

HIV/AIDS POLICY & LAW REVIEW

Male circumcision and HIV prevention: a human rights and public health challenge

Three recent randomized clinical trials from Africa concluded that male circumcision can lead to a significant reduction in HIV risk for men. As a result, an exponential scale-up of services required to circumcise men is already figuring in the thinking of AIDS policy-makers at many levels. At this writing, the World Health Organization (WHO) is reviewing the three studies and other evidence, and is developing policy recommendations for making this HIV prevention intervention widely available. WHO says that this policy exercise “will need to take into account cultural and human rights considerations associated with promoting circumcision,” among other factors.¹ In this article, Joanne Csete identifies some of the most important human rights questions that should be taken into account in the development of guidelines for national governments. The author argues that a scale-up of services to provide male circumcision provides an excellent opportunity to address issues concerning the subordination of women.

Introduction

Results of recent research on the protective effect of male circumcision with respect to HIV transmission have taken the AIDS world by storm — and rightly so. When HIV prevention victories continue to be few and often unsustainable, it is easy to be swept up in the excitement about an intervention that promises men something on the order of a 50 to 60 percent reduction in HIV risk. It is no surprise that male circumcision has been hailed as the “AIDS vaccine for the real world,”² especially

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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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Male circumcision and HIV prevention: a human rights and public health challenge

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as the prospect of an effective HIV vaccine of the conventional sort continues to be years away.

Research on HIV and male circumcision is a story of high drama, as health research goes. For years, epidemiologists had noted that HIV prevalence appeared to be lower in societies where male circumcision was the norm. But it was clear that other variables — including sexual norms and practices that may be associated with the same religious differences that affect circumcision practices — might “confound” the conclusion that lower HIV prevalence was caused by circumcision. Only a randomized study — that is, one in which men were randomly assigned to be circumcised or be in an uncircumcised control group — could control for possible confounding factors, or at least come close enough to lead to policy recommendations.

It took some years to make randomized trials a reality, but three such trials in Africa — one from a French-funded research team working in Orange Farm, South Africa, and two from U.S.-funded projects in western Kenya and Uganda — have now reported results.³ In all three cases, the studies were discontinued before their planned end dates because the HIV protective effect of circumcision was so strong that it was unethical to deny it to those in the control group.

These three studies examined only the effect of circumcision with respect to HIV transmission from

women to men. A study funded by the Gates Foundation in Uganda, expected to be completed in 2008, seeks to quantify the effect of male circumcision on sexual transmission of HIV from men to women.⁴ A preliminary analysis of data from this study presented at a technical WHO meeting in March 2007 indicated that women may face higher-than-normal HIV risk from having sex with recently circumcised men before the incision from the circumcision is completely healed, but WHO officials were quick to say that these findings did not negate the important preventive effect of circumcision overall.⁵

Strong views are the norm on a topic such as male circumcision, steeped as it is in religious and cultural values and sexual mores. The procedure is characterized by some as cruel and inhuman “male genital mutilation,” by others as a sacred rite, and by still others as a step forward for hygiene and sexual pleasure. These divergent views make for a challenging policy discussion about scaling up male circumcision in national AIDS programs.

Male circumcision and women’s vulnerability to HIV

WHO’s statement on male circumcision and HIV echoes a theme that virtually every author on the subject emphasizes — that circumcision is at best only partially protective against HIV and can be regarded only as one

element of a comprehensive approach to prevention.⁶ As others have done, WHO notes the danger that men who are circumcised will develop “a false sense of security” and as a result might engage in “high-risk behaviours [that] could negate the protective effect of male circumcision.”⁷

It is important that these caveats be well highlighted, but what is the “comprehensive” prevention approach of which scaled-up male circumcision would be part? The U.S. National Institute of Allergy and Infectious Diseases (NIAID), which funded the circumcision studies in Kenya and Uganda, was quick to note when those studies were stopped that male circumcision must be part of “a comprehensive prevention strategy that also stresses the ABCs: *abstinence and delay of sexual debut, overall partner reduction and reduction in number of concurrent partners (“being faithful”), and correct and consistent use of condoms.*”⁸

Whether ABC really represents comprehensive or, for that matter, effective HIV prevention has been widely questioned. In particular, while sexual abstinence and fidelity may be worth emphasizing for some people, many experts have noted that women and girls frequently have little control over whether they can abstain from sex or delay their first sexual experience, and certainly do not control the sexual practices or number of sexual partners of their male partners.⁹ Condom use remains

low in many settings,¹⁰ and it is clear that women's subordinate social and economic status plays a considerable role in that outcome.

WHO's experts must, therefore, grapple with the question of whether male circumcision will be one more element of a supposedly "comprehensive" strategy that still ignores the real situations of many women and exacerbates their inability in many cases to demand safer sex. If negotiating condom use is challenging for women under the best of circumstances, how difficult will it be with circumcised men who have the "false sense of security" of which WHO warns?

Is women's subordination with respect to sexual negotiations an important enough problem to preoccupy the policy-makers now shaping plans to scale up male circumcision?

Difficulty of demanding safer sex

Is women's subordination with respect to sexual negotiations an important enough problem to preoccupy the policy-makers now shaping plans to scale up male circumcision? It is difficult to quantify directly the challenge that women and girls face in demanding use of condoms. It is probably safe to assume that women who face or have faced domestic

violence — an extreme but unfortunately not rare form of subordination of women in the home — are unable or unlikely to demand condom use of their sexual partners on a regular basis.

WHO's recent ground-breaking ten-country study on domestic violence may be a good place to start to understand the context of safer sex negotiations.¹¹ Among the sobering results of data from over 24 000 women around the world were these conclusions:

- In most countries, between 10 and 50 percent of women reported having suffered sexual abuse at some time by a husband or other partner in the home. For example, in highly AIDS-affected Ethiopia, nearly one-third of women said they had been forced to have sex against their will in the last 12 months.
- The percentage of women who reported facing physical violence in the home in the last 12 months — including being slapped, struck with a fist, kicked, dragged or threatened with a weapon — was between 11 and 21 percent in most countries. In every country, over half of women who had faced such violence experienced the act of violence more than once.
- A higher level of education among women was associated with less domestic violence in many of the countries. (WHO is still analyzing a number of other factors as determinants of violence.)
- In many countries, women themselves believe violence against women is justified when women are "disobedient" to their hus-

bands or other partners or when a wife refuses sex with her husband.

These results indicate that women from across the world, in great numbers, face extreme barriers to autonomy about sex. And, of course, violence is only one aspect of the subordination of women and their vulnerability to HIV. Whether they face violence in or outside the household, women in many countries are limited in being able to flee difficult or dangerous unions because they cannot initiate divorce or because they do not enjoy equal rights with men with respect to marital property.¹² Discrimination based on sex may keep women from job opportunities that would also allow them more freedom in being able to leave unsafe domestic situations.

Funding and policy initiatives to address women's vulnerability

None of these problems is easy to address. But none of these problems has benefited from the considerable resources that have flowed to other aspects of combating HIV/AIDS. While there are probably hundreds of excellent gender analyses of the global AIDS epidemic, many of which offer policy recommendations, it is hard to find major funding for programs that address root causes of women's HIV vulnerability and gender-based barriers to treatment, care and support.

Many women's organizations work doggedly to improve women's social, economic and legal status and to reduce causes of inequality and violence, but they often do so on a shoestring. In 2005, the Association for Women's Rights in Development surveyed over 400 women's organi-

zations around the world and found that more than half of them had less funding and less secure funding than they had five years earlier.¹³ Many of the respondents noted that “gender mainstreaming” — the practice among some donors of working gender concerns into all areas of programming, rather than having separate programs and budget lines for women’s or gender issues — had made funding much less available for advancement of women’s rights.

Since 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria has been a major source of new funding for national AIDS responses. The Global Fund’s proposal guidelines encourage countries to submit proposals that address gender inequality and discrimination against women related to HIV/AIDS.¹⁴

In October 2006, the Canadian HIV/AIDS Legal Network reviewed the published descriptions of the 78 country-level AIDS projects then having received funding through the second granting phase of the Global Fund. Of them, none mentioned the rights of women; only four projects (all from Latin America) mentioned human rights at all; and only one included a program component meant to help girls develop negotiating skills with respect to safer sex.¹⁵

In the end, the Fund can only respond to the proposals it receives from the Country Coordinating Mechanisms (CCMs), which are meant to include government, donor and civil society representatives in each country. What is happening in CCMs that so completely leaves behind as program priorities the root causes of women’s vulnerability to HIV? If scale-ups of male circumcision ignore gender inequality and subordination of women to the degree

that scaling up other HIV/AIDS programs has done, a crucial opportunity will be missed for attacking the epidemic at its roots.

If scale-ups of male circumcision ignore gender inequality and subordination of women, a crucial opportunity will be missed for attacking the epidemic at its roots.

The questions, then, that should burn their way to the top of WHO’s agenda are these: Will resources found for scaling up male circumcision include major support for reducing women’s vulnerability to HIV, including reducing violence against women, strengthening women’s capacity to demand safer sex, and supporting greater economic autonomy for women? Or will scaling up male circumcision reveal even further, and perhaps exacerbate, the gender inequalities that so effectively feed this destructive epidemic? Will male circumcision be the “quick fix” that draws enormous donor resources, while addressing structural causes of women’s HIV vulnerability remains the marginalized “hard issue” that no one touches?

Male circumcision and implications for HIV prevention counselling and education

The three randomized studies of HIV and male circumcision in Africa all

featured counselling and provision of basic HIV/AIDS information for the men who participated. The researchers and research funders involved in these studies saw this counselling as a crucial part of the study design¹⁶ — and, especially, as a way to ensure that men would be reached with the message that circumcision does not afford full protection from HIV. WHO’s statement on the findings of the randomized trials indicates that the agency will seek to provide guidance to ensure that “risk reduction counselling” is part of any large-scale investment in male circumcision for HIV prevention.¹⁷

If scale-up of male circumcision were to include a serious investment in HIV counselling, including couples counselling, it could provide an opportunity to address questions related to women’s vulnerability to HIV as well. Counselling linked to HIV testing, especially testing of pregnant women, has been seen by some experts, for example, as a useful tool for helping women to mitigate the worst consequences of violence, abandonment and other abuses they may face if their HIV-positive status is disclosed.¹⁸ Nonetheless, investments in HIV counselling capacity in many countries have been inadequate, and the lack of trained counsellors remains an impediment to access to HIV testing.¹⁹

Even as it underscores the importance of counselling with respect to male circumcision, WHO has proposed “provider-initiated” strategies of HIV testing that would make testing more routine (including of pregnant women) while eliminating pre-test HIV counselling in favour of a “simplified” process of giving some “pre-test information” about HIV.²⁰

There seems to be little room in this new conception of the HIV testing process for ensuring that pregnant women and others seeking HIV testing have the opportunity to discuss their concerns about HIV and the possible consequences of testing HIV-positive with a well-informed counsellor, privately and in confidence.

It would be unfortunate and possibly dangerous to skimp on counselling for men seeking circumcision for HIV prevention in the same way. HIV counselling before and after circumcision, like pre- and post-test counselling, imparts information to which people have a right and contributes to people's ability to ensure the security of their person — that is, to have control over what happens to their bodies.²¹ If scaling up male circumcision includes public information or mass media programs, or school-based programs, these programs should also include components that address vulnerability of women and girls and negotiating skills for them.

The fact that young men and adolescent boys will likely be among those seeking circumcision makes the scale-up of this intervention an ideal opportunity for the kind of counselling and public education that could shape their attitudes toward women and girls in important ways. Donors and governments investing in male circumcision should do everything possible to ensure that the weaknesses of support for counselling linked to HIV testing, particularly in pregnancy, are not repeated in the scale-up of male circumcision. Explicit attention should be given to advancing respect for women and women's rights as part of the counselling and education initiatives that accompany male circumcision.

Safety of circumcision and informed consent

In many societies where male circumcision is the norm, boys are circumcised soon after birth or at a very young age. Adolescent boys may also be circumcised as part of traditional rites of passage to adulthood. Circumcision of men and adolescent boys generally carries a greater risk of adverse surgical outcomes than circumcision of baby boys.²²

A UNAIDS fact sheet notes that “where health professionals have been trained and equipped to perform safe male circumcisions,” post-operative complications occur in 0.2 to 2 percent of cases.²³ In many parts of the world, however, male circumcision takes place under conditions that are less ideal than these, including circumcision by “traditional surgeons” associated with rituals of initiation into manhood. There are many reports of adverse outcomes of traditional circumcision of boys and young men, including sepsis, haemorrhage, dehydration and death.²⁴ HIV transmission may be another consequence, especially where the same instruments might be used for multiple circumcisions.²⁵

As a matter of respecting, protecting and promoting the human right to the highest attainable standard of health,²⁶ ensuring sanitary conditions and technical competence of those performing the procedure should be a major concern in planning for any scale-up of this intervention.

In spite of the risk of adverse outcomes, the randomized trials and other research indicate that circumcision can be widely acceptable to men in communities where it is not the cultural or traditional norm. For example, a study in Malawi, a highly

AIDS-affected country, indicated that both men and women in regions where male circumcision was not traditionally practiced would welcome male circumcision services if they were affordable, sanitary and protected by confidentiality.²⁷ Similar attitudes were found among men and women in a high-HIV prevalence community in South Africa.²⁸

HIV/AIDS policy-makers at all levels face a human rights and public health challenge when it comes to male circumcision.

Although theoretical acceptability of male circumcision is high, informed consent is a crucial issue in consideration of scaling up male circumcision services.²⁹ A particular challenge is establishing ethical standards for obtaining consent from boys who have not attained the age of legal majority. The *Convention on the Rights of the Child* asserts the right of people under 18 years of age to participate in decision-making in any administrative procedures affecting them such that their voices are “given due weight in accordance with the age and maturity of the child” and the child's or young person's “evolving capacities.”³⁰

WHO should review existing guidance by government regulators and medical associations in this matter. The British Medical Association, for example, advises its

members that children “who are able to express views about circumcision should be involved in the decision-making process” and recommends that where parents and children disagree, “doctors should not circumcise the child without the leave of a court.”³¹

WHO needs to grapple with specifying the role and rights of parents or guardians, and perhaps community or cultural leaders where parental guidance is not available. Working respectfully and in a confidential manner with young people is particularly important in communities where many young people are without parental support, as is often the case in AIDS-affected communities. In elaborating recommendations on this subject, WHO may also be guided by the debates that have occurred in many countries on consent to HIV testing for people under age 18.³²

As the HIV prevention benefits of male circumcision are more widely known, men and boys may feel social pressure of various kinds to undergo the procedure. Strong adherence to informed consent processes and strict attention to surgical safety are crucial in an atmosphere of enthusiasm about the protective effect of this intervention.

Conclusion

HIV/AIDS policy-makers at all levels face a human rights and public health challenge when it comes to male circumcision. As a matter of ethics and good clinical practice, circumcision requires the capacities and structures to ensure the procedure is safe, comes with high-quality counselling, and ensures informed consent on the part of men and boys undergoing it. But the implications of male circumcision

for women’s health and human rights must figure equally prominently in policy and programs.

Without concrete, sustained attention to the many manifestations of gender inequality that fuel the epidemic, scaling up male circumcision risks becoming yet another factor that reveals and exacerbates women’s subordination and vulnerability to HIV, best intentions notwithstanding. Will scaling up male circumcision be another distraction from efforts to ensure women’s equal status in society and under the law, and their autonomy in their sexual relations with men?

It would be the ultimate expression of the sexism and gender inequality at the heart of HIV/AIDS to boost male circumcision without attempting through counselling and other means to use this scale-up to address subordination of women. It would be the ultimate expression of desperation for a “magic bullet” against HIV to accelerate access to male circumcision without scaling up measures to ensure both the safety of the procedure and the establishment of informed consent processes.

It would, finally, be the ultimate dismissal of the lessons of 25 years of the response to HIV/AIDS if counselling and education linked to male circumcision were not designed and adequately funded to contribute to the well-being and human rights of both men and women.

– Joanne Csete

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Note to readers: WHO issued policy and program recommendations on male circumcision near to the time this article went to press. The recommendations include that countries “adopt approaches to the scale-up of male circumcision services that include the goals of changing gender norms and roles and promoting gender equality.” Program managers are encouraged to “monitor and minimize potential negative gender-related impacts of male circumcision programs.” WHO also emphasizes the importance of safe and sanitary surgical practices in scaling up male circumcision and suggests that a minor should be given the opportunity to consent to the procedure “according to his evolving capacity,” following the guidance of the *Convention on the Rights of the Child*. We look forward to further guidance from WHO on concrete actions and examples of best practice with respect to these recommendations. The recommendations are available at www.who.int/hiv/mediacentre/news68/en.

¹ WHO, *Statement on Kenyan and Uganda Trial Findings Regarding Male Circumcision and HIV: Male Circumcision Reduces the Risk of Becoming Infected with HIV, But Does Not Provide Complete Protection*, December 2006. Available via www.who.int/mediacentre.

² T. Rosenberg. “A real-world AIDS vaccine?,” *New York Times Magazine*, 14 January 2007, p. 11.

³ B. Auvert et al, “Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial,” *PLoS Medicine* (on-line journal) 2:e298 (2005), available at www.plosmedicine.org; R.C. Bailey et al, “A randomized controlled trial of male circumcision to reduce HIV incidence in Kisumu, Kenya: progress to date,” paper presented at the XVI International Conference on AIDS, 2006, Toronto (abstract no. TUAC0201). See also, U.S. National Institutes of Health, National Institute of Allergy and Infectious Diseases (NIAID), *Questions and Answers: NIAID-Sponsored Adult Male Circumcision Trials in Kenya and Uganda*, December 2006. Available via www3.niaid.nih.gov.

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- ⁵ D. Brown, "HIV study raises caution about circumcision," *Washington Post*, 7 March 2007, p. A14.
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- ¹⁶ See, e.g., B. Auvert et al, Authors' reply (letter), *PloS Medicine* (on-line journal) 3(1): e74 (2006). Available via www.plosmedicine.org; NIAID, *Questions and Answers*.
- ¹⁷ WHO, *Statement on Kenyan and Uganda Trial Findings Regarding Male Circumcision and HIV*.
- ¹⁸ See, e.g., A. Medley et al, "Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes," *Bulletin of the World Health Organization* 82 (2004): 299–307, especially p. 305.
- ¹⁹ See, e.g., United Nations General Assembly, *Scaling up HIV Prevention, Treatment, Care and Support*, UN doc. A/60/737, 24 March 2006, especially pp. 10–11.
- ²⁰ WHO and UNAIDS, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities (draft for comment)*, November 2006.
- ²¹ See *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), art. 9(1) and 19(2).
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- ³⁰ *Convention on the Rights of the Child*, 1577 U.N.T.S. 3 (1989), art. 12(1) and 14.
- ³¹ British Medical Association, Medical Ethics Committee, *The Law and Ethics of Male Circumcision — Guidance for Doctors*, 2003 (revised 2006). Available via www.bma.org.uk.
- ³² The HIV testing page of the Youth Policy Project of the Constella Futures Group Policy Project and YouthNet, found at www.youth-policy.com/content.cfm?page=vct, contains links to numerous national policies related to consent by minors to HIV testing and other services.

Engendering bold leadership against HIV/AIDS

The importance of leadership, especially human rights-driven leadership, in the fight against HIV/AIDS is widely recognized. However, argues Michael Pates in this commentary, the type of bold leadership required to really make a difference has been lacking. Pates calls for the development of an AIDS Leadership Initiative and describes how it might happen.

Virtually all international strategies addressing the AIDS pandemic place a premium on high-level, human rights-driven leadership. But despite major advances in treatment and funding inspired by these plans, the worldwide havoc wrought by AIDS, including threats to national security and global stability, continues to outpace the response.¹ More, better and sustained leadership is therefore needed.

