

HIV/AIDS POLICY & LAW REVIEW

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Delivery past due: global precedent set under Canada's Access to Medicines Regime

Four years to the month after Parliament passed a law to enable the supply of lower-cost generic medicines to developing countries in need, the first exports are finally about to happen. In this article, Richard Elliott provides an overview of recent developments under Canada's Access to Medicines Regime (CAMR), and identifies key reforms needed to streamline the regime so that it can more easily be used to address public health problems in developing countries.

WTO rules and Canada's law on exporting generics

Under the World Trade Organization's (WTO's) treaty on intellectual property, the *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS),¹ member countries must grant exclusive patent rights on medicines. But they retain the right to grant compulsory licences, which legally authorize the production of lower-cost, generic versions of patented drugs in exchange for royalties paid to the patent-holder. Breaking the patent-holder's monopoly and introducing competition brings down prices.

TRIPS also states, however, that products made under compulsory licences must be "predominantly for the supply of the domestic market," thereby limiting the use of compulsory licensing in one WTO member country to produce generic medicines predominantly or exclusively for export to any other country. This undermines the ability of importing developing countries to use compulsory licensing effectively

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Published by the Canadian HIV/AIDS Legal Network
1240 Bay Street, Suite 600
Toronto, Ontario
Canada M5R 2A7
Tel: +1 416 595-1666
Fax: +1 416 595-0094
info@aidslaw.ca
www.aidslaw.ca

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Managing Editor:

David Garmaise dgarmaise@gmail.com

Editor, Canadian Developments:

Alison Symington asymington@aidslaw.ca

Editor, International Developments:

Richard Pearshouse rpearshouse@aidslaw.ca

Editor, HIV/AIDS in the Courts — Canada:

Sandra Ka Hon Chu schu@aidslaw.ca

Editor, HIV/AIDS in the Courts — International:

Leah Utyasheva lutyasheva@aidslaw.ca

Coordinator: Vajdon Sohaili

Translators: Roger Caron, Jean Dussault, Josée Dussault, Johanne Forget

Layout: Liane Keightley

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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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as a tool to get lower-cost treatment for patients.

In August 2003, WTO members, under pressure from developing countries and treatment activists, adopted a General Council Decision waiving this restriction under certain conditions.² In May 2004, following an eight-month advocacy campaign by civil society groups,³ both houses of the Parliament of Canada unanimously passed legislation amending the *Patent Act*⁴ and the *Food and Drugs Act* to implement this 2003 WTO Decision.⁵

Canadian civil society organizations succeeded in obtaining significant improvements to the bill originally introduced by the government, but they warned that the remaining flaws could hinder the usefulness of the legislation. Nonetheless, they said that they would support efforts to use it to benefit patients in developing countries.⁶

After further pressure from NGOs, the law and accompanying regulations were brought into force one year later, in May 2005.⁷ At the request of international humanitarian organization Médecins Sans Frontières (MSF), Canada's largest generic pharmaceutical manufacturer, Apotex, Inc., produced "Apo-Triavir," a new fixed-dose combination of existing anti-retroviral AIDS medicines zidovudine, lamivudine and nevirapine (AZT/3TC/NVP).

The combination of these three medicines into one tablet, taken twice

daily, simplifies one of the first-line combination regimens recommended by the World Health Organization (WHO) for treating people living with HIV/AIDS.⁸ This combination did not previously exist.

MSF indicated that it would seek to use the CAMR to place an order for the Apotex product for use in one or more of its AIDS treatment projects in the field. Under the CAMR and the terms of the underlying 2003 WTO Decision, this would require at least some degree of cooperation by the government of the developing country into which MSF would import the product.

Three years after the law was passed and two years after it came into force, not a single pill had yet been exported under the CAMR.

The Apotex product was approved by Health Canada as meeting the same regulatory standards as a medicine intended for sale in the domestic market, a condition imposed by Canada's legislation implementing

the 2003 WTO Decision but not required by the WTO Decision. The Health Canada review process took seven months; the product received approval in July 2006.⁹ On 10 August 2006, shortly before the XVI International AIDS Conference in Toronto, the WHO Prequalification Programme, having reviewed the dossier submitted by Apotex to Health Canada, also gave its stamp of approval.¹⁰

However, by May 2007 — three years after the law was passed and two years after it came into force — not a single pill had yet been exported under the CAMR, in part because of the apparent unwillingness of any developing country eligible to import under the CAMR to make the requisite notifications to the WTO or the Government of Canada.¹¹ As a result, MSF ultimately informed Apotex that it could not follow through on its original plan to place an order for the product.

Breakthroughs: Rwanda takes historic step, first licence issued, order placed

Finally, in July 2007, almost four years since the original WTO Decision was adopted, and following interventions by the Clinton Foundation HIV/AIDS Initiative, Rwanda became the first — and to date, only — country to notify the WTO of its intention to import the Apotex product.¹² Rwanda's noti-

fication stated that it anticipated importing up to 260 000 packs of Apo-TriAvir. Rwanda's notification was a necessary precondition for Apotex to pursue the process under Canadian law for obtaining a licence to manufacture the product legally for export.

In response, Canadian health activists expressed cautious optimism about moving this important step closer to possible use of the CAMR, but noted that even if this one case turned out to be successful, Canada still needed to reform its legislation if there was to be any real likelihood of it being used again.¹³

The following month, media reports indicated — incorrectly, as it turned out — that Apotex had succeeded in negotiating voluntary licences with all the brand-name pharmaceutical companies holding the relevant Canadian patents on the constituent products in the new generic fixed-dose combination, which licences would allow Apotex to export its generic product to Rwanda.¹⁴

In fact, in the end no voluntary licences were issued, and in early September, Apotex proceeded to file its application for a compulsory licence with the Commissioner of Patents, in accordance with the legislation.¹⁵

On 19 September 2007, the Commissioner issued the requested licence, authorizing Apotex to produce and export the quantity notified by Rwanda, amounting to 15 600 000 tablets over a period of up to two years.¹⁶ (As treatment consists of two tablets daily, this would amount to a year's course of treatment for more than 21 000 patients, or two years' worth of treatment for half that number of people.)

In October 2007, Canada notified the WTO of this compulsory licence having been issued.¹⁷

The Government of Rwanda subsequently initiated an international tendering process. Equipped with a compulsory licence authorizing the legal production of Apo-TriAvir for export to Rwanda, Apotex submitted a bid to the Rwandan government quoting a price of US\$0.195 per tablet — meaning treatment with this regimen would cost US\$146 per patient per year, lower than the then-lowest price from a generic source (US\$176 per patient per year) reported publicly.¹⁸

Canadian health advocates renewed their long-standing call to the government and to Parliament to reform the regime.

On 7 May 2008, Apotex announced that it had succeeded in the competition: The Rwandan government had decided to purchase the Apotex product.¹⁹

Canadian health advocates welcomed the announcement, but highlighted that this breakthrough came after four years and only as a result of the commitment of one company and various civil society interveners — hardly a sustainable process, and one unlikely to be repeated unless the CAMR process were drastically simplified.²⁰ They renewed their long-

standing call to the government and to Parliament to reform the regime.

Fixing the flaws: the push to reform the CAMR

The 2004 law that created the CAMR required the federal Minister of Industry to review the law within two years of it coming into force (i.e., May 2005), and to report back to Parliament shortly thereafter.

In August 2006, during the International AIDS Conference in Toronto, the Minister of Health, responding to pressure, publicly committed to speeding up the review and to making necessary changes to make it work.²¹

As part of that review, in January 2007 interested parties, including a range of civil society groups, made submissions to the Government of Canada.²² Further submissions with recommendations for reform were made three months later to a Parliamentary committee at hearings into the failure of the legislation to date to deliver on the pledge of greater access to affordable medicines.²³ An international expert consultation also identified numerous aspects of the CAMR that were of concern.²⁴

However, in a report finally tabled in Parliament on Friday, 14 December 2007 — six months late and on the last day Parliament was in session before rising for an extended break — the Minister of Industry indicated the government's view that it would be premature to bring forward any amendments to CAMR. Instead, it planned to continue publicizing the regime to developing countries.²⁵

Health advocates criticized the government for its failure to act, stepped up their lobbying of individual Members of Parliament and

began to approach members of the opposition parties about the possibility of bringing amendments forward through a private member's bill.

Remedying the regime: proposals for reform

The ostensible purpose of the CAMR is to facilitate the export of lower-cost, generic versions of medicines manufactured in Canada to eligible developing countries. The one successful use of the CAMR, which was the result of determined and persistent effort over several years, was achieved despite the disincentives built into the current regime — hard proof that the regime is workable.

Consequently, Canadian civil society advocates have identified numerous reforms aimed at making the regime more user-friendly for developing countries (i.e., the potential purchasers) and for generic manufacturers (i.e., the potential suppliers) — the two parties that must use the CAMR if patients in developing countries are to benefit.

The most concrete proposals have been prepared by a broad-based civil society coalition, the Global Treatment Access Group (GTAG),²⁶ and by the Canadian HIV/AIDS Legal Network, which fleshed out the GTAG proposals in much more technical detail — including sample statutory amendments.²⁷

A core recommendation of the civil society groups was to go beyond merely tinkering with the CAMR in the form of minor adjustments. Rather, the groups have urged the government to replace the existing CAMR process for licensing the production and exportation of generic medicines, which is based on the underlying 2003 WTO Decision, with a simpler procedure that would be

much more likely to be used repeatedly to address developing countries' public health needs. The proposals for reform advanced by civil society groups are summarized here.

Eliminate limits on products subject to compulsory licensing

Currently, the legislative provisions constituting the CAMR include a limited list of pharmaceutical products covered by the regime, consisting primarily of drugs on the WHO's Model List of Essential Medicines (as it stood in early 2004 when the law was enacted by Parliament) plus most of the other anti-retroviral AIDS drugs then under patent in Canada.²⁸

An order by Canada's federal Cabinet is required to add any product not already on the list (which step has been taken twice since the legislation was originally enacted, including to add the AZT/3TC/NVP combination product developed by Apotex).

The underlying 2003 WTO Decision imposes no requirement to limit the list of medications.

However, the underlying 2003 WTO Decision imposes no requirement to limit the list of medications. The Canadian law should be amended to remove the "gatekeeping" function of this list and of the Cabinet, and should instead clarify that a compulsory licence may be issued on

any patented product, so as to be as flexible as possible in responding to needs identified by developing countries themselves.

Given the scope of the original WTO Decision, an amended Canadian law should also clearly state that it applies to active pharmaceutical ingredients of medicines (rather than simply the finished product), and any diagnostic kits needed for the use of a pharmaceutical product.

Avoid a discriminatory double-standard against non-WTO countries

Currently, the CAMR treats all "least developed countries" (recognized as such by the United Nations) and all developing countries belonging to the WTO as potentially eligible importers of Canadian-made generics. However, the CAMR creates unjustified hurdles for developing countries that are not WTO members (and that are not "least developed countries").

Specifically, in order to be added to the list of eligible importers of Canadian-made generics, a non-WTO developing country must declare "an emergency or other circumstances of extreme urgency," and must also agree that the imported product will not be used for "commercial purposes" — a vague term which is undefined and could conceivably be interpreted to mean interference with distribution of the product in the importing country through private, for-profit pharmacies.

Contrary to oft-repeated and inaccurate claims, there is no requirement on WTO member countries to use compulsory licensing only in the event of public health crises or other emergencies (despite the best efforts by the United States and some other high income countries to include such

a provision). To impose this requirement on non-WTO countries represents a double standard and an act of bad faith.

Eliminate additional barriers to NGO procurement

Currently, the CAMR requires that a non-governmental organization (e.g., MSF) purchasing Canadian-made generics for importation into an eligible country must have the “permission” of the country — although nowhere is this term defined.

This is an unnecessary hurdle and should be eliminated. If the medicine in question meets the requirements for approval that are established by the country’s drug regulatory authority — be it a review conducted by the country’s own technical experts or, as is often the case with many developing countries, relying on approval by the WHO Prequalification Project or the drug regulatory agency in a more highly-resourced country — that should suffice.

Eliminate requirement of Health Canada approval as only one acceptable

The CAMR currently prohibits the Commissioner of Patents from granting a compulsory licence permitting exports to a generic manufacturer unless Health Canada has confirmed the product meets all the same regulatory standards as products approved for sale in Canada. The principle of ensuring the quality of medicines is a good one.

However, the current approach is unnecessarily inflexible. Instead, the CAMR could specify that *either* Health Canada approval *or* approval from the WHO’s Prequalification Project (a standard widely referenced

and understood by developing countries) is sufficient.

An alternative would be to simply leave it to the importing country to determine the standards to be met (which could very well include accepting the approval of a well-developed and stringent drug regulatory authority). This creates greater flexibility and respects better the autonomy of developing countries, while providing quality assurance.

Eliminate requirement of advance disclosure of importing country

Under the CAMR’s current provisions, before a compulsory licence can be issued to a generic manufacturer, it must first attempt to negotiate a voluntary licence with the patent-holder — and in so doing, it must have disclosed to the patent-holder(s), for a period of at least 30 days, the name and specific quantity of the product it wishes to produce for export, and also the name of the destination country that seeks to import the generic product.

