

Canadian HIV/AIDS Legal Network

HIV/AIDS POLICY & LAW REVIEW

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Legislation contagion: the spread of problematic new HIV laws in Western Africa

Model legislation can be a useful tool for fighting HIV/AIDS, but only if it is based on sound human rights principles. In 2004, AWARE-HIV/AIDS prepared a model law on HIV for use in Western Africa. Several countries in the region have already drafted national laws based on the model law. In this article, Richard Pearshouse reviews some of the key provisions in the model law, identifying a number of human rights concerns that should be addressed before such legislation should be considered as a model to be implemented by national legislatures.

Introduction

It has been almost 20 years since the Australian High Court judge Justice Michael Kirby warned of the spread of a dangerous kind of a virus, “highly inefficient laws.”¹ Even at that early stage of the epidemic, Kirby identified what he described as “variant strains” of highly inefficient laws, such as laws providing for the mandatory testing of vulnerable groups, or restrictions on the freedom of movement of people living with HIV.

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Trilingual issue

This issue has been published in three languages: English, French and Russian — a first for the *Review*! The Russian version is located in the middle of this volume, and its page edges are shaded grey.

Special Section: Law and Health Initiative

This issue of the *Review* includes a special section which contains a series of articles describing interventions in Africa and Eastern Europe that link AIDS and human rights. These interventions were piloted by the Law and Health Initiative of the Open Society Institute Public Health Program.

See page 59.

Выпуск на трех языках

Данный выпуск журнала публикуется на трех языках: английском, французском и русском – впервые в истории Обзора! Русская версия расположена в середине данного тома; края страниц русской версии окрашены в серый цвет.

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The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

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The Open Society Institute (OSI) (www.soros.org), a private operating and grantmaking foundation, aims to shape public policy to promote democratic governance, human rights, and economic, legal and social reform. The Law and Health Initiative and the Health Media Project are parts of the OSI Public Health Program, which promotes health policies based on social inclusion, human rights, justice and scientific evidence. The Law and Health Initiative fosters civil society efforts to advance health and human rights through use of legal remedies as creative tools to advance public health. The Health Media Project aims to increase public awareness of health issues, especially stigmatized health issues involving marginalized populations.

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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Legislation contagion: the spread of problematic new HIV laws in Western Africa

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He noted that

the virus of which I speak is not detectable under the microscope. It is nonetheless a tangible development, which may be detected in a growing number of societies. In some ways, it is as frightening and dangerous as the AIDS virus itself. It attacks not the body of an individual but the body politic.²

In the twenty years since this warning, a considerable number of countries across the globe have chosen to adopt national laws on HIV/AIDS. Frequently, these are general HIV laws – i.e., wide-ranging, “omnibus” laws specifically about HIV.

(Not all countries have adopted general HIV laws. Some jurisdictions have chosen to revise existing laws, such as those relating to public health or anti-discrimination — while others have not adopted specific legislation, but instead have established a national response in a framework policy document, such as a national strategic plan.)

While there is no established format per se for the general HIV laws, there are now enough examples that it is possible to identify common features, positive and negative. Often, such laws establish a national body to co-ordinate activities on HIV/AIDS and undertake surveillance; mandate education and information activities; provide for the safety of blood, tissue and organ supplies; establish the legal principles underpinning HIV testing and counselling; contain protections

against HIV-related discrimination; and include guarantees regarding the confidentiality of HIV status. HIV laws can also provide for criminal penalties for certain breaches of the law, and may even include specific offences of transmission of, or exposure to, HIV.

Practically unnoticed by those outside the region, Western Africa has witnessed a proliferation of national HIV laws in the last few years. Since 2005, seven national HIV laws have been passed in the region (in Benin, Guinea, Guinea-Bissau, Mali, Niger, Togo and, most recently, Sierra Leone).³ According to one observer, a further six countries currently have national HIV bills under development.⁴ These developments make Western Africa one of the most “legislated” regions in the world (if not *the* most legislated) when it comes to HIV.

The development of so many HIV laws so quickly has not come about by chance. Rather, it is a consequence of a project to promote a model law on HIV in the region.⁵

Model law

In September 2004, a small project, Action for West Africa Region–HIV/AIDS (AWARE–HIV/AIDS), held a workshop in N’jamena, Chad. Based in Ghana, AWARE–HIV/AIDS operates across Western Africa. It receives USAID funding, and is implemented by Family Health International with additional funding from US-based organizations such as

Population Service International and the Constella Futures Group.⁶

The stated purpose of the workshop held in N’jamena was to adopt a model law on HIV. A large number of parliamentarians from the region attended. Over the three days of the meeting, a model law on HIV/AIDS for West and Central Africa (the model law) was adopted by the participants, together with a plan to promote the model law throughout the region.

Model laws are only useful if they are substantively good laws; otherwise, the problems and errors risk being repeated in laws based on the model law.

Model legislation is a relatively common tool for law reform. It involves the development of a legislative “template” which individual jurisdictions are free to modify and adopt. Model legislation offers the advantages of sharing experiences and avoiding the duplication of drafting separate laws in each jurisdiction.

The UN, for example, has model legislation against racial discrimination.⁷ Model legislation is also effective in standardizing legal approaches across jurisdictions with similar legislative frameworks, including within countries that have a federal system of government.

However, model laws are only useful if they are substantively good laws; otherwise, the errors and problems contained in the model risk being repeated in laws that are based on the model law.

The AWARE- HIV/AIDS model law is described in press releases as addressing the need for “human rights legislation in that region to protect those who are infected and exposed to HIV.”⁸ In its introduction, the model law notes that

[t]he irrational fear of this infection is fuelled by ignorance, leading to prejudices, discrimination and stigmatisation of PLWHA and those related to them. The violation of the human rights of people affected or infected by HIV/AIDS is of critical concern in the prevention, treatment and management of HIV/AIDS.⁹

There are several positive features of the model law, including:

- provisions guaranteeing pre- and post-test counselling;
- provisions guaranteeing health care services for people living with HIV/AIDS (PLHIV);
- protections of medical confidentiality; and
- prohibitions of discrimination on the basis of actual or perceived HIV status, including in the workplace, in educational facilities, in health care settings, and in relation to credit and insurance coverage.

However, when examined through a human-rights lens, the model law contains a number of problematic provisions.

The AWARE-HIV/AIDS model law through a human-rights lens

There exists specific guidance on how human rights should be incorporated into HIV legislation. For example, the *International Guidelines on HIV/AIDS and Human Rights* (International Guidelines), which were developed at an series of expert consultation meetings convened by the U.N. High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), contain 12 specific guidelines on how human rights should be promoted and protected in the context of the HIV/AIDS epidemic.¹⁰

The *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (Handbook for Legislators), developed by the Inter-Parliamentary Union and UNAIDS in 1999,¹¹ presents concrete measures that legislators and state officials can take to implement the International Guidelines.

Unfortunately, many parts of the model law run counter to this guidance.

Education and information

Article 2 of the model law provides for the establishment of education and information campaigns in schools. One part of this Article states that “[i]t is forbidden to teach courses such as the one provided for in this Article to minors without prior consultation with parents whose approval is required both for the content and the materials used for such as course.”

Such an approach is at odds with the reality of the age of first sexual intercourse in many countries. In Mali and Guinea, for example, the median age of first intercourse for girls is 16.¹² Children’s access to health education should not be determined by what their parents think is appropriate.

Rather, comprehensive education programs that provide complete, factual and unbiased information about HIV prevention, including information about the correct and consistent use of condoms, are crucial for adolescents and young adults in such contexts. Access to information about HIV/AIDS is a human right.

The *International Covenant on Civil and Political Rights* (ICCPR) guarantees that all people have the right to “seek, receive and impart information of all kinds,” including information about their health.¹³ The right to education is guaranteed by numerous international legal instruments, including the *Convention on the Rights of the Child*.¹⁴

The International Guidelines call on states to take positive steps to “ensure the access of children and adolescents to adequate health information and education, including information related to HIV/AIDS prevention and care, inside and outside school, which is tailored appropriately to age level and capacity and enables them to deal positively with their sexuality.”¹⁵

Disclosure obligations and the “duty to warn”

Article 26 of the model law requires a person diagnosed with HIV to disclose his or her HIV status to a “spouse or regular sexual partner” as soon as possible and at most within six weeks of the diagnosis. The

testing centre shall be required to disclose to spouses or sexual partners after six weeks, “provided all efforts are made to enable to partners to have full understanding of the situation.”

This requirement is overly broad. Why is disclosure required by law, without regard to the degree of risk of transmission? Requiring this blanket disclosure to every sexual partner — regardless of such things as the sexual conduct in question, whether precautions to prevent transmission are taken, the PLHIV’s ability to disclose safely, and the PLHIV’s concerns about repercussions — unjustifiably infringes privacy and exposes PLHIV to stigma, discrimination, violence and other abuse.

Disclosure of HIV-positive status can be difficult for various reasons, not least the stigma and shame that often surround a diagnosis of HIV infection.

Disclosure of HIV-positive status can be particularly difficult for various reasons, not least the stigma and shame that still too often surround a diagnosis of HIV infection. In some cases — particularly for women — fear of violence may be a reason for not notifying a partner. Some jurisdictions include screening for domestic violence or referral to specialized

services for victims of domestic violence as part of the partner notification process.¹⁶ The International Guidelines recommend voluntary partner notification, but with provision for exceptional circumstances:

Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:

- The HIV-positive person in question has been thoroughly counselled;
- Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
- The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
- A real risk of HIV transmission to the partner(s) exists;
- The HIV-positive person is given reasonable advance notice;
- The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice;
- Follow-up is provided to ensure support to those involved, as necessary.¹⁷

HIV testing issues

Article 18 of the model law prohibits mandatory HIV testing, but creates a number of specific exceptions:

- “when a person is indicted for HIV infection or attempt to infect another person with HIV”;
- when a person is indicted for rape;

- “when determining HIV status is necessary to solve a matrimonial conflict”;
- organ, cell or blood donations; or
- “when a pregnant woman undergoes a medical checkup.”¹⁸

Because of the invasive nature of mandatory and compulsory HIV testing, such testing violates an individual’s right to privacy and right to bodily integrity.¹⁹ HIV testing without consent is almost never justified²⁰ and, as with other infringements of human rights, requires careful scrutiny of the justifications claimed.

Compulsory testing of people indicted on charges of rape and HIV infection or attempted infection

Legislating compulsory HIV testing of people accused of such crimes should be undertaken with extreme caution. The primary reasons are that such testing:

- does not provide timely or reliable information about the sexual assault survivor’s risks of contracting HIV infection;²¹
- is a misdirected, potentially negative approach to addressing the needs of a sexual assault survivor;²²
- infringes on the rights of an accused to bodily integrity, privacy and human dignity; and²³
- might not facilitate the survivor’s psychological recovery.²⁴

The presumed goal of compulsory testing of accused sexual offenders is to provide an opportunity for victims to receive post-exposure prophylaxis (PEP) where they may have been exposed to HIV. However, the

law should ensure that all victims of sexual offences are given access to PEP and counselling about PEP, regardless of whether compulsory testing of sexual offenders is mandated.

Compulsory testing to resolve a marital dispute

Rarely, if ever, will the resolution of a matrimonial conflict require forced HIV testing. Moreover, it is not recommended that HIV status be a ground for voiding a marriage because this would increase stigma against people living with HIV.

Compulsory testing of pregnant women

A UNAIDS policy statement on HIV testing and counselling states that

[r]egardless of the presence of risk factors or the potential for effective intervention to prevent transmission, [pregnant] women should not be coerced into testing, or tested without consent. Instead, they should be given all relevant information and allowed to make their own decisions about HIV testing, reproduction and infant feeding.²⁵

The routine *offer* of HIV testing to pregnant women (as distinct from routine testing, where testing is done automatically unless the person explicitly refuses), accompanied by counselling and informed consent, is an appropriate response that seeks both to advance public health objectives and to respect, protect and fulfil human rights.

Criminalisation of HIV transmission or exposure

Article 36 of the model law addresses the issue of criminalization of

HIV transmission or exposure. Unfortunately, particularly given the complexity of this issue, Article 36 is awkwardly drafted and unclear. For no apparent reason, the order of the sub-paragraphs is reversed in the French and English versions, and there are clear discrepancies between the texts of each version.

One portion of Article 36 of the model law creates an offence of “wilful transmission.” It states, “Any person who is guilty of wilful transmission of HIV shall be sanctioned with ... [penalty].” “Wilful transmission” is defined in Article 1 as transmission of HIV “through any means by a person with full knowledge of his/her HIV/AIDS status to another person.” “HIV transmission” is also defined, with the clarification that infection “can occur through sexual intercourse, blood transfusion or the sharing of intravenous needle[s], skin piercing instruments or through [m]other-to-child transmission.”

To the extent that criminal law is used in the context of HIV, the International Guidelines recommend that:

[c]riminal and/or public health should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.²⁶

With respect to this section of Article 36, it is appropriate to include actual knowledge of HIV infection as a necessary precondition of criminal liability.

However, the phrase “through any means” casts the net too widely, particularly in light of how “HIV transmission” is defined in the model law. The effect might be to impose criminal penalties in situations where:

- a person practices safer sex, regardless of whether the person disclosed to the sexual partner and regardless of the actual risk of transmission;
- a person takes steps to disinfect an intravenous needle or other skin-piercing instrument, again regardless of whether there was disclosure and regardless of the actual risk of transmission; and

The model law does not address any of the social, cultural, economic and legal factors that make women more vulnerable to HIV infection.

- a mother transmits HIV to a child, including *in utero* or during labour and delivery, regardless of precautions taken to reduce the risk of transmission and regardless of the actual risk of transmission.

Omissions in the model law

Women

Among the “principles” enunciated in the model law are the following:

The government shall vigorously address conditions which increase the transmission of HIV infection including poverty, gender inequality, traditional practices....

The government shall recognize the increasing vulnerability of women and children and take actions to address their specific needs.

However, the model law does not mention women's rights, nor does it address any of the specific social, cultural, economic and legal factors that make women more vulnerable to HIV infection, and more prone to experience adverse effects as a result of HIV infection.

Prisoners

Article 8 of the model law provides that information on HIV be provided "in the most appropriate way" in all prison institutions. It gives the Ministries of Justice, Interior and Health the power to implement this article. Although it is implicit that certain details are to be established by subsidiary legal regulations, Article 8 provides no direction as to what such regulations should include. To be effective, information about HIV needs to be accompanied by the actual provision of materials to prevent HIV in prison settings, such as condoms and sterile injecting equipment.

Other vulnerable persons

There is very little in the model law on vulnerable persons or on programs to be directed towards them.

National HIV laws

Proponents of model law often cite the sovereignty of states as a "check and balance" on model law. In other words, states remain free to adopt,

adapt, modify or reject the template legislation in accordance with their specific context and needs.

Given the experience of the N'djamena model law, such a view is naïve. Despite the numerous provisions that are problematic from a human rights perspective, the model law is presented as model (i.e., ideal or best practice) legislation. Indeed, all of the national HIV laws in Western Africa have clearly been influenced by the model law. One of them, the law recently passed in Guinea-Bissau, replicates the model law almost word for word.

What usually happens is that the national laws are based closely on the provisions of the model law — with certain modifications, additions and omissions, but following the same general legislative framework. For example, the provisions on partner notification and a health care professional's "duty to warn" in the laws from Niger, Mali and Togo are substantially the same as the corresponding model law provisions discussed above.

Sometimes, the national laws contain additional provisions that are an extension of the same legislative intent behind the model law. Where the model law's provisions have ignored human rights law and principles, the corresponding provisions in national laws may compound such problems. For example:

- Article 2 of the Guinean law adds a further restriction (to the text found in the model law) on HIV/AIDS education and information by specifically providing that it is forbidden to give HIV/AIDS education to children under 13.

- Article 28 of the Guinean law requires mandatory HIV testing before marriage.
- Article 50 of the Togolese law provides for periodic mandatory testing of sex workers for HIV and sexually transmitted diseases.²⁷

Despite the recommendation in the International Guidelines that there be no HIV-specific offences,²⁸ all the national HIV laws establish offences of "wilful HIV transmission."²⁹ None of the laws define "wilful," which omission runs counter to the caution in the International Guidelines that in the case of criminal transmission or exposure offences, states "should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties."³⁰

Only the law of Togo provides some guidance as to the requisite mental element in establishing criminal guilt: Article 53 of this law says that it is a criminal offence for a person to have "unprotected sexual relations with the *intention* of transmitting the virus or any other activity to *wilfully* spread the virus."

If a provision on criminal transmission is to be included in law, the application of criminal sanctions should be limited to conduct that shows this high level of malicious intent, thus limiting the scope of the state's most serious legal tool and penalties to those cases which are clearly deserving of such treatment.

Other national laws are far more vague with respect to the conduct they would criminalize. For example:

- Article 27 of the Benin law makes it a crime for any person

who knows she or he has “the AIDS virus [sic]” to engage in “unprotected sexual relations” without disclosing her or his infection to the sexual partner. No actual transmission of HIV is required.

- Article 14 of the law in Togo imposes an obligation upon all persons to use male or female condoms “in all risky sexual relations.” In effect, it makes any vaginal or anal sex without a condom an illegal act, regardless of the circumstances. Article 13 specifically targets PLHIV, prohibiting them from any “unprotected sex” — regardless of whether they have disclosed their infection to a sexual partner who is consenting, and regardless of the HIV status of their sexual partner.

Some national laws appear to treat mother-to-child transmission of HIV as a criminal offence.

- In the law from Guinea, the basic crime of “wilful HIV transmission” arises out of both Article 35 (which makes transmission through sex or blood an offence) and the underlying definition in Article 1 of the term “wilful HIV transmission.” The definition appears to include not only those

circumstances in which the virus is actually transmitted through HIV-contaminated substances, but also any exposure to such substances regardless of the consequences.

This definition also appears to impose criminal liability, for transmission and even for exposure, without regard to: (a) whether the person knew she or he had HIV or was aware of the risk of transmission; (b) the actual risk of transmission associated with the activity; (c) whether the PLHIV disclosed to the other person, or the other person was aware in some way of the HIV infection; (d) whether the person took any steps to reduce the risk of transmission (e.g., condom use, other safe practices, cleaning of drug injecting equipment); and (e) whether in the circumstances the PLHIV had control over the degree of risk (e.g., use by husband or partner of a condom).

- The definition of “HIV transmission” in some laws (e.g. Guinea, Guinea-Bissau, Mali, Niger) include mother-to-child transmission (MTCT): Certain definitions of “HIV transmission” refer explicitly to MTCT; others would appear to include MTCT as a form of transmission by way of blood. Because such definitions could be determinative in establishing the offence of “wilful HIV transmission,” these laws appear to establish that MTCT is a criminal offence.
- The law in Sierra Leone contains two distinct articles establishing an offence of “HIV transmission.” Article 21(1) establishes

that a person who is infected with HIV (and aware of the fact) must “take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of a pregnant woman, the foetus.” According to Article 21(2), a person who is infected with HIV (and aware of the fact) must not knowingly or recklessly place another person (“and in the case of a pregnant woman, the foetus”) at risk of becoming infected with HIV, unless that person knew of the fact and voluntarily accepted the risk of being infected.³¹

There are several problems with these provisions. First, they would violate the right to medical treatment with voluntary, informed consent. Informed consent to undergoing antiretroviral therapy to reduce MTCT is important because the treatment may affect the health of the pregnant woman.³²

Second, it is not specified what “all reasonable measures and precautions” would include. Indeed, it is not at all clear that such measures and precautions are clearly enough articulated and understood by health care professionals and pregnant women in a way that would make it appropriate to apply criminal sanctions for a departure from those measures and precautions. To cite just one example, would HIV transmission that occurred during breastfeeding attract criminal liability?

Third, fear that giving birth in a health care facility could expose women to criminal liability risks driving women away from health care facilities and particularly maternity care. Fourth, it is

doubtful that criminal punishment of a mother would be in the best interests of her newly-born child.

Conclusion

The pressure on legislators and governments in jurisdictions across the globe to produce a legal response to HIV is enormous.³³ However, laws pertaining to HIV, even those dressed in the garb of human rights, are not always progressive. These laws can be instrumental in promoting effective initiatives to address the HIV/AIDS epidemic, but they can also impede such initiatives.

A detailed framework of human rights principles (the International Guidelines) exists to guide legislators in the process of legislating in relation to the pandemic. To contribute constructively to reducing the impact of HIV, national laws need to establish a genuinely supportive environment for people living with the virus or those most vulnerable to infection. Far too often, this point seems to have been ignored in recently adopted HIV laws in Western Africa.

— Richard Pearshouse

Richard Pearshouse (rpearshouse@aidslaw.ca) is Director of Research and Policy for the Canadian HIV/AIDS Legal Network.

³ The "Law on prevention, care and control of HIV/AIDS" (No. 2005-31 of 5 April 2006) in Benin; the "Law on prevention, care and control of HIV/AIDS" (No. 2005-25) in Guinea; the "Framework law relating to the prevention, treatment and control of HIV/AIDS" in Guinea-Bissau; the "Law establishing rules relating to the prevention, care and control of HIV/AIDS" (No. 06-28 of 29 June 2006) in Mali; the "Law relating to the prevention, care and control of Human Immunodeficiency Virus (HIV)" (No. 2007-08 of 30 April 2007) in Niger; "The Prevention and Control of HIV and AIDS Act (2007)" in Sierra Leone; and the "Law on the protection of people with respect to HIV/AIDS" (No. 2005-012) in Togo.

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¹⁹ See, e.g., art. 17 of the ICCPR.

²⁰ The one exception to the prohibition on mandatory testing is the case of blood and human tissue or organ donation, where there is an obvious health imperative to perform HIV testing and where the state owes a duty of legal care towards potential recipients.

²¹ An accused's negative HIV test result does not conclusively prove that the victim was not exposed to HIV because alleged offenders may be tested during the "window-period" during which HIV tests do not detect infection: Legal Assistance Centre (LAC), *A Case Against Mandatory HIV Testing of Rapists*, 1997; AIDS Law Project (ALP), Centre for Applied Legal Studies, *Submission on the Compulsory HIV Testing of Alleged Sexual Offenders Bill*, February 6, 2003.

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²³ *Ibid.*

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²⁵ UNAIDS, *UNAIDS Policy on HIV Testing and Counselling*, 1997, p. 1. The International Guidelines emphasize that "States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose": International Guidelines, para. 38(f).

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Drug treatment courts in Canada: an evidence-based review

Drug treatment courts (DTCs), which are judicially mandated treatment alternatives to the incarceration of illicit drug offenders, were introduced in Canada in late 1998. Recent announcements from the federal government suggest that the drug treatment court model will continue to operate and expand in a number of Canadian jurisdictions. Two major evaluations of these programs — in Vancouver and Toronto — have been conducted. In this article, D. Werb et al. analyze the results of these evaluations. Their analysis reveals that, despite the evaluations, little is known regarding the success of DTCs in contributing to the long-term reduction of drug use and recidivism among their participants; and that the cost-effectiveness of these programs requires further study. The authors conclude that further funding for DTCs in Canada should be dependent on the implementation of randomized controlled trials that measure the success of these programs in reducing drug use and recidivism in the long term; that measure the impact of DTCs on societal end-points such as rates of crime and incarceration of injection drug users; and that include components to measure the cost-effectiveness of DTCs compared with other interventions aimed at reducing the negative effects of problematic drug use and drug-related crime.

Introduction

Drug-related crime and the adverse public health consequences of unsafe drug use continue to plague numerous urban centres in Canada and in many other countries.^{1,2} At the street level, drug markets and drug use continue to be strongly related to public disorder, as well as to acquisitive and property crime.^{3,4} Certain forms of drug use, such as injection drug use, have also been shown to seriously compromise the health of drug user populations.⁵

Though a growing number of municipal governments, such as the City of Vancouver, have structured their responses to these issues using a so-called “balanced approach” that includes the “four pillars” of law enforcement, prevention, harm reduction, and addiction treatment, recent evidence suggests that an overwhelming emphasis on enforcement persists,⁶ and that this emphasis often undermines efforts to reduce health-

related harms among people who use drugs.⁷

Despite this apparent imbalance, in March 2007, Canada’s governing Conservative Party announced the introduction of a National Anti-Drug Strategy that emphasizes a drug policy model focused exclusively on enforcement, prevention and treatment,⁸ and that also includes funding for extra-judicial treatment and diversion programs for drug offenders. One such program embraced by the current federal government is DTCs.

DTCs are judicially-mandated treatment programs that offer an alternative to jail time.⁹ Generally, participants are selected from a pool of non-violent offenders charged with drug-related crimes (most often possession, possession for the purposes of trafficking, or trafficking; generally, individuals charged with commercial trafficking or violent offences are excluded), and in most DTC models the individual must plead guilty before entering the program. Once

enrolled, participants are regularly tested for use of illegal drugs and placed in a treatment stream adjusted to their progress.

Key to the DTC model is the participant’s regular attendance at a court in which a non-adversarial team, generally made up of a judge, prosecutor, defence lawyer and treatment counsellor, collaborates in order to address the participant’s progress and work towards treatment goals.¹⁰ All DTCs operate on the same principle of coercive, abstinence-based addiction treatment, with only limited tolerance for relapse.^{11, 12}

Since the establishment of the first DTC in Florida in 1989, over 1600 DTCs have been instituted in the U.S., and hundreds more are in development.¹³ In many U.S. jurisdictions, DTCs represent a key point of contact between people who use drugs and addiction treatment services.¹⁴ DTC programs were also implemented in Australia and the United Kingdom.¹⁵ Numerous evaluations

of mixed quality and rigour have provided data regarding the effectiveness of DTCs in treating drug addiction and in reducing rates of recidivism.^{16, 17, 18, 19, 20, 21} However, while hundreds of drug treatment courts in the U.S. regularly perform self-evaluations,²² there have been only a small number of peer-reviewed DTC evaluations, and some of these have been identified as containing substantial methodological shortcomings.²³

All drug treatment courts operate on the same principle of coercive, abstinence-based addiction treatment, with only limited tolerance for relapse.

Only three randomized control trial (RCT) evaluations of DTCs have been conducted. One RCT evaluation conducted in Baltimore found no statistically significant differences between participants in the experimental (DTC) and control (judicial) groups in rates of crime, alcoholism, employment, mortality and strength of family and social relationships three years after acceptance into the Baltimore DTC.²⁴ Another RCT evaluation in Maricopa County, Arizona found that after 36 months, the experimental (DTC) group had a recidivism rate of 33 percent compared to 44 percent for a control (judicial) group, and that this differ-

ence reached statistical significance.²⁵ Finally, a RCT conducted in New South Wales found no statistical significance between the experimental (DTC) and control (judicial) groups one year after program completion.²⁶

The Canadian experience with DTCs has been limited, with the opening of two DTCs in Toronto and Vancouver in 1998 and 2001 respectively.^{27, 28} However, the recent establishment of DTCs in Edmonton and Regina,^{29, 30} federal funding of \$13.3 million allocated to the development of additional DTCs in Winnipeg and Ottawa,³¹ and the current government's emphasis on extra-judicial diversion programs suggest that these programs are becoming more attractive to Canadian policy-makers.

Three central hypotheses drive the expansion and popularity of DTCs, namely that DTCs lower rates of recidivism and drug use,³² and that DTCs are cost-effective.³³ The first two have been proposed as evidence that DTCs effectively treat drug addiction.³⁴ The argument that DTCs are cost-effective is based on the DTC's alleged ability to relieve pressure on correctional services by processing individuals with drug dependence who would otherwise serve jail time.³⁵ However, it remains unclear whether DTCs produce such benefits, and there has been limited discussion regarding the impacts of coercion and the requirement of abstinence on program effectiveness.

Evaluations of DTCs in Canada

Two major DTC evaluations have been undertaken in Canada, in Toronto and Vancouver. It should be noted that while an evaluation of the Edmonton DTC has also been conducted, the small sample size (seven) and an eval-

uation period of five months limits greatly the utility of this study.³⁶

The Vancouver DTC evaluation

The Vancouver DTC evaluation employed a non-randomized design. The authors identified the unfairness of denying addiction treatment to individuals who may benefit from it and the desire of pilot study staff to recruit the most eligible participants into the program as key obstacles to randomization.³⁷ The evaluation team used a selected group of individuals, matched to the DTC participant group on key pre-specified variables, as controls. This control group (327 people) was made up of volunteer incarcerated offenders and a virtual cohort of individuals who were traced through probation files and electronic records of drug offenders with reported addiction problems.