Take, for example, the 2001 UN *Declaration of Commitment on HIV/AIDS*, the first global consensus instrument on the subject, and the (U.S.) President's Emergency Plan for AIDS Relief (PEPFAR), now a driving force behind the international response to the pandemic. The Declaration states up front that "[l]eadership by Governments in combating HIV/AIDS is essential and their efforts and should be complemented by the full and active participation of civil society, the business community and the private sector."²

Further, "respect for the rights of people living with HIV/AIDS drives an effective response" and requires the enactment and enforcement of legislation to "eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people

living with HIV/AIDS and members of vulnerable groups..."³

Three years later, under the heading, "Engendering Bold Leadership," PEPFAR echoed the Declaration:

Early and effective action by high-level political leaders can contain and even roll back epidemics.... Where leaders have been silent, inactive, or worse — combative, or propagating incorrect or stigmatizing messages — HIV continues to spread despite the best efforts of communities and contributors.⁴

Yet, in 2006, a five-year status report on the Declaration found that

[a]lthough most national strategies recognize the importance of a multi-sectoral effort, of protecting human rights and of addressing the vulnerabilities of some populations, there is a gap between what exists on paper and what exists in the real world, and between what politicians promise and what they deliver.⁵

Further, although PEPFAR has been a boon to treatment efforts in the countries it has targeted, the term "human rights" goes virtually unmentioned in the plan, and several of the plan's funding policies have been criticized as antithetical to human rights and, therefore, counter-productive.⁶

Engendering better and bolder leadership thus remains pivotal to stemming the pandemic. As Laurie Garrett, Senior Fellow for Global Health at the Council on Foreign Relations, recently noted,

With billions of dollars on the table [to fight HIV/AIDS], we still lack clear national health governance in the hardest-hit countries and see no genuine international leadership. Getting to sustainable, just, and fiscally rational approaches to global health crises requires global leadership and innovative thinking.⁷

Recognizing this critical need for high-level leadership, in June 2001 (as the U.N. Declaration was being finalized), the International Crisis Group (ICG) issued a report, *HIV/AIDS as a Security Issue*, recommending that the UN Secretary-General appoint a "high-powered council" of former world leaders to push implementation of Declaration principles.⁸ This council was to "give the war on AIDS the urgency and serious priority it deserves by empowering the front-line technical responders with the political support needed to accomplish their tasks."

No such council was formed then. However, given the recent or pending retirements of several national and world leaders who have demonstrated

their commitment to tackling the pandemic — combined with the ongoing urgent need for strong and sustained leadership worldwide — the idea warrants revisiting.

An AIDS Leadership Initiative

As outlined below, an AIDS Leadership Initiative similar to the council ICG envisioned would provide a reliable forum for marshaling the prestige, influence and other unique resources of the world’s top leaders against AIDS, and would better enable them to encourage, promote and invest in bold leadership from others. It could serve as an international showcase for those already providing such leadership and coax leaders disengaged from AIDS to join the fight — and could “shame” those who obstruct, delay or do nothing.

Why

In 1994, the late Dr Jonathan Mann and colleagues posited that “discrimination, marginalization, stigmatization and, more generally, a lack of respect for the human rights and dignity of individuals and groups heightens their vulnerability to becoming exposed to HIV.” This pattern, they concluded, “may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability and premature death is linked to the status of respect for human rights and dignity.”⁹ Since then, Mann’s view has grown beyond serious dispute.

In this light, the potential of an AIDS Leadership Initiative is profound, for even if it spurs national leadership against stigma and discrimination alone, the increases in HIV testing and prevention likely to

result would be a significant human rights achievement.¹⁰ But if it also advances human rights and public health more broadly (as seems possible), it has the long-term potential to foster security, stability and development nationally, regionally and globally.

An AIDS Leadership Initiative would provide a reliable forum for marshaling the prestige and influence of the world’s top leaders against AIDS.

Put another way, if preserving national security and global stability requires reducing the spread of HIV, and if reducing the spread of HIV requires advancing human rights, then preserving national security and global stability requires advancing human rights. In this sense, AIDS takes human rights advancement from noble aspiration to interest-based imperative, offering unprecedented political leverage for advancing human rights generally.

Who

A sensible first step to engendering bold leadership is to identify who is best placed to do the engendering — namely, persons who already have provided leadership themselves, particularly former national or world leaders no longer tethered politically to the vagaries of current events. Former heads of state or ministry with a demonstrated commitment to

human rights-oriented AIDS advocacy would be a formidable force for engendering similar leadership in others, including incumbent office holders.

These leaders could include (among others): Kofi Annan, former UN Secretary-General; Tony Blair, soon-to-be former Prime Minister of Great Britain; Bill Clinton, former U.S. President; Gareth Evans, former Foreign Minister of Australia; Richard Holbrooke, former U.S. Ambassador to the UN; Kenneth Kaunda, former President of Zambia; Nelson Mandela, former President of South Africa; Colin Powell, former U.S. Secretary of State; and Mary Robinson, former President of Ireland and former UN High Commissioner for Human Rights.

What

A simple pledge put forward by such a group, and backed by consistent, personal advocacy for the pledge by group members, could provide the missing impetus for engendering bold leadership on AIDS. The pledge might read as follows:

We, former heads of state and ministry representing all regions of the globe and committed to stopping the HIV/AIDS pandemic, hereby affirm:

1. that the HIV/AIDS pandemic is a threat to national security, economic development, and global stability;
2. that reducing this threat requires bold and sustained leadership committed to promoting open discussion of HIV/AIDS, eliminating stigma and discrimination against people infected with or affected by the virus, and facilitating reliable access

to treatment and prevention services; and

3. that we pledge our enduring commitment to providing and assisting such leadership and encouraging other leaders to join our efforts.

Such a pledge endorses the core human rights elements of an effective response — namely, freedom from discrimination and access to treatment — without invoking human rights terminology directly, thus avoiding regrettable but predictable resistance to that label by some incumbent leaders. The group’s advocacy could take any number of forms, but perhaps the single most effective form would be to speak openly and often against stigma and discrimination in one’s home country and in other countries where incumbent leaders find it difficult to do so themselves. Equally important, the group’s trumpeting of bold and effective leadership by incumbent leaders would give that leadership the global prominence it deserves (and which those leaders may prize).

Preserving national security and global stability requires reducing the spread of HIV and, by extension, advancing human rights.

How

At least two organizations appear well positioned to undertake such an AIDS Leadership Initiative, whether

individually or jointly: the Clinton Foundation and the Club of Madrid.

The William J. Clinton Foundation, through its Clinton Global Initiative (now in its second year), seeks commitments from leaders representing the public, private and civil society sectors to make the world better in four focus areas, including global health. Its annual reporting requirement ensures commitments made are followed-up. And the foundation’s status as a private organization would reduce or eliminate the political machinations to which an AIDS Leadership Initiative would be subject if it were part of the UN or another intergovernmental organization.

The Club of Madrid, comprised of 68 former heads of state and government, is a consultative body for governments, democratic leaders and institutions engaged in democratic transition. Along with other high-level politicians and governance experts, the Club converts ideas into action plans.

Although promotion of democracy is the Club’s main focus, the threat AIDS poses to emerging democracies, human rights and the rule of law surely puts the pandemic within the Club’s scope of concern. The Namibian Institute for Democracy, for example, reports that HIV/AIDS is affecting the democratic process in Namibia by reducing the number of people who vote in elections and participate in civic programs. Therefore, it calls upon political leaders to “more clearly set leadership examples by talking openly about their own status” and recommends that messages to reduce HIV/AIDS stigma and discrimination be incorporated into future campaigns.¹¹

Conclusion

The interests to be served by increasing human rights leadership against

HIV/AIDS are no longer merely domestic or humanitarian, but also global and strategic: to prevent the pandemic from further undermining, as Colin Powell put it, “the social, economic, and political systems that underpin entire nations and regions.”¹² In the age of AIDS, human rights, public health, national security, sustainable development and *leadership* are, to echo Mann, inextricably linked. If all are to be strengthened, leadership must be strongest among them.

– Michael Pates

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¹ In 2000 the UN Security Council declared HIV/AIDS a potential national and global security threat — the first and only disease so declared (S/RES/1308(2000)). In 2002, then-U.S. Secretary of State Colin Powell noted that “HIV doesn’t just destroy immune systems; it also undermines the social, economic and political systems that underpin entire nations and regions” (Woodrow Wilson International Center for Scholars Conflict Prevention Project, *Preventing the Next Wave of Conflict: Understanding Non-Traditional Threats to Global Stability* 101 [2003]). In 2005, Alexander Zhukov, Russia’s Deputy Prime Minister, described HIV/AIDS as “an issue of strategic, social, and economic security” in Russia (Kaisernet.org, *Daily HIV/AIDS Report*, 31 March 2005). See also, L. Garrett, *HIV and National Security: Where Are the Links?*, Council on Foreign Relations (2005).

² United Nations Resolution S-26/S, *Declaration of Commitment on HIV/AIDS* (2001) at 36.

³ *Ibid.* at 58.

⁴ Office of the U.S. Global AIDS Coordinator, *President’s Emergency Plan for AIDS Relief: U.S. Five-Year HIV/AIDS Strategy*, 19, 2004.

⁵ International Council of AIDS Service Organizations, *Community Monitoring and Evaluation: Implementation of the UNGASS Declaration of Commitment on HIV/AIDS*, 2006.

⁶ See, e.g., L.S. Rubenstein and E. A. Feldman, "Human rights and the President's AIDS Initiative," *Human Rights* 31 (2004) (citing criticism of PEPFAR's abstinence-until-marriage provisions for censoring or distorting information about HIV transmission and prevention, denying protection to women who are at risk of HIV infection from their husbands, and discriminating against gays and lesbians who cannot legally marry).

⁷ P. Farmer and L. Garrett, "From 'marvelous momentum'

to health care for all [Garrett replies]," *Foreign Affairs* 161 (March/April 2007).

⁸ International Crisis Group, Issues Report No. 1, 19 June 2001. At www.crisisgroup.org (click on "Thematic Issues").

⁹ J. Mann, L. Gostin et al., "Health and human rights," *Health and Human Rights: An International Journal* 1:1 (1994): 6–23.

¹⁰ Uganda's example is illustrative. In the 1980s, President Yoweri Museveni, fearing his military's potential decimation by AIDS, instituted a nationwide program of action emphasizing openness, non-discrimination and

access to care for persons living with HIV/AIDS — key human-rights elements in what became the renowned Abstinence, Be faithful, use Condoms ("ABC") approach, which has reduced HIV incidence in Uganda dramatically. Although this response is neither a comprehensive human-rights approach nor consistent in all its particulars with international human rights laws and norms, there can be little doubt that these core human rights elements, backed by Museveni's leadership, have been pivotal to its success.

¹¹ Kaisernet.org, *Daily HIV/AIDS Report*, 29 August 2006.

¹² See note 1.

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. Except where otherwise indicated, 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.

Subcommittee fails to recommend legal reforms needed to promote human rights of sex workers

In December 2006, the House of Commons Subcommittee on Solicitation Laws released its long-awaited report on the criminal laws related to prostitution in Canada, entitled *The Challenge of Change: A Study of Canada's Criminal Prostitution Laws*.¹ The Subcommittee's report fails to call for amendments to the *Criminal Code* provisions which have been demonstrated to increase the health and safety threats faced by sex workers. The Canadian HIV/AIDS Legal Network and two sex worker organizations, Stella and Maggie's, jointly published an analysis of the report.²

In February 2003, in response to scores of brutal killings and disappearances of sex workers in Vancouver and Edmonton, the House of Commons resolved unanimously to review Canada's crimi-

nal laws related to sex work. The Subcommittee on Solicitation Laws was created "to review the solicitation laws in order to improve the safety of sex-trade workers and communities overall, and to recom-

mend changes that will reduce the exploitation and violence against sex-trade workers."³ The Subcommittee reviewed published literature and heard testimony from about 300 witnesses, including sex workers, aca-

demographic and legal researchers, policy experts, social service and health workers, police officers and private citizens.

Subcommittee report

Throughout its report, the Subcommittee presents two “philosophies” of sex work into which it says most witnesses divided themselves: “sex work as victimization” and “sex work as work.”⁴ The Subcommittee members admit that they failed to bridge the irreconcilable “philosophical” differences between these philosophies. Nonetheless, the report includes six unanimous recommendations, one majority recommendation (supported by all but the Conservative members), and a Conservative dissent to the majority recommendation.

Unanimous recommendations

Five of the recommendations are directed at the Government of Canada (generally):

1. Ensure that the commercial sexual exploitation of minors “remains a serious crime subject to severe penalties.”
2. Ensure that the problem of trafficking in persons remains a priority.
3. Recognize that the status quo with respect to Canada’s laws dealing with prostitution is unacceptable, and that the laws that exist are unequally applied.
4. Establish and develop education campaigns to prevent people from entering prostitution, and “develop exit strategies to assist those involved in prostitution who wish to leave in regaining control of their lives.”
5. Fund research on sex work “to obtain a clearer picture of prostitution activities in the country, the

associated problems, and the needs of people involved in those activities,” and conduct a legal analysis of the *Criminal Code* provisions related to sex work.

One recommendation is directed specifically to the Department of Justice:

6. Coordinate research on prostitution on a priority basis with other levels of government, institutions, and non-governmental organizations, as well as persons selling sexual services.

Prostitution is, above all, a public health issue.

Majority recommendation

The recommendation by the Liberal, New Democratic and Bloc Québécois members of the Subcommittee arises from their belief that prostitution is, above all, a public health issue, and not only a criminal law issue, thus requiring a pragmatic approach. Their recommendation (no. 7 in the report)

calls for concrete efforts to be made immediately to improve the safety of individuals selling sexual services and assist them in exiting prostitution if they are not there by choice. In addition, the federal government should consider increasing transfer payments to the provinces to enable them to provide significant resources for income support, education and training, poverty alleviation and treatment for addictions, while respecting provincial areas of jurisdiction.⁵

Minority dissent

The Conservative members of the Subcommittee stated that “the most realistic, compassionate and responsible approach to dealing with prostitution begins by viewing most prostitutes as victims.”⁶ They regard the *Criminal Code* provisions on sex work as imperfect but “believe that marginalization [of prostitutes] is not a function of the laws themselves but of attempts to circumvent them.”⁷ They call for reforms that would criminalize the “abusers (johns and pimps)” and “improve the ability of those engaged in prostitution — the victims — to quit.”⁸

Analysis and commentary

According to the analysis of the report jointly published by the Legal Network, Stella and Maggie’s, the Subcommittee failed to meet the challenge of recommending legislative changes that are urgently needed to protect and fulfill the health, safety and human rights of adult sex workers in Canada.

The final report does not address how certain *Criminal Code* provisions, and the way in which they are enforced, push sex workers into situations that put their health and safety at risk and leave them open to stigma and discrimination, violence and possible exposure to HIV. Instead, the report focuses too much attention on the sexual exploitation of children and human trafficking — problems that are already adequately addressed by the *Criminal Code* and that have little to do with the murders and disappearances of sex workers in Canada or the relentless day-to-day abuses they face.

The three organizations criticize the Subcommittee’s devaluation of human rights as unacceptable, and undermining of the idea that all peo-

ple in Canada are deserving of equal respect and dignity. Rather than seeing the fulfillment of human rights as a baseline standard to be met by all Canadian laws, the report characterizes human rights — particularly those of sex workers — as just one “philosophy” of sex work.

The three organizations call on Parliament to repeal the four *Criminal Code* sections that make “communicating,” “bawdy-houses” and “living on the avails” illegal; and to include sex workers in the policy and law reform process. The organizations say that sex workers must

have a say in modernizing the laws and policies that affect them.

These steps are essential to protecting sex workers’ rights under the *Canadian Charter of Rights and Freedoms* and international human rights law, and to enabling sex workers to share the health, safety and human rights to which all people in Canada are entitled.

— Leon Mar and Glenn Betteridge

Leon Mar (lmar@aidslaw.ca) is Director Communications for the Canadian HIV/AIDS Legal Network.

¹ House of Commons, Subcommittee on Solicitation Laws, *The Challenge of Change: A Study of Canada’s Criminal Prostitution Laws*, December 2006. At www.parl.gc.ca/sslr.

² Canadian HIV/AIDS Legal Network, Stella and Maggie’s, *Not Up to the Challenge of Change: A Comment on the Report of the Subcommittee on Solicitation Laws*, February 2006. Available via: www.aidslaw.ca/sexwork.

³ *House of Commons Debates*, 055 (7 February 2003) at 1425. Available via www.parl.gc.ca.

⁴ See the characterization of these two views as a philosophical difference on p. 92 of *The Challenge of Change*, and the juxtaposition of these views in the report at, e.g., pp. 29, 31, 34, 76–77, among other references.

⁵ *The Challenge of Change* at p. 89.

⁶ *Ibid.* at 90.

⁷ *Ibid.* at 91.

⁸ *Ibid.*

Conservative government ends funding for research on Insite

The federal government has stopped providing funding for for the ongoing evaluation of Insite, North America’s only supervised injection facility (SIF), even as the latest studies continue to demonstrate the positive impact of the facility.

When Insite was established in 2003, as a three-year pilot project, it was agreed that the operating costs of the facility would be borne by the British Columbia government through the Vancouver Coastal Health Authority, and that the federal government would provide funding for an ongoing evaluation of the project. The evaluation funding ended in September 2006.

That same month, following considerable pressure from activists, scientists and editorial writers, the federal government announced a time-limited extension (to the end of 2007) of Insite’s exemption under

Section 56 of the *Controlled Drugs and Substances Act*. This exemption was necessary to allow Insite to continue to operate.

At the time, federal Health Minister Tony Clement said that additional studies would have to be conducted on how supervised injection sites affect crime prevention and treatment.¹ Despite Clement’s statement, the federal government chose not to renew funding for the evaluation of Insite.² Currently, bridge funding for the evaluation is being provided by the Vancouver Coastal Health Authority.

(In January 2007, the *Vancouver Province* quoted Clement as saying, “I don’t think that it is up to us to organize the research. I expect more research to be done, and we will evaluate the research.”³)

Thomas Kerr, one of the researchers at the British Columbia Centre for Excellence on HIV/AIDS who have been involved in the ongoing evaluation of Insite, said that the implications of the cuts to the evaluation funding are significant because, although temporary bridge funding has been secured, and funding will be sought from other sources,

“the future of this important evaluation remains uncertain.” Kerr said that

[t]he cut is also worrisome because Health Canada enlisted three internationally recognized experts in the areas of injection drug use and HIV/AIDS to provide anonymous peer reviews of our proposal for continued evaluation funding. All three reviewers strongly recommended that funding be continued. Despite these recommendations, the federal government cut the funding, which suggests that politics and ideology — not science — is driving important decisions concerning the health of people who inject drugs in Canada.⁴

Recent studies

In November 2006, a study published in the *Canadian Medical Association Journal* (CMAJ) summarized the findings from various studies conducted during the first three years of Insite.⁵ The CMAJ study concluded that Insite “has been associated with an array of community and public health benefits without evidence of adverse impacts.” Specifically, the study found that Insite:

- has resulted in large reductions in public drug use, publicly discarded syringes and syringe sharing;
- has led to increased uptake of drug treatment programs;
- has referred users to a range of other community and medical resources;
- has been a key venue for educating users on safe injecting; and
- has not resulted in increases in drug dealing in the vicinity of the facility, in drug acquisition crime, or in rates of new injection drug users or relapse into injection drug use among former users.

The evaluations also showed that Insite was widely accepted within the local injection drug use community and attracted a particularly high-risk population.

Other studies on Insite published recently revealed:

- that among injection drug users who used Insite frequently, positive changes in injecting practices were observed, including less reuse of syringes;⁶ and
- that SIFs such as Insite can play an important role in managing drug overdoses.⁷

“Politics and ideology — not science — is driving important decisions concerning the health of people who inject drugs in Canada.”