This means that, even before the generic manufacturer can give the importing country any guarantee that it can legally supply the product, the country will likely face pressure from the patent-holder(s) and any governments opposed to the use of compulsory licensing (e.g., the United States) to refrain from going this route.

This concern cannot be dismissed lightly, given the history of such pressure — including, in some instances, threats of trade sanctions or refusal by patent-holding companies to register existing or new medicines in a country. This is likely one factor explaining why, to date,

Rwanda is the only country to have notified the WTO that it intends to use the mechanism of the 2003 WTO Decision.

The CAMR legislation should be amended to remove this requirement of advance disclosure as a prerequisite to getting a compulsory licence. The law could instead require simply that a generic manufacturer, when first requesting a voluntary licence from the patent-holder(s), state that it will disclose the name of the country following receipt of the licence and will pay the applicable royalty rate pursuant to the existing formula — and that, if this were not acceptable to the patent-holder(s), the generic manufacturer would then be able to proceed to apply for a compulsory licence.

To date, Rwanda is the only country to have notified the WTO that it intends to use the mechanism of the 2003 WTO Decision.

Of course, such an approach would not remove the possibility of retaliation against countries that make use of compulsory licensing. It would, however, at least eliminate an early window period during which a country risks retaliation in advance of

any certainty of obtaining the generic medicine it seeks.

Eliminate negotiations for voluntary licences in urgent situations

At the moment, the CAMR requires a generic manufacturer to first attempt to negotiate with the patent-holder(s) for a voluntary licence to produce the medicine for export. This reflects a requirement under Article 31 of the WTO's TRIPS Agreement. Yet, that article also provides that a country's law can dispense with this requirement in cases of "emergency or other circumstances of extreme urgency," in cases of public non-commercial use of the product in question, or when a compulsory licence is being issued to remedy a practice by the patent owner that has been found by a judicial or administrative process to be anti-competitive. So, it is odd that Canada's legislation does not take full advantage of this undisputed flexibility already found in TRIPS. The CAMR should be amended to eliminate the negotiating requirement.

Abolish arbitrary two-year time limit on compulsory licences

Without any foundation in any WTO legal instrument, the CAMR arbitrarily imposes a two-year limit on the length of any compulsory licence issued under its provisions, thus tying the hands of purchasing countries and generic manufacturers unnecessarily. This limitation should be removed.

Clarify option for re-exportation from importing country within regional trading bloc

Where a developing or least-developed WTO member country is party to a regional trade agreement with

other countries, at least half of whom are least-developed countries, the 2003 WTO Decision allows that country to re-export, to the other developing or least-developed country members of that regional bloc, generic pharmaceutical products that have been imported under a compulsory licensing process.

However, the current wording of the CAMR's provisions creates uncertainty as to whether this would be allowed under the terms of a compulsory licence issued to a Canadian generic manufacturer — it could arguably be grounds for terminating the compulsory licence.²⁹ Further, it is unclear what the applicable royalty rate would be in such a case.

The 2003 WTO Decision is "neither expeditious, nor a solution."

The CAMR needs to be reformed to clearly permit the issuing of a compulsory license to supply, under a simple process and with a single licence, a number of developing countries within a regional trade group, as allowed under the 2003 WTO Decision.

Eliminate extra opportunities for litigation by patent-holders

Inserted at the last minute, some provisions in the CAMR create additional opportunities for patent-holders to initiate litigation with a view to

having the courts revoke, or vary the terms of, a compulsory licence issued to a generic manufacturer.³⁰ These provisions create additional disincentives for generic manufacturers to use CAMR, and are not based on the 2003 WTO Decision.

The potential for vexatious litigation by patent-holders to block or rescind compulsory licences issued to generic manufacturers cannot be dismissed, in light of the long and litigious history between the patented and generic pharmaceutical industries. These provisions should be removed.

Streamline CAMR: the "one-licence solution"

While the reforms outlined above would eliminate certain hurdles currently marring the CAMR, what is required is more fundamental reform. The experience to date with the CAMR has highlighted that the central problem has to do with the basic process for licensing the production and exportation of generics — and that the problem is rooted in the original 2003 WTO Decision itself.

It is instructive that, more than four years after the WTO General Council adopted that Decision, Rwanda remains the sole country to have indicated its intent to use the mechanism.³¹ MSF's experience, as illustrated through its hands-on effort to use the Canadian legislation to obtain an inexpensive medicine to treat patients living with HIV/AIDS, has led it to conclude that the 2003 WTO Decision is "neither expeditious, nor a solution."³²

In May 2008, having finally succeeded in making the first — and to date, only — use of CAMR, generic manufacturer Apotex repeated that

it was not interested in attempting to use the regime again absent significant changes.³³

If Canada's Parliament wishes the CAMR to be a useable tool to assist developing countries, it will need to rethink the basics of the 2003 WTO Decision and be willing to streamline the CAMR dramatically.

The WTO Decision, as embodied in the CAMR, creates unnecessary hurdles for generic companies and developing countries to use compulsory licensing — and even if a compulsory licence is obtained to produce a given medicine, the CAMR authorizes exportation only of a pre-determined quantity and only to a single country, forcing a repeat of the process for any other drug orders from the same or other countries. The legal process must be more user-friendly for developing countries and generic manufacturers.

This basic premise is the root of the “one-licence solution” advocated by Canadian civil society organizations. Put simply, a generic manufacturer would require but one compulsory licence. That single licence should authorize the manufacturer and export any pharmaceutical product patented in Canada, not just those on CAMR's current limited list. The licence should be obtainable *before* any particular country or specific quantity of the pharmaceutical product in question has been determined.

Such legal authorization could be achieved most directly, and with the least transaction cost, by simply enacting a specific section of the *Patent Act* that statutorily authorizes the generic production of any patented pharmaceutical product solely for purposes of export to any eligible country specified in the legislation.

As an alternative, if the law maintained a requirement that a given generic manufacturer had to make a specific application for a licence on a particular product, that licence could be granted as of right, rather than requiring the manufacturer to apply for a separate licence to cover every separate order of a drug. The licence would authorize the company to export the medicine in question to any eligible country specified in the legislation.

Whichever approach to granting a licence were used, one of its conditions would be to require the generic manufacturer to pay royalties to the patent-holder(s). This could be done with the formula for calculating royalties that is already in the CAMR.

Having obtained such a licence at the outset, the generic manufacturer would be equipped to negotiate multiple contracts with multiple countries, rather than separate agreements with each country and for specific pre-determined quantities. The royalties payable would be based on whatever contracts the generic manufacturer succeeds in negotiating; it would be a condition of the licence that these details be reported periodically when remitting the royalty payments.

This simplified process, allowing for multi-country, larger-volume supply contracts, could achieve considerable economies of scale, creating further incentives for generic manufacturers to participate, and also further reducing the final price of products to developing countries. Such a process would also eliminate the need for any period of attempting to negotiate voluntary licences with patent-holders — and the accompanying exposure of a country to pressure before the generic manufac-

turer can guarantee delivery of the medicine.

Furthermore, it would allow for greater flexibility for developing countries, which would be able to adjust over time the quantities of a product that it requires, rather than, as is the case now with the CAMR and the 2003 WTO Decision, having to fix a quantity in advance and then having the generic manufacturer apply for a specific compulsory licence authorizing production of just that amount.

The mechanism set forth in the 2003 WTO Decision is not the only option open to WTO member countries.

The one-licence solution is distinct from the mechanism set forth in the 2003 WTO Decision. However, that mechanism, as embodied in the CAMR and in the law of several other jurisdictions, is not the only option open to WTO member countries. The 2003 WTO Decision explicitly states that it is “without prejudice to the rights, obligations and flexibilities that [WTO] Members have under the provisions of the TRIPS Agreement ... and to their interpretation.”³⁴

In 2002, a number of developing countries and various NGOs, with the support of the WHO, had proposed that another part of the TRIPS Agreement (Article 30) could provide

a basis for addressing the problem that the 2003 WTO Decision, as it was ultimately adopted, was supposed to solve — namely, the restrictions (under TRIPS Article 31) on the use of compulsory licensing for export.³⁵ TRIPS Article 30 states:

Exceptions to Rights Conferred

Members may provide limited exceptions to the exclusive rights conferred by a patent, provided that such exceptions do not unreasonably conflict with a normal exploitation of the patent and do not unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties.

As pointed out by the industry association representing generic manufacturers,

the intent of the [2003 WTO] Decision is that if an eligible importing member seeks drugs under the system, a rapid response is important and consistent with the Decision (see preamble). Any conflict with normal exploitation of a patent, if consistent with that objective, cannot be unreasonable. The eligible importing member or its citizens are third parties with legitimate interests.³⁶

It should be recalled as well that TRIPS Article 30 is open-ended, and that TRIPS also states explicitly that WTO “[m]embers shall be free to determine the appropriate method of implementing the provisions of this Agreement within their own legal system and practice.”³⁷

In the 2001 Doha Declaration, WTO members unanimously agreed that TRIPS should be interpreted and implemented so as to promote access to medicines and reaffirmed “the right of WTO Members to use, to

the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.”³⁸

Conclusion

Canada was one of the first countries in the world to implement the 2003 WTO Decision, has witnessed sustained efforts to use its domestic regime to implement the Decision, and has seen the only use of any such mechanism to date anywhere in the world, four years after it was created.

Canada is, therefore, well positioned to show leadership in acknowledging that the current approach does not offer the rapid, flexible, sustainable solution that is needed and was promised, and to legislate instead a different approach that stands a greater chance of being workable for developing countries and generic manufacturers.

Legally, Canada could replace the current CAMR with a streamlined process along the lines of what has been proposed here, and could defend it against challenge at the WTO under the rubric of TRIPS Article 30.

The question, therefore, is not one of legal incapacity. The question is: Will Canada’s parliamentarians have the political will to take the action that is needed to help increase access to affordable AIDS or other treatment for tens or hundreds of thousands of people in the developing world?

— Richard Elliott

Richard Elliott (relliott@aidslaw.ca) is Executive Director of the Canadian HIV/AIDS Legal Network. For more information on the CAMR, see the Government of Canada’s website at www.camr.gc.ca, and materials from civil society groups via www.aidslaw.ca/gtag.

¹ Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), 15 April 1994, Annex 1C of the Marrakesh Agreement Establishing The World Trade Organization, Legal Instruments — Results of the Uruguay Round, Vol. 31, 33 I.L.M. 1197 (1994).

² WTO General Council, *Decision on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, WTO Doc. IP/C/W/40 (30 August 2003) [“2003 WTO Decision”], available via <http://docs.online.wto.org>. For more detailed discussion, see: R. Elliott, “Delivering on the pledge: global access to medicines, WTO rules and reforming Canada’s law on compulsory licensing for export,” *McGill International Journal of Sustainable Development Law & Policy* 3(1) (2007): 23, available via www.aidslaw.ca/gtag.

³ For a more detailed discussion of the campaigning efforts, see 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* 8(3) (2003): 1; R. Elliott, “Steps forward, backward, and sideways: Canada’s bill on exporting generic pharmaceuticals,” *Canadian HIV/AIDS Policy & Law Review* 9(3) (2004): 15; both available via www.aidslaw.ca/review; R. Elliott, “Delivering on the pledge.”

⁴ *Patent Act*, RSC 1985, c. P-4. Available via <http://laws.justice.gc.ca>.

⁵ *An Act to Amend the Patent Act and the Food and Drugs Act (Jean Chrétien Pledge to Africa)*, S.C. 2004, c. 23, at www.canlii.org/ca/as/2004/c23/. For a quick summary, see www.parl.gc.ca/3773/parlbus/chambus/house/bills/summaries/c9-e.pdf. In addition to Canada, as of May 2008, a few other jurisdictions — Norway, India, the European Union, Netherlands, South Korea and China — had adopted legislation, regulations, policy directives or other instruments that in some way, with varying degrees of specificity and restrictiveness, implement the 2003 WTO Decision to permit compulsory licensing of patented pharmaceuticals for export to certain eligible countries. For additional information and materials, see the compilation by Knowledge Ecology International (formerly Consumer Project on Technology), “Legislation to Allow for the Export of Pharmaceuticals Under Compulsory License”, at www.cptech.org/ip/health/cl/cl-export-legislation.html.

⁶ For more detailed discussion, see: R. Elliott, “Pledges and pitfalls: Canada’s legislation on compulsory licensing of pharmaceuticals for export,” *International Journal of Intellectual Property Management* 1(1/2) (2006): 94–112, available via www.aidslaw.ca/gtag; Canadian HIV/AIDS Legal Network and Interagency Coalition on AIDS and Development, *The Jean Chrétien Pledge to Africa Act and Its Impact on Improving Access to HIV/AIDS Treatment in Developing Countries*, August 2006, available via www.aidslaw.ca/gtag.

⁷ Industry Canada, “Coming into force of the *Jean Chrétien Pledge to Africa Act*,” news release and backgrounder, Ottawa, 13 May 2005. Available via <http://www.ic.gc.ca>. See also, *Use of Patented Products for International Humanitarian Purposes Regulations*, S.O.R. 2005/243; *Food and Drugs Regulations* (1402 — Drugs for Developing Countries), S.O.R. 2005/141; *Medical Devices Regulations* (Developing Countries), S.O.R. 2005/142, all in the *Canada Gazette (Part II)*, Vol. 139 (No. 11), June 1, 2005, all available via <http://canadagazette.gc.ca/partII/2005/20050601/html/index-e.html>. For more information about what the government has since labelled “Canada’s Access to Medicines Regime,” see www.camr.gc.ca.

