation in Vancouver.

According to the report, harm reduction outreach strategies include workers trained in substance use and mental health issues going into the community to find people who may be in need of help; and the provision of health promotion information and supplies for safer drug use, safer sex and other prevention measures.

The report, which was prepared by the city's Drug Strategy Advisory Committee, was scheduled to be discussed by Toronto City Council in December 2005. The advisory committee included five city councillors, as well as representatives of the city's public health, police, housing and social development departments, and representatives from Health Canada and the Canadian Department of Justice. It also included 26 community members representing drug users themselves, as well as drug prevention, treatment,

mental health and harm reduction organizations.²

The report recommends that Toronto adopt a comprehensive approach to drugs similar to the "four pillars" approach (prevention, harm reduction, treatment and law enforcement) adopted in Vancouver several years ago.

The report says that given the decentralized nature of drug use in Toronto, and the fact that crack cocaine (and not heroin) is the drug of choice, it is not clear whether Toronto needs a supervised safe injection facility along the lines of the one being piloted in Vancouver. The report recommends that Toronto conduct a needs assessment and feasibility study.

The report recommends that the city establish a Toronto Drug Strategy Implementation Committee and a dedicated secretariat to oversee

implementation of the strategy and to monitor and respond to emerging substance use issues. Other recommendations in the report call on Toronto to:

- develop an appropriate service delivery model for a 24-hour crisis centre for people using legal and illegal substances;
- develop strategies to address service barriers for all people with substance use issues;
- develop strategies to address stigma and discrimination toward people who use substances;
- support the development of a drug users group to undertake a range of activities, including advocacy for the rights of people who use illegal drugs, harm reduction initiatives, education, community development and consumer representation;

- expand its overdose prevention strategies for all substances;
- develop comprehensive strategies to inform the public about substances and substance use issues; and
- increase enforcement efforts targeting high-level drug traffickers, importers and producers of illegal substances.

The report also includes recommendations directed at other levels of government. For example, the report:

- calls on the government of Ontario to develop a comprehensive drug strategy for the province;
- urges officials in the criminal justice system to make more referrals to the Toronto Drug Treatment Court as an alternative to incarceration for non-violent drug offenses;
- recommends that the federal and provincial governments provide increased harm reduction services, including needle exchange, in all correctional facilities; and

- calls for increased availability of drug treatment options in prisons, including methadone maintenance therapy for any inmate with an opiate addiction.

– David Garmaise

¹ Drug Strategy Advisory Committee. *The Toronto Drug Strategy: a comprehensive approach to alcohol and other drugs in the City of Toronto*. City of Toronto, October 2005. Available at www.toronto.ca/health/drugstrategy/pdf/tds_report.pdf.

² Stopthedrugwar.org. Toronto moves toward four pillars-style drug policy. 21 October 2005.

Saskatchewan issues substance abuse plan

The government of Saskatchewan has produced an action plan for substance abuse that increases funding for prevention and treatment programs.¹ The action plan also provides new funding for supply reduction (i.e., enforcement) measures. Workers in community-based organizations (CBOs) in Saskatchewan have been critical of the action plan.

The cost of the action plan, which was released in August 2005, is \$10 million a year. According to the government, as a result of the action plan and other measures, the budget for addiction prevention and treatment has risen by 60 percent in the last year.²

Most of the funding for the action plan will go toward front-line prevention and treatment programs, including:

- providing new treatment facilities for youth;
- making substance-abuse treatment available to individuals who are in custody;

- expanding existing methadone services and needle exchange programs; and
- undertaking a province-wide media campaign to educate users and other residents about substance abuse.

As part of the action plan, Saskatchewan Health will create a new Alcohol and Drug Prevention and Education Directorate.

In terms of supply reduction, the action plan provides for the hiring of additional police officers, and measures to restrict the supply of ingredients used in the manufacture of

crystal methamphetamine. The plan also says that Saskatchewan will urge the federal government to strengthen penalties for drug possession.

The plan was based on a series of recommendations contained in a report prepared for the Premier by a Member of the Legislative Assembly.³

CBOs say that while considerable amounts of money are being spent on prevention and treatment, most of it is for crystal methamphetamine, which is used primarily by white middle class youth, whereas the real problems in Saskatchewan are with cocaine. As well, the CBOs point out, there is barely any mention in

the plan of services for people who are injecting drugs.

CBOs cannot access any of the funds in the action plan. They were not consulted in the development of the plan, even though CBOs are the ones that are providing services

and that have developed trusting relationships with people who are injecting drugs.

– David Garmaise

¹ Government of Saskatchewan. *Premier's Project Hope: Saskatchewan's action plan for substance abuse.*

August 2005. Available at www.publications.gov.sk.ca/details.cm?p=10319.

² New alcohol and drug services for the North. News release. Regina, Government of Saskatchewan, 4 August 2005.

³ G Addley. *Healthy choices in a healthy community: a report on substance abuse, prevention and treatment services in Saskatchewan.* June 2005. Available at www.publications.gov.sk.ca/details.cm?p=10320.

In brief

Safe injection facility attracts high-risk injection drug users, study finds

A study of injection drug users in Vancouver has found that the city's safe injection facility (SIF) attracts "higher-risk" users – i.e., users who are at elevated risk for blood-borne diseases and overdose – and users who contribute to the public drug use problem and unsafe syringe disposal problems.¹ The Vancouver SIF, North America's first medically supervised SIF, is situated in the Downtown Eastside. It was opened in September 2003 as a pilot project.

The authors of the study conclude that "it is likely that the Vancouver SIF is creating additional opportunities for intervention by attracting a population in need of health care support, including addiction treatment, as well as support from social services for problems such as homelessness."²

Previous studies revealed that injection drug users who use the SIF are less likely to share syringes than users who do not use the facility;³ and that the opening of the SIF has

led to measurable reductions in public drug use and unsafely discarded syringes.⁴

In related developments:

- In the City of Ottawa, despite opposition from some city councilors and others, a study is being undertaken into whether an SIF would help stop the spread of HIV and hepatitis C.⁵
- Federal Health Minister Ujjal Dosanjh said that if neighbourhoods, health officials and local politicians are in favour of SIFs, he thinks that there should be more of them across the country.⁶

– David Garmaise

Crack users welcome City of Ottawa's kit distribution program

According to an article in the Ottawa Citizen, crack users credit the City of Ottawa's crack kits distribution program with keeping them healthy.⁷

Distribution of the kits started April 2005 after considerable debate.⁸

Several users are quoted as saying that smoking crack is part of their daily routine, and that they depend on the city's program for clean pipes. One man who said that he is infected with hepatitis C stated that the city's program saves hundreds of his fellow junkies from a similar fate.

Since April, about 1500 pipe kits – which include condoms, lip balm, chewing gum, a pipe-disposal mechanism and information on drug use and prevention – have been distributed. The number of handouts will likely grow as people become more aware of the program.

Among community social service agencies in Ottawa, there is more support for the city's needle exchange program, which has been around since 1991, than for the new crack distribution program. Some agency officials would like to see more proof that the crack distribution program actually works. The health risk of re-using pipes may not be as obvious as that of injecting drugs with dirty needles.

Meanwhile, in Winnipeg, which has also been distributing crack kits, a spokesperson for the Winnipeg Regional Health Authority said that while there was some public resistance to the program at first, the resistance has faded with time.⁹

– David Garmaise

Rapid HIV test approved for clinical use

On 25 October 2005, the Medical Devices Bureau of the Therapeutic Products Directorate, Health Canada approved for sale in Canada a rapid test for HIV antibodies.¹⁰ The test, which is manufactured by Biolytical Laboratories of Richmond, British Columbia, is intended for use in clinical settings such as a physician's office, clinic or hospital emergency room.

Using just a drop of blood, the Insti HIV test can detect antibodies within an average of 60 seconds. The test is designed as a screening test, not a diagnostic test. Any person who gets a positive result using the Insti HIV test needs to go for confirmatory testing.

Each test will cost between CA\$7 and CA\$10. Biolytical says that the Insti HIV test has been shown to be 99.9 percent accurate, and that the rate of false positives is about the same as current laboratory tests.

This is the only rapid HIV test currently available for clinical use in Canada. In 2004, the *Review* incorrectly reported that a rapid test produced by MedMira of Nova Scotia had been approved for clinical use.¹¹ In fact, that test had only been approved for use in the laboratory.

The Insti HIV test is not intended

for home use. No HIV rapid tests have been approved for home use in Canada.

Biolytical intends to seek approval to sell the Insti HIV test in the US in late 2006, and is considering seeking approval in China, India, Eastern Europe and sub-Saharan Africa.

The introduction of rapid testing technology raises numerous legal and ethical concerns. The Canadian HIV/AIDS Legal Network has analyzed these concerns and made recommendations for the appropriate use of rapid HIV-antibody testing.¹²

– David Garmaise

Update on status of needle exchange in federal prisons

In April of 2005, the Public Health Agency of Canada (PHAC) and the Correctional Service of Canada (CSC) entered into a memorandum of understanding regarding the potential introduction of a prison needle exchange program (PNEP) in federal correctional institutions.¹³

Under the memorandum, PHAC will provide scientific, medical and technical advice on the effectiveness of needle exchange programs in prisons from a public health perspective; analyze published and unpublished evaluations concerning the effectiveness of PNEPs; and analyze the potential risks and benefits of introducing PNEPs in Canadian prisons.

The work under the memorandum was supposed to have been completed by the end of August 2005. The review of the documentary evidence was completed on schedule. However, it was only in late September that PHAC, CSC and

union representatives visited PNEPs in Germany and Spain. PHAC is expected to deliver its report, including advice and recommendations, to CSC in early 2006.

This is not the first CSC prison needle exchange study group visit to PNEPs in other countries and prepare advice on the issue. In 1999 CSC established the NEP Study Group. A delegation, including CSC, union and public health advisors, conducted a visit to PNEPs in Switzerland. The study group recommended that CSC obtain ministerial approval for a multi-site PNEP pilot program in men's and women's federal institutions. The recommendation was never acted upon.

In a related development, at its 138th annual meeting in Edmonton in August of 2005, the Canadian Medical Association passed the following resolution:

The Canadian Medical Association recommends that Correctional Service of Canada develop, implement and evaluate at least one pilot needle exchange program in prison/s under its jurisdiction.

The resolution was sponsored by the Ontario Medical Association which released a report in 2004 calling for the immediate introduction of PNEPs in federal and provincial institutions in Ontario.¹⁴

– Glenn Betteridge

Call for new hepatitis C strategy

Community-based organizations involved in the fight against hepatitis C have called on the federal govern-

ment to invest CA\$37.5 million a year in a new five-year Canadian Hepatitis C Strategy. The total cost of the strategy over five years would be CA\$187.5 million. The call is contained in a paper that provides a series of recommendations concerning the contents of the proposed strategy.¹⁵

The federal government had a CA\$50 million five-year Hepatitis C Prevention, Support and Research Program which ended in March 2004; single year funding has twice been extended, but there is no indication that this funding, or a multi-year strategy, will be extended beyond the program's end date of 31 March 2006.¹⁶

The paper recommends that the proposed strategy contain components on prevention and education; care, treatment and support; research; and community action. The recommendations include the following:

- educational programs targeting the general public, service providers, at-risk groups and HCV-positive individuals;
- support for existing and expanded harm reduction programs (including needle exchange, safer crack use programs and safe injection facilities);

- promotion of organ donations;
- the establishment of a network of comprehensive hepatitis C care clinics; and
- sustained funding for community-based organizations.

It is estimated that 250,000 Canadians are currently infected with hepatitis C¹⁷ and that 5,000 more are infected each year.¹⁸ Almost one-quarter of the approximately 49,600 Canadians living with HIV/AIDS are also co-infected with hepatitis C. Liver disease has recently become a leading cause of death among those who are co-infected.¹⁹

– David Garmaise

⁶ Health minister says if cities want them, safe injection sites should open. *Canadian Press*, 23 September 2005.

⁷ R Delisle. Crack users say pipe program helps them stay healthy. *Ottawa Citizen*, 6 October 2005.

⁸ D Garmaise. Ottawa: City Council approves distribution of crack kits. *HIV/AIDS Policy & Law Review* 2005; 10(3): 16-17.

⁹ T.O. report supports drug-use zones. *Broadcast News*, 17 October 2005.

