

HIV/AIDS POLICY & LAW REVIEW

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Scaling up HIV testing: human rights and hidden costs

The calls for provider-initiated routine HIV testing are growing more intense. In this article, Joanne Csete and Richard Elliott discuss the human rights and ethical issues raised by the routine testing approach. Some points in this paper are inspired by an international expert meeting on HIV testing and human rights convened by the Center for Health and Gender Equity, Gay Men's Health Crisis and the Canadian HIV/AIDS Legal Network in Montreal in October 2005. The meeting was attended by academic experts, UN officials, activists and people living with HIV/AIDS from around the world.

The World Health Organization (WHO) estimates that only about 10 percent of persons living with HIV/AIDS in low- and middle-income countries know their HIV status;¹ this is a global crisis. Access to humane and accurate HIV testing is essential for an effective global response to HIV/AIDS. There is complete consensus among AIDS activists and policy-makers in favour of universal access to affordable and high-quality HIV testing. There are differing views, however, on the essential elements of HIV testing and on the means by which universal access to HIV testing should be achieved.

The objective of this article is to respond to the increasingly frequent and forceful calls to accelerate the expansion of HIV testing by redesigning accepted international norms of HIV testing. In the proposed new approach, sometimes described as "routine testing," HIV testing would be initiated by test providers rather than by those tested and would not necessarily include counselling about HIV/AIDS, the

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

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

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Comments?

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

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Scaling up HIV testing: human rights and hidden costs

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opportunity for the person tested to consent to the test in an informed way, or a guarantee of confidentiality of test results.

The ground shifts

In the early years of the HIV/AIDS epidemic, there were aggressive calls for punitive or forcible testing for this new and feared disease. These were sometimes accompanied by calls to ensure that the HIV status of those who tested positive for HIV should be publicly known – in the worst cases, that these people be known in their workplaces and communities as HIV-positive, even that they be tattooed to show their status.

AIDS activists understood that those most affected by the disease, particularly gay and bisexual men and drug users, were already socially marginalized, stigmatized, in many cases even criminalized, and fearful of seeking government services. Layering that fear with the added fear of public scorn would mean that the populations most affected by HIV/AIDS would be the least likely to be tested.

On these grounds, as noted by WHO and UNAIDS in their 2004 *Policy statement on HIV testing*, three underpinning principles of HIV testing (sometimes called the “three Cs”) were established as norms, namely:

- *confidentiality* of test results and of the fact of seeking a test;
- *counselling* and information about HIV/AIDS before and after the test; and

- *consent* to be tested given in an informed, specific and voluntary way by the person to be tested.²

As WHO and UNAIDS emphasize, the primary model for HIV testing in most countries has been one of voluntary counselling and testing (VCT) initiated by clients. However, increasingly, *provider-initiated* testing is being advocated by public health officials in many settings.

WHO and UNAIDS recommend that a *routine offer* of an HIV test be made to pregnant women, people seeking services for other sexually transmitted infections, and asymptomatic persons where HIV is prevalent and antiretroviral treatment is available. However, even when testing takes place as a result of a provider-initiated routine offer, the agencies recommend that there be sufficient pre-test counselling to ensure that there is a good process of informed consent and that people know that *they have the right to refuse a test*.

The WHO/UNAIDS policy distinguishes between *routine offer* and *routine testing*. In practice, however, it may require considerable effort to ensure that offering HIV tests routinely does not turn into an effective testing of everyone who doesn't refuse a test, which would be *routine testing*. WHO and UNAIDS also apparently assume that confidentiality can be preserved in a system of routine offer of HIV tests, but this, too, may require special efforts.

Others have called for a major abridging of the three Cs model. In a widely cited paper, in 2002 De Cock and colleagues called for routine HIV testing that “should not require specific consent or pre-test counselling.”³ In their view, particularly in high-prevalence settings, HIV testing should be the routine or default practice in health facilities, with people having the possibility to opt out of testing.

Increasingly, provider-initiated testing is being advocated by public health officials in many settings.

The rationale of De Cock et al, which has been echoed by others,⁴ is largely an argument against “AIDS exceptionalism.” That is, they say that the protections of human rights of people being tested for HIV provided by the three Cs are no longer justified, if they ever were; and, further, that the three Cs are an impediment to an effective HIV/AIDS response. In particular, they argue that:

- VCT, especially with counselling and informed consent, is too slow and costly to be a useful tool for a public health emergency on the scale of HIV/AIDS, especially in high-prevalence countries;

- HIV/AIDS awareness is already very high in most high-prevalence countries, and therefore there is less need for counselling;
- the exceptional human rights protections related to HIV testing compared to those of other infectious diseases only adds to stigma; normalizing HIV testing and less insistence on anonymity of testing will reduce stigma; and
- VCT actually may undermine social justice in that it restricts people's access to testing, which is essential to treatment and care.

De Cock and colleagues have further suggested that Africa is a special case in terms of needing emergency public health measures unencumbered by “the need to protect individual freedoms.” As they wrote in 2002: “An exceptionalist approach to HIV/AIDS prevention would almost certainly not be applied in the USA or Europe if an epidemic of African severity existed....”⁵

Routine testing raises serious concerns

The arguments of De Cock and others in favour of routine provider-initiated testing, which we take to be motivated by sincere concern for public health, nonetheless raise a number of serious concerns, in our view.

Testing without the three Cs violates human rights

Arguments in favour of models of HIV testing that eliminate or minimize informed consent and counselling generally do not adequately take into account the link between elements of VCT and human rights. All people have the human right to enjoy the “highest attainable standard” of health, which essentially means the

highest attainable standard of health information, goods and services.⁶

The authoritative comment on this right, from the UN committee that monitors governments' progress on attaining this right, suggests that the right to health includes basic services, including HIV/AIDS-related health services, that are “scientifically and medically appropriate and of good quality,” as well as respectful of culture and medical ethics.⁷ We take this to include HIV testing.

The elements of VCT have a clear foundation in human rights law. Informed consent protects the human right to security of the person – that is, to have control over what happens to one's body⁸ – as well as the right to receive information.⁹ Pre-test counselling contributes to the protection of these same human rights. Post-test counselling also imparts information to which people have a right. Confidentiality of test results and of the fact of seeking an HIV test is part of protecting and respecting the right to privacy.¹⁰

The elements of voluntary counselling and testing have a clear foundation in human rights law.

Beyond the components of the testing process itself, governments have a responsibility to ensure that HIV testing, like all other essential health services, is not offered or provided in a way that discriminates against any person or group of people.¹¹ The right to be free of discrim-

ination and the right to security of the person, in our view, also require that in setting HIV testing policy and overseeing its practice, governments take into account the outcomes of HIV testing for people – including stigma, discrimination, violence and other abuse – and do all that they can to prevent human rights violations associated with this health service.

Simply increasing the number of people tested is not a sufficient goal without regard to the consequences of testing

Although there are very few studies of provider-initiated routine HIV testing, it would certainly be no surprise for this practice to yield higher rates of testing than the VCT approach, given that provider initiated routine testing involves testing patients for HIV unless they explicitly state that they do not wish to be tested. But are more tests alone a sufficient achievement? Just the fact of having been tested may not necessarily be a positive outcome if the extra margin of people who are routinely tested includes a significant number who were not well prepared for testing, who do not have adequate information to understand what their test result means for their lives and those around them, who may have irrational fears of HIV because they have had little information about the disease, or who may not know how to begin to disclose their status to sexual or drug-using partners.

Depression, suicide, abandonment, violence and other abuse may result, and these need to be addressed and accounted for in the policy calculus about ratcheting up HIV testing. More research is urgently needed to investigate whether the absence of informed consent and counselling

affects people's experiences of abuse or other negative outcomes as a result of testing HIV-positive.

Few public health professionals would see a greater rate of testing alone as an achievement in itself. Testing for HIV is valuable insofar as it assists with HIV prevention and access to care, treatment and support. Those who call for more provider-initiated routine testing argue that a low rate of testing keeps people who need treatment from getting it and impedes prevention by making it impossible to target safer-behaviour education to people who are HIV-positive but who do not know their status.

The experience of antiretroviral treatment roll-out – even though the roll-out is still less extensive than it should be – has shown that when treatment is available, people generally come forward voluntarily in large numbers for testing. When treatment is unavailable, it is unsurprising that people are reluctant to be tested. It is, moreover, unethical to expose people to the stigma and other negative consequences that may derive from testing without linking testing to other support, treatment and care.

Without the three Cs, testing loses its power as a prevention tool

For testing to be part of a comprehensive, effective and human rights-based prevention effort, it should provide the people tested the opportunity to understand and ask questions about HIV/AIDS transmission and care and to get help on the difficult matter of disclosing their HIV status. HIV testing that includes neither counselling nor informed consent loses its power as a prevention tool. As Heywood has argued, high “awareness” of HIV/AIDS,

including in high-prevalence countries in Africa, is not the same as real knowledge that can guide and inspire behaviour change. This knowledge is much more likely to come through counselling and the chance to ask questions.¹²

HIV testing that includes neither counselling nor informed consent loses its power as a prevention tool.

Counselling was seen from the early years to be an important component of testing, particularly assisting people with well adapted, culturally appropriate information and with the chance to ask questions in a discreet and confidential way. There is no doubt that the absence of qualified counsellors has been a bottleneck at various times, particularly in heavily affected communities. This is a question of resources and program priorities. Many low-income countries have shown that relatively rapid training of HIV counsellors is possible when resources are available.

Has VCT failed, or has it not been adequately financed?

There is a large body of research, including case studies, some of it compiled by the UN, that demonstrates the effectiveness of VCT as part of comprehensive prevention, treatment and care strategies.¹³ Before VCT is pronounced a failure, it is important to understand whether it is the VCT model that has “failed” or whether testing and counselling

have not been adequately supported to realize their potential.

Over the decade from 1988 to 1998, when sub-Saharan Africa should have been building HIV counselling and testing capacity, official development assistance for all HIV/AIDS programs, including testing, was scandalously low and actually declined on a per-HIV-positive-person basis.¹⁴ In this period, with so little hope of offering effective treatment for HIV/AIDS, it is unsurprising that many countries tended to invest in general education programs or promotion of condom use rather than pushing people to be tested.

It is only since 2002, the year in which De Cock and his colleagues declared the failure of VCT, that greater flows of HIV/AIDS assistance through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria have opened the possibility for large-scale building of counselling capacity as well as expansion of treatment access.

The growing hope of access to antiretroviral treatment should be seen as highlighting the need for urgent scale-up of counselling capacity to ensure that HIV testing has the preventive value and the strong link to treatment and care that it should have. Scale-up of testing is urgently needed and, with appropriate investment, that scale-up could minimize HIV-related abuse and encourage confidence in the health system that is needed for long-term treatment and care. But that is unlikely to happen outside the VCT framework.

Leaving out the three Cs could increase the negative outcomes of testing

A recent WHO-supported review of 17 studies from Africa and southeast

Asia concludes that from four to 28 percent of women reported negative outcomes following the disclosure of their status. These outcomes included blame, abandonment, violence, anger, stigma and depression.¹⁵ Of these women, between 2.5 percent and 14.6 percent reported having faced violence as a reaction to disclosure of their HIV status.

The authors of this review suggest that some screening of women most at risk of negative outcomes of disclosure – as well as targeted, intensive counselling to help such women, especially those already exposed to domestic violence and sexual coercion – could help women minimize abuse following disclosure.¹⁶ Other researchers have noted that if the two partners in a sexual relationship can be counselled together – which costs more in outreach time and is not always possible – abusive situations may be effectively defused.¹⁷

Even before the WHO review, it was clear that having one's HIV-positive status known carried many risks, especially for women, young people, persons who are already criminalized such as sex workers and people who use drugs, and others who are socially or legally marginalized.

While measures may be taken to mitigate negative outcomes of HIV testing, it is clear that even where the three Cs are respected as a matter of policy, access to such measures is bound to be limited. In addition, for some people, such as women in violent relationships, the only action that may reduce the harm they face from being known to be HIV-positive may be leaving the relationship, which may be impeded by factors that counselling and information cannot address.

Nonetheless, it is important to try to mitigate harms in any way that

is possible with available resources. We hasten to add that even if measures are in place to minimize the negative impact of testing, it remains in our view an abuse of the human rights of people being tested to conduct an HIV test without their informed consent.

It is an abuse of the human rights of people being tested to conduct an HIV test without their informed consent.

The policy of routine testing is not justified if it exposes people to abuse

In their call for routine testing without informed consent, De Cock et al. recognize that disclosure of HIV status may result in stigma and abuse and suggest that “routine HIV testing should be accompanied by structural changes such as legal and social interdictions against discrimination or abuse of infected people.”¹⁸

The recommendation for strong anti-discrimination measures is a laudable one. But when is it justified to expose people to abuse, including violence, through a public health measure? In cases of epidemics of highly contagious diseases, for example, violating people's freedom of movement by instituting quarantines or their right to informed consent by conducting mandatory screening may be justified in pursuit of the larger goal of protecting the population from disease.

In 1985, a UN human rights body suggested conditions under which it

may be justifiable for a society or for public health authorities to limit or infringe upon human rights to some degree. Among the conditions identified are the following:

- when the limitation on human rights “responds to a pressing public or social need,” “pursues a legitimate aim and is proportionate to that aim”;
- when the limitation represents “no more restrictive means than are required for the achievement of the purpose of the limitation”;
- when the limitation is not applied in an arbitrary or discriminatory manner;
- when the limitation is provided for by law; and
- when the limitation does not violate “non-derogable” rights, which include the right to life; freedom from torture and cruel, inhuman or degrading treatment; freedom from medical or scientific experimentation without free consent; freedom from slavery; and freedom of conscience and religion.¹⁹

In our view, these conditions are not met sufficiently to justify the exposure to human rights abuses that may follow from testing people without their consent and without the counselling that may help minimize violence and abuse. In particular, VCT, when adequately supported by resources, has the potential to be a means of reaching HIV/AIDS prevention and treatment goals that is much less restrictive of human rights than routine HIV testing without consent or counselling.

Testing women in violent unions for HIV, for example, without even trying to apply tools that would

enable them better to protect themselves from violence, may constitute exposing them to cruel and degrading treatment. Increasing investment in counselling of couples would be more effective and less restrictive than routine testing for long-term goals of behaviour change and linking HIV-positive people to treatment and care.

There is no evidence that “routine” testing would reduce stigma and discrimination

Whether routine testing without consent or counselling would reduce stigma and discrimination by treating HIV/AIDS more like other diseases is an empirical question that has not been tested in research. It would be difficult to test such a hypothesis in ethical ways. In countries where certain categories of people – such as all people who enter military service, all prisoners, or all immigrants – are subjected to mandatory or compulsory HIV testing, there is no evidence that suggests that the routinization of testing reduces stigma and discrimination.

In our view, HIV/AIDS does remain exceptional among infectious diseases in the degree to which it is associated with severe, even demonizing, stigma in the public mind and abusive responses from individuals and communities. There remains relatively little investment in most countries in real protection from HIV-related discrimination and abuse, particularly for women, sex workers, men who have sex with men, people who use drugs and prisoners.

Even where protection against discrimination on the grounds of HIV/AIDS status is well established in the law, it is sometimes undermined by the use of criminal law related to HIV transmission and exposure.

There is little reason to believe that the routinization of testing would be effective in combating the wide range of forms and instances of HIV-related discrimination and abuse. Moreover, knowing the health system is testing people for HIV without counselling and consent might very well discourage people from seeking care and make them suspicious of health professionals with whom they need a relationship of confidence.

Increasing investment in counselling of couples would be more effective and less restrictive than routine testing.

Conclusion

For years the world somehow tolerated the idea that people in wealthy countries would be treated for HIV/AIDS and those in resource-poor countries would have to get by with “low-cost” prevention measures and palliative care. This idea was undoubtedly partly a function of the high cost of antiretroviral treatment. After years of activism, treatment – while still too inaccessible – is now recognized as the right of all people living with HIV/AIDS. Efforts have been made not only to scale up treatment access but to lower the costs of treatment.

There is no doubt that effective voluntary counselling and testing are also costly. But both are essential to an effective HIV/AIDS response, and both are human rights obligations

of governments. If there is a way, through better HIV counselling and outreach efforts to increase counselling of couples, to reduce abuse and violence against HIV-positive persons and to increase confidence in health services – even if this is more expensive than simply testing everyone who comes to a health facility without explicit consent – this investment must take place.

It is increasingly recognized, moreover, that all aspects of an effective HIV/AIDS response, including treatment, require greater investment in the training and retention of health workers and in health infrastructure.²⁰ Building counselling and testing capacity goes hand in hand with building capacity for treatment and care.

It is crucial that HIV testing be scaled up, but it is equally crucial that this scale-up be done in a manner that minimizes harm and maximizes benefits. In our view, this will happen when scaling up HIV testing is understood to mean scaling up of the capacity of health systems both to respect people’s right to consent to a medical procedure that has great consequences in people’s lives, and to give them as much information as possible to protect themselves from abuses that may accompany the knowledge of their HIV status. Like combination antiretroviral therapy, this will cost money. Like combination therapy, it is indispensable and is the human right of all people.

– Joanne Csete and Richard Elliott

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¹ UNAIDS and WHO. *UNAIDS/WHO policy statement on HIV testing*. 2004. Available at http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf.

² *Ibid.*

³ K De Cock et al. Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century. *Lancet*, 2002; 360: 70. Dr. De Cock will be the director of the HIV/AIDS Department at the WHO's Geneva headquarters as of March 2006.

⁴ R Holbrooke and R Furman. A global battle's missing weapon (op-ed). *New York Times*, 10 February 2004: A35.

⁵ *Ibid.* at 69.

⁶ *International Covenant on Economic, Social and Cultural*

Rights. United Nations General Assembly Res. 2200A, 16 December 1966, article 12(1). See also interpretation of this right in UN Committee on Economic, Social and Cultural Rights. General Comment No. 14: The right to the highest attainable standard of health: Art 12 E/C.12/2000/4, 11 August 2000.