While the evaluators matched 166 individuals from both the DTC group and the comparison group on five key variables — ethnicity, gender, previous violent offences, age and previous number of sentences — this sub-cohort of matched individuals differed significantly from the larger DTC group on age, ethnicity and gender. The results derived from a comparison of the matched participants may not, therefore, have necessarily reflected the outcomes of the DTC group as a whole.

Participants in the comparison group were also on average more likely to be older, male and Caucasian than those in the DTC group. Further, critical differences existed in the criminal histories of the two groups' participants. Compared with participants in the DTC group, participants in the comparison group had spent double the average days in remand (153 vs. 75), more months in custody

(35.8 vs. 20.16) and were less likely to have committed drug offences (29.1 percent vs. 67.7 percent). These differences at baseline between the DTC group and the comparison group likely affected the evaluation findings, and could potentially account for differences in rates of post-program drug use and criminal recidivism between the two groups.

The Vancouver DTC was evaluated over a span of approximately 3.5 years, from December 2001 to March 2005. During this time, 322 participants were admitted, of which 34 (10.6 percent) graduated and eight (2.5 percent) otherwise completed the program (meaning that they reduced their drug use substantially and met certain levels of economic and social stability). As of March 2005, 185 participants (57.5 percent) had either withdrawn voluntarily or been expelled, 25 (7.8 percent) were currently suspended, and 64 (19.9 percent) were still participating in the program. Six participants (1.5 percent) died during their participation in the DTC.³⁸

Of note, program participation had no statistically significant bearing on the rate of charges that participants accrued during the time they spent in the program. Additionally, no statistical difference was observed between DTC participants and the comparison group with regard to accumulated post-program criminal charges measured six months after participation in the DTC. The Vancouver DTC evaluators did not collect data related to post-program drug use. Without this data there is no way to gauge the program's success in this regard.

The Toronto DTC evaluation

The Toronto DTC evaluation consisted of what the evaluators referred

to as a “quasi-randomized trial,” in which the DTC participant group was compared with two control groups. The primary comparison was made with 64 participants who were eligible for drug treatment court but who opted not to participate in the program and who were subsequently processed by the traditional judicial system. This group was referred to as the judicial comparison group. All DTC participants were followed for approximately 18 months after admission to the program, and each DTC participant was assessed on a number of variables that included socio-demographic factors and indicators of drug use, criminal recidivism and health.

The Toronto drug treatment court evaluation did not yield reliable information concerning post-program drug use.

Overall, when compared with DTC group participants, individuals in the judicial comparison group had a much higher rate of criminal activity constituting a major income source prior to enrolment (23.3 percent vs. 6.9 percent), were younger than the DTC group (30.8 vs. 34.2), were more likely to be chronically unemployed (62.8 percent vs. 34.2 percent), more likely to be female (48.4 percent vs. 24.1 percent), and had used cocaine more often in the

90 days prior to the DTC clinical assessment (an average of 54.5 days vs. 34.3 days) than their counterparts in the DTC group.

In general, the evaluators characterized the judicial comparison group as generally more heavily marked by substance abuse and criminal activity.³⁹ Some of the variables listed above on which the groups' participants differed have been shown to be associated with heightened risk of drug dependence and related harms, and injection drug use in particular, among at-risk populations.^{40, 41, 42, 43, 44} Consequently, the DTC group included offenders who possessed fewer indicators of drug dependence than the judicial comparison group, and the DTC group therefore presumably contained individuals who had a better chance of succeeding in treatment as compared to those individuals in the judicial comparison group.

Additionally, because the judicial comparison group was made up of individuals who were eligible for, but opted not to enter, the DTC group, the evaluators may have introduced a selection bias into the evaluation as DTC group participants may have been potentially more motivated to seek and comply with treatment than those in the judicial comparison group.

In the period from 1 April 1999 to 1 October 1 2003, out of a total of 365 participants, 57 (15.6 percent) “graduated” from the Toronto DTC, while 308 (84.4 percent) were either expelled or withdrew from the program.⁴⁵ With respect to the assumption that DTCs reduce recidivism, follow-up analysis shows that participants in the Toronto DTC group had a reduced overall rate of charges and convictions after participating in the DTC program compared to their

rate of charges and convictions prior to their enrolment in the program. However, a similar and significant drop in criminal charges and convictions was also present among the judicial comparison group.⁴⁶

The Toronto DTC evaluation did not yield reliable information concerning post-program drug use and socio-economic status among either the DTC participants or the comparison groups. Therefore, little is known regarding the effect of the Toronto DTC on its participants' post-program lives, and particularly on its participants' drug use patterns, in the long-term.

Costs and cost-effectiveness of the Vancouver and Toronto DTCs

The Vancouver DTC evaluation clearly outlined its costs over 3.5 years and compared the cost-effectiveness of enrolling participants in the program against the matched comparison group. In comparing the direct cost of DTC participants who either withdrew or were discharged from the program with their matched counterparts in the comparison group, the evaluation found direct cost savings in favour of the comparison group of approximately \$6,000 for individuals who withdrew and \$10,000 for individuals who were discharged from the DTC. However, in the smaller matched group of DTC graduates and comparison group members, a cost saving of approximately \$4,000 was found in favour of the DTC graduates as compared to individuals in the comparison group.

Overall, the cost per person was found to be \$21,265 for Vancouver DTC participants and \$13,117 for the matched comparison group, which

amounts to a disparity of approximately \$8,000 between individuals in the DTC and those in the comparison group. As the evaluators of the Vancouver DTC stated, "Overall, in order to achieve cost efficiency with a DTC strategy, a larger number of participants must exhibit positive outcomes (i.e., fewer convictions). According to the current data, this might be feasible if the program was in a position to graduate a higher proportion of participants."⁴⁷

This suggests that the ineffectiveness of the Vancouver DTC's treatment delivery model may be the primary reason for the low cost-effectiveness of the program. However, because of the lack of data on post-program drug use, Devlin and colleagues were unable to include the costs associated with continued drug use in their cost-benefit analysis, which limits the scope of their cost evaluation.

Finally, the total costs of the Vancouver DTC during the period of December 2001 to March 2005 were \$4,058,819.⁴⁸ With 42 participants who either graduated or completed the program, the cost per graduate or completer was \$96,639.

The federal Department of Justice allocated \$1.6 million to fund the Toronto DTC over a trial period of four years. However, this figure does not include the costs of treatment services and infrastructure provided by the Centre for Addiction and Mental Health (CAMH), which acted as the Toronto DTC's treatment partner. The Toronto evaluators did carry out a cost analysis of the DTC by calculating all costs associated with the court component of the program and adding these costs to the estimated costs of treatment, community coordination and sentencing. Using this

method, the average cost per Toronto DTC client was found to be \$42,564. On average, graduates cost \$53,555, participants who dropped out of the program within the first three months cost \$29,748, and participants who opted to stay in the program longer than three months but who subsequently withdrew or were expelled cost \$72,322.⁴⁹

The focus of the drug treatment courts on abstinence causes those individuals characterized by severe drug dependence to often be at highest risk of "failing" the program.

However, the evaluators were unable to provide a figure for the total costs of the program, and excluded many costs related to the DTC such as treatment or judicial services provided in kind, the cost of non-CAMH treatment providers, costs related to court-ordered treatment included in sentencing (which refers to treatment carried out as part of a sentence that is separate from the DTC program), and indirect costs.⁵⁰

Canadian media and at least one researcher have made the claim that the Toronto DTC is cost-effective, with treatment per DTC participant estimated at \$3,000–\$5,000 per year⁵¹ as opposed to the \$48,000–\$52,000 annual cost of incarcerating an offender. However, Canadian statis-

tics show that for 83 percent of those who are incarcerated for drug-related crimes, the median incarceration period for offenders charged with possession is 15 days, while for trafficking charges the median incarceration period is three months.^{52, 53} Therefore, claims that DTCs represent cost-savings when comparing annual rates of incarceration with annual rates of treatment misrepresent the fact that the incarceration periods for offenders charged with drug-related crimes are often much shorter in length than DTC programs, and consequently have lower associated overall costs.

The role of coercion and abstinence in DTC models

DTCs operate on a principle of legal coercion, in which the power of the courts and the threat of incarceration operate as motivating factors in promoting the DTC participant's treatment compliance.⁵⁴ However, evaluations examining the use of coercion in drug treatment delivery have so far produced inconclusive findings.^{55, 56, 57, 58, 59}

While the Vancouver and Toronto DTCs are treatment-oriented programs, both require their participants to abstain completely from drug use in order to graduate. This focus on abstinence neglects the impact of the role of relapse on the natural history of drug dependence.⁶⁰ An established body of literature demonstrates that addiction is a chronic and relapsing condition, shaped by a multitude of behavioural and social-contextual characteristics that may not be amenable to abstinence-based programs in all cases.^{61, 62}

Finally, the DTC focus on abstinence causes those individuals characterized by severe drug dependence

to often be at highest risk of "failing" a DTC program.⁶³ As can be seen from past DTC evaluations, the most dependent users often fail the program and are sent back to the judicial system, while less dependent individuals (who have a better chance of managing their drug use and, consequently, of graduating) are rewarded; for example, in a study that sought to identify predictors of retention among DTC participants, those individuals who reported alcohol or marijuana as their primary substance of choice and who had fewer prior arrests were the most likely to successfully graduate from the DTC program.⁶⁴

Conclusion

The evaluations of Canadian DTCs have so far failed to demonstrate that these programs are effective in reducing rates of recidivism and drug use among program participants. Both the Vancouver and the Toronto DTC evaluations, like many other DTC evaluations, suffer from methodological problems (which are particularly severe in the case of the Vancouver evaluation) that make it difficult to properly assess the efficacy of these programs.

Furthermore, the high failure rates that mark DTCs have the potential to exacerbate the interaction that drug offenders have with the judicial system, as those who fail DTC programs are often returned to the traditional judicial system. This may result in an increase in both the overall costs to the judicial and correctional system and the prolongation of the individual's placement within these systems, despite the failure of these systems to effectively address drug dependence.

Given the many unknowns surrounding DTCs, particularly in

the Canadian context, the federal government's decision to expand the Canadian DTC system therefore appears premature. While evaluations of the Toronto and the Vancouver DTCs have been carried out, neither evaluation offers a comprehensive analysis of the effect of these interventions on their participants.

Funding for DTCs in Canada, therefore, should be made dependent on the implementation of evaluative studies that utilize randomized controlled trial methodology and that include a number of measures of success. Specifically, DTC evaluative studies in Canada should include measures of long-term efficacy (i.e., long-term measures of drug use and recidivism) and safety; should measure the impact of DTCs on societal end-points such as rates of crime and incarceration of injection drug users; and should include components to measure the cost-effectiveness of DTCs compared with other interventions aimed at reducing the negative effects of problematic drug use and drug-related crime. Without this additional data, it is impossible to justify the expansion of these programs in Canada.

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⁶¹ A.I. Leshner, "Addiction is a brain disease, and it matters," *Science* 278 (1997): 45–47.

⁶² P. Owen and G.A. Marlatt, "Should abstinence be the goal for alcohol treatment?" *American Journal on Addictions* 10 (2001): 289–295.

⁶³ M.B. Hoffman, "The drug court scandal," *North Carolina Law Review* 78 (2000): 1437–1527.

⁶⁴ R.H. Peters, A.L. Haas, and M.R. Murrin, "Predictors of retention and arrest in drug courts," in S. Belenko et al. (eds), *National Drug Court Institute Review, Vol. II* (Alexandria, Virginia: National Drug Court Institute, 1999), 30–48.

Use of soft law to address HIV/AIDS in Southeast Asia

Non-binding agreements, or “soft law,” have played a role in influencing government policy and reducing HIV vulnerability among construction workers in the Greater Mekong Subregion of Southeast Asia. In this article, David Patterson et al state that soft law sometimes offers advantages over treaty law, but that challenges remain in the implementation of soft law.

In recent years, most economies in Southeast Asia have experienced rapid economic growth and investment in major infrastructure projects. While many of the mostly male construction workers for these projects may be internally mobile nationals, many others may be migrants (documented or undocumented) from other countries in the region.

All of these workers are at increased risk for HIV infection because they have money to spend on alcohol and other drugs and sexual services; they are far from their families and social support networks; and they may not be reached by HIV prevention programs for local communities (where they exist) due to language and literacy barriers. When they return home, they may bring HIV and other infections to their sexual and drug-injecting partners.

Most governments in the Southeast Asian region have shown little interest in ratifying existing treaties on migrant workers' rights.¹ The *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* has only been ratified by the Philippines and Timor-Leste. Cambodia and Indonesia have signed but not ratified the Convention. Only the Philippines has ratified the *Migrant Workers (Supplementary*

Provisions) Convention of the International Labour Organization (ILO).

HIV-specific non-binding international and regional agreements offer advantages over treaty law in that they can be created relatively quickly and, if regional, they can be adapted to local contexts. Monitoring mechanisms can also be more informal and flexible than the corresponding treaty mechanisms.

In November 1999, the Association of South East Asian Nations (ASEAN) Task Force on HIV/AIDS (ATFOA) proposed that “ASEAN governments adopt a common policy recommending the integration of HIV prevention programmes as a precondition for construction and infrastructure development contracts bidding and approval.” A regional inter-governmental meeting in Bangkok in October 2003 adopted “Recommendations on Building HIV Resilience along the ASEAN Highway” (Bangkok Recommendations) which incorporated this provision.²

In the 2001 *Declaration of Commitment on HIV/AIDS*, all U.N. Member States undertook, “...by 2005, to develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes

for migrants and mobile workers, including the provision of information on health and social services...”³ The monitoring framework developed to measure the implementation of the Declaration also included references to mobile populations.⁴ The Declaration was reaffirmed by the U.N. General Assembly in 2006.⁵

In 2004, six countries (Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam) agreed in a Memorandum of Understanding (Regional MOU), *inter alia*, to “...strengthen collaboration among Ministries responsible for agriculture, construction, finance, health, home affairs, labour, public works, public security and transport sectors to promote the updated Bangkok Recommendations on infrastructure construction along the ASEAN Highway Network...”

The Regional Strategy on Mobility and HIV Vulnerability Reduction in the Greater Mekong Subregion 2002-2004 (Regional Strategy) was developed by the U.N. Regional Task Force on Mobility and HIV Vulnerability Reduction (UNRTF). In 2006, the Regional Strategy was revised and extended for the period 2006-2008, and incorporated a reference to the Regional MOU (albeit noting that national implementation was so far limited).⁶

In 2005, an assessment tool was developed and administered in Cambodia, Lao PDR, Thailand and Vietnam to assess country recognition of, and compliance with, these agreements. This national policy self-audit was used to draw the attention of government and non-government stakeholders to their international commitments and to stimulate discussion of, and commitment to, advancing the policy reform process.

Thailand, for example, reported that although it does not require an HIV impact assessment, it would develop guidelines on how such an assessment should be undertaken. Thailand also committed to developing a policy on the integration of HIV prevention programs as a precondition for construction contracts bidding and approval.⁷

Thailand committed to developing a policy on the integration of HIV prevention programs as a precondition for construction contracts bidding and approval.

In June 2007, the health ministers of the countries that make up the Asia Pacific Economic Cooperation (APEC) endorsed guidelines for APEC economies which reference the ILO *Code of Practice on HIV/AIDS and the World of Work*, and which incorporate key elements of the Bangkok Recommendations.⁸

Specifically, the APEC guidelines recommend that HIV impact assessments be undertaken as part of the feasibility study phase for infrastructure projects, and that preconditions for bidding and approval include integration of comprehensive gender-sensitive occupational health and HIV prevention programs.

Case study: Cambodia

The national response to HIV in Cambodia is coordinated by the National AIDS Authority (NAA). In 2004, the NAA convened a multi-sectoral technical working group (MTWG) on HIV and mobility. A member of the MTWG, the Ministry of Public Works and Transport (MPWT), also created a Ministerial Committee on HIV/AIDS. In 2005, this Committee developed its own HIV action plan.

Priority areas for advocacy and policy reform in the MPWT action plan include the implementation of the Regional MOU as it relates to large infrastructure projects. An advocacy training workshop was held for MTWG members in October 2005.⁹ The workshop included the development of an advocacy plan for the adoption of a policy regarding the allocation of a budget for HIV activities in infrastructure projects.

In 2006, the MPWT adopted a suite of policies on HIV/AIDS, including one explicitly designated to implement obligations incurred under the Regional MOU, which was referenced in the introduction and included as an annex. This policy provides, *inter alia*, that “all budgets in the bidding contracts on project development programmes on public infrastructure construction shall be submitted to the chairman of the AIDS Committee of the Ministry

of Public Works and Transport for review and recommendation to the ministry management for approval of prevention programmes against HIV/AIDS and STD epidemics...”¹⁰

Discussion

The experience of Cambodia demonstrates that non-binding agreements between states can promote national HIV policy reform consistent with international guidance and best practice.

The challenges of implementation remain, and countries are reluctant to include HIV budgets in loan agreements, arguing that these funds should be provided as grants. There is as yet no general commitment from donors to include grants for HIV prevention activities in the budgets of infrastructure projects, although some funders have supported such activities as part of their assistance.¹¹

For Southeast Asia, advocacy through regional bodies such as the UNRTF, ATFOA and APEC is needed to encourage donors to incorporate such grants routinely in infrastructure project budgets.¹² The potential negative social and economic harms to be addressed can be quantified using tools developed for this purpose.¹³

As with treaties, there is still the risk that governments will take their obligations lightly. To date, the Regional MOU and the APEC guidelines have only been endorsed by ministers of health. To increase national engagement, such agreements should also be endorsed by national HIV multi-sectoral bodies and ministries with convening powers, such as the Ministry of Economic Planning or equivalent.

– David Patterson, Tia Phalla,
Thuan Nguyen and Sarun Im

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2007, ASEAN leaders adopted the *Declaration on the Protection and Promotion of the Rights of Migrant Workers*, which reiterated this commitment.

² The Bangkok Recommendations were updated in Yangon, Myanmar, in February 2004. L-N Hsu, *Mobile Populations and HIV Vulnerability: Selected Responses in South East Asia*, United Nations Development Programme (UNDP), 2002, at 13.

³ Declaration of Commitment on HIV/AIDS, U.N. General Assembly Resolution S-26/2, adopted 27 June 2001, at para. 50.

⁴ *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on the Construction of Core Indicators*, UNAIDS, 2005.

⁵ *Political Declaration on HIV/AIDS*, U.N. General Assembly Resolution 60/262, adopted 2 June 2006.

⁶ Available at www.hiv-development.org.

⁷ *Consolidated National Policy Self Audits: Cambodia, Lao PDR, Thailand and Vietnam*, CSEARHAP, 2006. At www.csearhap.org.

⁸ *Guidelines for Creating an Enabling Environment for Employers to Implement Effective Workplace Practices for People Living with HIV/AIDS*, APEC, 2007.

⁹ See *Summary Report of the Workshop on Advocacy and*

Policy Promotion Related to Mobility and HIV/AIDS, NAA, Cambodia, 2005. The workshop was conducted by PACT Cambodia in cooperation with the NAA, with funding and technical assistance from CSEARHAP.

¹⁰ *Policies on HIV/AIDS Prevention in Response to Activities of Public Works and Transport Sectors in the Kingdom of Cambodia*, official translation from Khmer, signed 18 August 2006.

¹¹ In 2001, the Japanese Bank for International Cooperation (JBIC) funded the reconstruction of the Sihanoukville Port in Cambodia. Some 300 workers a day were employed on the project, and the sex industry around the port flourished. In response, JBIC initiated HIV prevention activities, implemented through the local health authorities and local and international non-governmental organizations. *HIV/AIDS Prevention for Mobile Population in Greater Mekong Subregion: Corporate Social Responsibility in JBIC Infrastructure Projects*, report of satellite meeting at the 7th International Congress on AIDS in Asia and the Pacific, Kobe, 2 July 2005. At www.jbic.go.jp

¹² See statement titled *Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS*, Toronto, Canada, 11 August 2006.

¹³ See *HIV Impact Assessment Tool: The Concept and Its Application*, UNDP, 2001.

¹ However, the ASEAN Vientiane Action Programme, adopted by ASEAN leaders in Vientiane, Lao PDR, on 30 November 2004, proposes the "...elaboration of an ASEAN instrument on the protection and promotion of the rights of migrant workers;" s. I.1.4.6. On 13 January

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. Readers are invited to bring stories to the attention of Alison Symington, editor of this section, at asymington@aidslaw.ca.

Supervised injection facility granted another temporary extension; legal action launched

Insite, the supervised injection facility located in Vancouver, has been granted another short-term renewal of its exemption under Section 56 of the *Controlled Drugs and Substances Act (CDSA)*. Meanwhile, seeking to end the ongoing uncertainty about the ability of Insite to continue operating legally, two organizations have launched court actions.

Insite has been open since September 2003, providing safe injection materials, medically supervised injection facilities, and support and referral services to people who inject drugs. Insite operates under an exemption to the CDSA granted by the Minister of Health. The original exemp-

tion applied through September 12, 2006. On the eve of its expiration, the Minister allowed an extension to December 31, 2007, stating that additional studies would need to be conducted on how supervised injection facilities affect crime, prevention and treatment.¹

In October 2007, Health Minister Tony Clement issued a short news release announcing that the Section 56 exemption had been extended until June 30, 2008. The news release states that “[t]his extension will allow research on how supervised injection sites affect prevention,

treatment and crime to be continued for another six months.”² The rationale is almost the same as that provided for the previous extension.

Legal action

In August 2007, an application was filed in Supreme Court of British Columbia by the PHS Community Services Society (who operate the facility) and two people who use the facility. According to the statement of claim, both of the individuals have been addicted to heroin for numerous years and test positive for hepatitis C.³

In their claim, the applicants advance two principal arguments. Firstly, they assert that should Insite close, or should they be otherwise subject to the provisions of the CDSA that criminalize the activities at Insite, they will face increased risks of overdose, infection, decline in their mental and psychological well-being and other health-related complications from drug use. As a result, they argue, they will be unjustifiably deprived of their rights to life, liberty and security of the person under Section 7 of the *Canadian Charter of Rights and Freedoms*.⁴

Secondly, they assert that the treatment of the medical and social causes and consequences of addiction and, in particular, the services provided at Insite are matters relating to health care and, therefore, fall within the exclusive jurisdiction of the provincial government.⁵

The applicants are asking the Court to declare: (a) that Insite is a public health service within the exclusive jurisdiction of the province of British Columbia; (b) that no CDSA exemption is required for Insite to operate lawfully; and (c) that the application of the CDSA to those

who use the facility is a deprivation of their rights to life, liberty and security of the person. In the alternative, they seek a declaration that any decision of the Minister to refuse to grant an extension pursuant to Section 56 of the CDSA constitutes a violation of the plaintiffs’ rights to life and security of the person under Section 7 of the Charter.⁶

A separate application was filed in the Supreme Court of British Columbia on behalf of the Vancouver Area Network of Drug Users (VANDU).⁷ VANDU is a non-profit society which has among its objectives to improve the quality of life for people who use illicit drugs and to develop local networks of people who will work to ensure public policies are favourable to people who use illicit drugs.

The VANDU application asserts that at no time do the staff of Insite possess or traffic any controlled drug within the meaning of the CDSA Sections 4(1) and 5, and that, therefore, Insite does not require an exemption under Section 56 of the CDSA.⁸ VANDU also asserts that the treatment of addicts is a medical concern to be dealt with by the provincial legislature,⁹ and that federal criminal law and the conditions of a Section 56 exemption are, therefore, inapplicable to Insite to the extent that they would ban or regulate the health-related activities carried out therein.¹⁰

Furthermore, VANDU argues:

- that the prohibition against the possession of controlled drugs in the CDSA violates the rights of injection drugs users to life, liberty and security of the person, as guaranteed under Section 7 of the Charter;

- that because the prohibited drugs are addictive and the sanction for possession includes imprisonment, the constant threat of the imposition of the law creates a high level of stress in injection drug users (IDUs), resulting in threats to the liberty and security of the person of the IDU;
- that, moreover, the criminal law prohibition effectively forces drug users to choose between their liberty and security of the person, and accessing service; and
- that the state’s action in imposing the prohibition has grossly disproportionate effects of impairing IDUs’ health, thereby affecting their life, liberty and security of the person.¹¹

VANDU also argues that Section 56 of the CDSA is unconstitutional because it contains no criteria or standards for the exercise of the Minister’s discretion in granting exceptions, thus violating Section 7 of the Charter.¹²

VANDU is asking the Court to declare the CDSA framework that is regulating Insite’s operation to be constitutionally invalid, and to issue an interlocutory order granting an interim exemption to the staff and users of Insite, pending the conclusion of the proceedings. If the Court determines that some form of exemption from the law is required, and agrees that CDSA Section 56 is unconstitutional, VANDU is asking the Court to issue a constitutional exemption for the staff and users, until such time as a constitutionally valid process for obtaining exemptions is put in place.¹³

Neither the VANDU nor the PHS Society applications have been heard in court yet.

Comment

For now, at least, Insite can continue to provide its services to drug users in Vancouver. Minister Clement's call once again for further research is troubling in that it continues to divert focus from the primary purpose of the facility, which is to reduce the harms associated with injection drug use.

Given that the Minister has repeatedly refused to make the Section 56 exemption permanent, it seems that the time has come to take the battle into the courts. Challenging the scheme on constitutional grounds may serve to refocus attention on

the human rights and public health aspects of harm reduction programs, and the responsibility of the government to provide appropriate health services to one of Canada's most marginalized communities.

– Alison Symington

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

² Health Canada, "Insite given six-month extension says Minister Clement," news release, Ottawa, October 2, 2007.

³ *PHS Community Services Society, Dean Edward Wilson*

and *Shelly Tomic v. Attorney General of Canada*, Statement of Claim, paras. 5–6. The statement of claim was filed by F. Andrew Schroeder and M. Pongracic-Speier of the firm Schroeder Speier, and Joseph J. Arvey of the firm Arvey Finlay.

⁴ *Ibid.*, para. 26.

⁵ *Ibid.*, para. 27.

⁶ *PHS Community Services*, para 29.

⁷ *Vancouver Area Network of Drug Users (VANDU) v. Attorney General of Canada and Minister of Health for Canada*. The statement of claim was filed by John Conroy of Conroy & Company in August 2006, amended in August 2007.

⁸ *Ibid.*, paras. 12 and 31(a).

⁹ Pursuant to ss. 92(7), (13) and (16) or any combination thereof of the *Constitution Act*, 1867.

¹⁰ *Vancouver Area Network*, paras. 22–23b.

¹¹ *Ibid.*, paras. 24–28.

¹² *Ibid.*, paras. 29–30.

¹³ *Ibid.*, para. 31.

First test of WTO mechanism for procuring generic medicines under compulsory licence, via Canada's Access to Medicines Regime

In July 2007, Rwanda became the first nation to initiate use of a procedure under the rules of the World Trade Organization (WTO) that is supposed to let developing countries import lower-cost, generic medicines produced in other countries under compulsory licences. And two months later, based on Rwanda's initiative, Canada's Commissioner of Patents issued the first compulsory licence under this system to permit the production of a patented AIDS drug to that country.

Background

In August 2003, WTO members unanimously agreed to waive, on an interim basis, the section in the WTO's treaty on intellectual property rules, the *Agreement on Trade-Related Aspects of Intellectual*

Property Rights (TRIPS), that restricted the use of compulsory licensing to produce lower-cost, generic medicines in a country with manufacturing capacity for purposes of exporting them to countries lacking that capacity.¹

This decision was intended to assist countries with insufficient ability to produce generic medicines for public health needs to be able to make "effective use of compulsory licensing" to obtain these more affordable medicines through impor-

tation. While supporting the underlying objective, health advocates expressed concerns that the procedure adopted for implementing the decision was overly cumbersome and inefficient.²

In May 2004, following extensive campaigning by civil society organizations,³ Canada became the first country to implement the 2003 WTO decision through a detailed legislative framework, now commonly referred to as “Canada’s Access to Medicines Regime” (CAMR).⁴

Using WTO procedure via Canada’s legal regime

What followed was several years of effort to use Canada’s legislative regime, specifically by Apotex, the largest Canadian generic pharmaceutical manufacturer, and the international humanitarian organization Médecins Sans Frontières (MSF) as a would-be purchaser of a generic product from Apotex.