⁸ For information about the product “Apo-TriAvir,” see: www.apotex.com/apotriavir.

- ⁹ Médecins Sans Frontières, *Neither Expeditious, Nor a Solution: The WTO August 30th Decision Is Unworkable — An Illustration Through Canada's Jean Chrétien Pledge to Africa*, August 2006, at p. 6. At www.accessmed-msf.org/fileadmin/user_upload/medinnov_accesspatents/WTOaugustreport.pdf.
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- ²² For the complete text of written submissions, see http://camr-rcam.hc-sc.gc.ca/review-reviser/index_e.html.
- ²³ For the committee's summary of issues raised before it, see House of Commons Standing Committee on Industry, Science and Technology, *Letter to the Hon. Maxime Bernier, Minister of Industry*, 14 May 2007, and accompanying summary. At http://cmte.parl.gc.ca/Content/HOC/committee/391/indu/webdoc/wd2967322/391_INDU_Letter/391_INDU_RelDoc_PDF-e.pdf.
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- ³⁷ TRIPS, Article 1(1).
- ³⁸ 4th WTO Ministerial Conference, *Declaration on the TRIPS Agreement and Public Health*, 14 November 2001, WTO Doc. WT/MIN(01)/DEC/2, at para. 4. At www.wto.org/english/thewto_e/minist_e/min01_e/mindcl_trips_e.htm.

Developing guidance for HIV prosecutions: an example of harm reduction?

Extensive discussion of the global trend towards the prosecution of individuals for HIV transmission has tended to focus on arguments of principle for or against such prosecutions. There has been less examination of how, where prosecutions are taking place, the community, the voluntary sector and relevant professional bodies (hereinafter the “HIV sector”) can mitigate ensuing harm and maximise fairness and understanding in the criminal justice process. In England and Wales, where prosecutions for reckless HIV transmission have been taking place since 2003, the HIV sector persuaded the Crown Prosecution Service (CPS) to consult on the production of Legal Guidance for CPS prosecutors and caseworkers (hereinafter “Guidance”) in this area of law, as well as an accompanying Policy Statement.¹ In this article, Yusef Azad describes both the process and the outcome, and attempts an initial assessment of whether this intervention has benefited people living with HIV.²

The law in England and Wales in relation to prosecution of HIV transmission

In an earlier article for the HIV/AIDS Policy & Law Review, Matthew Weait and I set out the application of the law in England and Wales to HIV transmission as it had emerged from the four cases which had at that point come to court and, in particular, as had been set out in two Court of Appeal judgments.³ In summary, since 2003, Section 20 of the Offences Against the Person Act 1861 (OAPA 1861) has been used to prosecute reckless HIV transmission as serious bodily harm. To date (March 2008), there have been 13 prosecutions under Section 20, 10 of which have resulted in conviction and three in acquittal. Prosecutions for intentional transmission are also possible under section 18 of the OAPA 1861, but none has as yet taken place.⁴

The Court of Appeal made clear that HIV infection was a serious harm; that causing such harm whilst

aware of the risk of so doing constituted recklessness; that a possible defence was that the person infected had consented to the risk of that infection occurring; but that such consent could not be inferred simply from the fact of having unprotected sex, but rather had to be on the basis of the infected person’s specific knowledge of the defendant’s HIV-positive status.

The two Court of Appeal judgments left many key questions unanswered for people living with HIV, faced for the first time with the prospect of police investigation and possible prosecution if they passed on HIV to another person. Amongst the areas of concern and uncertainty were: What sort of sexual behaviours will the courts consider “reckless” for the purposes of HIV transmission? Is condom use a defence? Can transmission of other infections be prosecuted or is this only about HIV? What knowledge of one’s HIV status and infectiousness is necessary for one to be considered reckless (the second man convicted had never had an HIV test)? Is exposing someone

to the risk of HIV transmission a crime?

In July 2004 the National AIDS Trust (NAT) and the Terrence Higgins Trust (THT), two key NGOs in the U.K. HIV sector, convened a seminar to discuss how the sector might best respond to the prosecutions. Participants included community activists, voluntary sector representatives, clinicians, academic researchers and lawyers. There was particular concern about the many issues where there was no clarity as to how the law applied. This is not surprising given a nineteenth-century law was being used to prosecute these cases, a law which had certainly not been drafted with HIV (or any other disease) transmission in mind.

Guidance for clinicians, for HIV support organisations and for people living with HIV were all identified as priorities, as was engagement with the media. But clarity as to the detailed circumstances of prosecutions could only be secured from the CPS itself. There was agreement that the CPS should be approached with

a request for clarity and guidance in this area of law.

By contrast, there was at the seminar, and there continues to be in the HIV sector, wariness about attempting to persuade Parliament and government of the need to amend the law and end prosecutions for the reckless transmission of disease. Newspapers reported in 2006 that the Labour Government had in its then nine years of power created over 3000 new criminal offences, twice the number of the previous Tory administration.⁵ The fashion, in other words, is not to decriminalize anything, and there was a consensus that inviting legislative review of HIV transmission carried a serious risk in the current political climate of making matters worse rather than better.

Consultation process

Recent CPS practice encouraged a view that there might be willingness to work with the HIV sector on guidance for prosecutors in this new area of law. Since 2002, a process of public consultation by the CPS, with the support also of an expert working group of “practitioners,” had been used to agree policy and guidance in a number of areas of social sensitivity, including homophobic crime, domestic violence, and racial and religious hatred.⁶

Initial attempts to persuade the CPS of the importance of the issue met with no success. This changed in October 2004 when the chief executives of NAT and THT wrote directly to the Director of Public Prosecutions, head of the CPS, drawing his attention to this new area of prosecution, the fact that the first three people convicted were all African migrants, the social vulnerability of the communities most

affected by HIV in the UK (gay and African), and the need to ensure prosecutions were conducted in a non-discriminatory manner and with a good understanding of the biological and social facts around HIV.

The letter was very deliberately copied to the Chair of the Commission for Racial Equality. This brought a prompt response and a commitment to engage with the HIV sector in a consultation process to identify appropriate policy and guidance for prosecutors.

The HIV sector advised and persuaded but, in the end, were not asked to agree any policy or guidance.

The process had all of the key elements which, according to the CPS, attend all their consultation exercises of this sort — a working group was established with key community stakeholders; it was made clear that the final policy and guidance would be that of the CPS alone, albeit “community informed”; a draft of the policy and guidance was produced for discussion and refinement within the working group and then sent out for a three-month public consultation process; qualitative exercises were held to complement the discussion process;⁷ based on the consultation responses, a revised draft was produced for further discussion with the working group; and the policy

and guidance was submitted to the Director of Public Prosecutions and Law Officers for final clearance, and then publication.

The working group for this consultation process included, from the HIV sector, representatives from NAT (the author), THT, the U.K. Coalition of People living with HIV and AIDS, the African HIV Policy Network and a senior clinician representing the British HIV Association. In addition, there were a number of CPS officials, someone from the Metropolitan Police, and representatives of both the Ministry of Justice (the department’s current title) and the Department of Health. The group worked both through meetings and email correspondence. Four meetings were held in total — three in advance of the public consultation and one soon after the consultation period had closed.

Two points should be stressed. First, the final policy and guidance was the responsibility of the CPS alone. The HIV sector advised and persuaded but, in the end, were not asked to agree any policy or guidance. This was important. The representatives from the HIV sector on the working group are all opposed in principle to the prosecution of reckless HIV transmission. It is one thing to advise on prosecution guidance to minimise harm and quite another to own and author it. Any requirement to agree would have produced no end product at all, and thus an opportunity to influence for the better would have been lost.

The second point is that the CPS could not question the interpretation of the law as set out in the two Court of Appeal judgments. There is a “public interest” test for prosecutions, and there were early attempts

to argue that given the claimed public health harm, it was not in the public interest to prosecute at all. It became clear, however, that the public interest test was in relation to whether or not a given individual should be prosecuted and was not about giving the CPS an effective public policy discretion to overrule the courts and Parliament. Inevitably, engaging the CPS on guidance for prosecutors meant managing expectations within the HIV sector — i.e., this was never going to be about ending prosecutions.

One of the earliest points made to the CPS was that it was discriminatory to single out HIV transmission alone for prosecution and not any other serious communicable disease. The CPS agreed to include within its terms of reference the sexual transmission of any serious infection. Thus, ironically perhaps, the result of the HIV sector's concern that HIV should not be stigmatized was that the CPS developed guidance for the prosecution of a wider group of infections, broadening the scope of the consultation. (There has not yet been a prosecution for any infection other than HIV.)

The public consultation itself, which took place from September to November 2006, excited great interest and resulted in over 60 submissions, almost all of which set out arguments against prosecutions for HIV transmission and identified issues that had to be borne in mind in any prosecution. Although it was not in the CPS's power to end prosecutions completely, in my view the arguments against prosecutions were not wasted. I believe that the force of these arguments helped to secure a minimal take on the scope for prosecutions.

A key development which occurred during the course of the consultation was the growing disquiet with respect to how scientific evidence and, in particular, phylogenetic analysis had been used by the prosecution ostensibly to "prove" responsibility for infection. The first effective challenge from an expert virologist to this misuse of evidence took place in August 2006 in a case at Kingston Crown Court and resulted in the first acquittal in one of these cases. In February 2007, NAT with NAM⁸ and a number of the experts involved published "HIV Forensics," which set out the value and limitations of phylogenetic analysis in prosecutions for reckless HIV transmission.⁹

The arguments against prosecutions for reckless transmission of disease were not wasted. The force of these arguments helped to secure a minimal take on the scope for prosecutions.

In response, the CPS also established a separate clinicians working group. This group made an important contribution, both confirming the arguments made on the limitations of the scientific evidence but also making helpful points including, for example, on the need to be aware of varying stages of infectiousness and on the shock of diagnosis undermin-

ing the ability to understand fully behavioural messages. Of course, such points had been made by others, but a doctor's voice carries weight and there is real value of making as much common cause as possible with HIV clinicians in addressing prosecution issues.

Whilst normally the published government response should have occurred three months after the close of the consultation period (which would have been March 2007), the CPS actually spent most of 2007 deliberating internally on the consultation responses and the evidence from the clinicians working group. It was only in the Autumn of 2007 that a new draft emerged for consideration by the community working group.

It was immediately apparent why the process had taken so long: The documents had been completely rewritten. They were, however, much improved, and input from the working group in the final months resulted in the vast majority of the group's suggestions being accepted and included. The Guidance document and the Policy Statement were published on 14 March 2008 on the CPS website.

Content of the Guidance

The CPS concluded that attempting to set down detailed criteria for prosecution for all possibly relevant sexually transmitted infections, with their varying degrees of seriousness and modes of transmission, was impossible. As a result, the Guidance is generic — the reader will note immediately that neither HIV nor any other infection is mentioned by name.

The following is a discussion of some of the key issues addressed in the Guidance. Readers are encour-

aged to go directly to the two CPS documents in question to consider their content in more detail. Whilst the interpretation in this article is the author's alone, it reflects the shared initial understanding of the CPS documents amongst colleagues in the HIV sector. It remains to be seen whether prosecution practice will be consistent with this interpretation.

Scientific evidence and infection

The Guidance makes clear that in all cases, and even where the defendant is thinking of pleading guilty, scientific evidence is crucial to determine the likelihood of the defendant having infected the complainant. Early cases had involved guilty pleas and convictions without any corroborative scientific evidence of the defendant's responsibility for the complainant's infection. The requirement that evidence must always corroborate even a guilty plea for either reckless or intentional infection is an important provision.

Even where a close match between the two samples is demonstrated, there may be other explanations for what happened — for example, the complainant could have infected the defendant, or they both could have been infected by a third party. Thus, the Guidance requires that even where samples are closely linked, other evidence needs to be obtained, for example detailed sexual histories of the complainant as well as the defendant, to prove the likelihood that the defendant was responsible for the complainant's infection.

The Guidance states that scientific evidence can demonstrate that the defendant was *not* responsible for the complainant's infection. Whilst the Guidance does not explicitly state this, the relevant scientific evidence

in relation to HIV will ordinarily be phylogenetic analysis of HIV samples from complainant and defendant.

In summary, the scientific evidence alone cannot conclusively prove the responsibility of the defendant for the complainant's infection, but it has to be part of any prosecution case. This position might be somewhat paradoxical, but it reflects both the importance and the limitations of the scientific evidence, and has been central to the recent decline in the number of cases going to court and the recent increase in acquittals.

The discussion of knowledge in the Guidance was clearly influenced by submissions from the HIV sector.

Knowledge and recklessness

The second case prosecuted in England involved the conviction of someone who had not had an HIV test but had been informed by his wife of her own HIV-positive diagnosis and of her doctor's advice that he also be tested. This raised the question of what knowledge was required for someone to be prosecuted for recklessness in transmitting HIV.