¹⁰ S Ubelacker. Health Canada Ok's first rapid-result HIV test for doctor's office, clinics. *Canadian Press*, 7 November 2005. Note that Health Canada maintains a Medical Devices Active License Listing (MDALL). The MDALL contains product-specific information on medical devices that are licensed in Canada, including the date of issue of the license. To access the MDALL, see www.mdall.ca/.

¹¹ G Betteridge. Health Canada approves rapid HIV test for sale in Canada. *HIV/AIDS Policy & Law Review* 2004; 9(3): 30-31.

¹² R Elliott, R Jürgens. *Rapid HIV screening at the point of care: legal and ethical questions*. Canadian HIV/AIDS Legal Network, 2000. Available at www.aidslaw.ca/Maincontent/issues/testing/finalreports/tofc.htm.

¹³ A copy of the Memorandum of Understanding was obtained under access to information legislation, and is on file with the author.

¹⁴ Ontario Medical Association. *Improving our health: why is Canada lagging behind in establishing needle exchange programs in prison?* 2004. Available at www.oma.org/phealth/omanep.pdf.

¹⁵ *Responding to the Epidemic: recommendations for a Canadian Hepatitis C Strategy*. Anemia Institute for Research and Education, Canadian AIDS Society, Canadian AIDS Treatment Information Exchange, Canadian Harm Reduction Network, Canadian Hemophilia Society, Canadian Hepatitis C Network, Canadian Liver Foundation, Hepatitis C Council of BC, Hepatitis C Society of Canada, Prisoners' HIV/AIDS Support Action Network. September 2005. Available at www.canadianharmreduction.com/readmore/Responding_e.pdf.

¹⁶ *Ibid.*, p 3.

¹⁷ *Ibid.*, p 3.

¹⁸ *Ibid.*, p 7.

¹⁹ *Ibid.*, p 5.

¹ E Wood et al. Do supervised injecting facilities attract higher-risk injection drug users? *American Journal of Preventive Medicine* 2005; 29(2): 126-130.

² *Ibid.* at p 128.

³ G Betteridge. First evaluation of Vancouver's safe injection facility. *HIV/AIDS Policy & Law Review* 2005; 10(2): 20.

⁴ G Betteridge. British Columbia: Studies show positive public health impact of harm-reduction measures for drug users. *HIV/AIDS Policy & Law Review* 2004; 9(3): 27.

⁵ Fight looming over safe injection sites. *CBC News* [online], 28 July 2005.

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.

United States: Challenges filed to anti-prostitution pledge requirement

Two separate lawsuits were filed recently in US federal courts challenging a provision of US law requiring that non-governmental organizations have a policy “explicitly opposing prostitution” as a condition of receiving funding under the *United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (US Global AIDS Act)*.¹ US-based plaintiffs in both cases argue that the anti-prostitution pledge requirement in the Act violates US Constitutional guarantees of free speech and due process, and undermines proven, effective efforts to fight HIV/AIDS among sex workers.

The first case, filed in August 2005, was brought by DKT International (DKT). One of the largest providers of HIV/AIDS services worldwide, DKT operates family planning and HIV prevention programs in eleven countries in Africa, Asia and Latin

America. In June 2005, DKT was awarded US\$60,000 in funds from the US Agency for International Development (USAID) for HIV/AIDS prevention work in Vietnam.

DKT has no policy on prostitution, and believes that remaining neutral

on this issue is in the best interest of its HIV/AIDS prevention work. In July, USAID informed DKT that it would be ineligible for USAID funding unless it certified that it had an anti-prostitution policy. When DKT refused to adopt or certify such a

policy, USAID canceled the grant. DKT receives about 16 percent of its budget from USAID. Hence, its ineligibility for US government funding threatens to curtail its lifesaving anti-AIDS work.

In September 2005, the Alliance for Open Society International (AOSI) and its affiliate, the Open Society Institute (OSI), brought a second challenge to the anti-prostitution pledge requirement. AOSI is currently in the middle of operating a project to fight HIV/AIDS in Central Asia, funded primarily by a US\$16.5 million USAID grant. OSI receives no USAID funds, but provides funding, technical assistance and administrative support to the project.

In August 2005, AOSI was notified that it would receive additional funding for its Central Asia project only if it certified compliance with the anti-prostitution pledge requirement. Recognizing that USAID would have eliminated funding for its anti-AIDS program, and to avoid the harm that clients would suffer in the event that the program would be shut down, AOSI crafted and signed a pledge. AOSI then sued USAID to secure its First Amendment and statutory rights to engage in a range of privately financed activities to fight HIV/AIDS. OSI joined the lawsuit to ensure that USAID would not seek to penalize AOSI or OSI for any of OSI's privately financed activities.²

Affidavits filed in both cases by a range of public health experts with expertise in designing and evaluating programs to prevent and respond to HIV/AIDS testify to the evidence supporting programs that approach sex workers in a respectful and non-judgmental manner. Such approaches are vital to earning sex workers' trust and engaging them in HIV preven-

tion efforts, including integrating peer-based outreach and education. Forcing grantees to oppose prostitution is likely to destroy these programs, exacerbate existing stigma and perpetuate discrimination against sex workers, driving them further underground and away from existing health and social services.

In addition to jeopardizing public health and rights-based program-

A chorus of voices has objected to a requirement that substitutes morality for evidence-based HIV prevention practices.

ming for health, the pledge requirement violates the First Amendment by forcing private organizations to adopt the government's point of view and by restricting what they can say and do with their private funding. While participating organizations are required to adopt the pledge, the government has refused to provide any guidance regarding just what it means to "oppose prostitution," casting a shadow of uncertainty over entire HIV/AIDS prevention programs. Organizations are left to wonder whether USAID will deem them to be non-compliant whenever they talk with allies, hold a conference or issue a publication related to sex work.

In filing these lawsuits, DKT, AOSI and OSI join a chorus of voices that have objected to a requirement that substitutes morality for evidence-based HIV prevention practices.

SANGRAM (Sampada Grameen Mahila Sanstha), an NGO based in Sangli, India, has been recognized by Indian and international organizations as an example of best practices for its HIV/AIDS prevention work with women in prostitution.³ In October 2005, SANGRAM stopped taking USAID money for its anti-AIDS work by mutual agreement, because it understood that the pledge requirement would violate both the spirit of working respectfully with at risk-persons, and the right of free expression of civil society organizations.⁴

In May 2005, Brazil rejected US\$40 million in US anti-HIV/AIDS grants because funding was conditional on recipient organizations adopting a pledge opposing sex work.⁵ In February 2005, 13 US-based NGOs criticized the USAID policy, saying that it "greatly undermines" AIDS prevention efforts.⁶

Even if DKT, AOSI and OSI prevail in their respective lawsuits, a victory is unlikely to cure impediments to HIV/AIDS work posed by the *US Global AIDS Act*. First, courts could limit the application of their decisions to US-based organizations, leaving foreign NGOs subject to the pledge.⁷ Second, the lawsuits do not challenge the Act's provision barring the use of funds to "promote or advocate the legalization or practice of prostitution."⁸

– Rebecca Schleifer

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¹ For previous coverage of this issue, see R Schleifer, United States: Funding restrictions threaten sex workers' rights. *HIV/AIDS Policy and Law Review* 2005; 10(2): 26-27.

² *Alliance for Open Society International, Inc. and Open Society Institute v USAID and Andrew Natsios*. Complaint filed in US District Court for the Southern District of New York, 23 September 2005. Available online at www.brennancenter.org/programs/downloads/complaints-osi.pdf.

³ The Indian National AIDS Control Organization, UNAIDS and UNESCO have all recognized SANGRAM for its HIV/AIDS work with women in prostitution. External evaluations conducted by the Avert Society, a USAID grantee, have recommended that the SANGRAM

project with women in prostitution be made into a demonstration and training centre.

⁴ Facsimile communication from David Kennedy, spokesman, US Embassy, New Delhi, to Meena Saraswathi Seshu, General Secretary, SANGRAM, 6 October 2005; email communication from Meena Saraswathi Seshu to Rebecca Schleifer, 7 October 2005.

⁵ MM Phillips, M Moffett. Brazil refuses US AIDS funds, rejects conditions. *Wall Street Journal*, 2 May 2005: A3.

⁶ Letter to Randall Tobias, US Global AIDS Coordinator,

regarding application of *US Global AIDS Act* restrictions on working with sex workers to US-based NGOs. 25 February 2005.

⁷ Compelling foreign organizations to adopt policies consistent with the government's viewpoint raises important constitutional concerns that courts could choose to address. See *DKT Memorial Fund Ltd. v Agency for Intern. Dev't* [1989] 887 F.2d 275 (D.C. Cir.) (Ginsberg, J., dissenting).

⁸ *US Global AIDS Act*. 22 U.S.C. Sec., 7631(e).

Methadone and buprenorphine added to the WHO list of essential medicines

In March 2005, methadone and buprenorphine were recently added as “complimentary” medicines to the 14th Model List of Essential Medicines (LEM) released by the World Health Organization (WHO).¹ Studies have shown that these drugs increase adherence to antiretroviral therapy as well as reduce the risk of HIV infection among injection drug users.

The listing as complimentary medicines does not signify a partial or limited endorsement of methadone or buprenorphine, but rather indicates that specialized diagnostic or monitoring facilities, or specialist medical care or specialist training are needed in conjunction with the use of these medicines.²

Methadone and buprenorphine are synthetic opioids widely used in opioid substitution therapy to manage opioid drug dependency. Methadone blocks opioid receptors in the brain, helping to reduce cravings for many opioid drugs such as heroin and morphine.³ The efficacy of the two drugs is enhanced because their effects last 24–36 hours (compared with only six hours for heroin) and they can be taken orally.⁴ These two factors help break injection habits and reduce cravings.

The LEM entry states that “[b]oth buprenorphine and methadone are effective for the treatment of heroin dependence. However, methadone maintenance therapy at appropriate doses is the most effective in retaining patients in treatment and suppressing heroin use.”⁵

The addition of methadone and buprenorphine to the LEM is significant because of the controversial nature of these substances in some parts of the world. The 1961 UN *Single Convention on Narcotic Drugs* classified methadone as a “schedule I drug.”⁶ This classification means the drug represents an “especially serious risk to public health and limited, if any, therapeutic usefulness.”⁷ This has resulted in methadone being declared an illegal substance in a number of countries, including Russia.⁸

In adding methadone and buprenorphine to the LEM, WHO has recognized the utility of these drugs and their effectiveness in opioid substitution therapy. Medicines are only added to the LEM if they satisfy conditions of public health, disease prevalence, safety, efficacy and cost effectiveness.⁹ There is substantial clinical evidence that demonstrates methadone and buprenorphine satisfy these criteria.¹⁰

There is also considerable evidence that methadone and buprenorphine are effective at reducing HIV infection among injection drug users.¹¹ Opioid substitution treatment is also associated with an increased adherence to antiretroviral treatment therapy in users infected with HIV.¹²

It is hoped that the addition of methadone and buprenorphine to the LEM will increase access to opioid

substitution treatment in countries where the HIV epidemic is fueled by injection drug use.¹³ Dr. Srdan Matic, Regional Adviser for Sexually Transmitted Infections/HIV/AIDS at the WHO Regional Office for Europe said:

We need to attack the spread of HIV/AIDS among drug users by strengthening links between both drug dependence treatment and HIV/AIDS treatment services.... The fact that methadone and buprenorphine have been added to the WHO List of Essential Medicines will facilitate countries in making substitution treatment available.¹⁴

The LEM is a standard on which many countries base their own essential medicine lists.¹⁵ Many international and non-governmental organizations around the world have also adopted the LEM and base their medicine supply on it.¹⁶ Essential

medicine lists are a very valuable health care tool and “result in a higher quality of care, better management of medicines (including improved quality of prescribed medicines), and more cost effective use of health resources.”¹⁷

– Greg Herget

Greg Herget is a second year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ World Health Organization. 14th Model List of Essential Medicines. March 2005. Available at www.who.int.

² *Ibid.*

³ J Johnson. The top pharmaceuticals that changed the world. *Chemical and Engineering News* 2005; 89 (25).

⁴ *Ibid.*

⁵ World Health Organization. 14th Model List.

⁶ UN. *Single Convention on Narcotic Drugs*. 1961. Available at www.unodc.org.