At MSF’s request, Apotex developed a new fixed-dose combination tablet, combining the existing anti-retroviral drugs zidovudine (AZT), lamivudine (3TC) and nevirapine into a single tablet for the first time, with a view to potentially exporting it under a compulsory license to one or more developing countries.⁵

Health Canada’s Therapeutic Products Directorate, the national drug regulatory authority, confirmed that the product met the necessary standards required by Canadian law, a pre-condition of export. The product was subsequently approved by the “Prequalification Programme” of the World Health Organization (WHO), thus providing some certainty to potential purchasers that the product

and the manufacturer meet accepted standards.⁶

A variety of procedural obstacles were encountered by Apotex and MSF in the process,⁷ and ultimately MSF notified Apotex that it was not able to secure the necessary action by a potential importing country that is required under the 2003 WTO procedure and Canadian law — namely, publicly notifying the WTO of its intent to use the procedure and specifying a particular quantity of a particular pharmaceutical product.

However, a breakthrough was finally achieved on 19 July 2007, when Rwanda deposited the first notification with the WTO that it intended to use the 2003 WTO procedure, possibly to import 15.6 million of the fixed-dose combination tablets produced by Apotex.⁸ On the basis of this notification, Apotex was able to initiate the process under the Canadian law of obtaining the licence needed to permit the legal production and export of this set quantity of the product to Rwanda.

Communications between Apotex and the three companies holding relevant Canadian patent rights on the three products did not ultimately produce an agreement on granting Apotex a voluntary licence permitting use of the relevant patents. Consequently, after the mandatory 30-day period of attempted negotiation, on 4 September 2007, Apotex filed an application for a compulsory licence with the Commissioner of Patents.⁹ The application was granted, and the compulsory licence issued to Apotex, on 19 September 2007.¹⁰ Canada subsequently notified the WTO of this development as required by the 2003 WTO decision.¹¹

At the time of writing, public reports indicated that the Apotex product would cost approximately US\$0.40 per tablet, compared to approximately US\$20 per tablet in the U.S. for treatment using brand-name equivalents. Apotex predicted that the price would drop further once active pharmaceutical ingredients were procured more cheaply and production was scaled up.¹² At the time of writing, it remained to be seen whether, following an international tender to be issued, Rwanda will conclude an agreement with Apotex to purchase this generic product.

Comment

This is not only the first compulsory licence under Canada’s Access to Medicines Regime, but also the first compulsory licence issued under any national legislation implementing the 2003 WTO decision. While these developments are welcome, it should be remembered that it took over four years since the adoption of the 2003 WTO procedure, and over three years since the adoption of Canada’s law implementing that procedure, to reach the stage of one single (potential) use.

This is not the rapid response that is needed to address the lack of access to affordable medicines in developing countries. Nor is the Canadian legislation, or the underlying WTO decision, the flexible solution that is needed to ensure countries lacking sufficient pharmaceutical manufacturing capacity can make effective use of compulsory licensing, which is what was called for and was promised in the *Doha Declaration on TRIPS and Public Health*, adopted by WTO Members in 2001.

Canadian civil society organizations in the Global Treatment Access Group (GTAG),¹³ including the Canadian HIV/AIDS Legal Network, have called, and continue to call, for amendments to Canada's legislation that would streamline the process for compulsory licensing and remove unnecessary restrictions, thereby increasing the likelihood that other developing countries and other generic manufacturers can and will use the legislative regime in future.

In particular, civil society organizations have called on the Government of Canada and Members of Parliament to amend the legislation to create a "one-licence solution" — namely, authorizing a generic company with a single licence to produce the drug for export to multiple countries, without requiring advance notification, pre-determined quantities of the product, and a separate licensing procedure for each separate country for each single drug order. While this would represent a somewhat different procedure than that laid out in the 2003 WTO decision, the civil society organizations argue that it would still be permissible under provisions of TRIPS that allow for some flexibility in the implementation of the agreement.

It had been expected that the federal Minister of Industry would table in Parliament a report on the results of a government review of Canada's regime by June 2007, as required

by law. However, as of the time of writing in November 2007, there was no indication of when such a report might be released.

— Richard Elliott

Richard Elliott (relliott@aidslaw.ca) is the Executive Director of the Canadian HIV/AIDS Legal Network. For a detailed analysis of Canada's legislative regime, and concrete amendments that have been proposed, see *Getting the Regime Right*, an extensive brief by the Canadian HIV/AIDS Legal Network to a Parliamentary committee that held hearings into the legislation in April 2007, available via www.aidslaw.ca/gtag (click on "Publications").

and Canada's Bill C-56," *Canadian HIV/AIDS Policy & Law Review* 8(3) (2003): 1, 7–18; and R. Elliott, "Steps forward, backward, and sideways: Canada's bill on exporting generic pharmaceuticals," *HIV/AIDS Policy & Law Review* 9(3) (2004): 15–21; both available via www.aidslaw.ca review. See, also, R. Elliott, "Medicines for all?: commitment and compromise in the fight for Canada's law on compulsory licensing for export," in J. Clare-Cohen et al., eds., *The Power of Pills: Social, Ethical and Legal Issues in Drug Development, Marketing and Pricing* (London: Pluto Press, 2006), pp. 227–238. Available via www.aidslaw.ca/gtag (click on "Publications").

⁴ An Act to amend the Patent Act and the Food and Drugs Act (*Jean Chrétien Pledge to Africa*), S.C. 2004, c. 23. At www.canlii.org/ca/as/2004/c23. For details of the regime, see the website established by the Government of Canada at www.camrgc.ca.

⁵ For information on the product, Apo-Triavir, see: www.apotex.com/apotriavir.

⁶ For more information about the WHO Prequalification Programme, see: <http://mednet3.who.int/prequal/>.

⁷ For a summary and timeline of efforts, see: Médecins Sans Frontières, *Neither Expeditious, Nor a Solution: The WTO August 30th Decision is Unworkable – An Illustration Through Canada's Jean Chrétien Pledge to Africa*, briefing paper prepared for the XVI International AIDS Conference, August 2006. At www.accessmed-msf.org/documents/WTOaugustreport.pdf.

⁸ Government of Rwanda, *Notification Under Paragraph 2(a) of the Decision of 30 August 2003 on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, WTO Doc. IP/N/9/RWA/1. At www.wto.org/english/tratop_e/trips_e/public_health_notif_import_e.htm.

⁹ The full application can be seen at http://strategis.gc.ca/sc_mrksv/cipo/jcpa/p4-e.html.

¹⁰ The authorization can be seen at http://strategis.gc.ca/sc_mrksv/cipo/new/CAMR_Authorization.pdf.

¹¹ Government of Canada, *Notification Under Paragraph 2(c) of the Decision of 30 August 2003 on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, WTO Doc. IP/N/10/CAN/1, online via: www.wto.org/english/news_e/news07_e/trips_health_notif_oct07_e.htm.

¹² "Canada issues compulsory licence for HIV/AIDS drug export to Rwanda, in first test of WTO procedure," *Bridges Weekly Trade News Digest* 11(32) (2007). Available via <http://www.ictsd.org/weekly/index.htm>.

¹³ E.g., see: Global Treatment Access Group, *Delivering on the Pledge: Reforming Canada's Access to Medicines Regime—Submission to the Government of Canada*, 24 January 2007. Available www.aidslaw.ca/gtag (click on "Publications").

¹ WTO General Council, *Decision on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, WTO Doc. IP/C/W/40 (30 August 2003). At www.wto.org/english/tratop_e/trips_e/implem_para6_e.htm.

² E.g., "WTO deal on medicines: a 'gift' bound in red tape," Joint NGO Statement on TRIPS and Public Health, 10 September 2003. At www.cptech.org/ip/wto/p6/ngos09102003.html.

³ See: R. Elliott, "TRIPS from Doha to Cancún... to Ottawa: global developments in access to treatment

Two Charter challenges launched against Canada's sex work laws

In March 2007, a constitutional challenge to Canada's sex work laws was filed with the Ontario Superior Court of Justice. Five months later, a second challenge was initiated in the province of British Columbia. These simultaneous, but separate, cases argue that significant portions of the sections of the *Criminal Code of Canada* related to adult sex work violate the free expression, liberty, security and equality provisions of the *Canadian Charter of Rights and Freedoms*.

The Ontario case was brought by three women, former and current sex workers.¹ The B.C. case was initiated by the Downtown Eastside Sex Workers United Against Violence (SWUAV).² The cases seek to strike down *Criminal Code* sections 213 (communicating for the purpose of prostitution),³ 210 and 211 (the bawdy house laws),⁴ and portions of 212 (the procurement law).⁵ Both cases are challenging the laws on the basis of sex workers' rights to (a) free expression and (b) life, liberty and security of the person as enshrined in the *Charter* (sections 2 (b) and 7 respectively). The B.C. case also argues that the laws infringe sex workers' equality rights under the *Charter* (section 15).

Selling sex is legal in Canada. However, *Criminal Code* sections 210–213 prohibit almost all of the activities surrounding the sale of sexual services. The plaintiffs argue that the criminal law regime governing adult sex work causes harms to sex workers by making it difficult for them to work safely, exposing them to risks of severe violence.

For example, both cases argue that the communicating law forces sex workers wishing to avoid harassment and arrest to enter the vehicles of potential clients without sufficient opportunity to assess whether the

client is dangerous. The B.C. challenge also maintains that risks arise “because sex workers must work alone and/or at a distance from others and travel to isolated or industrial locations to avoid attracting the attention of police.”⁶ SWUAV's Statement of Claim also notes that “there is a disproportionate number of missing women across Canada known to have engaged in sex work and whose disappearances have been connected to their occupation.”⁷

With respect to the bawdy house law, both challenges argue that violence is significantly reduced or eliminated in most indoor settings.⁸ The laws therefore prevent sex workers from establishing safer working conditions. Both cases also maintain that portions of the procuring provision deprive sex workers of the ability to work together or for others in a way that might benefit their health and safety.⁹

SWUAV also argues that the provisions single out sex workers for differential and discriminatory treatment. SWUAV maintains that the laws have a negative impact on the treatment of sex workers by the public, social and health service providers, employers and the police.

This is not the first time that these provisions will be reviewed. In 1990,

the Supreme Court of Canada upheld the constitutional validity of the communicating and bawdy house provisions in a case called the *Prostitution Reference*.¹⁰ In 1992, the Supreme Court upheld the procuring provision in *R v. Downey*.¹¹

In addition, government committees have researched the topic and explored possible reforms. Most recently, after holding consultations across the country, in December 2006 the Parliamentary Subcommittee on Solicitation Law issued a report but failed to fulfill its mandate to recommend specific legal reform.¹²

If successful, these challenges could spur fundamental change in the criminal law framework governing sex work in Canada.

– Julie Shugarman

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See additional coverage relating to this issue in the Canadian Developments sections of Issue 11 (2/3) and Issue 12 (1) of the *Review*.

¹ The legal team is being led by Osgoode Law Professor Alan Young.

² Katrina Pacey, of Pivot Legal LLP, and Joseph J. Arvay, of Arvay Finlay, have been retained as co-counsel.

³ The Ontario case is challenging s. 213(1)(c); the B.C. case is challenging s. 213 in its entirety.

⁴ The bawdy house laws prohibit keeping or having control over a location that is used for prostitution; living in or being found in that location; taking or directing people to that location; and permitting others to use that location. The Ontario challenge did not explicitly name s. 211 in its Notice of Application.

⁵ The procurement laws being challenged prohibit facili-

tating or managing another person's sex work, referring clients, forming business relationships, and sharing income from sexual services. The section being challenged in Ontario is 212(1)(j). In B.C., all of s. 212 is being challenged with the exception of subsections (g) and (i) and 212(2).

⁶ *SWJAV v. Her Majesty the Queen*, Statement of Claim, August 3, 2007 at para 8(a).

⁷ *Ibid.* at para. 8(d).

⁸ *Terri Jean Bedford, Amy Lebovitch and Valerie Scott v. Her Majesty the Queen*, Notice of Application, March 20, 2007 at para. 2(e).

⁹ The Ontario challenge, for example, highlights that

s. 212(1)(j) makes it illegal to "hire managers, drivers, and security personnel" (Notice of Application at para. 2(e)).

¹⁰ *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] 1 S.C.R. 1123.

¹¹ *R. v. Downey* [1992] 2 S.C.R. 10. It is worth noting that evidence of the effects of the impugned laws as well as Charter jurisprudence have developed substantially since the *Prostitution Reference* and *R. v. Downey*.

¹² For commentary on the Subcommittee's report, see: 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.

Conservative government announces new anti-drug strategy

On October 4, 2007, Prime Minister Stephen Harper officially unveiled his government's National Anti-Drug Strategy, promising to crack down on what he termed "drug criminals" while acting with compassion towards their victims. First outlined in the March 2007 federal budget, the new strategy comes with \$63.8 million additional funding over two years.¹

The stated priorities of the new strategy are to combat production and distribution of illicit drugs; to create awareness of illicit drugs and their negative effects, particularly among youth; and to treat and rehabilitate those with drug dependencies. According to the government, these three components together "form a focused approach to reducing the supply of and demand for illicit drugs, as well as addressing the crime associated with illegal drugs, leading to safer and healthier communities."²

The additional funding supplements the \$385 million per year already directed towards drug-related

programs and initiatives. It includes \$21.6 million to support law enforcement in combating the use of illegal drugs, proactively targeting marijuana grow operations, methamphetamine labs and gangs.

Ten million dollars will be spent on a prevention campaign directed at youth and their parents. Drug dependence treatment services will receive an additional \$32.2 million, with particular attention paid to programs for youth, and First Nations and Inuit populations.³ The government also promised to introduce mandatory prison sentences for drug producers and sellers.⁴

Critics charge that the strategy is based on ideology rather than evidence and that it mimics the United States' so-called "war on drugs" which has been ineffective at reducing drug supply and consumption in the U.S. Moreover, they say, it inappropriately treats drug addiction primarily as a criminal matter, rather than an issue of public health.⁵

Commentary

While the Conservative government has branded this strategy as "new," the funding allocations bear a striking resemblance to the previous strategy. Since enforcement already made up

almost three-quarters of the government's spending in the fight against illicit drugs, the additional allocations for prevention and treatment have little impact in the overall distribution of funds. Law enforcement will continue to be the central focus of the strategy, with prevention and treatment garnering approximately the same percentage of funding as under the previous strategy.⁶

Moreover, from both a public health and a human rights perspective, the absence of harm reduction as a "pillar" of the strategy should raise red flags. (The four pillars of the previous drug strategy were law enforcement, prevention, treatment and harm reduction.⁷) Harm reduction programs — including needle exchanges, methadone clinics and supervised drug consumption facilities — have been shown in numerous studies to lessen the harms associated with illicit drug use, including by reducing the transmission of HIV and hepatitis C.⁸ Harm reduction is therefore essential to a human rights-based approach to HIV/AIDS.

The abandonment of harm reduction within Canada's national approach to illegal drugs may have a chilling effect on drug programs at the provincial and municipal levels. It may also damage Canada's reputation internationally as a country known for including harm reduction

as an element of its response to drug use and public health issues such as HIV and hepatitis C. It may also have implications for existing harm reduction programs that fall within federal jurisdiction, such as those in federal prisons.

Finally, while it is not yet known what will be included in the promised new legislation regarding tougher punishment for drug producers and sellers, the Prime Minister has already indicated that the government will propose mandatory minimum sentences for people convicted of serious drug offences. (It is worth noting that the government tried to introduce mandatory minimum sentences during the last session of Parliament, but the effort was ultimately undone by amendments at the committee stage, in part due to lobbying by the Legal Network and others.)

There is no evidence that mandatory minimum sentences reduce drug use or the harms associated with it. Moreover, research shows that incarcerating injection drug users is one factor contributing to the spread of HIV in Canada.⁹ Mandatory sentencing policies in the U.S. have also been shown to have disproportionate impacts of women, people of colour and members of marginalized communities.¹⁰ By taking away judges' discretion to sentence in accordance

with specific circumstances and mitigating factors in individual cases, justice is poorly served.

— Alison Symington

¹ Department of Finance Canada, *The Budget Plan 2007: Aspire to a Stronger, Safer, Better Canada*, tabled in the House of Commons by the Honourable James M. Flaherty, P.C., M.P., March 19, 2007.

² *Ibid.* at p. 257.

³ *Ibid.*, p. 258.

⁴ "Prime Minister pledges crackdown on drug criminals, compassion for their victims," speech by Prime Minister Stephen Harper, Winnipeg, October 4, 2007.

⁵ See, e.g., Canadian HIV/AIDS Legal Network, "Ottawa adopting failed U.S.-style 'war on drugs': new National Anti-Drug Strategy plays politics with people's lives," news release, Toronto, October 1, 2007; AIDS Committee of Toronto, *Harm Reduction and the Federal Government's New Anti-Drug Strategy*, position statement, October 2007; and "Drug policy offers same old failures: 'fresh approach' continues enforcement focus despite decades of costly, futile efforts," *Times Colonist (Victoria)*, October 10, 2007, p. A12.

⁶ Personal communication with Kora DeBeck, Urban Health Research Initiative, BC Centre for Excellence in HIV/AIDS. See also, K. DeBeck et al., "Canada's 2003 renewed drug strategy — an evidence-based review," *HIV/AIDS Policy & Law Review* 11 (2/3) (2006): pp. 1–11.

⁷ Government of Canada, *Canada's Drug Strategy: What is it?* Cat. H 128-1/05-443-1, 2005.

⁸ See N. Hunt, *A Review of the Evidence-Base for Harm Reduction Approaches to Drug Use*, Forward Thinking on Drugs — A Release Initiative, 2003.

⁹ Canadian HIV/AIDS Legal Network, *Mandatory Minimum Sentences for Drug Offences: Why Everyone Loses*, briefing paper, April 2006, pp. 1–2.

¹⁰ *Ibid.*, pp. 3–4.

Ottawa: Crack pipe program cancelled by city council

In July 2007, Ottawa City Council voted to discontinue the Safer Crack Use Initiative amidst controversy over the effectiveness of the harm reduction program.

The program, which distributed safer inhalation equipment to people who smoke crack, had been introduced on April 1, 2005. The surprise motion to cancel the initiative was introduced by Councillor Rick Chiarelli, who claimed the program sent out “one of the most ironic mixed messages a municipal government could send.”¹ The motion, which had the support of Mayor Larry O’Brien, passed by a vote of 15 to 7 on July 11. The program had cost the city \$7,500 annually, with the remainder of its \$40,000 budget coming from the provincial government.

The cancellation took effect immediately. By cancelling the program, council acted contrary to the advice of the city’s chief medical officer of health, Dr. David Salisbury. Salisbury repeatedly told council that the program was working — it was saving lives, savings millions in future medical expenses and was good for public health.² The kits were intended to help prevent the spread of hepatitis and HIV. They included glass stems, rubber mouth-pieces, brass screens, condoms, other items and educational materials.

Abrasions on cuts on the lips are common in people who smoke crack. Because crack pipes are frequently shared, users can be exposed to potentially infectious blood. Smoking is generally considered safer than injecting drugs, but studies have shown that smokers remain

at high risk of contracting HIV and hepatitis C (HCV). Ottawa is reportedly experiencing a boom in crack smoking. Users in Ottawa have the highest rate of hepatitis infection in Canada, and a high rate of HIV infection as well.³

A study of over 500 Ottawa drug users by University of Ottawa Assistant Professor Dr. Lynne Leonard found that the practice of sharing crack pipes had decreased significantly after the safer crack use program was introduced. A switch in drug use behaviour from injecting to smoking, a lower-risk behaviour, was also observed. They study also found that 4000 crack users came into contact with health workers as a result of the program.⁴

However, Mayor O’Brien stated publicly that he did not believe that the program was working, and that he thought it foolish to give out tools to do something which is detrimental to health. Others who voted against the program felt that the city was encouraging drug use by handing out the pipes.

The mayor has encouraged agencies to instead focus on treatment and, to that end, announced on August 18, 2007 that the city would spend \$25,000 on a study to determine the best way to help drug users in Ottawa, including by building a new residential drug treatment facility. The money will be matched by the province. O’Brien and Ontario

Minister of Health Promotion Jim Watson stated that the study will not consider reinstating a crack pipe distribution program.

In a letter to Mayor O’Brien and the Ottawa city councillors, the Canadian HIV/AIDS Legal Network urged the council to reconsider their decision. Joanne Csete, then Executive Director of the Legal Network, wrote that

[c]ancelling the crack kit distribution program constitutes a huge step backwards, and not just in terms of public health and human rights. As you heard from Ottawa’s chief medical officer of health, the program was a sensible investment of taxpayer’s dollars, considering the savings to the public purse of preventing new cases of HIV and HCV infection. Your constituents deserve a responsible, effective response to drug addiction that is based on sound evidence and respect for human rights. You can deliver such a response by reinstating the Safer Crack Use Initiative....

A coalition of community organizations announced in August that they will keep the program going. The AIDS Committee of Ottawa, five community health centres, Centre 507, the Youth Services Bureau, the Elizabeth Fry Society and the Wabano Centre for Aboriginal Health will spend \$15,000 to maintain the program until the end of 2007, amid hopes that long-term funding will be in place by that time.⁵

Safer crack use initiatives have also been implemented in other Canadian cities, including Vancouver, Winnipeg, Toronto, Montreal, Guelph and Halifax. However, there is concern that some of these programs could also be cancelled in light of an emerging trend away from a harm reduction approach and towards a law-and-order agenda.

A similar program was discontinued in Nanaimo, British Columbia, in June 2007. Vancouver Island Health Authority chief executive

office Howard Waldner stated that the program will be reconsidered “in due course.” In the Nanaimo case, harassment of community health nurses and concerns expressed by some residents and city councillors were cited as the reasons for the program suspension.⁶

– Alison Symington

See additional coverage of this issue in the Canadian Developments section of Volume 12(1) of the *Review*.

¹ D. Puddicombe, “Off the crack pipes; council kills ‘stupid’ program; doc warns of HIV toll,” *The Ottawa Sun*, July 12, 2007, p. 4.

² J. Rupert, “Health agencies seek to resurrect crack-pipe program: it’s too valuable to let go, says official with Inner City group,” *The Ottawa Citizen*, July 13, 2007, p. F1.

³ *Ibid.*

⁴ L. Leonard et al., “I inject less as I have easier access to pipes: injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed,” *International Journal of Drug Policy*, published online, 2007. Available via www.canadianharmreduction.com/articles.php.

⁵ M. Gillis, “Piping up for addicts; coalition finds cash for axed program,” *The Ottawa Sun*, August 1, 2007, p. 3.

⁶ J. Rudd, “Nanaimo halts crack-pipe handouts,” *Times Colonist (Victoria)* (on-line edition), June 21, 2007.

In brief

Alberta proclaims law authorizing forced HIV testing

On 1 October 2007, Alberta’s *Mandatory Testing and Disclosure Act*, and accompanying regulations, came into force.¹ The new Act replaces an earlier act, the *Blood Samples Act*,² that was passed in 2004 but was never proclaimed into force because the government decided it wished to amend the legislation to resemble more closely a model statute drafted by the Uniform Law Conference of Canada.³

The Act creates a mechanism for certain persons exposed to bodily fluids — such as firefighters, paramedics and peace officers, as well as anyone providing emergency assis-

tance — to get a court order forcing the person who is the source of the exposure (“source person”) to provide a bodily substance for testing for viruses such as HIV. The results of the test will then be disclosed to the exposed person.

Under the Act, the exposed person must apply to the Alberta provincial court within 30 days of the exposure. The application must be accompanied by a physician’s report assessing the significance of the exposure. Both documents must be served on the source person and filed with the court. If the court orders the source person to provide a sample of a bodily substance for testing, the local medical officer of health follows up with the source person. Once the testing and analysis is done, the results are provided to the physicians of both the source person and the exposed person.

The Act declares that it creates “a fair process which balances the desire of individuals to know the

health status of a person who may have exposed them to a disease and the rights of individuals who are requested to submit a bodily sample.” However, organizations such as the Canadian HIV/AIDS Legal Network have criticized such legislation as unnecessary, unjustified and, arguably, unconstitutional.⁴

– Richard Elliot

Richard Elliott (relliott@aidslaw.ca) is executive director of the Legal Network.

For the text of the Alberta statute and regulations, and copies of the relevant protocols and forms for implementing the Act, see: www.health.gov.ab.ca/professionals/MTDA.html. For details of the Alberta legislation and similar legislation in several other Canadian provinces, see the Legal Network’s 2007 publication *Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV*, available via www.aidslaw.ca/testing.

Anonymous HIV tests made available in Manitoba

On September 19, 2007, Manitoba Healthy Living Minister Kerri Irvin-Ross announced a \$1.3 million investment in testing, treatment and prevention of sexually transmitted infections (STIs).⁵ With this funding, Manitoba will create a formal HIV program.

A notable component of the announcement is expanded access to STI testing services, including the introduction of anonymous and rapid testing for HIV. Quebec, Ontario, Newfoundland and Labrador, New Brunswick, Nova Scotia, Alberta and Saskatchewan already offer anonymous testing.⁶

The anonymous system allows people to be tested without giving their name or health card number. People who otherwise might not be tested because of the stigma associated with HIV/AIDS infection are more likely to be tested if anonymity is assured.

In Manitoba, AIDS activists estimate that close to 1400 people are living with HIV, and 400–500 people are infected and do not know it.⁷ According to an editorial in the *Winnipeg Free Press*, for years Manitoba has resisted implementing the sort of HIV testing and prevention programs that exist in other provinces. “The new HIV program means Manitoba is finally admitting to having an HIV problem,” the *Free Press* said.⁸

Other aspects of the program will include investing up to \$110,000 over two years in a coalition of community-based organizations working to address HIV/AIDS within immigrant and refugee communities; providing

up to \$100,000 to help develop culturally appropriate resources on sexual health for Aboriginal youth; and providing up to \$270,000 in funding to address sexual health promotion within the province’s gay, lesbian, bisexual, two-spirit and transgender communities.

– Alison Symington

New 60-second HIV test available in Ontario

The Ontario provincial government announced in June 2007 that it will make free, anonymous rapid point-of-care (POC) tests available at 50 sites across the province, including community health centres, sexually transmitted infection clinics and midwifery clinics. Twenty-four of the sites will be newly designated, focusing on northern and rural communities in order to provide more equitable access.⁹

As compared to traditional HIV tests where patients need to wait two weeks to receive their results, rapid POC tests provide almost immediate results to those wanting to know their HIV status. A drop of blood can be tested for antibodies to HIV within 60 seconds. Together with pre-test and post-test counselling, the entire process takes about 20 minutes. Tests that show a presence of HIV antibodies will require additional blood analysis from a laboratory to confirm a positive HIV test result.¹⁰

Ontario will be the first jurisdiction in Canada to offer the new form of testing. The Ministry of Health estimates that the program will cost approximately \$350,000 annually.¹¹

Providing anonymous, rapid tests can help increase the number of peo-

ple who are getting tested, especially in high-risk communities that may have less access to, and more apprehension of, traditional health services. Rapid tests can also be especially useful in cases of sexual assault, occupational accidents with potentially HIV-contaminated materials, pregnant women going into labour and transient communities, where immediate results can allow people to get the information, treatment and support they require.¹²

Given the speed with which the test can be administered however, the risk of compelling people to take a test without informed consent or without proper counselling increases.¹³

– Alison Symington

Safer needles mandated for Ontario healthcare facilities

New regulations under the *Occupational Health and Safety Act* will make safety-engineered needles or needle-less systems mandatory in Ontario hospitals as of September 1, 2008.¹⁴ Similar requirements will come into effect for long-term care homes, psychiatric facilities, laboratories and specimen collection centres in 2009, and in other health care workplaces (e.g., home care, doctors’ offices, ambulances) in 2010.