The Guidance contains a strong subjective test of knowledge as it relates to recklessness — “prosecutors will look for evidence that the defendant ‘knew’ that they had a sexually transmissible infection and

were potentially infectious to others if they engaged in unprotected sexual activity.” The implication is that someone who “should” or “ought to” have known” that they were or could be infected cannot be prosecuted when actual, subjective knowledge of infection is absent.¹⁰

The Guidance states that the “best, and usual, evidence” of such actual knowledge is a medical diagnosis — i.e., “evidence to prove that the defendant had been tested, and had been told of his infection and advised about ways of reducing the risk of transmission to others, and that he or she had understood such advice.”

An important argument used by many in the HIV sector against prosecutions was the possible deterrent effect of prosecutions on willingness to test for HIV, if criminal liability was so closely linked to diagnosis. The CPS notes in its introduction to the Policy Statement that “the strong public interest in encouraging testing amongst those who may be at risk from any sexually transmissible infection”. The Guidance states that “[t]hose who choose not to be tested will not necessarily avoid prosecution for the reckless transmission of a sexually transmissible infection if all the circumstances point to the fact that they knew that they were infected.”

In the Guidance, the examples given of knowledge without diagnosis — or “wilful blindness” as the CPS perhaps unhelpfully terms it — include “where the defendant has a preliminary diagnosis from a clinician who has recommended that they have a formal confirmatory test for presence of the sexual infection but the defendant has failed to act on that recommendation.” Other examples where knowledge could be present in the absence of diagnosis are “clear

symptoms associated with the sexual infection” from which knowledge could reasonably be inferred, or the diagnosis of a sexual partner who could only have been infected by the defendant.

The Guidance emphasises, however, that such cases without diagnosis will be “rare” and “exceptional.” It is important to be clear that these examples of knowledge without diagnosis are not instances of “should” or “ought to” have known. The prosecution still has to prove actual, subjective knowledge by the defendant of his/her infected status. Whether this could ever be proved in a court of law in the absence of a diagnosis may be open to doubt. But this is nevertheless one issue to watch with care.

The discussion of knowledge in the Guidance was clearly influenced by submissions from the HIV sector. The Guidance requires not only evidence of a diagnosis having been delivered but of it having been understood. Referring to the shock of a positive diagnosis and the difficulty in understanding all that may then be communicated, the Guidance states that “prosecutors will need to be satisfied that the defendant really did understand that they were infectious to other people, and how the particular infection concerned could be transmitted”; and that “proof of knowledge is likely to be difficult.”

In summary, the emphasis on proof of subjective knowledge of infection and infectiousness, and the acknowledgement of some of the social factors which compromise such knowledge, result in a high evidential threshold for prosecution. As the CPS states in the introduction to the Guidance, “The criminality of the offending lies in the *mens rea*. This means that the relevant offences will

be difficult to prove to the requisite high standard...”

Behaviour and recklessness

The Guidance states that “recklessness” means the defendant foresaw the risk of infection to his or her sexual partner but still went on to take that risk, and did so unreasonably. The requirement of subjective knowledge is thus complemented by a more objective evidential requirement linked to the concept of “reasonableness.” There is a theoretical and remote risk of infection from a very wide range of sexual behaviours but in many cases, whilst foreseeable, the risk is so low as to make taking that risk reasonable. For an objective view of which behaviours involve a relevant degree of risk to possibly be prosecuted, the Guidance refers the prosecutor to “current scientific advice regarding the need for and use of safeguards.”

One important result of keeping the Guidance at this generic level is the absence in the document of any explicit statement as to what sexual behaviour would constitute recklessness in relation to HIV transmission. Instead, the prosecutor has to ensure that s/he understands the nature of the sexual infection in question, how it is transmitted, the varying degrees of infectiousness possible, and the place of “appropriate safeguards” in preventing transmission risks. In all these areas the prosecutor should get advice from an expert.

There are undoubted difficulties in this approach for those who wanted clarity from the CPS. The judgement for the purposes of prosecution as to whether a particular behaviour was reckless or a particular safeguard appropriate is one for individual experts and prosecutors.

It appears that the expert would ordinarily be a clinician. Whilst clinicians might be able to provide expertise on degrees of risk, it is not necessarily the case that they have a single or objective view as to what behaviour might be reckless, a very different sort of judgement. There is the possibility of both prosecution and defence calling clinicians as expert witnesses to argue the point, and of inconsistency of approach. We still do not know, for example, whether a prosecution might be attempted for HIV transmission from oral sex.

There is no explicit statement in the Guidance as to what sexual behaviour would constitute recklessness in relation to HIV transmission.

It could be argued, on the other hand, that the lack of stipulation, whilst not excluding any behaviour from prosecution, does not unequivocally include any behaviour either — i.e., we have avoided an unhelpful list which puts beyond doubt that a particular behaviour will be deemed reckless. This allows for development in scientific understanding and consensus, and also for a nuanced approach which could take more account of risk reduction or different stages in infectiousness. It could even be argued that the CPS have effectively given back to the HIV

sector the responsibility to establish the consensus as to what constitutes behaviour with a serious risk of harm.

Safeguards as a defence

As striking as the absence of the word “HIV” from the Guidance is the absence of the word “condom.” Again, this arises from the decision to provide generic advice applicable to the range of sexually transmissible infections. It is possible that the term “safeguard,” which is used in the Guidance, might be interpreted to mean not only a device or technology but also an aspect of behaviour which reduces risk. The main kind of safeguard in relation to HIV will nevertheless be the condom.

The Guidance states that evidence of consistent use of safeguards (read condoms) will make it “highly unlikely that the prosecution will be able to demonstrate that the defendant was reckless” even though infection has nevertheless occurred. This statement, which is effectively about condom use as a defence against prosecution, is, of course, very welcome, and reinforces public health messages. The Guidance goes on to state that even if the safeguard employed is inappropriate or incorrectly used, “only where it can be shown that the defendant knew that such safeguards were inappropriate will it be likely that the prosecution would be able to prove recklessness.”

Other issues

The Guidance restates the position of the Court of Appeal that a possible defence is that the person infected (the complainant) had consented to the risk of that infection occurring. This involves specific knowledge of the defendant’s HIV status when the HIV transmission took place. But the

Guidance makes clear that whilst disclosure would be the most usual way for the complainant to be informed, there are other routes for the information, such as from a third party, a hospital visit or “the appearance of sores” — and this is clearly not an exhaustive list.

With respect to intentional transmission, the Guidance states that an offence of “attempted intentional transmission” is possible, but also explicitly says that there is no offence of “attempted recklessness.” In other words, there is no crime of recklessly exposing someone to the risk of HIV transmission. Nor is someone guilty of rape who has consensual intercourse without disclosing his/her infection.

There is no guidance on the sensitivities around the application of the law to young people living with HIV reaching adolescence and becoming sexually active. As well, there is only a brief, and inadequate, account of how the law applies in cases of condom breakage during sex.

Next steps

The CPS is requiring that its local offices refer these sensitive cases to headquarters, which should establish some expertise and consistency. There is also to be a review of the Guidance and Policy Statement in a year’s time, which will be an opportunity to revisit uncertainties or continuing concerns.

A seminar for the HIV sector is being jointly organised by NAT and THT to discuss collective understanding of the CPS documents and next steps. There is clearly a need to communicate to individuals, professional bodies and organizations the implications of the Guidance. Tailored resources will need to be produced

for different audiences. Given the significant role envisaged for expert clinical evidence, it will be important to review the helpful guidance on prosecutions produced for clinicians in March 2006.¹¹

Also important will be to work with police forces to establish some consistent best practice in the investigation of these cases. A review is being undertaken of selected cases by the Metropolitan Police and THT to identify examples of both good and bad practice in investigation. NAT will draw on the results of this review to work with the Association of Chief Police Officers on the development of nationally applicable best practice guidelines for police investigation.

Conclusion

Judging success depends a lot on one’s initial expectations. The CPS were not in a position to end prosecutions for reckless transmission or disagree with the interpretation of the OAPA 1861 as set out by the Court of Appeal. What they could do — and what they did do — was consider in greater depth, and on the basis of detailed evidence, what is required to prove responsibility for infection, knowledge, recklessness and appropriate use of safeguards. An informed understanding of these elements has, even in the context of current criminal law, resulted in fewer and fairer prosecutions. As the CPS says in its Policy Statement, “[O]btaining sufficient evidence to prove the intentional or reckless sexual transmission of infection will be difficult ... accordingly it is unlikely that there will be many prosecutions.”

Therefore, we should consider this to be a successful example of policy intervention as harm reduction. It was not without its risks. Success

was due to a number of factors, not least of which was a CPS that was already committed to taking seriously the concerns and experiences of affected communities when considering prosecutions in socially sensitive areas of law. Some jurisdictions will not have such an enlightened prosecution service, and so the HIV sector will need to start further back in terms of engaging with the authorities. But it may be possible, even given the different legal contexts of different countries, to use the CPS Guidance to help bring about improvements in practice elsewhere.

The process was helped immensely by the commitment from an extraordinarily wide range of partners within the HIV sector, encompassing NGOs, academics, clinicians, virologists and, above all, people living with HIV.

Although harm may be reduced, it has not been ended — prosecutions for reckless HIV transmission remain and will continue. There is an urgent need to restate the ethical and policy case against such prosecutions and to

consider freshly how and when we might engage with political decision-makers on this issue.

— *Yusef Azad*

Yusef Azad (yusef.azad@nat.org.uk) is Director of Policy and Campaigns for the National AIDS Trust.

"Intentional or Reckless Sexual Transmission of Infection." Available at www.cps.gov.uk/legal/section7/chapter_h.html. The two documents contain very similar text. In this article, the Guidance is cited except where the Policy Statement states something additional.

² The description is not exhaustive and, in particular, cannot capture the broader and sustained level of community and sector engagement on the issue, which included publications, surveys, information dissemination, challenging stigmatizing coverage and engaging on sentencing policy and on public health law reform.

³ M. Weait and Y. Azad, "The criminalization of HIV transmission in England and Wales: questions of law and policy," *HIV & AIDS Policy & Law Review* 10(2) (2005): 1, 5–12.

⁴ There have been two or three attempts to charge individuals with intentional transmission, but they have never reached the courts.

⁵ "Blair's 'frenzied law-making': a new offence for every day spent in office," *The Independent*, 16 August 2006.

⁶ See www.cps.gov.uk/publications/prosecution/index.html for documents concerning CPS prosecution policy and guidance.

⁷ In this case, the CPS held a wider focus group in December 2005 for people from the HIV sector to feed in to the preparation of the document for public consultation.

⁸ NAM (formerly 'National AIDS Manual') is a leading UK HIV NGO which provides treatment and other HIV-related information. See www.aidsmap.com.

⁹ NAT/NAM, *HIV Forensics*, 2007, at www.nat.org.uk/document/230; see also, E. Bernard, *Criminal HIV Transmission*, NAM, 2007.

¹⁰ For a helpful account of the English legal context on recklessness, see M. Weait, *Intimacy and Responsibility: The Criminalisation of HIV Transmission* (London: Routledge-Cavendish, 2007), pp.158–160.

¹¹ British HIV Association, *HIV Transmission, the Law and the Work of the Clinical Team*, 2006, at www.bhiva.org.

¹ The Policy Statement¹ is designed for a general readership; its full title is "Policy for Prosecuting Cases Involving the Intentional or Reckless Sexual Transmission of Infection." Available at www.cps.gov.uk/publications/prosecution/index.html. The Legal Guidance for prosecutors and caseworkers is more detailed; its full title is

Access to condoms in U.S. prisons

Despite overwhelming evidence that condom use prevents the transmission of HIV, U.S. prison officials continue to limit the availability of condoms to incarcerated persons. Concern for transmission of HIV in prison and in the community upon prisoners' release has increased the interest of some policymakers in the issue. In this article, Megan McLemore addresses security concerns as well as human rights arguments in support of efforts to adopt a public health approach to harm reduction in U.S. prisons.¹

The management of infectious disease in prisons is a human rights imperative as well as a matter of public health. Given the high level of HIV infections among those who enter prison, making condoms readily accessible to inmates is an effective and inexpensive measure that corrections officials should take to limit the spread of infection.

Recent studies indicate no adverse security consequences in correctional systems where condoms are available. These findings, and a growing imperative to reduce transmission in the community when offenders are released, have prompted efforts in several states and the U.S. Congress to permit condom use in prison. These efforts should be endorsed by corrections professionals and policymakers.

Since 2006, legislators from states with the largest prison populations, such as Texas, California, Illinois, New York and Florida, have introduced bills permitting non-profit or medical personnel to provide condoms to inmates. At the federal level, Representative Barbara Lee has introduced the *Justice Act of 2006* (HR 6083), a comprehensive attempt to address HIV/AIDS in prison which includes a provision permitting condom distribution to reduce transmission.

None of these bills has become law, but their introduction reflects

the willingness of lawmakers to revisit a controversial issue in the interest of public health. In Texas, for example, Representative Garnet Coleman explained to the Corrections Committee considering his bill that it was intended to protect not only the health of inmates but the health of members of the African-American community, where HIV transmission rates are alarmingly on the rise. In California, Governor Arnold Schwarzenegger vetoed a bill permitting widespread condom distribution but authorized a pilot program in one prison to evaluate the feasibility of such a program.