In a commentary published alongside the study published in CMAJ, Mark Wainberg, Director of the McGill University AIDS Centre, criticized the federal government for cutting research funding. “Why would the government on the one hand announce that additional time is needed to study the potential success of the Vancouver safer injecting facility and on the other hand eliminate the funding needed for such evaluations?” Wainberg asked.⁸

Julio Montaner, Director of the B.C. Centre for Excellence on HIV/AIDS, said that the federal

government simply does not want to hear that Insite has been having a positive effect. “I think that there is a profound bias in this administration, Montaner said. “Unfortunately, no matter how many attempts we have made to have an intelligent and educated discussion about this issue, their principles stand in the way of evidence-based decision making.”⁹

In January 2007, following a visit to the site, federal opposition leader Stéphane Dion called Insite “quite a success” and said that a federal Liberal government would provide funding for supervised injection facilities in more Canadian cities if local authorities requested them.¹⁰

In a related development, in its annual report, the International Narcotics Control Board (INCB) criticized a number of countries, including Canada, for allowing drug injection rooms to remain in operation. The INCB said that these rooms are contrary to international drug control treaties, that they facilitate the abuse of drugs, and that they provide an opportunity for illicit drug distribution.¹¹

This is not the first time that the INCB has claimed that SIFs violate drug control treaties, despite the fact that the UN Office of Drug Control and officials in the countries that have allowed SIFs to operate have all reached a different conclusion.¹²

— David Garmaise

¹ See D. Garmaise, “Supervised injection facility granted time-limited extension,” *HIV/AIDS Policy & Law Review* 11, 2/3 (2006): 21–23.

² No public announcement was made of the decision not to renew funding for the evaluation; the information was contained in a letter to the Vancouver Coastal Health Authority.

³ I. Bailey, “Tories decline Insite study,” *Vancouver Province*, 3 January 2007: A14.

⁴ Personal communication with Thomas Kerr, 10 April 2007 (on file with the author).

⁵ E. Wood et al, "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility," *Canadian Medical Association Journal* 175, 11 (2006): 1399–1404.

⁶ J.-A. Stoltz et al, "Changes in injecting practices associated with the use of a medically supervised safer injection facility," *Journal of Public Health* 29, 1 (2007): 35–39.

⁷ T. Kerr et al, "A micro-environmental intervention to

reduce the harms associated with drug-related overdose: evidence from the evaluation of Vancouver's safer injection facility," *International Journal of Drug Policy* 18 (2007): 37–45; T. Kerr et al, "Drug-related overdoses within a medically supervised safer injection facility," *International Journal of Drug Policy* 17 (2007): 436–441.

⁸ M. Wainberg, "The need to promote public health in the field of illicit drug use," *Canadian Medical Association Journal* 177, 11 (2006): 1395.

⁹ "Vancouver's safe injection site successful: study – top AIDS researcher suggests Harper government

has 'profound bias' against site," *CBC News* (online), 20 November 2006.

¹⁰ D. Ward, "Safe injection project 'quite a success': Dion," *Vancouver Sun*, 26 January 2007: A5.

¹¹ International Narcotics Control Board, *Annual Report 2006*, March 2007, paras. 175–177.

¹² See Canadian HIV/AIDS Legal Network and Open Society Institute, *Closed to Reason: The International Narcotics Control Board and HIV/AIDS*, February 2007. Available via www.aidslaw.ca/drugpolicy.

Draft evaluation suggests pilot safer tattooing program had potential to reduce disease transmission

As reported in the last issue of the *Review*, effective 30 September 2006 the Canadian federal government terminated the pilot safer tattooing initiative which had been operating in six prisons.¹ A draft of the evaluation report, obtained under access to information laws, detailed positive outcomes, constraints and enhancements to address implementation issues and cost-effectiveness of the initiative.²

The evaluation was conducted by Correctional Service of Canada's (CSC) Evaluation Branch, based on an evaluation strategy developed by CSC's Health Services and the Public Health Agency of Canada. The evaluation examined the operational component (tattoo rooms in six federal prisons) and educational component (information regarding unsafe tattooing provided to prisoners at regional reception centres and at the six prisons with tattoo rooms) of the initiative on the basis of: success, cost-effectiveness, implementation, unintended effects and continued relevancy. The evaluation used both

quantitative and qualitative research methods to gather information.

Facts and key findings

The evaluation reported that between 1 August 2005 and 31 August 2006, 324 prisoners received a tattooing through the initiative; 60 were on waiting lists.³ The evaluation contained 10 key findings,⁴ three of which are over-arching in their scope:

- The initiative has demonstrated potential to reduce harm, reduce exposure to health risks, and enhance the safety of staff members, prisoners and the general

public, which potential varies according to a number of site-specific factors. Specifically, the evaluation results suggested that illicit tattooing is most prevalent in medium-security institutions, and that during the course of the initiative there was a reduction in illicit tattooing in such institutions.

- The initiative resulted in an enhanced level of knowledge and awareness among staff and prisoners regarding blood-borne disease prevention and control practices.
- The initiative was consistent with the federal government's strategy to address HIV/AIDS.⁵

Other findings related to implementation shortcomings which negatively impacted on the effectiveness and efficiency of the initiative. Tattooing activities at most sites were constrained by a lack of trained tattoo artists, and sporadic hours of operation at some sites had an impact on the number of tattoos provided. In terms of cost-effectiveness the evaluation found that while the cost of the initiative is low relative to the potential benefits, a more cost-effective model could be implemented to yield the same or better results without compromising safety.

Finally, the evaluation suggested a number of ways to address the implementation-related shortcomings and make the initiative more cost-effective and efficient. Notable among these enhancements was the suggestion that CSC consider using community tattoo services.⁶

Recommendations and reaction

The evaluation recommends that “[t]o maintain an enhanced level of knowledge and awareness of infection prevention and control practices, CSC should continue the education component of the Safer Practices Tattooing Initiative.”⁷

(A second recommendation was blacked-out in the draft report; CSC relied on exemptions in the access to information law as authority for doing so.⁸)

Canada’s Chief Public Health officer, Dr. David Butler-Jones, was quoted as saying that the program was not given enough time to conclusively demonstrate its effects on the rates of HIV, hepatitis C and other infectious diseases.⁹

– Glenn Betteridge

¹ G. Betteridge, “CSC closes safer tattoo pilot sites,” *HIV/AIDS Policy & Law Review* 11, 2/3 (2006): 28. For further information on the initiative, see G. Betteridge, “Safer tattooing piloted in six federal prisons,” *HIV/AIDS Policy & Law Review* 10, 2 (2005): 15.

² M. Nakef, *Draft Evaluation Report: Correctional Service Canada’s Safer Tattooing Practices Pilot Initiative*, Correctional Service Canada, undated. On file with the author.

³ *Ibid.*, p. 10.

⁴ *Ibid.*, p. vii.

⁵ Canada, *The Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS*, 2004.

⁶ *Draft Evaluation Report*, p. 37.

⁷ *Ibid.* at p. 22.

⁸ *Access to Information Act*, R.S. 1985, c. A-1, ss. 21(a) and (b) provide that the head of a government institution may refuse to disclose advice or recommendations developed by or for a government institution or a minister of the Crown, or an account of consultations or deliberations in which directors, officers or employees of a government institution, a minister of the Crown or the staff of a minister participate.

⁹ W. Kondro, “Prison tattoo program wasn’t given enough time,” *Canadian Medical Association Journal* 176, 3 (2007): 307–308.

Public health agency says prison needle exchanges reduce risk, do not threaten safety or security

In April 2006, the Public Health Agency of Canada (PHAC) provided a report to the Correctional Service of Canada (CSC) regarding the potential risks and benefits of introducing needle exchange programs in Canadian federal prisons (PNEPs).¹ The PHAC report concludes that while definitive data concerning the impact of PNEPs on the transmission of blood-borne pathogens among prisoners does not exist, such programs have resulted in a decrease in behaviours which risk transmission and have not threatened prison safety or security.

In 2005, CSC and PHAC entered into an agreement under which PHAC was to provide to CSC scientific, medical

and technical advice on PNEPs.² The advice was to include “an analysis of the applicability and potential risks

and benefits of PNEPs in a Canadian setting.”³ In preparing its report, PHAC made site visits to selected

Canadian federal prisons, undertook study tours of prisons in German and Spain with PNEPs, conducted an extensive literature review (over 200 documents), and hosted a meeting of domestic and international experts.

The literature review revealed three highly significant factors which underpin the examination of prison needle exchange in the Canadian context. First, the “[a]vailable evidence strongly suggests that a large proportion of injection drug users who inject in [Canadian] correctional settings share (borrow or lend) needles and other injection equipment.”⁴

Second, internationally, “many injection drug users appear to switch to more harmful injecting practices during imprisonment ... [and] some inmates with no history of injection drug use begin to inject during imprisonment.”⁵

Third, given that when compared with HIV, HCV is more prevalent among Canadian prisoners, more easily transmitted and more resistant to bleach, “reliance on bleach as an element of HCV prevention strategy is not advisable, either in the community or the prison context.”⁶

Report’s conclusions

Given the comprehensive nature of the review undertaken by PHAC, and the fact that the report has not been made publicly available, we reproduce here all of the report’s conclusions:⁷

Definitive data concerning the impact of PNEPs on the incidence of blood-borne viruses do not exist.⁸

Evidence of behaviour change following PNEP implementation in a number of international prisons reflect these commonalities:

- PNEPs do not lead to increased injection drug use;

- needle-sharing practices decrease in prisons where PNEPs are offered;
- referrals to drug-treatment programs increase in prisons where PNEPs are offered;
- health care interventions related to injection-site abscesses decrease in prisons where PNEPs are offered; and
- the number of overdose-related health care interventions and deaths decrease in prisons where PNEPs are offered.

With respect to issues of safety and security, the current body of evidence indicates that:

- PNEP syringes and needles are not used as weapons;
- PNEPs do not result in increased altercations, whether between inmates or by inmates against prison staff;
- PNEPs do not result in increased cases of needle-stick injuries;
- PNEPs do not result in increased seizures of illegal drugs or drug-using paraphernalia;
- PNEPs do not result in increased cases of drug-use;
- PNEPs do not result in increased initiation of injection drug use during incarceration; and
- prison staff attitudes and readiness to accept PNEPs shifted from fear and resentment to acknowledgement that PNEPs represent an important and necessary addition to a range of harm reduction services and health and safety interventions — many staff advocate strongly to safeguard the ongoing support and delivery of the programs.

Commentary

The PHAC report echoes the conclusions reached by the Legal Network in its report, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*.⁹ Unfortunately, the PHAC report stops short of recommending that CSC introduce pilot needle exchange programs — in effect, the report does not offer any advice.

Due to a variety of factors, many of which are set out in the report, it is unlikely that definitive evidence concerning the impact of PNEPs on HIV and hepatitis transmission will be forthcoming. In the absence of such definitive evidence, and in light of the report’s conclusions, there was an unequivocal basis upon which PHAC could have advised CSC to pilot PNEPs. While such advice may have been offered in another way, there is no public evidence of this.

The current federal government is strongly opposed to harm reduction measures, both within the prison setting and in the community, and has little appreciation for public health evidence regarding harm reduction interventions. A spokesperson for the responsible minister stated when asked about the report and the possibility of introducing PNEPs, “We prefer to educate inmates about the dangers of using drugs in prison. Tolerance Zero.”¹⁰ In this climate, it appears that litigation is the only viable course of action open to prisoners and advocates who wish to see PNEPs introduced in federal prisons.

— Glenn Betteridge

¹ Public Health Agency of Canada. *Prison needle exchange*.

Review of the evidence. April 2006. The report was obtained by the author in October 2006, and is on file with the Canadian HIV/AIDS Legal Network.

² G. Betteridge, "Update on status of prison needle exchange in federal prisons," *HIV/AIDS Policy & Law Review* 10, 3 (2005): 19.

³ *Prison needle exchange* at p. 10.

⁴ *Ibid.* at p. 19.

⁵ *Ibid.* at p. 20.

⁶ *Ibid.* at p. 32.

⁷ *Ibid.*, p. 33.

⁸ See *ibid.*, p. 28, where the limitations of existing PNEP evaluations are explained as follows: "Definitive data concerning the impact of PNEPs on [blood-borne virus] incidence do not exist. Limitations common to all PNEP evaluations include: small sample sizes, relatively short

follow-up timeframes, inconsistent testing methodologies, and absence of comparison groups."

⁹ R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, Canadian HIV/AIDS Legal Network, 2nd ed., 2006. Available via: www.aidslaw.ca/prisons.

¹⁰ W. Kondro, "Conservative government scuttles needle exchange," *Canadian Medical Association Journal* 176, 3 (2007): 308.

Ontario passes new mandatory blood testing law: a preliminary review

In December 2006, the *Mandatory Blood Testing Act, 2006* passed third reading in the Legislative Assembly of Ontario.¹ When this new Act comes into force, it will replace the existing administrative system for forced blood testing, currently operating under Ontario's public health law. Responsibility for forced blood testing will shift from the Minister of Health and Long-Term Care to the Minister of Community Safety and Corrections.²

In 2001, Ontario amended the *Health Protection and Promotion Act*, giving medical officers of health the power to receive applications from individuals to test the blood of another person for communicable disease.³ The 2001 amendments and associated regulations came into force in 2003.⁴

The medical officers of health are the key decision-makers in the process. They determine whether to order such testing after reviewing the relevant evidence related to an alleged exposure by one person to another person's potentially infective bodily substances, and can conduct hearings to this end. The province's chief medical officer of health is authorized to hear appeals of a refusal to grant an order.

The new Act will result in a number of changes to the process by

which certain people can apply to have someone tested without consent for certain communicable diseases, including HIV and hepatitis B and C.

Under the new Act, people who believe they may have become infected with a virus that causes a communicable disease as a result of an exposure will still be required to make an application to a medical officer of health. However, medical officers of health will no longer be the key decision-makers. Instead, under the new Act, the role of a medical officer of health appears to be primarily limited to attempting to contact the person from whom the blood sample is sought, and requesting that the person provide a blood sample (or other evidence of seropositivity for the listed communicable diseases).

A person who receives a request

for the so-called "voluntary blood sample" will have two days to provide the sample. If the person fails to do so by the end of the second day, the medical officer of health will be obliged to refer the matter to the Consent and Capacity Board, which has been assigned the duty of deciding applications in such circumstances.

The Board was originally established to hear matters arising under the *Health Care Consent Act, 1996*. The legal test that the Board will be required to apply in deciding whether to order the taking of a blood sample is substantially similar the test currently applied by medical officers of health. However, the timelines for the process have been shortened under the new Act. The Board must commence and conclude the hearing within seven days, unless the parties

agree to extend the time, and must release its decision within one day after the conclusion of the hearing.

The decision of the Board will be final and there is no right of appeal in the new Act. Therefore, in order to challenge the Board's decision, a party will have to apply to a court requesting a judicial review, which review is at the discretion of the court.

As is the case with the current law, under the new Act, the Superior Court of Ontario may issue an order against a person who has not complied with

the Board's order. Under existing law, the medical officer of health or the Minister of Health can apply for such a court order; under the new Act, only the applicant may apply. As a protection for the person compelled to provide a blood sample, the new Act explicitly provides that an order under the Act and the results of the blood test will not be admissible as evidence in criminal proceedings.

As of mid-April 2007, the *Mandatory Blood Testing Act, 2006* had not come into force, and the regu-

lations required to complete the new administrative scheme had not yet been published. A thorough analysis of the new scheme will only be possible once the regulations are available.

– Glenn Betteridge

¹ *Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26.

² Regarding the change in Ministers, see *Ontario Gazette*, 140, 13 (2007), O.C. 556/2007.

³ R.S.O. 1990, c. H 7, s. 22.1.

⁴ Orders Under Section 22.1 of the Act, O. Reg. 166/03.

Bill eliminating conditional sentences amended to exclude drug offences

Opposition parties in the House of Commons have forced changes to legislation introduced by the minority Conservative government designed to eliminate conditional sentencing for certain offences. The legislation no longer applies to drug offences.¹

Bill C-9, *An Act to Amend the Criminal Code (conditional sentence of imprisonment)*, as tabled on 4 June 2006, would have removed the possibility of handing down a conditional sentence where a person is found guilty of an offence “prosecuted by way of indictment for which the maximum term of imprisonment is ten years or more.”² This is a form of mandatory minimum sentencing.

The provisions of the original bill were very broad, and would have covered a number of drug offences in the *Controlled Drug and Substances Act*, including “trafficking” or “[possessing] for the purposes of

trafficking” any quantity of certain substances, such as heroin, cocaine or methadone.³

On 26 September 2006, the Canadian HIV/AIDS Legal Network appeared before the House of Commons Justice Committee, which was reviewing the bill, and raised a number of concerns about the legislation.⁴ The Legal Network said:

- that the bill would undermine efforts to reduce the harms associated with drug use (including HIV infection);
- that it would be bad public health policy to increase the incarceration

rate of people who use drugs, especially since Canadian prisons fail to provide access to sterile syringes; and

- that the burden of the mandatory minimum sentences would fall not on large-scale drug dealers but rather on people involved in small, street-level drug distribution.

The Legal Network also said that evidence from the U.S. indicates that mandatory minimum sentences for drug offences do not work, and that Justice Canada had already reached this same conclusion.

When the the Justice Committee completed its review of the legislation, it amended the bill to exclude drug-related offences. The House of Commons passed the amended bill on 3 November 2006, and it is currently before the Senate.

The legislation, as amended, will still preclude conditional sentencing

in cases of certain “serious personal injury offences” (including sexual assault), terrorism offences or criminal organization offences where these carry a sentence of at least 10 years or a minimum term of imprisonment.

– David Garmaise

¹ Canadian HIV/AIDS Legal Network, “Update on Bill C-9, An Act to Amend the Criminal Code (conditional sentence of imprisonment),” November 2006. Available via www.aidslaw.ca/drugpolicy.

² See, G. Betteridge, “Conditional sentences to be abolished for some drug offences,” *HIV/AIDS Policy & Law Review* 10, 2/3 (2006): 27.

³ Canadian HIV/AIDS Legal Network, “Update on Bill C-9.”

⁴ See Canadian HIV/AIDS Legal Network, *Misleading and Misguided: Mandatory Incarceration for Certain Drug Offences*, 26 September 2006. Available via www.aidslaw.ca/drugpolicy.

Vancouver: Mayor proposes new treatment plan for stimulant-drug users

Vancouver Mayor Sam Sullivan is pushing for the establishment of a drug substitution treatment program for the city’s cocaine and crystal-meth users. The program would take the form of a clinical trial for up to 700 users.¹

Sullivan said that the drug treatment program, along with three other key elements that he said have to come from Ottawa or Victoria, would eliminate most of Vancouver’s problems with homelessness, panhandling and drug dealing. The other elements are money for social housing, a more aggressive plan for taking care of the mentally ill, and the use of community courts to channel drug users into the drug treatment program Sullivan is proposing.²

Sullivan is under considerable pressure to improve Vancouver’s social conditions in time for the 2010 Winter Olympics.

The Vancouver Sun reported on 22 January 2007 that Sullivan is lobbying the federal government for an exemption from Canada’s narcotics laws (similar to the exemption that has allowed Insite, the city’s

supervised injection facility, to operate).³ However, subsequent media reports suggested that an exemption would not be required because the substitute drugs provided under the plan would be legal prescription drugs. Nevertheless, Health Canada would still have to approve any clinical trial.⁴

Sullivan hopes that the drug treatment program will be privately funded, but integrated with public health systems. A non-profit organization, Inner Change, is being established to raise the funds. Lois Johnson, a long-time Conservative, who was B.C. co-chair for federal Health minister Tony Clement’s campaign for the leadership of the Conservative party a few years ago, will become the first director of Inner Change. The goal is to raise about \$500,000 a year to implement the program.⁵

As well, three prominent doctors have agreed to advise the mayor on this drug treatment plan. They are Dr Perry Kendall, the province’s chief medical officer; Dr John Blatherwick, the chief medical officer for the Vancouver Coastal Health Authority; and Dr David Marsh, leader of addiction medicine for the Authority.⁶

No one has yet mounted a large-scale trial of this kind, though small-scale trials have been conducted in Australia, the U.K. and the U.S., with favourable results.⁷

Some observers questioned whether the trial will see the light of day anytime soon, given that the Conservative government in Ottawa has made it clear that it opposes any treatment or harm reduction programs that involve providing addicts with drugs.