Safety-engineered needles help prevent health care workers from accidental needlestick injuries. When a worker’s skin is punctured with a used needle or medical sharp device, she or he may be exposed to blood-borne diseases, including HIV and hepatitis C. Unlike regular needles, the safety needles have plastic guards

and retractable heads to reduce the risk of a stick.

Annually, about 70 000 Canadian health-care professionals are accidentally pricked by needles, according to the Ontario Nurses' Association, and about half of those injuries take place in Ontario.¹⁵ Unions representing Ontario's health care workers had been pushing for this regulation for several years and a private members' bill on the subject was introduced in 2005.¹⁶ Safety needles are already mandated in Saskatchewan and Manitoba.

– Alison Symington

Two new studies confirm higher hepatitis C and HIV infection among inmate populations

Two studies featured in the July 2007 *Canadian Medical Association Journal* had strikingly similar findings. In seven provincial prisons under study in Quebec, the overall prevalence of HIV infection was 3.4 percent. It was significantly higher among women (8.8 percent, compared to 2.4 percent among men).¹⁷ The overall prevalence of hepatitis C (HCV) infection was 18.5 percent (29.2 percent for women and 16.6 percent for men).¹⁸ Both HIV and HCV infections were found mainly among injection drug users.

Results from the study conducted in Ontario remand facilities (jails, detention centres and youth centres) demonstrated a prevalence rate for HIV infection of 2.1 percent among

adult males and 1.8 percent among adult females (no young offenders tested HIV-positive). The prevalence of HCV infection was found to be 15.9 percent among men, 30.2 percent for women, and 0.4 percent for young offenders. Those most likely to be infected were older than 30 years of age and injection drug users.¹⁹

The prevalence of HIV and HCV infections in the general population is estimated to be 0.8 percent and 0.18 percent respectively.²⁰

Richard Elliot, Executive Director of the Canadian HIV/AIDS Legal Network, stated in a commentary accompanying the articles that

[n]either the high prevalence of HIV or HCV infections among prisoners nor its correlation to these risk activities is a surprise, even to correctional authorities. Nor is it any secret what should be done in light of this evidence. In studies conducted outside prison, access to sterile injection equipment has been shown time and again to be one of the most important HIV prevention interventions among people who inject drugs.²¹

Elliot suggested that in the face of the Canadian government's continuing disregard of evidence such as that from these studies, legal action may be appropriate.

– Alison Symington

¹ S.A. 2006, c. M-3.5, as amended by S.A. 2007, c. 18; Mandatory Testing and Disclosure Regulation, A.R. 190/2007; available via www.health.gov.ab.ca/professionals/MTDA.html. See: Order in Council, O.C. 400/2007,

12 September 2007; at www.qp.gov.ab.ca/documents/orders/orders_in_council/2007/907/2007_400.html.

² S.A. 2004, c. B-4.5.

³ Uniform Law Conference of Canada, *Mandatory Testing and Disclosure Act* (Draft and Commentary). At www.ulcc.ca/en/us/Uniform_Mandatory_Testing_and_Disclosure_Act_Draft_En.pdf.

⁴ E.g., see Canadian HIV/AIDS Legal Network, *Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV*.

⁵ Province of Manitoba, "More than \$1.3 million invested to create Manitoba HIV program, reduce spread of sexually transmitted infections, promote sexual health," news release, Winnipeg, September 19, 2007.

⁶ C. Sanders, "Anonymous HIV tests overdue," *Winnipeg Free Press*, September 19, 2007, p. A16.

⁷ *Ibid.*

⁸ "Editorial: HIV testing is smart," *Winnipeg Free Press*, September 20, 2007, p. A14.

⁹ Ontario Ministry of Health and Long-Term Care, "New 60 second test and expanded testing program provides more options for HIV testing," backgrounder, June 22, 2007. At www.health.gov.on.ca/english/media/news_releases/archives/nr_07/jun/hivtesting_bg_05_20070622.pdf.

¹⁰ Ontario Ministry of Health and Long-Term Care, "McGuinty government advances new options for HIV testing," news release, Toronto, June 22, 2007.

¹¹ "Ontario to offer 60-second HIV Test," *CBC News* (online), June 22, 2007.

¹² Canadian HIV/AIDS Legal Network, *Prevention and Protection: Enhancing Both HIV Testing and Human Rights in Canada*, 2007. Available via www.aidslaw.ca/testing.

¹³ *Ibid.*, p. 25.

¹⁴ Needle Safety, Ontario Regulation 474/07, made under the *Occupational Health and Safety Act*, August 22, 2007.

¹⁵ S. Rennie, "Ontario to supply safety needles," *Globe and Mail*, August 24, 2007, p. A6.

¹⁶ See D. Garmaise, "Health care workers push for use of safer hypodermic needles," *HIV/AIDS Policy & Law Review* 11 (1) (2006): pp. 18–19.

¹⁷ C. Poulin et al., "Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons," *Canadian Medical Association Journal* 177(3) (2007): 252–256, p. 254.

¹⁸ *Ibid.*, p. 254.

¹⁹ L. Calzavara et al., "Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities," *Canadian Medical Association Journal* 177(3) (2007): 257–261, p. 257.

²⁰ *Ibid.*

²¹ R. Elliot, "Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons," *Canadian Medical Association Journal* 177(3) (2007): 262–264 at 262.

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.

South Africa: Firing of Deputy Health Minister Madlala-Routledge

On 8 August 2007, South Africa's President Thabo Mbeki dismissed the Deputy Health Minister, Nozizwe Madlala-Routledge.¹ The President's office stated that the dismissal was because Madlala-Routledge had traveled without permission to Madrid to attend the International AIDS Vaccine Initiative Conference.² HIV/AIDS activists and other supporters of Madlala-Routledge believe that the Madrid incident merely provided Mbeki with a long sought-after excuse to remove his Deputy Health Minister.³

According to media reports, Madlala-Routledge undertook the trip on the understanding that approval was pending; however, upon arrival in Spain, she was informed that her request had been denied by Mbeki.⁴

Mbeki is widely considered an AIDS denialist because he has consistently refused to acknowledge that HIV is the cause of AIDS.⁵ His government only began making antiretroviral treatment available

to people living with HIV/AIDS in 2004, several years after much less wealthy African countries took the initiative.⁶ Mbeki is supported by Health Minister Manto Tshabalala-Msimang, who has been dubbed "Dr

Beetroot” and “Garlic Manto” by her critics for advising people living with HIV/AIDS to eat more garlic, beet root and potatoes as solutions to the virus.⁷

During her time in the South African government, Madlala-Routledge introduced antiretroviral treatment into the military, denounced AIDS denialism and made calls for more people to get tested for HIV.⁸ Such activities were widely credited as improving the image of the South African government internationally and among South Africa’s civil society organizations.⁹

The main achievement of Madlala-Routledge’s period as Deputy Health Minister was the development of an aggressive National Strategic Plan (NSP) on HIV/AIDS and Sexually Transmitted Infections, designed to guide the country’s response to HIV/AIDS from 2007 to 2011.¹⁰

In response to criticism following the XVI International AIDS Conference in Toronto in August 2006, the government revived the South African National AIDS Council (SANAC), an inter-ministerial committee, under the new leadership of South Africa’s Deputy President, Phumzile Mlambo-Ngcuka.¹¹ When Health Minister Tshabalala-Msimang fell ill towards the end of 2006, Mlambo-Ngcuka asked Madlala-Routledge to rewrite the national AIDS strategy.¹² In March 2007, the government formally launched the NSP.

The stated objectives of the NSP are to provide comprehensive care and treatment for people living with HIV/AIDS and to strengthen the national health system. The primary aims are to reduce the number of new HIV infections and to reduce the impact of HIV and AIDS on indi-

viduals, families, communities and society. The NSP focuses on four main priority areas: prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance.¹³

Earlier governmental HIV/AIDS initiatives had been criticized as being poorly-developed and ineffective. In 2000, the South African Department of Health developed a five-year plan to combat HIV/AIDS. In November 2003, the government announced a second plan to make antiretroviral treatment publicly available. The latter initiative took effect in March 2004.

One year later, in March 2005, the initiative was already falling short of its targets for treatment access. By February 2007, the number of patients receiving antiretroviral treatment constituted only 36 percent of target.¹⁴

The new NSP was acclaimed as a “credible plan with clear targets.”¹⁵ The plan aims to reduce the national HIV incidence rate by 50 percent by 2011. The NSP says that by that year, an appropriate package of treatment, care and support services should be provided to 80 percent of people living with HIV and their families.¹⁶ Unlike previous governmental HIV/AIDS initiatives, the NSP emphasizes human rights, gender equality, protection of children and cooperation between government and civil society groups.¹⁷

AIDS activists in South Africa and around the world have expressed concern that without Madlala-Routledge at the helm of the NSP, the plan could falter.¹⁸

Madlala-Routledge’s dismissal was widely condemned. Stephen Lewis, the former special envoy for AIDS in Africa, stated that her firing

“was a dreadful setback against the pandemic, a blow to those fighting it internally and a blow to those outside watching developments in South Africa.”¹⁹

The Joint Civil Society Mentoring Forum, an organization that represents over twenty health and research organizations in South Africa, described the dismissal as “a major setback to the development of a unified national response to HIV/AIDS, so crucial to the effective implementation of the NSP.”²⁰

Subsequently, the government has demanded payment from her of outstanding debts dating back to 1996, as well as reimbursement for the unauthorized trip to Spain. Madlala-Routledge’s supporters allege she is being victimized and humiliated by what they term the government’s “selective debt collecting.”²¹ The Treatment Action Campaign (TAC) launched a fund to provide short-term financial assistance to Madlala-Routledge.²²

TAC has also written Mbeki requesting the reinstatement of Madlala-Routledge as well as the immediate dismissal of Tshabalala-Msimang “on the basis of the current dismal state of our health system and her poor performance.”²³ TAC contends that “our people continue to die and become infected because of lack of leadership and deliberate obstruction from Health Minister Manto Tshabalala-Msimang.”²⁴

– Courtney Ashton

Courtney Ashton is a student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ South African Government Information, "President Mbeki relieves Deputy Minister of Health," news release, Pretoria, August 8, 2007. At www.info.gov.za/speeches/2007/07081008151001.htm.

² South African Government Information, "Publishing of the president's letter," news release, Pretoria, August 11, 2007. At www.info.gov.za/speeches/2007/07081308151001.htm.

³ TAC, "President Mbeki: Do not dismiss Deputy-Minister Nozizwe Madlala-Routledge. Can our people trust you on HIV/AIDS?" August 9, 2007. At www.tac.org.za/nl20070809.html.

⁴ International AIDS Vaccine Initiative, "IAVI states facts relating to dismissal of South African Deputy Health Minister," August 10, 2007. At www.iavi.org/viewfile.cfm?fid=46389

⁵ AVERT, "AIDS in South Africa: treatment, transmission and the government," updated September 12, 2007. At www.avert.org/aids-south-africa.htm.

⁶ K. Butler, "A president in denial, a ravaged nation denied hope," *The Independent*, August 10, 2007. At <http://news.independent.co.uk/world/africa/article2851447.ece>.

⁷ M. Wines, "Taking on apartheid, then a nation's stance on AIDS," *New York Times*, September 8, 2007. At www.nytimes.com/2007/09/08/world/africa/08madlala.html?_r=1&oref=slogin.

⁸ TAC, "President Mbeki: Do not dismiss"

⁹ Ibid.

¹⁰ SANAC, *HIV & AIDS and STI Strategic Plan for South Africa 2007–2011*, March 2007. At www.info.gov.za/otherdocs/2007/aidsplan2007/.

¹¹ AVERT, "The history of AIDS from 2003 onwards," updated June 2007. At www.avert.org/aidshistory.htm.

¹² M. Wines.

¹³ SANAC.

¹⁴ Joint Civil Society Mentoring Forum, *South African Antiretroviral Programme Treatment Gap*, May 2007. At www.jcsmf.org.za/?q=node/40.

¹⁵ TAC, "HIV/AIDS denialism is dead." At www.tac.org.za/AidsDenialismIsDead.html.

¹⁶ AVERT, "AIDS in South Africa..."

¹⁷ Joint Civil Society Mentoring Forum, *South Africa's National HIV Strategy (2007-2011): An Opportunity for*

Health Equity, an Embodiment of Health Rights, June 2007. At www.jcsmf.org.za/?q=node/114.

¹⁸ TAC, "Open letter: commitment to National Strategic Plan," August 21, 2007. At www.tac.org.za/documents/OpenLetterToDeputyPresident.pdf.

¹⁹ L. Ensor, "Fury over Mbeki's axing of Madlala-Routledge," *Business Day* (undated). At www.businessday.co.za/Articles/TarkArticle.aspx?ID=2935537.

²⁰ Joint Civil Society Mentoring Forum, "Civil society outrage over dismissal of the deputy minister of health," news release, Braamfontein, August 16 2007. Available via www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=376.

²¹ "Govt screws tighten on Madlala-Routledge's finances," *Mail and Guardian Online*, August 26, 2007. At www.mg.co.za/articledirect.aspx?articleid=317536&area=%2fbreaking_news%2fbreaking_news_national%2f.

²² Information on the fund, called "The Support Good Governance — Support Nozizwe Madlala-Routledge Fund," can be found via www.tac.org.za.

²³ "Govt screws tighten..."

²⁴ TAC, "Open Letter..."

China: Two steps forward, one step back for new AIDS rights organization

A new AIDS law centre has been established in China, and continues to operate, despite a pre-Olympics crackdown on AIDS groups by Chinese authorities.

AIDS law centre

Since January 2007, Asia Catalyst (a U.S.-based non-profit organization) has been working with China Orchid AIDS Projects (COAP, a Beijing-based NGO) to assist it to establish a new project: the Korekata AIDS Law Center. The center plans to litigate cases of discrimination against people living with HIV/AIDS (PLHIV), transmission of HIV through blood transfusions (a widespread problem in China), and other issues.

The center's name symbolizes the founders' commitment to promot-

ing regional cooperation. Kojima Korekata was a lawyer and later chief justice of Japan's Supreme Court. In the late 19th century, his cases established the independence of Japanese courts, and were among the earliest to promote rule of law in Asia.

Asia Catalyst's role in this project is to assist COAP with strategic planning, budgeting, fundraising, capacity-building and international outreach. At the request of the Korekata Center, Asia Catalyst also published a research report on how countries have handled HIV outbreaks in their blood supplies; the report included policy

recommendations directed to the government of China.¹

Gradually, over the past few years, China has begun to permit some small, grassroots NGOs to form on the ground. While heavily restricted, these groups have done remarkable work in organizing PLHIV, men who have sex with men, and people who use drugs. Their programs include outreach, counselling and preventive services.

Increasingly, some of these groups — notably, the Aizhixing Health Education Center led by Wan Yanhai — have also conducted legal advoca-

cy and legal research. A few, such as Beijing-based Yirenping, have begun to litigate cases of transmission of HIV through blood transfusions.

The Korekata Center plans to bring these activities together in one place, litigating selected high-impact cases, publishing materials, holding workshops and establishing a network of lawyers and NGOs, linking them to AIDS law organizations globally.

Government crackdown on AIDS groups ahead of Olympic games

The Korekata Center encountered obstacles after being swept up in a pre-Olympics crackdown on AIDS groups. To launch the Center, Asia Catalyst and COAP planned to hold an international conference on AIDS and law in China on August 2–3, 2007.

The conference was to have brought together in Guangzhou representatives of the AIDS Law Project (South Africa), the Lawyers' Collective (India), the Thai Treatment Action Group, the Canadian HIV/AIDS Legal Network and Temple University Law School (U.S.). There, they were to meet with about fifty PLHIV, lawyers, scholars

and representatives from Chinese AIDS NGOs from around the country.

Conference participants planned to share their experiences in litigating blood transmission and discrimination cases in China and internationally, and to strategize ways to coordinate future work.

However, on July 26, 2007, the hotel in Guangzhou contacted COAP staff in Beijing and informed them that police had ordered the hotel to cancel the conference. That evening, security agents in Beijing detained Li Dan, the executive director of COAP, for twenty-four hours. COAP and Asia Catalyst were informed that the combination of AIDS, law and foreigners was “too sensitive.” Authorities feared that the meeting would affect the official launch on August 8, 2007 of the one-year countdown to the Beijing Olympics, thus marring China's public image.

In August, the crackdown spread: Police forbade a planned meeting of support groups of PLHIV in Henan province and shut down two Henan offices of COAP that provided aid to children affected by AIDS.

The experience was discouraging. Chinese AIDS lawyers and activists privately expressed frustration that

“we can't even hold so much as a meeting” and worried that the fight against AIDS would grind to a halt for a year until the Beijing Olympics concluded.

However, AIDS groups in China have carefully continued to move forward. Since August, some small meetings of AIDS groups have successfully convened around the country. Though the conference was cancelled, the Korekata AIDS Law Center continues to make plans. For 2008, these will include: developing pamphlets and resource guides on Chinese AIDS law, for both lawyers and PLHIV; developing a certification course for Chinese lawyers on AIDS law; and publishing materials on AIDS law in other countries in the Chinese language.

– Sara (Meg) Davis

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¹ Asia Catalyst, *AIDS Blood Scandals: What China Can Learn from the World's Mistakes*, September 2007. Available via www.asiacatalyst.org.

Thailand: Report analyses barriers to ART for people who inject drugs

The HIV epidemic among people who use drugs mars Thailand's reputation as a success story in the global fight against AIDS. A new report has revealed that people who use drugs still face serious obstacles in obtaining needed health care.¹

HIV prevalence among people who inject drugs has remained extremely high, steadily increasing from over 40 to over 50 percent over the last two

decades.² Indeed, the Thai government has acknowledged that the HIV infection rate among people who use drugs “has sustained itself at an unacceptably high level in Thailand since the very beginning of the epidemic.”³

The report, prepared by the Thai AIDS Treatment Action Group (TTAG) and Human Rights Watch (HRW), found that many health care providers either do not know or do not follow HIV/AIDS treatment guidelines and continue to deny antiretroviral treatment (ART) to people who need it based on their status as people who use drugs, even if they are in methadone treatment programs.

The report also found that people who use drugs and who do receive ART are unlikely to tell their physicians about their drug use, or to seek information about drug dependence treatment from their physician, out of fear of reprisal. This fear is not unfounded: The report confirms that many public hospitals and clinics in Thailand share information about drug use with law enforcement, both as a matter of policy and in practice.

The government has provided minimal support for harm reduction services for people who use drugs, notwithstanding the proven effectiveness of such services. Thailand’s limited harm reduction programs are seriously undermined by the government’s ongoing, repressive anti-drug campaigns.

Police regularly interfere with the efforts of people who use drugs to seek health services by harassing clients outside of drug treatment centres and by using the possession of sterile syringes, or presence at a methadone clinic, as a basis for laying drug charges.

During research for the report, a police superintendent in Chiang Mai — the site of many extrajudicial executions during the 2003 “war on drugs” — acknowledged that his office maintained a blacklist of suspected people who use drugs and said that possession of clean needles, although legal, was a legal basis for a police officer to question someone on the blacklist.

The deputy secretary general of the Office of the Narcotics Control Board (the coordinating and policy-making bureau for drug control efforts) confirmed that despite the full legality of syringe possession, in practice clean syringes are sometimes taken by police officers as evidence of drug use.

Peer outreach workers play a key role in ensuring access to lifesaving information and services to people who use drugs. But the report found that routine harassment and arrest by police (sometimes at or near methadone clinics), as well as the lasting effects of the drug war, created major obstacles to outreach work. In turn, the harassment of people who use drugs directly impacts the effectiveness of peer outreach programs.

Many Thais who use drugs spend time in pre-trial detention or prison, often cycling in and out of government detention facilities. According to the report, incarcerated people who use drugs have an even harder time obtaining needed services and prevention care.

The research found that ART is available only on an extremely limited basis to prisoners; and further, that the government has failed to take measures to ensure that fundamental services (medical care, harm reduction, drug dependence treatment, psychosocial support) are linked in the

general community, or with services provided on entry to, or exit from, prison.

In June 2007, Thailand introduced its 2007-2011 National AIDS Plan. The plan recognizes its failures in combating HIV and AIDS among people who use drugs and among prisoners, and proposes to scale up efforts to ensure that they can access to HIV and AIDS prevention, care and treatment services.⁴

This commitment follows a number of other public undertakings that have, to date, remained unfulfilled. In its report to the UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2006, the Thai government acknowledged that “little has been done to address specific challenges” of providing HIV testing and counselling, care and support and ART for people who use drugs, and recommended that the government “act quickly” to scale up outreach, related harm reduction, ART and other HIV/AIDS services for people who use drugs.⁵

At UNGASS itself, the government pledged to promote and implement HIV prevention and harm reduction services for all those who need them; to increase access to methadone maintenance; and to enable and empower people who use drugs to take measures to reduce unsafe injecting practices and to enter treatment programs.⁶

These commitments must be followed by prompt and forceful action to address the systematic violations of human rights against people who use drugs and against prisoners by law enforcement and health care providers, as well as the widespread prejudices by government and civil society against them. If Thailand fails to take such steps, it will con-

tinue to encourage the course of its epidemic among some of Thailand's most marginalized people.

– *Rebecca Schleifer, Paisan Suwannawong
and Karyn Kaplan*

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TTAG, and Karyn Kaplan is the director of policy and development at TTAG.

¹ TTAG and HRW, *Deadly Denial: Barriers to HIV Treatment for People Who Use Drugs in Thailand*, 2007. Available via www.hrw.org.

² Thailand Ministry of Public Health and WHO Regional Office for South-East Asia (WHO-SEARO), *External Review of the Health Sector Response to HIV/AIDS in Thailand*, 2005, pp. 10, 26.

³ Thailand Ministry of Public Health, *Towards Universal Access by 2010: Thailand National HIV and AIDS Program*, 2006.

⁴ Thailand Ministry of Public Health, Department of Disease Control, *Book 1: National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011: Key Contents*, National Committee for HIV and AIDS Prevention and Alleviation, 2007, pp. 8, 11–15, 19, 28, 30.

⁵ Thailand, *Follow-Up to the Declaration of Commitment on HIV/AIDS (UNGASS) Country Report*, 2006, p. 19.

⁶ Thailand Ministry of Public Health, *Towards Universal Access by 2010: Thailand National HIV and AIDS Program*, 2006.

Botswana and Swaziland: Report links violations of women's rights to HIV

In May 2007, Physicians for Human Rights (PHR) released a report investigating the links between discriminatory views against women in Botswana and Swaziland and sexual risk-taking and, in turn, extremely high HIV prevalence in those countries. The report also examines the role of women's lack of political and economic power in those countries, and the connection to HIV infection.¹

According to UNAIDS, HIV prevalence of 39 percent was reported among young women (15–24 years) attending antenatal clinics in Swaziland, while HIV prevalence rates among women in Botswana were as high as 47 percent in some districts.²

The report outlines the results of a population-based study designed to assess factors contributing to HIV infection. The study was conducted in 2004 and 2005 with 1268 respondents in Botswana and 788 participants in Swaziland. In addition, 24 people living with HIV/AIDS in Botswana and 58 people living with HIV/AIDS in Swaziland were inter-

viewed, along with key informants in both countries.³

According to the report, four key factors were found to contribute to women's vulnerability to HIV:

- women's lack of control over sexual decision-making (including the decision to use a condom) and multiple sexual partners by both women and men;
- the prevalence of HIV-related stigma and discrimination (which hinders testing and disclosure of status);
- gender-discriminatory beliefs, which were associated with sexual risk-taking; and

- a failure of traditional and government leadership to promote the equality, autonomy and economic independence of women.

In interviews, persons living with HIV/AIDS noted that women's dependence on men creates greater vulnerability to HIV. Testimony revealed that women's lesser status in both countries fosters ongoing harm to women even after they become infected, and increases the precariousness of their ability to meet basic needs for food, shelter and transport.

The interviews revealed that many HIV-positive women are forced to engage in risky sex with men in

exchange for food for themselves and their children. As one interviewee put it, “Woman are having sex because they are hungry. If you give them food, they would not need to have sex to eat.”⁴

The reports details inequalities between men and women reflected in the laws of both countries. For instance, intimate partner and marital rape are not criminalized in Botswana. Under customary law, women lack independent legal capacity and are subjected to the guardianship of their fathers, brothers, uncles or husbands. In Swaziland, women are assigned legal status equivalent to that of a minor child upon marriage. Domestic violence is not criminalized, and marital rape is excluded from domestic general assault and rape laws.⁵

Interviewees indicated that women in Botswana and Swaziland frequently do not have the option to make decisions about having sex due to their lesser legal status. According to one HIV-positive interviewee, “Here in Swaziland, the husband is the one that bosses you around so there is nothing you can do without him. My rights lie with my husband. He decides whether

we use condoms. I don’t have a choice about prevention.”⁶

The report offers comprehensive recommendations. The recommendations focus on increasing the financial self-sufficiency of women, providing food aid in the short term, enacting women’s rights and protection legislation in both countries, shoring up governmental institutions that address women’s issues, and offering financial support for local women’s and AIDS NGOs.

The report encourages the U.S. to institute changes to programs administered by USAID to clearly identify gender inequality as a key issue propelling the AIDS pandemic, and to require that a gender focus be incorporated into PEPFAR-funded prevention, treatment and care programs.

The U.S. is also encouraged to increase PEPFAR’s financial investment in programs that promote women’s and girls’ access to income and other resources, support primary and secondary education for girls, and promote the strengthening of women’s legal rights. Finally, the report says that U.S. and country programs should only undertake mass HIV test-

ing where confidentiality and other rights are respected.

“National leaders, with the assistance of foreign donors and others, are obligated under international law to change the inequitable social, legal, and economic conditions of women’s lives which facilitate HIV transmission and impede testing, care and treatment,” said PHR’s Senior Research Associate Karen Leiter, lead investigator of the study.⁷

– Kate Krauss

Kate Krauss (kkrauss@phrusa.org) is media coordinator for PHR’s Health Action AIDS Campaign.

¹ Physicians for Human Rights, *Epidemic of Inequality: Women’s Rights and HIV/AIDS in Botswana & Swaziland: An Evidence-based Report on Gender Inequity, Stigma and Discrimination*, May 2007. Available via <http://physiciansforhumanrights.org>.

² UNAIDS/WHO, *AIDS Epidemic Update: December 2006*, pp 13–14.

³ The study on which the report is based was designed and implemented by PHR and two local field partners: Members of the Faculty of Nursing at the University of Botswana in Gaborone, Botswana; and Women and Law in Southern Africa Research Trust (WLSA) in Mbabane, Swaziland.

⁴ Physicians at p. 11

⁵ Ibid., pp 28–38 and 74–86.

⁶ Ibid. at p. 12.

⁷ Personal conversation with the author, April 2007.

UN agencies issue new guidelines for HIV testing

In May 2007, UNAIDS and the World Health Organization (WHO) issued *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (the Guidelines).¹ The Guidelines position health care provider-initiated testing and counselling (PITC) as a tool to increase the uptake of HIV testing and recommend an “opt-out” approach to PITC, where individuals must specifically decline the HIV test if they do not want it performed.

The Guidelines recommend this approach to HIV testing for all patients, irrespective of epidemic setting, whose clinical presentation might result from underlying HIV infection; as a standard part of medical care for all patients attending health facilities

in generalized HIV epidemics; and more selectively in concentrated and low-level epidemics.