⁷ General Comment No. 14 at paras 12c and 12d.

⁸ *International Covenant on Civil and Political Rights*. United Nations General Assembly Res. 2200A, 16 December 1966, article 9(1).

⁹ *Ibid.* at article 19(2).

¹⁰ *Ibid.* at article 17(1).

¹¹ *International Covenant on Economic, Social and Cultural Rights*, article 2(2).

¹² M Heywood. Human rights and HIV/AIDS in the context of 3 by 5: time for new directions? *Canadian HIV/AIDS Policy & Law Review*, 2004; 9(2): 1, 7-13.

¹³ See, e.g., research summaries by USAID at www.usaid.gov/our_work/global_health/aids/TechAreas/voluntarycounsel/vct_research.html and by Family Health International at www.fhi.org/en/hivaids/pub/fact/vctforhiv.htm.

¹⁴ A Attaran and J Sachs. Defining and refining international donor support for combating the AIDS pandemic. *Lancet* 2001; 357(9249): 57-61.

¹⁵ A Medley et al. Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes. *Bulletin of the World Health Organization*, 2004; 82(4): 302.

¹⁶ *Ibid.* at 305.

¹⁷ Voluntary HIV-1 Counseling and Testing Efficacy Study Group. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad: a randomised trial. *Lancet* 2000; 356(9224): 103-112.

¹⁸ De Cock et al at 71.

¹⁹ UN Economic and Social Council, UN Sub-Commission on Prevention of Discrimination and Protection of Minorities. *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights (Annex)*. UN Doc E/CN.4/1984/4 (1984), articles I.A., II.D.

²⁰ T Rosenberg. Think again: AIDS. *Foreign Affairs* 2005; March/April: 22-26.

CANADIAN DEVELOPMENTS

This section provides brief reports of developments in legislation, policy, and advocacy related to HIV/AIDS in Canada. (Cases before the courts or human rights tribunals in Canada are covered in the section on HIV in the Courts – Canada.) The coverage is based on information provided by Canadian correspondents or obtained through scans of Canadian media. Most of the articles for this section were written by David Garmaise, the editor of Canadian Developments, and Glenn Betteridge, Senior Policy Analyst at the Canadian HIV/AIDS Legal Network. Address correspondence to David Garmaise at dgarmaise@rogers.com. Glenn Betteridge can be reached at gbetteridge@aidslaw.ca.

Health Canada authorizes access to experimental HIV drugs, but only after a long struggle

Five men living with HIV/AIDS, who had developed resistance to conventional antiretroviral therapies and who were seriously ill, have finally obtained access to two experimental antiretroviral drugs.

In March 2004, the men's physician, Dr Julio Montaner, a well-known HIV researcher, submitted a request on behalf of the five men to the Special Access Programme (SAP) of Health Canada's Therapeutic Products Directorate for the drugs TMC 114 and TMC 125.¹ The SAP allows

practitioners to request access to drugs that are unavailable for sale in Canada.²

The drugs are manufactured by Tibotec, Inc., a research firm based in Belgium and owned by US pharmaceutical giant Johnson & Johnson. The drugs had shown promising

results in separate trials, but had never been used in combination.³

In his request to the SAP, Dr Montaner said the drugs would be used in combination. Health Canada denied the request on the grounds that there was not enough evidence proving that the drugs were safe.⁴

Health Canada said that the drugs were too experimental and that taken together they might pose a health risk to the men. It added that the SAP was not designed for drugs at such an early stage of development.⁵

In September, Dr Montaner issued an appeal to Health Canada, but it was also denied on the same grounds.⁶

In a news release, the British Columbia Society of Persons with AIDS Society (BCPWA) called on then federal Health Minister Ujjal Dosanjh “to save the lives of those HIV-positive Canadians requiring compassionate access to ... TMC 114 and TMC 125.... These patients have no other effective drugs left available; one person has died waiting.”⁷

During the federal election campaign in December 2005, BCPWA organized a demonstration outside Dosanjh’s constituency office to protest the Health Canada decision.

On 20 December 2005, Health Canada announced that it had found another way to make the drugs available. Health Canada approved a compassionate use clinical trial protocol for TMC 114 and TMC 125. The only participants in the trial are the five B.C. men. Health Canada said that all persons living with HIV/AIDS who might need these drugs in the future would benefit from the knowledge gathered in the controlled environment of this clinical trial.⁸

Dr Montaner said that he is hoping to offer TMC 114 and TMC 125 soon to up to 600 patients across Canada as part of a broader clinical trial.⁹

Comment

It is not clear why the requests for access to TMC 114 and TMC 125 could not have been approved under the SAP. The reason cited by Health Canada was that there was not enough evidence to show that the drugs were safe when used in combination.

According to a Health Canada fact sheet, access under the SAP “is limited to patients with serious or life-threatening conditions on a compassionate or emergency basis when conventional therapies have failed, are unsuitable, or are unavailable.”¹⁰

The fact sheet says that the physician “is responsible for initiating a request on behalf of a patient and ensuring that the decision to prescribe the drug is supported by credible evidence available in the medical literature or provided by the manufacturer.”¹⁰

The instructions which Health Canada has issued to physicians on the use of the SAP state that

SAP authorization does not constitute an opinion or statement that a drug is safe, efficacious or of high quality. The SAP does not conduct a comprehensive evaluation to ensure the validity of drug information or attestations of the manufacturer respecting safety, efficacy and quality. These are important factors for practitioners to consider when recommending the use of a drug and in making an appropriate risk/benefit decision in the best interests of the patient.¹¹

The purpose of the SAP program is to provide access to experimental

drugs when conventional therapies have failed. The goal is to prolong life until other options become available. Both the patient and physician know there there is great risk and no guarantee of success.

Health Canada cannot guarantee the safety of the drugs authorized under the SAP, as the department itself acknowledges. When a drug is requested through SAP, Health Canada’s primary responsibility with respect to safety should be to ensure that there is no evidence of imminent danger.

– David Garmaise

¹ AIDS patients dying waiting for Health Canada approval. News release, Vancouver, British Columbia Persons with AIDS Society, 24 November 2005. Available at www.bcpwa.org/articles/news_release_aids_patients_dying.pdf.

² Health Canada. *Special Access Programme – Drugs*. Fact sheet. November 2002. Available at www.hc-sc.gc.ca/dhp-mps/acces/drugs-drogues/sapfs_pasfd_2002_e.html.

³ P O’Neil. HIV patients get drugs, politicians vie for credit. *Vancouver Sun*, 21 December 2005.

⁴ AIDS patients dying waiting for Health Canada approval.

⁵ P O’Neil. B.C. man first Anglican cleric in Canada to come out: Priest dying of AIDS pleads for new drug. *Vancouver Sun*, 3 December 2005.

⁶ AIDS patients dying waiting for Health Canada approval.

⁷ Ibid.

⁸ AIDS patients in Vancouver get Health Canada approval for new drugs. *Canadian Press*, 20 December 2005.

⁹ D Hansen. Artist lives on a promise: a month after starting a new therapy for AIDS, Tiko Kerr shows encouraging results – and he feels “really good.” *Vancouver Sun*, 4 February 2006.

¹⁰ Health Canada. Fact sheet.

¹¹ Health Canada. *Special Access Programme (SAP) – Instructions for Making a Special Access Request*. August 2003. Available at www.hc-sc.gc.ca/dhp-mps/acces/drugs-drogues/sapg2_pasg2_e.html.

COMMENTARY

Question period: how will Canada's new minority government approach HIV/AIDS?

Clocking in at 55 days, Canada's recent federal election campaign was unusually long, uncharacteristically negative and largely defined from the outset by the Conservative Party's string of almost daily policy announcements — none of which focused on HIV/AIDS. In fact, HIV/AIDS was given only passing mentions in the platforms of the Liberals, New Democrats, Blocquistes and Greens. In the case of the Conservatives, it was simply not mentioned at all.

In and of itself, the failure on the part of the political parties, the media and voters to see HIV/AIDS as an issue worthy of national debate was disappointing. And, in the context of Canada's role as host country for the XVI International AIDS Conference (AIDS 2006), the silence of the federal party leaders on this issue was deafening.

The Canadian HIV/AIDS Legal Network and the Interagency Coalition on AIDS and Development (ICAD) jointly called on the party leaders to define their approaches to combating HIV/AIDS. The Canadian AIDS Society (CAS) followed suit. The questions were detailed and precise. Unsurprisingly, the answers — when answers were given — were not.¹

The parties all agreed on the need to increase foreign aid, though none of them provided an explanation of how this would be done or by when. While the Liberals continued to tout

fiscal prudence as the basis for not committing to a detailed plan, the NDP and the Bloc vowed to continue to pressure the next government to set a binding timetable to increase Canada's foreign aid to the United Nations target of 0.7 percent of gross national income by 2015.

On the question of providing affordable medicine to developing countries, only the NDP gave a clear and actionable answer, saying it would reduce the length of patents for prescription drugs in Canada, triple existing funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and work "through the United Nations to reform the International Monetary Fund and World Bank to eliminate the drastic lending conditions that cut health and education investment in developing nations, which often result in cuts to AIDS treatment and prevention programs."

Although all the parties made vague pronouncements on increasing funding to reduce women's risk of HIV infection, only the NDP clearly stated it would do so. As for prison needle exchange programs, there was unanimity on the need for further study, but none of the parties went so far as to say they would actually implement such programs.

Ultimately, with the ballots cast, the polls closed and the results tallied, Canada was left with its second minority government in a row — this time, a Conservative one.

Ominously, the Conservative Party was the only party represented in the previous Parliament that failed to provide answers to the questions posed by the Legal Network and ICAD. And though it did give a reply to CAS, its one-page letter was little more than "politesse oblige," reading in part:

The Conservative Party sympathizes with the more than 50,000 Canadians living with AIDS. We are steadfast in our belief that all Canadians are entitled to fulfill their potential and to share in the comforts afforded by our generous society. If elected, a Conservative government would be open to hearing your thoughts and suggestions on this very important issue.

Yet, if the Conservatives were reticent to answer questions from AIDS organizations, their leader, Stephen Harper, was unequivocal about the party's position on one particular HIV/AIDS issue: injection drug use. In the opening weeks of the campaign, Harper was widely reported to have framed the funding of Insite, North America's only safe injection site, as taxpayer-subsidized drug use — and he vowed to shut it down. (The Vancouver facility's current exemption from the federal *Controlled Drugs and Substances Act* expires in September 2006.)

The first of the five key questions posed to party leaders by the Legal Network and ICAD was, "Will

you establish a permanent legal framework to allow Canada's only safe injection site to continue its life-saving work?" It seems that the Conservative leader's response – had there been one – would have been "no."

Pre-election campaigning and post-election governing, however, are often different things. The week after the election, *The Globe and Mail* reported on a study published in the *British Medical Journal* confirming Insite's positive impact and dispelling fears that safe injection facilities lead to increased harms to drug users.² The article included a sliver of hope for Insite advocates:

Mr. Harper's promise is not a death knell for the centre, said John Reynolds, the former campaign co-chair for the Conservatives in [British Columbia]. "Once Mr. Harper gets

this cabinet sworn in, he'll be talking to [Vancouver Mayor] Sam [Sullivan] about it," Mr. Reynolds said.

The outcome of this conversation may well determine Insite's future (or lack thereof). It might also set the tone for HIV/AIDS policy under the new Conservative government. Will Canada stay the course on its approach to HIV/AIDS, or take a right turn down the road of abstinence-based strategies of countries like the United States?

Over 15,000 delegates from around the world, including presidents and prime ministers, as well as media outlets, are expected to gather in Toronto this August for AIDS 2006. As Canada is the host country, our response to the epidemic will be under heightened scrutiny. What will the world hear from Canada's prime minister about this country's response

to the ongoing public health tragedy of HIV/AIDS among people who inject drugs? Will his government commit to supporting proven health protection measures such as Insite?

– Leon Mar

Leon Mar is the Director Communications for the Canadian HIV/AIDS Legal Network. He can be reached at lmar@aidslaw.ca.

¹ For the full text of the questions and answers, visit www.aidslaw.ca and www.icad-cisd.com.

² Study plays down fears over safe injection site. *The Globe and Mail*, 31 January 2006.

HIV-positive woman suing police, man who allegedly infected her and his family

By statement of claim dated 18 April 2005, a Windsor woman is suing a man she alleges infected her with HIV.¹ She is also suing the Windsor Police Service and the man's family.

In June of 2004, the man was arrested by Windsor police and charged with a number of criminal offences related to exposing several women to HIV. The woman who launched the civil law suit alleges that the man repeatedly carried out a battery on her.

Battery is a civil cause of action akin to the criminal offence of assault, and essentially involves touching a person without that person's consent.

She also alleged, among other things, that he acted negligently when he failed to tell her about his HIV

status, engaged in unprotected intercourse with her, and failed to warn her of the risks of contracting HIV by doing so. The woman alleges that she was 16 years old when she met the man, who was allegedly 26 at the time.

The woman further alleges that four members of the man's family knew about the man's HIV status, knew that he had infected other women with HIV and, as a result, were negligent when they failed to disclose his HIV-positive status to the woman. Finally, in relation to the police, the woman alleges that the Windsor Police Service was negligent in that it failed to warn the public that the man was systematically exposing women to HIV, thereby depriving the woman and members of the community of the opportunity of protecting themselves from harm.

The woman is seeking a total of CA\$10 million in damages to compensate her for permanent injury, interference with her health, safety

comfort and convenience, loss of income and other expenses, including significant medical, pharmaceutical and other costs associated with the treatment of her HIV.

A judge ordered a publication ban on the case to protect the identity of the woman and her family. The man, his family and the Windsor Police Service have each filed defences to the claim. The woman has requested that the case be heard by a jury. There is no word on when the case is scheduled to go to trial.

If the case is not settled, the court's decision is likely to set a number of precedents. It would be the first time a Canadian court has addressed the issue of the legal duty that individuals and police have to

take steps to prevent people being exposed to possible HIV infection. It would also be the first case in which a court considers the civil liability of a person living with HIV/AIDS who fails to disclose his or her HIV status and exposes or transmits HIV to another person through sexual intercourse.

– Glenn Betteridge

¹ *Roe v Leone et al*, Windsor 05-CV-4732CM (Ontario Superior Court of Justice). The Statement of Claim and other documents in the case are on file with the author.

Medical marijuana users continue to experience legal barriers

Four recent developments highlight that people continue to face significant legal and administrative barriers to using marijuana for medical purposes – despite the existence of the *Marihuana Medical Access Regulations (MMAR)*¹, enacted by the federal government, as a result of court rulings, to enable people who require marijuana for medical purposes to exercise their constitutional right to such medicine.

In one development, three British Columbia men are suing the city of Vancouver after the police, acting under the authority of a search warrant, raided a private home looking for a marijuana grow-operation.² Two of the men allege that they were held at gun-point during the raid and subsequent search of the residence.

No charges were laid against the three men, one of whom has legal authorization to grow and possess marijuana for medical purposes. However, police seized equipment and placed a “no-occupancy” citation on the residence. The City of Vancouver maintains that marijuana plants found in the backyard were not

authorized, and that the indoor growing operation, while authorized, did not meet municipal by-law standards in relation to electrical wiring.

In another development from Vancouver, a man licensed to grow and possess marijuana has filed a human rights complaint against a landlord who turned down his rental

application.³ The licensed marijuana user is claiming that the landlord illegally discriminated against him on the basis of his disability when he refused to rent the apartment to him knowing he would be growing marijuana. The case will be heard by the British Columbia Human Rights Tribunal.

In Saskatchewan, a user whose license had expired and his family were held by police, allegedly in handcuffs, during a raid on their home.⁴ The man, a person living with HIV/AIDS who has been licensed to grow marijuana for the past five years, reported that he was awaiting the renewal of his licence by Health Canada. Police seized his marijuana plants and growing equipment, and charged him with one count of production of a controlled substance. Subsequent to the police raid, the man obtained a faxed copy of his license renewal from Health Canada.

Finally, it was recently reported that close to half of the people licensed to possess medical marijuana who buy their supply from the government-designated producer are in arrears.⁵ A government spokesperson reported that accounts in arrears are turned over to a collection agency after 180 days. Nineteen licensed users have had their supply terminated because of non-payment.

Comment

The starting point for the consideration of medical marijuana is the body of court decisions which have established the constitutional right of people living with a serious illness to use marijuana for medical purposes. Courts have also been clear that this right has limits: The government is within its legal authority to

establish a program to determine who may legally possess and produce (or obtain) marijuana for medical purposes.

Yet, as evidenced by the two developments involving police raids on people's private homes, those people who grow or use marijuana for medical purposes continue to be treated by police as dangerous criminals. As part of a package of recent amendments to the *MMAR*, Health Canada was given the authority to communicate to any Canadian police force conducting an investigation detailed information about people licensed to possess and produce marijuana under the program.⁶ Police organizations lobbied vigorously for the inclusion of this provision.

As of December 2005, over 1100 people were licensed to possess marijuana, and over 850 were licensed to produce marijuana, for medical purposes.⁷ While police can now gain access to information about licensed producers, it is not clear from these two developments whether the police will now use that access to protect the constitutional rights of the medical marijuana users involved, or to prosecute them – or whether they will fail altogether to communicate with Health Canada when conducting investigations and deciding whether to charge people with offences related to marijuana.

In both cases reported above, the police raids were based on search warrants obtained from a justice of the peace. Should not justices of the peace be requiring police to show that they have reasonable and probable grounds to believe a crime has been committed – including that the police have verified whether the alleged operator of a grow-op is a

legally licensed to producer of marijuana? One questions whether the police and justices of the peace have been sufficiently educated about the *MMAR*.