Infectious disease in prisons

More than 2.2 million persons are currently incarcerated in U.S. prisons. Incarcerated individuals bear a disproportionate burden of infectious diseases, including the hepatitis B virus (HBV), the hepatitis C virus (HCV), and HIV/AIDS. Although inmates comprise only 0.8 percent of the U.S. population, it is estimated that 12–15 percent of Americans with chronic HBV infection, 39 percent of those with chronic HCV infection, and 20–26 percent of those with HIV infection pass through a correctional facility each year.²

The HIV prevalence in state and federal prisons is two and a half

times higher than in the general population.³ The prevalence of HCV among prisoners approaches 40 percent.⁴ Co-infection is also a concern: A significant number of HIV-positive inmates are also infected with HCV.

Although the majority of inmates infected with HBV, HCV and HIV acquired the infection outside of prison, the transmission of infectious disease in prison is increasingly well documented.⁵ Targeted interventions to reduce the risk of HIV transmission in prison, such as the provision of condoms, methadone maintenance treatment, and supplying bleach to clean needles and syringes, have proven highly effective in preventing HIV transmission in prisons, just as they have been when implemented outside.

These harm reduction approaches have been endorsed by the World Health Organization (WHO), UNAIDS and the UN Office of Drugs and Crime as an integral part of HIV prevention strategies, including in prison.⁶ Government failure to ensure access to harm reduction services puts inmates at unnecessarily increased risk of infection.

Regardless of institutional regulations, sexual activity, both consensual and coerced, is common in prisons. Sex among inmates has been documented extensively not only in academic studies and by human rights organizations, including Human

Rights Watch, but by correctional systems themselves in the form of individual grievances and disciplinary actions against inmates engaging in prohibited behaviour.⁷

The Prison Rape Elimination Act (2003)⁸ found that an estimated 13 percent of U.S. prisoners had been sexually assaulted in prison, and called for research into its prevalence and patterns. A national Prison Rape Elimination Commission has held a series of hearings examining sexual violence in local, state and federal correctional facilities; the U.S. Bureau of Justice Statistics has begun a nationwide survey of sexual violence in detention; and national standards are being developed to address the problem.

Government failure to ensure access to harm reduction services puts inmates at unnecessarily increased risk of infection.

Correctional policy and condom distribution

Despite overwhelming evidence that condom use prevents the transmission of HIV, U.S. prison officials continue to limit the availability of condoms to incarcerated persons. Fewer than one percent of correctional facilities provide condoms to inmates, though those that do include some of the nation's largest urban prisons.

These policies stand in stark contrast to the public health approach taken by prison officials in Canada, Western Europe, Australia, Ukraine, Romania and Brazil, where condoms have been available to inmates for years. Moreover, several large, urban prisons in federal jurisdiction, as well as one state, have provided condoms to inmates, either through medical staff or more general distribution. Where institutional policy provides for condom distribution, no correctional system has yet to find any grounds to reverse or repeal that policy.

Leading correctional health experts endorse condom distribution in prisons. The National Commission on Correctional Health Care (NCCHC), the nation's primary standard-setting and accreditation body in the field of corrections, has endorsed the implementation of harm reduction strategies, including condom distribution. The Commission states, "While NCCHC clearly does not condone illegal activity by inmates, the public health strategy to reduce the risk of contagion is our primary concern."⁹ Further, the American Public Health Association Standards for Health Services in Correctional Institutions (3rd Edition, 2003) recommends that condoms be available for inmates.

Condom distribution programs: U.S. prisons

Some corrections officials have expressed concern that condom distribution would negatively affect institutional security. This concern has proved unfounded in studies from Canada and Australia.¹⁰ As discussed below, a recent evaluation of a U.S. condom distribution program provides further evidence that security is not compromised by this vital harm reduction measure.

One study examined the condom distribution program in effect since 1993 at the Central Detention Facility in Washington, D.C. (CDF). The study found that the CDF housed approximately 1400 adult males, 100 adult females and 40 juveniles, and processed an average of 2800 inmates per month. It was staffed by 551 correctional officers.

Condoms were provided free of charge through public health and AIDS service organizations. Inmates had access to the condoms during health education classes, voluntary HIV pre-test or post-test counselling, or upon request to members of the health care staff. Approximately 200 condoms were distributed each month according to inventory audits.

Both inmates and staff were interviewed about their opinion of the condom distribution program. The findings indicate that 55 percent of inmates and 64 percent of correctional officers supported the availability of condoms at the CDF facility. Objections related primarily to moral and religious concerns about homosexual activity.

Thirteen percent of correctional officers said that they were aware of institutional problems associated with condom distribution, though none provided descriptions of those problems. No major security infractions related to condoms had been reported since commencement of the program. There was no evidence that sexual activity had increased, based upon staff interviews as well as a review of disciplinary reports for the relevant period. The researchers stated:

Permitting inmates access to condoms remains controversial among most correctional professionals. Even so, no jail or prison in the United States

allowing condoms has reversed their policies, and none has reported major security problems. In the Washington, D.C. jail, the program has proceeded since 1993 without serious incident. Inmate and correctional officer surveys found condom access to be generally accepted by both.¹¹

Several large urban prisons, including the Los Angeles and San Francisco County prisons, make condoms available to inmates. San Francisco Sheriff Michael Hennessey was a strong supporter of California's legislation permitting condom distribution in prison, which was passed in 2005 and again in 2007, but was vetoed in both instances by the Governor.

In an editorial opinion letter published April 19, 2005 in the *San Francisco Chronicle*, Sheriff Hennessey stated that correctional officials should "do everything we can to prevent sexual activity in custody, but we shouldn't turn a blind eye to the reality that it occurs." Further, he noted that the risk of contraband smuggling was much greater from routine contact between inmates and outside visitors than from the availability of condoms inside the facility. Significantly, following his recent veto of the bill, Governor Schwarzenegger agreed to permit a pilot program for condom distribution, the first of its kind in the California state prison system.

Legal standards and guidelines

International legal standards

In its treatment of prisoners, the U.S. must comply with its international human rights obligations. The U.S. is a party to the International Covenant on Civil and Political Rights (ICCPR), which guarantees to all per-

sons the right to life, and to be free from cruel, inhuman or degrading treatment; and, if deprived of their liberty, to be treated with humanity and with respect for the inherent dignity of the human person.

The U.S. is also a party to the Convention Against Torture (CAT), which protects all persons from torture and ill treatment; and is a signatory of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which guarantees the right to the highest attainable standard of health.¹²

States have a "positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty."

The obligations to protect the rights to life and health, and to protect against torture and other ill treatment create positive duties on the government to ensure access to adequate medical services and to take appropriate measures necessary to prevent and control disease.¹³

International human rights law clearly affirms that prisoners retain fundamental rights and freedoms guaranteed under human rights law, subject to the restrictions that are unavoidable in a closed environment. The conditions of confinement should

not aggravate the suffering inherent in imprisonment, because loss of liberty alone is the punishment.

States have positive obligations to take measures to ensure that conditions of confinement comply with international human rights norms and standards. The Human Rights Committee, an expert UN body that monitors state compliance with the ICCPR and provides authoritative interpretations of its provisions, has explained that states have a "positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty."

The ICESCR recognizes in Article 12 "the right of everyone to the highest attainable standard of health." The ICESCR requires that states take all the steps necessary for "the prevention, treatment and control of epidemic ... diseases" which include the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS.

Realization of the highest attainable standard of health requires not only access to a system of health care; according to the UN Committee on Economic, Social and Cultural Rights, it also requires states to take affirmative steps to promote health and to refrain from conduct that limits people's abilities to safeguard their health. Laws and policies that are "likely to result in ... unnecessary morbidity and preventable mortality" constitute specific breaches of the obligation to respect the right to health.

Key international instruments establish the general consensus that prisoners are entitled to a standard of health care equivalent to that available in the general community,

without discrimination based on their legal status.

In some cases, state obligations to protect prisoners' fundamental rights, in particular the right to be free from ill-treatment or torture, the right to health, and ultimately the right to life, may require states to ensure a higher standard of care than is available to people outside of prison who are not wholly dependent upon the state for protection of these rights.¹⁴ In prison, where most material conditions of incarceration are directly attributable to the state, and inmates have been deprived of their liberty and means of self-protection, the requirement to protect individuals from risk of torture or other ill-treatment can give rise to a positive duty of care, which has been interpreted to include effective methods of screening, prevention and treatment of life-threatening diseases.

Guidance from the WHO, UNAIDS and United Nations Office on Drugs and Crime (UNODC) elaborate measures to protect prisoners' fundamental rights to HIV/AIDS prevention, care and treatment.¹⁵ The principle of equivalence is specifically set forth in the *Basic Principles for the Treatment of Prisoners*, adopted by the United Nations General Assembly in 1990: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."¹⁶

The WHO guidance also state that prisoners are entitled to prevention programs equivalent to those available in their community, and specifically addresses the issue of condom distribution in a prison environment:

Preventative measures for HIV/AIDS in prison should be complementary to and compatible with those in the com-

munity. Preventative measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injection drug users and unprotected sexual intercourse.... Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention.¹⁷

U.S. legal standards

The Eighth Amendment to the U.S. Constitution protects prisoners from "cruel and unusual punishment" and requires corrections officials to provide a "safe and humane environment." In the U.S., prisoners have a right to health care beyond that of the general population. As Justice Marshall explained in the *Estelle* decision:

These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or lingering death," the evils of most immediate concern to the drafters of the Amendment.

In less serious cases, denial of medical care may result in pain and suffering, which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation, codifying the common law view that "it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself."¹⁸

The *Estelle* case, however, applies a difficult standard to Eighth

Amendment claims, requiring inmates to demonstrate that officials were "deliberately indifferent to serious medical needs." This standard involves both an objective (serious medical need) and subjective (deliberately indifferent) component. Courts have consistently held that prisoners diagnosed with HIV/AIDS have demonstrated a "serious medical need."¹⁹

The subjective component has been interpreted as met when a prison official "knows of and disregards an excessive risk to inmate health or safety."²⁰

In *Farmer*, a transgendered prisoner sued federal prison officials for compensation for a brutal beating and sexual assault that, the complaint alleged, could have been prevented by prison officials. The Supreme Court remanded the case for further hearing, but the opinion contains a detailed discussion of the scope of the duty of prison officials to protect prisoners from harm when the risk of harm is known or acknowledged.

There are no reported U.S. cases addressing the constitutionality of a prison system's failure to provide condoms to inmates but, arguably, the refusal to implement condom distribution programs in prisons meets the "deliberate indifference" standard, particularly when the rates of infection among inmates, their high-risk behaviour, and the incidence of transmission of disease is increasingly well documented.

Conclusion

Despite increasing documentation of high rates of infectious disease, the occurrence of high-risk behaviours, and transmission of disease among inmates, the distribution of condoms in U.S. prisons continues to be limit-

ed. Opposition to these programs on the basis of security concerns is not supported by the evidence provided in reports from prisons in jurisdictions that have established, evaluated and chosen to retain their condom distribution policies. U.S. policy-makers should endorse current efforts to adopt a public health approach to this issue, thereby ensuring compliance with the recommendations of national correctional health experts as well as with international legal standards and guidelines.

– Megan McLemore

Megan McLemore (mclmem@hrw.org) is with the Human Rights and HIV/AIDS Program at Human Rights Watch.

¹ Except in quoted text, this article uses the term "prison" to designate all correctional facilities, including jails.

² C. Weinbaum et al., "Hepatitis B, hepatitis C, and HIV in correctional populations: a review of epidemiology and prevention," *AIDS* 19(3) (2005): 41.

³ U.S. Bureau of Justice Statistics, *HIV in Prisons 2005*, September 2007. Available via www.usdoj.gov.

⁴ A. Spaulding et al., "A framework for management of hepatitis C in prisons," *Annals of Internal Medicine* 144 (10) (2006): 763; S. Allen et al., "Hepatitis C among offenders — correctional challenge and public health opportunity," *Federal Probation* 67(22) (2003): 22.

⁵ See, e.g., "HIV Transmission among male inmates in a state prison system — Georgia 1992-2005", *CDC Morbidity and Mortality Weekly Report (MMWR)*, 55(MM15) (2006): 421. For a review of HBV, HCV and HIV transmission studies for both international and U.S. prisons, see R. Jurgens, "HIV/AIDS and HCV in prisons: a select annotated bibliography," *International Journal of Prisoner Health* 2(2) (2006): 131. For a review of the U.S. literature in this area, see T. Hammett, "HIV/AIDS and other infectious diseases among correctional inmates: transmission, burden and an appropriate response," *American Journal of Public Health* 96(6) (2006): 974.

⁶ See, e.g., WHO/UNAIDS/UNODC, *Effectiveness of Interventions to Manage HIV in Prisons — Prevention of Sexual Transmission*, 2007.

⁷ See, e.g., C.P. Krebs et al., "Intraprison transmission: an assessment of whether it occurs, how it occurs, and who is at risk," *AIDS Education and Prevention* 14(Supp. B) (2002): 53; A. Spaulding et al., "Can unsafe sex behind bars be barred?" *American Journal of Public Health* 91(8) (2001): 1176; N. Mahon, "New York inmates' HIV risk behaviors: the implications for prevention policy and programs," *American Journal of Public Health* 86 (1996): 1211; and Human Rights Watch, *No Escape: Male Rape in US Prisons*, 2001.