⁷ European Parliament. Working document on the UN conventions on drugs. Committee on Citizens' Freedoms and Rights, Justice and Home Affairs. 2002.

⁸ Russia: Drug law reforms help combat AIDS, curb abuses. *Human Rights Watch* (online edition). 21 May 2004.

⁹ World Health Organization. Expert Committee on the Selection and Use of Essential Medicines. WHO medicine strategies: revised procedures for updating WHO's Model List of Essential Drugs. E/B 109/8, 7 December 2001, para 12. Available at www.who.int.

¹⁰ A Antela et al. Influence of a methadone maintenance programme on the improved outcome of a cohort of injecting drug users with advanced HIV disease. *AIDS* 1997; 11: 1405-1406.

¹¹ See, e.g., L Gowing et al. Substitution treatment of injecting opioid users for prevention of HIV infection. *Cochrane Review* (Online). In: The Cochrane Library 2004; 4.

¹² See, e.g., S Clarke et al. Assessing limiting factors to the acceptance of antiretroviral therapy in a large cohort of injecting drug users. *HIV Medicine* 2003; 4(1): 33-37.

¹³ L Gowing et al.

¹⁴ World Health Organization/Europe. Experts call for opioid substitution treatment to prevent HIV/AIDS transmission in prisons. July 2005. Available at www.who.dk.

¹⁵ World Health Organization. Expert Committee.

¹⁶ *Ibid.*

¹⁷ *Ibid.* at para 2.

Southern Africa: AIDS-affected children face systemic discrimination in accessing education

In June 2005, Human Rights Watch (HRW) conducted an investigation in Kenya, South Africa and Uganda to document AIDS-affected children's experiences of inequality and neglect in the school system.¹ HRW found, consistent with previous research, that the sickness of one or both parents due to HIV/AIDS led many children withdraw from school to perform household labour or offset lost family income. Parental death often led to abandonment, discrimination within extended and foster families, and emotional trauma that interfered with school performance.

Human rights abuses against (usually female) caregivers, such as property grabbing and wife inheritance, crippled caregivers' ability to earn property and pay for the education of orphans and other HIV/AIDS-affected children in their care. With few exceptions, governments' response to these deep-rooted problems consisted

of giving small grants to community-based organizations to provide care and support to orphans, rather than reviewing and reforming their education and foster care systems.

Discussions around HIV/AIDS and access to education often focus on overt stigma and discrimination in the school system against children living with or affected by HIV/AIDS. In numerous countries, HIV/AIDS and human rights organizations have documented cases of children being blocked, expelled or chased from school based on their or their parents' HIV status.² The recent case of the Nyumbani Children's Center in Kenya, in which a home for HIV-positive orphans had to sue the Kenyan government for permission to enroll its children in government schools, stands as a grim reminder of how far we have to go in order to ensure equal access to education for children affected by AIDS.³

Perhaps more widespread than such overt discrimination, however, are cases of HIV/AIDS-affected children having to drop out of school simply because their school systems – while not overtly discriminatory – fail to address their extraordinary needs. Recent surveys in heavily HIV/AIDS-affected areas of East and Southern Africa have shown that children who experience the death of one or both parents are more likely than their peers, including those living at comparable levels of poverty, to withdraw, fall behind or not advance in school.⁴

These children are also less likely to have limited family resources spent on their education, an indication of possible discrimination against orphans (and favoritism of biological children) within extended families. These disparities cannot

fully be explained by overt discrimination by schools, but rather stem from broader factors having to do with the impact of parental sickness and death on children's access to education.

Taken together, these hardships add up to a form of systemic discrimination in access to education. Under the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* and the *Convention on the Rights of the Child*, children are entitled to equality in access to social services irrespective of their or their parents' HIV status.⁵ The Committee on Economic, Social and Cultural Rights has stated that the *ICESCR* protects not only against direct discrimination – for example, children being expelled from school on the basis of HIV status – but also against “de facto discrimination,” or discrimination that arises from underlying social disadvantage.⁶

A finding of de facto discrimination triggers a government's obligation to take affirmative steps to improve educational access, and also obliges international donors that have ratified the *ICESCR* to assist these children to the maximum extent possible. These obligations should be viewed as essential to achieving the broader goal of universal access to education for all.

HIV/AIDS-affected children require special accommodation in schools in the same way children with physical disabilities may require the installation of wheelchair ramps, or foreign language students may require foreign language teachers. In all cases, the failure of governments to accommodate the unique situation of a discrete and traditionally marginalized minority – indeed, to ensure substantive rather than just formal

equality – results in disparate rates of school enrollment, attendance and advancement. Governments should make addressing the unique educational needs of AIDS-affected children a central part of their response to HIV/AIDS as well as of their overall education strategy.

– Jonathan Cohen

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¹ Human Rights Watch. *Letting them fail: barriers to education for children affected by AIDS*. Vol. 17, No. 13(A), October 2005. The report is available at <http://hrw.org/english/docs/2005/10/07/safric11838.htm>.

² For a recent study, see Human Rights Watch. *Future forsaken: abuses against children affected by HIV/AIDS in India*. July 2004, pp 63-84.

³ Kenya: AIDS-law sensitization results in schooling for orphans. Undated news release. Kenya AIDS NGO Consortium. See also, Landmark suit a big victory for the Kenyan child. *The Children Act Monitor*, January 2004, no. 0013/04.

⁴ See, e.g., T Yamano and TS Jayne. Working-age adult mortality and primary school attendance in rural Kenya. *Economic Development and Cultural Change* 2005; 53(3): 619-654; A Case and C Ardington. The impact of parental death on school enrollment and achievement: longitudinal evidence from South Africa. Unpublished manuscript, 7 February 2005; D Evans and J Miguel. Orphans and schooling in Africa: a longitudinal analysis. Unpublished manuscript, March 2005; and M Ainsworth, K Beegle and G Koda. The impact of adult mortality and parental deaths on primary schooling in north-western Tanzania. *The Journal of Development Studies* 2005; 41(3).

⁵ UN General Assembly. *International Covenant on Economic, Social and Cultural Rights (ICESCR)*. Res. 2200A. Adopted 16 December 1966 (entered into force 2 January 1976), art. 2(2) (non-discrimination) and art. 13 (right to education); UN General Assembly. *Convention on the Rights of the Child*. Res. 44/25. Adopted 10 November 1989 (entered into force 2 September 1990), art. 2(1) (non-discrimination) and art. 28 (right to education); Committee on the Rights of the Child. *General Comment 3: HIV/AIDS and the rights of the child*. CRC/GC/2003/1, 13-31 January 2003, para 7 (noting that “other status” encompasses HIV status of a child or his or her parents).

⁶ Committee on Economic, Social and Cultural Rights. *The right to education (Art. 13)*. E/C.12/1999/10, 12 August 1999, paras 6, 37.

Report documents criminalization of HIV exposure and transmission in Europe

In April 2005, the Global Network of People Living with HIV/AIDS Europe and the Terrence Higgins Trust published a report on the criminalization of HIV transmission in Europe.¹ Based on a rapid scan of the situation, the report provides a snapshot of the laws that criminalize HIV transmission and exposure in 41 European countries, and of the prosecutions under those laws.

Laws and prosecutions

In the summer of 2004, the two organizations distributed over 600 questionnaires regarding criminal law and HIV exposure or transmission to NGOs, government departments, UN country representatives, and people working on HIV/AIDS issues in the 45 European countries that have signed the *Convention for the Protection of Human Rights and Fundamental Freedoms*.²

While only 87 questionnaires were completed and returned, sufficient information was obtained to report on the experiences of 41 countries. In 36 of these countries, the actual or potential transmission of HIV can constitute a criminal offence, and in 21 countries it was reported that at least one person has been prosecuted.

Fourteen countries reported having enacted or amended legislation to deal specifically with the transmission of HIV or other sexually transmitted infections. In countries without HIV-specific legislation, prosecutions for transmitting HIV or exposing someone to HIV had been brought under three broad categories of offences: transmission of contagious diseases, bodily harm and assault, and manslaughter and homicide.

The countries with the highest number of prosecutions were Austria, Sweden and Switzerland, with over 30 prosecutions each. Overall, at least 130 people have been convicted of transmitting HIV or exposing another person to HIV. In countries where information on the gender of the convicted person was obtained, more than 90 percent of people convicted were HIV-positive men who had had sexual intercourse with a woman. There were no convictions reported for HIV transmission from mother to child.

Impact of criminalization on human rights

The report also briefly examined the human rights issues involved in criminalization, and the role of the media and of organizations supporting people living with HIV/AIDS. The main human rights issue identified was the disproportionate number of immigrants convicted of HIV/AIDS-related offences who are often deported as a result of the criminal conviction. The report's authors suggested that the deportation of a person to African countries where treatment is not widely available could amount, in some circumstances, to a violation of the person's right to

life, health and freedom from cruel, inhuman or degrading treatment.

Regarding the media, the report noted:

In most cases, the popular press appeared to "sensationalise" the cases, often depicting those convicted as being a threat to the population. Media, and media-shaped negative public view points, were cited by a number of respondents as a key factor in criminal prosecutions and their public impact.

The report indicated that organizations whose mission includes supporting people living with HIV/AIDS fulfill a number of roles in relation to criminalization, ranging from monitoring events, to supporting people who have been criminally accused, to campaigning for changes to laws. The report also remarked upon the lack of resources for, and advocates on behalf of, people living with HIV/AIDS faced with criminalization:

There was, however, often a sense that organisations had been overtaken by events. It may be possible that, in the face of media or public hostility, and hampered by the difficulties in obtaining factual information or in agreeing to a view on the issue, some organisations thought it prudent to remain silent. Whatever the cause,

it was noticeable that in a number of countries there was no easily located source of community or NGO expertise on HIV and the law.

The authors of the report concluded with a call for research and better information collection in order to get

a more complete understanding of issue and trends involving criminalization in Europe.

– Glenn Betteridge

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¹ M Nyambe. *Criminalisation of HIV transmission in Europe: a rapid scan of the laws and rates of prosecution for HIV transmission within signatory States of the European Convention on Human Rights*. Global Network of People Living with HIV/AIDS Europe and Terrence Higgins Trust. April 2005. Available via www.gnpplus.net/downloads.shtml.

² [European] *Convention for the Protection of Human Rights and Fundamental Freedoms*, (ETS 5), 213 UNTS. 222.

Botswana: Refugees not entitled to same services as citizens

Botswana, among the countries with the highest HIV/AIDS prevalence rates in the world, has been recognized internationally for its ambitious program to offer voluntary counseling and testing, prevention of mother-to-child transmission (PMTCT) and antiretroviral (ARV) treatment to all residents. Unfortunately, these policies have not been extended to the large numbers of refugees in Botswana. Botswana's *Refugee Recognition and Control Act*¹ does not recognize a refugee as an ordinary resident.

The Government of Botswana, in collaboration with the United Nations High Commissioner for Refugees (UNHCR), set up the Dukwi refugee camp in 1975. All of the recognized refugees in Botswana are staying in the Dukwi camp. The camp, located in the central east part of Botswana, holds 3194 resident refugees from Angola, Namibia, Zimbabwe, Somalia, Burundi, Uganda and Democratic Republic of Congo. Just over half are adults. The exact rate of HIV prevalence in the camp is unknown, but the overall rate in the surrounding Tutume sub-district is 37.7 percent.

Twice a week, 90 peer educators promote awareness about HIV/AIDS in Dukwi camp, visiting all the zones of the camp except the fastest growing one – the camp cemetery. “Many young people are dying from AIDS,” said Mavis Matenge, UNHCR’s officer for HIV/AIDS at Dukwi refugee camp. “If HIV is still spreading, it is not for lack of information.”²

Even though isolated by the camp, refugees commonly interact with the local population. Marriage and commercial sex activities between refugees and locals are not rare. These close interactions and its repercussions with respect to HIV/AIDS

transmissions cannot be ignored.

A 2002 Presidential directive stated that refugees at the Dukwi Refugee camp should continue to be provided with public medical services. There is a government clinic in the camp, which offers facilities for care and testing. However, the government clinic does not offer ARV treatment or a PMTCT program – services that are available elsewhere in Botswana. A PMTCT program was provided at one point, but the government revoked the program in July 2004. These discriminatory practices are driven by the view that ARV treatment will be wasted on

those who repatriate to their countries of origin where ARV may not be available.