The developments also attest to the ways in which legal medical marijuana users may find themselves enmeshed in legal battles when they attempt to exercise their constitutional right. In one case, it is alleged that a licensed user ran afoul of municipal by-laws; another user is claiming that he was refused housing due to his use of marijuana to palliate the symptoms of his disability.

To date, Health Canada has provided little if any information to licensed users on the interplay of licenses issued under the *MMAR* with other laws of general application that may pose legal barriers (e.g., municipal by-laws; housing legislation) or offer legal support (e.g., anti-discrimination legislation).

Finally, advocates for medical marijuana users continue to report that the cost of marijuana is a significant barrier to ensuring access to medical marijuana. While the courts have recognized a legal right to choose to use marijuana for medical purposes, they have not directed the government to pay for it.

Unlike prescription medications, marijuana is not covered under provincial prescription drug programs or private insurance programs. For low-income people living with HIV/AIDS, the cost of marijuana may stand in the way of them accessing the medicine they need to eat, sleep, alleviate pain, or stave off nausea so that they can adhere to complex HIV antiretroviral medication regimes.

When viewed in this light, there is a strong argument that police

raids on licensed growers, invariably involving seizure of growing equipment and destruction of marijuana plants, amount to an unconstitutional infringement of the constitutionally protected right to be secure from unreasonable search and seizure, and to security of the person.

– Glenn Betteridge

¹ SOR/2001-227, as amended. For a review of the leading court cases regarding the constitutional status of medical marijuana, see G Cruess. Ontario court affirms that medical marijuana regulations are unconstitutional. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 53-56.

² D Hansen. City faces lawsuit over raid on legal marijuana growers. *Vancouver Sun*, 15 November 2005: A1.

³ Medical pot user claims discrimination. *Canadian Press*, 25 January 2006.

⁴ D Bueckert. Medical pot advocates angry. *Canadian Press*, 2 February 2006; J Pruden. Ottawa bureaucrats blunder Regina AIDS patient's file. *Regina Leader-Post*, 3 February 2006.

⁵ D Beeby. Patients on disability chased by government collection agencies. *Canadian Press*, 5 February 2006.

⁶ *Regulations Amending the Marijuana Medical Access Regulations*, SOR/2005-177 at s 28, 29. For more information, see D Garnaise. New medical marijuana regulations approved. *HIV/AIDS Policy & Law Review* 2005; 10(2): 21; G Betteridge. Proposed amendments to medical marijuana regulations released for comment. *HIV/AIDS Policy & Law Review* 2004; 9(3): 28-29.

⁷ See Health Canada, Drugs and Products Directorate, Medical Use of Marijuana, December 2005 Stakeholder Statistics, available at www.hc-sc.gc.ca/dhp-mps/marihuana/stat/2005/dec_e.html.

New developments in mandatory blood testing legislation

In November 2005, the Liberal government in Ontario introduced a bill¹ that would allow police officers, other community safety workers and victims of crime to find out more quickly whether they have been exposed to infection from certain viruses.² Meanwhile, the Saskatchewan Medical Association (SMA) is opposing similar legislation enacted in that province.

Ontario already has legislation designed to enable police officers, victims of crime and others to apply for an order to require that a person who is the source of an exposure to a bodily substance undergo blood testing.³ Under the current legislation, a medical officer of health can issue such an order if a blood sample is not provided voluntarily.

The Ontario government says that the existing process, from application to testing, can take “up to 70 days or more” to complete.⁴ Under the new bill:

- authority for ordering the blood sample would be vested in

the independent Consent and Capacity board;⁵

- the voluntary compliance period would be reduced from seven days to two; and
- decisions on applications would be made within seven days.⁶

Medical officers of health would continue to be responsible for screening applications, seeking voluntary samples, and supervising the process after an order is issued.⁷

Three other provinces – Nova Scotia, Alberta and Saskatchewan – have also passed blood samples legislation.⁸ The SMA is opposing the new law in that province.⁹ According

to Saskatchewan Justice Minister Frank Quennell, Saskatchewan is the first province to give a judge the authority to order a test.¹⁰ As part of the legislation, physicians are required to provide the court with an assessment of the level of risk that the exposure has created.

“This legislation is seriously flawed in a couple of respects,” says Dr. Anne Doig, chair of the SMA’s legislative committee. It is almost impossible to assess the risk exposure poses without key information about the person who may pose the risk, Dr Doig said. “We’re concerned that our names, our reputations and our professional judgment are being used

to lend credibility to a process that in itself isn't credible."¹¹

Dr. Keith Ogle, who teaches medical ethics at the University of Saskatchewan College of Medicine, says he would refuse to complete the assessment form. "I'm not sure a lot of doctors would want to sign that form recognizing that, as a result of that act, somebody will be tested against their will. It tends to place a physician in a position in which they are almost an accomplice to a coercive act." Ogle is also concerned the tests will give the applicant a false sense of security, since diseases such as HIV have a period of incubation before showing positive.¹²

Arthur Schafer, a medical ethicist and the director of the University of Manitoba's Centre for Professional and Applied Ethics, says the law invades people's civil liberties.

"Canadian courts have ruled that no one can 'intermeddle' with the body of an adult against their wishes. You need a very good reason to violate that principle."¹³

– David Garmaise

¹ Bill 28. An Act to require the taking and analysing of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons and to make consequential amendments to the *Health Care Consent Act, 1996* and the *Health Protection and Promotion Act*. 2nd Session, 38th Legislature, Ontario 54 Elizabeth, 2005. The text of the bill is available via www.ontla.on.ca/library/bills/382/28382.html.

² Proposed legislation on blood testing means better pro-

tection for public safety workers. News release, Toronto, (Ontario) Ministry of Community Safety and Correctional Services, 15 November 2005.

³ RSO 1990, c H.7, as amended. See also, R. Carey. Ontario adopts "blood samples" legislation. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 39-40; R. Carey. Ontario: People can now apply for forced HIV testing in certain situations. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 25-27.

⁴ Proposed legislation on blood testing means better protection for public safety workers.

⁵ The Board currently conducts hearings under the *Mental Health Act*, the *Health Care Consent Act*, the *Personal Health Information Protection Act* and the *Substitute Decisions Act*.

⁶ Proposed legislation on blood testing means better protection for public safety workers.

⁷ Ibid.

⁸ S Bahk. Saskatchewan: Mandatory "bodily substances" testing legislation passed. *HIV/AIDS Policy & Law Review* 2005; 10(2): 20.

⁹ AJ Ehman. Saskatchewan MDs oppose new mandatory testing law. *Canadian Medical Association Journal* 2005; 173(12): 1437-1438.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

¹³ Ibid.

Health care workers push for use of safer hypodermic needles

Unions in Ontario and British Columbia representing nurses and other health care workers are lobbying for safer hypodermic needles in hospitals, long-care facilities and other medical settings.¹

In Ontario, three unions representing health care workers have launched a CA\$100,000-plus advertising campaign to seek public support for changing provincial labour laws and obtaining new health funding for safer equipment. NDP MPP Shelley

Martel has introduced a private member's bill which would entrench in law the mandatory use of safety needles.²

Unlike regular needles, safety needles have plastic guards and retractable heads to limit the chance

of cutting the user.³ Cuts can expose the user to blood-borne diseases such as HIV and hepatitis C.

Linda Haslam-Stroud, president of the Ontario Nurses Association, said up to 33,000 injuries a year could be prevented by the use of "safety-engi-

neered medical sharps.” Nurses and other health-care workers who were injured on the job told a media conference in Toronto about their anxiety as they awaited their test results.⁴

Haslam-Stroud said a regular syringe costs about 10 cents each, while a needle with a safety feature goes for about 25 cents. However, according to the Services Employee International Union, each needle injury costs the health care system nearly CA\$2,000 in testing and treatment, which adds up to about CA\$66 million a year in Ontario. The union estimates that mandating safety-engineered needles in acute-care hospitals would cost about CA\$22 million a year.⁵

In British Columbia, the B.C. Nurses Union expressed disappointment with what it termed a “weak”

new regulation intended to make safety needles mandatory in health care facilities across the province. The proposed regulation would make safety needles mandatory only for vascular injections, such as intravenous lines. The union says that nurses spend two-thirds of their time providing shots of medicine or vaccine, an activity that would not require the use of a safety needle under the regulation.⁶

Meanwhile, the Vancouver Island Health Authority has provided virtually all of its facilities with safety needles. The Authority said that the move is expected to reduce needle-stick injuries by up to 70 percent. A spokesperson for the nurses’ union applauded the decision, but said that the union would prefer to see all-retractable needles, rather than those

with plastic cap guards which have to be pushed over the needle head manually and so could still lead to a cut.⁷

– David Garmaise

¹ A Artuso. Needles a threat: nurses; province’s failure to mandate safer syringes puts workers at risk: unions. *Ottawa Sun*, 16 November 2005; R Shaw. Needle regulation falls short: nurses. (*Victoria Times Colonist*, 9 December 2005.

² A Artuso.

³ R Shaw. Needle switch aims to reduce injuries: old ones lack retractable heads, created high-risk of medical staff contacting blood-borne diseases. (*Victoria Times Colonist*, 9 December 2005.

⁴ Ibid.

⁵ Ibid.

⁶ R. Shaw. Needle regulation falls short: nurses.

⁷ R. Shaw. Needle switch aims to reduce injuries.

Vancouver safe injection facility: more positive results

Two recently published articles report on the positive impact of Insite on drug use among people who inject drugs.

Insite, opened in Vancouver’s Downtown Eastside in September 2003, is North America’s first medically supervised injection facility (SIF). Insite provides sterile injecting equipment, interventions in the event of overdose, primary health care, addictions counselling and referral to external health and social services.

In one study, the authors sought to determine if the opening of Insite was associated with increased rates of relapse among former injection drug users or reduced rates of stopping drug use among current users.¹ The authors examined the behaviour of 871 people who injected drugs in the one-year period before and after

the opening of Insite.

The study found “no substantial increase in the rate of relapse into injected drug use (17 percent versus 20 percent) and no substantial decrease in the rate of stopping injected drug use (17 percent versus 15 percent).” The authors also found a substantial reduction in the starting

of binge drug use after the opening of the facility.

In the other study, the authors examined factors associated with syringe sharing among 594 Insite users.² The authors looked at syringe borrowing among HIV-negative participants and syringe lending among HIV-infected participants in a six-month period after Insite had opened.

The study results indicate that “a minority of SIF users continue to share syringes outside of the SIF.” Ten percent of the HIV-negative participants reported borrowing a used syringe, and syringe borrowing was associated with public drug

use and requiring help injecting. Sixteen-and-one-half percent of HIV-infected people reported lending a used syringe, and syringe sharing was associated with daily cocaine injection and shooting gallery use.

The authors conclude that “syringe sharing remains prevalent among a minority of SIF users, although rates of syringe sharing among this population are substantially lower than the rate observed previously in this community and it is noteworthy that exclusive SIF use was associated with reduced syringe sharing.”

These studies follow on earlier studies showing positive results, for

both people who inject drugs and the community, associated with Insite.³

– Glenn Betteridge

¹ T Kerr et al. Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study. *British Medical Journal* 2006; 332: 220-222.

² E Wood et al. Factors associated with syringe sharing among users of a medically supervised safer injecting facility. *American Journal of Infectious Disease* 2005; 1(1): 50-54.

³ Cited in the above-noted studies. See also G Betteridge. First evaluation of Vancouver safe injection facility. *HIV/AIDS Policy & Law Review* 2005; 10(2): 20; and D Garmaise. Safe injection facility attracts high-risk injection drug users, study finds. *HIV/AIDS Policy & Law Review* 2005; 10(3): 18.

Gay man launches suit over refusal to accept blood donation

Adrian Lomaga, a McGill law student who is gay, is suing Héma-Québec because it refuses to accept his blood donation. Héma-Québec, which is the blood collection agency for the province, imposes a lifetime ban on blood donations from men who have had sex with another man even once since 1977.¹ The Canadian Blood Services has the same policy.

Lomaga, who filed suit in November 2005 in the small-claims division of Québec Court seeking \$1,500 for “moral injury,” alleges that the ban violates the equality and non-discrimination guarantees in the Canadian and Québec charters of rights. Lomaga said that the decision to refuse his blood made him feel “like a second-class citizen, that somehow my blood was poison and I could never help another person in need.”²

Lomaga objected to the fact that the questionnaire he filled out at the blood collection centre did not target the behaviour that produces the risk. He also argued that the questionnaire holds gays and bisexuals to a “higher standard of perfection” than heterosexuals. Héma-Québec imposes only a 6-12 month ban on heterosexuals who have had sex with a prostitute or a person whose sexual background they did not know.

Héma-Québec did not comment directly on the case except to say that its policy is that “giving blood is a privilege, receiving blood is a right.”³ Lomaga decided to sue after the Québec Human Rights Commission would not accept his complaint.

Although he said he would not term the current policy as “discriminatory,” because its goal is safety, Dr Norbert Gilmore, an AIDS specialist and professor at McGill University,

said that the lifetime ban on men who have had sex with men is “archaic.”⁴ He suggested that a new set of rules be developed covering all at-risk groups. He pointed out, however, that since all of North America is organized as one blood-products pool, there would need to be one standard for Québec, Canada and the US.

Many legal experts question whether there is a case to be made on the basis of the Canadian Charter of Rights, which allows for “reasonable limits” to rights.

The Montreal-based *Table de concertation des lesbiennes et des gais du Québec*, representing 40 organizations, has no formal position on the issue. Claude Cote, the group’s president, said that he sees both sides in the debate, adding that he personally agrees the questionnaire should focus on risky behaviour rather than sexual orientation.⁵

There is another case before the courts in Ontario where the Canadian Blood Services is suing a man for falsely answering “no” to the screening question about whether he has

had sex with another male even once since 1977.⁶

– David Garmaise

¹ J Block. Nothing wrong with gay blood: student sues Héma-Québec for discrimination. *The (Montréal) Gazette*, 27 November 2005.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ *Canadian Blood Services v Freeman*, [2004] OJ No 4519 (SCJ) (QL). See B Mysko. Canadian AIDS Society granted intervenor status in blood donor case. *HIV/AIDS Policy & Law Review* 2005; 10(1): 53-54; and G Herget. Egale granted intervenor status as party in Canadian blood donor case. *HIV/AIDS Policy & Law Review* 2005; 10(3): 38.

In brief

Vancouver police crack down on drug users, safe injection facility

In November 2005, the Vancouver Area Network of Drug Users (VANDU) reported that the Vancouver Police Department was waging a crackdown on people using drugs in public in Vancouver’s Downtown Eastside.¹ That neighbourhood is home to Insite, North America’s first supervised injection facility.

According to VANDU, the police “have flooded the 2 blocks surrounding the injection facility with plain clothes officers and uniformed officers on foot and on horseback and are arresting anyone known to be holding or using drugs.” VANDU also reported that plain clothes officers, posing as drug users, were entering

Insite. The police affirmed its plan to increase arrests of people who inject drugs in public, claiming that the aim is to steer people to Insite.²

Community-based organizations have responded to the increased police presence and activity. VANDU held two protest rallies. The Canadian HIV/AIDS Legal Network issued a news release and sent a letter to Mayor-Elect Sam Sullivan calling for a stop to the police crackdown.³ The letter stated that

[p]eople who use drugs have a right to the highest attainable standard of health services and goods, and Insite is an example of moving toward the realization of this right. But we very much fear that this new police practice will undermine the effectiveness of Insite, and of the four-pillar strategy more broadly, by once again allow-

ing law enforcement considerations to overshadow effective public health measures.”

The Legal Network also called for an expansion of the services offered by Insite to include assisted injection, an increase in the number of safe injection facilities in the Downtown Eastside, and greater, meaningful involvement of people who use drugs in strategies to address drug use.

– Glenn Betteridge

Toronto City Council adopts drug strategy

As reported in a previous issue, the City of Toronto Drug Strategy Advisory Committee had developed a comprehensive report to address

drug use in the city.⁴ At its meeting of 14 December 2005, the Toronto City Council adopted the report, with a number of changes.⁵

The recommendation regarding supervised consumption facilities (recommendation 65), which called for Toronto to consider establishing a safe injection facility for hard drug users similar to the one already in operation in Vancouver, was amended at Council. Under the amendment, the needs assessment and feasibility study must include information on the effects of drug use on neighbourhoods and communities, businesses, crime and property values, and an in-depth examination of a mobile safe use program that exists in Berlin, Germany. As well, residential groups identified by ward councillors must be consulted for the study.

A further, amendment requires that federal, provincial and municipal government approval, as well as police approval, must be given prior to the establishment of a supervised consumption facility. In addition,

Council adopted a recommendation calling for a team of Toronto officials (police, city staff and councillors) to assess the operation of an existing supervised consumption facility, such as Insite in Vancouver.

A number of recommendations that did not appear in the Committee's report were also added by Council. Some of the recommendations relate to liquor licencing, while others call for tougher sentences for people convicted of drug dealing. Finally, a recommendation was adopted that the Medical Office of Health for the city be requested to explore "promoting withdrawal clinics and long-lasting abstinence therapies" and report to the Board of Health.

In a letter sent to the City Council prior to the debate on the report, the Canadian HIV/AIDS Legal Network expressed its support for the "visionary report and recommendations of the Toronto Drug Strategy Advisory Committee."⁶ In particular, the Legal Network voiced support

for distribution of safer crack kits and for a needs assessment and feasibility study for a supervised consumption site.

– Glenn Betteridge

¹ Personal correspondence with A Livingston, 11 December 2005. On file with the author.

² No more shooting in public, Vancouver police tell junkies. *CBC News*, 29 November 2005. Available at www.cbc.ca/story/canada/national/2005/11/29/open-drug20051129.html.

³ Safe injection site should not be law enforcement tool. News release. Toronto, Canadian HIV/AIDS Legal Network, 30 November 2005. Available, along with the letter to Mayor-Elect Sam Sullivan, via www.aidslaw.ca/Maincontent/issues/druglaws.htm.