The Guidelines recognize, however, that in the case of vulnerable populations or low-level epidemics, an opt-in approach, where the patient must affirmatively agree to the test, may be more appropriate than the opt-out approach.²

The Guidelines recommend that, regardless of whether an opt-out or opt-in approach is chosen, pre-test information and counselling should be provided. However, they submit that two elements of pre-test counselling under the Voluntary Counselling and Testing (VCT) model — risk assessment and prevention counselling — can be moved to post-test counselling in a PITC setting. The Guidelines justify this approach on the basis that health care providers may be pressed for time. The Guidelines also suggest that, depending on local conditions, healthcare providers consider counselling patients pre-test in group health information talks.³

Nevertheless, the Guidelines maintain that pre-test counselling must meet certain minimum standards, such as explaining to patients why testing is recommended, what the benefits and risks of testing are, and that treatment is available regardless of the outcome of the test.⁴ The Guidelines state that verbal consent to HIV testing suffices — i.e., that written consent is not required.⁵

The Guidelines emphasize that post-test counselling is integral to HIV testing. They recommend, in the case of positive test results, providing emotional support in addition to advising the patient of treatment options and methods to prevent transmission.⁶ In the case of negative test

results, the Guidelines suggest advising higher-risk individuals to undertake repeat testing during subsequent visits to health centres.⁷

According to the Guidelines, PITC should be accompanied by adequate HIV-related prevention, treatment, care and support, as well as concurrent social, policy and legal efforts, to ensure an environment responsive to the needs of people living with, or at risk of contracting, HIV/AIDS.⁸ Although access to anti-retroviral treatment (ART) is not an absolute pre-requisite for PITC, the Guidelines submit that PITC efforts must be accompanied by a reasonable expectation of access to ART “within the framework of a national plan to achieve universal access to [ART] for all who need it.”⁹

The Guidelines differ in some important respects from recommendations made by the UNAIDS Reference Group on HIV and Human Rights (the Reference Group) during the drafting process.¹⁰ In September 2007, following the issuance of the official Guidelines by UNAIDS and WHO, the Reference Group issued a statement recognizing the efficacy of the PITC model in increasing the quantity of HIV tests administered.¹¹ However, the Reference Group said, an opt-in approach is preferable to an opt-out approach, in order to ensure that consent is voluntary and that the security of person is respected.¹²

The Reference Group recommended that in future UNAIDS and WHO, together with health facilities undertaking HIV testing, develop and adopt a model code of conduct for practitioners of HIV testing and counselling, whether the opt-out or opt-in approach is adopted.¹³ This would supplement the Guidelines’ existing plan for monitoring and

evaluating the implementation of the PITC model.

— Madhavi Swamy

Madhavi Swamy is a student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

See R. Jürgens, “Increasing access to HIV testing and counselling while respecting human rights” in the Special Section of this issue for a discussion of the response from the Open Society Institute to the UNAIDS and WHO Guidelines.

¹ UNAIDS and WHO, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities*, May 2007. Available via www.unaids.org

² *Ibid.*, p. 5.

³ *Ibid.*, p.36.

⁴ *Ibid.*, p.9.

⁵ *Ibid.*, p.36.

⁶ *Ibid.*, pp.10, 39.

⁷ *Ibid.*, p.41.

⁸ *Ibid.*, p.30.

⁹ *Ibid.* at p.8

¹⁰ The Reference Group was set up in 2002 to advise UNAIDS on matters relating to HIV and human rights, and comprises advocates, jurists, ethicists, people living with HIV, and people working in NGOs, academia and the community sector. In January, 2007, before the Guidelines were finalized, the Reference Group issued *Comments on the Draft Document: Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities*, January 2007. At <http://data.unaids.org/pub/Guidelines/2007/RGcomments-PITCguidance.pdf>.

¹¹ UNAIDS Reference Group on HIV and Human Rights, *Statement and Recommendations on Scaling Up HIV Testing and Counselling*, September 2007. At http://data.unaids.org/pub/ExternalDocument/2007/20070905_rghr_statement_testing_en.pdf.

¹² *Ibid.*, p. 3.

¹³ *Ibid.*, p. 4.

In brief

Singapore retains Penal Code provision criminalizing sex between men

On 23 October 2007, the government of Singapore struck down a provision of its *Penal Code* prohibiting oral and anal sex between consenting heterosexual adults, but retained a provision criminalizing sex between men.¹

Member of Parliament Siew Kum Hong supported the repeal of the latter provision by sponsoring a public petition which delivered 2341 signatures to Parliament from a broad cross-section of Singaporeans. A three-day online campaign initiated by a Singaporean activist garnered a further 8000 signatures from around the world.

In addition, the International Gay and Lesbian Human Rights Commission wrote to Singaporean Prime Minister Lee Hsien Loong describing how retaining the provision criminalizing sex between men would relegate lesbian, gay, bisexual and transgender (LGBT) people to the status of second-class citizens, with no protection from discrimination and no rights as sexual minorities.

Opponents of the repeal argued that gay men are not a legitimate minority community in Singapore and that sex between men is not a “victimless crime because oral and anal sex spread HIV and AIDS.”²

The Prime Minister contended that repealing the Penal Code provision criminalizing gay sex would ultimately not provide LGBT people acceptance in Singaporean society since

the majority of Singaporeans are opposed to “granting [gay individuals the] same rights as heterosexual men and women.” In his view, repealing the provision would polarize the nation and it was preferable for “gay rights” to evolve gradually.³

– Sandra Ka Hon Chu

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APEC: Members adopt broad HIV workplace guidelines

In September 2007, at the 15th Asia Pacific Economic Cooperation (APEC) Economic Leaders Meeting in Sydney, Australia, the 21 assembled leaders endorsed wide-ranging guidelines on HIV in the workplace for APEC member economies.⁴

The guidelines are based on two publications from the International Labour Organization (ILO): the *Code of Practice on HIV/AIDS and the World of Work* and *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work*. The guidelines also address issues not covered in the Code such as gender, children who work, and migrants and mobile populations.

The guidelines are intended for the governments of APEC member economies, public and private employers, business associations, workers, trade unions and other worker organizations, organizations of people living with HIV, and all other groups with

responsibilities and activities related to HIV and AIDS in workplace settings. The guidelines are an example of a “soft law” approach to policy development.⁵

Development of the guidelines was supported by Health Canada during its period as Chair of the APEC Health Task Force. The Health Task Force will work closely with organizations such as the ILO and the Asia Pacific Business Coalition on AIDS to ensure the guidelines are disseminated and promoted in APEC member economies from 2008 onwards.

– David Patterson

David Patterson (david.patterson@videotron.ca) is an HIV, law and human rights consultant based in Montreal, Canada.

¹ International Gay and Lesbian Human Rights Commission, “Singapore update: law against homosexuals to remain,” 24 October 2007. Available via www.iglhrc.org.

² Ibid.

³ Ibid.

⁴ Available at www.apec.org. Click on “APEC Groups” – “SOM Special Groups” – “Health Task Force”, and look for “Current Activities.”

⁵ See also D. Patterson, “Use of soft law to address HIV/AIDS in Southeast Asia” in this issue.

HIV/AIDS IN THE COURTS – CANADA

This section presents a summary of Canadian court cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on criminal and civil cases. The coverage aims to be as complete as possible, and is based on searches of Canadian electronic legal databases and on reports in Canadian media. Readers are invited to bring cases to the attention of Sandra Ka Hon Chu, Editor of this section, at schu@aidslaw.ca. All of the articles in this section were written by Ms Chu.

Senior administrators of blood system acquitted of criminal charges in tainted blood tragedy

On 1 October 2007, the Ontario Superior Court of Justice acquitted senior administrators of the blood system on charges of criminal negligence causing bodily harm and common nuisance related to the infection of haemophiliacs with HIV in 1986 and 1987.¹ The victims, whose names were withheld due to a publication ban, had all used HT Factorate, a blood coagulation product used to treat haemophilia and manufactured by Armour, a pharmaceutical company based in New Jersey.

Four counts of criminal negligence and one count of common nuisance had been brought against Armour, one of its senior officers, the Director of the Bureau of Biologics in Canada, the Chief of the Blood Products Division and the National Director

of the Blood Products Services of the Canadian Red Cross, who had been involved in the manufacture, licensing and distribution of HT Factorate.

Each count of criminal negligence was identical but for the time period covered (from seven to 18 years)

and the identity of the four alleged victims, three of whom had died of AIDS related illnesses. The nuisance charge covered a period of over three years and involved victims in Ontario, British Columbia, Manitoba and Alberta. Armour had also been

charged with failing to report a product deficiency under the *Food and Drug Act*.²

HT Factorate was heat-treated to kill pathogens such as HIV but the process did not work. The criminal charges alleged that the accused knew the product was potentially tainted and failed to act to prevent its distribution and to warn recipients of the danger.

A conviction of criminal negligence required the Crown to demonstrate that the accused showed a wanton and reckless disregard for the lives and safety of users. On the common nuisance charge, the Crown needed to show that their actions deviated from what a reasonable person would do in the circumstances.

After providing a summary of the evidence, including the development of scientific knowledge about HIV,

the treatment of haemophilia, and the series of events up to and beyond the HIV infections in question, Madam Justice Benotto held that the “evidence taken as a whole establishes a thoughtful, careful and considered course of conduct” on the part of the accused.

Furthermore, she said, the “allegations of criminal conduct on the part of these men and this corporation were not only unsupported by the evidence, they were disproved.” In Madam Justice Benotto’s view, the medical information available at the time confirmed that screening blood plasma for HIV was an additional level of security and that a withdrawal of HT Factorate was unnecessary. She concluded that the accused had acted professionally and reasonably in the face of a public health problem.

Despite his acquittal, Dr. Perrault, the National Director of the Blood Products Services of the Canadian Red Cross, faces six additional criminal charges of common nuisance in a case scheduled to begin this year in Hamilton. Perrault is alleged to have risked public health by neglecting to properly test donors, implement testing for blood-borne viruses and warn the public of danger regarding hepatitis C and HIV.

¹ *R. v. Armour Pharmaceutical Co.*, [2007] O.J. No. 3733 (Q.L.).

² In May 2005, the Canadian Red Cross pled guilty to distributing a contaminated drug, a violation of the *Food and Drug Act*. It was fined \$5,000 for its role in the HIV infections, the maximum penalty for the charge. The Red Cross also agreed to give \$1.5 million to the University of Ottawa for a research endowment fund and a scholarship for family members of those affected.

Federal Court says Crown not liable for HIV-positive inmate’s illness

In March 2007, the Federal Court held that Brian Donald Hickey, an HIV-positive federal penitentiary inmate, failed to establish on a balance of probabilities a causal link between the over-prescription of an antiretroviral medication (ART) by prison health care employees and the development of peripheral sensory neuropathy, a painful form of nerve damage.¹ The Court also held that the Crown was not liable for the harm caused by the negligence of an independent contracting physician. As a result, Hickey’s action for negligence against the Crown was dismissed.

Hickey first discovered he was HIV-positive in June 1996, while he was incarcerated at the Matsqui Institution in British Columbia and was referred

to an outside physician in October and November 1996 to receive medical care and treatment from an HIV specialist. The HIV specialist rec-

ommended that Hickey commence a course of ART.

The prison’s institutional physician agreed, but erred in the amount he

indicated should be administered to Hickey. Hickey took the incorrect dosage between November 1996 and January 1997. Hickey developed peripheral neuropathy shortly after the administration of the ART; his symptoms continued after he stopped taking the medication and persisted at the time of the trial.

Madam Justice Hansen considered whether Hickey was precluded from suing Correctional Services Canada (CSC) in light of a previous Federal Court decision holding that the Crown was not liable for the harm caused by the negligence of an independent contracting dentist to an inmate who was incarcerated in a correctional facility operated by the CSC.²

Madam Justice Hansen found that since the prescribing doctor in the federal penitentiary was an independent contractor, the case was not distinguishable from the previous Federal Court decision and, therefore, no action could be taken against the Crown for his negligence. Although the principles articulated in the previous Federal Court decision were determinative of the outcome of the case, Madam Justice Hansen ruled that it was nonetheless “important from the Plaintiff’s perspective to have the negligence claim considered on its merits.”

While it was established during trial that peripheral neuropathy could be attributed to either the ART or to Hickey’s HIV infection, Madam Justice Hansen held that Hickey’s peripheral neuropathy was more likely related to his HIV, given the

limited period he took the incorrect dosage, and given that neuropathy caused by HIV takes a longer period of time to resolve than neuropathy caused by medication.

Madam Justice Hansen found the testimony of the Crown’s expert medical witness persuasive concerning the relatively short period of time for damage arising from the ART to be repaired once the medication is stopped. In contrast, suppression of the HIV virus to permit the body to repair the cell damage underlying peripheral neuropathy would be a much longer process.

Hickey also argued that CSC has a legislated duty to provide health care to the inmates in accordance with recognized community standards; that since CSC is in a fiduciary relationship with the inmates, this imposes a higher standard of care on CSC; and the CSC should be held liable for torts about which it knows or should have been aware.

In Madam Justice Hansen’s view, there was insufficient evidence — i.e. concerning whether there were staff pharmacists at the relevant time who may have detected the error; concerning whether checks were in place to avoid recording errors; and concerning the level of knowledge or the expected level of knowledge of the medical staff having regard to what was known about antiretroviral drugs — to support the argument.

At trial, Hickey advanced a new argument that had not been previously disclosed to opposing counsel centring on section 74 of the *Corrections and Conditional Release*

Act. This provision stipulates that CSC “shall provide inmates with the opportunity to contribute to decisions of the Service affecting the inmate population as a whole, or affecting a group within the inmate population, except decisions relating to security matters.”

Hickey’s counsel argued that the consequence of contracting physicians without first consulting with inmates is that as between the inmate and CSC, the institutional physician is to be considered a CSC servant, agent or employee, and the Crown should therefore not be shielded from liability. Madam Justice Hansen held that since the argument advanced did not arise from the negligence claim or Hickey’s pleadings, a challenge of this nature ought to be advanced by way of judicial review, and so the Court ought not to consider the argument further.

¹ *R v. Hickey*, [2007] F.C.J. No. 345 (QL).

² *Oswald v. Canada*, [1997] F.C.J. No. 203 (QL).

Criminal law and HIV transmission or exposure: four new cases

Two years imprisonment for woman who “ought to have known” that she was HIV-positive *

On 16 January 2007, the Ontario Superior Court of Justice convicted Suwalee Iamkhong, a landed immigrant from Thailand, of criminal negligence causing bodily harm and aggravated assault for knowingly infecting her husband with HIV through unprotected sex.¹

Prior to coming to Canada, Iamkhong worked as an exotic dancer in Hong Kong, where she tested HIV-positive in 1995. Iamkhong refrained from having sex after she learned of her HIV status. Shortly after, Iamkhong moved to Canada to work as an exotic dancer in a Toronto club and underwent various medical tests before beginning her employment.

Iamkhong testified that she believed an HIV test was among the medical tests she underwent. When her employer indicated her tests results were “okay,” Iamkhong understood this to mean that she did not have HIV.

Iamkhong subsequently began work as an exotic dancer in the Toronto club where she met her husband, who she married in 1997. In 2004, Iamkhong became sick with meningitis and tested HIV-positive when she sought treatment. Iamkhong divulged her HIV status to her husband who also tested HIV-positive. Charges were laid against Iamkhong in May 2004 and her trial commenced in October 2006.

Although Iamkhong claimed she did not know that she was HIV-positive, Justice Todd Ducharme ruled that she ought to have known, and that a “reasonable person” would have sought further testing and information.

On 16 August 2007, Justice Ducharme sentenced Iamkhong to two years’ imprisonment. Justice Ducharme also rejected Iamkhong’s application for a stay of proceedings based on unreasonable delay, holding that much of the total delay of 29 months between the date of her arrest and the opening of the trial had been the responsibility of the defence.

Crown drops charges against woman for allegedly failing to disclose her HIV status

In May 2007, the Crown dropped an aggravated sexual assault charge against a woman for allegedly failing to disclose her HIV-positive status to a man she had sex with.² Jennifer Murphy had maintained the man was fully aware of her health status and that a condom was used. Two witnesses, who Murphy had ensured were present when she disclosed her HIV status to the man, had been prepared to testify on her behalf.

In 2005, Murphy had been convicted of sexual assault and sentenced to one year of house arrest and three years probation for failing to tell a soldier from the Canadian Forces Base Borden in Ontario with whom she had sex that she was HIV-positive.

At the time, the Department of National Defence issued a warning to Canadian Forces personnel in Canada, encouraging them to see a doctor if they had had sexual contact with Murphy, and circulated claims of her “lewd behaviour.”

Although the latest charge against Murphy was ultimately dropped, the decision to charge her in the first place, despite the exculpatory evidence, was ostensibly facilitated by the stigmatization arising from her first conviction. At the time, various media sources described Murphy as “preying upon men in the married quarters and in the men’s barracks at the Ontario base,”³ while investigators alleged she frequented the single-living quarters on the base, making “direct sexual advances to male residents.”⁴

Man accused of failing to disclose HIV-positive status convicted of 15 counts of aggravated sexual assault

Carl Leone pled guilty to 15 counts of aggravated sexual assault for having unprotected sex with 20 women between 1997 and 2004 without disclosing his HIV status. Leone originally faced 20 counts of aggravated sexual assault. Leone’s plea bargain was announced on 27 April 2007 in the Ontario Superior Court of Justice, eight weeks into his trial and just before the first of his victims was scheduled to testify.⁵

* A December 2008 update to this article is available at [http://www.aidslaw.ca/EN/12\(2-3\)_update-EN.pdf](http://www.aidslaw.ca/EN/12(2-3)_update-EN.pdf)

Five of the 20 women had tested positive for HIV since having sex with Leone.⁶ A court-imposed publication ban prevented disclosure of the victims' names or any other identifying information.

Leone was arrested by Windsor police in June 2004, seven years after he had tested HIV-positive at the Windsor Essex County Health Unit. The Crown and Leone's counsel indicated there would not be a joint submission at the sentencing, and Leone was ordered to undergo a psychiatric evaluation to determine whether he should be declared a dangerous offender.

Leone's sentencing was adjourned to December 2007 to allow the filing of the psychiatrist's report, at which time a hearing on the Crown's dangerous offender application would proceed. If Leone is declared a dangerous offender, he could face an indefinite prison term subject to review every seven years. The Crown has indicated that if it does not succeed with the application, it would seek to have Leone designated a long-term offender, which status would subject Leone to a lengthy period of supervision after his eventual release from prison.⁷

Thirty-month sentence for three counts of aggravated sexual assault

In April 2007, an HIV-positive former bodyguard from the Democratic Republic of the Congo pled guilty to three counts of aggravated sexual assault for having unprotected sex with three Sudbury women between September and December 2005 without disclosing his HIV status.⁸ Fidel Mombo MacKay, who had been imprisoned in Sudbury since December 2005, was sentenced to an additional 30 months imprisonment.

MacKay learned he was HIV-positive while receiving medical treatment for injuries suffered in a car accident in November 2002. In December 2005, the Greater Sudbury Police arrested MacKay in relation to a Canada-wide warrant issued by the Saskatoon police against MacKay for having unprotected sex without informing his partner of his HIV status. MacKay was arrested while he was in bed with one of the victims.

After his arrest, police released MacKay's picture to the media, urging individuals who had sex with him to seek medical advice and to contact

them. This resulted in two more Sudbury women coming forward. Of the three women, one tested positive for HIV after having unprotected sex with MacKay.

In addition to his prison term, MacKay's name was entered in the federal government's national registry of sex offenders, his DNA was placed in the federal DNA databank, and he was prohibited from possessing weapons for 10 years. At the time of his sentencing, MacKay was expected to be returned to Saskatchewan to respond to the original charges that resulted in the Canada-wide warrant.

¹ P. Small, "HIV-positive stripper infected husband, court hears," *The Toronto Star* (on-line edition), 5 June 2007.

² "Crown withdraws case against woman charged with spreading HIV," *The Telegram*, 15 May 2007.

³ S. Taylor, "Military's concern over HIV on base legitimate," *Esprit de Corps* (on-line edition), 27 March 2005.

⁴ "Woman charged with HIV assault denied bail," *CTV News* (online), 30 March 2005.

⁵ D. Schmidt, "Plea ends HIV trial; Leone admits guilt in 15 sex assaults," *The Windsor Star*, 28 April 2007, p. A1.

⁶ D. Schmidt, "Positive HIV test drove Leone to tears, trial told," *The Windsor Star*, 17 April 2007, p. A3.

⁷ D. Lajoie, "Leone sentencing delayed; report needed before deciding if he should be deemed a dangerous offender," *The Windsor Star*, 25 July 2007, p. A5.

⁸ B. Vaillancourt, "Man with HIV jailed for having sex with 3 women," *The Sudbury Star*, 12 April 2007, p. A1.

In brief

Application for judicial review allowed in case of HIV-positive refugee claimant

On 2 August 2007, the Federal Court allowed M.O.O.'s application for

judicial review of a decision of the Refugee Protection Division of the Immigration and Refugee Board (IRB). The IRB had concluded that O.O. and her four children were not Convention refugees or persons in need of protection under the

*Immigration and Refugee Protection Act.*¹

In her application, O.O. claimed that her HIV-positive status, among other factors including her ethnic Acholi identity, would subject her to discrimination in Uganda. The

IRB responded by noting that the Ugandan government had taken measures to fight AIDS and that the availability of health care, while imperfect and expensive, undermined the applicant's claim of persecution on this ground.

In its decision, the IRB did not refer to written evidence regarding O.O.'s possible persecution in Uganda, including a statement from a purported expert in human rights violations in Uganda claiming that O.O. would be perceived by the Ugandan government as a political opponent and that she would be persecuted.

The Federal Court ruled that while it is open to the IRB to conclude that O.O.'s claim was not credible on most issues, the IRB has a duty to identify relevant evidence that is directly contradictory to its conclusion, and explain why it decided that such evidence is not credible. The Court decided that because the IRB had failed to do so, the IRB decision should be set aside and the matter referred to a differently constituted IRB panel for re-determination.

HIV/AIDS educator's application to stop deportation rejected

On 21 September 2007, the Federal Court denied an application for stay of removal for David Nyachieo, Electa Nyachieo and their three children.²

The principal applicant, David Nyachieo, migrated from Kenya to the United States in 1999 and lived there with his family until 2004, when most of the Nyachieo family entered Canada. At the time, the applicants made refugee claims alleging persecution in Kenya from

a member of the Kenyan Parliament. They claimed they were threatened because David Nyachieo made efforts to raise awareness about human rights, HIV/AIDS and female genital mutilation in the community.

The applicants' initial claims for refugee protection were rejected by the Refugee Protection Division of the Immigration and Refugee Board (IRB), which found a lack of fear or risk for the applicants and the absence of grounds to believe that, if removed to Kenya, they would be in danger. The applicants sought a judicial review of that ruling, which was dismissed.

A subsequent motion for a Pre-Removal Risk Assessment (PRRA) was rejected in January 2007, and an application to have the applicants' refugee claim re-opened on humanitarian and compassionate grounds was denied in August 2007. The applicants filed a new and pending application to judicially review the last decision.

On 5 September 2007, an agent of Canada Border Services Agency (CBSA) made the decision to deport the family, on the basis that no exceptional circumstances existed which would justify a deferral. The applicants argued that a stay of removal should be granted pending the disposition of their humanitarian and compassionate application for judicial review.

The Federal Court held that the refusal to defer the removal order was reasonable, and that the applicants' claim of irreparable harm attributed to the disruption of the applicant children's studies had not been proven. Furthermore, the Court held that the fact that a person has an outstanding application for humanitarian and compassionate relief is not

a sufficient ground to defer removal, since the application could be pursued outside Canada.

Federal Court rejects motion to stop deportation of HIV-positive woman to Zambia

On 28 August 2007, the Federal Court dismissed a motion by Rabecca Dia for a stay of removal scheduled for 31 August 2007.³ Dia, who is HIV-positive, left Zambia for Canada in 2003 to escape her alcoholic and abusive husband, who is also a polygamist. Dia's initial claim for refugee status was rejected on the basis that she was not "credible," which the Court did not elaborate upon. A subsequent Pre-Removal Risk Assessment (PRRA) was negative, and a removal order was issued against her.

In her application for a stay of removal, Dia claimed that her recent participation in a movie which was highly critical of Islamic polygamy in Zambia would come to the attention of both her husband and the Zambian authorities. Although Federal Court Justice Harrington did not indicate in his decision how Dia argued this would ultimately affect her, he held that the PRRA officer was entitled to give the movie "short shrift" as the evidence did not demonstrate that Dia would be subject to risk of persecution by the authorities for speaking out against polygamy.

Nor did Justice Harrington indicate how Dia argued her HIV status would impact her in Zambia. Nevertheless, he stressed that although the PRRA officer did not specifically deal with Dia's HIV status, under section 97 of the *Immigration and Refugee*

Protection Act, a risk caused by an inability of a country to provide adequate health or medical care does not constitute a risk to life or a risk of cruel and unusual treatment or punishment. Justice Harrington ruled that, in any case, HIV treatment is available in Zambia, and Dia would be returning to Lusaka (the capital city), where HIV treatment is more readily available.

Court of Appeal rules that HIV status is not a reason for denying contact between child and parent

On 12 February 2007, the Court of Appeal of Alberta allowed the appeal of a decision dismissing the appellant's application for a contact order granting him access to a three-and-a-half-year-old girl, to whom the appellant acted as a parent for the three years immediately following her birth.⁴

The appellant had sought a contact order against the biological parents of the child. The appellant had been in a relationship with the male respondent for six and a half years, during which time they befriended the female respondent who was also in a long term same-sex relationship.

The parties decided that the female respondent would attempt to birth children, one child for each couple, utilizing assisted conception, with the male respondent donating the sperm. The child was born in May 2003, and lived with the appellant and the male respondent in their home and as a family until the two men separated in June 2006.

Since the separation, the respondents had refused to allow the appel-

lant to have contact with the child, citing the appellant's HIV-positive status as one reason for denying contact. In August 2006, the appellant applied unsuccessfully under Alberta's *Family Law Act* (FLA) for a contact order granting him access to the child. The appellant had submitted before the chambers judge that he was the parent of the child or stood in the place of a parent in accordance with Section 48 of the FLA.

While the chambers judge recognized the significant relationship between the appellant and the child, he determined that the respondents' wishes as guardians were entitled to considerable weight. The judge further determined that the appellant had not shown how contact with the child would contribute to her best interests, given that her parents had decided otherwise.

In the Court of Appeal's view, the evidence established that there were three adults who had significant relationships with the child and that the appellant stood in the place of a parent to the child. Furthermore, the Court said, the reasons given for the denial of contact by the two respondents, including the appellant's HIV-positive status, were an inadequate foundation upon which to refuse the contact order.

The Court stated that the trial judge had failed to take into account the benefit derived from additional affection from someone who has been directly involved in the child's parenting since birth, as well as the potential for emotional harm occasioned by the sudden withdrawal of parental attention and support. The Court ruled that the appellant was therefore entitled to reasonable access to the child.

Settlement approved in case of improperly sterilized medical equipment

On 16 August 2007, the Trial Division of the Newfoundland and Labrador Supreme Court approved a settlement agreement in a class action on behalf of 333 patients and spouses of patients of a medical clinic where improperly sterilized equipment was used.⁵

The hospital board responsible for the clinic realized gynaecological equipment was not being properly sterilized in March 2003. It corrected the problem and issued a press release notifying the public that the problem had been discovered and corrected. The board also sent letters to patients requesting them to undergo medical testing at the hospital to determine whether they had contracted HIV, hepatitis B, hepatitis C, chlamydia or gonorrhoea.

While none of the patients sustained infections, the plaintiffs alleged that the board had breached its duty of care and violated patients' privacy by conducting medical testing in such a manner that the identities of patients became obvious to other patients and thereby known in the small community where they lived. The settlement required the board to pay compensation of \$450 to uninfected patients and \$100 to uninfected spouses, and to offer a public apology. The agreement also imposed measures on the hospital board to ensure improper sterilization did not reoccur.

The Court held that the test to be applied in approving settlements of class actions is whether a settlement is fair and reasonable and in the best interests of the class as a whole.

After reviewing the evidence, the Court ruled that the agreement met the goals of class action members, that proceeding to trial might not yield better results and would involve more time and expense, that the class action members had adequately participated in the negotiation of the settlements, and that there was an adequate plan for notifying members of the settlement approval that was in place.

Claimants must establish entitlement to have damages assessed by HIV fund's referee

On 16 March 2007, the Ontario Superior Court of Justice provided directions as to the interpretation and application of its June 2006 order requiring provincial and territorial governments to pay Multi-Provincial/Territorial Assistance Program (MPTAP) benefits to individual claimants to an HIV fund established by the Canadian Red Cross Society.⁶

The MPTAP was established in 1993 by the provinces and territories to provide financial assistance to persons directly infected with HIV through the blood system in Canada.

The Canadian Red Cross Society had also made available a fund of money (the HIV fund) to meet the claims of various groups of persons who had contracted HIV from blood products supplied by the society. The fund was established pursuant to the Canadian Red Cross Society Plan of Arrangement and Compromise (the plan).