Not all refugees in Dukwi wish to remain in Botswana; this has become an obstacle in their hopes of receiving treatment. Many refugees are keen to repatriate. Since December 2004, for example, more than 300 Angolan refugees have been repatriated.

The situation for refugees is complicated further by the large number of illegal immigrants in Botswana. Refugee movements occur as part of mixed migratory flows, including large numbers of illegal immigrants who are labeled as refugees. Political and economic problems in Zimbabwe, for example, have prompted more than 60,000 people to seek sanctuary in Botswana as illegal immigrants. The lack of distinction between refugees and illegal immigrants creates confusion both in the public's perception and in government policy, threatening the effectiveness of international protection for refugees. The lack of durable solutions for refugees and illegal immigrants has been eroding the generosity of refugee asylum in Africa.

"The numbers [of illegal immigrants] swell the registers of asylum

countries, and the time-consuming task of processing their claims clogs the systems of adjudication," UNHCR regional representative Ebrima Camara was quoted as saying while attending a workshop on refugees and internally displaced persons in the Southern African Development Community (SADC).³

A cross-border approach may be the answer. The SADC workshop recommended consistent refugee policies and HIV/AIDS treatment plans for all member countries as a way forward.⁴ In addition, the World Bank is currently addressing the issue by funding the Great Lakes Initiatives on HIV/AIDS with the involvement of six African governments.⁵ As the *Refugee Recognition and Control Act* is silent on certain aspects of refugee protection, new refugee legislation may be needed to harmonize national law with international law.

Excluding refugees from an HIV/AIDS treatment program is highly discriminatory and epidemiologically counterproductive. For Botswana to achieve its national goal of an AIDS-free nation by 2016,⁶ concerted intervention has to be maintained in Dukwi and a review of national HIV/AIDS policies and programs will be essential. As long as they are within

Botswana's borders, refugees are its responsibility and they must be able to enjoy the right to life.

– Vanisree Trippayya

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¹ *Refugees Recognition and Control Act*. Botswana 1967, c25:01, s13.

² M Sunjic. Botswana camp fights uphill battle against HIV and AIDS. *UNHCR News Stories*. 23 February 2005. Available via www.unhcr.ch.

³ Botswana Press Agency. Workshop highlights problems stalling repatriation. *Daily News* (Gaborone, Botswana), 24 August 2005: 3. The third regional meeting on refugee issues for national refugee commissioners and other senior government officials from SADC took place in Gaborone from 22-23 August 2005. The meeting, entitled "Effective Refugee Protection in SADC" was hosted by the Botswana Government, UNHCR and SADC.

⁴ *Ibid.*

⁵ On 15 March 2005, the World Bank approved a US\$20 million grant to fight against HIV/AIDS in the six countries of the Great Lakes region.

⁶ Vision 2016 is Botswana's national manifesto for the people of Botswana. Launched in 1996, it is the statement of the long term goals that identifies the challenges implied by these goals, and a set of strategies to address the challenges.

Global Fund fundraising drive comes up well short of target

The Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis has raised only about half of the funds it was seeking for 2006 and 2007. The shortfall in funding means that many programs to fight HIV/AIDS, malaria and tuberculosis cannot proceed, at a time when countries should be scaling up their responses. “The current funding gap will have devastating effects,” said Anandi Yuvaraj, a Global Fund Board member, “depriving poor women, men and children from the hope of accessing life-saving prevention and treatment services...”¹

At a Global Fund replenishment meeting in London, England on 5-6 September 2005, donor countries pledged US\$3.7 billion. The Fund was looking for US\$7.1 billion. As a result, two of the three rounds of funding scheduled for 2006 and 2007 (if not all three) will likely have to be postponed. The US\$3.7 billion in pledges is sufficient to pay for grant renewals in 2006 and 2007, but not for any new proposals. (Global Fund grants are normally for five years, but funding is initially approved only for two years, and then renewed for a further three years if the programs funded by the grants are performing well.)

At US\$658 million, France was the largest contributor, followed by the US at US\$600 million and Japan at US\$500 million. The US may contribute up to US\$300 million more, depending on the outcome of discussions taking place in the US Congress. The US has said that its contribution must not exceed one-third of total contributions to the Global Fund. Many people have interpreted this as a commitment to fund a full one-third share. To meet this commitment, the US would have to raise its pledge from US\$600 million to US\$1,550 million.

With many of the grants approved in the early rounds of funding now coming up for renewal, and more new rounds of funding being scheduled each year, the financing needs of the Global Fund are much greater today than they were a few years ago. Many activists argue that the Global Fund’s US\$7.1 billion target for 2006 and 2007 was too low. UNAIDS estimates that the resource needs for HIV/AIDS alone will be US\$18.1 billion for 2007 (and US\$22 billion for 2008).² The Global Fund estimates that it provides about 20 percent of all international funding for HIV/AIDS.

The Global Fund also experienced a fundraising shortfall in 2005, which resulted in delays in implementing some of the successful proposals submitted in the fifth round of funding. At its meeting in September 2005 in Geneva, Switzerland, the Global Fund Board approved 26 grants worth US\$382 million and provisionally approved a further 37 grants worth US\$344 million. These 37 grants will not be formally approved unless sufficient additional funds are received by the end of June 2006.

Activists have argued that contributions to the Global Fund should

not be based on voluntary pledges, but rather should be predictable and should be based on each donor country’s fair share. Accordingly, activists developed advocacy targets for donor countries and included these targets in an international appeal for full funding for the Fund.³

In its short history, the Global Fund has produced many positive results. According to the Fund itself, by the end of 2004, after three years in operation, Global Fund financing had helped to provide: 130,000 people with antiretroviral treatment for HIV; more than one million people with voluntary HIV testing; 385,000 patients with tuberculosis treatment; more than 300,000 people with highly effective artemisinin combination treatments for malaria; and more than 1.35 million families with insecticide-treated mosquito nets.⁴

At the G8 meeting in Gleneagles, Scotland in July 2005, leaders committed to getting “as close as possible to universal access to [HIV/AIDS] treatment for all who needed by 2010.”⁵ If the Global Fund does not meet its fund-raising targets, it is very unlikely that the G8 commitment can be met.

The Global Fund obtains virtually all of its resources from donor coun-

tries. It is clear that these countries will need to significantly scale up their global spending on HIV/AIDS. The donor countries have agreed to hold another replenishment meeting in June 2006.

– David Garmaise

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¹ International HIV/AIDS Alliance. US misses its own target to finance the Global Fund. News article. September 2005. Available via www.aidsalliance.org.

² UNAIDS. *Resource needs for an expanded response to AIDS in low and middle income countries*. June 2005.

Available at www.unaids.org/html/pub/publications/irc-pub06/resourceneedsreport_24jun05_en.pdf.

³ For details on the international appeal and the advocacy targets, consult the website of Aidspan, an NGO that works on Global Fund issues, at www.aidspace.org/replenishment/.

⁴ International Council of AIDS Service Organizations. *Advocacy alert: Global Fund financing*. 4 August 2005. Available via www.icaso.org.

⁵ *Ibid.*

In brief

India: Military recruits to undergo HIV testing

In September, 2005, the Indian Government announced plans to test all new military recruits for HIV.¹ In addition, wives of personnel in the service will undergo pre-natal screenings for the virus. Among India's 1.3 million active troops,² it is estimated that 20,000 may be HIV-positive. The military cites some two-hundred AIDS-related deaths in its military forces over the past two years.³

The policy raises a number of ethical concerns related to privacy and human rights. These include the equality of treatment of HIV-positive service people and the issue of disclosure of their HIV status. In particular, there is concern that the military could use HIV as a sole basis for assessing the fitness of a recruit. In 2000, the High Judicature of Bombay upheld the Indian Navy's decision to refuse to re-engage a serviceman solely on the grounds of his HIV status.⁴

In 2002, the Canadian HIV/AIDS Legal Network prepared a report for UNAIDS addressing the issue of HIV testing among UN peacekeepers and military personnel in general. The report found that HIV status does not necessarily affect a service person's capacity to perform or pose a health risk to others, and recommended HIV testing and counseling on a voluntary and individual basis in place of a mandatory regime.⁵

– Tim Franklin

Tim Franklin is a first year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

Indonesia: Men refusing to wear condom with sex workers are liable to fines

The Merauke regency⁶ in the Indonesian province of West Papua

has introduced Bylaw No. 5/2003 on HIV/AIDS prevention. The bylaw allows men to be fined up to Rp 5 million (approximately US\$500) for refusing to wear a condom during sex with sex workers. The bylaw also allows sex workers to refuse service to clients who will not wear a condom during sex.

Officials hope to enforce the bylaw in areas such as red-light districts, bars and hotels. However, enforcement of the bylaw will be challenging due to the private nature of sexual intercourse.

Joseph Rinta, the head of Merauke regency's health office said, "[t]he prostitutes can file a report," when their clients refuse to wear condoms.⁷ John Rahail, the director of the Indonesian Planned Parenthood Association in Jayapura (the capital city of West Papua) said, "[t]he bylaw is a positive move, showing the administration's effort to prevent the spread of the virus. But without strong supporting efforts, the bylaw will mean nothing."⁸

Rinta plans to undertake a three month implementation program to raise awareness of the bylaw among sex-workers and their clients. As part of this program, a medical team has also been assigned to perform monthly medical checkups on sex workers. If found to have a sexually transmitted disease, they will be prevented from engaging in sex work for as long as they still pose a risk of transmission.⁹

Many regencies in West Papua are also trying to make condoms more accessible in the area by installing "Condom ATM machines." These condom vending machines are referred to as ATM machines by locals because they operate by ATM cards. It is hoped the machines will increase the availability of condoms to men who are often too embarrassed to purchase condoms at pharmacies.¹⁰

West Papua deputy governor Constant Karma has said that as of March 2005 there are 1847 people living with HIV/AIDS in West Papua.¹¹ The World Health Organization estimates the actual number could be as high as 10,000-15,000. A total of 305 people have died of AIDS-related illnesses since HIV was first reported in the province in 1992.¹²

– Greg Herget

Southeast Asia: National policy audits on HIV and migration

The Canada Southeast Asia Regional HIV/AIDS Programme (CSEARHAP) has developed a tool to test the compliance of southeast Asian countries with leading stan-

dards on HIV policy for migrants and mobile populations. The tool measures whether a country has endorsed a particular migration instrument (such as the *Migrant Workers Convention*) and records data on the degree of compliance from key informant interviews.

CSEARHAP aims to reduce the vulnerability to HIV infection of migrants and mobile populations in four adjacent countries in the Greater Mekong Subregion: Cambodia, Lao PDR, Thailand and Vietnam. The project, funded by the Canadian International Development Agency, is intended to build the capacity of government ministries to design, deliver and coordinate relevant programs, laws and policies relating to HIV and migrants and mobile populations.

Migration and mobility are recognized as necessary for economic growth in the region, yet they also contribute to the spread of HIV infection. In 2002, the United Nations Regional Task Force on Mobile Populations and HIV Vulnerability developed a strategy on HIV vulnerability reduction.¹³ Rather than seek to limit migration and mobility, the strategy promotes the concept of "safe mobility." Safe mobility includes elements such as the inclusion of affected populations in policy making, and the development of national rights-based institutions and mechanisms to protect mobile people (including drug users and sex workers) from HIV.

In addition to the strategy, there are other regional and international legal and policy instruments which provide guidance to governments, donors and other stakeholders on HIV and migration. These include international human rights treaties, the *UNGASS Declaration*

of Commitment on HIV/AIDS, and the regional *Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability related to Population Movement*.

The results of the CSEARHAP national policy self-audits, which should be official government reports, will be used for national and regional advocacy to improve laws, polices and programs. CSEARHAP is planning to establish a public website where the documentation will be posted.

– David Patterson

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California: Senate fails to pass bill to allow condom distribution in state prisons

In August 2005, Bill AB1677 was held in suspense by the California Senate Appropriations Committee, effectively killing the bill for this legislative year.¹⁴ The Bill would allow non-profit organizations and health care agencies to distribute condoms and other safe sex material in California State prisons.