⁴ D Garmaise. Toronto: Report calls for more harm reduction measures for drug users. *HIV/AIDS Policy & Law Review* 2005; 10(3): 16-17.

⁵ City of Toronto. *Fact sheet: Toronto Drug Strategy – City Council Motions*. Public Health. January 2006. Available via www.toronto.ca/health/drugstrategy/index.htm.

⁶ A copy of the Canadian HIV/AIDS Legal Network's letter, dated 12 December 2005, and the accompanying news release ("Legal Network supports 'visionary' Toronto Drug Strategy") is available via www.aidslaw.ca/Maincontent/issues/druglaws.htm.

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.

WTO approves TRIPS amendment on importing under compulsory licensing

On 6 December 2005, the World Trade Organization (WTO) amended the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement to allow WTO member states to produce, under compulsory licences, lower-cost generic pharmaceutical products for export to countries that lack domestic production capacity to make such products.¹ The amendment makes permanent the previous decision of 30 August 2003, which has not yet proven to be an effective mechanism to encourage the supply of more affordable medicines and other pharmaceutical products to countries in need.

The history of the recent amendment began in November 2001 with the Doha Declaration on TRIPS and Public Health, unanimously adopted by all WTO member states.² The Doha Declaration stated that TRIPS “can and should be interpreted and

implemented in a manner supportive of WTO Members’ right to protect public health and, in particular, access to medicines for all.”³ The Doha Declaration was a response to the original TRIPS Agreement, which allowed governments to issue

compulsory licenses but with serious limitations. Compulsory licences authorize a manufacturer to make, use and sell patented products without the permission of the patent holder.

One key limitation, under Article 31(f) of TRIPS, was that compul-

sory licenses could only be issued “predominantly for the supply of the domestic market.”⁴ In the Doha Declaration, WTO member states recognized that this limitation made it difficult for countries lacking domestic manufacturing capacity in the pharmaceutical sector to “make effective use” of compulsory licensing, because potential exporters in other WTO member states, if they could obtain compulsory licences, could only do so predominantly for supplying markets in their own countries.⁵ WTO Members committed to finding an expeditious solution to this problem.

After 21 months of negotiations, on 30 August 2003, the WTO General Council adopted a decision providing a mechanism by which a member country could export, in significant quantities, pharmaceuticals produced under compulsory licenses in accordance with specific criteria.⁶ The 2003 decision waived, on an interim basis, the restriction in TRIPS Article 31(f), that a compulsory licence could only be used predominantly for supplying the domestic market of the country in which it was issued. The 2003 decision was only intended to remain in force until a permanent amendment of the TRIPS Agreement replaced the decision.⁷

On 6 December 2005, the WTO made the 30 August 2003 decision permanent.⁸ The move was opposed by many organizations due to the lack of evidence that the waiver actually increased access to drugs for developing countries. Although the waiver was in place for two years, the mechanism was never used during that time.⁹ Many advocates feel that the permanent amendment will not increase access to medicines for developing countries.¹⁰

Médecins Sans Frontières (MSF) criticized that the amendment as “overly cumbersome and inefficient.”¹¹ Under the amendment, importing countries will have to notify the Council of TRIPS (the body responsible for overseeing the administration and the operation of the TRIPS Agreement) of their intention to use the system, specify the name and expected quantities of the product it wants to import, establish that it has insufficient production capacity for the product in question (if the country is not a least-developed country), and confirm that it will issue a compulsory license.¹²

An exporting country will also have to notify the Council for TRIPS of its intention to issue a compulsory license and provide the name and address of the licensee, the products for which the licence has been granted, the quantity for which it has been granted, the country to which the products are to be supplied, and the duration of the licence.¹³ In addition, there are a number of other requirements such as posting information about the drugs being exported or imported on a dedicated website, and taking measures to ensure that system is not abused. Many countries will also have to amend their own laws to export drugs made under compulsory licenses.

MSF stated that

[t]he amendment has made permanent a burdensome drug-by-drug, country-by-country decision-making process, which does not take into account the fact that economies of scale are needed to attract interest from manufacturers of medicines. Without the pull of a viable market for generic pharmaceutical products, manufacturers are not likely to want to take part

in the production-for-export system on a large scale.¹⁴

If this prediction is accurate, the mechanism provided by this new amendment will be ineffective, and most likely will fail to accomplish its objective of providing greater access to important medicines for developing countries that cannot produce these medicines domestically.

– Greg Herget

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

¹ Members OK amendment to make health flexibility permanent. News release. Geneva, World Trade Organization, 6 December 2005.

² World Trade Organization. *Doha Ministerial Declaration on the TRIPS Agreement and Public Health*. WT/MIN(01)/DEC/2, 14 November 2001. For a more detailed discussion, see: R. Elliott. WTO Ministerial Conference adopts declaration on TRIPS and public health. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3): 50-52.

³ *Ibid.* at para 4.

⁴ TRIPS Agreement, Article 31(f).

⁵ Doha Declaration, para 6.

⁶ World Trade Organization. *Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*. Decision of the General Council of 30 August 2003. WT/L/540, 1 September 2003. Available at www.wto.org. See also: R. Elliott. TRIPS from Doha to Cancún... to Ottawa: global developments in access to treatment and Canada's Bill C-56. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 1, 7-18.

⁷ *Ibid.*, para 11.

⁸ World Trade Organization. *Implementation of Paragraph 11 of the General Council Decision of 30 August 2003 on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*. IP/C/41, 6 December 2005.

⁹ Amendment to WTO TRIPS Agreement makes access to affordable medicines even more bleak. News release. Geneva, Médecins Sans Frontières, 6 December 2005.

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² World Trade Organization. *Implementation of Paragraph 6*, para 2(a).

¹³ *Ibid.*, para 2(c).

¹⁴ Amendment to WTO TRIPS Agreement.

COMMENTARY**Who killed HIV/AIDS activist Steve Harvey?**

On 30 November 2005, Jamaican HIV/AIDS activist Steve Harvey was found murdered. Harvey was a staunch defender of the human rights of people living with, and vulnerable to, HIV/AIDS. Since 1997, he had worked at Jamaica AIDS Support. In this commentary, Garry Mullins examines the deep roots and social acceptance of homophobia, and its consequences, in Jamaican society.

Sometime between 11 pm and midnight on 30 November 2005, Steve Harvey was intercepted by a gang based in the Jamaican ghetto community of Grants Pen. We aren't sure of all that happened, but eyewitnesses attest that at about 1 am the gang members invaded his house with him as a captive and interrogated his roommates at gun point, making it clear that that because Steve was gay they were going to kill him.

With their other victims before and after Steve, their intent was to rob and release them; Steve, however, was to die. Yet by the time they were arrested, there was already a tense debate over whether Steve's murder was a hate crime. Despite the eyewitness testimony, to the relief of Jamaica, the police have since declared that it was not.

Such determined denial is not surprising. That a debate was taking place at all was the result of recent, critical shifts in the public and private mindset in Jamaica where the implications of homophobia have been hotly, and sometimes coldly, debated. With the summer 2004 campaign against dancehall artists whose lyrics celebrated assault and murder of sexual minorities, Jamaica had begun to struggle with the larger

meanings of the music that permeates its everyday life, and what it means to be enmeshed in a global village whose norms conflict with a hatred that had come to be seen locally as meaningless.

When Human Rights Watch (HRW) released its report on homophobic violence later that year,¹ documenting in real life what the lyricists had been touting in music, the country exploded into a rage in defence of itself. Many opinion leaders, including university lecturers, media, and church and political leaders, either jokingly or vehemently affirmed that not only were these accusations of violent homophobia an evil lie, but there was no place in Jamaica for homosexuals anyway.

A national nerve had been pinched, and what for many was an innocuous part of the social fabric was now labelled in European and North American government circles and the international press a pathology of shocking global proportions. Jamaica was used to propelling itself into the global market as paradise with smiling couples playing on white sand at the edge of pristine blue-green waters. Now, something else had entered that space on the global stage. The survival of famous

men whose gayness was an open secret was presented as final proof that in fact none of the hundred plus stories of violence, at the hands of community and police alike, could be true.

In some more cultured local circles, what was most distressing about the HRW report was that the violence had been dismissed as justified by some of the very state actors and institutions whose responsibility it was to preserve order and stability in the nation. Formal and informal institutions that formed the backbone of society were smeared. The contradiction between the outrage over the accusations, combined with public statements in defence of homophobia, was lost in the melee.

We come back to the question of who killed Steve Harvey, viewing it with a different lens. Some people hold firm that it was a gang of homophobes from deep, deep, deep in the ghetto. Others hold that such a gang of men and women is always and only a product of their environment, their members hardened by poverty and ingrained and mercenary violence, where everyone's life is meaningless, where some people's lives – the homeless, prisoners, the mentally ill, gay men, the poor and oth-

ers – are taken for sport, and where people like Steve Harvey’s killers make ghosts, passing the time before they too are shot and die.

But when columnists and clergymen and lecturers and politicians sing a song in one voice condemning homosexuals, can those at the bottom

of that society be held as the sole culprits in taking that song to its brutal conclusion?

– Garry Mullins

Garry Mullins is a founding member of Jamaica Forum for Lesbians, All-Sexuals

and Gays (www.jflag.org) and has been active with that organization since 1998. He can be reached at admin@jflag.org.

¹ Human Rights Watch. *Hated to death: homophobia, violence and Jamaica's HIV/AIDS epidemic*. 2004.

Thais protest US-Thai FTA talks

On 11 January 2006, thousands of Thai citizens and HIV/AIDS advocacy groups converged in Chiang Mai, Thailand to protest the latest negotiations of the proposed US-Thailand Free Trade Agreement (FTA).¹ The FTA is believed to include intellectual property (IP) provisions that will pose a threat to Thailand’s national HIV/AIDS treatment program, which relies on local production of inexpensive generic medicines to treat people living with HIV/AIDS.

The US-Thailand FTA is ostensibly designed to organize and increase trade between the two nations by regulating a number of key trade industries, including agriculture and pharmaceuticals. The negotiations in January were the sixth round of FTA talks between the US and Thailand over the past two years.

Thai citizens and groups have expressed concern over the lack of transparency in the negotiations, which have excluded the participation of the Thai parliament and prompted allegations of contraventions of the Thai constitution of 1997.² On 17 January 2006, the head negotiator for the Thai government resigned amid mounting political social and political pressure and a lack of progress in the talks.³

A date for the seventh round of negotiations has not been made public.

It is believed that the FTA provisions include an extension of the standard 20-year patent protection to 25 years, thus increasing the period of time before generic versions of new medicines can be produced. The provisions are also expected to include a five-year data exclusivity program which would prevent the Thai Food and Drug administration from releasing clinical trial data to generic drug companies during that period.

In addition, it is also believed the FTA provisions contain restrictions on the ability of the Thai government to issue compulsory licenses which allow the generic production of drugs

to deal with emergencies such as the current HIV/AIDS crisis.⁴

The FTA IP provisions could jeopardize Thailand’s HIV/AIDS treatment program by preventing competition from generic drug producers and extending monopoly pricing. Currently, the Thai Government Pharmaceutical Organization produces generic antiretroviral drugs at a cost equal to four percent of the branded patent price.⁵

Access to health care services is a right guaranteed by the Constitution of Thailand of 1997.⁶ An estimated 70,000 persons living with HIV/AIDS in Thailand receive government-funded HIV treatment under a national HIV/AIDS treatment program that the Thai government hopes to expand

over the coming years.⁷ The treatment program reaches approximately 10 percent of the estimated 700,000 Thai citizens currently living with HIV/AIDS,⁸ a number which includes 30,000 children who contracted the condition through mother-to-child transmission.⁹

Médecins Sans Frontières (MSF) claims that the annual cost of second-line antiretroviral drug combinations could rise up to \$3500 per patient under the proposed FTA,¹⁰ which would seriously tax the resources of the government-funded program. MSF has argued that the FTA IP provisions far exceed international norms set by the World Trade

Organization in 2001 in the Doha Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health.¹¹

According to Oxfam, previous FTAs between the US and other countries have extended patent protections and have restricted imports of affordable medicines by limiting patent-holders' rights to import and export previously sold products.¹²

– *Tim Franklin*

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

¹ D Borak. US seeks to conclude Thai trade talks. United Press International, 12 January 2006.

² P Hongthong and J na Thalang. Thai-US FTA stumbling blocks. *The Nation* (Thailand), 12 January 2006.

³ C Pongvuthitham. Free trade: top FTA official throws in the towel. *The Nation* (Thailand), 18 January 2006.

⁴ P Hongthong.

⁵ 3D -> Three. *International trade, health, and children's rights – Thailand*. December 2005. Available at www.3dthree.org/en/.

⁶ Asia Pacific Health Economics Network. *The universal coverage police of Thailand: an introduction*. 19 July 2001.

⁷ D Borak.

⁸ Ibid.

⁹ 3D -> Three.

¹⁰ US-Thailand free trade agreement: MSF calls on Thailand to protect access to medicines in the face of US pressure. News release, Bangkok, Médecins Sans Frontières, 11 January 2005.

¹¹ Ibid.

¹² D Borak.

Lesotho embarks on universal HIV testing

On 1 December 2005, this past World AIDS Day, Lesotho embarked on the “Know Your Status” initiative to provide country-wide voluntary counselling and testing (VCT) for HIV/AIDS. In a country of two million people with a 29 percent HIV infection rate, the universal testing initiative may help prevent a humanitarian and economic crisis capable of destroying the country. However, the initiative raises human rights concerns.

The VCT initiative is a joint effort between the World Health Organization (WHO) and the Lesotho Ministry of Health. Local and international officials hope that every resident of Lesotho over the age of 12 will have been tested by the end of 2007. The King of Lesotho, Letsie III, is himself participating in the testing initiative, becoming the first African king to be publicly tested.

One of the most innovative aspects of the initiative involves health care workers going door to door with testing kits for the inhabitants, in order to make testing as convenient as possible. The government plans to employ 7,500 additional health care workers to administer the tests. The testing initiative has involved community elders and people living with HIV/AIDS in program design, so as

to offer testing in a culturally sensitive manner, and ensure that testing is confidential and voluntary.

In Lesotho, the encouragement of being tested in a variety of convenient local settings, and at no cost, is seen by many as an opportunity to engage the willing population in an effort to stop rampant infection rates. There are clear public health benefits to identifying people who may not

otherwise receive testing, including the potential prevention of further HIV infections through sexual contacts and vertical transmission.

Further, early identification of infection may permit access to anti-retroviral therapy for some people, treatment of opportunistic infections and improved education regarding health and nutrition. The counselling involved in testing may prove to be an excellent opportunity for further education on safe sexual behaviour.

However, universal testing is controversial.¹ An overarching concern is the extent to which the testing will be truly voluntary. Under international human rights legal norms, and Lesotho's plans, testing should not be mandatory.² By offering door-to-door testing, the health care staff may be overzealous in promoting the benefits of testing, and the right to refuse may be downplayed. Stigma may exist for those refusing testing, an issue that has already been detrimental for the individual rights of people living with HIV/AIDS in Lesotho.³

Efforts to conduct the counselling and testing in private may be a challenge considering the small dwellings (a reflection of Lesotho's rampant poverty) of most residents. It also seems clear that along with counselling for HIV/AIDS, efforts to improve gender inequalities will be required as women and girls are most likely to be affected by stigma, violence and abuse if their seropositivity is known by partners and the community.⁴

WHO, in promoting a rights-based approach to testing, has urged that testing should be linked to treatment and an appropriate health care system capable of treating newly identified seropositive people.⁵ Considering that Lesotho has a current physician population of 100 (five physicians per 100,000 population)⁶ and that only 5,000 of an estimated 56,000 people requiring immediate antiretroviral therapy are receiving treatment,⁷ it seems doubtful that provision of care can be used as an incentive for testing.

An urgent scale-up of treatment options is required in order for patients to take the risk of stigma, anxiety and depression that may be associated with knowing their seropositivity. Without access to treatment, patients take all of the risk of testing with few benefits for the individual.

While the potential benefits of Lesotho's universal testing initiative to the community as a whole are clear, the potential for negatively impacting the lives of individual inhabitants are also present. Large-scale testing initiatives may be able to test large populations in a short time, but only initiatives that promote individual rights and provide treatment as an incentive will encourage people to seek follow-up testing and help reduce risky behaviours and their HIV vulnerability over time.⁸

– Edward J. Mills and
Stephanie Chong

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See also "Scaling up HIV testing: human rights and hidden costs," a feature article elsewhere in this issue.

¹ S Rennie, F Behets. Desperately seeking targets: the ethics of routine HIV testing in low-income countries. *Bulletin of the WHO* 2006; 84: 52-55.

² *International Covenant on Economic, Social and Cultural Rights*. Articles 5 and 12. See also, Centers for Disease Control. *Revised guidelines for HIV counseling, testing, and referral*. MMWR Recommendations and Reports, 2001; 19: 1-58. Available via www.cdc.gov.

³ Pia Caspersen. *Stigma kills in drought-hit Lesotho*. International Federation of Red Cross and Red Crescent Societies, 29 October 2002. Available via www.ifrc.org.

⁴ Human Rights Watch. *Expanding resources, narrowing approaches: moralizing the epidemic (2000-2005)*. January 2006. Available via www.humanrightswatch.org.

⁵ WHO/UNAIDS. *Policy statement on HIV testing*. June 2004. Available via www.who.int.

⁶ See A Hagopian et al. The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain. *Human Resources for Health* 2004; 2: 17. Table 1 shows physician workforce distribution and number of medical schools by African country.

⁷ UNAIDS. *Lesotho fact sheet*. June 2005. Available via www.who.int.

⁸ Human Rights Watch.