A dispute had arisen amongst counsel as to the identity of the HIV claimants who were meant to benefit from the order. The provinces and territories contended that the order was only meant to cover those claimants who had applied to the HIV fund within the timeline required under the plan, whose claim arose as a result of an HIV infection from blood within the meaning of the plan, and who are also entitled to an assessment of damages in accordance with the plan. Counsel for certain claimants argued that an HIV claimant need only have made a claim to the HIV fund in order to qualify under the order.

Justice Blair held that, for the purposes of securing MPTAP benefits, claimants must establish an entitlement to have their damages assessed by the plan's referee. This would require a confirming letter

from counsel for the trustee of the HIV fund stating that claimants are entitled to have damages assessed by the referee, subject to proving that their claims arise as a result of an HIV infection from blood within the meaning of the plan. The latter could be proven by providing the Canadian Blood Agency with the necessary information to allow the agency to confirm that a government program has already accepted that individual's claim for compensation on the basis that he or she was infected with HIV from the Canadian blood supply.

¹ *O.O. v. Canada (Citizenship and Immigration)*, 2007 F.C. 811 (CanLII).

² *Nyachio v. Canada (Minister of Citizenship and Immigration)*, [2007] F.C.J. No. 1216 (QL).

³ *Dia v. Canada (Minister of Public Safety and Emergency Preparedness)*, [2007] F.C.J. No. 1130 (QL).

⁴ *D.W.H. v. D.J.R.*, [2007] A.J. No. 187 (QL).

⁵ *Rideout v. Health Labrador Corp.*, [2007] N.J. No. 292 (QL).

⁶ *Canadian Red Cross Society (Re)*, [2007] O.J. No. 937 (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 Leah Utyasheva, editor of this section, at lutyasheva@aidslaw.ca.

India: Court upholds patent law denying patents for slightly modified versions of existing drugs

In August 2007, the Madras High Court struck down a petition by the Swiss pharmaceutical company Novartis to declare the anti-evergreening provision in Indian patent law invalid.¹ Evergreening is the practice of effectively extending the patent on a drug by filing a new patent for a marginal modification to that drug, such as a change in its shape, dosing range or color.² The Court's decision is critical for global access to essential medicines in the form of affordable generic drugs from India.³

In 2006, Novartis filed a petition with the Madras High Court to strike down Section 3(d) of the *Indian*

Patents Act, 1970, amended by *The Patents (Amendment) Act of 2005* (the Patents Act), which denies pat-

entability to “the mere discovery of a new form of a known substance which does not result in the enhance-

ment of known efficacy of that substance....” Novartis argued that the Patents Act was:

- non-compliant with India’s international obligations under the agreement on *Trade Related Aspects of Intellectual Property Rights* (TRIPS) of the World Trade Organisation (WTO), which India signed in 1995; and
- illogical and vague, and thus could lead to the arbitrary exercise of power by the Patent Controller, offending the equality provision in the Indian Constitution.⁴

In response to Novartis’ claim that Section 3(d) takes away the right to have an invention patented, which is guaranteed under Section 27 of the TRIPS agreement, the Court ruled that it did not have jurisdiction to decide this question, since it could not override the dispute resolution mechanism of the WTO, which is fixed in the TRIPS agreement.⁵

In relation to the second claim, Novartis contended that, given that Section 3(d) grants a patent to a new form of a known substance only when the latter results in the enhancement of the known efficacy of that substance, the Indian Parliament ought to have provided guidance as to what constitutes “efficacy” or “enhanced efficacy” in this provision, since otherwise it places wide discretion in the hands of the Patent Controller.

The Court, defining efficacy in this instance to mean “therapeutic efficacy,” responded that “[P]arliament is not an expert ... [and] always thinks it wise to use only general expressions in the Statute, leaving it to the Court to interpret it depending upon

the context in which it is used and the facts that are available in each case.”

The Court added that both the Patent Controller and the patent applicant are further aided by the Explanation attached to Section 3(d), which is capable of “being worked out and understood in a normal manner” by both parties, and which gives guidance as to which forms of a substance shall be considered the same substance unless a significant improvement in efficacy is shown. The Court concluded that, especially with regard to laws dealing with economic issues, such as the Patents Act, it should give large latitude to the Legislature.⁶

While Novartis has lost this case (and has decided not to appeal), it might nevertheless challenge the Patents Act at the WTO.

India has a US\$5 billion pharmaceutical industry; 65 percent of the drugs are sold to the developing world and poorer people in the developed world.⁷ According to the NGO Medecins Sans Frontières (MSF), 84 percent of the AIDS drugs that it prescribes to its patients worldwide come from Indian generic drug companies.⁸

Commentary

Importantly, the judgment of the Madras High Court allows continued access to affordable drugs.⁹ It should be noted, however, that with the amendment of the Indian patent law in 2005, which marked the completion of India’s transition from a process patent regime (under which the generic drug industry flourished) to a product patent regime (which has been criticized for giving primacy to the interests of pharmaceutical companies), it will now be easier for the

pharmaceutical companies to obtain patents in India.

– Madhavi Swamy

Madhavi Swamy is a student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

For more discussion of Indian patent law and the development of the Novartis case, see *HIV/AIDS Policy and Law Review* 10(2) (2005): 29–30; and 12(1) (2007): 35.

¹ *The Patents (Amendment) Act*, No. 15 of 2005.

² V. Kondro, “Supreme Court rules against drug patent ‘evergreening,’” *Canadian Medical Association Journal* 175(12) (2006): 1508.

³ MSF, “After Indian court ruling, MSF hands over petition with 420,000 signatures to Novartis,” news release, 8 August 2007. Available via www.msf.org.

⁴ *Novartis AG et. Al. v. Union of India et. Al.* (August 6, 2007), Madras W.P. Nos. 24759 and 24760 of 2006.

⁵ *Ibid.*, paras. 6–8.

⁶ *Ibid.*, paras. 10–18.

⁷ A. Gentleman, “Indian law on generic drugs is upheld,” *International Herald Tribune*, 6 August 2007. Available via www.iht.com.

⁸ MSF.

⁹ A. Gentleman.

Pardon granted to health care workers sentenced to death by Libyan court

On 24 July 2007, five Bulgarian nurses and a Palestinian doctor sentenced to death in Libya for intentionally infecting children with HIV were extradited to Bulgaria and pardoned by Bulgarian President Georgi Parvanov.

The medical workers, who began working at Al Fateh Hospital in Benghazi, Libya in 1998, were detained in February 1999 during an investigation into an HIV outbreak at the hospital. Initially, six Bulgarians, one Palestinian and nine Libyans were accused of infecting the children as part of a ploy with Israel's secret service, the Mossad, to undermine Libya.¹

The trial commenced on 7 February 2000.² In 2002, the People's Court in Tripoli, which addresses matters of state security, acquitted all defendants of conspiracy and referred the case to the criminal court to hear the charges of deliberately causing the infection.³ On 6 May 2004, five of the Bulgarians and the Palestinian doctor were sentenced to death by firing squad. The sixth Bulgarian was acquitted.⁴

On appeal, on 25 December 2005 the Libyan Supreme Court overruled the death sentences and ordered a retrial. The retrial ended in a second death sentence for all six medical workers, delivered on 19 December 2006.⁵ The judgment was upheld on appeal to the Supreme Court on 11 July, 2007.⁶

On 17 July 2007, the High Judicial Council of Libya overruled the decision of the Supreme Court and commuted the death penalty to life in prison, after the families of the infected children accepted a compensation

package of approximately US\$1 million each.⁷ Initially, the families had insisted on compensation of US\$10 million per infected child.⁸

The medical workers were released from prison on 24 July and, in accordance with the 1984 prisoner transfer agreement between the two countries, were flown to Bulgaria where they were pardoned.⁹ The Palestinian doctor had previously been granted Bulgarian citizenship so that he could also be transferred to Bulgaria.¹⁰

Bulgarian Prime Minister Sergei Stanislav attributed the release of the medical workers largely to Bulgaria joining the European Union (EU) on January 2007.¹¹ The EU, member states and even private corporations channelled large amounts of aid into Libya to help resolve the case. The EU also established treatment programs in Libya for the children, built medical facilities and supplied medical equipment.¹²

Bulgaria transferred approximately US\$57 million of Libya's debt to a fund created to provide treatment to the infected children, but noted that the cancellation of the debt was a gesture of goodwill, and not an admission of the medical workers' guilt.¹³

The trial of medical workers lasted nearly eight years, despite considerable evidence of their innocence. In 2001, two of the world's leading AIDS experts, Dr Luc Montagnier

and Dr Vittoria Colizzi investigated the hospital and concluded that the spread of HIV was the result of poor sanitary conditions.¹⁴ They traced the source of the infection to a single subtype of the HIV virus which was brought into the hospital by an identified child in 1997, well before the arrival of the medical workers.¹⁵

Further, some of the children were infected after the medical workers were arrested.¹⁶ On 3 September 2003, during the medical workers' first trial, Dr Montagnier presented the findings of his investigation in court.¹⁷ In Dr Montagnier's opinion, the medical workers were charged despite scientific evidence of their innocence because "[t]he hospital needed a scapegoat."¹⁸ The case has been described by many as not "a criminal case, but a political game."¹⁹

The medical workers allege that, during their confinement, they were tortured to extract confessions.²⁰ On 22 March 2002, twenty Libyan officers were arrested for allegedly torturing the medical workers. On 7 June 2005, the Tripoli court acquitted all nine officers charged.²¹ Many of the officers then accused the medical workers of slander; however, on 27 May 2007, a Libyan court acquitted the workers of these charges.²² In 2007, Bulgarian prosecutors laid torture charges against many of the officers and indicated that they plan to pursue the case.²³

The 426 children were infected with HIV between April 1997 and March 1999. At least fifty of the children have since died.²⁴

– Courtney Ashton

Courtney Ashton is a student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

For previous discussion of this case see *HIV/AIDS Policy and Law Review* 9(3) (2004): 61; and 11(1) (2006): 51.

¹ E. Rosenthal, "Libyan court upholds death sentences in HIV case," *New York Times*, 11 July 2007.

² "Timeline: Bulgarian medics' trial in Libya," *Sofia News Agency*, 15 November 2005.

³ H. Saleh, "Libya court rejects HIV plots charges," *BBC News*, 12 February 2002.

⁴ "Chronology: Libya HIV trial of Bulgarian medics," Reuters (on-line), 19 December 2006.

⁵ *Ibid.*

⁶ "Timeline."

⁷ *Ibid.*

⁸ M. Brunwasser, "Workers arrive in Bulgaria after being freed," *New York Times*, 24 July 2007.

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ Republic of Bulgaria, "Sergei Stanishev: welcome home, the drama is over," news release, Sofia, 24 July 2007. At www.government.bg/cgi-bin/e-cms/vis/vis.pl?s=001&p=0137&n=000443&g=.

¹² E. Rosenthal.

¹³ "Bulgaria signs agreement to transfer \$57M of Libya's debt to international fund for HIV-positive children,"

Kaiser Daily HIV/AIDS Report, 5 September 2007.

¹⁴ E. Rosenthal.

¹⁵ Physicians for Human Rights, *Open Letter on Death Sentence for Bulgarian Nurses, Palestinian Doctor*, 23 June 2007. At www.bta.bg/site/libya/en/08experts.htm.

¹⁶ E. Rosenthal.

¹⁷ *Ibid.*

¹⁸ *Ibid.*

¹⁹ M. Brunwasser.

²⁰ "Medical workers sentenced to death in HIV infection case were tortured during incarceration," *Kaiser Daily HIV/AIDS Report*, 10 August 2007.

²¹ "Timeline."

²² "Medical workers in Libyan HIV infection case acquitted on slander charges," *Kaiser Daily HIV/AIDS Report*, 29 May 2007.

²³ "Medical workers sentenced..."

²⁴ "Deal could save foreigners accused in Libyan HIV case," *CBC News* (online), 10 July 2007.

U.N. Committee holds that Colombia failed to protect right to benefits for same sex couple

On May 14 2007, the U.N. Committee of Human Rights found that Colombia breached equality provisions of the *International Covenant on Civil and Political Rights (ICCPR)*¹ when it rejected a pension transfer to a member of a same sex couple.² The Committee stated that the refusal to grant X his same sex partner's pension amounts to discrimination on the basis of sexual orientation, which is prohibited under Article 26 of the ICCPR.

In September 1994, after his partner Y had died following a relationship of 22 years, during which they lived together for seven years, X lodged an application with the Social Welfare Fund of Colombia seeking a pension transfer. In 1995, the fund rejected X's request, on the grounds that the law did not permit the transfer of a

pension to a person of the same sex.

X instituted an action for protection in Bogotá Municipal Criminal Court, seeking a response from the Benefits Fund of the Colombian Congress. On 14 April 1995, the Court dismissed the application on the grounds that there had been no violation of fundamental rights.

There followed a series of unsuccessful appeals in Colombian courts:

- On 15 September 1995, the Bogotá Circuit Criminal Court No. 18 rejected the application, finding that there were no grounds for protecting the rights in question.

- In October 2005, the Bogotá High Court upheld the lower court's decision.
- In 2000, the Cundinamarca Administrative Court rejected X's application on the grounds of the lack of constitutional or legal recognition of homosexual unions as family unions.
- Also in 2000, the Council of State upheld the ruling of the Administrative Court, arguing that under the *Constitution*, the family is formed through natural or legal ties between a man and a woman.³

X then filed a complaint to the U.N. Human Rights Committee. In his complaint, X claimed that he was discriminated against on the ground of sexual orientation and that this discrimination violated several articles of the ICCPR: Article 2(1), protection of rights without distinction; Article 3, equal rights of men and women; Article 5, prohibition of limitation and restriction of rights guaranteed in the ICCPR; Article 14(1), equality before the courts; and Article 17(1), interference with privacy.

X also claimed that the refusal of the Colombian courts to grant him a pension on the grounds of his sexual orientation violated his rights under Article 26 of the ICCPR. Article 26 guarantees equality and equal protection of the law to everyone without any discrimination, prohibits any discrimination, and guarantees to all persons equal and effective protection against discrimination on any ground, including sex.

The U.N. Human Rights Committee discussed in detail the alleged violation of Article 26 of the ICCPR. It noted that X was not recognized as the permanent partner of

Y for pension purposes because court rulings based on national law found that the right to receive pension benefits was limited to married couples and members of heterosexual de facto marital unions.

In response to the claims made by X, the representative of the Colombian government had argued that “the state party has no obligation to establish a property regime similar to that established [for heterosexual couples] for all the different kinds of couples and social groups, who may or may not be bound by sexual or emotional ties.”⁴

However, in earlier jurisprudence, the Committee had stated that the prohibition against discrimination under Article 26 includes discrimination based on sexual orientation.⁵ The Committee had also previously found that differences in benefit entitlements between married couples and heterosexual unmarried couples were reasonable and objective, because the couples in question had the choice to marry or not, with all ensuing consequences.⁶

However, in this case, the Committee noted that (a) it was not open to X to enter into marriage with his same-sex permanent partner; and (b) the national law of Colombia does not make a distinction between married and unmarried couples, but rather between homosexual and heterosexual couples.

The Committee concluded that the distinction between same-sex partners, who are not entitled to pension benefits, and unmarried heterosexual partners, who are so entitled, is not reasonable and objective, and that there is no evidence to justify such a distinction. Thus, the Committee found that Colombia had violated Article 26 of the ICCPR by denying

X's right to his life partner's pension on the basis of his sexual orientation.

In light of this finding, the Committee decided that it is not necessary to consider the claims made under other articles of the ICCPR. The Committee ruled that X is entitled to reconsideration of his request for a pension without discrimination on grounds of sex or sexual orientation.

As a party to the ICCPR and the *Optional Protocol to the ICCPR*, Colombia is obligated to provide an effective and enforceable remedy in a case where there has been a violation of the treaty.⁷ Colombia also has an obligation to publish the Committee's finding, to take steps to prevent similar violations of the ICCPR in the future, and to report on the measures taken to give effect to the findings within 90 days of the date of the ruling.⁸

– Leah Utyasheva

¹ *International Covenant on Civil and Political Rights*, 1966, entered into force 23 March 1976.

² U.N. Human Rights Committee, Communication No. 1361/2005: Colombia, 14/05/2007/ CCPR/C/89/D/1361/2005 (Jurisprudence).

³ *Ibid.*, para. 2.7.

⁴ U.N. Human Rights Committee, Communication No. 1361/2005, para. 7.1.

⁵ U.N. Human Rights Committee, Communication No. 941/2000, *Young v. Australia*, Views of 6 August 2003, para. 10.4.

⁶ U.N. Human Rights Committee, Communications Nos. 180/1984, *Danning v. Netherlands*, Views of 9 April 1987, para. 14; and 976/2001, *Derksen and Bakker v. Netherlands*, Views of 1 April 2004, para. 9.2.

⁷ Art. 2 of the ICCPR and the *Optional Protocol to the ICCPR*, 1966, entered into force 23 March 1976.

⁸ U.N. Human Rights Committee, Communication No. 1361/2005, para. 10.

South Africa: Constitutional Court protects privacy rights of people living with HIV

On 4 April 2007, the Constitutional Court of South Africa set aside the judgment of the Johannesburg High Court and ruled that applicants' rights to privacy, dignity and psychological integrity were violated by publication of their HIV status without their consent in the case of *NM and Others v Smith and Others*.¹

In March 2002, the names of three HIV-positive women were published in a biography of a politician Patricia de Lille. The three women alleged that their names had been published without their prior consent, and that their rights to privacy, dignity and psychological integrity were violated. They sued for damages in the Johannesburg High Court, naming de Lille, the author of the biography, Charlene Smith, and the publisher, New Africa Books, as respondents.

Between 1999 and 2001, the three women participated in a clinical drug trial that ended after concerns were raised regarding illness and fatalities among trial participants. The three women participated in a subsequent investigation during which their names were disclosed (and mentioned in the final report of the investigation). De Lille, known for her stand in relation to the rights of people living with HIV, participated in the investigation. A description of de Lille's work on HIV/AIDS was published in her biography, together with the names and HIV status of the three plaintiffs.

In May 2005, the High Court held that the defendants acted reasonably in disclosing private information, noting that nothing suggested that the information contained in the inquiry report was confidential. The Court said that the defendants could not be held liable for the disclosure of the three wom-

en's HIV status, but that the publisher was liable for damages subsequent to the book's publication. The publisher was ordered to pay each plaintiff damages of 15,000 Rand (approximately US\$2,240) and to delete from all copies of the book in its possession any references to the plaintiffs' names.

In the case before the Constitutional Court, the applicants complained that the High Court had failed to protect their rights to privacy, dignity and psychological integrity.

The Constitutional Court stated that

[d]isclosure of an individual's HIV status ... deserves protection against indiscriminate disclosure due to the nature and negative social context the disease has as well as the potential intolerance and discrimination that result from its disclosure. The affirmation of secure privacy rights within ... [the] Constitution may encourage individuals to seek treatment and divulge information encouraging disclosure of HIV which has previously been hindered by fear of ostracism and stigmatisation.... As a result, it is imperative and necessary that all private and confidential medical information should receive protection against unauthorised disclosure.²

The Court further stated that the assumption that others are allowed access to private medical information once it has left the hands of authorised physicians and other personnel

involved in the facilitation of medical care is fundamentally flawed. The Court said that this assumption fails to take into account an individual's desire to control information about him or herself and to keep it confidential from others.³

The Court held that de Lille and Smith did not sufficiently pursue efforts to establish if the necessary consent had been obtained, and concluded that the publication of the HIV status of the applicants constituted a wrongful publication of a private fact, and so the applicant's right to privacy was breached by the respondents.⁴

In respect to the claim that the applicants' dignity was violated, the Court stated that there is nothing shameful about living with HIV/AIDS, but that it is nevertheless an affront to an infected person's dignity for another person to disclose details about the infected person's HIV status or any other private medical information without his or her consent.⁵ The Court thus concluded that the respondents violated the dignity and psychological integrity of the applicants, and that no evidence was presented that the disclosure was in the public interest.

The majority of judges asserted that the invasion of privacy was intentional, and that the respondents were aware that the applicants had not given their consent to the disclo-

sure (or that the respondents at least foresaw the possibility that the consent had not been given).

The majority judgment notes that as campaigners in the field of HIV/AIDS, the respondents knew well that their conduct was wrong, and that the disclosure of private facts was likely to invade the privacy rights of the applicants.⁶ The Court also raised the amount of damages paid to each applicant to 35,000 Rand (approximately US\$5,230).

Mark Heywood, of the NGO AIDS Law Project, commented that this is the first case heard by the Constitutional Court which was brought by very poor people who had tried, in vain, to protect their privacy rights against invasion by very powerful people.⁷

– Leah Utyasheva

For previous discussion of this case, see *HIV/AIDS Policy and Law Review* 10(2) (2005): 53.

¹ *NM and Others v Smith and Others* (CCT 69/05) [2007] ZACC 6 (4 April 2007). The full text of the judgment is available via www.saflii.org.

² *Ibid.* at para. 42.

³ *Ibid.*, para. 43.

⁴ *Ibid.*, para. 45.

⁵ *Ibid.*, para. 47.

⁶ *Ibid.*, para. 63.

⁷ Mark Heywood, "Power, AIDS stigma and the law." At www.alp.org.za/index.php?catid=38.

Criminal Law and HIV/AIDS: two new cases

Russia: Man sentenced to three years and three month in prison for HIV transmission

On 1 June 2007, the Beloyarskiy Regional Court in the Russian oblast of Sverdlovskaya sentenced a man to three years and three months in prison for intentionally transmitting HIV to two women.¹

Ch was diagnosed with HIV in 2001 and was warned about criminal responsibility for HIV transmission. During the period from 2002 to 2005, Ch had sexual relationships with two women; both later tested HIV-positive.

Russian law makes it a crime to (a) knowingly expose someone to HIV (punishable by up to one year in prison); and (b) transmit HIV when the person knew he or she was HIV-positive (punishable by up to five years in prison). Negligent

HIV infection by medical personnel is also a crime (punishable by up to five years in prison, and deprivation of license and right to practice). HIV transmission committed against two or more people or against a minor is punishable by a prison term of up to eight years.²

This article of the *Criminal Code* is supplemented by an annex, which excludes criminal responsibility for HIV exposure and transmission in cases where the partner knew about the risk and voluntarily consented to sexual relations.

According to commentaries to the *Criminal Code*,³ condom use can be used as defence in charges against HIV exposure, but it is not clear if this defence has actually been used in court.⁴ Russia is a civil law country; there are not many known prosecutions for HIV transmission.

– Leah Utyasheva

Australia: Court denies application to appeal conviction of man who argued HIV does not exist

In January 2006, Parenzee was convicted of three counts of endangering life on the basis that he had unprotected sexual intercourse with three women when he knew he had HIV and had been advised of the risk of HIV transmission if he were to engage in unprotected sex.

The prosecution had argued that Parenzee knew that the acts were likely to endanger the life of each of the women, and that he was recklessly indifferent as to whether their lives were endangered. One of the women later tested HIV-positive. Parenzee was sentenced to nine years in prison.

Parenzee applied for permission to appeal his conviction to the Supreme Court of South Australia,

claiming there had been a miscarriage of justice because at trial his legal representatives did not have the opportunity to call important experts. Parenzee claimed that new evidence showed (a) that HIV cannot be proven to exist, (b) that, even if it existed, it cannot be demonstrated that HIV can be transmitted by sexual intercourse; and (c) that there is no evidence that AIDS was caused by HIV.⁵

On August 24, 2007, Parenzee's application for permission to appeal was refused by the Supreme Court of South Australia (Court of Criminal Appeal). The judges held that the material before them overwhelmingly supported the conclusion that HIV exists and is identifiable, that HIV can be transmitted by sexual intercourse, and that it causes AIDS.⁶

– Leah Utyasheva

¹ "Three years in prison for double HIV transmission" ("Za dvoynoe zarazhenie VICH dali tri goda kolonii"), *Rambler Planeta* (online), 3 June 2007.

² *Criminal Code*, 1996, # 63-FZ [Russian Federation], art. 122.

³ Commentary to the legislation is composed by academic experts in the field and used as handbooks.

⁴ A.V. Naumov (ed). *Commentary to the Criminal Code of the Russian Federation*, Moscow: (Yurist, 1997). See also, *Commentary to the Criminal Code, Legislation of Russia* at www.labex.ru.

⁵ *R v Parenzee* [2007], SASC 143, Supreme Court of South Australia, 27 April 2007.

⁶ *R v Parenzee* [2007] SASC 316, Supreme Court of South Australia (Court of Criminal Appeal), 24 August 2007.

In brief

Central Asia: Several HIV outbreaks linked to transfusions of tainted blood and poor sanitary conditions in hospitals

On 27 June 2007, 17 health workers in Shymkent, Kazakhstan were convicted of criminal negligence by the Shymkent Court, following an HIV outbreak among children who received blood transfusions.¹ The medical workers received sentences ranging from several months to eight years in prison.

However, four senior health officials were given suspended sentences, much to the outrage of victims' families.² Medical workers in Shymkent claim that the convicted doctors were "scapegoats," and that the source of the outbreak has still not been definitively pinpointed.³

The defendants claimed that the children contracted HIV through moth-

er-to-child transmission. The mothers were tested and found HIV-negative. A medical investigation conducted by the U.S. Centers for Disease Control and Prevention identified transfusions of tainted blood as the source of the Shymkent HIV outbreak.⁴

In Central Asia, blood transfusions are commonly used "to fortify a healthy body and remedy diseases that are not blood related," a practice that, according to experts, is unnecessary and not medically proven.⁵

According to some reports, the causes of the outbreak lie in the general poor quality of health care and lack of resources. Court records show that syringes and catheters at Shymkent's three children's hospitals were routinely reused. The judge in the case also listed evidence of negligence, abuse of patients and theft of health funds.⁶

The outbreak resulted in 118 children becoming infected with HIV.

Since 2006, 10 of these children have died.⁷ Since the Shymkent case, transfusions of tainted blood have been linked to HIV outbreaks in other Central Asian countries: in March 2007, in Andijan, Uzbekistan, nine people became infected with HIV; in July 2007, in Osh, Kyrgyzstan, 22 people were infected with HIV, 17 of them children.⁸

– Leah Utyasheva

Russia: Courts find authorities responsible in two cases of HIV transmission in hospitals

In March 2007, the Voronezh Central District Court awarded 3.5 million rubles (approximately US\$141,000) in moral damages to X as a result of

a case involving negligent HIV transmission in a health institution.⁹

In 2005, X received tainted blood products in a maternity hospital in the Voronezh region in the south of Russia. She later tested HIV-positive. A criminal prosecution was launched against the director of the blood bank, but was later discontinued because an amnesty was granted by the State Duma (federal parliament) to certain classes of cases in connection with the 100th anniversary of the Duma.

Meanwhile, X sued the local blood bank and the department of health for damages. In finding in favour of the plaintiff, the Court ruled that the fact that the criminal case was discontinued has no bearing on the lawsuit, and that the blood bank and the department of health must therefore pay X moral damages.

In September 2007, in another case, the Pushkinsky Military Garrison Court awarded four million rubles (approximately US\$161,000) to Vyacheslav Temnikov, a military officer who was infected with HIV and hepatitis C in a military hospital in 2001.

During an operation, Temnikov sustained a heavy blood loss, his life was in danger and the medical personnel performed a “direct” blood transfusion with blood taken from 10 soldiers and officers, one of whom later tested HIV-positive. The prosecutor decided not to lay criminal charges in this case.¹⁰

As these cases show, in Russia people infected with HIV as a result of medical negligence can receive monetary compensation for damages, but criminal prosecution of negligent

HIV transmission by health personnel is rare.

– Leah Utyasheva

¹ “Doctors in Kazakhstan convicted for criminal negligence following HIV outbreak among children who received blood transfusions,” *Kaiser Daily HIV/AIDS Report*, June 28, 2007.

² “Doctors in Kazakhstan on trial for medical malpractice following HIV outbreak among children who received blood transfusion,” *Kaiser Daily HIV/AIDS Report*, March 20, 2007.

³ “Probe ordered in Kyrgyzstan HIV outbreak,” *Radio Free Europe, Radio Liberty*, July 30, 2007.

⁴ “Doctors in Kazakhstan convicted...”

⁵ “Doctors in Kazakhstan on trial...”