– David Garmaise

¹ F. Bula, "Mayor wants city exempted from federal narcotics laws: Sullivan proposes 'revolutionary' treatment plan for addicts," *Vancouver Sun*, 22 January 2007: A2.

² Ibid.

³ Ibid.

⁴ C. Bains, "Drug project has flaws, B.C. doctors' group warns," *Canadian Press/Globe and Mail* (online), 5 March 2005.

⁵ F. Bula, "Ex-Tory organizer to lead mayor's drug program," *Vancouver Sun*, 16 February 2007.

⁶ A. Ivens, "Doctors to advise Vancouver mayor on drug

addictions problems before Olympics," *Canadian Press/Vancouver Province*, 15 February 2007.

⁷ "Alternative treatments give addicts a chance: maintenance programs for cocaine and heroin users isn't so different from giving meth to hyper-active children," editorial, *Vancouver Sun*, 24 January 2007: A12.

Funding announcements from federal government, Gates Foundation

In two separate announcements, in December 2006 and February 2007, the federal government allocated new funding for HIV/AIDS. The latter announcement was accompanied by a pledge from the Gates Foundation.

Global HIV/AIDS Initiatives

On World AIDS Day, 1 December 2006, International Cooperation Minister Josée Verner announced \$120 million in new funding for global HIV/AIDS projects focussing on prevention, strengthening health systems, promoting women's empowerment and promoting children's rights.¹

A similar funding announcement had been expected at the International AIDS Conference in Toronto in August 2006, but was postponed because the Conservative government said the conference had become too political.

The \$120 million included \$41 million for the International AIDS Vaccine Initiative; \$20 million for the government of Tanzania and \$10 million for the government of Mozambique to support national HIV/AIDS plans; \$19 million for a project in Haiti providing STI treat-

ment and HIV prevention; \$15 million for the International Partnership for Microbicides; and \$6 million for the Global Health Research Initiative. Funding for a number of smaller projects was contained in the announcement, including:

- \$4.4 million over five years to the South African national and provincial departments of health to build their capacity to manage and disburse funds to NGOs working on HIV/AIDS;
- \$3 million over three years to the Open Society Institute to improve the capacity of local organizations to deliver harm reduction services in Eastern Europe; and
- \$1.5 million to CARE Canada to improve the health of children and raise AIDS awareness in Zambia.

AIDS and development activists welcomed the new funding, but said that it failed to break new ground. They

noted that most of the funds were for initiatives that Canada is already supporting. Spokespersons for the Canadian HIV/AIDS Legal Network and Oxfam Canada were critical of the fact that the announcement contained no measures to ensure that Canada delivers on its unfulfilled pledge to supply more affordable medicines to developing countries.²

Canadian HIV/AIDS Vaccine Initiative

On 20 February 2007, Prime Minister Stephen Harper announced that the Canadian government and the Gates Foundation had committed funding for a new Canadian HIV/AIDS Vaccine Initiative.³ The federal government committed "up to \$111 million" and the Gates Foundation provided "up to \$28 million."

The Canadian HIV/AIDS Vaccine Initiative will support Canadian researchers and institutions to work

with collaborators around the world on a range of HIV vaccine research activities, including discovering new vaccine candidates, strengthening clinical trials capacity, manufacturing promising vaccine candidates for trials, and addressing policy, regulatory and social issues related to HIV vaccine development.

The government said that the initiative will support research priorities identified in the Global HIV Vaccine Enterprise, an alliance of researchers, funders and advocates dedicated to accelerating HIV vaccine development.

According to the Associated Press and the South Florida Sun-Sentinel,

part of the funding will be used to build a research facility to support Canadian and other researchers. The facility will have the capacity to manufacture experimental vaccines. The news outlets said that the federal government will accept proposals from provinces interested in hosting the facility.⁴

Reaction to the announcement from AIDS researchers was generally positive. Reaction from AIDS groups and frontline workers was more mixed. All welcomed the new funding, but some pointed out that the development of an AIDS vaccine was just one part of a comprehensive response, and that more funding was needed for research

on ways to slow the spread of HIV among vulnerable populations.⁵

– David Garmaise

¹ Canadian International Development Agency, "Canada committed to global AIDS fight," news release, Ottawa, 1 December 2006.

² "AIDS funding welcomed but incomplete, activists say," *CBC/CA News* (online), 4 December 2006; "Feds \$120M pledge panned," *Toronto Sun*, 2 December 2006: 28.

³ Prime Minister's Office, "Canada's new government and Gates Foundation announce support for HIV/AIDS vaccine research," news release, Ottawa, 20 February 2007.

⁴ B. Duff-Brown, "Canada and Gates join to fight aids; \$119 million promised for research to develop vaccine," *Associated Press/South Florida Sun-Sentinel*, 21 February 2007: A16.

⁵ G. Galloway, "Gates joins Canada in AIDS fight," *Globe and Mail*, 21 February 2007; I. Rodrigue, "Gates et Harper annoncent 139 millions \$ pour un vaccin contre le sida," *Presse canadienne* (français), 20 February 2007.

In brief

Progress report on national pharmaceuticals strategy released

In September of 2004, Canada's first ministers identified elements of a National Pharmaceuticals Strategy (NPS), as part of a multi-year plan to reform health care, and directed federal, provincial and territorial health ministers to develop and implement the NPS.¹ In June 2006, the task force of health ministers released a progress report.²

Three fundamental themes are identified in the report, all of which are relevant to people living with HIV in Canada: access; safety, efficacy and appropriate use; and system

sustainability. The report notes that access to prescription drugs (outside of hospitals) "is determined predominantly by where one resides or works and not necessarily by need."³

A significant issue for some people living with HIV is access to so-called catastrophic drug coverage — providing drugs to people who would otherwise suffer undue financial hardship as a result of the costs of the drugs. The task force established a number of principles, three of which are universality, equality and transparency. Accordingly, all Canadians should be eligible for comparable coverage that is easy to understand and access.

The task force will now focus its work on catastrophic drug coverage on designing and undertaking a cost analysis of two different schemes. Under one scheme, people would be eligible for coverage where drug costs are in excess of a fixed percent-

age of their income; under the other, the eligibility threshold would be lower at lower income levels and rise as income rises.

The report recognizes that there is inconsistency and inequity, principally based on a person's province or territory of residence, in the drugs that people can access. The task force recognizes the benefits of the existing Common Drug Review process and calls for its expansion.⁴ In addition, the task force will continue to work to design a common national drug formulary (i.e., a list of drugs approved for coverage by public programs).

Regarding improvements to drug safety and effectiveness, the task force has recommended that stakeholders be consulted about the four interdependent strategies it has identified (an oversight body, a research network, engagement of primary care and hospital teams, and the establish-

ment of clear standards and transparency of evidence).⁵

– Glenn Betteridge

Auditor-General critical of Health Canada regulatory performance

There a number of problems with the way Health Canada operates its regulatory programs, such that the department cannot tell whether it is “fully meeting its responsibilities as the regulator of drug products, medical devices and produce safety.” This is the conclusion of the Report of the Auditor-General of Canada, tabled in Parliament on 28 November 2006.⁶

Auditor-General Sheila Fraser said that Health Canada has failed to set performance targets for all of its regulatory programs, and has not determined the level of activities the programs must carry out to meet the Department’s regulatory responsibilities, or the level of resources required to do so.

Fraser said that program funding levels have remained constant, while demand on the programs is increasing, thus making it “more difficult for program managers to fully meet the regulatory responsibilities of protecting the health and safety of Canadians,” including protecting against unsafe or ineffective therapeutic products.

Fraser said that Health Canada “needs to decide what it is trying to achieve, what its priorities are, and direct resources towards programs and services that help Canadians.”

The report identified a number of areas in which oversight is particularly deficient, including conducting suitable risk assessments of products; issuing “timely and accurate” health

warnings to the public; conducting inspections of drug ingredients and manufacturing practices; conducting investigations of clinical trials; conducting investigations of Internet pharmacies; investigating reports, complaints and recalls of medical devices; and virtually all aspects of post-market surveillance, whether investigations of consumer complaints or tracking of adverse events.

The report makes 10 specific recommendations for improvements in Health Canada’s oversight of regulatory programs. The department has agreed to implement the reforms by the end of the fiscal year 2007-2008.

– David Garmaise

Ottawa police accused of undermining crack distribution program

The City of Ottawa’s chief medical officer, Dr David Salisbury, accused the city’s police force of actively trying to thwart the city’s crack pipe program and other harm reduction programs. Salisbury said that the programs are crucial to the city’s health, but that police and others are undermining public confidence in the programs by spreading inaccurate information.⁷

Police chief Vince Bevan had suggested that the programs increase drug use and have little impact on the spread of disease. In response, Salisbury said that not only do dozens of studies in other cities prove the chief wrong, but also the programs are starting to have positive effects on controlling the spread of disease in Ottawa.⁸

On 17 February 2007, the *Ottawa Sun* said that it had obtained a copy

of an evaluation report to be tabled by the city’s Integrated Drugs and Addictions Strategy in June 2007. The *Sun* quotes the report as saying that there has been a significant reduction in harmful drug use since the crack program began in April 2005. Among drug users surveyed for the report, the number who were sharing crack equipment dropped from 37 percent before the program was introduced to 13 percent one year later.⁹

The City of Ottawa’s public health department has a budget of \$40 million, of which \$50,000 goes towards harm reduction. The crack pipe initiative costs the city \$8,000 a year.¹⁰

– David Garmaise

¹ More information on the 10-year Plan to Strengthen Health Care, and other federal/provincial/territorial health care initiatives, is available via the Health Canada website: www.hc-sc.gc.ca.

² Federal/Provincial/Territorial Task Force, *National Pharmaceuticals Strategy Progress Report*, June 2006. At www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2006-nps-snp/index_e.html.

³ *Ibid.* at p. 7.

⁴ The Common Drug Review is a process established by the federal government and most provinces to review drugs that have been newly approved for sale in Canada and to provide formulary listing recommendations to participating publicly-funded federal, provincial and territorial drug benefit plans.

⁵ For more information on post-approval drug surveillance and HIV treatment in Canada see Canadian Treatment Action Council, *How this came to PASS: The Current Post-Approval Surveillance System in Canada*, March 2006, and related documents. Available via: www.ctac.ca.

⁶ Auditor-General of Canada, *Report of the Auditor-General Of Canada, November 2006*. Chapter 8: Allocating Funds to Regulatory Programs — Health Canada. At www.oag-bvg.gc.ca/domino/reports.nsf/html/20061108ce.html.

⁷ J. Ruper, “Drug programs ‘crucial’ to city’s health: medical officer lauds needle exchange, crack pipe plan,” *Ottawa Citizen*, 18 January 2007: F1.

⁸ *Ibid.*

⁹ N. Elayoubi, “Piping up for crack programs; fearing budget cuts, harm reduction advocates organize rally,” *Ottawa Sun*, 17 February 2006: 5.

¹⁰ *Ibid.*

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.

Thailand: Government issues compulsory licences for HIV/AIDS drugs

In January 2007, the government of Thailand issued compulsory licences for two medicines in an effort to lower prices on drugs for treatment of heart disease and HIV/AIDS.¹ The drugs in question are Plavix, a blood thinner for heart disease, and the HIV/AIDS drug Kaletra. A compulsory licence had previously been issued for Efavirenz, another HIV/AIDS drug, in November 2006.²

The licences make it possible for other companies to produce generic versions of patented drugs in Thailand without the consent of the patent-holder.³ They also make it possible to import cheaper generic versions of

the drugs from other countries, effectively breaking the drug companies' patents.⁴ According to Public Health Minister Dr Mongkol Na Songkhla, the licenses were needed because "we don't have enough money to

buy safe and necessary drugs."⁵ He indicated that more licenses may be issued in the future.⁶ Media reports later claimed that a ministerial panel was studying what other drugs Thailand needed.⁷

According to article 31 of The World Trade Organization (WTO) *Agreement on Trade-Related Aspects on Intellectual Property Rights* (TRIPS),⁸ governments may issue compulsory licenses in cases of “national emergencies,” and “other circumstances of extreme urgency” or for “public non-commercial use.”⁹ The 2001 *Doha Declaration on the TRIPS Agreement and Public Health* clarifies governments’ “right to grant compulsory licences and the freedom to determine the ground upon which such licences are granted.”¹⁰

Hoping to prevent the government from producing the generic drugs, the U.S. pharmaceutical company Abbott Laboratories, patent holder for Kaletra, has entered into talks with the government of Thailand about lowering the costs of this medicine.¹¹ Thawat Suntrajarn, director general of Thailand’s Disease Control Department, said that “[i]f the negotiations don’t lead to satisfactory results, the Government Pharmaceutical Organization will contact the original drug companies to discuss royalties” and “decide whether to buy the medicines from suppliers offering competitive prices or produce the medicines itself.”¹²

Suvit Wibulpolprasert, from the Ministry of Public Health, said that “Abbot has agreed in principle with the Thai government to make Kaletra more affordable for all Thais.”¹³ According to Wibulpolprasert, “Merck already agreed to cut the

price of Efavirenz from 1,300 baht to 880 baht, because Thailand is starting to import the drug from India at the price of 650 baht.”¹⁴

In a related development, the new Director-General of the World Health Organization, Dr Margaret Chan, was widely criticised following comments she made on 2 February 2007. During a visit to Thailand’s National Security Health Office, Dr Chan said that “we have to find a right balance for compulsory licensing. We can’t be naïve about this. There is no perfect solution for accessing drugs in both quality and quantity.”¹⁵

In an open-letter with over 400 signatories dated 8 February 2007, concern was expressed that Dr Chan’s comments did not reflect the WHO mission to “work for the attainment by all peoples of the highest possible level of health” and that Dr. Chan should have “congratulated Thailand for its efforts, completely legal under WTO rules, to increase public health and access to medicines for its people.”¹⁶

On the previous day, Dr. Chan had written to the Public Health Minister Dr. Songkhla.¹⁷ She stated that “WHO unequivocally supports the use by developing countries of the flexibilities within the TRIPS agreement that ensure access to affordable, high quality drugs. This includes the use of compulsory licensing.”¹⁸

Liisa Seim is an exchange student at the University of Toronto Faculty of Law, and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ “Thailand allows copycat AIDS, heart disease drugs,” Reuters (on-line edition), 29 January 2007.

² “Thailand authorizes generic production of two more patented drugs,” *Bridges Weekly Trade News Digest*, 11(3) (2007).

³ *Ibid.*

⁴ “Thailand in talks on cheaper AIDS drugs,” *Agence France Presse English*, 9 February 2007.

⁵ “Thailand authorizes generic production ...”

⁶ *Ibid.*

⁷ N. Wong-Anan, “Thailand plans to break patents on 14 drugs: firms”, Reuters (online version), 14 February 2007.

⁸ *Agreement on Trade-Related Aspects of Intellectual Property Rights* [TRIPS], Apr. 15, 1994, Marrakesh. Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299, 33 I.L.M. 1197 (1994).

⁹ TRIPS, art. 31(b).

¹⁰ WTO, *Declaration on the TRIPS Agreement and Public Health*, WT/MIN(01)/DEC/2, 20 November 2001, s. 5(b).

¹¹ “Thailand in talks on cheaper AIDS drugs.”

¹² “Thailand, Abbot Laboratories to hold talks over compulsory licensing of antiretroviral Kaletra,” *Kaisernet.org*, 8 February 2007.

¹³ “Thailand in talks on cheaper AIDS drugs.”

¹⁴ *Ibid.*

¹⁵ A. Treerutkuarkul, “WHO raps compulsory licensing plan: Govt urged to seek talks with drug firms,” *Bangkok Post*, 2 February 2007.

¹⁶ Letter to Margaret Chan, Director General of the WHO, 8 February 2007. The letter is available at <http://worldaidscampaign.info>

¹⁷ Letter to Dr Mongkol Na Songkhla Minister of Public Health from Dr Margaret Chan, Director-General of the WHO, 7 February 2007. The letter is available www.cptech.org/blogs/ipdisputesinmedicine/2007

¹⁸ *Ibid.*

– Liisa Seim

U.S.: Proposed federal legislation to allow condom distribution and HIV testing in prison

Representative Barbara Lee (D-CA) is reintroducing legislation in the U.S. House of Representatives that would require federal correctional facilities to allow community organizations to distribute condoms and provide voluntary counselling and testing for HIV and STDs for inmates.¹ The bill has been referred to the House Judiciary Committee's Subcommittee on Crime, Terrorism, and Homeland Security.

The "Justice for the Unprotected Against Sexually Transmitted Infections Among the Confined and Exposed Act" (JUSTICE Act, H.R. 178), would prohibit correctional authorities from considering possession of condoms as evidence of prohibited activity. Currently, many states prohibit sexual activity among inmates, and between inmates and staff.² The bill would also require the Department of Health and Human Services to conduct an annual survey of correctional facilities to determine STD incidence and prevalence; availability of prevention education; access to condoms; availability of counselling and testing services for HIV/AIDS and STDs; incidence of sexual violence, and types of pre- and post-release referrals.

Only two states (Vermont and Mississippi) and five cities (Los Angeles, New York, Philadelphia, San Francisco and Washington, D.C.) currently provide condoms to inmates.³ Lee first introduced the bill in 2006 as a response to California Governor Arnold Schwarzenegger's veto of state legislation that would have allowed non-profit organizations to distribute condoms and dental dams in state prisons.⁴ The earlier version of the bill (JUSTICE Act of 2006) was also referred to the House

Judiciary Committee, after which no further legislative action was taken.

While Lee's bill emphasizes voluntary testing and counselling, 46 states and the District of Columbia currently mandate some form of HIV testing in the criminal justice system, and 23 states require HIV testing for all inmates.⁵ Several more states are considering mandatory testing legislation. On the federal level, the "Stop AIDS in Prisons Act" of 2006 (H.R. 6038) proposed by Representative Maxine Waters (D-CA) would have required correctional facilities to provide HIV testing to inmates "as part of a comprehensive medical examination immediately following admission to a facility," on an opt-out basis.

Waters plans to reintroduce the bill in the current session.

The World Health Organization (WHO) and UNAIDS both stress that "testing must be voluntary and ... patients must retain the right to decline the test."⁶ WHO recommends that "[p]reventive measures for HIV/AIDS in prisons should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviors actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse."⁷

The U.S. Supreme Court has not yet ruled on the constitutionality of mandatory HIV testing, nor on inmates' rights to HIV testing. Two federal cases have discussed the right to an HIV test. *Doe v. Wigginton* held that an inmate was not deprived of his eighth amendment rights to medical care when his request for an HIV test was denied.⁸ *Feigley v. Fulcomer* suggested that denial of an HIV test to relieve an inmate's anxiety about his or her HIV status was not a violation of his or her constitutional rights.⁹

There were nearly 2.2 million incarcerated individuals in the United States in 2005.¹⁰ Data from 2003 show that 0.51 percent of the total prison population and 2.8 percent of inmates in federal prisons are HIV-positive (as compared with 0.15 percent of the general population).¹¹ Seroprevalence rates in state prison systems vary, with the greatest prevalence being in the District of Columbia (7.6 percent), New York (4.3 percent) and Massachusetts (4.0 percent).¹²

However, it should be noted that poor surveillance systems, brief incarceration periods, lack of medical care in prisons (including HIV counselling and testing), and stigma surrounding HIV/AIDS and STDs

makes it difficult to accurately determine the prevalence of infection. Reported rates most likely underestimate the true prevalence of HIV/AIDS in the U.S. prison system. Many inmates are reluctant to get tested because they fear reprisals and stigma from prison authorities or fellow inmates.