CEE/CA: Report calls for decriminalization of sex work

In December 2005, the Central and Eastern European Harm Reduction Network (CEEHRN) released a report calling for the decriminalization of sex work in the 27 countries of Central and Eastern Europe and Central Asia (CEE/CA).¹ The report brings together a wealth of published and original information concerning sex work, laws regulating sex work, epidemiological data regarding HIV and other sexually transmitted infections (STIs), services available to sex workers, and human rights abuses faced by sex workers.

The report notes that nearly all of the countries in CEE/CA have experienced an increase in sex work fuelled by economic necessity since the collapse of the Soviet Union. Against this backdrop, the report highlights the rapid growth in HIV and other STIs in many countries in CEE/CA, the region with the fastest growing HIV epidemic in the world. It examines the situation of female sex workers and notes that sex workers in the region can be divided into three types: street workers, apartment workers and elite/hotel workers.

The report focuses on street sex workers, a group which is “most likely to inject drugs, have lower rates of condom use, and be migrant workers, all factors that tend to isolate them from HIV and STI prevention and care services.”² In addition, the report finds that street workers had less knowledge regarding HIV and other STI transmission than other sex workers.

The information concerning sex work, sex workers and laws regulating sex work(ers) was principally collected from, and with the assistance of, non-governmental harm reduction programs working with injection drug users and sex workers or working in the area of human rights, and from expert informants.

All of the CEE/CA countries prohibit pimping and brothel-keeping. However, individual prostitution is treated differently among the countries. In 14 countries, individual prostitution is illegal (as either a criminal or administrative offence); in 11 countries, it is not regulated; and in Hungary and Latvia, individuals are permitted to engage in sex work under regulatory regimes. As part of these regimes, sex workers must undergo regular medical examinations, including HIV testing, as a condition of working legally. The report points out that the enforcement of the law and police practices are largely unrelated to the existing written laws.

The report documents numerous human rights abuses faced by sex workers in the region, both as a direct result of police misconduct and at the hands of state and non-state actors. Migrant sex workers, given their precarious legal status, are especially vulnerable to abuse. “In all 27 surveyed countries, local observers and project staff report that police harassment represents one of the most significant factors contributing to sex workers’ vulnerability to violence and health risks.”³

Police harassment takes many forms: physical violence, detention or deportation without due process

based on lack of documents, coercion for sex, bribes and extortion, displacement of sex workers, forced HIV or STI testing, and the failure to enforce laws against people who victimize sex workers. Violence from clients and pimps, and media harassment, are also cited as prevalent human rights abuses.

Sex workers’ right to the highest attainable standard of health is reportedly violated on a daily basis by their inability to access health services. A significant barrier which impedes migrant sex workers from accessing national health systems is their lack of status and documentation. But even sex workers who were entitled to access national health services reported high levels of discrimination by health care workers.

The report directs recommendations to policymakers, health authorities, law-enforcement authorities, service providers and external donors. The recommendations are intended to recognize and protect the human rights of sex workers by providing them access to comprehensive, pragmatic services. The report notes that this will help to stem the transmission of HIV not only among sex workers and their clients, but also among other people in the community, since sex workers may be a “bridge” for

HIV transmission between people who inject drugs and others.

In a related development, an NGO has reported the General Prosecutor's Office and the Ministry of Internal Affairs of Kyrgyzstan are considering a number of legislative initiatives to provide for more severe sanctions

against those involved in sex work in that country.⁴

– Glenn Betteridge

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¹ CEEHRN. *Sex work, HIV/AIDS, and human rights in Central and Eastern Europe and Central Asia*. July 2005. Available via www.ceehtm.org.

² *Ibid.* at p 20.

³ *Ibid.* at p 41.

⁴ G Kurmanova. Kyrgyzstan: Measures for more severe sanctions for sex-work. *Central and Eastern European Harm Reduction Network News Digest*, 31 December 2005. Available via www.ceehtm.org.

UK: Legal action launched against government's guidelines on non-occupational post-exposure prophylaxis

In December 2005, two gay men were granted legal aid on public interest grounds by the Legal Services Commission to take the UK Department of Health to court over its policy regarding non-occupational post-exposure prophylaxis for HIV (NPEP).

One of the pair became infected with HIV when his partner's condom split during sex. The couple (which has chosen to remain anonymous) claim that because they were unaware of NPEP, they did not ask for the treatment. They also argue that they should have been informed about NPEP by their doctors, which would have enabled them to ask for the treatment.¹

The couple's lawyer is asking for judicial review of the UK Department of Health's guidelines regarding the use of NPEP, arguing that adequate guidelines should be introduced and a publicity campaign regarding NPEP launched. Their case is expected to be heard in the Queen's

Bench Division of the High Court, an administrative court that deals with judicial review matters, in February 2006.

Post-exposure prophylaxis (PEP) can significantly reduce the risk of HIV infection when given immediately after exposure. Guidelines on the administration of PEP were issued by the Department of Health.² The guidelines deal primarily with occupational exposure and do not contain a procedure on the dispensation of PEP following sexual exposure to HIV.

The Department of Health's arguments against the widespread availability of NPEP are: (a) there is a lack of data on the effectiveness of

NPEP; and (b) NPEP could lead to an increase in HIV risk-taking behaviour.³

However, in relation to the former, recent evidence suggests that PEP is effective in sexual exposure cases,⁴ especially if given within 72 hours of exposure but ideally within 24 hours.⁵ As for the latter, the available evidence suggests that NPEP is not associated with an increase in sexual risk-taking.⁶

The Department of Health's failure to mention NPEP contrasts with the first UK NPEP guidelines from the British Association of Sexual Health and HIV, a non-governmental association of medical practitioners, scientists and health care work-

ers interested in HIV/AIDS. The Association's guidelines give clear guidance on when and to whom information regarding NPEP should be provided as well as the importance of fully discussing other proven risk-reduction strategies.⁷

However, NPEP has been described in the media, as well as solicitor firm's press release, as a "morning after pill" for HIV.⁸ This wrongly suggests that NPEP could be a substitute for safer sex and condom use, hence leading to greater complacency about HIV. Rather, NPEP should be considered as an emergency HIV preventive measure to be used when other conventional and proven methods of prevention have failed (e.g. condom split). If the cou-

ple's case is successful, any revised guidelines and subsequent awareness campaign would have to give a clear and responsible message regarding the use of NPEP.

– Delphine Valette

Delphine Valette is the Director of the UK AIDS and Human Rights Project. She can be contacted at delphine.valette@aidsrightsproject.org.uk.

¹ HIV "morning after pill" battle. *BBC News* (online edition), 19 December 2005. Available at <http://news.bbc.co.uk/1/hi/health/4541582.stm>.

² Department of Health. *HIV post-exposure prophylaxis: guidance from the UK Chief Medical Officer's Expert Advisory Group on AIDS*. February 2004. Available via www.dh.gov.uk.

³ HIV "morning after pill" battle.

⁴ M Schechter, R F Iago, R Ismerio et al. Acceptability, behavioural impact, and possible efficacy of post sexual exposure chemoprophylaxis (PEP) for HIV. 9th Conference on Retroviruses and Opportunistic Infections, Seattle, Washington, 2002 (abstract 15). See also, M Schechter. Occupational and sexual PEP – benefit/risk? 6th International Conference on Drug Therapy in HIV Infection, Glasgow, UK, 2002 (abstract PL 6.1); and SD Pinkerton et al. Cost-effectiveness of postexposure prophylaxis after sexual or injection-drug exposure to human immunodeficiency virus. *Archives of Internal Medicine* 2004; 164: 46-54.

⁵ Department of Health.

⁶ See the research summarised in DK Smith et al. Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States: recommendations from the US Department of Health and Human Services. *MMWR Recommendations and Reports* 2005; 54(RR-2): 1-20.

⁷ British Association of Sexual Health and HIV. *UK national guideline for the use of post-exposure prophylaxis for HIV following sexual exposure*. April 2004. Available at www.bashh.org/guidelines/ceguelines.htm.

⁸ Couple denied "morning after" pill launch action against Department of Health. News release. London, Leigh Day & Co. (solicitors), 19 December 2005. Available via www.leighday.co.uk.

Lithuania: Legal Network meeting discusses model legislation project

On 7-8 November 2005, the Legal Network held a meeting in Vilnius, Lithuania as part of its model legislation project.

The event was a working meeting of some twenty legal experts, harm reduction advocates and government representatives from the former Soviet Union/Central and Eastern Europe (fSU/CEE) regions, including experts from Russia, Ukraine, Tajikistan, Georgia, Kyrgyzstan, Kazakhstan, Hungary, Slovenia, Bulgaria and the Czech Republic.

The meeting was held in both English and Russian, and was funded by CIDA's Conference Secretariat and the International Harm Reduction Programme of the Open Society Institute.

The Legal Network has been developing model legislation to establish a model legal framework to address services for people who use

drugs in the context of the HIV/AIDS epidemic. The legislation contains a series of chapters, each encompassing model laws which enable services for people who use drugs and protect them from human right abuses. The document incorporates relevant human rights principles and is informed by the examples of a handful of countries that have passed pro-

gressive laws concerning drug policy and harm reduction services.

Certain chapters address particular harm reduction services, such as opioid substitution treatment (and drug dependency treatment), sterile syringe programs and safe drug consumption facilities. One chapter sets out modifications to the criminal law relating the legal status of controlled substances, and alternative sentencing measures to provide alternatives to incarceration for people charged with minor drug offences.

Another chapter addresses stigma and discrimination faced by people who use drugs by expanding pre-

existing anti-discrimination law to cover people dependent on drugs. A further chapter of the model legislation specifically addresses issues of HIV (and other blood-borne pathogens) and drug use in prisons.

The Legal Network was represented by Richard Elliott and Richard Pearshouse. The group of regional experts provided feedback and comments on the draft model legislation, as well as insights into how the document can more directly address HIV and drug policies in fSU/CEE countries.

The model legislation is still in draft form at this stage, and further

revisions and consultations will be undertaken before the final text is established. Following the development of the model legislation, the project will move towards specific law reform advocacy on issues related to HIV/AIDS in fSU/CEE countries where the epidemic is driven by injection drug use and where current legislation impedes effective HIV prevention policies.

– Richard Pearshouse

Richard Pearshouse is the Legal Network's Senior Policy Analyst with primary responsibility for model legislation project. He can be reached at rpearshouse@aidslaw.ca.

In brief

Russian Federation: Duma repeals Russian Criminal Code reforms

On 21 December 2005, the Russian State Duma approved an amendment to the Russian Federation's Criminal Code which would repeal recent reforms to Russian narcotics law.¹ The Bill passed its third and final hearing, and must now be passed by Russia's Federation Council, the upper chamber of Russia's parliament, before becoming law.

The reforms, which came into effect on 14 May 2004, had introduced the concept of "average one-time dose" into the Criminal Code in order to distinguish liability levels for possession of different amounts of

narcotics. The concept of "average one-time doses" provided a means of differentiating possession for personal use and possession for the purposes of trafficking or dealing.

Punishments for possession of small quantities of doses were eased, while those for large quantities were made stricter.² Punishment for possession of under 10 "one-time doses" was a fine rather than criminal liability or incarceration.³ The reforms were hailed as a move away from earlier mass-incarceration policies for drug possession towards policies grounded in human rights and public health concerns.⁴

The Bill will remove the concept of "average one-time dose" from the Russian Criminal Code. This will effectively eliminate the distinction between possession of narcotics for personal use and possession for deal-

ing, resulting in an increase in the number of incarcerations.

The State Duma is also expected to redefine the statutory definitions of "large" and "extra-large" quantities of drugs before the amendment takes effect, potentially introducing stricter punishment for possession of quantities above the personal-use level.⁵

High incarceration rates among people who inject drugs have raised serious concerns about increasing prisoners' risk of exposure to HIV/AIDS through injection drug use. Needle-sharing is widespread in Russian prisons and results in an increased risk of contracting HIV/AIDS.⁶ In addition, people living with HIV/AIDS acquired through injection drug use face heightened stigmatization as a result of criminalization.⁷

– Tim Franklin

UK: Home Office announces new policy initiative on prostitution

On 17 January 2006, the Home Office released a new strategy to address prostitution.⁸ The strategy is the result of an 18-month process of consultation across government agencies and involving significant public input.

The strategy has five main features: prevention, to stop people from becoming involved in prostitution; tackling demand for prostitution services; developing routes to help people leave prostitution; prosecuting those involved in exploitation of, or violence against, those involved in prostitution; and addressing the commercial exploitation of people working in-doors, especially where the people are young or have been trafficked.

The government's strategy is premised upon cooperation among various levels of government and non-governmental agencies. The UK government's main role is to provide guidance for policy and programs in relation to the five main features. Although prostitution is not illegal in England and Wales, there are a number of criminal and other offences which are enforced against sex workers, clients and others involved in prostitution.

The strategy document proposes two legislative changes. Firstly, the offences of loitering and soliciting set out in the *Street Offences Act 1959* would be changed to permit people accused under those sections to be diverted from criminal prosecution, and courts would be permitted to order people convicted under those sections to undergo programs such as mandatory drug treatment. Secondly, the UK government proposes to

change the court-made definition of a "brothel" so that two or three sex workers can legally work together. Currently, it is illegal for sex workers to work together.

The English Collective of Prostitutes was critical of the government's strategy, stating that "the government is today announcing that it is abandoning its consultation and proposed review of prostitution in favour of increased enforcement. This goes against all the evidence which shows that criminalization and crackdowns make sex workers more vulnerable to rape, other violence and even murder."⁹

During the consultation, the Collective was critical of the "strong bias against sex workers" contained in the consultation document and the failure of the document to examine the harmful effects of laws that criminalize aspects of the practice of prostitution.¹⁰ The Collective called for an end to the criminalization of sex workers and their clients.

– Glenn Betteridge

Germany: Study shows effectiveness of prison needle exchange

An article published in December 2005 reports findings from a study on the effectiveness of needle exchange programs in two German prisons.¹¹ The study was carried out from October 1998 to June 2001 in a men's and a women's prison in Berlin. Any prisoner who had ever used illicit drugs was eligible to participate in the study.

Study participants were tested for HIV, hepatitis B (HBV) and hepatitis C (HCV) when they enrolled and at four month intervals thereafter, mak-

ing this one of the only studies to systematically examine the relationship between prison needle exchange and seroconversion. Needles were distributed by automatic dispensing machine in the women's prison and by an NGO using hand-to-hand exchange in the men's prison.

Of the 174 prisoners (out of a total prison population from both prisons of 213 people during the study period), 91 percent reported injecting in the six months prior to their enrolment. Seventy-one percent of prisoners who had previously injected in prison reported syringe sharing in prison prior to their enrolment in the study. Significantly, injection drug use (during a period of imprisonment prior to the study) was found to be an independent predictor of HIV and HCV infection.

During the course of the study, 67 percent of females and 90 percent of males continued to inject with heroin and cocaine. However, the authors report "an impressive reduction of syringe sharing": syringe sharing decreased to 11 percent at month four of the study, two percent at month eight, and zero percent in subsequent follow-ups. During the course of the study, no participants HIV- or HBV-seroconverted. Four out of 22 people who were HCV negative at the outset of the study seroconverted. However, three of these prisoners reported sharing paraphernalia in the preparation of drugs.

There were no adverse events (e.g. overall increase in injection drug use, violence involving needles against staff or other prisoners) observed during the study period. The limitation of the study was the relatively short time during which follow up was conducted (a median of 12 months), which did not allow the authors to

assess long-term preventative effects of the needle exchange program.

– Glenn Betteridge

UK: Groups call for comprehensive response to HIV and hepatitis in prison

In December 2005, two groups released a joint report on the state of the HIV/AIDS and hepatitis epidemics, and prison systems' inadequate responses, in England, Wales, Scotland and Northern Ireland.¹² The report from the National AIDS Trust and the Prison Reform Trust is based on information drawn from a survey of officials responsible for prison health care, individual correspondence and focus groups with prisoners, and consultative meetings involving prison health officials and non-governmental organizations working with prisoners.

The report documents high rates of HIV and hepatitis C (HCV) infection in UK prisons, driven principally by injection drug use and the incarceration of injection drug users, against a backdrop of increasing rates of incarceration. Adding to the prison HIV epidemic is the high incarceration rate among the black African population in the UK, a population with an elevated HIV prevalence.

The report details the abject failure of prisoner services in the UK to take steps to stem HIV and HCV transmission within prisons, to provide adequate care, treatment and support for prisoners living with HIV or HCV infection, and to adequately educate prisoners and train staff. Where there is a policy to provide programs – such as condom and disinfectant tablet distribution, methadone

maintenance (MMT) to treat opiate addiction, and education – the actual existence and implementation of such programs are inconsistent across and within the four countries.

The report calls for a “best practice framework for prevention, treatment, care and support in relation to HIV and hepatitis C,” which would form the basis of policy in every prison establishment in the UK. The report says that the framework should be based upon the principle that prisoners are entitled to health care services, including preventative services, equivalent to those in the community, and on the principle of harm minimization regarding drug injecting and sex.

Specific recommendations include: extension of MMT to all prisons; access to disinfecting tablets to clean needles; a scaling down of mandatory drug testing; widespread availability, free of charge, of condoms, female condoms, dental dams and lubricants; and the provision of information and education on HIV and hepatitis for prisoners and staff. The report also calls for pilot programs for needle exchange and safer tattooing.

– Glenn Betteridge

Australia: ACT considers prison needle exchange program

In November 2005, the Minister of Health of the Australian Capital Territory (ACT) announced that the department is considering implementing a needle exchange program in a proposed prison in the ACT.¹³ Such a program would be the first in Australia. The ACT government is expected to make a final decision on the issue late in 2006.¹⁴

If it proceeds, the program would involve providing inmates with clean needles to prevent sharing, thus reducing the number of blood-borne infections in the Australian prison system. In the country's prisons, the hepatitis C virus has been found in over one-third of the male prison population and over one-half of prisoners using injection drugs.¹⁵ Public interest groups have also expressed concerns about the threat blood-borne diseases pose to the public in general.¹⁶ With average prison sentences currently below 12 months,¹⁷ infections acquired in prisons pose a significant risk to public health when prisoners return to their communities.