⁸ *Prison Rape Elimination Act, 2003*, Public Law 108-79, 108th Congress.

⁹ NCCHC Position Statement, *Journal of Correctional Health Care* 11(4) (2005).

¹⁰ Correctional Services of Canada, *Evaluation of HIV/AIDS*

Harm Reduction Measures in the Correctional Service of Canada, 1999; L. Yap et al., "Do condoms cause rape and mayhem? The long-term effects of condoms in New South Wales prisons," *Sexually Transmitted Infections (STI) Online* (December 19, 2006), at www.stibmj.com.

¹¹ J. May and E. Williams, "Acceptability of condom availability in a US jail," *AIDS Education and Prevention* 14(Supp. B) (2002): 85.

¹² In signing the ICESCR, but not yet ratifying it, the U.S. has not agreed to be legally bound by the Convention, but should not take regressive steps in relation to the obligations therein and is obliged to refrain from acts which would defeat the object and purpose of the treaty (Article 18 of the *Vienna Convention on the Law of Treaties 1969*).

¹³ These leading international human rights instruments may be found online at the website of the United Nations High Commissioner for Human Rights, www.unhcr.ch/html/intlinst.htm.

¹⁴ See, R. Lines, "From equivalence of standards to equivalence of objectives: the entitlement of prisoners to standards of health higher than those outside prisons," *International Journal of Prisoner Health* 2 (2006): 269.

¹⁵ WHO, *Guidelines on HIV Infection and AIDS in Prisons*, 1999; UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 2006; UNODC, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for Effective National Response*, 2006.

¹⁶ Basic Principles for the Treatment of Prisoners, U.N. General Assembly Resolution 45/111 (1990), para. 9.

¹⁷ WHO, para. 20.

¹⁸ *Estelle v. Gamble*, 429 U.S. 97 (1976).

¹⁹ See *Smith v. Carpenter*, 316 F.3d 178 (2d Cir. 2003); and *Montgomery v. Pinchak*, 294 F.3d 492 (3d Cir. 2002).

²⁰ *Farmer v. Brennan*, 511 U.S. 825, 114 S.Ct. 1970 (1994).

CANADIAN DEVELOPMENTS

This section provides brief reports of developments in legislation, policy, and advocacy related to HIV/AIDS in Canada. (Cases before the courts or human rights tribunals in Canada are covered in the section on HIV in the Courts — Canada.) The coverage is based on information provided by Canadian correspondents or obtained through scans of Canadian media. Readers are invited to bring stories to the attention of Alison Symington, editor of this section, at asymington@aidslaw.ca. Ms. Symington is the author of all of the articles in this section.

Legislation imposing mandatory minimum sentences for drug offences passes second reading

Bill C-26, *An Act to amend the Controlled Drugs and Substances Act*,¹ passed second reading in the House of Commons on 16 April 16 2008, and was referred to the Standing Committee on Justice and Human Rights. The legislation has been proposed as a component of the National Anti-Drug Strategy.²

Currently there are no mandatory prison sentences for offences under the *Controlled Drugs and Substances Act* (CDSA). In November of 2007, Bill C-26 was tabled by the Minister of Justice and Attorney General of

Canada, who called it “another step in our Government’s plan toward tackling crime and strengthening the security of Canadians.”³

The legislation proposes to add mandatory terms of imprisonment

to offences of production, trafficking, possession for the purpose of trafficking, importing and exporting, and possession for the purpose of exporting of drugs listed in Schedule 1 (e.g., heroin, cocaine and metham-

phetamine) and Schedule 2 (e.g., cannabis and marijuana) of the CDSA.

The bill sets out two lists of “aggravating factors.” The first list includes offences committed for the benefit of, or in association with, organized crime; offences involving the use or threat of violence; instances where the offender carried, used, or threatened to use, a weapon; and instances where the offender was convicted of, or served time in prison for, a drug offence (excluding simple possession) within the previous ten years.⁴

The second list includes instances where the offence was committed near a school, school ground or other public place usually frequented by persons under 18 years of age; instances where the offence was committed in a prison; and instances where a person under 18 years of age was used in the commission of the offence.⁵

The bill also sets out a series of aggravating factors related to health and safety, including that the offender used real property that belongs to a third party in the commission of the offence; that the production of Schedule 1 or 2 drugs constituted a potential security, health or safety hazard to persons under 18 years who were in the location where the offence was committed or in the immediate area; and that the offender set a trap likely to cause death or bodily harm to another person.⁶

The mandatory minimum sentences set out in the bill are as follows:

- For trafficking, and possession for the purposes of trafficking, of Schedule 1 substances, or of Schedule 2 substances amounting to more than three kilograms: a minimum of one year imprison-

ment if one of the aggravating factors from the first list is present; a minimum of two years if one of the aggravating factors from the second list is present.⁷

- For importing and exporting of Schedule 1 substances amounting to less than one kilogram: a minimum of one year imprisonment; if more than one kilogram, a minimum of two years imprisonment.⁸
- For importing and exporting of Schedule 2 substances for the purposes of trafficking: a minimum of one year imprisonment.⁹
- For production of Schedule 1 substances: a minimum of two years imprisonment; where one of the health and safety factors is present: a minimum of three years imprisonment.¹⁰
- For the production of Schedule 2 substances: a minimum sentence ranging from six months to three years, depending on the substance, the quantity and whether any of the health and safety factors apply.¹¹

In addition, the bill would move GHB and flunitrazepam (commonly called “date rape drugs”) from Schedule 3 to Schedule 1, which means that offences involving these drugs would be subject to higher penalties, including the mandatory minimum sentences.¹²

Finally, the bill includes an exception for accused persons who participate in approved Drug Treatment Court programs. The court can suspend the imposition of a mandatory penalty and impose a lesser sentence if the person successfully completes the drug treatment program.¹³

A previous attempt in 2006 to implement mandatory minimum sen-

tences for certain drug offences (Bill C-9) failed. As originally drafted, Bill C-9 would have amended the *Criminal Code* to remove conditional sentencing as an option for anyone convicted of an indictable offence that carries a possible penalty of imprisonment of 10 years or more. In other words, incarceration would be mandatory.

The Canadian HIV/AIDS Legal Network was concerned about how Bill C-9 would affect people who use drugs, and was concerned that it would undermine efforts to reduce the harms associated with drug use, including HIV transmission. The Legal Network appeared before the Justice Committee regarding Bill C-9 in September 2006. The legislation was amended before third reading so that it no longer applied to drug offences.¹⁴

Commentary

Bill C-26 suffers the same flaws as Bill C-9. The legislation is presented as targeting drug dealers, but in practice the burden of mandatory prison sentences falls on people involved in small-scale, street-level drug distribution and consumption to support addictions. It is also bad public health policy to increase the incarceration rate of people who use drugs, especially since Canadian prisons fail to provide access to sterile syringes.

Evidence from the United States indicates that mandatory minimum sentences do not work for drug offences, resulting in the incarceration of large numbers of non-violent drug offenders while doing nothing to curb drug-related crime or problematic drug use.

Finally, by mandating incarceration for non-violent offences and denying judges’ discretion to craft sentences

proportionate to each conviction, the legislation is contrary to fundamental sentencing principles of Canadian law and violates human rights.¹⁵

¹ Bill C-26, *An Act To Amend the Controlled Drugs and Substances Act and To Make Consequential Amendments to Other Acts*, 2nd Sess., 39th Parl., 2007.

² See "Conservative government announces new anti-drug strategy," *HIV/AIDS Policy & Law Review* 12(2/3)

(2007): 27–28.

³ "Speaking notes for the Honourable Rob Nicholson, P.C., Q.C., M.P. for Niagara Falls, Minister of Justice and Attorney General of Canada for the Announcement of Tabling of Legislation on Mandatory Prison Sentences for Serious Drug Crimes," 20 November 2007.

⁴ Bill C-26, cl. 1(1)(a)(i).

⁵ Bill C-26, cl. 1(1)(a)(ii).

⁶ Bill C-26, cl. 3(2).

⁷ Bill C-26, cl. 1(1)(a)(i) and (ii).

⁸ Bill C-26, cl. 2.

⁹ Ibid.

¹⁰ Bill C-26, cl. 3(1)(a).

¹¹ Bill C-26, cl. 3(1)(a.1) to (b)(vi).

¹² Bill C-26, cl. 6.

¹³ Bill C-26, cl. 5(4) and (5).

¹⁴ Canadian HIV/AIDS Legal Network, *Update on Bill C-9, An Act To Amend the Criminal Code (Conditional Sentence of Imprisonment)*, Briefing Paper, November 2006.

¹⁵ Ibid.; Canadian HIV/AIDS Legal Network, *Mandatory Minimum Sentences for Drug Offenses: Why Everyone Loses*, Briefing Paper, April 2006.

Manitoba legislation would authorize testing for HIV without informed consent

Manitoba's Health Minister has introduced legislation that would authorize the forced testing of people for HIV and other infections in some situations of possible occupational and non-occupational exposure to blood or other bodily fluids.

Entitled *The Testing of Bodily Fluids and Disclosure Act*, the legislation would permit a person who has come into contact with a bodily fluid of another person to apply for a testing order if the contact happened as a result of being a victim of a crime, while providing emergency health services or first aid, or while performing duties as a firefighter or emergency medical response technician.¹

The legislation sets out a process by which a person applies to a court for a standard testing order or to a justice of the peace for an expedited testing order. The judge or justice of the peace can then issue an order for the person who is the source of the exposure (the "source individual") to

report to provide a blood sample for testing for viruses such as HIV.

No physician's report is required for the expedited process. A physician's assessment of the risks posed to the applicant's health as a result of the contact, and the necessity of the test results in order to take measures to prevent infection, is required for the standard process.

The test results are provided to the physician of the applicant and to the physician of the source individual if they have provided that information, otherwise to the medical officer of health.

If the testing order is issued under the expedited process, the source person has 24 hours to register an

objection. If an objection is raised, the order becomes invalid and the applicant would need to make an application to the court for a standard testing order. The source person has the opportunity to present the court with evidence that the taking of the sample would cause a significant risk to his or her physical or mental health. If the judge finds that there is significant risk, s/he must not issue the order.

Commentary

Legislation of this sort already exists in Alberta, Saskatchewan, Ontario and Nova Scotia.² It is based on a flawed rationale and raises serious human rights concerns.

The bill introduced in Manitoba shares all of the faults of the legislation that exists in the other provinces, but the proposed expedited process arguably would make Manitoba's legislation worse, if passed, because it could increase the chance that these testing orders will be issued based on inflated fears about HIV and other blood-borne diseases following occupational exposures. Justices of the peace are unlikely to have the medical information needed to properly assess an application for testing.

In addition, several general objections can be raised to forced testing legislation of this sort. First, forced testing disregards the ethical and legal principle of informed consent, thereby constituting a violation of the rights to security of the person and privacy. The Supreme Court of Canada has repeatedly recognized that a person cannot be subjected to medical procedures without first giving their informed consent.³

Second, the risk of transmission through occupational exposure is incredibly low. For example, the risk of infection from a single percutaneous exposure (e.g., a needle stick) to blood that is known to be HIV-infected is 0.3 percent (1 in 300).⁴ This type of direct, under-the-skin exposure to contaminated blood represents the greatest risk of transmitting HIV, and even then the risk is very low.

If the person's HIV status is unknown, or the exposure is to a mucous membrane or broken skin rather than percutaneous, statistically the chance of infection is even lower.

In fact, there has only been one confirmed case (and two probable cases) of occupational transmission of HIV in Canada since the beginning of the epidemic.⁵

Third, forced testing legislation offers little benefit to those who may have been exposed. Most sources person agree to be tested and to provide relevant information to the exposed person in these circumstances.⁶ If a source person does not voluntarily consent to be tested: Because of the time required to comply with procedural protections, conduct the tests and obtain the results; and because of the possibility of false negative test results — the information to be gleaned from forced testing is of limited use to a person who has to make decisions about (a) post-exposure treatments to reduce the risk of infection; and (b) behavioural changes to prevent possible secondary transmission (e.g., to a sexual partner or breastfeeding infant).

The "3 Cs" approach to HIV testing has been endorsed both globally and within Canada as the accepted rights-based approach to HIV testing.⁷ That is, HIV testing may occur only with specific, informed consent; appropriate pre- and post-test counselling must be provided; and confidentiality of test results must be assured. Forced testing legislation, such as that introduced in Manitoba, is contradictory to this rights-based approach.

For these reasons, organizations such as the Canadian HIV/AIDS Legal Network have argued that

forced testing legislation does not represent an appropriately balanced approach to the issue of occupational and non-occupational exposure to HIV. It is not necessary, and does not adequately respect and protect human rights.⁸

The legislative process with respect to this bill can be followed on the website of the Legislative Assembly of Manitoba: www.gov.mb.ca/legislature/. A more detailed analysis of forced testing legislation in Canada is available in Canadian HIV/AIDS Legal Network, *Forced HIV Testing: Questions & Answers*, November 2007, available via www.aidslaw.ca.