– Anna Dolinsky

Anna Dolinsky (dolinksa@staff.abanet.org) is the Project Assistant for the American

Bar Association's AIDS Coordinating Committee.

¹ This bill, as well as Water's bill discussed later, can be accessed through the U.S. Library of Congress legislative database at <http://thomas.loc.gov>.

² B.V. Smith, "Prison and punishment: rethinking prison sex, self-expression and safety," *Columbia Journal of Gender & Law* 15 (2006): 185–226.

³ Human Rights Watch, *Letter to the Governor's Office in Support of Assembly Bill 1677*, 25 August 2006. At www.hrw.org.

⁴ For previous coverage of this issue, see R. Pearshouse, "California governor vetoes prison condom bill," *HIV/AIDS Policy & Law Review* 11(2/3) (2006): 38.

⁵ Examples of state legislation on HIV testing in the crimi-

nal justice system include mandated testing for charged or convicted sex offenders, persons charged or convicted of prostitution, prisoners to be released or paroled, and any prisoner who presents a possible risk of transmission. See National HIV/AIDS Clinicians' Consultation Center, University of California San Francisco, *State HIV Testing Laws*, 2006.

⁶ UNAIDS/WHO, *Policy Statement on HIV Testing*, 2004.

⁷ WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993.

⁸ *Doe v. Wigginton* [1994] 21 F.3d 733 (6th Cir. 1994).

⁹ *Feigley v. Fulcomer* [1989] 720 F. Supp. 475 (M.D. Pa. 1989).

¹⁰ L.M. Maruschak, *HIV in Prisons*, 2003, Bureau of Justice Statistics Bulletin, September 2005.

¹¹ *Ibid.*

¹² *Ibid.*

Russian Federation: Governments threaten freedom of association and assembly for LGBT organizations

Moscow Mayor Yuri Luzhkov has insisted that he will not allow the Moscow's Gay Pride parade, scheduled for 27 May 2007, to go ahead, calling it a "satanic" event.¹ Luzhkov banned the first planned Gay Pride parade which was scheduled to take place on the same date in 2006.² On that occasion, the authorities stated that permission for the event was denied because of impossibility to provide adequate security for the participants.³ Two court decisions later affirmed the ban.⁴

In February 2007, the organizers of the Pride parade submitted an application to the European Court of Human Rights claiming that the ban of the parade by the authorities violated several rights guaranteed by the *European Convention for the Protection of Human Rights and Fundamental Freedoms*.⁵

In response to numerous inquiries about the ban on Moscow's Gay Pride parade,⁶ the government issued

a statement in which it insisted that it supports the right of sexual minorities to freedom of assembly.⁷ The statement affirmed that peaceful demonstrations in favour of sexual minority rights cannot be banned; that police have a duty to protect such demonstrations; and that a general ban of a peaceful gathering can be justified only if there is a real danger of disorder which cannot be prevented by reasonable measures.⁸

However other statements and actions by governmental officials contradict this statement. According to reports, the lesbian, gay, bisexual and transgendered (LGBT) community faces difficulties registering organizations and protecting rights and freedoms of its members.⁹ In late 2006, the Federal Registration Agency in the Tyumen region refused on three occasions to register a LGBT organization called "Raduzhnyi dom"

(Rainbow house).¹⁰ Earlier that year, the national parliament established new rules restricting registration and reporting requirements for foreign and national NGOs, and requiring re-registration of existing organizations.¹¹

The official notification that Raduzhnyi dom was refused registration noted that the organization is of extremist character:

[T]he mandate of the organization is to protect human rights of people of non-traditional sexual orientation. Activities of the organization stated in the founding documents are aimed at fulfilling this mandate, and thus will lead to propaganda of non-traditional sexual orientation.¹²

“Our experts concluded that the mandate of this organization is not in accordance with the Constitution of the Russian Federation,” said the head of the Agency.¹³ The officials further stated that the organization is “extremist” and “incite[s] national hatred.”¹⁴

According to Article 16(1) of the Federal Law “On Public Associations,” “creation and activity

of public organizations whose goals and mandate are directed towards extremist activity are prohibited.”¹⁵

However, the goals of Raduzhnyi dom include the protection of human rights and freedoms, fighting against discrimination on the ground of sexual orientation, and educating LGBT people to see themselves as equal and valuable citizens.

This is not the first instance of an LGBT group being refused registration.¹⁶

According to Russian law, freedom of association and assembly is guaranteed by the Constitution.¹⁷

— Leah Utyasheva

Leah Utyasheva (lutyasheva@aidslaw.ca) is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network.

¹ “Moscow mayor: Gay Pride is ‘satanist happening.’” *GayRussia*, 29 January 2007. At www.gayrussia.ru/en/news/detail.php?ID=8425.

² “Moscow Gay Pride ban goes to the European Court of Human Rights,” *GayRussia*, 29 January 2007. At www.gayrussia.ru/en/news/detail.php?ID=8421. May 27th commemorates the day when, in 1993, homosexuality was decriminalized in Russia.

³ *Ibid.*

⁴ A decision of the Tverskoi district court of Moscow of 26 May 2006 supported the ban. The Moscow City Court, in its appeal judgment, affirmed the ban in July 2006. At www.gayrussia.ru/en/inf/detail.php?ID=5307.

⁵ “Moscow Gay Pride ban...”

⁶ Human Rights Watch, *Letter to Mayor Yuri Luzhkov* (“Russia: Gay Parade should not be banned”), 27 February 2006. At www.hrw.org/english/docs/2006/02/27/russia12729.htm.

⁷ Parliamentary Assembly of the Council of Europe, Reply from the Chairman of the Committee of Ministers (“Ban on a Moscow demonstration by homosexuals”), Doc. 11175, revised 12 February 2007. At <http://assembly.coe.int/Main.asp?link=/Documents/WorkingDocs/Doc07/EDOC11175.htm>.

⁸ *Ibid.*

⁹ Russian LGBT Network, “Dve LGBT-organizatsii v tretii raz podali dokumenti na registratsiyu” (Two LGBT organizations apply a third time for registration), 11 January 2007. At www.lgbtnet.ru/news/detail.php?ID=2851.

¹⁰ “Chinovniki otkazivayt LGBT organizatsiyam v prave na sushestvovanie” (Bureaucrats deny LGBT organizations the right to exist), 28 December 2006, *Informational Agency LINA, GayNews.RU*. At www.gaynews.ru/gaylife/article.php?ID=2787.

¹¹ *Law on Public Associations*, # 82-ФЗ, 1995, amended on 10 January, 2006.

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ “Chinovniki otkazivayt...”

¹⁶ Russian LGBT Network, “Omskoi LGBT-organizatsii Favorit snova otkazali v gosudarstvennoi registratsii” (Omsk LGBT organization “Favorit” was again denied governmental registration), 31 January 2007. At www.lgbtnet.ru/news/detail.php?ID=2853.

¹⁷ *Constitution of the Russian Federation*, 1993, art. 30.

Russian Federation: Inhumane conditions in drug treatment facilities lead to tragedy

On 9 December 2006, a fire in a Moscow drug treatment hospital caused the death of 44 HIV-positive women undergoing treatment for drug dependence, and two hospital staff. An additional 11 people were severely burnt in the fire.

While the reason for the fire remains unclear, the death of so many victims has been blamed on security

measures in place at the hospital. According to reports, the fire happened on the second floor of the

building, where the windows were barred; there were no handles on the windows.¹ All the rooms were

locked at night, the main exit was blocked by a locked gate, and even the fire-escape ladder was barred.

There was no fire alarm or any other signal to warn of a fire in the hospital building.² As reported by the head of the State department of fire inspection, the personnel of the hospital delayed the call to the fire department by 20–30 minutes. The firemen arrived six minutes after the call was made, but it was already too late.

The Office of the Prosecutor General of the Russian Federation announced initiation of criminal cases under two articles: malicious destruction of property and disregard of fire safety resulting in death. To date, no charges have been laid.

In an open letter to the Minister of Health and Social Development of the Russian Federation, AIDS groups said that there is an urgent need to revise the concept of the drug treatment.³ The letter attributes the main cause of the tragedy to the inhumane

and ineffective system of drug treatment. The letter identifies an urgent need to review and reform the basic principles of drug dependence treatment in Russia and other countries of the Former Soviet Union. It adds that respect for the human rights of patients and modern evidence-based approaches should become the foundations of drug treatment programs.

Many Russian media sources were quick to blame drug users for the tragedy.⁴ This approach reinforces the negative image towards people who use drugs held by the general public, and so increases stigma and discrimination.

Security measures like the permanently locked safety exits were in place at the drug treatment hospital in Moscow because of the authorities' fear that some drug addicts could flee. Locked drug treatment wards are a legacy of the Soviet era, when narcologists subjected alcoholics and drug addicts to hypnosis, aver-

sion therapy and forced labour. In present-day Russia, people seeking drug treatment are offered minimal or no psychological support and rehabilitation. Instead, their names are registered by the government, and they are marginalized and discriminated against: this discrimination is even greater if they are living with HIV/AIDS and are women.

– Leah Utyasheva

¹ "Fires at Russian hospitals kill over 50 in 2 days, neglect of safety rules blamed," *International Herald Tribune (Europe edition)*, 9 December 2006. At www.iht.com/articles/ap/2006/12/10/europe/EU_GEN_Russia_Hospital_Fire.php.

² An account of the events (in Russian) is available at the website of the Russian Harm Reduction Network via www.harmreduction.ru.

³ Russian Harm Reduction Network and the International Treatment Preparedness Coalition, *Open Letter to the Minister of Health and Social Development of the Russian Federation*. At http://itpcru.org/en/moscow_tragedy.

⁴ "Fires at Russian hospitals..."

U.K.: New publications on HIV transmission and exposure and the criminal justice system

Two important new medico-legal publications aimed at individuals who work within — or are in contact with — the criminal justice system have recently been published by two U.K.-based organisations, NAM (a community-based provider of HIV information) and the National AIDS Trust (NAT). Although both publications are U.K.-focused, much of the information is relevant to other settings.

Although prosecutions for HIV exposure and transmission have taken place in many jurisdictions around the world since the 1980s, they are

becoming an increasingly common occurrence. Until now, no single resource has provided an overview of the issues: NAM's new book,

Criminal HIV Transmission, aims to bridge that gap. The book should be useful to anyone who requires up-to-date information in clear, layman's

language about the science — medical, clinical, social, epidemiological and forensic — of HIV transmission as it relates to the criminal law.

The preface, written by South African Supreme Court Justice Edwin Cameron, notes that

the criminal law's use lies in denouncing and punishing unacceptable behaviour that causes harm or exposes others to harm. But what we consider 'unacceptable behaviour' and 'harm' depends on society's values, on current attitudes, and on legal and constitutional principles. The most important determinant of these should not be fear, prejudice and stigmatising preconceptions. It should be good, up-to-date, well-presented and scientifically-based, medically sound information about HIV and the AIDS epidemic. It is for this reason that I am pleased and proud to be writing the preface to this book... The book is written clearly and comprehensibly, and provides a meticulous overview of HIV-related medical and social science, and law.

The opening chapter, "HIV in context," provides basic information on transmission, testing, treatment, prognosis and life expectancy. It also provides background information on life with HIV in 2007 and the communities most affected by HIV in the U.K.; and it compares and contrasts HIV with other blood-borne or sexually transmitted infections (including viral hepatitis.)

The "HIV and behaviour" chapter elucidates further on the social context of HIV transmission by providing the reader with a working knowledge of how individuals, at-risk communities and society as a whole are informed about, interpret and act upon sexual HIV risk-taking. This chapter also explains how HIV-relat-

ed stigma and discrimination — both actual and perceived — affect the acquisition and sharing of information about HIV on an individual, community and societal level. It also shows how and why the terms "safer sex" and "disclosure" can take many forms and mean different things to different people.

The chapter on "Sexual HIV transmission" provides a detailed overview of how HIV can be transmitted sexually, and what factors increase or decrease the likelihood of transmission. In addition, the latest information on the risks of different types of sexual intercourse, condoms, HIV viral load, circumcision and other probable or possible factors is summarized. The chapter also explains the difference between HIV exposure and HIV transmission and points out the very real difficulties of knowing when a person may have exposed someone to HIV and when a person has been infected with HIV.

The final chapter, "HIV forensics," explains how evidence can be used to prove or disprove the fact, timing and direction of sexual HIV transmission. In particular, it shows how and why individual elements of the scientific evidence collected during a criminal investigation should only be seen as small pieces of a much larger puzzle. The chapter covers virological evidence — notably, phylogenetic analysis — as well as other aspects of the medical histories of both the complainant and defendant.

Phylogenetic analysis — a complex scientific process that estimates how closely two or more HIV strains are genetically related — has been used to "prove" HIV transmission in some criminal prosecutions in several jurisdictions. However, a briefing paper published jointly by NAT and

NAM explains in detail why criminal investigations of alleged sexual HIV transmission cannot be proved conclusively by this kind of scientific evidence alone.

The second publication, a briefing paper entitled *HIV Forensics: The Use of Phylogenetic Analysis as Evidence in Criminal Investigation of HIV Transmission*, details the limitations and potential pitfalls of using phylogenetic analysis as forensic evidence. The paper also makes several recommendations about how expert witnesses should carry out phylogenetic analysis for HIV forensic purposes, as well as how the results are interpreted. Finally, the paper discusses the legal background to criminal HIV transmission prosecutions, and how and when legal precedent for phylogenetic analysis was established in several jurisdictions.

– Edwin J Bernard

Edwin J Bernard (edwin@nam.org.uk) is a staff member of NAM and editor of *AIDS Treatment Update and Criminal HIV Transmission*. *Criminal HIV Transmission* (£14.95; £9.95 for voluntary organizations) is available from NAM (+44 20 7840 0050, info@nam.org.uk, www.aidsmap.com). *HIV Forensics: The Use of Phylogenetic Analysis as Evidence in Criminal Investigation of HIV Transmission* (free) was co-authored by Edwin J Bernard, Yusef Azad (NAT), Anne-Mieke Vandamme (the Rega Institute for Medical Research, Belgium), Matthew Weait (the Research Institute for Law, Politics and Justice at Keele University), and Anna Maria Geretti (the Department of Virology, Royal Free Hospital, London). It is available as a PDF download from NAM or NAT's websites. Printed copies are also available from NAT (+44 20 7814 6767, info@nat.org.uk, www.nat.org.uk).

In brief

India: Multi-national pharmaceutical company challenges patent law

In February of 2007, the Madras High Court began hearing a landmark challenge to India's *Patents Act*.

In January of 2005, amendments to the Act, intended to bring India into compliance with its obligations under the World Trade Organization's *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS), came into force.¹ Section 3(d) of the Act was amended to include the following as inventions that are not patentable under the Act:

the mere discovery of a new form of a known substance which does not result in the enhancement of the known efficacy of that substance or the mere discovery of any new property or new use for a known substance or of the mere use of a known process, machine or apparatus unless such known process results in a new product or employs at least one new reactant.

This section was designed to prevent “‘evergreening,’ whereby pharmaceutical companies patent trivial modifications of already existing drugs” to extend their monopoly on the sale of a medication.²

In 1998, the pharmaceutical company Novartis had applied for a patent for a new formulation of its cancer medication Gleevec. At the time, a generic version of the medication, produced according to Novartis' original formulation, was already being produced and sold in

India. An Indian generic pharmaceutical manufacturer filed an opposition to the granting of Novartis' application.

On 25 January 2006, the Assistant Controller of Patents and Designs issued a decision refusing Novartis' application, based in part on section 3(d) of the Act, finding that “this patent application claims only a new form of a known substance without having any significant improvement in efficacy.”³

Novartis is challenging the refusal in the High Court. Among other grounds, Novartis is claiming that section 3(d) of the Act is not in compliance with TRIPS and violates Article 14 of the Indian Constitution which prohibits discriminatory and arbitrary state action.

The outcome of this case may have a profound impact on global access to essential medicines. India is the world's foremost producer of generic medications, supplying not only the Indian population but also many developing countries. For example, a 2007 fact sheet from *Médicins Sans Frontières* reports that 70 percent of HIV antiretroviral medications purchased by global aid and funding agencies used to treat patients in 87 countries come from Indian generic suppliers.⁴

– Glenn Betteridge

Glenn Betteridge is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network.

U.S.: Proposed easing of restrictions for HIV-positive short-term entry visas

In December 2006, the White House announced a proposal to ease the short-term travel restrictions which currently bar entry to the United States for people living with HIV/AIDS. A White House fact sheet released on World AIDS Day stated that President Bush would issue an executive order to the Secretary of State and Secretary of Homeland Security to “initiate a rule-making that would propose a categorical waiver for HIV-positive people seeking to enter the United States on short-term Visas.”⁵

Only those traveling on tourist and business short-term visas would be affected. The statement did not explain how the travel ban waiver would work, or whether individuals would still be required to declare their HIV-positive status to U.S. officials under the new rules.⁶

Despite the announcement, no changes have yet been made. Currently, people living with HIV/AIDS are prevented from entering the U.S. without a travel ban waiver. Waiver applications include a personal interview at a U.S. embassy and extensive decision wait-times, during which the applicant's passport is held, as well as a permanent, stigmatizing passport stamp if the application is successful.⁷

Leonard Rubenstein, executive director of Physicians for Human Rights, noted that the proposed changes do not “go far enough... If

you want to remove stigma from AIDS, you have to go the whole distance, and eliminate all restrictions on entry to the United States for people with HIV.”⁸ To this effect, a spokesperson for Democratic Congresswoman Barbara Lee announced plans to introduce legislation in the 110th Congress that would overturn the entry ban for both immigrants and visitors.⁹ No bill has yet been introduced.

– Cheryl Robinson

Cheryl Robinson is a student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro bono Students Canada.

UNHCR: New strategy for provision of antiretroviral therapy to refugees

In January 2007, the Office of the United Nations High Commissioner for Refugees (UNHCR) announced a new strategy regarding access to antiretroviral therapy (ART), care and support for HIV-positive refugees and other displaced persons worldwide. Designed to offer guidance to UNHCR and governments of countries hosting refugees and displaced people, the policy complements earlier UNHCR HIV/AIDS policies and guidelines.¹⁰

The strategy notes that refugees often live for years in relatively stable situations, making access to ART a practical consideration. Consequently, it addresses the provision of short-term preventative measures such as prevention of mother-to-child transmission and post-exposure prophylaxis.

The strategy also outlines long-term ART provision for refugees, advocating that “every effort should be made to secure prompt continuation of treatment”¹¹ for those who had received ART in their home countries. For those who had not, “ART should be provided when such treatment is available to surrounding populations.”¹² For refugees voluntarily returning to their countries of origins, UNHCR indicates that “returnees should be allowed and assisted to return to areas where continuation of ART can be secured.”¹³

Furthermore, the policy calls for interventions to be included in “the earliest possible stages of an emergency response to forced displacement.”¹⁴

The UNHCR strategy stresses the need for refugees to receive equivalent services to those available to surrounding host communities. Paul Spiegel, the senior HIV/AIDS technical officer for UNHCR, said, “We’d like to see refugees able to get drugs the same way local populations do.... We are advocating for governments to include refugees’ antiretroviral needs in their proposals for funding, for example, from the Global Fund.”¹⁵

– Cheryl Robinson

Indonesia: On the road to a harm reduction model?

Indonesia’s Third National Conference on HIV/AIDS was held in Surabaya, the country’s second-largest city, in early February 2007. Over 1500 delegates, including high-level national and provincial officials and many representatives of organi-

zations of people living with HIV, were present.