The Bill's express purpose is to reduce the spread of HIV in California's prisons. The American Centers for Disease Control and Prevention estimate that 1240 prisoners in California are HIV-positive, costing the state up to US\$18 million per year for HIV-related medical care.¹⁵ Given that most of California's inmates leave prison to return to their families, friends and

communities, ensuring access to condoms is essential to protect the health of California's inmates as well as the communities to which they return.

The Bill was passed by the California Assembly in June 2005 before being suspended by the Senate Appropriations Committee, a body concerned with the funding and budgeting of bills, so that it could be further reviewed. A number of prominent groups backing the bill, including the AIDS Healthcare Foundation and Human Rights Watch, expressed frustration at the Bill's failure to pass.¹⁶ The Bill will again be eligible for approval when the Senate reconvenes in January 2006.

Condoms are already available at municipal jails in Los Angeles and San Francisco, and in state prisons in Vermont and Mississippi.¹⁷

– Tim Franklin

California: Insurers cannot deny transplants based on HIV status

In September 2005, the Governor of California enacted a law prohibiting health insurance companies from denying organ transplants to HIV-positive individuals based solely on their serostatus.¹⁸ The California Senate had approved the Bill in August 2005 with bipartisan support.

Insurance companies have commonly refused transplants to HIV-positive individuals. In the 1980s and 1990s, patients with HIV or AIDS were thought to show higher rates of post-transplantation infection and neoplastic complication. However, with advances in transplantation methods and effective drug

treatments for HIV, recent studies have indicated that HIV-positive transplant recipients have a similar success rate to HIV-negative recipients.¹⁹

The new law has special relevance to HIV-positive individuals co-infected with hepatitis C. Liver complications caused by hepatitis C may diminish their bodies' capacity to metabolize highly active anti-retroviral treatment (HAART) medication and may result in toxicity. In such individuals, a liver transplant may be necessary in order for a HAART regimen to be effective.

The California law is the first US bill to address the issue of such denials by insurance companies. In April 2005, similar guidelines were issued in the UK recommending that HIV infection would no longer be an absolute bar to liver transplantation.²⁰

– Tim Franklin

WHO Europe report strongly endorses harm reduction in prisons

In May of 2005, the World Health Organization (WHO) Europe released a report on prisons, drugs and harm reduction.²¹ The report summarizes the evidence on harm reduction on prisons and aims to provide evidence for action that will reduce drug-related harms in prisons and, by extension, the community.

The report recognizes the “overwhelming” public health rationales and evidence related to harm reduction measures in the prison setting, and advocates for the adoption of a human rights approach to address drug-related harms:

[T]he underlying basic needs of prisoners remain crucial: decent space and less overcrowding, good hygienic conditions, acceptable nutrition, a stable and safe environment and prison regimens that are conducive to improving health and self-esteem and to helping prisoners take back control of their lives.”²²

The right of prisoners to free and equivalent access to public and preventative health measures as part of prisoners' right to health is explicitly recognized. Particular attention is paid to the evidence of the success of, and need for, substitution therapy and needle and syringe exchange programs in prison. The report calls for the involvement of all levels of government, civil society, community-based and non-governmental organizations, and people with personal experience of severe drug dependence and life with HIV/AIDS in the development and implementation of harm reduction policies.

The report concludes that “[t]he public health case for action is strong.”²³ While the report is specifically geared to the needs of prison systems in Europe, it is consistent with United Nations and WHO guidelines and European standards and, therefore, is relevant in a global sense wherever prison systems are facing health crises brought about by illicit drug use.

– Glenn Betteridge

¹ India to start HIV testing military recruits. Reuters South Africa, 24 September 2005.

² Statistics from UNAIDS, available via www.unaids.org.

³ India to start HIV testing.

⁴ *A. v Union of India*, Writ Petition No. 1623 01 2000.

INTERNATIONAL DEVELOPMENTS

High Judicature of Bombay, 28 September 2000.

⁵ R Jürgens. HIV testing for peacekeeping forces: legal and human rights issues. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(2).

⁶ West Papuan administrative units are known as regencies, which are composed of a number of districts.

⁷ ND Somba. To wear or not to wear, condom matters in Merauke. *The Jakarta Post* (Jayapura, Indonesia) (online edition), 4 October 2005.

⁸ Ibid.

⁹ Ibid.

¹⁰ ND Somba. Papuans use condoms to limit HIV/AIDS. *The Jakarta Post* (Jayapura, Indonesia) (online edition), 21 July 2005.

¹¹ Ibid.

¹² Ibid.

¹³ UN Development Programme. *South East Asia HIV and Development Programme, Phase II. Strategy on HIV vulnerability reduction in the Greater Mekong Subregion*. 2002. Available at www.hiv-development.org/sea_introduction.htm.

¹⁴ Largest U.S. AIDS group criticizes California Senate leadership for stopping condoms in prisons bill. PR Newswire, 25 August 2005.

¹⁵ California Bill AB 1677 (Koretz), available online at <http://info.sen.ca.gov>.

¹⁶ Human Rights Watch. *Protect prisoners' human right to health: support AB 1677*. Letter to California Governor Arnold Schwarzenegger. 27 April, 2005. Available via www.hrw.org; Largest U.S. AIDS group.

¹⁷ Measure allowing condoms to be distributed to

inmates approved by senate. Associated Press, 1 June 2005.

¹⁸ California law prohibits transplant surgery denial based on HIV status. *Advocate.com*, 11 October 2005. Available via www.advocate.com.

¹⁹ S Moren et al. Liver transplantation in HIV-infected recipients. *Liver Transplantation* 2005, 11(1): 76-81.

²⁰ G Cruess. UK: guidelines for liver transplants for HIV-positive people issued. *HIV/AIDS Policy and Law Review* 2005; 10(2): 34.

²¹ Status paper on prisons, drugs and harm reduction. World Health Organization Europe. May 2005. Available at www.euro.who.int/document/e85877.pdf.

²² Ibid. at p 2.

²³ Ibid. at p 15.

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.

Vancouver shopping mall liable for discrimination against Aboriginal and disabled people

In a decision released on 13 July 2005, the British Columbia Human Rights Tribunal (the Tribunal) found that the owners of a mall and the security company contracted by the mall had engaged in both individual and systemic discrimination.¹ Among other findings, the Tribunal determined that Henderson Development (Canada) Limited (Henderson) and Securiguard Services Limited (Securiguard) discriminated against mall patrons who were Aboriginal, or who were perceived to be living with a disability, including drug dependence and HIV/AIDS.

Henderson owned and operated the International Village Mall (the mall), located in Vancouver's downtown eastside (DTES). Henderson intended the mall to be an up-scale

shopping and entertainment complex. The Tribunal described the DTES "as an area in which poverty and social ills which attend it are rampant," and cited in particular the lack of eco-

nomie opportunities, inadequate and insufficient housing and medical care, crime, drug use and prostitution.²

The Tribunal heard evidence that Aboriginal people make up 16-18

percent of the DTES population. The mall was subject to a statutory right of way, which granted the public a right to pass through the mall as if it were, in effect, a public street. Securiguard was contracted by Henderson to provide security services for the mall.

Henderson and Securiguard put in place a number of policies which they argued were intended to provide a safe environment for the mall's customers and merchants. A zero-tolerance policy for "suspicious people and vagrants" provided that "all suspicious people and vagrants must be denied access at the main doors" or removed from the mall.³

The criteria security guards used to determine whether someone was suspicious or a vagrant included: ripped or dirty clothing, the person's attitude when approached by security, the person's willingness to answer questions, taking to oneself, the presence of open sores and wounds, red eyes, acting intoxicated or stoned, bothering customers, and begging for money or cigarettes on the street.

Securiguard had a "meet and greet" policy, under which security guards would "greet" suspicious looking people at the mall doors, inquire about where they were going and what business they had at the mall, and follow people they believed were suspicious. Securiguard also kept a book in which they listed people who had been banned from the mall.

Individual complaint of discrimination

The Tribunal decided that Henderson and Securiguard discriminated against Gladys Radek in regard to a service ordinarily available to the

public based on her race, colour, ancestry and physical disability, contrary to section 8 of the British Columbia *Human Rights Code* (the *Code*).

The incident giving rise to the complaint took place on 10 May 2001, when Radek and a companion entered the mall to go to a coffee shop. Radek, a 49-year old visibly Aboriginal woman who walked with a limp as a result of a lower limb amputation, and her companion were approached by a security guard, who proceeded to question them in a demanding and confrontational manner. When Radek and her companion ignored the security guard, a reaction based on numerous previous experiences of harassment by the same security guard, the security guard followed them closely.

After a short time, Radek turned around and challenged the security guard's actions. When challenged, the security guard told Radek and her companion that they had to leave the mall. The incident escalated and additional security staff, including supervisory staff, joined the effort to have Radek and her companion removed from the mall. When Radek attempted to walk away, one security person touched her. Radek and her companion eventually left the mall and called the police to report an assault, but no charges were laid and the police were sympathetic to the mall security personnel's interests.

In analyzing whether Radek had been subject to discrimination contrary to the Code, the Tribunal adopted an intersectional approach, examining the interrelationship between a number of intersecting grounds of discrimination alleged in the case (i.e., race, colour, ancestry and disability). Such an approach

focuses on people's lived experience of discrimination rather than narrowly on the legal grounds of non-discrimination abstracted from one another and from the way in which people experience the multiple facets that make up their identity.

"I find it difficult to imagine that events would have unfolded in the same way if Ms. Radek had been white."

As articulated by Radek, she was discriminated against "because of the way I look" – which the tribunal took to mean a middle-aged, economically disadvantaged Aboriginal woman with a disability. In finding that Radek had been discriminated against, the Tribunal commented: "I find it difficult to imagine that events would have unfolded in the same way if Ms. Radek had been white."⁴ The Tribunal found that Radek's race, disability (as manifest in a limp), and her economic circumstances all formed part of how she appeared to security personnel, and as a result, determined the treatment she was subjected to at their hands.

The Tribunal found that the conduct of Henderson and Securiguard's employee demeaned Radek's human dignity and had a devastating affect upon her. "[T]o be harassed, demeaned and excluded from International Village was to be excluded from their own community, and denied access to shops and services which were important to their quality of life and acceptance by

mainstream society.”⁵ The Tribunal ordered Henderson and Securiguard to pay Radek CA\$15,000 as compensation for injury to her dignity, feelings and self-respect.

Systemic discrimination

Radek alleged that the discriminatory incident was part of a larger pattern of systemic discrimination against mall patrons on the ground of race, colour, ancestry and disability. At an earlier step in the same case, Securiguard and Henderson unsuccessfully challenged Radek’s application to the Tribunal to amend her complaint to include the allegation of systemic discrimination.⁶

During the course of the 13 days of Tribunal hearings, and in documents placed before the Tribunal, 17 witnesses gave evidence of how they had been treated by Securiguard and Henderson personnel, and what action had been taken when they had lodged complaints with Henderson about such treatment. Among those who testified before the Tribunal were members of the Vancouver Area Network of Drug Users (VANDU) and staff of the Portland Hotel Society, a social service and housing organization in the DTES.

The Tribunal found

a pattern of systemic discrimination against Aboriginal people on the basis of their race ... individuals being denied entry to the mall, being questioned on entering the mall, being followed through the mall, and otherwise being subjected to discourteous treatment by guards.⁷

The Tribunal also found evidence of

overt discriminatory attitudes on the part of guards against persons with some kinds of disabilities, in particular drug addicts and people with HIV/AIDS.... Questions posed to “undesirable persons” banned from the mall with respect to drug use and HIV status are strong evidence of this policy, as was the evidence of the guards themselves.⁸

The Tribunal ordered Henderson and Securiguard to refrain from discriminating against people on the basis of their race, colour, ancestry and disability, and to pay the costs of an expert report relied upon by Radek to prove systemic discrimination.

Further, the Tribunal ordered Henderson to ensure that the policies and practices used by mall security personnel were non-discriminatory, to provide mall staff anti-discrimination training, to put in place a complaints procedure, and to provide anyone who requested a copy of the Tribunal’s decision and other relevant policies and documents. At the time of the hearing, Securiguard no longer provided security services in the mall, so no systemic orders were made against it.

Comment

The Tribunal’s decision is a forceful repudiation of discriminatory practices of a private business visited on some of the most marginalized people in Canada. It is also a testament to the strength and people and organizations that call Vancouver’s DTES home. In particular, members of VANDU have long advocated for changes to the discriminatory security practices at the mall; as detailed in

the Tribunal’s reasons, VANDU held a 200-person strong protest march in the mall and organized a movie night to gather evidence of discriminatory treatment.