⁶ *Ibid.*

⁷ “HIV outbreaks linked to blood transfusions discovered in Central Asia since Kazakh doctors were convicted of criminal negligence,” *Kaiser Daily HIV/AIDS Report*, September 18, 2007.

⁸ *Ibid.*

⁹ “Voronezh court estimated HIV transmission was worth 3,5 million of rubles,” *Newsland* (online), March 14, 2007.

¹⁰ “Officer infected with HIV won case against Ministry of defence,” *Agency of Social Information*, October 8, 2007.

THE LAW AND HEALTH INITIATIVE: LINKING HIV/AIDS AND HUMAN RIGHTS

The Open Society Institute (OSI) is a private operating and grant-making foundation that aims to shape public policy to promote democratic governance, human rights, and economic, legal and social reform. In 2005, OSI'S Public Health Program launched the Law and Health Initiative (LAHI). LAHI supports the integration of legal and paralegal advocacy into community-based health services, as well as litigation and law reform related to public health. In this special section of the *HIV/AIDS Policy & Law Review*, we present a series of articles that attest to the range of interventions that LAHI has piloted — and that other funders can support — to make the link between AIDS and human rights a reality. Each of the articles is written by LAHI staff, consultants, partners or grantees from Africa and the former Soviet Union. The special section was edited by Jonathan Cohen, Project Director for LAHI.

Putting law and human rights on the agenda: an introduction to the articles in this special section

For the Open Society Institute (OSI), linking legal advocacy to health care through the Law and Health Initiative (LAHI) came naturally. After years of funding in global health, OSI and

its partner foundations in Africa, Eastern Europe and the former Soviet Union had developed a rich understanding of the health needs of socially marginalized groups such as

people who use drugs, sex workers, Roma, people living with HIV/AIDS, and people in palliative care.

These populations demanded more than just health care. They wanted

legal services to defend against violence and discrimination, stronger laws to protect their rights as patients, and greater literacy in human rights to defend their interests before the police, health providers and other authorities. With its long experience funding law reform and human rights advocacy, OSI was ideally positioned to fill this need.

Nowhere was this need more acute than in the field of HIV/AIDS. With billions of dollars flowing to AIDS programs in poor countries, law and human rights were missing from the agenda. Funding rightly focused on scaling up access to antiretroviral treatment and, to a lesser extent, on expanding prevention, testing and palliative care services. But people living with, and affected by, HIV/AIDS, marginalized and stigmatized since long before AIDS came along, wanted more than medicine.

Women widowed by HIV sought legal defence against disinheritance, eviction and violence. Drug users wanted somewhere to complain when police confiscated their sterile syringes or conducted crackdowns outside methadone programs. People in palliative care needed help writing wills, finding guardians for their children and applying for social grants. For all of these populations, health literacy was not enough: they also wanted legal literacy so they could defend their rights, confront abuse and truly focus on living positively.

LAHI was created in 2005 to try to address some of these needs. The articles in this special section provide a snapshot of the work that LAHI is doing.

Suzanne Maman and her colleagues from KwaZulu-Natal, South Africa describe a unique intervention to include legal education and referral

in a package of HIV post-test support for pregnant women. They hypothesize that legal protection against violence and discrimination will empower pregnant women to disclose their HIV status to their intimate partners and thereby improve their clinical outcomes.

This intervention is particularly critical as governments move to streamline HIV testing and counseling under new guidance provided by UNAIDS and WHO. As Ralf Jürgens and colleagues describe, it is more critical than ever to ensure that human rights protections form a meaningful part of HIV testing initiatives, particularly for women.

Also in South Africa, Joan Marston and Tamar Ezer describe an initiative to bring together lawyers and palliative care providers to defend the rights of people with terminal illness. This initiative, which encompasses issues ranging from wills and estates to access to pain medication, illustrates how legal services form a key component of comprehensive health care for the dying. With South Africa having explicitly committed to human rights interventions in its HIV and AIDS and STI Strategic Plan for 2007-2011, it is hoped that such interventions will soon become national policy.

The need for HIV-related legal services is no less acute in the former Soviet Union, where rampant police abuse and other violations against people using drugs fuel injection-driven HIV epidemics. Maxim Demchenko, a lawyer in Ukraine, describes a direct legal aid project for drug users begun with the support of OSI's International Harm Reduction Development Program (IHRD).

LAHI and IHRD are also funding legal services for drug users

in Georgia, where the Parliament recently passed legislation imposing a range of harsh administrative sanctions against drug use. In a country where nearly 65 percent of HIV cases stem from injection drug use, this represents a substantial threat to public health. Describing this legislative development, Nina Kiknadze and David Otiashvili argue that lack of government appreciation for evidence-based drug policy represents one of the main threats to Georgia's response to HIV.

Given the reality that private foundations cannot meet the entire demand for legal services, test case litigation is a core part of LAHI's strategy to provide legal assistance to people living with HIV/AIDS. Erik Iriskulbekov and Asylgul Balybaeva describe a landmark case in Kyrgyzstan brought by LAHI grantee ADILET to vindicate the privacy rights of a person with HIV who was involuntarily filmed for a television documentary while in hospital with advanced AIDS.

In the Southern African context, Tamar Ezer argues that test case litigation provides a source of hope to women in Swaziland, where a new constitution provides an explicit guarantee of equality in a country beset by patriarchal laws, gender-based violence and the highest rate of HIV in the world.

Other articles in this special section focus on the legislative framework governing national responses to HIV/AIDS. As of five years ago, according to the United Nations, only one-third of countries worldwide had adopted legal measures outlawing discrimination against populations vulnerable to HIV.

Unfortunately, parliaments that do undertake to enact HIV-specific laws sometimes do so in a manner

that is hostile to human rights. This is most evident in a wave of legislative initiatives in East, West and Southern Africa that impose significantly over-broad criminal penalties to HIV transmission or exposure, and impose mandatory HIV testing at certain stages of life. Delme Cupido describes an effort to reach a consensus between HIV/AIDS, human rights and women's rights groups in Southern Africa on the need to aggressively prosecute gender-based

violence while not criminalizing HIV transmission.

In East Africa, Anne Gathumbi discusses a highly neglected area of HIV legislation, that of the rights and responsibilities of home-based caregivers. MaryFrances Lukera describes the human rights impact of criminalizing prostitution in Kenya, and the need to reform colonial-era prostitution laws to better protect sex workers from violence, discrimination and marginalization.

Whether through integrating legal services into HIV/AIDS programs, supporting test cases, or urging rights-based law reform, LAHI has a critical role to play in advancing human rights responses to HIV. It is an honour for us to share our experiences in the pages of the *HIV/AIDS Policy and Law Review*. We invite other grant makers to join us in harnessing the power of the law to bring HIV and AIDS to heel.

– Jonathan Cohen

Integrating health, psychosocial and legal support for pregnant women in South Africa

Can combining HIV testing with legal support help pregnant women disclose their HIV status safely to their partners? Suzanne Maman and her colleagues describe the South Africa HIV Antenatal Care Post-Test Support Study (SAHAPS), a unique intervention to include legal education and referral with a package of post-test support services in KwaZulu-Natal, South Africa.

Disclosure of HIV status has been associated with a number of positive outcomes including reduced anxiety and depression and increased social support. Disclosure may also have negative repercussions for people, including stigma and discrimination, violence and abandonment.¹ Disclosure of HIV status to partners presents an opportunity for couples to communicate about risk reduction and plan for the future.

There are many barriers to disclosure, including fear of negative repercussions such as violence and discrimination. One of these barriers may be the lack of legal protections,

or access to such protections, in the face of violence, threats of violence or other human rights abuses.

A systematic review of the literature on the rates, barriers and outcomes of HIV status disclosure indicates that women who test in the context of antenatal care are least likely to disclose, and most likely to suffer negative social consequences when they do disclose.² For this reason, disclosure is thought to be a critical barrier to women's uptake of Prevention of Mother-to-Child Transmission (PMTCT) services.

Despite growing evidence of effective interventions using short

course zidovudine^{3,4,5} or single dose nevirapine,⁶ which reduce mother-to-child transmission by 37–50 percent, an estimated 235 000 children are HIV-infected in South Africa. A national PMTCT strategy in South Africa was implemented in 2002, and South Africa now has the largest PMTCT program globally with 2525 sites (60 percent of all public health facilities).⁷

Even with the infrastructure to support PMTCT, it is estimated that only 23 percent of pregnant women in South Africa access voluntary counselling and testing (VCT) services,⁸ that 55.6 percent of HIV-positive

women receive the single-dose NVP,⁹ and that only 13 percent of women adhere to correct breastfeeding practices.¹⁰ As a result, the mother-to-child transmission rate remains high (22.4 percent).¹¹

SAHAPS is a randomized controlled trial designed to evaluate the efficacy of enhanced post-test support, including legal support, for HIV-positive and HIV-negative pregnant women in Durban, South Africa. Through this study, 1495 women will be enrolled in a public health clinic that serves one of the poorest townships in Durban.

Women will be randomized to receive either the standard PMTCT services, or a model of PMTCT that includes enhanced and integrated post-test support. The clinic has had a PMTCT program in place since 2001, though low uptake of these services remains a persistent challenge at this site.

The SAHAPS study will determine whether providing women with enhanced, integrated post-test support following HIV testing will result in better outcomes, including higher rates of participation in PMTCT, greater risk reduction between partners, and better psychosocial outcomes for women. We hypothesize that these outcomes will be mediated through higher rates of disclosure among women who receive the enhanced post-test support.

The enhanced support available to women in SAHAPS includes:

- a health education video immediately prior to HIV pre-test counselling that begins to raise women's awareness of the decisions that they will need to make regarding HIV testing, disclosure and participation in PMTCT programs;

- HIV pre- and post-test counselling sessions that build on the standard counselling protocols by offering more opportunities to discuss barriers to disclosure and risk reduction with counsellors;
- two additional post-test counselling sessions that coincide with the six- and 10-week postpartum immunization visits that women make to the clinic for their infants (these additional post-test sessions will include a focus on legal education, partner testing and family planning);
- access to an ongoing post-test support group; and
- access to legal services.

The enhanced post-test support is designed to comprehensively address the health, psychosocial and legal issues that pregnant women face when learning of their HIV status. To our knowledge, this is the first time that legal support will be integrated directly into HIV counselling services at a clinic for pregnant women.

The legal needs of pregnant women in South Africa most often relate to domestic violence, child support and access to resources. The legal needs of HIV-positive pregnant women are not substantively different than those of other pregnant women, though their needs are often exacerbated because of dire resource constraints and the stigma and discrimination that they face as a result of their infection.

Research nurses will be trained to provide basic education on legal rights to women in the second post-test counselling session that women receive six weeks postpartum. The nurses will raise women's awareness about some of their rights. Women who need legal assistance will be

invited to schedule an appointment at a legal aid outreach clinic that we will establish at the clinic. The legal clinic will be run by the University of KwaZulu-Natal Campus Law Clinic and staffed by an attorney, several candidate attorneys and groups of fourth year law students.

The legal component of the trial will be evaluated by measuring women's knowledge of their legal rights pre and post-intervention. Case studies of women who access the legal services will be developed to describe the impact of these services.

The SAHAPS study is being conducted at a time when recent changes in national and international HIV testing policies have reduced the emphasis placed on counselling. Counselling has been portrayed as a barrier to uptake of HIV testing.^{12,13} The central goal of the revised HIV testing policies is to expand the numbers of individuals who are aware of their HIV status, so that treatment coverage goals can be realized. While increasing treatment coverage is unquestionably an important public health goal, there are concerns that testing in the absence of adequate support may lead to adverse outcomes for individuals, particularly women.

The evidence from women's experiences with HIV testing suggests that women need more counselling and support, not less, to minimize negative psychosocial outcomes and to maximize the benefits of HIV prevention and treatment services. The SAHAPS study is designed to evaluate the impact of enhanced and integrated post-test support for women. The inclusion of legal services in the intervention arm will not only address the common concern that violations of human rights are a deterrent to

disclosure, but more broadly will shed light on the link between legal services and women's health.

– *Suzanne Maman, Dhayendre Moodley, Allison Groves and Elaine Smith*

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¹ World Health Organization, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes*, Report No. WC 503.7, 2003.

² 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 programs," *WHO Bulletin* 82(4) (2003): 299–307.

³ F. Dabis et al., "6-month efficacy, tolerance, and acceptability of a short regimen of oral zidovudine to reduce vertical transmission of HIV in breastfed children in Côte d'Ivoire and Burkina Faso: a double-blind placebo-controlled multicentre trial," *Lancet* 353(9155) (1999): 786–792.

⁴ S.Z. Wiktor et al., "Short-course oral zidovudine for prevention of mother-to-child transmission of HIV-1 in Abidjan, Côte d'Ivoire: a randomised trial," *Lancet* 353(9155) (1999): 781–785.

⁵ N. Shaffer et al., "Short-course zidovudine for perinatal HIV-1 transmission in Bangkok, Thailand: a randomised controlled trial," *Lancet* 353(9155) (1999): 773–780.

⁶ L.A. Guay et al., "Intrapartum and neonatal single-dose

nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial," *Lancet* 354(9181) (1999): 795–802.

⁷ D.J. Jackson et al., "Operational effectiveness and 36 week HIV-free survival in the South African programme to prevent mother-to-child transmission of HIV-1," *AIDS* 21 (2007): 509–516

⁸ Department of Health (South Africa), *Annual Report 2004/2005*, 2005.

⁹ D.J. Jackson et al.

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² P. Van de Pierre, "HIV voluntary counselling and testing in community health services," *Lancet* 356(9224) (2000): 86–87.

¹³ U.S. Centers for Disease Control and Prevention (CDC), *Advancing HIV Prevention: New Strategies for a Changing Epidemic*, MMWR Recommendations and Reports 52, 2003, pp. 329–332.

Increasing access to HIV testing and counselling while respecting human rights

Two days after the World Health Organization (WHO) and UNAIDS released the final version of their *Guidance on Provider-initiated Testing and Counselling in Health Facilities* ("the Guidelines"),¹ OSI's Public Health Program issued an updated version of its paper on *Increasing Access to HIV Testing and Counseling While Respecting Human Rights*.² Since then, as Ralf Jürgens reports, the paper has served as the basis for a statement and recommendations on scaling up HIV testing and counselling issued by the UNAIDS Reference Group on HIV and Human Rights.³ In addition, it has helped inform guidance currently being developed by WHO and the U.N. Office on Drugs and Crime (UNODC) on HIV testing for prisoners and for people who use drugs.

A first draft of the OSI paper had been widely disseminated in December 2006, and served as the basis for extensive comments provided by OSI and others on a draft of the WHO and UNAIDS Guidelines (released in November 2006).

OSI's paper is based on a review of the literature and extensive consultations with people providing services to, or shaping policy for, populations vulnerable to HIV in sub-Saharan Africa, Asia, Eastern Europe, Latin America and North America. It

focuses on the issues raised by proposals to "routinize" HIV testing in low- and middle-income countries.

Importantly, while most of the literature and policy-making around HIV testing has concerned itself primarily with sub-Saharan Africa or the

“hidden epidemic” in high-income countries, the paper also seeks to address how this debate affects vulnerable populations in other parts of the world where the epidemic is often very different.

Main conclusions

The following is a summary of the main conclusions on the OSI paper:

1. No controversy — the need to scale up counselling and testing

The paper starts from the premise that greater access to HIV counselling and testing is both a public health and a human rights imperative.

2. VCT is not enough — new approaches must also be implemented

In addition to the traditional model of client-initiated voluntary counselling and testing (VCT), new approaches to HIV counselling and testing must be implemented in more settings, and on a much larger scale than has so far been the case. While it will be important to continue — and scale up — efforts to improve and better resource VCT, there is agreement that this alone will not be sufficient to achieve vastly scaled-up access to HIV testing and counselling.

3. Informed consent to HIV testing is critical

In order to make it feasible for health-care providers to offer HIV testing to all their patients, in some settings it may be justified to relax, to some extent, pre-test counselling requirements.

From both a human rights and public health perspective, cumbersome procedures for pre-test counselling are not required. However, both human

rights and public health imperatives require that regardless of whether persons are routinely offered an HIV test in a health care setting or whether they initiate HIV testing themselves, such persons be able to seek and receive sufficient information to enable them to give informed and truly voluntary consent to testing. These imperatives also require that people receive post-test counselling, and that confidentiality of test results and of the act of seeking a test are guaranteed.

4. Considering an alternative to opt-out testing: opt-in PITC

According to the WHO and UNAIDS Guidelines, HIV testing is recommended as a standard part of medical care for all patients attending health facilities in countries with generalized HIV epidemics, as well as under certain other circumstances. The Guidelines recommend an “opt-out” approach to such provider-initiated testing and counselling (PITC), meaning that individuals would have to specifically decline the HIV test if they do not want it to be performed.

The OSI paper suggests that another way to rapidly scale up access to HIV testing that may be as effective as a matter of public health, and more respectful of human rights, would be to routinely offer and recommend “opt-in” HIV testing and counselling. Experience has shown that where implementation of an opt-in approach is adequately supported, it can be as successful as an opt-out approach in increasing the number of people who test for HIV. As well, the opt-in approach has the potential to have a positive impact on access to care, treatment and prevention — similar to what could be achieved using an opt-out approach.

Ultimately, any form of PITC — whether opt-in or opt-out — will have to be carefully monitored and evaluated to ensure that, in practice, when providers offer and recommend testing, patients give informed and voluntary consent to the test.

5. VCT may not be enough — but scaling up VCT is essential

Efforts to scale up access to HIV testing and counselling, which currently focus on PITC in formal health settings, need to devote greater attention to how client-initiated VCT services can be improved and scaled up, particularly for socially marginalized groups.

Scaling up access to VCT is particularly important because large numbers of people do not use formal health services and may need other ways to gain access to HIV testing and counselling, especially if they live in rural areas poorly served by the health care system, are mobile, or belong to vulnerable communities that face stigma and discrimination in health settings.

6. Linking HIV testing scale-up with scale-up of ART and evidence-based prevention

Access to evidence-based prevention measures and to antiretroviral therapy (ART) remains limited in many countries and many settings, particularly for the most at-risk populations. Countries need to recognize that HIV testing is never a goal in itself, but rather is linked to larger prevention, care, treatment and support goals. Consequently, the efficacy of testing policies and programs is partially determined by the availability of effective prevention, care, treatment and support programs. Efforts to

scale up access to HIV testing and counselling will have to be coordinated and integrated with increased efforts to scale up access to ART and to evidence-based prevention.

7. Moving from human rights rhetoric to real action on human rights

Increasing testing and counselling must go hand in hand with much greater investment in real protection — in practice, and not just on paper — from HIV-related discrimination and abuse, particularly for women, children and adolescents, sex workers, men who have sex with men, people who use drugs, and prisoners. To date, few countries have costed, budgeted and implemented national programs that would secure legal and human rights protections for people living with, affected by, or vulnerable to, HIV/AIDS. If scale-up of HIV testing is to reach its goals, HIV-related human rights must become a much higher priority.

8. Gathering necessary evidence

In order to be able to assess whether increased uptake of testing allows countries to achieve prevention and treatment goals, more information is needed about the number of people who obtain their test results; disclose their HIV status; ultimately change their sexual or drug using behaviours; and access care and treatment, including ART. More research is also needed to capture the experience of HIV testing and that of people who may be at risk of adverse outcomes.

9. The need for technical and financial resources

Scaling up HIV testing and counselling will require significant human and

financial resources. Currently, these resources are lacking, creating a serious risk that countries will fail to scale up access to HIV testing and counselling; will do so without creating the enabling environment necessary to maximize the benefits of testing and minimize its potential harms; or will divert resources from other essential efforts, such as (a) increasing access to evidence-based prevention and antiretroviral treatment, and (b) human rights interventions.

10. Opposing compulsory and mandatory testing

Mandatory and compulsory HIV testing continues to occur in many countries and contexts, in violation of ethical principles and basic rights of consent, privacy and bodily integrity. There are concerns that making testing more routine — particularly in countries that adopt approaches under which people are tested unless they specifically decline the test — may, in practice, result in even more instances of HIV testing without consent. Countries need to amend laws, policies and practices in order to prohibit mandatory testing, and facilitate access to VCT, prevention, care, treatment and support.

Other related developments

Since it was launched in June, OSI's paper on *Increasing Access to HIV Testing and Counseling While Respecting Human Rights* has served as the basis for a number of documents and policy statements on HIV testing and counselling.

One of them is a statement on scaling up HIV testing and counselling issued by the UNAIDS Reference Group on HIV and Human Rights.⁴ The statement is addressed

to WHO and UNAIDS, national governments, donors, health care providers, NGOs and others involved or interested in efforts to scale up access to HIV counselling and testing as part of global efforts to achieve universal access to HIV prevention, treatment, care and support by 2010.

In its statement, the Reference Group welcomes the WHO and UNAIDS Guidelines and calls for “rapid action to scale up access to HIV testing and counselling, with full funding and programmatic attention to the protections to patients provided in the guidance.” In this spirit, the Reference Group raises some concerns and makes 21 recommendations, urging WHO, UNAIDS, national governments, donors and others involved to move quickly to address them.

The Reference Group points out that “in many countries there are many abuses around the manner in which HIV testing and counselling are conducted.” It expresses concern that implementation of the guidance “may lead to further abuses, rather than to increased benefits for human rights and public health” unless governments put in place

sufficient measures prior to and during implementation of provider-initiated testing and counselling to ensure that the three prerequisites, outlined by the [Guidelines], for provider-initiated testing and counselling are indeed in place:

- access to HIV prevention, care and support services, including a reasonable expectation that access to antiretroviral therapy will become available in the near future as part of a national plan to achieve universal access to antiretroviral therapy;

- sufficient capacity of health care providers to implement provider-initiated testing and counselling under the conditions of informed consent, confidentiality and counselling; and
- sufficient programmatic attention to protecting people from stigma and discrimination.

In addition, the OSI paper has helped inform a background paper⁵ and a policy statement on HIV testing and counselling for prisoners. These were commissioned in July 2007 by UNODC and WHO. The two agencies recognized that while the WHO and UNAIDS Guidelines briefly address issues related to HIV testing and counselling for prisoners, there is a need for more in-depth analysis of these issues, to respond to two major concerns:

- firstly, that there is a risk that the WHO and UNAIDS Guidelines

will be misinterpreted and used to justify more routine forms of HIV testing that fail to ensure that prisoners provide truly informed consent; and

- secondly, that, on the other side, there is a risk that prisoners will be left out of efforts to scale up access to HIV testing and counselling, and continue being left out of efforts to scale up access to prevention, treatment, care and support.

The background paper was first discussed at an international consultation on HIV testing and counselling for prisoners held in Varna, Bulgaria, on 26 September 2007. In November 2007, the draft policy statement on HIV testing and counselling for prisoners was scheduled to be disseminated to solicit feedback from a wide range of experts. It is expected that the policy statement will be finalized in early 2008. A similar process will

be used to develop a policy statement on HIV testing and counselling for people who use drugs.

– Ralf Jürgens, Jonathan Cohen, Françoise Girard and Chris Beyrer

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¹ WHO and UNAIDS, *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities*, 2007. Available via www.unaids.org.

² R. Jürgens, *Increasing Access to HIV Testing and Counselling While Respecting Human Rights — Background Paper*, OSI, August 2007. At www.soros.org/initiatives/health/articles_publications/publications/testing_20070907.

³ UNAIDS Reference Group on HIV and Human Rights, *Statement and Recommendations on Scaling Up HIV Testing and Counselling*, 2007. At http://data.unaids.org/pub/ExternalDocument/2007/20070905_rghr_statement_testing_en.pdf.

⁴ Ibid.

⁵ UNODC and WHO, *HIV Testing and Counselling for Prisoners — Draft Background Paper*, September 2007.

Comprehensive care: palliative care and legal services in South Africa

A fundamental and neglected part of the global response to HIV and AIDS, palliative care is also a critical entry-point for legal services. As Tamar Ezer and Joan Marston write, providing legal services to patients in palliative care can both protect human rights and improve health outcomes.

In South Africa, a newly-formed reference committee of palliative care and legal service providers is carrying forward an initiative to integrate

legal and human rights advocacy and services into hospices and palliative care programs. In a country where 5.54 million people are infected with

HIV — almost 13 percent of the population — and where the infection rate among pregnant women is 30.2 percent,¹ this comprehensive package

of services is crucial for addressing both acute physical needs and the social dimensions of the epidemic.

Palliative care aims to improve the quality of life for patients and families facing life-threatening diseases by relieving pain and suffering through the provision of physical, psychosocial and spiritual care.² Dealing with legal and human rights issues that arise is thus a natural part of this holistic approach. Providing legal services to people in palliative care not only can protect their rights, but also can reap improvements in their health, well-being and quality of life.

People living with HIV/AIDS often face complicated legal questions related to the disposition of property, planning for children, gaining access to social benefits, and combating discrimination in employment, housing and education. Children, elderly caregivers and child- and youth-headed households are particularly vulnerable to human rights abuse.

The reference committee initiative aims to create the partnerships necessary between the palliative care and legal communities for the provision of comprehensive services that enable both pain management and the tackling of important social concerns. With a robust legal community in addition to a growing network of hospice and palliative care providers, South Africa is an ideal place to pilot such an integrated initiative.

Based in Cape Town, the reference committee is made up of three working groups composed of legal and palliative care practitioners from across South Africa. The working groups focus on the need for materials straddling both the palliative care and legal disciplines; the integration of legal services in hospices; and advocacy for improving access to palliative care (including pain relief) in the public sector as a basic human right.

Projects already underway include a joint paralegal and palliative care manual on comprehensive end-of-

life services, a university law student placement in a hospice to defend the rights of palliative care patients, and a background paper and curriculum exploring legal arguments and mechanisms to promote palliative care as a human right. It is hoped that the project will serve as a model for the integration of health and legal services in other disciplines and regions.

– Tamar Ezer and Joan Marston

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¹ South African Department of Health, *National Strategic Plan for HIV, AIDS, TB and STIs 2007-2011*.

² World Health Organization Definition of Palliative Care, 2002. At www.who.int/cancer/palliative/definition/en/print.html.

Legal aid works! Harm reduction and legal services in Poltava, Ukraine

Drug users' inability to protect their rights makes them easy targets for extortion and false arrest by law enforcement officials, writes Maxim Demchenko, a lawyer from Poltava. In response, a legal aid project supported by LAHI and OSI's International Harm Reduction Development Program (IHRD) has succeeded in defending drug users against criminal charges and changing the attitudes of some police officers.

Ukraine has obligations under both national and international law to respect the human rights of people liv-

ing with HIV and those who are vulnerable to HIV infection from the use of illicit drugs. For these obligations

to be met, the cooperation of all government authorities, particularly the Internal Affairs agencies, is essential.

The reality, however, is that it is common practice among law enforcement bodies in Ukraine to arrest drug users, confiscate their narcotic substances, register them on official lists, and initiate criminal proceedings against them.

Such conduct is encouraged by documents in the Ministry of Internal Affairs of Ukraine that still authorize criminal proceedings for illegal preparation, purchase or storing of a relatively small amount of psychoactive substances for personal use (Article 309(1)). A majority of persons prosecuted through this article are those who suffer from drug dependency and are themselves victims of organized drug crime. Unless this law is repealed or amended, it will be impossible to improve the conduct of law enforcement officials towards drug users and, in turn, to reduce HIV vulnerability.

Drug users in Ukraine cannot adequately protect their rights. Knowing this, law enforcement officials institute criminal proceedings against them without any policy justification, leading to severe overcrowding in prisons and jails.

Prisons in Ukraine are not designed to accommodate the present number of sentenced persons, a majority of whom are chemically dependent and living with HIV/AIDS. As a result, incarceration conditions do not meet even the existing sanitary and hygienic norms required by Ukrainian legislation, let alone international human rights standards.

Currently, police officers are required to submit regular performance reports based on a series of indicators, one of which is the number of criminal cases instituted for crimes in the area of illegal drug trafficking. This compels officers to

institute criminal cases with no valid evidence in order to avoid being fined, which is contrary to the goals of both the criminal law and public health.

In the city of Poltava, it is quite common to charge drug users (a majority of whom are HIV-positive) with unsolved crimes not even related to drug use. Police officers deliberately make false accusations, justifying their illegal actions by claiming that drug users are guilty of some sort of offence in any case.