The government presented survey data showing that about half of new HIV transmission in Indonesia is linked to injection drug use, much of it injection of heroin. The conference was notable for the very public support expressed by high-level officials for rolling out harm reduction measures — including sterile syringe programs and methadone therapy — so that they are eventually available even in local health facilities across the country.

The Coordinating Minister of the People’s Welfare, Aburizal Bakrie, the highest-level official to address the meeting, repeated the government’s commitment to harm reduction as part of the national AIDS response. Dr. Nafisah Mboi, the chairperson of the National AIDS Commission, outlined a plan to ensure that harm reduction services would be accessible to all who need them.

Little was said in the meeting, however, about what may be the biggest impediment to harm reduction services in Indonesia — the country’s harsh drug laws and enforcement practices. The drug law allows for the imposition of long sentences for relatively minor crimes of possession of drugs, and for the death penalty in cases of drug trafficking.

In 2004, Amnesty International estimated that of 54 persons on Indonesia’s death row, 30 were convicted of drug offences, including 22 persons from outside Indonesia who were convicted of bringing drugs into the country.¹⁶ Short of the death penalty, there have been press reports of police targeting patients at methadone clinics,¹⁷ the kind of practice that in many other countries has

impeded roll-out of addiction treatment programs.

— *Joanne Csete*

Joanne Csete (jcsete@aidslaw.ca) is the Executive Director of the Canadian HIV/AIDS Legal Network.

Africa: New report on how HIV/AIDS programming is failing LGBT people

The International Gay and Lesbian Human Rights Commission (IGLHRC) recently published a new report which reveals how African governments and the global HIV/AIDS policy and funding community is denying basic human rights to lesbians, gays, bisexual and transgender people (LGBT) people in Africa.¹⁸ The report documents some shocking examples of how LGBT people in Africa are denied access to effective HIV prevention, counselling and testing, treatment and care.

The report found that

[d]espite increasing evidence of the need for HIV-related interventions for same-sex practicing people, there are scarcely more than a handful of formal HIV prevention, testing, treatment, or care programs targeting men who have sex with men in Africa and even fewer for same-sex practicing women....

Without immediate attention to this human rights crisis, efforts to effectively combat the AIDS epidemic in Africa may be seriously challenged.

Among the recommendations of the report are: the repeal of laws that criminalize same-sex consensual conduct; the removal of restrictions on U.S. reproductive health funding that increase the stigma against sexual

minorities; and increased funding to African governmental agencies and civil society organizations ready to implement HIV programs for same-sex practicing people in Africa.

For more information, contact the report's author, Cary A Johnson (cjohnson@iglhrc.org).

Cameroon: ILO conducts HIV training for labour courts in francophone Africa

From 18-21 September 2006, the International Labour Organization (ILO) convened a seminar entitled "HIV/AIDS and Employment Issues for Labour Courts" in Douala, Cameroon. Attending the seminar were judges from labour courts and industrial tribunals, as well as representatives from workers' and employers' organizations, from Benin, Burkina Faso, Cameroon, Democratic Republic of the Congo, Togo and l'Ile Maurice.

A seminar held in South Africa earlier in 2006 addressed the same topic for a similar number of judges, employers and trade unions members from Anglophone African countries.

The seminar represented recognition by ILO of the need to close the significant gap between the upgrading of labour laws with respect to HIV/AIDS in the workplace and the training provided to the industrial tribunals which enforce these laws. Over the course of the four days, the seminar attendees were engaged in a variety of modules, comprising lectures, panel discussions and working groups.

Sessions included a focus on the specific vulnerability of women liv-

ing with HIV/AIDS in the workplace. Other modules held during the course of the seminar focused on case studies of national legislation on HIV/AIDS in the workplace, and the role of workers' and employers' organizations in the AIDS pandemic.

The sum of these exercises was a greater appreciation by the participants of the need to educate judges, arbitrators and workers' and employers' organizations with respect to HIV/AIDS, and to debunk the myths commonly held by workers regarding HIV/AIDS in the workplace, in order to end the resulting stigma and discrimination.

— *Glenn Dodge*

Glenn Dodge is a student in the International Project Management Program at Humber College, and a volunteer with the Legal Network. For further information on these trainings, contact Jane Hodges at ILO at hodgej@ilo.org.

U.S.: All states to move to names-based HIV reporting in 2007

By the end of 2007, all 50 U.S. states and Washington D.C. are expected to be recording HIV cases using names-based (as opposed to code-based) reporting systems. Beginning this fiscal year, federal funds under the Ryan White CARE Act will be based on HIV data from names-based reporting systems.

Eight states and the District of Columbia started collecting the names of HIV patients in 2006, Massachusetts began in January 2007. The remaining states using code-based reporting — Vermont,

Maryland and Hawaii — are expected to change their systems shortly.¹⁹

In 1999, the federal Centers for Disease Control and Prevention (CDC) recommended that all U.S. states should conduct confidential name-based HIV case surveillance as part of their AIDS case surveillance activities.²⁰ According to the CDC:

[c]ompared with HIV reporting systems based on other types of identifiers (such as those based on a code or name-to-code), confidential name-based HIV reporting has proven to be more cost-effective, and it routinely achieves high levels of accuracy and reliability. Confidential name-based HIV infection reporting is consistent with reporting for other infectious diseases, including AIDS.²¹

Many HIV/AIDS advocates have expressed concerns that collecting names will deter some people from getting tested and seeking treatment, and that names may be released because of security breaches.²² Some states have responded to these concerns by strengthening efforts to protect the confidentiality of the data. A

Vermont bill, already passed by the senate in that state, would restrict the storage and processing of information, and provide for civil lawsuits for malicious disclosure of such information.²³

— Richard Pearshouse

January 2007. Available via www.unhcr.org/publ/.

¹¹ *Ibid.* at p. 7.

¹² *Ibid.* at p. 8.

¹³ *Ibid.* at p. 8.

¹⁴ *Ibid.* at p. 6.

¹⁵ "Africa: streamlining ARV provision for refugees," *IRIN News*, 29 January 2007.

¹⁶ Amnesty International, *Indonesia: A Briefing on the Death Penalty*, 2004. Available via www.amnesty.org.

¹⁷ "Police arrests haunt harm reduction program," *Jakarta Post*, 19 January 2007. Available via www.asia-pacific-action.org/southeastasia/indonesia/netnews/.

¹⁸ IGLHRC, *Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa*, 2007. Available via www.ighrc.org.

¹⁹ C. Johnson, "All states will track HIV cases: names will be in systems nationwide by end of '07," *The State Journal-Register*, 2 April 2007. At www.sj-r.com/sections/news/stories/111370.asp.

²⁰ CDC, "Guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome," *Morbidity and Mortality Weekly Reports* 48 (1999): 1–28.

²¹ CDC, "HIV Infection Reporting," at www.cdc.gov/hiv/topics/surveillance/reporting.htm.

²² See C. Johnson. For example, in 2005, a health department employee at the Palm Beach County Health Department (Florida) inadvertently e-mailed a confidential list containing the names of about 6500 HIV-positive people in the county to 800 county health workers: "Palm Beach County, Fla. official accidentally e-mails confidential list of HIV-positive people to health dept. employees," *Kaiser Daily HIV/AIDS Report*, 22 February 2005.

²³ SB 192, "HIV name-based reporting," at www.leg.state.vt.us/database/status/summary.cfm?Bill=S%2E0192&Session=2008.

¹ "Indian court hears arguments in case against country's Patents Act," *Kaiser Daily HIV/AIDS Report*, 16 February 2007.

² C. Park, *The Struggle for Affordable Medicines*, 2007. Available via www.infochangeindia.org.

³ *Novartis A.G. Switzerland v. Natco Pharma Ltd, India (January 25, 2006)*, (V. Rengasamy, Assistant Controller of Patents and Designs).

⁴ Medecins Sans Frontières, "Examples of the importance of India as the 'pharmacy for the developing world.'" Available via www.accessmed-msf.org.

⁵ Office of the Press Secretary, *Fact Sheet: World Aids Day 2006*, 1 December 2006. Available via www.whitehouse.gov/news/.

⁶ E.J. Bernard, "US promises 'streamlined' process for HIV-positive tourist visas," *Aidsmap News*, 4 December 2006. Available via www.aidsmap.com.

⁷ *Ibid.*

⁸ *Ibid.*

⁹ "U.S. Law banning HIV-positive foreigners from entering country hampering testing efforts, panel members say," *Kaiser Daily HIV/AIDS Report*, 22 November 2006.

¹⁰ UNHCR, *Antiretroviral Medication Policy for Refugees*.

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. For this issue, the editor of this section was Glenn Betteridge. Readers are invited to bring cases to the attention of David Garmaise, Managing Editor of the Review, at dgarmaise@rogers.com.

Federal Court of Appeal examines for first time refugee protection on the basis inadequate health care

On 10 November 2006, in a precedent-setting case, the Federal Court of Appeal dismissed an application by a Mexican national to remain in Canada as a “person in need of protection” under the *Immigration and Refugee Protection Act (IRPA)*.¹ The principal issue before the Court was whether the IRPA excludes from protection people who face a risk to life if returned to their home country, where the risk arises from the fact the government does not provide affordable medical treatment.

Covarrubias, a failed refugee claimant, suffered from end-stage renal failure and was receiving life-sustaining hemodialysis treatment in Canada. Under the IRPA, failed refugee claimants are entitled to make a claim to remain in Canada as a “per-

son in need of protection.” Section 97(1)(b) of the IRPA recognizes “a person in need of protection as a person in Canada whose removal to their country of nationality ... would subject them personally ... to a risk to their life.”

However, such protection is available only if “the risk is not caused by the inability of that country to provide adequate health or medical care” — the so-called health care exclusion.² Covarrubias claimed that the government in Mexico did not

provide this treatment, that he could not afford to pay for it and, thus, that he would quickly die if returned to Mexico.

The IRPA health care exclusion was the subject of a recent lower court decision.³ This case is the first time the Court of Appeal has examined the issue.

Covarrubias argued that the “person in need of protection” provision of IRPA is intended to protect people who face a risk to their life as a result of a violation of international human rights or standards. Thus, he argued, the IRPA’s health care exclusion should be interpreted in light of the right to health in international law, so as to exclude from refugee protection only people from countries which are truly unable for financial reasons to provide needed medical treatment to their nationals — not those people from countries where public policy choices have resulted in inadequate medical treatment.

In dismissing his application, the Court wrote:

... the phrase “not caused by the inability of that country to provide adequate health or medical care” in subparagraph 97(1)(b)(iv) of the IRPA excludes from protection persons whose claims are based on evidence that their native country is unable to provide adequate medical care, because it chooses in good faith, for legitimate political and financial priority reasons, not to provide such care to its nationals. If it can be proved that there is an illegitimate reason for denying the care, however, such as persecutorial reasons, that may suffice to avoid the operation of the exclusion.⁴

The Court provided an example of such persecutorial reasons, involving HIV treatment, drawing a distinction between a country’s “inability” to provide adequate health care and a “refusal” to do so:

... where a country makes a deliberate attempt to persecute or discriminate against a person by deliberately allocating insufficient resources for the treatment and care of that person’s

illness or disability, as has happened in some countries with patients suffering from HIV/AIDS, that person may qualify under the section, for this would be refusal to provide the care and not inability to do so.⁵

The decision provides an opening for a failed HIV-positive refugee claimant to legally remain in Canada where the country to which she is to be deported has in bad faith failed to provide adequate health or medical care to people living with HIV/AIDS.

— Glenn Betteridge

¹ *Covarrubias v. Canada (Minister of Citizenship and Immigration)*, 2006 F.C.A. 365.

² *Immigration and Refugee Protection Act*, S.C., 2001, c 27 ss. 97(1)(b)(iv).

³ *Travers v. Canada (Minister of Citizenship and Immigration)*, 2006 F.C. 44, reviewed in J. Chan, “Federal Court orders re-determination of HIV-positive Zimbabwean’s refugee claim” *HIV/AIDS Policy & Law Review* 11, 2/3 (2006): 42–43.

⁴ *Covarrubias v. Canada* at para. 41.

⁵ *Ibid.* at para. 39.

Criminal law and HIV transmission or exposure: new cases and developments

Three ground-breaking developments in the first HIV-related murder case

The Ontario Superior Court of Justice has handed down three decisions on pre-trial matters in the first Canadian case in which a person living with

HIV has been charged with murder as a result of non-disclosure of HIV status. In total, Aziga faces 13 charges of aggravated sexual assault and two of murder. The murder charges related to the deaths from HIV-related complications of two women he is alleged to have infected with HIV.

Each of the three decisions involved a legal issue that, to the best of the editors’ knowledge, has not been previously examined by a Canadian court in the context of an HIV-related criminal prosecution.

On 14 November 2006, the Court decided to admit into evidence the

video-taped statements, and transcripts of those statements, of the deceased women.¹ The police obtained from each of women a death-bed statement relevant to the criminal trial.

As a general rule, under the Canadian law of evidence, video-taped statements are considered hearsay evidence and thus inadmissible in court proceedings. However, there are two relevant exceptions to the hearsay rule, which the prosecution relied on in making the application to have the video tapes and transcripts admitted as evidence. The exceptions are to be applied together.

The first exception presumes that so-called “dying declarations” — statements about the circumstances of death made where there is a settled, hopeless expectation of death — are admissible into evidence. Under the second exception, hearsay evidence may be admitted where it is necessary to prove a fact in issue and the information is trustworthy. The judge concluded that both women’s video-taped statements met the exceptions and were thus admissible as evidence.

On 29 December 2006, the Court ruled that statements Aziga had made to public health authorities after he was served with a public health order were not admissible in evidence.² In October of 2002, Aziga was served with a public health order under Ontario’s *Health Protection and Promotion Act* (HPPA)³ requiring him, among other things, to provide public health authorities with a list of the people with whom he had engaged in unprotected penetrative sex since being diagnosed with HIV in 1996, to attend counselling sessions with a public health nurse, and to abstain from unprotected sexual intercourse.

Public health had reason to believe that Aziga was not abiding by some

terms of the order and met with him to discuss his behaviour. Public health authorities applied under the HPPA for, and were granted, a Superior Court order restraining Aziga from breaching the previously issued public health order.⁴ Aziga was arrested in late August 2003, after which time he spoke with a public health nurse on three occasions while in detention.

Under section 7 of the Charter, only statements made freely and voluntarily by an accused person can be admitted into evidence.

The issue before the Court was whether admitting into evidence at trial Aziga’s statements to public health authorities would infringe the guarantee against self-incrimination contained in the *Canadian Charter of Rights and Freedoms*. Under section 7 of the Charter, as a matter of fundamental justice, only statements made freely and voluntarily by an accused person can be admitted into evidence. The Court examined the four considerations underlying the constitutional principle against self-incrimination.⁵

The Court found that the statements had been *coerced* and were made in the context of an *adversarial relationship*. To allow such statements to be entered into evidence would undermine the *effectiveness of the regulatory scheme* established by public health law for partner reporting by inducing people to provide unreliable information. Finally, to

permit the police to rely on private and extremely personal information might increase the *likelihood of abusive conduct by the state*. The Court went on to comment on the important balancing of societal and individual interests at play in such a situation:

[I]t must be recalled that the purpose of the *Health Protection and Promotion Act* is not to assist police in the investigation of specific crimes. Accordingly, the balance which must be struck in the context of the *Act* is not between self-incrimination concerns on the one hand and the effectiveness of criminal prosecutions on the other. Rather the balance that must be struck is between a person’s right not to be compelled to self-incriminate in criminal proceedings and the province’s interest in preventing the spread of disease. The balance struck by the granting of use immunity [i.e., the statements made to public health authorities could not be used as evidence in the criminal trial] appears to be the most effective way of achieving valid public objectives without sacrificing the principle against self-incrimination.⁶

In the third case, decided on 10 January 2007, the Court granted Aziga’s application to adjourn the criminal trial to permit him to obtain the services of a scientific expert to advise his lawyers. The issue was whether such expert assistance was necessary for him to make a full answer and defences to the criminal charges. In granting the application, the Court referred to the complexity of the case “involving scientific evidence for which a special laboratory and new scientific protocols had to be created” and the fact that the prosecution had taken a great deal of time to prepare its scientific evidence it will rely upon.⁷

– Glenn Betteridge

Judge imposes two-year sentence; says treatment needs likely better met in federal prison

In June 2006, Williams, an HIV-positive man, pled guilty to two charges of aggravated assault and two charges related to breach of his bail conditions. Despite knowledge of his status, Williams had unprotected sex with two women over several years without disclosing his HIV status. In December 2006, a judge in the Ontario Court of Justice ordered that Williams be sentenced to twelve months incarceration for each offence, to be served consecutively, and three years probation.⁸

Citing *R. v. Cuerrier*,⁹ the leading Supreme Court case that established an affirmative duty on HIV-positive people to disclose their HIV status prior to unprotected sexual intercourse, the judge wrote that “[d]eterrence and denunciation” are the primary sentencing goals in such cases.¹⁰ The judge reviewed the circumstances and sentences in prior cases involving HIV exposure through unprotected sex, which ranged from one to eleven years of incarceration, and concluded that a period of “true imprisonment”¹¹ was consistently imposed. In addition, the judge cited the principle of proportionality, as outlined in s. 781.1 of the *Criminal Code of Canada*, which allows for determination of the appropriate sentence based upon “the gravity of the offence and the defendant’s responsibility.”¹²

In determining the appropriate sentence for Williams, the judge weighed a variety of mitigating and aggravating factors. Among the aggravating factors considered were the significant public health concerns

arising from potential HIV transmission by Williams’ sexual partners to other individuals. The judge also took into account the potential individual consequences for the women, both medical and social, including the considerable emotional and psychological distress experienced by one of the women upon learning of Williams’ HIV status. Another aggravating factor cited by the judge was the “callous indifference”¹³ Williams’ showed to the fate of the two women, demonstrated by his knowing repetition of unprotected sex.

Among the mitigating factors taken into account by the judge was the fact that neither of the women was infected with HIV as a result of the unprotected sex with Williams. Williams’ decision to plead guilty was taken as evidence that he has accepted responsibility for his misconduct. The sincerity of this remorse was further supported by his pre-sentence conduct in which Williams pursued volunteer counseling and outreach work on behalf of a community AIDS organization. Finally, the judge looked favourably upon Williams’ minimal prior criminal history and his demonstrated potential for rehabilitation.

Based on these factors and the principle of proportionality, the judge reasoned that each aggravated assault conviction warranted a sentence of between 18 to 21 months, and arrived at a global sentence of 38 months. The amount of time Williams spent in pre-sentence custody was deducted. Of note, the judge also took into account Williams’ HIV status and associated health needs when arriving at a sentence:

Having heard extensive evidence on the facilities, programs and level of care

provided at federal and provincial institutions, it is my view that Mr. Williams’ therapeutic needs are more likely to be better met within the federal correctional system. It is for this reason — along with the fact that a penitentiary sentence more appropriately reflects the gravamen of the assault offences in this case than does a reformatory disposition — that I have imposed a sentence of two years rather than one at or very near the high-end of that range served in provincial institutions.¹⁴

Under the *Criminal Code*, sentences of up to two years less one day are served in a provincial institution; sentences of two years or more are served in a federal penitentiary.

– Cheryl Robinson

Cheryl Robinson is a student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro bono Students Canada.

Fifty-six-month sentence for unprotected sex with two girlfriends

In January 2007, Walkem pled guilty to two counts of aggravated sexual assault based on the fact he had unprotected sex with two ex-girlfriends without first disclosing his HIV-positive status. An Ontario Superior Court judge characterized Walkem’s behaviour as “wanton, reckless and self indulgent” before sentencing him to 56 months in a federal penitentiary.¹⁵

Recognizing the sentencing objectives of deterrence and denunciation as paramount, the judge relied heavily upon the principles articulated and the approach taken in the *Cuerrier* and *Williams* cases to determine the appropriate sentence.¹⁶ Accordingly,

both mitigating and aggravating factors were balanced against the sentencing principle of proportionality.¹⁷ The defendant's guilty plea was noted as a mitigating factor.