The Tribunal’s use of the intersectional approach to analyze claims of discrimination is an important step in the development of anti-discrimination law. While this was not the first human rights tribunal to do so, the thoroughness of the Tribunal’s intersectional analysis in this case will no doubt help entrench the intersectional approach as part of Canadian anti-discrimination law.

By adopting the intersectional approach, the Tribunal signalled its willingness to meet people where they are at, and not compartmentalize their lives and their complaints of discrimination in overly formal legal categories. The challenge for advocates and human rights commissions in Canada is to ensure that the intersectional approach informs the analysis of complaints throughout the complaint procedure, from initial intake to commissions’ recommendations of whether a complaint should proceed to a hearing.

– Glenn Betteridge

¹ *Radek v Henderson Development (Canada) Ltd*, 2005 BCHRT 302.

² *Ibid.* at para 76.

³ *Ibid.* at para 126.

⁴ *Ibid.* at para 471.

⁵ *Ibid.* at para 495.

⁶ *Radek v Henderson Development (Canada) Ltd*, 2003 BCHRT 67.

⁷ *Radek v Henderson Development (Canada) Ltd*, 2005 BCHRT 302 at para 542.

⁸ *Ibid.* at para 523.

Court opens door to more claims under Red Cross HIV compensation fund

The Ontario Superior Court has allowed families of deceased individuals who contracted HIV from tainted blood to proceed with their claims against the Canadian Red Cross for compensation despite the existence of a compensation plan and fund.¹

In 2000, the Ontario Superior Court sanctioned a plan to provide compensation to certain people who had contracted HIV and other blood-borne diseases as a result of tainted blood products provided by the Canadian Red Cross Society (the Red Cross).²

Under the plan, a referee has authority to determine whether and to what extent individuals infected with HIV from blood products at various times can apply to the HIV Fund for compensation. In doing so, the referee has the power to determine whether a person has brought a claim for compensation within the time required by law, known as a limitation period. The plan set 20 July 1998 as the date the limitation period ended.³

This case is the latest of numerous cases that been brought seeking to exempt certain people and groups of people from the operation of that limitation period so that they can bring claims for compensation. Five years have elapsed since the HIV Fund was established, yet no compensation has been paid out because of litigation concerning the limitation period and other eligibility criteria.

In this case, the trustee of the plan sought directions from the court as to whether the estates of HIV-infected persons who died more than two years before 20 July 1998 without having commenced litigation against the Red Cross, and any family members of such individuals, can bring

proceedings seeking an order that the two-year limitation period does not apply to their claims. The estates and family members argued that the limitation period should not apply because the Red Cross fraudulently concealed the facts giving rise to their claims.

The legal doctrine of fraudulent concealment is an equitable principle which can be relied upon to prevent a limitation period from operating “as an instrument of injustice.” The trustee sought further direction, if such proceedings can be brought, as to the process to be used in having the issues determined. A number of individuals living with HIV/AIDS and the estates of deceased individuals who have also submitted claims to the HIV Fund, but who were not excluded by the limitation period, argued that the other claims should be excluded.

As a starting point for its consideration of the issue, the Court found that the gist of the plan was that in exchange for releasing the Red Cross, all claimants with provable claims against it would be entitled to have their claims assessed by the referee. In arriving at its decision, the Court stated that the statutes governing disposal of the HIV Fund should be interpreted liberally in order to facilitate maximum access to compensation.

The Court noted that to exclude the fraudulent concealment argument

would effectively eliminate 50 per cent of the family claimants and 75 per cent of the estate claimants from compensation.⁴ The Court found that the estates of HIV-infected persons who died more than two years before 20 July 1998 could proceed to invoke the doctrine of fraudulent concealment to delay the operation of the limitation period. The Court ordered the lawyers representing the various parties to arrange a case conference to determine the process for having the fraudulent concealment argument heard the Court.

Finally, the Court expressed concern about the continued depletion of the HIV Fund’s resources, currently standing at around \$14.7 million, caused by expenditures to resolve issues (such as the limitation period) raised by potential claimants.

– Tim Franklin

Tim Franklin is a first year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ *Re Canadian Red Cross Society*, [2005] OJ 4177 (QL).

² Amended Plan of Compromise and Arrangement of the Canadian Red Cross Society. 31 July 2000.

³ RSO 1990, c T23, s 38(3).

⁴ *Re Canadian Red Cross*, para 35.

In brief

Federal Court of Appeal rules contaminated-blood litigation cannot proceed

As previously reported in the *Review*, the plaintiffs were infected with HIV from a tainted blood product used to treat hemophilia.¹ The plaintiffs brought an action against the Canadian government and government officials claiming that they destroyed evidence that would have allowed the plaintiffs to successfully prove that the plaintiff's HIV infection was caused by the officials' negligence.²

At the Federal Court, Campbell J allowed the plaintiff to proceed to trial.³ The Federal Court of Appeal has reversed that decision. The Court stated that the case could not proceed to trial because the plaintiffs could not prove that Canada and government officials caused undue delay in the importation of clean blood product into Canada.⁴

The Court relied on a 2001 Ontario Court of Appeal decision which determined that there was no undue delay in the importation of the blood product into Canada.⁵ The Court applied the principle of "issue estoppel," which holds that once an issue is decided in one legal proceeding, that finding applies in all subsequent proceedings based on the same facts, and the issue may not be re-litigated. Accordingly, the plaintiffs

could not prove loss and thus their claims could not succeed.⁶

– Greg Herget

Greg Herget is a second year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

Egale granted intervenor status as party in Canadian blood donor case

In a recent development in *Canadian Blood Services v Freeman*, the Ontario Superior Court granted Egale Canada Inc. (Egale) application for leave to intervene as a party. Egale is a national organization that attempts to advance equality for gay, lesbian, bisexual and trans-identified people. As a party in the case, Egale now has the authority to fully participate in all aspects of the proceeding.⁷

Freeman, the defendant, lied on question 18 of the questionnaire that the Canadian Blood Services (CBS) requires all donors to answer prior to giving blood. The question asked whether Freeman had had sex with another man since 1977; Freeman said that he had not. CBS brought an action against Freeman for misrepresentation. Freeman counterclaimed that question 18 offended his consti-

tutional right to equality on the basis of his sexual orientation.

In deciding Egale's application for leave to intervene, Master Beaudoin determined that Egale had a direct interest in the matter since Egale's members would be directly affected by the results of the case. He also stated that the "depth of Egale's experience, the breadth of its perspective and the expertise that it can bring will enhance the Court's ability to determine the constitutional question in issue."⁸

As previously reported, the Canadian AIDS Society (CAS) was granted intervenor status in the same case in the more restricted role of a friend of the court.⁹

– Greg Herget

¹ A Ketter. Federal Court permits contaminated blood-litigation to proceed. *HIV/AIDS Policy & Law Review* 2004; 9(3): 57-58.

² *Leblanc v Canada*, [2004] FCJ No 984 (Federal Court) (QL).

³ *Ibid.*

⁴ *Leblanc v Canada*, [2005] FCA 234 (Federal Court of Appeal).

⁵ *Robb Estate v Canadian Red Cross Society* (2001), 152 OAC 60 (Ontario Court of Appeal).

⁶ *Leblanc v Canada*, [2005] FCA 234.

⁷ *Canadian Blood Services v Freeman*, [2005] OJ No 2159 (QL).

⁸ *Ibid* at para 32.

⁹ B Mysko. Canadian AIDS Society granted intervenor status in blood donor case. *HIV/AIDS Policy & Law Review* 2005; 10(1): 53-54.

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.

Hong Kong: Court says laws criminalizing sexual activity infringe rights of gay men

On 24 August 2004, the Hong Kong Court of First Instance declared four sections of Hong Kong's Criminal Ordinances to be inconsistent with the rights of gay men as set out in the *Hong Kong Basic Law and Bill of Rights*.¹

William Roy Leung, a 20-year-old gay man, brought an application challenging the legality of four sections of Hong Kong's Criminal Ordinances which made illegal certain sexual acts involving consensual sex between men in situations where such acts would not be illegal if engaged in between people of the opposite sex. Although Leung had not been criminally charged under the Ordinances,

the Court decided that he was legally entitled to challenge the laws.

Criminal Ordinances drew distinctions

Until 1991, under Hong Kong law, all same-sex acts between males were subject to penalty; after that time, same-sex acts performed in private by consenting males over 21 years old were permitted. The four

sections of the Criminal Ordinances challenged in the case drew distinctions between heterosexual and same-sex sexual acts between males based on the age of the participants. The four sections effectively:

- established the legal age of consent for sexual intimacy between men at 21 years (compared with 16 years for heterosexuals and lesbians);

- made illegal group sexual intimacy involving more than two men regardless of their age (compared with group sex between heterosexual or lesbians which was not illegal as long as the participants were at least 16 years old);
- established the legal age for buggery (penetrative anal sexual intercourse) between men at 21 years old (compared with 16 years old for vaginal intercourse between a male and a female); and
- made illegal buggery between two men where one or more other persons was present (compared with anal penetrative intercourse between a man and a woman where one or more other persons was present, which was only illegal if the woman was under 21 years old).

Leung argued that all four provisions were inconsistent with the *Hong Kong Basic Law and Bill of Rights*, specifically the articles of those laws that prohibit discrimination and guarantee all people equal and effective protection of the law, guarantee the right to equal enjoyment of all civil and political rights, and guarantee the right to protection against arbitrary or unlawful interference with privacy.

The Hong Kong Secretary of Justice accepted, and the Court agreed, that the guarantees of equality in the Basic Law and the Bill of Rights protect people from discriminatory treatment based on their sexual orientation, which the Court understood to be included under the term “sex” found in those laws. The Secretary of Justice conceded that three of the four sections challenged infringed the rights and protections guaranteed to gay men.

Challenge to the legal age for buggery

The parties’ arguments and the Court’s reasons focused on the Criminal Ordinance which made it illegal for gay men under 21 to engage in buggery. The law also made it illegal for a man to engage in buggery with a woman under the age of 21, but did not impose a criminal penalty on the woman.

The Secretary of Justice conceded that three of the four sections challenged infringed the rights and protections guaranteed to gay men.

The Secretary of Justice put forward two arguments to support the constitutionality of the age limit on buggery. First, the Secretary asserted that it was up to the legislature to determine how to best protect young persons. The Court dismissed this argument, finding that in matters of high constitutional importance involving fundamental rights, courts owe only a limited deference to the legislature. The Court found that the government had an obligation not to “mark with perversity by the law” gay men, and in relation to the guarantee of privacy, a responsibility to promote conditions “in which personal self-realization can take place.”²

Second, the Secretary of Justice argued that the law did not discriminate against gay men since it also criminalized men who engaged in

buggery with women under the age of 21. The Court dismissed this argument, finding that the challenged section discriminated against gay men both directly and indirectly. Regarding the direct discrimination, the inequality of treatment arose because when two men engaged in buggery both were subject to criminal penalties, whereas only the man was criminalized when a man and a woman engaged in buggery.

In analyzing indirect discrimination, the Court looked at the legislative scheme regulating sexual relations under the Criminal Ordinance. The Court rejected in strong terms the contention that males under the age of 21 were in need of special protection because of the risk of being “recruited” into homosexuality, and went on to state:

The four sections are demeaning of gay men, who are, through the legislation, stereotyped as deviant. The sections also constitute a grave and arbitrary interference with the right of gay men to self autonomy in the most intimate aspect of their private lives.... The primary purpose of the four sections is to discourage vulnerable young men from what is perceived to be a chosen lifestyle of which the majority of the community disapprove.... I fail to see how imprisoning young men because of their sexual orientation, when there has been no abuse or exploitation of a third party, can today represent a proportionate response to any perceived need to protect those young men against moral degradation.³

The Court declared the four challenged provisions of the Criminal Ordinances unconstitutional and ordered the government to pay Leung his legal costs.