Coercive and illegal interrogation methods, including threats of physical and psychological violence, and the use of unmediated withdrawal from opiates as a form of physical duress, are used to extort confessions from accused persons, after which they sign the relevant documents without knowing their content or the likely outcomes of their action.

Through a combination of human rights monitoring of police investigations, awareness-raising among law enforcement officials, and meetings with top officials of the agencies of the Ministry of Internal Affairs, it has been possible for civil society organizations to significantly lessen these abuses.

In 2005, with the support of the Soros-funded International Renaissance Foundation (IRF) and the cooperation of the law firm YUREKS, the NGO Light of Hope established a Legal Assistance Centre at its harm reduction program in Poltava. Over 100 drug users, people living with HIV, or their relatives have received some form of legal assistance.

A number of drug users were found not guilty of criminal charges as a result of lawyers pointing to the lack of evidence to prosecute

their case. The mere presence of a powerful and professional legal organization working closely with drug users has changed the attitude of even some of the most hardened members of the Ministry of Internal Affairs, which has helped to prevent a significant number of human rights violations.

The IRF-funded project also includes educational workshops for various branches of the police and prosecutors to educate them about harm reduction and antiretroviral treatment for HIV. The workshops emphasize that police are, first and foremost, members of the community, with a responsibility to protect other citizens.

Our experience has shown that intensive and continuous awareness-raising among police is one of the key ways to foster tolerant attitudes towards drug users and people living with HIV/AIDS. These workshops are so essential that we conduct them even when we do not have the funds to do so. Also, as a result of the workshops, we have succeeded in establishing constructive partnerships with the top officials of the city and regional departments of the Ministry of Internal Affairs of Ukraine.

In spite of this progress, the same human rights violations that we initially observed three years ago are still particularly acute in the Poltava region, particularly in the towns of Kremenchuk, Lubny and Khorol. These violations are not limited to the criminal justice sphere. We have also observed many instances of denial of high-quality health care, involuntary disclosure of HIV status by health workers, and refusal to admit children living with, or affected by, HIV/AIDS or addiction to kindergartens.

We will continue to work on these issues, as we have since 2003. In a short time, we have gained experience in protection of the rights and freedoms of our clients, improved our relationships with local authorities,

and earned a positive image as an organization that can stand up for the rights of its most marginalized clients.

– Maxim Demchenko

Maxim Demchenko (slnadiya@kot.poltava.ua) is Executive Director of the charitable association Light of Hope in Poltava, Ukraine.

Georgia: Anti-drug law violates human rights

At a time when the Georgian government should be protecting the human rights of people who use drugs, Parliament enacted a law that specifically aims to increase stigma against drug users by imposing a range of administrative sanctions against them, Nina Kiknadze and David Otiashvili write.

In July 2007, legislation entered into force in Georgia imposing a range of administrative sanctions against people who use drugs in order to increase social stigma against drug use. The legislation deprives drug users of several rights and privileges for a period of three years. These rights include: the right to drive a vehicle; the right to hold a medical license; the right to advocate as a lawyer; the right to teach and take part in educational institutions; the right to participate in state or local public administration bodies; certain voting rights; and the right to manufacture, purchase, store and carry firearms.

The situation of drug use and related harms (such as HIV infection) has worsened in Georgia in the last ten years. According to a 2005 public opinion survey, the general public views the drug use as the second most serious problem in Georgia after unemployment.¹

Injecting drug use presents one of the most serious threats to public health in the country. As many as 63.9 percent of all identified cases of HIV occur among injecting drugs users. Still, the government has undertaken no concrete steps to adequately respond to this problem. There is a dire lack of treatment options, especially for drug users from lower social classes who cannot afford to pay for treatment. Existing drug programs are outdated, and evidence-based treatment is lacking.

In 2005, only 603 drug users were estimated to have entered treatment in Georgia, although the demand for treatment was much higher. Thousands of drug users are on waiting lists for opiate substitution treatment, which is the most effective proven treatment for opioid addiction.

This huge gap results from significant funding cuts in recent years in the government's budget for addiction treatment. Government funding

for prevention, treatment, rehabilitation, harm reduction and research has decreased from 430,000 GEL (US\$275,475) in 1997 to 50,000 GEL (US\$32,032) in 2006.

Civil society organizations identify the main barriers to addressing Georgia's drug problem as lack of political acknowledgement of the real problems underlying, and caused by, drug use — as well as a weak commitment on the part of decision-makers to solve these problems in an evidence-based way. Proven evidence-based interventions are severely neglected.

The government employs a simplistic, but politically expedient, prohibitionist approach as the main tool for solving drug problems. Georgian legislation qualifies any drug offence as a severe crime and criminalizes drug use itself. Yet this strict criminal approach has not been effective to reduce drug problems in Georgia (or anywhere else for that matter).

It is in this context of failed drug policy that Georgia's Prosecutor General introduced the additional administrative restrictions described above. Defending these restrictions in July 2007, the Deputy Prosecutor General, Nika Gvaramia, said that

[t]he main weakness of the old legislation was that no one was informed about the drug use of other people. If you look in the archives of the Administrative Court, you'll be surprised how many famous people you'll find there fined for drug use. But this information was not known to the society.... We have not hardened the sanctions for drug users, we have only introduced new administrative restrictions that will make the use of drugs shameful and that will destroy the "attractive icon" of the drug user. We built a new type of stigma — everyone will know about the person who uses drugs and he won't be able to even go out. After this, people will think twice about whether it's worth

to continue using drugs, and others will not want to find themselves in the same situation.²

This intentional infliction of social stigma against a socially marginalized group is a cause of great concern. The restriction of rights contemplated by the Prosecutor General's bill fail to comply with Georgia's obligations under international human rights law. They treat people unfairly because they belong to a particular group or have a particular characteristic.

The restrictions will cause labeling and further isolation of drug users from the general society, which will lead to even greater stigma and discrimination. These measures will pose a serious obstacle to the implementation of public health and social programs, including drug treatment, harm reduction, and HIV prevention and treatment programs.

Finally, the proposed sanctions will make it difficult for health pro-

fessionals to reach people who use drugs, meaning that drug users will lose the opportunity and stimulus to seek medical and social assistance. This will further foster prejudicial attitudes toward drug users, and will direct efforts toward punishing "offenders" rather than understanding and assisting people in need.

— Nina Kiknadze and David Otiashvili

Nina Kiknadze (nkiknadze@osgf.ge) is project director of the Law, Media and Health Program at the Open Society Georgia Foundation. David Otiashvili is Director of the Addiction Research Center, Union Alternative Georgia.

¹ J. Javakhishvili et al, *Drug Situation in Georgia – 2005*, Southern Caucasus Anti-Drug Programme, 2006.

² N. Gvaramia, speech delivered at "Addiction, Rehabilitation, and the Criminal Justice System," a conference organized by Penal Reform International and the Norwegian Rule of Law Mission to Georgia, Tbilisi, July 6, 2007.

First HIV legal precedent in Kyrgyzstan: breach of medical privacy

A recent court case of a breach of the privacy rights of a person living with HIV/AIDS in Kyrgyzstan is the first of its kind in Central Asia, write Erik Iriskulbekov and Asylgul Balybaeva. ADILET, the NGO that brought the case to court, is one of only a few NGOs in Central Asia that provide legal assistance related to HIV and AIDS.

After learning he was HIV-positive, Mirlan (not his real name), a former injecting drug user, sought medical assistance at the Regional HIV/AIDS

Prevention Centre (RAPC) in Jalal-Abad, Kyrgyzstan. Shortly thereafter, in autumn 2005, regional television reporters approached the chief physi-

cian of the RAPC, Dr Aibolov (not his real name), and requested and received permission to prepare a video of the centre's work to be

televised on the eve of the World AIDS Day.

After informing the reporters about the problems and achievements of his institution, Dr Aibolov proceeded to suggest that the reporters film HIV patients in the RAPC. Although filming patients without their consent would constitute a gross violation of medical secrecy laws and professional conduct, Dr Aibolov's apparently wanted to increase the profile of his centre in the media and diversify reporting of HIV/AIDS in the country.

By that time, Mirlan was a patient at RAPC awaiting a transfer to a cancer hospital by his infectious disease specialist. Dr Aibolov offered Mirlan an interview with the reporters, but he flatly refused. At that point Dr Aibolov suggested to the reporters that they film Mirlan without his consent. From a window in Dr Aibolov's office, with Dr Aibolov holding open the curtains, the reporters filmed Mirlan sitting on a bench in the enclosed courtyard of the RAPC awaiting his infectious disease doctor. Mirlan was clearly identified in the footage as a person living with HIV/AIDS.

A regional television station subsequently broadcast the video recording of Mirlan, prompting a swift and hostile reaction from residents of the small provincial town where Mirlan lived. Mirlan's life immediately turned into one of continuous victimization. He could not show up in the street without being jeered at and insulted. People pointed fingers at him, refused to serve him at stores and other facilities, and drove him out of public places. Friends and family turned their back on him and refused to allow him to see his own children or even visit his native village.

The families of both Mirlan and his wife left their village. Mirlan's children also faced persecution and insults, with other kids calling them "AIDS carriers" and chasing them from school. The life of Mirlan and his family life became unbearable. He eventually despaired, stopped taking his medicine and tried to commit suicide. His condition deteriorated rapidly.

Apparently because of this emotional experience, Mirlan's mother took to her bed and died. It was as though she could not physically survive such disgrace and public ostracism. The tragedy of his mother's death prompted Mirlan to seek legal advice from the Public Foundation Legal Clinic (known as ADILET), which specializes in defending the rights of people living with HIV and other vulnerable groups. Mirlan hoped to defend his rights and to punish those responsible for misfortunes that fell upon him and his family. Tragically, he was not able to witness the outcome, as he died in hospital the day after his consultation with the attorney.

Following Mirlan's death, his attorney initiated legal proceedings related to the statutory offence committed by the RAPC chief physician. Dr Aibolov was accused of an unjustified breach of medical secrecy regarding Mirlan's HIV status, resulting in grave consequences.

The subsequent trial was difficult and complicated, largely due to deep professional solidarity among physicians (making it difficult to call expert witnesses), intense pressure exerted by the defendant, Dr Aibolov, and threats that hospital officials who testified truthfully would lose their jobs.

On some occasions, Dr Aibolov openly threatened physical harm

against witnesses and court officials. Opposing counsel received intimidating visits from strangers dressed like police colonels and professional thugs. These difficulties were aggravated by the victim's family's lack of trust in judicial system itself and, hence, lack of faith in an independent trial and fair adjudication.

Nevertheless, investigative agencies mounted inculpatory evidence against Dr Aibolov, leading him to plead guilty and receive a just criminal penalty. The actions of the reporters, however, went unpunished. Although the victim's attorney attempted to hold the television reporters equally to account, three times he was denied permission to institute legal proceedings.

This landmark case, the first of its kind in Central Asia, is instructive in many ways. First, HIV/AIDS is still a relatively young epidemic in Kyrgyzstan, meaning that many issues such as the privacy rights of people with HIV remain unexplored. Second, it is important to view this case as not simply a medical issue, but as an issue with social, economic and even political ramifications that ultimately have far-reaching effects across Kyrgyzstan. Finally, this case is the first legal precedent in Kyrgyzstan related to HIV/AIDS.

Thus, it is hoped that this story will send a signal to all institutions and agencies working on HIV/AIDS, and will lead to increased HIV-related jurisprudence in the country and region.

– Erik Iriskulbekov and Asylgul Balybaeva

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Asylgul Balybaeva is a lawyer at the clinic.

Swaziland: Widows fighting for their rights

The AIDS epidemic in Swaziland — the world's most severe — has wrought a generation of widows facing deep discrimination and violence. But the enactment of a new constitution, and support for the legal empowerment of women, provide new hope, Tamar Ezer writes.

At 42.6 percent, Swaziland has the highest prevalence of HIV infection in the world, and life expectancy has dropped to 33 years.¹ The burden of this epidemic has fallen on widows with special severity, increasing both their number and vulnerability.

AIDS has dramatically magnified the effects of discriminatory inheritance laws and of a legal and policy vacuum that denies women adequate protection.² Disempowered and financially dependent widows are more vulnerable to the disease since they may be forced to participate in the practices of widow inheritance,³ polygamy and prostitution in order to survive.⁴

Impoverished widows also have reduced capacity to cope with the disease should members of their families become infected.⁵ As one journalist explained, “Women who lose their husbands to AIDS — and who might themselves be HIV-positive — can ill-afford to sacrifice an inheritance that may go some way towards compensating for the loss of a breadwinner, or subsidizing the purchase of antiretroviral drugs.”⁶

Moreover, women widowed by AIDS are particularly vulnerable to abuse by relatives. Widows have to contend with widespread property grabbing, eviction from their homes, witchcraft accusations⁷ and, sometimes, even the loss of their children. Women in polygamous families have to further split any meagre inheritance they do receive.

SWAPOL (Swaziland Positive Living), a grassroots organization that works to empower and improve the quality of life for women and children affected by AIDS in Swaziland, has made it its mission to assist these women. Siphwiwe Hlophe, SWAPOL's Director, speaks with fervour of the plight of the women with whom she works and of the need for justice. She recounts one heartbreaking story after another. One woman whose husband passed away refused to let her brother-in-law “inherit” her. As a result, he cut down the branches of all her fruit trees, and she now lives in a barren land.

Another widow was accused of witchcraft and had her home and belongings burned. Relatives then threatened to kill her, and she now lives in hiding with five young grandchildren (the oldest is nine) with SWAPOL's support. When the police were contacted about this case, they responded that it was a family matter and so they could do nothing.

However, these widows are not passively accepting their victimization; rather, they are fighting for recognition and justice. They are working with SWAPOL to document the abuses they have suffered in preparation for advocacy and litigation. And, the time is ripe for action. Swaziland's new *Constitution*, the first one in 30 years, proclaims, “Women have the right to equal treatment with men and that right shall include equal opportunities in

political, economic and social activities.”⁸

In July 2007, SWAPOL's Tengetile Hlophe attended the video-advocacy institute of WITNESS, an organization that trains human rights defenders to integrate video advocacy in their work. The hope is that this will bring “unseen images, untold stories and seldom heard voices to the attention of the audiences who hold the power to create lasting change.”⁹ Tengetile is eager to put these new skills to use and has already identified five widows to participate in the making of a documentary. The widows of Swaziland will not be silenced.

— Tamar Ezer

For more information on SWAPOL, please see www.swapol.net.

¹ U.S. Department of State, *Background Note: Swaziland*. Available at www.state.gov/r/pa/ei/bgn/2841.htm; “AIDS scourge in Africa shows urgent need for new women's agency: UN envoy,” United Nations News Service, March 17, 2006.

² Under Swazi Law and Custom, governing the majority of the population, women and girls are unable to inherit, and a male heir will always take over the family property, no matter how distant the family relationship; R. T. Nhlapo, “The legal situation of women in Swaziland and some thoughts on research,” in J. Stewart and A. Armstrong (eds), *The Legal Situation of Women in Southern Africa* (Harare, Zimbabwe: University of Zimbabwe Press, 1990), 97, 124–125; Z. Hlanze and L. Mkhabela, *Beyond Inequalities: Women in Swaziland* (Harare, Zimbabwe: Women and Law in Southern Africa, 1998), 25. This situation is not unique to Swaziland; it is a serious problem throughout sub-Saharan Africa. As one newspaper put

it, widows are denied inheritance, and the husband's relatives "are cashing in on AIDS. Women are left with nothing but the disease;" S. Lafraniere, "AIDS and custom leave African families nothing," *New York Times*, February 18, 2005, at A1.

³ Under this practice, the widow is herself "inherited" by a relative of her husband.

⁴ R. S. Strickland, *To Have and To Hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa*, International Center for Research on Women, 2004, p. 5; L. K. Altman, "Female Cases of HIV.

Found Rising Worldwide," *New York Times*, November 24, 2004, p. A11; L. Garrett, "Polygamy, poverty, and oppression of women are fueling AIDS epidemic in Africa," *Seattle Times*, July 10, 2000, p. A3.

⁵ R.S. Strickland, p. 11.

⁶ J. Hall, "Swaziland: For women, constitution is a curate's egg," International Press Service, February 22, 2005.

⁷ Accusations of witchcraft against widows are not uncommon. This phenomenon stems from the pervasive belief that the widow is an outsider with questionable

loyalties. Witchcraft accusations are further fueled by fears and misunderstandings surrounding HIV/AIDS.

⁸ Swaziland, *Constitution* § 28(1). The Constitution goes on to explicitly state, "A surviving spouse is entitled to a reasonable provision out of the estate of the other spouse whether the other spouse died having made a valid will or not and whether the spouses were married by civil or customary rites;" § 34(1).

⁹ Email from Kelly Matheson at WITNESS to Janet Haven at the Open Society Institute Information Program, February 27, 2007.

Responding to the rising tide of calls for the criminalization of HIV transmission in southern Africa

Faced with the enduring injustice of HIV transmission through sexual violence, African women's groups are increasingly supporting legislative proposals to criminalize deliberate transmission of HIV. In this article, Delme Cupido describes efforts to forge a consensus between these groups and human rights activists concerned about the adverse consequences of HIV-specific criminal laws.

Against a backdrop of increasing calls for harsher sentences for sexual assault and rapes that result in HIV infection, as well as for the criminalization of harmful HIV-related behaviour, the Open Society Initiative for Southern Africa (OSISA) and the AIDS and Rights Alliance of Southern Africa (ARASA) hosted a consultative meeting on June 11, 2007 on the criminalization of wilful transmission of HIV. The meeting was attended by diverse members of civil society, including people living with HIV and rights-based HIV activists and faith-based communities from a range of countries within

the Southern African Development Community (SADC).

Advocates for the rights of women argued forcefully that marriage, in southern Africa, heightens women's vulnerability to HIV, and expressed concerns about harmful HIV-related behaviour related to the subordinate position of women within marriage and other relationships. They viewed laws criminalizing HIV-specific risk behaviours as helping to address this vulnerability.

Human rights activists and people living with HIV, on the other hand, maintained that HIV-specific legislation was both undesirable and

unnecessary. The meeting ultimately agreed on four common position statements, paraphrased here:

- **Position statement one:** Women are more vulnerable to HIV transmission as a result of various social, economic and political factors, and steps should be taken to address these.
- **Position statement two:** Victims of both gender-based violence and non-consensual HIV transmission have a legitimate demand for justice, but the primary problem to be addressed is lack

of access to justice and the lack of sensitivity of our laws to the plight of women.

• **Position statement three:** In the context of harmful HIV-related behaviour, the law should be used to protect the rights of vulnerable groups, and should only be used when the harmful HIV-related behaviour is intentional. Where existing criminal laws are adequate, they ought to be used (instead of creating a new offence).

• **Position statement four:** Criminalizing [wilful transmission] of HIV/AIDS and placing responsibility for transmission solely on those who know their status are inappropriate. The role of government, public health, policy and education in reducing harmful HIV-related behaviour cannot be ignored.

These four position statements represent an important step forward in achieving a regional consensus on this divisive issue in AIDS law and

policy. It is critical that a diverse cross-section of civil society continue to inform national, regional and international debates on the criminalization of HIV transmission and risk behaviour.

– *Delme Cupido*

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Home-based care: who is responsible?

Home-based care is a critical element of national responses to HIV and AIDS. However, governments have largely delegated the responsibility for home-based care to community and faith-based organizations. In this article, Anne Gathumbi argues that governments should articulate the rights and responsibilities of care-givers in national HIV/AIDS legislation and policy.

Haga was diagnosed with AIDS in 2000 at the age of 63, after having become bedridden with opportunistic infections. Due to her age, neither her family nor her doctors suspected she could be HIV-positive until she had already developed full-blown symptoms. Upon diagnosis, Haga's doctors advised her family to take her home because a continuous hospital stay would end up being too costly.

One of her daughters took her into her house to provide the necessary care. With the support of a nurse who made weekly visits to the house

to monitor how Haga was responding to the medications she was given, Haga's condition was successfully turned around. She is now back in her own house and is living a full life, save for monthly visits to the doctor for antiretroviral therapy.

This situation is not unique to Haga's family. It is now widely acknowledged that home-based care offers a more viable alternative to many people living with HIV than hospital-based care. In sub-Saharan Africa, the high prevalence of HIV continues to exert pressure on already

weak health systems, leaving them severely constrained and grossly under-resourced. Poor and run-down facilities, lack of medication, overcrowding and a shortage of health care providers are among the many challenges that characterize public health institutions.

The increasing numbers of people becoming infected with HIV and requiring care, including many health workers themselves, will only weaken the system further. In this context, home-based care becomes a viable option for easing pressure on hospi-

tal-based care. In addition to being less costly, home-based care involves an integrated approach that combines clinical and nursing care with psychosocial support.

Home-based care enables the creation of a social support network of family, relatives and friends of the infected person while, at the same time, providing patients with medication and access to health workers on a regular basis. An additional advantage of home-based care is that through caring for the sick at home, those who offer support learn more about HIV and ways of prevention.

An increasing number of agencies have adopted home-based care as a model of providing care for people living with HIV. According to a representative of CARE International in highly AIDS-affected Kisumu, Kenya, “the CARE team is convinced that this is a better option. Not only do patients get good medical and other support, but the costs involved make the care much more accessible to the very poor, who bear the brunt of the epidemic.”¹

Governments, too, have adopted home-based care and articulated policy documents promoting the concept as a way of easing pressure on already over-stretched health care facilities. Some governments have moved a step further and have invested resources in the development of guidelines and manuals for use in training of community-based care givers. For the most part, however, NGOs, especially faith-based organizations (FBOs) and community-based organizations (CBOs), have stepped in to train caregivers and, in some instances, offer them material or financial support.

Unfortunately, governments have relied heavily on NGOs, FBOs and CBOs to meet the need for home-

based care without clearly articulating the rights and responsibilities of caregivers. A glaring gap in the delivery of home-based care, for example, is the failure by governments to articulate how caregivers can obtain the materials needed to care to the sick. Caregivers are left to obtain materials on their own and often spend meagre savings on necessities such as plastic bags, cotton wool, swabs, razor blades, scissors, plastic containers, disinfectants, clean pieces of cloth, soap, towels, bandages and clean water.

Governments are also silent about who is responsible for meeting the nutritional needs of people living with HIV, leaving this responsibility to charitable individuals and organizations. With home-based care thriving on voluntary services rendered by care givers, it is unrealistic to expect them to shoulder the additional burden of food provision in circumstances of high poverty.

Even countries that have enacted policy and legislative frameworks on HIV/AIDS, such as Kenya, have failed to clearly acknowledge the rights and responsibilities of caregivers in their national legislation. Section 2 of Kenya’s recently-enacted *HIV/AIDS Prevention and Control Act* of 2006 elaborately defines the various categories of health care providers and health services in the context of HIV, but completely fails to mention home-based caregivers as a key pillar of health service provision. Indeed, there is no mention of home-based care in the entire Act.

Section 19 of the Act also addresses access to health care services and upholds the principle of non-discrimination in access to health care on the basis of HIV status. Subsection 19(2) calls upon the government to take

steps to ensure access to essential health care services, including affordable medicines for those living with and at risk of HIV infection.

Here, too, there is a failure by the government to recognize or render support to home-based care services. The fact that home-based care givers are not formally included in the category of “providers” implies that they may not be able to obtain post-exposure prophylaxis or HIV medication in the event of an occupational exposure. Needless to say, the needs of women — who, in the vast majority of cases, are the caregivers of their infected partners, children and extended family members — do not find expression in this law.

The omission of home-based care from national HIV/AIDS legislation not only represents a failure by the government to recognize the fact that the home-based care system currently sustains most sick people, but it also contradicts established and far-reaching policy guidelines for home-based care provision in the treatment of HIV/AIDS. This would appear to be a case of giving with one hand and taking away with the other. There is an urgent need for governments to realize that whether care is provided in a hospital setting or within a home care setting, caring for the sick requires having the necessary tools of trade and employment protections.

Home-based care is a complicated enterprise that should not be viewed as a “quick fix” to the burden of caring for increasing numbers of people living with HIV. Moreover, it should not provide an avenue for governments to abdicate to their populations the responsibility of providing primary health services.

To give meaning to existing home-based care policies, governments

should invest in the development of various models of providing home-based care, should conduct studies to determine which models are most cost-effective, and should make commitments for scaling up the best models. Developing viable and cost-

effective models of implementing home-based care will ultimately ease the burden on home-based caregivers and enable them do their work with minimal difficulties.

– Anne Gathumbi

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¹ Interview with CARE International staff, Kisumu, August 2007.

Documenting human rights violations against sex workers in Kenya

The human rights of sex workers are an increasing concern for prominent women's rights organizations such as the Federation of Women Lawyers (FIDA). As FIDA-Kenya's MaryFrances Lukera writes, documenting human rights abuses against sex workers is critical to responding to Kenya's HIV epidemic.

The criminalization of sex work in Kenya has not resulted in eradicating sex work or even reducing the number of people involved in the industry. The Kenyan legal framework on sex work was inherited from the colonial government. It is, at best, unclear and, at worst, a tool that has in many ways facilitated a significant amount of violence against sex workers.

Kenyan law criminalizes both prostitution and living on the earnings of prostitution.¹ By effectively criminalizing sex workers, the law increases their vulnerability to violence and exploitation because it forces them further underground, hinders their access to health and legal services, and increases the stigma attached to sex work. This is particularly troubling in the wake of HIV and AIDS, which can be transmitted faster

through sex work if laws and policies fail to recognize and positively deal with the presence of sex workers and their clients in the country.

In response to this situation, FIDA Kenya, an NGO working towards the realization of a just society that is free from all forms of discrimination against women, is conducting a research study on the legal and policy environment relating to sex work and the forms of human rights violations experienced by sex workers in Kenya. By so doing, FIDA Kenya hopes to highlight the plight of sex workers as a particularly vulnerable group in the context of Kenya's HIV epidemic. The study will provide much-needed first-hand information on the human rights situation of sex workers so as to inform interventions on their behalf.

Research undertaken so far reveals that sex workers experience different levels of violence at the hands of the police and other law enforcement sectors, that sex workers fear being arrested, and that sex workers believe that complaints of police misconduct will not be taken seriously.

Sex workers are exposed to human rights infringements by the very authorities that are supposed to protect them. The risk of violence from clients is also high. Furthermore, sex workers may experience abuse from intimate partners, members of the general public and pimps. Sex workers feel that they are widely considered immoral and deserving of punishment.

The criminalization of sex work in Kenyan law contributes to an environment in which violence against

sex workers is tolerated, leaving them less likely to be protected. Therefore, many sex workers consider violence “normal” or part of their job, and they lack any information or awareness about their rights. As a result, sex workers are reluctant to report human rights violations. Even if they do report, their claims are often dismissed. The violators are rarely brought to justice or even charged. This suggests a desperate and urgent need to end the violators’ impunity and to recognize and protect sex workers’ human rights in Kenya.

The many adverse health consequences of violence against sex workers cannot be overestimated. Sex work is highly stigmatized. Sex workers are often subjected to blame, labelling, disapproval and discriminatory treatment. Violence has a direct and indirect bearing on sex workers’ ability to protect themselves from

HIV and maintain good sexual health. Sex workers find it difficult to negotiate safer sex with intimate partners and clients in the context of physical and sexual violence (and threats of violence) perpetrated against them.

This situation is not unique to commercial sex workers in Kenya. In a recent survey conducted among Vietnamese sex workers in Cambodia, 30 percent reported that they had been sexually coerced by clients who were unwilling to put on a condom. It is hoped that the FIDA study will add to the critical body of knowledge on sex workers’ health and human rights.

– MaryFrances Lukera

MaryFrances Lukera (maryfrances@fidakenya.org) works with FIDA in Kenya, a grantee of LAHI and OSI’s Sexual Health and Rights Project

(SHARP). This article is drawn from research led by Catherine Mumma for FIDA. As part of this research, the following documents were consulted:

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World Health Organization, *Violence Against Women and HIV/AIDS: Critical Intersections – Violence Against Sex Workers and HIV Prevention*, Information Bulletin Series, No. 3, 2005.

¹ Laws of Kenya, *Penal Code*, Chapter 63.