However, the judge remained unconvinced of Walkem's remorse, noting that unlike Williams, Walkem had made little effort to gain insight into the manner in which his activities affected others.¹⁸ The judge also took a dim view of an online blog maintained by Walkem, in which he bragged about unprotected sexual intercourse with one of the complainants.¹⁹

The judge noted the defendant's repeated recklessness in engaging in unprotected sex, even though he was bound by a public health order providing that he should not engage in sex without prior disclosure of his medical condition and without wearing a condom.²⁰ The judge remarked upon the defendant's subterfuge in the face of questions posed by his sexual partners regarding his HIV status, the frequency and nature of penetrative sex, and also the fact that one of the two complainants tested HIV-positive during the course of their relationship.²¹

The judge weighed these significant aggravating factors and his "complete revulsion and disgust for Walkem's actions and activities, both before and after the events which gave rise to the charges proper" against the principle that a first sentence of imprisonment should be as short as possible and tailored to the individual circumstances of the accused.²² Accordingly, the judge arrived at consecutive sentences of 36 months on the fist charge and 22 on the second, minus time already served. The judge commented that the federal correctional system was capable of handling the defendant's

medical condition and maintaining his antiretroviral regime.²³

– Cheryl Robinson

Ex-professional football player guilty of two counts of aggravated sexual assault

In the most publicized case to date in Canada involving criminal charges related to the non-disclosure of HIV status, ex-football player Trevis Smith was found guilty of two charges of aggravated sexual assault.²⁴ After a trial before a judge of the Saskatchewan Provincial Court sitting without a jury, on 8 February 2007 the judge concluded that Smith had engaged in unprotected sexual intercourse with two women without first disclosing to them that he was HIV-positive. The judge's findings of guilt were based on credibility; the evidence of the two women complainants was found to be more credible than that of Smith. On 22 February 2007, Smith filed a notice appealing the guilty verdicts.²⁵

On 26 February 2007, the judge sentenced Smith to six years in prison; five-and-one-half years for the two aggravated sexual assault convictions and six months for breaching the conditions of his release pending trial.²⁶

– Glenn Betteridge

Court rejects appeal where man disclosed HIV status to police, claimed he didn't know HIV endangered life

In a case which recently came to the attention of the editors, in a January

2006 decision the Québec Court of Appeal granted in part an appeal by an HIV-positive man.²⁷ However, all of the grounds of appeal relating specifically to his HIV status were rejected. He had been convicted, among other charges, of aggravated sexual assault for failing to disclose his HIV status before engaging in unprotected sexual intercourse.

On appeal, the man claimed that the trial court made an error by permitting to be introduced evidence of his HIV status obtained in contravention of this Charter rights. When he was arrested by police at this apartment, he told the police that they must bring his medication with them. The issue before the Court of Appeal was whether the police obtained the information that he was HIV-positive in a way that infringed the Charter rights against self-incrimination, to be free from unreasonable search and seizure, and to legal counsel.

The Court's decision in relation to all three alleged Charter violations turned on whether the man voluntarily told the police he was HIV-positive or whether this information was obtained by police in a coercive manner. The Court found that the man had spontaneously declared to police that he was HIV-positive and had asked that his medications be brought.

The man also claimed that the trial court erred by convicting him of aggravated sexual assault in the absence of proof beyond a reasonable doubt that he knew that having unprotected sexual intercourse endangered his sexual partners' lives. Under section 273 of the Criminal Code, an aggravated sexual assault is a sexual assault during which the accused "wounds, maims, disfigures or endangers the life of the complainant."

As part of the offence of aggravated sexual assault, the prosecution must prove that the accused had objective foresight that his actions would, in the case of HIV, endanger the life of the complainant. The Court found that the evidence demonstrated that the man knew that unprotected intercourse could endanger the life of his sexual partners.

– Glenn Betteridge

¹ *R. v. Aziga*, [2006] O.J. No 4545 (QL).

² *R. v. Aziga*, [2006] O.J. No 5232 (QL).

³ R.S.O. 1990, C. H.7, s. 22.

⁴ *Ibid.*, s. 102.

⁵ The Supreme Court of Canada set out these considerations in *R. v. White*, [1992] 2 S.C.R. 417.

⁶ *R. v. Aziga* [2006] O.J. No 5232 at para. 48.

⁷ *R. v. Aziga*, [2007] O.J. No 61 (QL) at para. 14.

⁸ *R. v. Williams*, [2006] O.N.C.J. 484.

⁹ *R. v. Cuernier*, [1998] 2 S.C.R. 371.

¹⁰ *R. v. Williams*, para. 17.

¹¹ *Ibid.* at para. 20.

¹² *Ibid.* at para. 21.

¹³ *Ibid.* at para. 23.

¹⁴ *Ibid.* at para. 28.

¹⁵ *R. v. Walkem*, [2007] O.J. No 186 (Westlaw) at para. 3.

¹⁶ *R. v. Cuernier*, [1998] 2 S.C.R. 371; *R. v. Williams*, [2006] O.N.C.J. 484 (Ontario Court of Justice).

¹⁷ *Ibid.*, paras. 20–21.

¹⁸ *Ibid.*, para. 25.

¹⁹ *Ibid.*, para. 8.

²⁰ *Ibid.*, para. 13.

²¹ *Ibid.*, para. 10.

²² *Ibid.* at para. 24.

²³ *Ibid.*, para. 28.

²⁴ J. Friesen, "Smith guilty, faces prison," *Globe and Mail*, 9 February 2007, p. A7.

²⁵ "Smith files appeal," *Leader-Post (Regina)*, 29 February 2007, p. A5.

²⁶ J.G. Pruden, "Ex-CFL player gets six years in HIV case: prosecutor questions sincerity of apologies," *National Post*, 27 February 2007, p. A10.

²⁷ *R. v. D.(N.)*, [2006] J.E. 2006-273; [2006] CarswellQue 19.

In brief

Human Rights Tribunal rejects application to dismiss discrimination complaint

In September 2006, the British Columbia Human Rights Tribunal denied an application by the Interior Health Authority (IHA) to dismiss a complaint brought by the complainant, Reid.¹ In the complaint, Reid alleged that IHA had discriminated against him in the provision of a service on the basis of his sexual orientation, contrary to the *Human Rights Code*.

Reid alleged that in the course of his hospitalization for an appendectomy in October 2005, he was subjected to discriminatory treatment after identifying himself as a gay man

to the attending physician. This treatment included inappropriate comments by the hospital staff regarding his sexual orientation, and repetitive queries about his HIV status culminating in his being tested for HIV without consent. In its response, IHA presented a different version of the facts, questioned the jurisdiction of the Tribunal to adjudicate upon matters of clinical and medical judgment, and filed an application to have the complaint dismissed.

Under the Code, a Tribunal can dismiss a complaint before a hearing into the merits of the case where, among other reasons, the alleged conduct does not contravene the Code, there is no reasonable prospect that the complaint will succeed, or proceeding with the complaint would

not further the purposes of the Code. The Tribunal declined to dismiss the complaint. The Tribunal held that, if proven, all the allegations made by Reid could constitute discrimination on the basis of sexual orientation contrary to the Code.²

In assessing whether there was a reasonable prospect that the complaint would succeed, the Tribunal determined that although the respondents presented a contradictory version of events to that of Reid, this was not sufficient grounds to dismiss a complaint.³ Furthermore, the Tribunal held that it had jurisdiction to determine whether a physician's conduct was discriminatory.⁴

– Cheryl Robinson

Appeal Court finds assisted contraception regulations do not discriminate against lesbians and gay men

In January 2007, the Ontario Court of Appeal upheld a decision of a lower court which determined that the donor exclusion guidelines of the *Processing and Distribution of Semen for Assisted Conception Regulations*⁵ were constitutionally valid.⁶ Under the Regulations, people with “indications of high risk for disease such as HIV,” such as men who have sex with men (MSM), were excluded from donating semen for assisted conception, as are men over 40 years of age.⁷

The appellant, a lesbian, had argued that the Regulations infringed her Charter equality rights and her rights to liberty and security of the person. The intervener D, a gay man over 40, was the lesbian’s intended sperm donor. He contended that his Charter equality rights were infringed since he was excluded as a donor.

The Court of Appeal rejected these contentions. The Court noted that the purpose of the Regulations was to protect the health of women and their unborn children, and to reduce their risk of acquiring transmissible infectious diseases.⁸ The Court held that the differential treatment experienced by lesbians was not based upon sexual orientation, but rather upon the lack of a spouse or partner who could donate sperm, thereby affecting heterosexual single women similarly.⁹

Furthermore, the Court held that the differential treatment did not involve prejudice, stereotyping and historical disadvantage. The court took notice of the fact that the

donor exclusions were no longer absolute. Since 2000, women with known donors were eligible to apply for “special access authorization,” subject to a six-month quarantine period in which the semen must test negative for infectious agents such as HIV.¹⁰ The Court also found that the regulations did not infringe the appellant’s right to liberty or security of the person.

The Court acknowledged that MSM are treated differently than heterosexual males, but determined that the differential treatment was not discriminatory. Referring to medical evidence establishing the higher prevalence of HIV among MSM than heterosexual men, the Court found the exclusion of MSM was justified on the basis of health considerations.¹¹ The lawyers representing both the appellant and D have indicated that they are considering asking the Supreme Court of Canada to review the decision.¹²

– Glenn Betteridge

Federal Court rejects “irreparable harm” argument of HIV-positive failed refugee claimant seeking to stop deportation

On 12 December 2006, the Federal Court denied an application for stay of removal for of an HIV-positive woman. The applicant came to Canada in November 2001 as a visitor and subsequently made a refugee claim, which was denied. She did not seek a judicial review of that denial. She was subsequently arrested and held pending removal (i.e., deportation) from Canada.

In response, she applied under the *Immigration and Refugee Protection Act* for a Pre-Removal Risk Assessment. She was scheduled to be removed from Canada on 17 December 2006. In response, she applied for a deferral of removal order. Both of her applications were denied by an immigration officer. She applied for permission to seek judicial review of both decisions.

She also applied to the Court to have the removal order stayed so that she could remain in Canada pending the outcome of the various legal proceedings she was involved in. Under the applicable legal test, a court will stay a removal order where the applicant demonstrates that there is a serious issue to be tried, that she would suffer irreparable harm if she was removed, and that the balance of convenience between the parties favours issuing the order.

The Court refused to stay the removal on the basis that her claim that she would suffer irreparable harm was “unsubstantiated and speculative.”¹³ Specifically, the Court pointed to a lack of evidence supporting the woman’s claims that she would suffer stigmatization and not be able to work in the food industry due to her HIV-positive status. Furthermore, the court held that loss of employment in the applicant’s area of choice does not amount to irreparable harm. In addition, the Court rejected the applicant’s argument that she would suffer irreparable harm associated with her need for medical treatment, stating that the applicant was not receiving treatment.

– Cheryl Robinson

\$6 million settlement in medical negligence case

A mother sued three physicians claiming that their negligence resulted in her child contracting HIV at or around the time of the child's birth. The case against one of the physicians was settled.

The mother, who sued on her behalf and on behalf of both her children, alleged that the physicians failed to recommend that the mother take steps to prevent HIV transmission during pregnancy with her second child. The physician alleged that the mother had declined an HIV test. The mother alleged that the handwritten note put forward by the physician in support of

his position was falsified, as was his evidence leading up to trial.

There was no ruling on the alleged falsification of records because the lawsuit was settled one day before the trial was scheduled to begin. As part of the settlement, one of the physicians agreed to pay \$6 million to the mother plus legal costs; the other two physicians consented to an order dismissing the action against them. Details of the case come from two courts decisions in which the court approved the settlement, determined the interest payable, and decided upon issues pertaining to the amount payable by the defendant physician.¹⁴

– Glenn Betteridge

¹ *Reid v. Interior Health Authority*, [2006] B.C.H.R.T.D. 464.

² *Ibid.*, para. 15.

³ *Ibid.*, para. 20.

⁴ *Ibid.*, paras. 19–22.

⁵ S.O.R./96-254.

⁶ *Susan Doe v. Canada (Attorney General)*, [2007] O.N.C.A. 11.

⁷ *Ibid.* at para. 8.

⁸ *Ibid.*, para. 20.

⁹ *Ibid.*, paras. 25–28.

¹⁰ *Ibid.*, para. 9, para. 40.

¹¹ *Ibid.*, para. 43.

¹² J. Tibbetts, "Sperm banks can reject gay men, court rules: no charter violation", *The (Montreal) Gazette*, 29 January 2007, p. A11.

¹³ *David v. Canada (Minister of Citizenship & Immigration)*, [2006] F.C. 1486.

¹⁴ [2006] O.J. No. 2762 (Ontario Superior Court of Justice) (QL); [2006] O.J. No. 4191 (Ontario Superior Court of Justice) (QL).

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 U.S. cases is very selective, as reports of U.S. cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of Alana Klein, editor of this section, at aklein@aidslaw.ca.

Mexico: Supreme Court rules discharge of HIV-positive troops unconstitutional

On 27 February 2007, Mexico's National Supreme Court of Justice ruled unconstitutional an article of the Social Security Institute Law for the Armed Forces that required HIV-positive service men and women to be discharged. The ruling came as the Court determined a group of 11 cases brought by HIV-positive ex-military personnel requesting constitutional injunctions against their dismissals from the armed forces.

The law in question determined that military personnel who had certain diseases or accidents would be considered "discharged for uselessness"

("retiro por inutilidad"). The list of diseases includes HIV seropositivity.¹ Eight of the 11 Supreme Court judges considered that the article violated

constitutional protections of non-discrimination and equality.

In the opinion of the majority of judges, the law was unconstitutional

because it required all HIV-positive personnel to be automatically discharged, without requiring a medical assessment of an individual's fitness to work. Presiding Judge Ortiz Mayagoitia explained that

[t]he Court has held that “uselessness” cannot be determined by the mere fact of being seropositive ... independent of the state of the disease's progression: if this [seropositiviy] is accompanied by an expert opinion that the person is not fit to carry out the activities required by his employment with the army, the discharge can be carried out and would be correct in terms of [the law].²

One of the 11 cases involved a soldier who had died before the case had been determined. The judges ordered that he was to be considered as being on active duty until his death, and so his family was to benefit from a full military pension.

It appeared that certain opinions of the judges in the minority were poorly informed with respect to issues of HIV transmission. At one stage, arguing in favour of the dismissal of the soldiers, Judge Azuela reasoned:

Take the experience of a kindergarten. What happens when a child arrives sick with something? When [the children] arrive there is a doctor who has to check them and if a child has arrived sick, they talk to the mother and say: take the child, and while he or she is sick, it can't attend.³

Also in favour of the dismissals, Judge Pimentel asked rhetorically:

Will the scientists have considered life in the barracks, where the 103 soldiers that make up a company sleep in beds side-by-side; or the conditions in which they carry out humanitarian aid in cases of disasters like the floods in [the states of] Chiapas and Oaxaca, with stagnant water, infested with mosquitoes that transmit diseases?⁴

The hearings were broadcast live on television, and such comments were widely criticized.⁵

In response to the finding of unconstitutionality, the Ministry of National Defense issued a statement that “in terms of the mentioned judicial decisions, those who should continue active service in the Mexican Army and Air Forces will be re-enlisted.”⁶ The Ministry of National Defense has also sent to the Office of Legal Counsel of the Federal Executive a proposal to reform the relevant law to bring it in line with the Court's decision.⁷ Legally, the Ministry of National Defence is obliged to continue applying the law until it is modified by the national Congress.⁸

According to media reports, over the past 13 years some 300 persons have been discharged from the military for being HIV-positive.⁹

– Richard Pearshouse

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¹ Article 226, category II, no. 45 of the Social Security Institute Law for the Armed Forces (*la Ley del Instituto de Seguridad Social de las Fuerzas Armadas*).

² “Lo que la Corte ha estimado, es que no solamente, por el solo hecho de ser seropositivo, que es el caso concreto, por sí solo sea determinante de inutilidad independientemente del grado de avance del padecimiento; si esto viene acompañado de un dictamen pericial en el sentido de que la persona ya no es apta para desarrollar la actividad a la que le obliga su enganche en el Ejército, la baja puede decretarse y será correcta...” Official transcript, 27 February 2007, p. 31. Available via <http://200.38.86.53/PortalSCJN/>.

³ “Aquí tenemos la experiencia de la guardería. ¿Qué sucede cuando un niño llega enfermo de cualquier cosa? Cuando llegan hay un médico que los tiene que checar y si un niño llega enfermo, se le habla a la mamá y se le dice: se lleva al niño, y mientras esté enfermo no entra.” Official transcript, 20 February 2007, p. 66. Available via <http://200.38.86.53/PortalSCJN/>.

⁴ “¿Habrán considerado los científicos la vida del cuartel, donde los 103 elementos que forman una compañía duermen en camas contiguas; o las condiciones en que se desarrollan las labores de ayuda en casos de desastres como las inundaciones en Chiapas y Oaxaca, con aguas estancadas, infestadas de mosquitos transmisores de enfermedades?” Official transcript, 26 February 2007, p. 6. Available via <http://200.38.86.53/PortalSCJN/>.

⁵ D. Cevallos, “Discharge of HIV-positive troops ruled unconstitutional,” Inter Press Service News Agency, 28 February 2007.

⁶ Department of National Defence, “The Department of National Defence will comply with the resolutions handed down by the National Supreme Court of Justice,” news release no. 18, Mexico City, 6 March 2007.

⁷ Department of National Defence, “The Department of National Defence ratifies its commitment to help military personnel infected with HIV/AIDS,” news release no. 22, Mexico City, 13 March 2007.

⁸ C. Avilés, “Corte ordena reinstalar a militares con VIH,” *El Universal*, 28 February 2007.

⁹ D. Cevallos.

Europe: Court finds lack of medical assistance in Russian detention facility to be in violation of human rights

On 26 October 2006, the European Court of Human Rights held in a unanimous decision¹ that Russian authorities violated *European Convention on Human Rights (the Convention)*² by, among other things, failing to provide qualified and timely medical assistance in a Russian detention facility.

Viktor Vasilyevich Khudobin, a Russian national who was HIV-positive and suffering from several physical and mental illnesses, spent more than one year in detention pending investigation and trial on a charge of drug trafficking before he was found not criminally liable for reasons of insanity.

During his detention, Khudobin, who was frequently placed in a hospital unit for patients with contagious diseases, contracted measles, bronchitis and acute pneumonia. He also had several epileptic fits while in prison, for which he received no assistance.

Khudobin's lawyers and family complained on several occasions to the Russian court, the prison administration and the Ministry of Justice about the conditions of detention, Khudobin's health problems and the lack of appropriate treatment. They also made requests for medical examinations by independent doctors hired by Khudobin and his family, but the requests were denied without reason.^{3,4}

The Court found that the Russian authorities had violated Article 3 of the Convention prohibiting torture and inhumane or degrading treatment or punishment. Although the Court accepted that "the medical assistance available in prison hospitals may not

always be at the same level as in the best medical institutions for the general public," it also stated that Article 3 imposes "an obligation on the State to ensure the physical well being of persons deprived of their liberty," which includes providing detainees with "requisite medical assistance."⁵

Khudobin was denied requisite medical assistance, in the Court's view.⁶ Although Khudobin's repetitive illnesses while in prison could "be partly explained by his past medical history, namely the fact that he was HIV-positive," the Court noted that "the sharp deterioration of his state of health in the detention facility raises certain doubts as to the adequacy of medical treatment available there."⁷

The fact that he was HIV-positive and suffered from a serious mental disorder "increased the risks associated with any illness he suffered during his detention and intensified his fears."⁸ Further contributing to his anxiety, Khudobin must have known that he could at any time suffer a medical emergency and that adequate medical assistance would not be provided.