Needle exchange programs operate in a number of Australian cities and communities, and are credited with significantly reducing infection rates of blood-borne diseases.¹⁸ Supporters of the proposal hope that the same benefits will be extended to prison environments.¹⁹

– Tim Franklin

Namibia: Anti-homosexuality law undermines HIV prevention in prisons

Human rights advocates have complained that the criminalization of sodomy in Namibian law is hindering condom distribution in prisons, a key HIV prevention tool.²⁰ A spokesperson for the Ministry of Safety and Security's Prison Services dismissed the possibility of distributing condoms in prison, stating that “[b]y giving them [prisoners] a condom, you are telling them to go ahead and do it.”²¹ Government ministers have repeatedly emphasized that Namibia's law criminalizes sodomy

as an “unnatural act” and have gone so far as to claim that “homosexuality is a crime.”²²

Article 10 of the *Namibian Constitution* states that, “[a]ll persons shall be equal before the law” and that “[n]o persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion creed or social or economic status.”²³ However, sexual orientation is not explicitly included as a ground for non-discrimination in the *Constitution*.

Namibia’s legal system is derived closely from that of South Africa. In that country, until relatively recently, sodomy was criminalized under the common law, section 20A of the *Sexual Offences Act* and the *South African Criminal Procedure Act* 1977.²⁴ However in 1998, the South African Constitutional Court declared that these laws violated the *South African Constitution* and were invalid.²⁵ In comparison with Namibia, the *South African Constitution* explicitly prohibits discrimination on the grounds of “sexual orientation.”²⁶

In Namibia, Article 144 of the *Namibia Constitution* states that international agreements binding upon Namibia “shall form part of the law of Namibia.”²⁷ On 28 November 1994, Namibia ratified the *International Covenant on Civil and Political Rights (ICCPR)*.²⁸ The Human Rights Committee that monitors the *ICCPR* has previously stated that the ground of “sex” in the non-discrimination provision of the *ICCPR* should be interpreted as including “sexual orientation.”²⁹ This suggests that the *ICCPR* prohibits discrimination on the grounds of sexual orientation and, since Namibia has ratified the agreement, that the prohibition should apply in Namibia.

To date there has not been a Constitutional challenge to Namibian law on this issue.

– Greg Herget

India: UNAIDS claims law criminalizing homosexuality hinders HIV prevention

On 4 January 2006, four men in Lucknow (the capital city of the state of Uttar Pradesh, in the north of India) were arrested by police who claimed the men had violated Section 377 of the Indian Penal Code (IPC).³⁰ Section 377 defines homosexuality as an unnatural act that is a punishable offence, with a possible sentence of 10 years.³¹ The men were accused of engaging in homosexual acts and running an online gay sex club.³²

UNAIDS condemned the action of the Lucknow police and called for the Indian government to repeal Section 377 of the IPC.³³ Denis Broun, UNAIDS India coordinator said, “[c]riminalization of people most at risk of HIV infection may increase stigma and discrimination, ultimately fuelling the AIDS epidemic.”³⁴ India has the second highest prevalence of HIV of any country in the world, with an estimated 5.1 million people carrying the virus.³⁵

This is not the first time that Lucknow police have made controversial arrests on the basis of Section 377. In July 2001, Lucknow police arrested two staff members from Naz Foundation International (NFI) and two staff members from Bharosa Trust on allegations that the organizations were running a “gay sex racket.”³⁶ The workers were formally charged with a number of offenses under Section 377, including sodomy.

The workers were held in detention for 47 days under extremely bad conditions until their eventual release.³⁷ These two organizations were registered NGOs and were recognized by the Uttar Pradesh State AIDS Control Society for their work in the prevention of the transmission of HIV.³⁸

In 2001, NFI initiated public interest litigation to challenge the constitutionality of Section 377.³⁹ NFI argued that the law violated the right to equality, the right to freedom and the right to life and liberty of the Indian Constitution.⁴⁰ The New Delhi High Court held in September 2003 that NFI did not have a cause of action, finding that “a petition cannot be filed just to test the validity of a legislation [sic].”⁴¹ In late 2004, the same New Delhi High Court dismissed a petition to review the earlier decision to reject the case brought by NFI.⁴² The case was never heard and the law remains in force.

– Greg Herget

¹ A Kozenko. Parliamentarians against drugs: State Duma adopted anti-drug amendments to Criminal Code. *Kommersant* (online edition), 22 December 2005.

² See L Levinson. Russian Federation: going backwards on drug policy. *HIV/AIDS Policy and Law Review* 2005; 10(2): 27.

³ Russia: Parliament approved anti-drug amendments to the penal code. *Kommersant*, 22 December 2005. Available in English at www.ceehm.org/index.php?Itemid=15591#2.

⁴ H Cartner, J Cohen. Russia: Letter protesting repeal of recent drug reforms. Human Rights Watch. 11 May 2005. Available via www.hrw.org.

⁵ Russia: Parliament approved anti-drug amendments to the penal code.

⁶ H Cartner.

⁷ *Ibid*.

⁸ Home Office, Government of the United Kingdom. *A coordinated prostitution strategy and a summary of responses to Paying the price*. January 2006. The strategy, consultation paper, regulatory impact statement and media release are available via www.homeoffice.gov.uk/documents/cons-paying-the-price/.

⁹ English Collective of Prostitutes. *Paying the price of criminalisation: a response to the government consultation paper on prostitution by the English Collective of Prostitutes*. 18 November 2004.

¹⁰ Ibid.

¹¹ K Stark et al. A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany. *Epidemiology and Infection* 2005. Electronic publication ahead of print.

¹² Prison Reform Trust and National AIDS Trust. *HIV and hepatitis in UK prisons: addressing prisoners' healthcare needs*. 2005. Available via www.nat.org.uk.

¹³ First for Australia: needle exchange program for ACT prison. News Release. Canberra, Australian Hepatitis Council, 18 November 2005. ACT prisoners are currently held in NSW prisons, a situation set to change with a new prison slated for the ACT in the next couple of years.

¹⁴ Ibid.

¹⁵ Hep C in Australian prisons: minimising the risk. News Release. Sydney, University of New South Wales, 25 November 2005.

¹⁶ First for Australia: needle exchange program for ACT prison.

¹⁷ Ibid.

¹⁸ BJ Almond. Opponents of needle-exchange programs should think about their message to drug users. *Medical News Today* (online edition), 24 March 2005.

¹⁹ Govt mulls needle exchange for prison inmates. *ABC News Online (Australia)*, 15 November 2005.

²⁰ Michaela Hübscle, from the non-governmental organization Criminals Return to Society, quoted in Natasha Tibinyane. In prison, a little latex could go a long way. *Inter Press News Service* (Online edition), 3 January 2006.

²¹ Ignatius Mainga, spokesperson for the Ministry of Safety and Security's Prison Services, quoted in In prison, a little latex could go a long way.

²² Human Rights Watch (HRW) and the International Gay and Lesbian Human Rights Commission. *More than a name: state-sponsored homophobia and its consequences in southern Africa*. 2003. Available at www.hrw.org. HRW reports that it is the Namibian common law that criminalizes sodomy. This common law comes from South Africa. Namibia also reportedly uses the South African Criminal Procedure Act 1977 (Act 51 of 1977). This Act classifies sodomy as a Schedule 1 offense which affects how police and other individuals can treat individuals participating in sodomy.

²³ The Namibian Constitution, Article 10. Available at www.gmnet.gov.na/intro.htm.

²⁴ Criminal Procedure Act 1977 (Act 51 of 1977) at Schedule 1. See *National Coalition for Gay and Lesbian Equality & another v Minister of Justice & others* 1998 (2) SACR 102 (W). Available at www.worldlii.org.

²⁵ Ibid. at para 106.

²⁶ *South African Constitution*, 1996 at section 9. Available at www.worldlii.org.

²⁷ Ibid., Article 144.

²⁸ Office of the United Nations High Commissioner of Human Rights. *Status of ratification: International*

Covenant on Civil and Political Rights. 2004. Available via www.ohchr.org.

²⁹ *International Covenant on Civil and Political Rights*. CCPR/C/50/D/488/1992, 4 April 1994. See *Nicholas Toonen v Australia*, U.N. GAOR, Hum. Rts. Comm., 15th Sess., Case no. 488/1992, UN Doc. CCPR/c/50/D/488/1992.

³⁰ P Kumar. Arrest of gay men in India fuels AIDS epidemic: UN. *Reuters Health* (online edition), 11 January 2006.

³¹ Homosexuality is punishable: HC. *The Times of India* (online edition), 3 November 2004.

³² P Kumar.

³³ UNAIDS concerned over arrests of men who have sex with men in India. News release. New Dehli, UNAIDS, 9 January 2006. Available at www.unaids.org.

³⁴ Ibid.

³⁵ UNAIDS. *The 2004 report on the global AIDS epidemic*. July 2004. Available online at www.unaids.org.

³⁶ Human Rights Watch. *Epidemic of abuse: police harassment of HIV/AIDS outreach workers in India*. July 2002. Available online at www.hrw.org.

³⁷ Ibid.

³⁸ Ibid.

³⁹ Homosexuality is punishable: HC.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² Ibid.

HIV/AIDS IN THE COURTS – CANADA

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

Supreme Court clarifies immigration medical inadmissibility provision

On 21 October 2005, the Supreme Court of Canada released a decision directing immigration authorities to consider an applicant's financial circumstances when determining whether the applicant's dependant with a mental and physical disability will place "excessive demand" on social services in Canada.¹ However, the potential impact of the decision upon the situation of people living with HIV/AIDS applying for permanent residence status is unclear.

The case involved two families in which the father applied for permanent residence as a member of the "business class" category under the *Immigration Act*. Hilewitz applied under the "immigrant investor" class, which requires applicants to have a net worth of CA\$800,000 or more. de Jong applied under the

"self-employed" class, which requires applicants to demonstrate that upon entering Canada they would successfully establish a business or create employment for themselves.

Both families had a child with an intellectual disability. Section 19(1)(a)(ii) of the *Immigration Act* requires immigration officials to

refuse permanent residence to persons who, in the opinion of a medical officer, have a disease or disability that "would or might reasonably be expected to cause excessive demands on health or social services."² Prior to the decision, immigration authorities routinely rejected permanent residence applicants based only on

a medical officer's assessment that their medical condition could place an excessive burden on social services.

Visa officers refused each applicant's permanent residence application based on the assessment that the child's disability would result in "excessive demands" on health and social services in Canada. Each family had demonstrated significant financial resources, and had put in place plans so that disabled child would not have to rely on social services such as state-funded schooling.

As framed by the Supreme Court, the issue in the case was "whether the financial resources that otherwise qualified the families for admission ... could nonetheless be disregarded in assessing the impact of their children's disabilities on Canada's social services."³ The majority of the Court (seven of nine judges) held that the *Immigration Act* calls for "individual assessment,"⁴ noting that "excessive demand" should be read as a comparative term which evaluates both medical and non-medical factors.⁵

Therefore, personal and financial circumstances are relevant factors in anticipating the possible impact of the person's disability on social services. The Court found that immigration authorities erred in not considering the families' financial circumstances, which might have alleviated the burden the families placed on Canada's social services. The Court referred each family's application to the Minister of Citizenship and Immigration for reconsideration and re-determination.

Comment

The *Immigration Act* was repealed in June 2002, and replaced with the *Immigration and Refugee Protection*

Act, 2001 (IRPA).⁶ However, the Supreme Court explicitly stated that its reasons apply to the interpretation of the medical inadmissibility provision set out in *IRPA* section 38(1)(c). Under that section, "excessive demand" is defined as exceeding the average per capita demand that Canadians place on health and social services.⁷

At a general level, the decision is positive as the Court called for a move away from generic "cookie-cutter" assessments under immigration legislation based only on the medical condition of the applicant, towards individualized assessment in which both medical and non-medical circumstances specific to the applicant should be considered.⁸ Applicants who have, or have a family member who has, HIV infection should be given the opportunity to demonstrate that their personal economic resources may mitigate the demand the condition will place on social services, such as welfare or income support for the disabled.⁹

However, the decision's application to the circumstances of people living with HIV/AIDS may be limited. First, the direction that financial resources should be taken into account in assessing "excessive demand" was specific to social services. It is unclear to what extent the decision will be applied to the assessment of demands applicants might place Canada's public health care services, the principal barrier for many permanent residence applicants living with HIV/AIDS. It is conceivable that in determining whether a person will place "excessive demand" on health services, an immigration official might be required to take into account the fact that the person can

cover the cost of her medications or medical care, either through personal resources or insurance.

Second, the decision was made in the context of business-class immigrants, who must demonstrate significant financial and economic resources as part of their requirements for admission to Canada. For applicants who do not have significant resources, the decision may merely open a window of opportunity to which they effectively have no access.

– Tim Franklin

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¹ *Hilewitz v Canada (Minister of Citizenship and Immigration)*; *De Jong v Canada (Minister of Citizenship and Immigration)*, 2005 SCC 57.

² *Immigration Act*, RSC 1985, c1-2, s 19.

³ *Hilewitz* at paras 7, 73.

⁴ *Ibid.* at paras 56, 57.

⁵ *Ibid.* at para 54.

⁶ *IRPA*, SC 2001, c 27.

⁷ *Immigration and Refugee Protection Regulations*, SOR 2002/227, s 1(1).

⁸ *Hilewitz*, para 56.

⁹ For more information on the relevance of HIV status under the *IRPA*, see Canadian HIV/AIDS Legal Network. *Canada's immigration policy as it affects people living with HIV/AIDS*. June 2005. Available at www.aidslaw.ca/Maincontent/issues/Immigration/ImmigrationQ&A2005.pdf.

Federal health information privacy cases from 2005

The federal *Personal Information Protection and Electronic Documents Act (PIPEDA)* governs the collection, use and disclosure of personal information.¹ *PIPEDA* is important legislation for people living with HIV/AIDS as it establishes rules for the handling of personal information, including personal health information. *PIPEDA* applies to personal information handled by commercial enterprises in the course of commercial activities throughout Canada, except in provinces that have significantly similar laws.² Complaints under *PIPEDA* are heard by the Privacy Commissioner of Canada (PC).³ This article reviews the interpretation and application of *PIPEDA* in complaints related to health information decided in 2005.

Disclosure of health information in insurance claims

Two cases highlight that individuals need to be aware of the details of the consent forms that they sign during employment-related benefits application and claim processes.

Principle 4.3 of *PIPEDA* states that knowledge and consent are required for the collection, use or disclosure of personal information.⁴ In one decision, one of the issues raised was whether an insurance company had violated the disclosure component of Principle 4.3 when it sent, without the employee's knowledge, a copy of a letter suggesting possible alternate occupations to a benefits specialist at the employee's work.⁵ The letter did not contain any sensitive health information about the employee, who had been receiving long-term disability benefits.

The PC held that there was no violation of Principle 4.3. The employee had signed the claim form and other medical assessment forms which included an authorization to disclose information. The PC found that "the complainant had provided his consent for the insurance company to share

information about the assessment of his claim, his fitness to work, and his functional abilities, to his employer."

The same employee brought a complaint against a physician alleging that the physician had inappropriately disclosed a medical report to the insurance company.⁶ The physician was an independent medical consultant to the insurance company and had prepared the medical report after reviewing the employee's medical file. The PC held that the consent form that the employee had signed when he applied for disability benefits authorized the sharing of personal information between any physician and the insurance company for the purposes of assessing his insurance claims.

Accessing personal information in insurance claims

Principle 4.9 stipulates that upon request, an individual shall be informed of the existence, use and disclosure of his or her personal information and shall be given access to that information.⁷ Section 2 of *PIPEDA* defines personal information as "information about an identifi-

able individual." The PC recently held that notes taken by a physician during an examination are "personal information" with the meaning of this section.⁸ Therefore, unless the physician can rely on an exception set out in *PIPEDA*, under Principle 4.9 the physician must provide access to notes in a medical record if requested to do so.

The PC also held that since the physician had not recorded the list of questions that were asked during the examination, the physician could not provide this information.⁹ The PC did not provide direction regarding whether an individual could require the doctor to make a record of all questions asked during a medical examination.

The physician in the case attempted to rely on a number of exceptions to refuse access to the personal information. Paragraph 9(3)(a) of *PIPEDA* states that an organization is not required to give access to personal information if the information is protected by solicitor-client privilege.¹⁰ The PC held that the physician was not formally retained by an insurance company as an expert in *ongoing* litigation, and that therefore

he could not rely on this exception to deny access to personal information.¹¹

Paragraph 9(3)(d) of *PIPEDA* states that an organization may not give access if the information was generated in the course of a formal dispute resolution process.¹² The PC held that the initial medical examination completed to assess a claim is not information generated to resolve a dispute.¹³

In another case, a non-treating physician denied an individual access to the individual's medical file.¹⁴ The physician was under contract with an insurance company to review medical records and provide an assessment. The PC found that because the physician did not have possession or control of the information, which was held in the insurance company's file, his refusal to provide the individual with access did not violate Principle 4.9.¹⁵

Pharmacy privacy policy

An individual complained to the PC that a pharmacy required him to agree to its privacy policy as a condition of service.¹⁶ The pharmacy provided clients with an extensive brochure explaining the policy. The brochure contained details about the types of information held by the pharmacy, the security of the pharmacy's records, the legal obligations of pharmacists, the persons to whom information might be disclosed, the circumstances under which such disclosure might occur, and the procedures whereby a patient can access his or her personal information or request corrections.