Comment

The Court's decision is a significant victory not only from the perspective of upholding the fundamental rights of gay men to equality and privacy, but also in addressing vulnerability to HIV/AIDS. The Secretary of Justice raised the argument that young gay men required special protection from the threat of HIV/AIDS associated with buggery. The Court dismissed this argument as irrational, and cited a Canadian case to the effect that, "there is no evidence that threatening to send an adolescent to jail will protect him (or her) from the risks of anal intercourse."⁴

The history of the HIV epidemic has demonstrated that human rights abuses promote rather than diminish HIV transmission among populations subjected to community disapproval, such as gay men, people who use drugs and sex workers. Thus, Guideline 4 of the *International Guidelines on HIV/AIDS and Human Rights* calls on states to "review and reform criminal laws ... to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups."

This case demonstrates the importance role played by the rule of law,

an independent judiciary, and constitutional protection for fundamental rights when governments are unwilling to fulfill their legal obligation to stop the persecution of vulnerable groups (such as gay men) and, by extension, to stop the HIV epidemic.

– Glenn Betteridge

¹ *Leung v Secretary for Justice*, [2005] HKEK 1334 (Court of First Instance).

² *Ibid.* at paras 115-116.

³ *Ibid.* at para 147.

⁴ *Ibid.* at para 150, quoting Abella JA in *R v CM* (1995), 23 OR (3d) 629 (Ontario Court of Appeal).

US: Mexican national eligible for asylum on basis of sexual orientation and HIV status

The United States Court of Appeals for the Ninth Circuit has overturned the findings of the Board of Immigration Appeals (BIA) and the Immigration Judge (IJ) who denied Jose Boer-Sedano's claim for asylum in the US, and his challenge against being removed from the US.¹

Jose Boer-Sedano experienced severe persecution in Mexico because he was gay. He was ostracized by his family and co-workers. On nine separate occasions, Boer-Sedano was forced to perform oral sex on a "high ranking police officer" who also abused him and threatened to kill him.

In 1989, Boer-Sedano was granted a visitor's visa to enter the US for six months. In 1990, he moved to San Francisco and, in 1992, he was diag-

nosed with HIV, which later developed into AIDS.

In 1997, removal proceedings were initiated against him for overstaying his visa. Boer-Sedano claimed asylum, challenged his removal from the US, and sought protection under the Convention Against Torture. The IJ decided against Boer-Sedano on all three grounds. The BIA adopted the decision of the IJ. Boer-Sedano petitioned the Court for a review of the

BIA's decision. At the time of the hearing, Boer-Sedano was working in a restaurant and received health insurance benefits through his employer.

Asylum claim

The IJ denied Boer-Sedano's claim for asylum on the basis that he failed to establish a well founded fear of persecution based on his membership in a particular social or political group. The IJ said that homosexual-

ity does not qualify as a social group. The IJ also characterized Boer-Sedano's experience with the police officer as a "personal problem" rather than ongoing harassment by a state official.

The Court of Appeal overturned the IJ's finding in relation to the asylum claim, stating that "alien homosexuals" constitute a particular social group and that the abuse Boer-Sedano experienced while in Mexico clearly created a well founded fear of persecution.² The Court found that relocation within Mexico was not a reasonable option for Boer-Sedano as the evidence demonstrated that "violence against homosexuals is not limited to any one area."³

The Court of Appeal also faulted the IJ for not taking into account the serious harm that he would face if he relocated within Mexico:

The record reflects that Boer-Sedano would face significant social and cultural constraints as a gay man with AIDS in Mexico, as hostility towards and discrimination against HIV/AIDS patients is common in Mexico.⁴

The Court accepted Boer-Sedano's doctor's evidence that he required investigational medicines for his AIDS treatment that were not available in Mexico. The Court found that due to discrimination against homosexuals in Mexico, Boer-Sedano would not be able to find a job that would provide him with comparable health coverage he currently has in the US that covers his AIDS medication. The Court remitted the case to the Attorney General to exercise his discretion whether to grant Boer-Sedano asylum.

Withholding of removal and Convention Against Torture claims

Having found that Boer-Sedano was eligible for asylum, the Court "remanded [the case] to the BIA to consider in the first instance Boer-Sedano's withholding of removal claim." Finally, the Court affirmed the denial of relief under the *Convention Against Torture*, finding that the IJ did not err in finding that

he would not face torture if removed to Mexico.

In a similar case in the Canadian context, as reported in the Review, the Federal Court of Canada overturned a negative Pre-Removal Risk Assessment of an HIV-positive Mexican man.⁵ The court relied on evidence documenting discrimination against people living with HIV/AIDS in Mexico and the resulting difficulty people have accessing HIV treatment.

– Greg Herget

Greg Herget is a second year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ *Boer-Sedano v Gonzales*, 418 F.3d 1082 (9th Circuit, 2005).

² *Ibid.* at para 6.

³ *Ibid.* at para 9.

⁴ *Ibid.* at para 10.

⁵ S Bahk. Federal Court overturns negative Pre-Removal Risk Assessment of HIV-positive failed refugee claimant. *HIV/AIDS Policy & Review* 2005; 10(2): 39-40.

New Zealand: Sections of city by-law effectively prohibiting small owner-operated brothels struck down

On 29 July 2005, the High Court of New Zealand decided the first case testing the scope of the by-law-making power given to cities under the *Prostitution Law Reform Act 2003 (the PRA)*.¹ The Court struck down the sections of a Christchurch by-law confining brothels to a defined area within the city's central business district.

The PRA, which decriminalized prostitution and established a system regulating sex work and brothels, gave cities the power to regulate by by-law the location of brothels. After

an extensive legislative drafting and consultation process, mandated by New Zealand law, Christchurch passed a by-law stating that, “no person may operate, or permit or suffer to be operated, a brothel in any part of the City other than within the area delineated on the map contained in the First Schedule.”²

The area delineated was 90 hectares and was located within the city’s central business district. Brothels that existed outside the delineated area prior to the passage of the by-law were permitted to continue in operation as long as they did not change character or increase in size.³

The legality of the by-law was challenged by a family trust which owned property outside the delineated area and whose trustee wanted to operate brothels on the property. The challenge was based on a number of grounds, grouped into three categories by the Court: the geographic scope of the by-law; the right to freedom of association; and the right to work.

The Court reviewed the geographic scope of the by-law and determined that it met the legal test applicable in the circumstances, finding that it was “reasonable.” The Court also rejected in short order the argument that the impugned section of the by-law limited sex workers’ right to freedom of association as guaranteed under the New Zealand *Bill of Rights*.

Right to work

The family trust argued that the section of the by-law which established the geographic area infringed the right of sex workers’ to work in small owner-operated brothels. The Court framed the right to work issue as follows: “[T]he ultimate questions ...

are what rights are conferred upon sex workers under the [*PRA*] and whether the by-law unreasonably interferes with those rights.”⁴

The *PRA* defines a “small owner-operated brothel” as a “brothel at which not more than 4 sex workers work and where each of those sex workers retains control over his or her individual earnings from prostitution carried out at the brothel.”

The Court heard evidence that, following a special consultation, the responsible sub-committee recommended to the city council that the by-law be amended to permit small owner-operated brothels (with a maximum of two sex workers) to operate outside the designated area. The city council rejected the recommendation; as enacted, the by-law required all brothels to operate within the designated area.

The Court found that “the rights of sex workers to engage in the business of prostitution was expressly recognized” in the *PRA*.⁵ The Court remarked that the *PRA* was intended to create a framework that safeguards the human right of sex workers, protects them from exploitation, and protects their welfare and occupational health and safety.⁶

The Court accepted evidence, including evidence from the New Zealand Prostitutes Collective, that the small owner-operated brothels were overwhelmingly located in the residential areas in the suburbs of the city and that they did not cause significant problems. The Court decided that the section of the by-law that provided for the designated area was invalid because its practical effect was to deny the existence of small owner-operated brothels in the city. It was legally “unreasonable” for the by-law to prohibit sex workers from

plying their trade at all in a substantial and important portion of the city even though there was no nuisance associated with their operation.

Comment

It is significant that the Court recognized that the *PRA* effectively granted sex workers the right to work. Sex workers can rely on this decision to challenge by-laws, based not only on the *PRA* but also on broader constitutional and other protections for the right to work. The decision is also commendable for its recognition of the special significance of small owner-operated brothels under the *PRA*, namely that such brothels have the greatest potential to maximize sex worker’s control over their working conditions and, by extension, their health and safety.

Unfortunately, the Court explicitly chose not to decide the issue of whether the city council has the authority to restrict small owner-operated brothels from being operated out of private homes. This issue may be the subject of new litigation if the city enacts a by-law that effectively makes illegal home-based small brothels.

– Glenn Betteridge

¹ *Willowford Family Trust v Christchurch City Council* (29 July 2005), Christchurch CIV-2004-409-002299.

² *Christchurch City Brothels (Location and Signage) Bylaw 2004*, section 6, cited in *Willowford Family Trust* at para 5.

³ *Ibid.*, section 7, cited at para 6.

⁴ *Willowford Family Trust* at para 80.

⁵ *Ibid.* at para 82.

⁶ *Ibid.*

Australia: HIV-positive Zambian national refused student visa on appeal

In September 2005, a three-judge panel of the Federal Court of Australia overturned a decision of a single judge of the Court granting an HIV-positive man a temporary student visa.¹

The granting of temporary student visas is subject to public interest provisions set out in regulations to the *Australian Migration Act of 1994* (the *Act*). The regulations require that the applicant not have a disease or condition such that would “result in a significant cost to the Australian community in the areas of health care and community services.”² A judge of the Federal Court sitting alone, reviewing the decision of the Migration Review Tribunal, decided that the cost would not be significant in the circumstances of the Zambian student’s case.³ The government appealed the decision.

The decision of the three-judge panel of the Court (the Full Court) turned on the meaning of the phrase “health care” in the regulations. The Court heard that as a result of the visa applicant’s HIV status, he would require blood monitoring four times a year for five years at a cost of AUS\$267 per quarter. He self-administered his antiretroviral treatment, which cost of AUS\$1188 per month.

In quashing the tribunal’s decision to reject the visa application, the single judge of the Court had found that the term “health care,” while applying to blood monitoring, did not extend to the prescription and dispensing of prescription medication that is self-administered. Therefore, the Court reasoned that the cost of

treatment to health care and community services would not be prohibitively high.

The Full Court disagreed with this construction of the regulations, finding that the term “health care” must at least include “[t]he prescription of medication by a legally qualified medical practitioner and the dispensing of that medication by a pharmacist.”⁴ The Court reasoned that the fact that the medication would be self-administered would not isolate the treatment from health care in general.

Moreover, the Court stated that the nature and extent of the monthly prescriptions would vary with respect to the results of the blood monitoring, tying them into the general domain of health care. Since the cost and administration of the antiretroviral medication should be included in the assessment of the visa application Act, the court allowed the appeal and rejected the visa application on the grounds of significant cost to health care and community services.

Subsequent to the decision, the Zambian applicant was granted a ban barring the publication of his name in any report of the proceedings.⁵ Counsel for the man argued that disclosure of his identity and HIV status would cause him and his family embarrassment and distress. The Court concurred, noting that the September 2005 decision had gener-

ated some media attention which could potentially stigmatize the man and his family. The Court held, moreover, that full disclosure of the applicant’s identity might discourage others who would seek to challenge administrative decisions linked to HIV/AIDS from coming forward, for fear of similar embarrassment and distress.

– Tim Franklin

Tim Franklin is a first year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ *Minister for Immigration and Multicultural and Indigenous Affairs v X*, [2005] FCAFC 209 (Federal Court of Australia). For an account of previous proceedings in the same case, see S Bahk, Australia: HIV-positive visa applicants successfully appeal refusals based on medical inadmissibility, *HIV/AIDS Policy & Law Review* 2005; 10(2): 46-47.

² *Migration Regulations 1994* (Cth), sch 4, cl 4005(c).

³ *X v Minister for Immigration and Multicultural and Indigenous Affairs*, [2005] FCA 429 (Federal Court of Australia).

⁴ *Minister for Immigration and Multicultural and Indigenous Affairs v X*, [2005] FCAFC 209, at para. 12.

⁵ *Minister for Immigration and Multicultural and Indigenous Affairs v X*, [2005] FCAFC 217 (Federal Court of Australia).