The denial of requisite medical assistance, added to the authorities' refusal to allow an independent medical examination of his health, created a strong feeling of insecurity that, in the Court's view, amounted to "degrading treatment" under article 3.⁹

The Court also found that Khudobin's pre-trial detention violated his rights to trial within a reasonable time or release pending trial, as guaranteed by Article 5(3) of the Convention, and a speedy hearing on the lawfulness of detention under Article 5(4). According to the court, Russian authorities did not provide sufficient justification for continuing his detention and his applications for release and were unduly delayed. Finally, the court held that the man's right to fair proceedings under Article 6(1) of the Convention were violated by potential police misconduct.

– Liisa Seim

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¹ *Khudobin v. Russia* [2006] ECHR 898.

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

³ *Khudobin* at para. 27.

⁴ K. Gibson, "Europe: Court declares admissible complaint about lack of medical assistance in Russian detention facility," *HIV/AIDS Policy and Law Review* 10, 3 (2005): 52.

⁵ *Khudobin v. Russia*, no. 59696/00 (26 October 2006) at para. 93.

⁶ *Ibid.*, para. 95.

⁷ *Ibid.* at para. 84.

⁸ *Ibid.* at para 96.

⁹ *Ibid.*

Australia: Coroner recommends prisoners be given access to sterile syringes

Following an inquest into the death of a prisoner at the Woodford Correctional Centre in Queensland, Coroner Michael Barnes has recommended that Queensland prisoners be given access to sterile syringes.¹ The recommendation was made in view of the inability of the Department of Corrective Services to keep prisons drug-free, and in recognition of its obligation to minimize the spread of blood-borne viruses among the prison population.²

Darren Michael Fitzgerald, who was serving a life sentence and the Woodford Correctional Centre for murder, was found dead, slumped at his desk in his cell around 2 a.m. on 13 June 2004. An orange syringe cap was found on the desk and a small syringe was found on the floor under the desk.³

During an autopsy, “scarring associated with recent and previous puncture marks” were found in the right elbow. Fitzgerald was also found to have injected heroin within 12 hours of his death and to be infected with hepatitis C (HCV).⁴

Findings of the inquest were delivered on 19 January 2007 in Brisbane Magistrates Court. Noting that Fitzgerald had previously tested positive for drug use on fifteen occasions, the Coroner stated that evidence indicated that despite some improvements in the last ten years, “illicit drug use remains a significant problem in the Woodford Correctional Centre and throughout Queensland correctional centres generally.”⁵

The Coroner added that “[t]he department quite reasonably recognizes that while the total elimination of drugs from prisons is a worthwhile long-term goal it is not achievable in the short term and in the meantime it is essential that harm minimisation

strategies be engaged to reduce the spread of blood borne viruses and of death due to overdoses.”⁶

According to the findings, the death was caused by an accidental overdose. The Coroner was satisfied that prison authorities had responded “expeditiously and appropriately” when they found Fitzgerald may be in need of assistance.⁷

The Coroner was critical of the prison authorities’ lack of efforts to reduce the harm of drug use in prison.

Although the Coroner did not believe anyone had directly contributed to Fitzgerald’s death, he was critical of the prison authorities’ lack of efforts to reduce the harm of drug use in prison, and particularly the failure to provide access to sterile syringes. He stated that since hypodermic needles were being treated

as illegal by the prison authorities, the inmates using drugs were almost certainly sharing syringes. The fact that the authorities knew that many of the prisoners were carrying blood-borne viruses, and that a significant number of them were injecting drugs, led the Coroner to believe that prison authorities had failed their duty to minimize the risk of harm to prisoners by not providing access to sterile syringes.⁸

Coroner Barnes stated that “[e]ven those, whose callousness might permit them to conclude prisoners do not deserve such consideration, can not ignore the risk that prisoners on release will infect family and others with diseases they have acquired in prison as a result of the Department’s refusal to allow access to syringes.”⁹ The coroner also rejected security concerns as a valid objection to providing access to sterile syringes in the Correctional Centre. “Automatically retracting needles are available and in any event there are currently clearly numerous needles circulating in the prison system – two were found in the unit in which Mr. Fitzgerald died and none have been used as weapons.”¹⁰

In addition to recommending access to sterile syringes, the Coroner also suggested that the Department

of Correctional Services “as a matter of urgency” establish opioid dependence pharmacotherapy programs using methadone and buprenorphine in order to reduce demand for illegal drugs in prison. Finally, the Coroner recommended that more resources be allocated to the intelligence section of the Woodford Correctional Centre, as this would enable the Department of Correctional Services to establish which prisoners, staff, contractors or visitors warrant active monitoring in order to reduce the supply of drugs.¹¹

Comment

Injection drug use and high rates of HIV and HCV infection among prisoners are common in many countries.¹² The elevated risk of HIV and HCV infection in prisons due to sharing injection equipment, along with the proven effectiveness of needle exchange programs in reducing that risk,¹³ has led numerous organizations, including the World Health Organization, UNAIDS and the United Nations Office on Drugs

and Crime, to recommend that prison needle exchange as part of minimum standards for responding to HIV in prisons.¹⁴

The failure to provide access to essential HIV and HCV prevention measures to prisoners is a violation of prisoners’ right to health in international law.¹⁵ Guideline 4 of the *International Guidelines on HIV/AIDS and Human Rights* states that prison authorities should provide prisoners with the means to prevent HIV transmission, including “clean injection equipment.”¹⁶

A number of countries currently provide needle exchange in prisons, including Armenia, Belarus, Germany, Kyrgyzstan, Luxembourg, Moldova, U.K. (Scotland only), Spain and Switzerland. Countries that have taken steps toward introducing prison needle exchange programs include Belgium, Iran, Portugal, Tajikistan and the Ukraine.¹⁷ In each of those cases, prison needle exchanges have been a response to evidence of the risk of HIV and HCV

transmission in prisons from sharing syringes to inject illegal drugs.

– Liisa Seim

¹ Inquest into the death of Darren Michael Fitzgerald, Coroner’s Court Brisbane, COR 1417/04(5), 19 January 2007, p. 16.

² Ibid.

³ Ibid., pp.3–5.

⁴ Ibid. at p. 6.

⁵ Ibid. at p. 8.

⁶ Ibid.

⁷ Ibid. at p. 6.

⁸ Ibid, pp.15–16.

⁹ Ibid. at p. 16.

¹⁰ Ibid.

¹¹ Ibid. at p. 9.

¹² See R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2nd ed., Canadian HIV/AIDS Legal Network, 2006, pp. 5–11.

¹³ See World Health Organization, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users (Evidence for Action Technical Papers)*, 2004. At www.who.int/hiv/pub/idu/pubidu/en/

¹⁴ World Health Organization, *Policy Brief: Reduction of HIV Transmission in Prisons*, 2004, WHO/HIV/2004-05.

¹⁵ Lines et al., pp. 14–18.

¹⁶ *International Guidelines on HIV/AIDS and Human Rights*, UNHCR res 1997/33, UN Doc E/CN.4/1997/150 (1997).

¹⁷ Lines et al., pp. i–iii.

Criminal law and HIV/AIDS: four new cases

Germany: Man sentenced to five and a half years for endangering and infecting several partners

A Bavarian court sentenced a man to five and a half years in prison for

having sex with at least seven women without using a condom and without disclosing that he was living with HIV.¹ The district court in the city of Würzburg had convicted the 38-year old Kenyan man of nine counts of attempted bodily harm and causing

grievous bodily harm for transmitting the virus to two partners and exposing the others to it.²

Prosecutors initially demanded an eight-year sentence. They alleged that the man intended to infect his partners with HIV because he was angry that

his ex-wife had passed the virus on to him. The court rejected this argument, finding instead that the man believed the risk of transmission was reduced because he was taking antiretroviral treatment. A psychiatrist testified at trial that the man had only rudimentary knowledge about HIV/AIDS.

The judges nonetheless determined that a five-and-a-half-year sentence was appropriate on the basis that the man was likely to continue with his risky behaviour.

– Alana Klein

UK: Bournemouth court imposes three-and-a-half-year sentence for reckless HIV transmission

On 17 January 2007, a 35-year-old man was sentenced in the Bournemouth Crown Court to three and a half years in prison after pleading guilty to one count of grievous bodily harm for recklessly having unprotected sex with his girlfriend, who later tested HIV-positive.³ The judge also ordered that the man, who is originally from Zimbabwe, be subject to a five-year extended sentence of supervision after his release from jail.

According to media reports, the couple had known each other from work but began their sexual relationship in May 2006 after meeting at a Bournemouth nightclub. The sexual relationship continued until July 2006.⁴ The court heard that the woman asked her boyfriend numerous times whether he was carrying any sexually transmitted infections, but that he assured her he was not and pressured her to have unprotected sex.

The man was taking antiretroviral medications, which the complain-

ant believed were for asthma. The woman contacted police after “finding paperwork confirming that her ex-boyfriend was diagnosed HIV-positive in 2000.”⁵

The case is reportedly the eleventh prosecution for reckless transmission of HIV in England and Wales since 2003; eight people pleaded guilty, two were convicted following trials and one was acquitted.⁶

– Alana Klein

UK: Man sentenced to nine years for reckless transmission of HIV and HCV

Giovanni Mola, an Italian national, was sentenced on 5 April 2007 to nine years in prison for reckless transmission of HIV and hepatitis C (HCV) to a former girlfriend.⁷

At trial, a judge and jury at the Glasgow High Court heard evidence that the 38-year-old man began a sexual relationship with the woman, known as Miss X, in September 2003, after being diagnosed with HIV three years earlier. Condom use appeared to be a central issue: During the trial, Mola maintained that he had worn condoms throughout the five-month relationship, but Miss X testified that he “aggressively” refused to wear condoms.⁸ The jury returned with a guilty verdict in February 2007.⁹

At sentencing, Lord Hodge stated that the jury must have believed Miss X to be a more credible witness than Mola the issue of condom use. He also appears to have questioned medical evidence that non-disclosure of HIV status is acceptable where condoms are used. He stated:

Standing the advice that you had received from medical practitioners that you did not have to disclose your viral status if you took care to wear a condom properly, I do not consider that you can be judged to be criminally culpable and reckless on the ground only that you did not disclose your viral status. It is not for me to judge whether the medical advice which you received was appropriate. Non-disclosure of viral status and sexual intimacy when using a condom may expose a partner to a relatively small risk of infection to which she has not consented. But medical practitioners are no doubt very aware of the damage to an infected individual caused by social isolation. As I say, it is not for me to judge the medical advice you received.¹⁰

This statement can be contrasted with a New Zealand Court’s ruling that people living with HIV/AIDS are not required to disclose their HIV status if they use condoms during vaginal sex.¹¹

This appears to be the first case in which someone has been convicted for transmission of HCV.¹² Some scientific evidence indicates that there is an extremely low risk of HCV transmission through heterosexual sex.¹³ News reports about the Mola case said little about the scientific evidence presented at trial on the risks of transmission of HIV and HCV for different sex acts.

– Alana Klein

Australia: HIV-positive man facing criminal charges fails attempt to have his identity suppressed

An HIV-positive man Melbourne man failed in a motion to have his

identity suppressed to protect his health and safety in relation to criminal charges against him. The man faces 122 charges for allegedly having unprotected sex with 16 different men while knowingly being infected with HIV.

The man's lawyer argued before the Melbourne Magistrate's court on 19 March 2007 that publicity surrounding the case had already jeopardized his client's health and safety, and that his client, who was being held in custody, had been threatened and attacked by other prisoners. He also stated that his client was suicidal and that this heightened around court appearances.

The prosecution argued that a suppression order would be "pointless" because the accused was already a high profile prisoner, and sufficient measures were already in place to protect his safety in custody.¹⁴

The Magistrate held that there was no evidence that the accused would be at greater risk if named and that

the existing measures to protect his safety in prison were sufficient.

The case has aroused controversy in the Australian state of Victoria, where public health officials apparently knew about the man's behaviour, but a recommendation from a panel that the man be detained failed to reach the chief health officer who would have had the power to order his detention.¹⁵ The Victorian Health Minister blamed the situation on a communication breakdown and has promised to review Victoria's policies for dealing with people living with HIV who continue to have unprotected sex despite warnings from public health officials.¹⁶

– Alana Klein

¹ "Kenyan jailed in Germany for infecting women with AIDS virus," *Deutsche Presse-Agentur*, 17 January 2007.

² "Kenyan jailed in Germany for passing on the AIDS virus," *Agence France-Presse*, 17 January 2007.

³ "Man jailed for giving woman HIV," *BBC Online*, 17 January 2007. At <http://news.bbc.co.uk/1/hi/england/dorset/6272233.stm>.

⁴ P. Willis and PA, "Man jailed for infecting his girlfriend with HIV," *Daily Telegraph*, 18 January 2007.

⁵ J. Magee, "HIV man infected other women, fear," *Dorset Echo*, 19 December 2006.

⁶ E. J. Bernard, "'Bournemouth man pleads guilty in tenth successfully prosecuted reckless HIV transmission case in England and Wales," *Aidsmap News*, 18 January 2007. Available via www.aidsmap.com.

⁷ *HMA v. Giovanni Mola*, (5 April 2007); "Man jailed after passing on HIV," *BBC Online*, 5 April 2007.

⁸ "HIV man challenged over safe sex," *BBC Online*, 6 February 2007.

⁹ "Chef guilty of infecting lover with HIV and hepatitis C," *BBC Online*, 7 February 2007.

¹⁰ *HMA v. Giovanni Mola*.

¹¹ *New Zealand Police v. Dalley*, CRI-2004-085-009168, 4 October 2005. See G. Betteridge, "New Zealand: Criminal charges dismissed against HIV-positive man who had unprotected oral and protected vaginal sex," *HIV/AIDS Policy and Law Review* 10, 3 (2005): 46.

¹² E.J. Bernard, "Man sentenced to nine years for 'reckless' transmission of HIV and HCV in Scotland (updated)," *Aidsmap News*, 5 April 2007. Available via www.aidsmap.com.

¹³ B. Marincovich et al., "Absence of hepatitis C virus transmission in a prospective cohort of heterosexual serodiscordant couples," *Sexually Transmitted Infections* 79 (2003): 160–162; but see J.S. Weisbord et al., "Prevalence and risk factors for hepatitis C virus infection among STD clinic clientele in Miami, Florida," *Sexually Transmitted Infections*, 79 (2003): 1–5.

¹⁴ M. O'Keefe, "HIV-positive man accused of infecting others," *The Australian*, 19 March 2007; "HIV-positive man infected others: court," *The Age*, 19 March 2007.

¹⁵ R. Wallace, "Chief medic 'not told' of HIV case," *The Australian*, 4 April 2007.

¹⁶ *Ibid.*

In brief

South Africa: Inmate who refuses ARVs will get hearing about whether he can die at home

On 1 February 2007, the South African department of correctional services settled a case with an inmate seeking a medical parole board hear-

ing to consider releasing him to die at home. The man alleged that he was denied release on an earlier application because he refused to take anti-retroviral drugs.

The man brought an urgent application to the Pretoria High Court asking that the department be compelled to convene a parole board hearing to reconsider his release on medical grounds. Under the settlement, which was made an order of the Court, the department agreed to convene the parole board and to allow the man's

doctor to treat him in jail in the meantime.

The man, who had been sentenced to 74 years' imprisonment for charges of robbery and escaping from custody, was diagnosed HIV-positive in March 2006. He was first denied release at an earlier parole board hearing when the prison doctor refused to recommend him for medical parole, despite his own private doctor's view that his health condition was very serious.

According to the prisoner, the doctor "refused to recommend me for

medical parole due to the fact that I refuse to take antiretroviral drugs. The reason for my refusal is my concerns regarding the side effects as echoed by the Minister of Health. I accept her advice to be true.”¹

– Alana Klein

China: Hospital to compensate 19 people infected with HIV through blood transfusions

In a court-mediated settlement, a hospital in Northeast China’s Heilongjiang province must pay compensation for the HIV infection of 19 people through illegal blood transfusions.

The case involves the largest group of patients in China to be infected with HIV at a hospital where they were being treated.² Fifteen patients were infected in 2004 by contaminated blood that was sold to the hospital by a man and his wife.³ The virus was later passed on by three of the patients to their spouses, and a mother infected her five-year-old child, bringing the total number of people infected following the transfusions of unscreened blood to 19.⁴ Two of the people have died.

Three hospital staff members were sentenced in June 2005 to between two and 10 years in jail for illegally collecting and supplying blood in violation of Article 334 of the *Criminal Law of the People’s Republic of China*. The couple who made their living selling donated blood to the hospital has died.⁵

The hospital will pay a lump sum of US\$25,500 plus US\$382 monthly to each of the 17 surviving victims. The hospital will also cover their

medical fees for the rest of their lives. Each family of the two patients that died of AIDS related illness will receive about US\$45,000.⁶

In 2006, in an effort to prevent the spread of HIV/AIDS, China enacted regulations that would severely punish those involved in collection and distribution of untested blood leading to HIV transmission or other serious consequences.⁷

– Liisa Seim and Alana Klein

India: Supreme Court suspends manufacture of ayurvedic medicine being sold as a “cure” for AIDS

In January 2007, the Indian Supreme Court ordered the drug manufacturer T.A. Majeed to stop producing “Immuno-QR,” an ayurvedic drug that the Majeed had advertised as a “cure” for AIDS, until the Kerala High Court had an opportunity to determine whether the company had violated the terms of its license.⁸ The Court also directed the Kerala High Court to expedite the hearings and dispose of matters related to Majeed’s production and advertising of the drug, preferably within three months.

Majeed had been granted a license by the Drug Controller of Kerala in 1993 to manufacture the ayurvedic medicine, which claimed to increase people’s resistance to symptoms such as night sweats, fever, cough and skin problems. In apparent violation of the terms of the license, however, Majeed started selling Immuno-QR as a “cure” for AIDS.

The state Drug Controller’s Office cancelled Majeed’s license in 1997 and Majeed challenged that cancellation before the Kerala High Court.

No final determination has yet been made about the validity of the license. In the interim, there have been various legal proceedings in the Bombay and Kerala High Courts and the Supreme Court of India over the manufacture and advertising of Immuno-QR. In 2000 and 2001, the Bombay and Kerala High Courts barred Majeed from advertising the drug as a cure for AIDS. However, until the Supreme Court Order of 2007, Majeed had continued to manufacture and sell the drug, with its website continuing to refer to its effectiveness for “killer viral diseases.”⁹

– Alana Klein

¹ Z. Venter, “Sick C-Max inmate wants to die at home,” *The Pretoria News*, 9 February 2007, p. 2.

² “AIDS victims to receive compensation”, *China Daily/People’s Daily* (online version), 5 December 2006. At http://english.people.com.cn/200612/05/eng20061205_328438.html.

³ “China hospital to compensate AIDS victims”, Reuters (online version), 5 December 2006.

⁴ “AIDS victims to receive compensation.”

⁵ “China hospital to compensate AIDS victims.”

⁶ “AIDS victims to receive compensation”; personal communication with Lin Hong, Legal Project Coordinator, Aizhixing Institute, China, 24 February 2007.

⁷ *Regulations on AIDS Prevention and Treatment*, adopted at the 122nd Executive Meeting of the State Council on 18 January 2006, effective 1 March 2006. At www.unchina.org/unaid/UNAIDS%20IN%20ENGLISH/documents/Regulations%20on%20HIV (English-language PDF file).

⁸ *India Network of Positive People v. T.A. Majeed & Ors* (January 3, 2007), Order of Supreme Court in SLP (Civil) No(s). 5527/2004.

⁹ J. Schreedar et al., “India: Good and bad news on AIDS,” *Newsweek*, 5 June 2006.