The PC held that the pharmacy did not contravene Principle 4.3.3, which states that an organization shall not, as a condition of the supply of a product or service, require an individ-

ual to consent to the collection, use or disclosure of information beyond that required to fulfil the explicitly specified and legitimate purposes.¹⁷ The pharmacy's privacy policy stated that it collected the information in order to meet professional, legal and regulatory requirements in dispensing medication, to ensure accuracy and prevent errors, and to contact customers in the event that a drug is recalled or withdrawn from the market.¹⁸

The pharmacy permitted clients to accept the policy either orally or in writing and trained staff members to explain the policy to those who did not want to read the brochure. The PC stated the policy was not overly broad and satisfied both Principle 4.3 and 4.3.3.¹⁹

Fitness to work

An employee complained to the PC because he believed that his employer was requiring him to provide more medical information than necessary.²⁰ The employee returned to work following an illness and was assigned to light duty work at first. One year after his return to work, because the employee was in a safety sensitive position (i.e., a position with safety implications for the employee and other employees), he was required to provide medical information that guaranteed that he was not at risk of sudden incapacity. The employer's requests for information spanned a number of months. During this time the employee refused to provide the requested information and, as a result, was suspended without pay for five months.

Principle 4.4.1 stipulates that organizations shall not collect personal information indiscriminately and shall be limited to that which is necessary to fulfil the purposes iden-

tified.²¹ Subsection 5(3) establishes that an organization may collect, use or disclose personal information only for purposes that a reasonable person would consider are appropriate in the circumstances.²² The PC held that the company did not violate Principle 4.4.1 or subsection 5(3) by requiring the employee to provide medical documentation as part of an annual review of his fitness to work because it was required in order to protect the safety of the employee and other employees.

Comment

While complainants were unsuccessful in a number of cases, the PC's reasons help clarify the limits of personal privacy protections involving medical information. These decisions provide people living with HIV/AIDS with a greater awareness of their rights and obligations regarding their personal health information, especially in relation to employment and group disability insurance. Where relevant and supportive, the PC's case summaries can be relied upon to assist people to assert their privacy rights where they are faced with collection, use and disclosure of their personal medical information.

– Greg Herget

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¹ *PIPEDA*. S.C. 2000, c-5. For more information about privacy of medical information and people living with HIV/AIDS, see Canadian HIV/AIDS Legal Network. *Privacy protection and the disclosure of health information: legal issues for people living with HIV/AIDS in Canada*. 2002.

² *PIPEDA*, s 26(2)(b). The federal government has legally recognized that Québec (see SOR/2003-374), Alberta (see SOR/2004-219) and British Columbia (see SOR/2004-220) have substantially similar privacy of personal information laws; therefore *PIPEDA* does not apply to commercial enterprises of a purely provincial nature in those provinces. Ontario has passed substantially similar legislation regulating personal health information, and therefore custodians of health information in Ontario are exempt from *PIPEDA* (see SOR/2005-399).

³ *PIPEDA*, s.11. Summaries of the Privacy Commissioner of Canada's decisions are available via www.privcom.gc.ca.

⁴ *PIPEDA*, Schedule I, Principle 4.3.

⁵ Case Summary #293, [2005] CPCSF. No 7 (Canada

Privacy Commissioner) (QL).

⁶ Case Summary #294, [2005] CPCSF No 8 (Canada Privacy Commissioner) (QL).

⁷ *PIPEDA*, Schedule I, Principle 4.9.

⁸ Case Summary #306 [2005] CPCSF No 20 (Canada Privacy Commissioner) (QL).

⁹ *Ibid.*

¹⁰ *PIPEDA*, s 9 (3)(a)

¹¹ Case Summary #306.

¹² *PIPEDA*, s 9(3)(d).

¹³ Case Summary #306.

¹⁴ Case Summary #294.

¹⁵ *Ibid.*

¹⁶ Case Summary #302, [2005] CPCSF No 16 (Canada Privacy Commissioner) (QL).

¹⁷ *PIPEDA*, Schedule I, Principle 4.3.3.

¹⁸ Case Summary #302.

¹⁹ *Ibid.*

²⁰ Case Summary #287 [2005] CPCSF No 1 (Canada Privacy Commissioner) (QL).

²¹ *PIPEDA*, Schedule I, Principle 4.4.1.

²² *PIPEDA*, s 5(3).

Criminal law and HIV transmission/ exposure: five new cases

HIV-positive intellectually impaired man spared jail time

In January 2006, an intellectually impaired, HIV-positive man plead guilty in an Ottawa court to charges of sexual assault of an intellectually impaired woman.¹ The judge ordered a suspended sentence and a period of three year's probation. As part of the sentence, the man is required to tell sex partners about his HIV status, and carry a note saying he is HIV-positive.

The accused was originally charged with aggravated sexual assault against two intellectually impaired women. The women, one of whom was having ongoing sexual relations with the accused, were unaware that the accused was HIV-positive. The charge relating to unprotected sex in the context of the ongoing sexual relationship was

dropped, and the remaining charge was reduced as a result of a plea bargain. Neither of the women has tested HIV-positive.

HIV-positive man convicted of aggravated sexual assault

A British Columbia man was convicted in December 2005 of aggravated sexual assault for having unprotected sex with numerous women without disclosing his HIV-positive status.² The accused admitted he had never told the women about his status, saying they had never asked and that he was unaware he had a legal obligation to tell them. The women testified that the man had not used a condom during sex.

Three of the man's former sexual partners are now HIV-positive.³ The man was convicted of five counts

of aggravated sexual assault, one of attempted aggravated assault and one of sexual assault.⁴ A date for sentencing has not been set.

House arrest for woman convicted of aggravated sexual assault

On 25 November 2005, an HIV-positive woman pleaded guilty to a single charge of aggravated sexual assault for having unprotected sex with a man.⁵ The incident occurred at Canadian Forces Base Borden, and prompted concern at Canadian military bases, which the woman frequented socially. The woman had originally been charged with two counts of aggravated sexual assault, and two counts of aggravated assault, related to two different men.

The court heard that the woman was suffering from a neurological

disorder which may have been exacerbated by her HIV status, prompting unpredictable behaviour.⁶ On 9 December 2005, the woman was sentenced to a 12-month conditional sentence, which she will serve under house arrest, and three years probation. She will be listed on the national sex offenders registry for 20 years.⁷

Man who assaulted police officer claimed he was HIV-positive

A Nova Scotia man was sentenced in December 2005 to five months in prison for assault causing bodily harm.⁸ The man, a transvestite, had been arrested by the officer for the theft of a purse. While in custody, the man scratched the officer, and

claimed he had AIDS. The court heard that the officer was fearful for the following months that he had contracted the virus, though the judge noted that HIV is very unlikely to be transmitted through a scratch. The accused man later tested negative for HIV.

HIV-positive man who used syringe in robberies sentenced to prison for five year

In November 2005, a 31-year-old HIV-positive man was sentenced to five years imprisonment after pleading guilty to 18 counts of armed robbery.⁹ The man used a syringe as a weapon when robbing corner stores. It was reported that the man is in the

terminal phase of AIDS with a life expectancy of six months to one year.

– *Tim Franklin*

¹ S McKibbin. No jail time for sex attack; mentally handicapped, HIV-positive man must carry note. *The Ottawa Sun*, 5 January 2006.

² Jury convicts HIV-positive man of aggravated sexual assault. *CBC.ca News*, 15 December 2005.

³ T Theodore. Man guilty of aggravated sexual assault for spreading HIV to three women. *The Edmonton Journal*, 14 December 2005.

⁴ Ibid.

⁵ T McLaughlin. No jail for HIV assault against soldiers. *The Toronto Sun*, 10 December 2005.

⁶ R Avery. House arrest for HIV-sex with soldier; had sex with soldier at Borden. *The Toronto Star*, 10 December 2005.

⁷ T McLaughlin.

⁸ R Cuthbertson. Transvestite gets five months for clawing a cop, telling him he has AIDS. *The Daily News (Halifax)*, 7 December 2005.

⁹ A Hanes. Five years for holdups with syringe; addict in terminal phase of AIDS. *The Gazette (Montreal)*, 29 November 2005.

HIV/AIDS IN THE COURTS - INTERNATIONAL

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

UK: Court of Appeals upholds deportation orders of four people with HIV

In November 2005, the UK Court of Appeals upheld deportation orders against four people with HIV who claimed that removal to their home countries, where they would be unable to obtain treatment, violated the rights to privacy and to be free from inhuman treatment under the *European Convention on Human Rights*. The Court of Appeal affirmed that only in exceptional circumstances could persons with HIV rely on the *European Convention* to avoid deportation. None of the applicants' circumstances were found to be exceptional. The decision reflects the UK courts' narrow approach to interpretation of the *Convention*, an interpretation that makes it unlikely that the vast majority of persons living with HIV/AIDS will be able to successfully challenge deportation orders even when they face illness and death if expelled.

The lead case, *ZT v Secretary of State for the Home Department*,¹ concerned an HIV-positive Zimbabwean woman who had legally entered the

UK as a visitor in July 2000. Shortly after her arrival, she was diagnosed HIV-positive, and started a course of antiretroviral treatment that suc-

ceeded in controlling the disease. She claimed that because she would almost certainly be unable to obtain the treatment necessary for her to live

if she was returned to Zimbabwe, her expulsion would violate article 3 of the *European Convention*, which provides that “no one shall be subjected to torture or to inhuman or degrading treatment,”² and article 8 of the *Convention*, which states that “everyone has the right to respect for his private and family life, his home, and his correspondence.”³

The other three individuals, NT, Mando,⁴ and Nsubuga⁵ were in similar situations and raised similar claims. The court determined that all four applicants could lawfully be deported.

Inhuman treatment

Lord Justice Baxton, with the agreement of the rest of the Court, held that ZT’s deportation would not violate article 3 of the *Convention*. In doing so, he relied heavily on House of Lords decision in *N(FC) v Secretary of State for the Home Department*.⁶ In that case, the House of Lords ruled that a person living with HIV/AIDS could lawfully be deported to a country where HIV treatment would be terminated absent “exceptional circumstances,” such as imminent death. Because N was in good health and her death was not imminent, her situation was not considered “exceptional.”

The requirement that a person’s illness *must* have reached a critical stage in order for circumstances to be considered exceptional represented a narrow reading of an earlier decision in which the European Court of Human Rights found that article 3 protected a man living with HIV/AIDS from being returned to St. Kitts where he would lack care.⁷

Lord Justice Buxton noted the “element of paradox” in the rule: “Like Ms. N and other HIV suffer-

ers in her situation, Ms. ZT is not dying; but that is only because she is in receipt of treatment that in realistic terms will cease once she is sent back to Zimbabwe.”⁸ He stated that the rule was necessary, however, to respect the principle stated in earlier cases that “article 3 does not require contracting states to undertake the obligation of providing aliens indefinitely with medical treatment lacking in their home countries.”⁹

Counsel for ZT had argued that her case was different from N’s because N’s home country, Uganda, was making proper efforts to counter the HIV epidemic. In Zimbabwe, by contrast, he said, the government was partly to blame for the situation of Zimbabweans with HIV, because of its “malevolent attitude, discriminatory practices in the application of health care, and systematic violation of human rights laws.” Counsel for ZT drew an analogy with a European Court of Human Rights case precluding extradition to the US of a person who is likely to face an unduly extended wait on death row.¹⁰

The court rejected the argument, stating that the behaviour of the receiving state is not *per se* relevant to determining whether a person will likely face an unjustified state of suffering. Lord Justice Buxton qualified, however, that he could “envisage a case in which the particular treatment afforded to an AIDS sufferer on return, in terms of ostracism, humiliation, or deprivation of basic rights that was added to her existing medical difficulties, could create an exceptional case...”¹¹

Finally, the court rejected the argument that ZT’s case might not be exceptional in Zimbabwe, but that her situation should be compared to that of people in the UK.

Right to private and family life

The Court of Appeals also rejected the argument that ZT’s deportation would unlawfully interfere with her right to her private and family life guaranteed under article 8 of the *Convention*. Article 8 has been construed broadly. For example, ZT relied on *Razgar*,¹² a recent House of Lords decision holding that a man with a psychiatric disability could not be deported on the basis that it would detrimentally affect his mental health in violation of his article 8 rights.

These decisions make it nearly impossible for people living with HIV/AIDS to rely on the European Convention to avoid deportation.

In that case, the House of Lords stated that “the rights protected by article 8 can be engaged by the foreseeable consequences for health of removal from the United Kingdom pursuant to an immigration decision, even where such removal does not violate article 3, if the facts relied on by the applicant are sufficiently strong.”¹³

Once again the Court of Appeal held that ZT’s case did not meet the threshold for violation of the article 8 rights to private and family life. It affirmed the Immigration Appeal Tribunal’s ruling that there was no “flagrant or fundamental” breach of

ZT's rights, and that her case did not fall within a "small minority of exceptional cases" required for it to be considered a violation, as required by *Razgar*.¹⁴

The other three HIV-positive individuals' appeals, which were also based on article 3 and 8 of the *European Convention*, were rejected for similar reasons.

Comment

The Court of Appeals' decisions in ZT and the companion cases render it nearly impossible for people living with HIV/AIDS to rely on the *European Convention* to avoid deportation to countries where they will likely die because of a lack of health care. ZT's complaint failed because it was not sufficiently exceptional, not because the circumstances she would face if returned to Zimbabwe were not sufficiently grim. There is some incoherence here. As Lord Sedley observed in his concurring comments:

If HIV were a rare affliction, readily treatable in the UK but not treatable except for the fortunate few in many other countries, the courts would have little hesitation in holding removal of sufferers to such countries to be inhuman treatment contrary to Article 3. It is the sheer volume of suffering now reaching these shores that has driven the Home Office, the Immigration Appellate Authority and the courts to find jurisprudential reasons for holding that neither Article 3 nor Article 8 can ordinarily avail HIV sufferers who face removal. Only cases which

markedly exceed even the known level of suffering now qualify for protection.

We have in consequence had to set the bar in both Article 3 and Article 8 cases unusually high for removal cases.¹⁵

In effect, questions of practicality, rather than principle, led the court to adopt a rule that whether a person's case is "exceptional" does not depend on the degree to which the applicant would suffer, but the degree to which the UK would suffer. As Lord Sedley said: "If what results are rules rather than law, that may be an unavoidable price to be paid for the maintenance of the *Convention* system. One had much rather in were not so."¹⁶

In addition, the decisions close off Article 8 of the *Convention* as a unique ground for challenging deportations. After *Razgar*, it had seemed that an HIV-positive person might be able to rely on article 8 where article 3 was unavailable.¹⁷ But the court's interpretation of exceptional circumstances in which a claimant can succeed under article 8, where they have failed under article 3, has resulted in an extremely high threshold for the application of article 8 to health care decisions in the immigration context.

An applicant would have to show that her suffering was somehow different from that of other people in similar health situations. In practical terms, the standard that a person would have to reach to show a violation of article 8 in the absence of

a violation of article 3 has become virtually unreachable.¹⁸

– Alana Klein

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¹ *ZT v Secretary of State for Home Department*, [2005] EWCA Civ 1425.

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

³ *Ibid.*, at article 8.

⁴ The cases of KM and Mando are discussed together in *KM v Secretary of State for Home Department*, [2005] EWCA Civ 1682.

⁵ *Nsuguba v Secretary of State for Home Department*, [2005] EWCA Civ 1683.

⁶ (2005) UKHL 31. See K Gibson. UK: House of Lords upholds deportation order. *HIV/AIDS Policy & Law Review* 2005; 10(2): 48-49.

⁷ *D. v. United Kingdom* (1997) 24 EHRR 425. See European court prevents deportation of man with AIDS. *Canadian HIV/AIDS Policy and Law Newsletter* 1998; 3(4).

⁸ *ZT v. Secretary of State for the Home Department* at para 12.

⁹ *Ibid.*, citing Lord Nicholls in *N(FC) v Secretary of State for the Home Department*.

¹⁰ *Soering v United Kingdom* (1989) 11 EHRR 439.

¹¹ *ZT v Secretary of state for the Home Department* at para 18.

¹² *R (on the application of Razgar) v Secretary of State for the Home Department*, [2004] UKHL 27.

¹³ *Ibid.* at para 10.

¹⁴ *Ibid.* at para 30.

¹⁵ *Ibid.* at para 41.

¹⁶ *Ibid.*

¹⁷ See A. Ketter. UK: House of Lords recognizes that privacy rights include protection of mental health. *HIV/AIDS Policy & Law Review* 2004; 9(3): 62-63.

¹⁸ See *ZT v Secretary of State for the Home Department*, para 31.

India: Exclusion of people with HIV from police force unconstitutional, administrative tribunal holds

The Karnataka Administrative Tribunal of India, a state quasi-judicial body, recently ruled that it is unconstitutional for the state to deny an HIV-positive applicant employment in the police force.¹ The implication this decision, should it stand, is that persons living with HIV/AIDS in one of India’s highest prevalence states will be protected against discriminatory exclusion from employment in the public sector.

The case involved an individual, RR, who was shortlisted for a position as a police constable in Shimoga, a district in Karnataka. Selection as a constable was subject to medical examinations, which included HIV testing without the informed consent of the individual. RR tested positive for HIV and his provisional selection was cancelled on the basis of a circular issued by the Director General and Inspector General of Police. The circular directed the Police Department to “take all precautions to ensure that persons with HIV [are] not inducted into the Police force” and mandated compulsory testing for specific posts.

RR filed an application to the Tribunal requesting that the cancellation be set aside. He argued that exclusion of people who test positive for HIV from employment in the police force violates Articles 14 and 16 of the Indian Constitution, which guarantee equality before the law and equality of opportunity in public employment. Furthermore, the petitioner emphasized that a compulsory HIV test was unlikely to achieve its public health objectives, and contra-

vened the National AIDS Prevention and Control Policy. RR sought relief by way of appointment to the post of police constable; he also sought benefits awarded from approximately the time of the employment denial.

The respondents claimed the maintenance of public order requires persons who are medically fit.