¹ Bill 18, *The Testing of Bodily Fluids and Disclosure Act*, 2nd Sess., 39th Leg., Manitoba, 2008.

² See Canadian HIV/AIDS Legal Network, *Undue Force: An Overview of Provincial Legislation on Forced HIV Testing*, October 2007; and previous editions of the *Review*.

³ *Reibl v Hughes*, [1980] 2 SCR 990; see also: *Hopp v Lepp*, [1980] 2 SCR 192; *Ciarllo v Schacter*, [1993] 2 SCR 119; *Malette v Shulman* (1990), 37 OAC 281 (CA); *Fleming v Reid* (1991), 82 DLR (4th) 298 (Ont CA); *Videto v Kennedy* (1981), 33 OR (2d) 497 (CA).

⁴ T. de Bruyn, *Testing of Persons Believed To Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Background*, Canadian Strategy on HIV/AIDS and Canadian HIV/AIDS Legal Network, 2001, p. 6.

⁵ *Ibid.*, p. 8.

⁶ *Ibid.*, p. 2.

⁷ E.g., see Canadian Public Health Association, *Leading Together: Canada Takes Action on HIV/AIDS (2005/2010)*, 2005; UNAIDS and Office of the U.N. High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, 2006.

⁸ See Canadian HIV/AIDS Legal Network, *Legislation To Authorize Forced Testing for HIV in the Event of Occupational Exposure: An Unjustified and Unnecessary Rights Violation — A Submission to the Government of Manitoba*, April 2008.

Organ donation regulations limit donations from gay men

New federal regulations intended to protect the health and safety of transplant recipients came into force on 7 December 2007.

The regulations outline requirements for the registration of transplant establishments; donor suitability assessment; packaging, labelling and storage; procedures with respect to errors and adverse reactions, and record keeping; and operating procedures.¹

To determine the suitability of the cells, tissues or organs for transplant, the transplant establishment is required to obtain a medical history of the donor, perform a physical examination of the donor and perform tests for certain diseases.² In addition, the establishment must determine that the donor is not unsuitable to donate on the basis of a set of the exclusionary criteria.³ The exclusionary criteria for donation of cells, tissues or organs include the following:

- any man who has had sex with another man in the preceding five years;
- persons who have injected illegal drugs in the preceding five years;
- hemophiliacs who have received human-derived clotting factor concentrates;
- persons who have engaged in sex for money or drugs in the preceding five years;
- persons who have had sex in the preceding 12 months with persons in any of the above categories, or with persons known to have HIV, hepatitis B (HBV) or hepatitis C (HCV);

- persons who have been exposed to HIV, HBV or HCV in the preceding year;
- current prisoners and people who were incarcerated for 72 consecutive hours or more in the preceding year;
- persons who have had a tattoo or body piercing in the previous year using a shared needle; and
- persons who have had close contact in the preceding year with someone who had clinically active viral hepatitis.⁴

In addition, for pediatric donors, children born to HIV-positive mothers or mothers who would be excluded under the above criteria are also excluded, unless it can be definitively determined that they are not infected with HIV.⁵

The new regulations also include provisions for “exceptional distribution.” Specifically, cells, tissues or organs that have not been determined safe for transplant (including because the donor would be excluded under the above mentioned criteria) can be used if another organ determined to be safe is not available, the transplant physician authorizes the exceptional distribution, and the recipient gives his or her informed consent.⁶

Some organ transplant specialists and gay rights activists condemned the new regulations, stating that they unreasonably singled out gay men as a health risk and that they

will reduce the supply of available transplant organs.⁷ For example, four faculty members of the Department of Bioethics at Dalhousie University questioned why the extra conditions for donations from donors who meet “high risk” criteria (on the basis of their histories) could not have been framed in the regulations as standard procedural content rather than as “exclusions.” They further note that “the message sent by the new regulations is problematic in other significant ways. It reinforces the existing negative, hurtful stigmatization of members of disadvantaged social groups. It also reinforces the wrong notion that these groups pose a significant risk to public health.”⁸

In a news release issued on 28 January, Health Canada defended the new regulations, explaining that they were the product of many years of consultation.⁹ According to Health Canada, in 1999 the House of Commons Standing Committee on Health recommended that national standards for cells, tissues and organs intended for transplant be made mandatory by incorporation by reference into regulations under the *Food and Drugs Act*. Therefore, national safety standards were published in June 2003 for public consultation.

Health Canada then began drafting federal regulations around these standards. The final version of the regulations was published in June 2007. Health Canada said that input was

sought from transplant experts and others at each stage of the process.¹⁰

Health Canada further explained in the news release that donors are assessed for risk factors for certain diseases (i.e., HBV, HCV and HIV) because, in rare cases, these diseases may be present but undetectable in the donor through testing. Health Canada said that the risk factors were determined by a group of Canadian transplantation experts and are the internationally accepted practice for screening donors.¹¹

Finally, Health Canada asserted that the risk criteria are not discriminatory: "These risk factors are based strictly on scientific evidence and are

used in an assessment that evaluates behaviours and medical circumstances, and is not meant to target specific groups."¹²

For the text of the regulations, see <http://canadagazette.gc.ca/partII/2007/20070627/html/sor118-e.html>.

¹ *Safety of Human Cells, Tissues and Organs for Transplantation Regulations*, SOR/07-118.

² *Ibid.*, s. 18(a),(c) and (d).

³ *Ibid.*, s.18(b), which refers to *Cells, Tissues, and Organs for Transplantation and Assisted Reproduction: General Requirements*, CSA Standard, CAN/CSA-Z900.

⁴ "Exclusionary Criteria for Risk Factors Associated with HIV, HBV, and HCV," *Cells, Tissues, and Organs for Transplantation and Assisted Reproduction: General*

Requirements, CSA Standard, Annex E, E.1.

⁵ *Ibid.*, E.2.

⁶ *Safety of Human Cells, Tissues and Organs for Transplantation Regulations*, s. 40.

⁷ "Ban on gay men donating organs scientifically unjustifiable: MD," *Hamilton Spectator*, 9 January 2008, p. A6; J. Miner, "Organ donor rules cut gay men," *The London Free Press*, 9 January 2008, p. A3; C. Spencer, "Time for a second opinion? Non-gay policy should be rethought: organ transplant specialist," *The Winnipeg Sun*, 9 January 2008, p.7; "Halifax doctors object to Health Canada ban on organ donations from gay men," *Halifax Chronicle Herald*, 8 January, 2008; and R. Howe, "Donor-discrimination wrong," *The Daily News (Halifax)*, 11 January 2008, p. 15.

⁸ J. Kirby et al, "Being sensitive won't kill us," *The Ottawa Citizen*, 25 January 2008.

⁹ Health Canada, "Fact Sheet — Safety of Cells, Tissues and Organs (CTO) for Transplantation," news release, 28 January 2008.

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² *Ibid.*

Complaint filed concerning judge's conduct

During a trial in December 2007, when it was disclosed that the complainant was living with HIV and hepatitis C, the presiding judge ordered the complainant to be masked or testify electronically from another courtroom. The Canadian HIV/AIDS Legal Network and the HIV& AIDS Legal Clinic of Ontario (HALCO) lodged a formal complaint with the Ontario Judicial Council¹ in response to what they termed "shockingly discriminatory thinking and practice."²

The incident took place during Lee Wilde's trial for allegedly sexually assaulting a fellow prisoner.³ In making the order, Justice Jon-Jo Douglas of the Ontario Court of Justice (Central East Region) expressed concern about a risk of HIV transmission.

The judge suggested a number of protections which he would accept to hear the witness' evidence, such as a larger courtroom so that he would not be seated so close to the witness,

employing a screen or technological device and, finally, that the complainant sit at a table behind counsel table.⁴ News reports also indicated that court staff wore latex gloves so as not to be exposed to the virus should it be on papers that the witness had touched.⁵

The Crown attorney challenged this treatment of the witness, even to the point of obtaining expert medical evidence that HIV and hepatitis C are only transmitted through contact

with certain bodily fluids, but Justice Douglas rejected this evidence and ordered the trial proceed with the witness masked or other protective accommodation. Justice Douglas refused the Crown's motion for a mistrial.⁶

The Crown therefore applied to a higher court for a decision on the matter. Justice Eberhard of the Superior Court of Justice dismissed the Crown's application noting that it is the trial judge's jurisdictional

right to take safety precautions in the courtroom, “even if his decision could be said to be ‘wrong.’”⁷ She recognized that in dismissing the application, she was placing a higher value on trials proceeding without interference if decisions are made within the jurisdiction of the trial judge, than on the protection of the witness’ right to be treated equally.⁸ Ultimately, Justice Douglas voluntarily removed himself from the trial.

The letter of complaint from the Legal Network and HALCO to the Ontario Judicial Council noted that ethical standards that guide Canadian judges require them to conduct themselves and proceedings before them so as to ensure equality before the law. This includes not being influenced by attitudes based on stereotype, myth or prejudice and avoiding comments, expressions, gestures or behaviour which reasonably may be interpreted as showing insensitivity

or disrespect for anyone. The letter of complaint further stated that:

As lawyers working on HIV-related legal issues, we are deeply troubled by these reports of this sort of conduct by a judge (and other courtroom staff), which appear to depart significantly from the professional, ethical standards that are required. This is, we think, a particularly extreme example of unacceptable conduct by a judicial officer. Yet it seems unlikely that misinformation about HIV/AIDS, and hence the potential for bias and overtly prejudicial conduct, is limited to just this instance.

HALCO and the Legal Network urged the Ontario Judicial Council to conduct an investigation into this particular incident and to take appropriate steps to address the conduct of Justice Douglas. They also urged the Council to consider a broader response to this manifesta-

tion of HIV-based stigmatization and discrimination. In particular, both organizations suggested that it would be appropriate to examine the extent to which judges receive information about HIV/AIDS, and related legal and human rights questions, in the course of judicial education.

To date, no official response to the complaint has been received by either the Legal Network or HALCO, beyond an acknowledgment of receipt.

¹ The Ontario Judicial Council is the agency that investigates complaints against provincially-appointed judges.

² Letter of complaint dated 17 January 2008 [on file with author].

³ See the Canadian Courts section of this issue of the *Review* for a full account of the case.

⁴ *R. v. Wilde*, Trial Proceedings (October 31, 2007), File No. 07-2285/07-7709.

⁵ L. Watt, “Judge’s actions met with outrage,” *The Barrie Advance*, 1 February 2008, p. 19.

⁶ *R. v. Wilde* (December 4, 2007), File No. 07-7709.

⁷ *R. v. Wilde* (December 12, 2007), File No. 07-314, para. 15.

⁸ *Ibid.*, para. 35.

Health Canada releases report on supervised injection facility

A report prepared by an expert advisory committee appointed by Health Canada has provided further evidence of the effectiveness of Insite, the supervised injection facility (SIF) located in Vancouver. ¹

Minister of Health Tony Clement appointed the committee to review the research that has been conducted on Insite and other SIFs around the world. The report was made public in April 2008.

Among the consensus points presented by the expert committee were the following:

- Over 8000 people have visited Insite to inject drugs, with 1506 people (18 percent) accounting for 86 percent of total visits.
- Insite provides a clean, supervised environment for injection drug use, clean injection equipment and nursing services including treatment for skin abscesses.
- Users of Insite are highly satisfied with the services.
- Insite staff have successfully intervened in over 336 overdose events since 2006, and no overdose deaths have occurred at the site.
- There is no evidence that supervised injection facilities influence

rates of drug use in the community.

- There is no evidence of increases in drug-related loitering, drug dealing or petty crime in areas around Insite.²

The advisory committee questioned conclusions reached in some studies about the site's impact on reducing HIV infection. The committee said that it did not accept as entirely valid the mathematical modeling based on assumptions about baseline rates of needle sharing and the risks of HIV transmission and other variables.³

The committee noted that self-reports from users of Insite and other

SIFs indicate that needle-sharing decreases with increased use of the facilities.⁴

Commentators and advocates for Insite viewed the advisory committee's report as generally positive, and noted that it confirms their research.⁵

As reported in previous issues editions of the *Review*, Insite is operating on a temporary federal exemption to the *Controlled Drugs and Substances Act*. The current exemption is set to expire on 30 June 2008. Meanwhile, the two lawsuits alleging that the federal government is overstepping its jurisdictional bounds, as reported in the last issue of the *Review*,⁶ are scheduled to be heard by

the British Columbia Supreme Court beginning 28 April 2008.⁷

¹ Health Canada, "Expert panel report on supervised injection site released," news release, Ottawa, 11 April 2008.

² Vancouver's INSITE Service and Other Supervised Injection Sites: What Has Been Learned from Research? Final Report of the Expert Advisory Committee on Supervised Injection Site Research. Prepared for the Hon. Tony Clement, Minister of Health, 31 March 2008.

³ Ibid.

⁴ Ibid.

⁵ F. Bula, "Drug injection site saves lives: report," *The Leader-Post (Regina)*, 12 April 2008, p. B8.

⁶ A. Symington, "Supervised injection facility granted another temporary extension; legal action launched," *HIV/AIDS Policy & Law Review* 12(2/3) (2007): 21–23.