UK: Local authority has no obligation to reveal HIV status of foster parent

The England and Wales High Court, Family Division ruled in July of 2005 that a local authority is under no obligation to reveal to a child's natural parents the fact that the child's foster father is HIV-positive. In his decision, Sumner J determined that the foster father's right to privacy outweighed any potential risk to the child.¹

During the course of an investigation of the long-term fitness of the foster father as a foster carer, a London Borough Local Authority learned of the man's HIV-positive status. The Authority sought the advice of the court regarding whether it had an obligation to disclose the foster father's HIV status to the biological father of the child, who was seeking permanent custody.

In reaching his decision, Sumner J relied on Article 8 of the *European Convention on Human Rights*, which was enacted into British law in the *Human Rights Act 1998*. Article 8 provides for the "respect for private and family life." Exceptions to this right in paragraph 2 of Article 8 provide that:

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health

or morals, or for the protection of the rights and freedoms of others.²

Sumner J referred to recent decisions applying Article 8 which held that where the disclosure concerned an intimate part of an individual's private life, the need for disclosure must be serious and pressing to set aside the privacy protections in Article 8. The judge took particular notice of a report prepared by a physician specializing in pediatric infectious disease, in which the physician provided the following opinion concerning the issue:

The confidentiality of the foster carer will be breached. This is likely to have a detrimental effect of the life of the foster carer and his family, as persons with HIV often suffer from discrimination and social isolation. I would not recommend that this confidentiality is breached if the child has only been exposed to normal non-sexual household contact.³

The Court decided against obliging the Local Authority to disclose the

man's HIV status. The Court found that the Local Authority owed a duty to the foster father to respect his privacy, and since the health risks to his foster daughter were negligible, there was no pressing need justifying disclosure. Sumner J acknowledged that, in certain circumstances, "where the risk is not negligible the duty to disclose may overcome [the foster-father's] rights and the duty owed to him. Each case will be dependent on its own facts."⁴

– Tim Franklin

¹ *London Borough of Brent v Mr & Mrs N, The Minor's Foster Carers, P, a minor (appearing by her Guardian)*, [2005] EWHC 1676.

² [European] Convention for the Protection of Human Rights and Fundamental Freedoms, (ETS 5), 213 UNTS, 222, Art 8.

³ *London Borough of Brent* at para 14.

⁴ *Ibid.* at para 32.

Criminal law and HIV transmission or exposure

New Zealand: Criminal charges dismissed against HIV-positive man who had unprotected oral and protected vaginal sex

In a significant judgment, the District Court at Wellington dismissed criminal charges against Dalley, finding that he had no legal duty to disclose his HIV status to a female partner prior to sex.¹

Dalley and the woman met through an internet dating service, followed by a face-to-face meeting at a bar, and subsequently met once to have sex. Dalley performed oral sex on the woman, she performed oral sex on him (but not to the point of ejaculation), and they had vaginal intercourse, during which a condom was used.

The woman was contacted by police and, as a result of her statement, Dalley was charged with criminal nuisance.² To prove a charge of criminal nuisance, the Crown had to prove that Dalley had a legal duty, that he failed to discharge that duty, and that in failing to do so, he endangered the life, health or safety of the woman.

Dalley was alleged to have breached the legal duty imposed on “persons in charge of a dangerous thing,” in this case HIV, “to take reasonable precautions against and to use reasonable care to avoid” endangering human life.³

Three physicians provided evidence concerning the risk of HIV transmission associated with the sexual acts which the charges were based upon. The Court also heard evidence from the physicians about counselling

practices for HIV-positive people, the public health guidelines developed by the Australasian College of Sexual Health Physicians, and the New Zealand AIDS Foundation position on disclosure of HIV status.

The Court decided that Dalley was under a duty not to engage in conduct which he could foresee would expose his female sexual partner to harm, and to take reasonable precautions against and use reasonable care to avoid such harm. As stated by the Court: “Clearly the HIV virus present in semen may endanger human life and accordingly the duty applies.”⁴ The Court rejected the argument that the duty applied only where there was a significant risk of transmission of the virus.

In order to determine whether Dalley breached that duty, the Court examined the facts of the case and the evidence regarding oral sex, then vaginal intercourse. Regarding oral sex, the Court found that

[t]he risk of transmission of the virus as a result of oral intercourse without a condom is not zero because it is biologically possible, but it is so low it does not register as a risk. In any event Mr Dalley did not ejaculate. On the basis of those 2 factors I find that reasonable precautions against and reasonable care to avoid such danger was taken by Mr Dalley.⁵

The issue regarding vaginal intercourse was whether the use of a condom was sufficient to constitute reasonable precaution against, and reasonable care to avoid, the transmission on HIV. In deciding this issue, the Court referred to the evidence it

had heard demonstrating the effectiveness of condoms at preventing the transmission of HIV. The Court decided that by using a condom, even though they are not failsafe, Dalley demonstrated reasonable caution and care, thereby fulfilling his duty.

In reaching its decision regarding the duty associated with vaginal intercourse, the Court not only took into account the evidence regarding the risk of HIV transmission and the efficacy of condoms, but also the evidence about the public health approach to HIV prevention.

The evidence was that, so far as public health needs are concerned, the steps necessary to prevent the transmission of HIV can be met without the requirement for disclosure. In other words, the use of a condom for vaginal intercourse is considered sufficient. I consider that I must attach significant weight to the approach of the relevant health professional bodies in this area.⁶

– Glenn Betteridge

UK: First woman sentenced for infecting sexual partner with HIV

In July of 2005, a 20-year-old woman accused of deliberately infecting her boyfriend with HIV pleaded guilty to a charge of unlawfully inflicting grievous bodily harm before the Cardiff Crown Court.⁷ She was believed to be the first woman in Britain convicted of knowingly infecting a sexual partner with HIV.⁸

The woman, who was 18 years old at the time of the offence, had been having unprotected sex with her boyfriend for 10 months while knowing that she was HIV-positive. After the couple separated in early 2004, he confronted her about her HIV-positive status, which she denied. The boyfriend found out he was HIV-positive in December of 2004.

After being arrested, the woman stated that she believed it was difficult for men to catch HIV during sex with a woman. She also indicated that she was aware of her HIV-positive status in June of 2003, but withheld this information from her boyfriend out of fear that he would leave her.

The woman was sentenced to two years in a youth detention centre. Her conviction was for reckless transmission of HIV.⁹ Reckless transmission is differentiated from deliberate transmission; in the case of the former, while the accused may not have disclosed his or her HIV-positive status to his or her partner, there was no intention to infect the partner with the virus.¹⁰ In delivering the sentence, the judge indicated that the gravity of the offence justified a custodial sentence. The name of the woman is not being released to protect the identity of her former boyfriend.

– Tim Franklin

UK: Leave to appeal grievous bodily harm conviction and sentence denied

The England and Wales Court of Appeal Criminal Division has denied Mohammed Dica's application for leave to appeal his sentence for inflicting grievous bodily harm by knowingly infecting two women with HIV.¹¹

Dica was originally convicted in 2003 for inflicting grievous bodily harm against the two women. At the trial, the court heard evidence that though he disclosed his HIV status, he convinced the women that there was no risk to their health on the grounds that he had had a vasectomy. An appeal of that conviction was allowed, and at retrial in March 2005 Dica was once again convicted, and was sentenced to four-and-a-half years imprisonment.¹²

Dica sought leave to appeal against both the conviction and the sentence. The Court of Appeal dismissed the appeal against conviction. Under the applicable rules of procedure, the Court can permit a party to appeal the case to the UK's highest court, the House of Lords. Dica's counsel requested that the Court grant leave to appeal the conviction to the House of Lords, which it refused to do. However, the Court certified that its decision involved a point of law of general public importance, stated as follows: "In what circumstances, if any, may a defendant who knows or believes that he is infected with a serious sexually-transmitted infection and recklessly transmits it to another through consensual sexual activity, be convicted of inflicting grievous bodily harm contrary to section 20 of the offences against the Person Act 1861?" It will now be up to the House of Lords to consider whether it will grant leave to hear the case.

Regarding the appeal against the sentence, Dica argued that it was "manifestly excessive."¹³ Counsel for Dica argued that he was a person of good character who had been vilified by the media, and had suffered through a long and arduous trial and appeal process. The Court disagreed, noting that by not submitting

a guilty plea, the appellant subjected his victims to the same lengthy process. Moreover, the Court agreed with the judge who heard the retrial that the harm inflicted on the victims was of the gravest character, and in light of the nature of the crime there were no mitigating circumstances. Accordingly, the Court denied leave to appeal the sentence.

– Tim Franklin

¹ *New Zealand Police v Dalley* (4 October 2005), CRI-2004-085-009168.

² "Common nuisance" is set out in section 145 of the *Crimes Act 1961*, as follows:

(1) Every one commits criminal nuisance who does any unlawful act or omits to discharge any legal duty, such act or omission being one which he knew would endanger the lives, safety, or health of the public, or the life, safety, or health of any individual.

(2) Every one who commits criminal nuisance is liable to imprisonment for a term not exceeding one year.

³ Section 156 of the *Crimes Act 1961* states: Every one who has in his charge or under his control anything whatever, whether animate or inanimate, or who erects, makes, operates, or maintains anything whatever, which, in the absence of precaution or care, may endanger human life is under a legal duty to take reasonable precautions against and to use reasonable care to avoid such danger, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.

⁴ *New Zealand Police v Dalley* at para 35.

⁵ *Ibid.* at para 39.

⁶ *Ibid.* at paras 47-48.

⁷ *Woman Infected Her Partner with HIV*, BBC News, 18 July 2005. Available at <http://www.aegis.org/news/bbc/2005/BB050713.html>.

⁸ R Savill. *HIV Girlfriend Sentenced to Two Years*. *The Telegraph* (online edition), 19 July 2005. Available at www.telegraph.co.uk/news/main.jhtml?xml=/news/2005/07/19/nhiv19.xml&Sheet=/news/2005/07/19/ixhome.html.

⁹ *British woman charged with criminal transmission of HIV*, Avert.org, 19 July 2005. Available at <http://www.avert.org/ukaidnews.htm>.

¹⁰ *Criminal, deliberate and reckless HIV transmission*. Avert.org. Available at <http://www.avert.org/criminal-transmission.htm>.

¹¹ *R v Dica*, [2005] EWCA Crim 2304. (Court of Appeal Criminal Division).

¹² For further information see G Cruess. *UK: Man sentenced to prison term; conviction of second man upheld*. *HIV/AIDS Policy & Law Review* 2005; 10(2): 54; and M Weait, Y Azad. *The criminalization of HIV transmission in England and Wales: questions of law and policy*. *HIV/AIDS Policy & Law Review* 2005; 10(2): 1, 5-12.

¹³ *Ibid.* at para [11].

In brief

New Zealand: Man fined for removing condom during sex with sex worker

Daniel Morgan was recently convicted under New Zealand's *Prostitution Reform Act 2003 (PRA)* for practicing unsafe sex with a sex worker.¹ He received a fine of NZ\$400 (approximately US\$272) for removing his condom during sexual intercourse.² The maximum fine for the offence under the *PRA* is NZ\$2000 (approximately US\$1360).³ It is believed that this is the first such charge under the *PRA*.

The *PRA* decriminalizes prostitution (while not endorsing or morally sanctioning prostitution or its use) and provides a framework that is con-

cerned with safeguarding the human rights of sex workers and promoting their occupational health and safety.⁴ The *PRA* explicitly requires both sex workers and clients to adopt safer sex practices by taking all reasonable steps to minimise the risk of acquiring or transmitting sexually transmissible infections.⁵ This includes the responsibility to ensure a condom or other appropriate barrier is used.⁶

Morgan said he removed the condom without the sex worker's knowledge because he knew that she would not have consented to unprotected sexual intercourse.⁷ Calum Bennachie, of the New Zealand Prostitutes' Collective, commented that even though the fine was not the maximum available under the *PRA*, "[t]he social penalty is a lot

larger...there's a lot of stigmatisation that goes along with [the fine]. Quite often the stigmatisation will prevent other people from doing the same thing."⁸ Bennachie said this case is evidence that the *PRA* is working.⁹

– Greg Herget

¹ NZ court fines man for unsafe sex. *BBC News* (online edition). 15 July 2005.

² *Ibid.*

³ *Prostitution Reform Act 2003*, No 28, s 9.

⁴ *Ibid.*, s 3.

⁵ *Ibid.*, s 9.

⁶ *Ibid.*

⁷ NZ court fines man for unsafe sex.

⁸ *Ibid.*

⁹ *Ibid.*