Justice Reddy and Mr Kotilingangoud, sitting for the Tribunal, referred to case law from India and abroad. The Tribunal’s decision turned on the issue of medical fitness. It held that the actions of the Superintendent of Police were “arbitrary, illegal and unconstitutional” under Articles 14 and 16. More specifically, the Tribunal reaffirmed the principle set out in previous case law that HIV-positive status alone, without regard to a person’s ability to perform the job requirements and the fact that the person does not pose any threat to others at the workplace is arbitrary and unreasonable, and cannot be a ground for denying employment.

However, the Tribunal did not stop there. It also required that a vacancy be created for the petitioner, even

where one did not currently exist for the petitioner, and that appropriate instructions be given to appointment and recruitment agencies to ensure that similar constitutional lapses do not occur for future appointments. The Tribunal required that these directives be fulfilled within 100 days of receipt of the order.

This decision marks a significant step forward for persons living with HIV/AIDS in Karnataka and adds to the growing jurisprudence in India on employment discrimination in the HIV context.

– Priti Radhakrishnan

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¹ *RR v. Superintendent of Police & others* (2005), Karnataka Administrative Tribunal

Australia: Court recognizes that HIV-positive people face special challenges in prison

An Australian appellate court granted bail to a man charged with two separate counts of endangering life for allegedly having unprotected sex with two partners without disclosing that he was HIV positive.¹ The man, who has pleaded not guilty to both charges, is accused of having committed the second offence while he was released on bail awaiting trial for the first. In deciding to release him, the Court considered, among other things, the unique difficulties that people living with HIV/AIDS face in prisons.

The Honourable Justice Bleby of the Supreme Court of South Australia reversed an earlier decision by the same Court to deny bail. He held that under the circumstances of his release, the man was unlikely to pose a danger to the community. He also determined that that the accused “was likely ... to be subject to stressors to which someone on bail and a non-HIV-sufferer in prison would not be subject” which, in his medical condition, would place him at a “significant disadvantage in the preparation of his case for trial.”

Justice Bleby considered that the man was unlikely to commit offences like those with which he was charged during his release on bail, for a number of reasons. First, both of the offences for which the man was charged were committed in the context of separate monogamous relationships (and not “one night stands”) and, at the time of the bail hearing, the accused was in a third such stable relationship with a woman who was aware of his HIV status. If that relationship ended or did not exist, Justice Bleby stated, he would be unlikely, “in the interests of the female community,” to consider releasing the man on bail.

In addition, stringent bail conditions helped guard against any poten-

tial that the accused would commit the offence of endangering life while awaiting trial. These conditions included electronic monitoring and detention in his fiancée’s home with a stipulation that he could leave the house only if accompanied by his mother, his fiancée, or a professional AIDS care worker, and then only to attend medical appointments or for specific officially-approved purposes.

Finally, the man’s mother provided a AUS\$50,000 guarantee, his fiancée provided a AUS\$2000 guarantee, and both satisfied the District Court Judge in discussions in court that they would report any breaches of bail conditions.

Justice Bleby also considered the difficulties that the accused would face in prison as a person living with HIV/AIDS. Justice Bleby recognized that the man required continued monitoring of his condition and varied drug treatment, especially considering the increased risk of opportunistic infection as his disease progressed. He carefully considered, but did not fully accept, the testimony of an HIV support worker that the prison system is unable to provide the basic requirements of regular and timely access to health care practitioners for monitoring and treatment of his condition.

Justice Bleby concluded from

the testimony of clinical director of the South Australia Prison Health Service, and from the accused’s medical records, that there are “certain inflexibilities within the prison system which create disincentives for optimum management and review of prisoner of prisoners suffering from HIV/AIDS compared with those outside the prison system,” but that any disadvantage was “not significant.” However, Justice Bleby did accept the social worker’s testimony that HIV sufferers in the prison system are generally subject to a greater degree of discrimination and harassment than other prisoners.

Upon granting bail, Justice Bleby imposed a further condition that the accused not engage in any sexual activity with any other person without first informing that person that he is a carrier of the HIV/AIDS virus and that the virus may be transmitted by sexual activity.

– Alana Klein

¹ R v P, AC [2005] SASC 451 (29 November 2005).

US: Kansas court strikes down harsher penalty for gay underage sex

In October 2005, the Kansas Supreme Court struck down a law that would impose harsher penalties for same-sex statutory rape cases than for heterosexual cases.¹ In arriving at its conclusion that the distinction had no rational basis, the Court noted that gay teenage sex is no more likely than adult or heterosexual sex to result in HIV transmission.

Matthew Limon was one week past his 18th birthday when, in July 2000, he had consensual oral sex with a 14-year-old in the school for developmentally disabled teens where they both lived. He was convicted of criminal sodomy and sentenced to 17 years in prison. If Limon had performed the same act on a 14-year-old girl, he would have received a sentence of 15 months, because he could have benefited from what is known as Kansas' "Romeo and Juliet" law. The law, which reduces penalties for statutory rape when a teenager 19 or younger engages in voluntary sex with a teen between the ages of 14 and 16, only applied to opposite-sex relations.

Justice Luckert for the Kansas Supreme Court held that law violated the Fourteenth Amendment to the United States Constitution and struck down the opposite-sex requirement. She rejected the Court of Appeals' finding that the exclusion protected public health and that "certain health risks were more generally associated with homosexual activity than with heterosexual activity."² First, she found no reason to believe that public health risks for minors engaging in same-gender sexual relations are greater than the risks for adults. Second, she noted that a given sex act

is no more likely to result in disease transmission when engaged in by homosexuals than by heterosexuals.

Regarding the risk of HIV transmission during sex between teenagers, Justice Luckert cited the following evidence presented in court:

[A]mong the population of HIV-positive young people ages 13-19, which includes the age range covered by the Romeo and Juliet statute, 61 percent are female. Yet, the risk of transmission of the HIV infection through female to female contact is negligible. Recognizing that HIV is transmitted through intravenous drug use of shared needles and other mechanisms besides sexual transmission, the gravest risk of sexual transmission for females is through heterosexual intercourse.

There is a near-zero chance of acquiring the HIV infection through the conduct which gave rise to this case, oral sex between males, or through cunnilingus. And, although the statute grants a lesser penalty for heterosexual anal sex, the risk of HIV transmission during anal sex with an infected partner is the same for heterosexuals and homosexuals.³

Justice Luckert concluded that distinction between same-sex and

opposite-sex relations in the Romeo and Juliet statute created a "broad, overreaching and undifferentiated status-based classification which bears no rational relationship to legitimate state interests."⁴ She struck down Limon's sentence and the phrase excluding same-sex relations from the statute. Limon will be resentenced, but he will likely be released for time served.⁵

– Alana Klein

¹ *State v. Limon*, (2005) 280 Kan 275.

² *State v. Limon*, (2004) 32 Kan.App.2d 369 at p 379.

³ *State v. Limon*, (2205) at p 299.

⁴ *Ibid* at p 302.

⁵ D Klepper. "Romeo and Juliet" exemption struck: harsher gay-sex sentence rejected. *Kansas City Star*. 22 October 2005.

Criminal law and HIV/AIDS: four new cases

Australia: Man sentenced to 12 years for transmitting HIV to two tourists

A Sydney man was sentenced to 12 years' imprisonment for maliciously causing grievous bodily harm by having unprotected sex with two tourists after falsely assuring them he did not have HIV.¹ Stanislas Kanengele-Yondjo, a 42-year-old father of five, pleaded guilty and became the first person in New South Wales to be sentenced for HIV transmission.

The New South Wales branch of People Living with HIV/AIDS responded that the man's behaviour was indefensible and "not reflective of the HIV-positive community at large."² Kanengele-Yondjo will be eligible for parole after nine years.

Australia: Queensland man sentenced for infecting his partner with HIV

In December 2005, Mark Kenneth Reid was convicted of intentionally transmitting a serious disease for having unprotected sex with his partner.³ The victim testified that Reid had repeatedly denied that he was HIV-positive throughout the two-month relationship, which included regular unprotected sex. Reid, who pleaded

not guilty, claimed that that his partner knew about his HIV status and that he consented to unprotected sex nonetheless.

The offence has a maximum penalty of life imprisonment. In giving the 10-and-one-half-year sentence, Judge David Robin, QC said he had difficulty accepting the prosecution's contention that the offence was equivalent to attempted murder.⁴ This is the first conviction for HIV transmission in Queensland.

Kenya: Man sentenced for sexually assaulting a child and infecting her with HIV

In January 2006, a man was sentenced to 15 years in jail for sexually assaulting an eight year old girl and infecting her with HIV.⁵ The prosecution claimed that Benzal Chepkwony, 48, had lured the girl away as she went to buy sugar and covered her mouth to prevent her from screaming. She later tested positive for HIV.

UK: Man pleads guilty in HIV transmission case

Derek Hornett, a 44-year-old HIV-positive man, pleaded guilty to inflicting grievous bodily harm for

having unprotected intercourse with 82-year-old woman. The court heard testimony that Hornett and begun a relationship with the woman because she was financially secure. He was sentenced to three years and three months in jail, and was also banned from associating with people over 60 or doing paid or unpaid work with people over 60.⁶

– Alana Klein

¹ G Jacobsen. Jail for giving women HIV. *Sydney Morning Herald*, 2 December 2005.

² Ibid.

³ J. Leggatt. Man jailed for 10 years for infecting lover with HIV. *Australian Associated Press*, 9 December 2005.

⁴ A. Watt. Infecting partner with HIV brings jail. *Courier-Mail*, 10 December 2005.

⁵ GO Sayagie, T Maero. Man gets 15 years for infecting girl with HIV. *East African Standard*, 27 January 2006.

⁶ Man infected woman, 82, with HIV. *BBC News*, 19 December 2005.

In brief

All of the In brief articles were authored by Alana Klein.

Australia: HIV-positive applicant for permanent residence obtains waiver of medical inadmissibility

In December 2005, the Australian Migration Review Tribunal (MRT) overruled an executive decision to refuse permanent residence to an HIV-positive man.¹ Australia's Migration Regulations require that in order to become a permanent resident, applicants must be free from a disease or condition that will "result in a significant cost to the Australian community in the areas of health care and community services."² However, the health requirement can be waived if admission will not result in result in "undue costs to the Australian community."³

The man, who met the criteria for permanent residence as a child of Australian parents, was declared medically inadmissible by a delegate of the Minister for Immigration and Multicultural and Indigenous Affairs in February 2005. The delegate refused to grant a waiver of the man's medical inadmissibility. She considered the estimated AUS\$250,000 cost resulting from the man's medical condition would be "undue" because, among other things, the man would be eligible for public health care; his mother, who was his sponsor, might have diminishing financial capacity to care for him; the applicant was unwilling to work; and there is a lack of discrimination against people with HIV in his country of origin.

The MRT overruled the delegate's waiver decision. It noted that the applicant's current state of health was good, that he was on a successful regimen of HIV therapies, and that he was unlikely to require acute care.⁴ The man had taken out private insurance and his family members indicated that they would provide for him, which would likely reduce any costs to the public.⁵

In addition, the MRT said, the applicant, who had not lived in his country of origin for 25 years, would suffer if sent back; his mother, for example, would not be able to join him.⁶ The MRT also looked at the man's volunteer work and found him likely to continue contributing to Australian society.⁷ The man also was found to have close family and community relationships in Australia.⁸

The Department of Immigration and Multicultural and Indigenous Affairs was directed to grant the waiver.⁹

Australia: Court quashes sentence of man convicted for HIV transmission

Western Australia's highest court quashed the sentence of a man convicted of unlawfully causing grievous bodily harm to his teenage girlfriend by having unprotected intercourse with her without disclosing that he knew he had HIV.¹⁰

In 2002, Ronald Houghton became the first person in Western Australia to be convicted for HIV transmission. He was convicted again in 2004 after a retrial.¹¹ Among Houghton's defences was that he honestly and reasonably believed that by withdrawing prior to ejaculation he could avoid

transmitting the virus even if he did not use a condom. In finding him guilty, the jury rejected his defence.

Houghton was sentenced to four years and eight months' imprisonment after his second trial.¹² He appealed the sentence claiming that it was "manifestly excessive." The Supreme Court of Western Australia held that the sentencing judge should have, in determining the appropriate sentence, drawn a conclusion about whether the offender honestly but unreasonably believed that HIV transmission could be avoided by withdrawal, or whether he did not honestly hold that belief.

The three-judge panel remitted the case to the sentencing judge for reconsideration, and directed the sentencing judge to draw a conclusion about the honesty of Houghton's belief.

US: Arizona ordered to cover HIV-positive woman's organ transplant

In October 2005, an administrative law judge ruled that a Phoenix woman is entitled to be a candidate for liver transplant even though she has HIV.¹³ Brenda Gwin, of Phoenix, Arizona, was diagnosed with end-stage liver disease caused by hepatitis C infection in November 2004. That month, the Arizona state Medicaid Program denied her coverage for a liver transplant because she was HIV-positive. A lawsuit was filed to overturn the decision.

Previously, the agency had argued that transplant recipients with HIV did not fare as well as those without the virus, but Gwin's lawyers cited a 2002 *New England Journal of Medicine* article finding no evidence of poorer survival rates.

This decision does not guarantee that Gwin will receive the transplant. She will be placed on the transplant list, but doctors will evaluate how successful a patient is likely to be on a case-by-case basis. In addition, the decision is limited to Brenda Gwin's case: the state Medicaid program has agreed to pay for her transplant, but has not changed its underlying policy of prohibiting people living with HIV/AIDS from receiving organ transplants paid for by the state.

UK: House of Lords refuses leave to appeal HIV transmission conviction

On 14 December 2005, the House of Lords refused to hear an appeal of *Regina v. Dica*,¹⁴ a seminal case about the role that consent plays in the criminal law regarding the sexual transmission of HIV in the United Kingdom. At the conclusion of a retrial in the case, Dica was convicted of maliciously inflicting grievous bodily harm on two women for having unprotected sex with them knowing that he was HIV-positive.¹⁵

One of his defences had been that his sexual partners had consented to the risk of transmission by agreeing to the unprotected sex. The Court of Appeal upheld the conviction.¹⁶ However, it stated that its decision involved an important point of law about criminalization of HIV transmission and ordered that public funds be made available to prepare the case for a possible appeal to the House of Lords.

By refusing to hear the appeal, the House of Lords has decided that the issue was adequately dealt with by the Court of Appeal and that no

points of law need clarification. The House of Lords decision not to hear the case is regrettable. The Court of Appeal's decisions in *Dica*, considered alongside other appellate court decisions about criminal HIV transmission,¹⁷ leaves numerous gaps in the law.¹⁸ Under the current state of the law, it difficult for people living with HIV to know the nature and scope of their legal responsibilities when engaging in sexual acts that risk transmitting HIV.

Libya: Death sentences of foreign health care workers overturned

The Libyan Supreme Court has overturned the convictions of five Bulgarian nurses and a Palestinian doctor who had been sentenced to death by firing squad for allegedly deliberately infecting over 400 Libyan children with HIV.¹⁹ The nurses and the doctor, who have been behind bars for seven years, were accused of infecting the children through contaminated blood products.²⁰

Human rights groups contend the medical workers are scapegoats, and AIDS experts have suggested that the real cause of the infections was poor sanitary conditions at the hospital where they worked. There have also been allegations that Libyan government agents tortured the defendants to extract confessions.²¹ In his ruling, Libyan Supreme Court President Ali Al-Alus said that prosecutors and defence lawyers agreed that there were "irregularities" in the way the workers were arrested and interrogated.²²

The decision came two days after Bulgaria, Libya, the US and the European Union agreed to establish

a fund to finance the children's medical care. The exact amount of the fund has not been determined. The Supreme Court ordered a new trial, but no date has been set.

¹ V05/01 275 [2005] MRTA 1122.

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

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

⁴ V05/01 275, paras 35-36.

⁵ *Ibid.*, para 37.

⁶ *Ibid.*

⁷ *Ibid.*, para 39.

⁸ *Ibid.*, paras 40-43.

⁹ *Ibid.*, paras 45-46.

¹⁰ *Houghton v. State of Western Australia* [2005] WASCA 216.

¹¹ See B Mysko. Australia: Man convicted on retrial. *HIV/AIDS Policy & Law Review* 2004; 9(3): 64.

¹² See A Ketter. Criminal law and HIV transmission/exposure: three new cases. *HIV/AIDS Policy & Law Review* 2005; 10(1): 61.

¹³ K Fehr-Snyder. Arizona Health Care Cost Containment System must cover transplant. *Arizona Republic*, 31 October 2005.

¹⁴ See House of Lords. Minutes of Proceedings, 15 December 2005. Available at www.publications.parliament.uk/.

¹⁵ See T Franklin. UK: Leave to appeal grievous bodily harm conviction and sentence denied. *HIV/AIDS Policy and Law Review* 2005; 10(3): 47.

¹⁶ *R v Dica* [2005] EWCA Crim 2304.

¹⁷ See e.g. *R v. Konzani* [2005] EWCA Crim 706.

¹⁸ For a detailed analysis of *Dica* case and its ambiguities, see M Weiat, Y Azad. The criminalization of HIV transmission in England and Wales: questions of law and policy. *HIV/AIDS Policy and Law Review* 2005; 10(2): 1.

¹⁹ CS Smith. Libyan court orders a retrial for 6 workers in H.I.V. case. *New York Times*, 26 December 2005.

²⁰ B Mysko. Libya: Foreign health-care workers sentenced to death for deliberate infection. *HIV/AIDS Policy and Law Review* 2004; 9(3): 61.

²¹ In the courts: Libyan court overturns death sentences, orders retrial of Bulgarian nurses accused of infecting children with HIV. *Kaiser Daily HIV/AIDS Report*, 3 January 2006. Available at www.kaisernet.org/daily_reports/rep_index.cfm?hint=1&DR_ID=34516.

²² *Ibid.*