⁷ G. Joyce, "Safe injection facility in Vancouver in limelight when court challenges begin," *The Canadian Press*, 13 April 2008.

In brief

Changes to the Immigration and Refugee Protection Act proposed in 2008 Budget

Bill C-50, *Budget Implementation Act, 2008*,¹ passed second reading in the House of Commons on 10 April 2008, and was referred to the Finance Committee.

The legislation included proposed changes to the *Immigration and Refugee Protection Act (IRPA)* that would give the Minister of Citizenship and Immigration increased discretion — including the power to decide what categories

of immigration applications should be fast-tracked and what categories should not be processed at all; and the power to decide not to process humanitarian and compassionate (H&C) applications submitted outside of Canada.²

If the Budget passes with these measures, immigration applications made on or after 27 February 2008 would be affected.

It remains to be seen how these changes could affect prospective immigrants and refugees living with or affected by HIV/AIDS. The fact that the Minister would be able to issue instructions not to examine

certain categories of claims should raise concern for any persons facing stigma and discrimination or seen to be a burden on Canadian health and social services, including people living with HIV/AIDS.

The fact that the bill eliminates the legal right to have an overseas H&C application examined could negatively affect people living with HIV for whom H&C applications are the only recourse. If Bill C-50 is passed, their applications may never be examined.

A coalition of non-governmental organizations is calling on the government to sever the IRPA amendments from Bill C-50 and refer

them to the Standing Committee on Citizenship and Immigration for extensive public hearings.

Independent review of prisons released

The report of the Correctional Services of Canada (CSC) Independent Review Panel, chaired by Rob Sampson, former Minister of Corrections for the Ontario Government, was released in December 2007.³

In preparing the report, entitled *A Roadmap to Strengthen Public Safety*, the panel visited penitentiaries, parole offices and halfway houses; met with prison staff, union representatives, CSC executives and non-governmental organizations; and accepted written submissions.

The Panel describes its report as “charting a roadmap that is a transformation of the way in which CSC does business.”⁴ It states that transformation is needed in large part because of the changing offender profile, which it describes as follows:

- nearly 60 percent of persons entering prison are serving sentences of less than three years and have histories of violence;
- there has been an increase of more than 100 percent in the proportion of offenders who are classified as maximum security upon admission;
- one in six prisoners now have known gang or organized crime affiliations;
- approximately four out of every five offenders arrive with serious substance abuse problems, of whom half have committed their crimes while under the influence of drugs or alcohol; and

- 12 percent of male and 26 percent of female offenders are identified as having very serious mental health problems.⁵

The report contains 109 recommendations, divided into five key areas: increasing offender accountability; eliminating drugs from prisons; developing employability and employment skills; renewing physical infrastructure; and eliminating statutory release and moving to earned parole.

Several of the Panel’s recommendations are of particular relevance to HIV/AIDS. Firstly, the Panel recommends that the *Canada Labour Code* be amended to require mandatory blood testing of prisoners following occupational exposures of prison staff, and the introduction of mandatory testing for infectious diseases upon incarceration.⁶

Secondly, while the Panel recommends numerous measures to control the introduction of illegal drugs into prisons — including more drug dog detection teams and perimeter surveillance, and more thorough searches of vehicles and people entering penitentiaries — it makes no recommendation to provide harm reduction materials within prisons, such as through controlled needle exchange programs.⁷

Provincial funding announced for Ottawa harm reduction program

In December 2007, the Ontario Ministry of Health and Long Term Care announced that it will fund the city of Ottawa’s safe inhalation program, which provides free, clean crack pipes to people who smoke illegal drugs. The program is intended

to reduce the sharing of used crack pipes and thereby reduce the transmission of communicable diseases such as hepatitis C and HIV.

As reported in the December 2007 edition of the *Review*, Ottawa City Council had voted to discontinue its funding of the Safer Crack Use Initiative in July 2007.⁸ A coalition of community groups had pledged to keep the program running until the end of 2007, amid hopes that more secure funding would be in place by that time.

The province will provide \$287,000 to Somerset Community Health Centre to run the program for one year.⁹

The mayor and several city councillors expressed their disappointment that the province had stepped in to support the program in opposition to their earlier decision to pull its funding. The councillor who had originally brought the motion to cancel the program stated that the money would be better spent on a residential drug treatment centre.¹⁰

Federal government diverts funding from community-based organizations to vaccine initiative

In 2004, the then federal government announced that annual funding through the Federal Initiative to Address HIV/AIDS in Canada would reach \$84.4 million by 2008-2009. The current federal government has committed to reaching this target, but HIV/AIDS organizations within Canada are seeing their funding reduced. Community AIDS programs in Ontario, for example, have had their federal funding cut by approximately 30 percent during

the last fiscal year, with similar cuts expected in other provinces and territories.¹¹

In February of 2007, Prime Minister Stephen Harper announced a collaborative initiative with the Bill & Melinda Gates Foundation, the Canadian HIV Vaccine Initiative, which is intended to contribute to the global effort to develop an HIV vaccine. Canada committed to contribute up to \$111 million, while the Gates Foundation is to provide \$28 million.¹²

Canadian HIV/AIDS organizations have charged that \$15 million has been taken out of the national HIV/AIDS strategy and redirected towards the Canadian HIV Vaccine Initiative.¹³ Organizations and oppo-

sition members of parliament have stated that they support the new vaccine initiative, but that the funding should not come out of existing HIV research, prevention and treatment programs in Canada.¹⁴

¹ The *Budget Implementation Act, 2008* is the short title for Bill C-50. The full title is *An Act To Implement Certain Provisions of the Budget Tabled in Parliament on February 26, 2008 and To Enact Provisions To Preserve the Fiscal Plan Set Out in That Budget*, 2nd Sess., 39th Parl., 2008.

² *Ibid.*, cl. 116.

³ *Report of the Correctional Service of Canada Review Panel: A Roadmap to Strengthening Public Safety*, Minister of Public Works and Government Services of Canada, October 2007.

⁴ *Ibid.*, at p. v.

⁵ *Ibid.*

⁶ *Ibid.*, p. 62.

⁷ *Ibid.*, pp. 61–2.

⁸ "Ottawa: Crack pipe program cancelled by city council," *HIV/AIDS Policy & Law Review*, 12(2/3) (2007): 29–30.

⁹ M. Pearson, "Crack program," *The Ottawa Citizen*, 22 December 2007.

¹⁰ "Ottawa mayor, councillors plan Ontario plan to fund crack pipe program," *CBC.CA News*, 24 December 2008.

¹¹ G. Galloway, "Ottawa redirects AIDS funds for Gates initiative," *Globe and Mail*, 29 November 2007.

¹² Office of the Prime Minister, "Canada's New Government and Gates Foundation announce support for HIV/AIDS vaccine research," news release, Ottawa, 20 February 2007.

¹³ "Liberals, Tories bicker over funding on World AIDS Day; Harper government accused of diverting \$15M from national strategy," *The Edmonton Journal*, 2 December 2007, p. A5.

¹⁴ R. Bruemmer, "Local care was cut to fund vaccine search: Liberals; Bill Gates getting cash patients need, MP Says," *The (Montreal) Gazette*, 2 December 2007, p. A3; Canadian HIV/AIDS Legal Network, Canadian AIDS Society and Canadian Treatment Action Council, "National AIDS organizations call on Ottawa to guarantee current funding for local AIDS programs and services," news release, Toronto and Ottawa, 29 November 2007.

INTERNATIONAL DEVELOPMENTS

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

Thailand: government re-launches war on drugs and people who use drugs

On 2 April 2008, Thailand Prime Minister Samak Sundarajev announced a new national drug strategy. Called “Thai Power, To Avoid the Danger of Drugs,” the strategy is intended to run for six months (from April to September 2008) and includes a number of activities designed to reduce the number of people who use drugs in Thailand.

The strategy focuses on rehabilitation through compulsory treatment and incarceration of people who use drugs (particularly those who are considered dependent on drugs or “hardcore users”). Notably, the policy does not include harm reduction

services for people who use drug, nor does it mention HIV/AIDS.¹ The strategy provides little indication of how it is to be implemented.

The government’s intention to launch the new strategy was revealed in February 2008, when Samak

announced that he would use the same tactics as employed in the 2003 war on drugs by his political predecessor, Thaksin Shinawatra.

According to Human Rights Watch, the first three months of the 2003 “war on drugs” led to some

2275 extrajudicial killings; arbitrary inclusion of drug suspects on poorly prepared government “blacklists” or “watchlists”; intimidation of human rights defenders; violence, arbitrary arrest and other breaches of due process by Thai police; and coerced or mandatory drug treatment.²

In disclosing the new drugs strategy, Samak stated, “I will not set a target for how many people should die.... We will pursue a suppression campaign rigorously. There will be consequences.”³ Other media reports quoted Samak as stating, “It is impossible to avoid killings when implementing drug suppression. When the crackdown is underway, killings will take place.”⁴

Echoing these comments, Thailand’s Interior Minister (and head of the new national centre tasked with solving the drug problem) Chalerm Yubamrung, said:

For drug dealers, if they do not want to die, they had better quit staying on that road.... [D]rugs suppression in my time as Interior Minister will follow the approach of [former Prime Minister] Thaksin. If that will lead to 3000–4000 deaths of those who break the law, then so be it. That has to be done.... For those of you from the opposition party, I will say you care more about human rights than drug problems in Thailand.⁵

The announcement of a new drug policy was met with widespread criticism. Former Senator Kraissak Chonhavan stated, “I wouldn’t want the minister to make a statement in such a manner, which is like giving the green light to police to use violence on drug dealers. This may prompt an urge to set up a ‘kill record’ to comply with the get-tough policy.”⁶

Sakda Puekchai, chairperson of the Thai Drug Users’ Network, stated, “If the war on drugs starts again, there is no doubt that our members will be forced to go underground, and will not be reached by health services, giving rise to new HIV cases.”⁷

On 23 April 2008, Thai civil society groups, led by the Thai AIDS Treatment Action Group and the Thai Network of People Living with HIV/AIDS, demonstrated at the meeting of the UNAIDS Programme Coordinating Board in Chiang Mai (northern Thailand), demanding that drug policy include harm reduction, that drug users be involved in policy development, and that the government cease repressive, punitive and compulsory measures.

In recent months, a number of reports of serious human rights violations have been made. Human Rights Watch has reported at least four killings of alleged drug traffickers across Thailand.⁸ There have also been reports of people who inject drugs discontinuing ARV treatment because of fear of going to a government health clinic; of seizure of assets of suspected drug dealers without due process; and of (one case) of torture and illegal detention of a suspected drug dealer.⁹

The decision of the government of Thailand to re-launch its “war on drugs” follows incomplete and largely futile investigations of the human rights abuses in 2003. In August 2007, the previous (military) government appointed a committee, chaired by former Attorney General Khanit na Nakhon, to investigate the extrajudicial killings that took place during the first “war on drugs.”

The final report was not made public, although figures were released: 2819 people were killed

between February and April in 2003, of whom only 1370 were involved in drug dealing; the remainder had no link to drugs.¹⁰ None of the killers of these people have been tried.

– Karyn Kaplan and Richard Pearshouse

Karyn Kaplan (karyn.kaplan@gmail.com) is Director, Policy and Development for the Thai Drug Users’ Network.

¹ Health and Development Networks, “Spotlight: Thailand’s new drug policy — A brief summary.”

² Human Rights Watch, *Not Enough Graves: The War on Drugs, HIV/AIDS and Violations of Human Rights*, June 2004. Available via www.hrw.org.

³ “Thailand PM targets drug dealers,” *BBC News*, 23 February 2008. At <http://news.bbc.co.uk/1/hi/world/asia-pacific/7260127.stm>.

⁴ “Samak denies link in killings in new drug war,” *The Nation*, 25 February 2008.

⁵ “Thailand PM targets drug dealers,” *BBC News*, 23 February 2008.

⁶ “Activists fear new war on drugs,” *The Nation*, 22 February 2008.

⁷ “Call for restraint in govt’s latest anti-drug campaign,” *The Nation*, 4 April 2008.

⁸ Human Rights Watch, “Thailand’s ‘War on Drugs,’”, backgrounder, 12 March 2008. At www.hrw.org/english/docs/2008/03/12/thaila18278.htm.

⁹ See Health GAP, Thai AIDS Treatment Action Group, “Update on the war on Thai drug users,” 20 April 2008.

¹⁰ “Most of those killed in war on drug not involved in drug [sic],” *The Nation*, 27 November 2007 (at <http://nationmultimedia.com/breakingnews/read.php?newsid=30057578>); Human Rights Watch, “Thailand: Prosecute Anti-Drugs Police Identified in Abuses”, online, 7 February 2008 (at <http://hrw.org/english/docs/2008/02/07/thaila17993.htm>).

Switzerland: Statement on sexual transmission of HIV by people on ART

In February 2006, Swiss experts issued a statement concluding that HIV-positive individuals who are on effective antiretroviral therapy (ART), and who do not have any sexually transmitted infections (STIs), cannot transmit HIV through sexual contact. The statement was authored by four of Switzerland's leading AIDS experts and was issued on behalf of the Swiss Federal Commission for HIV/AIDS.¹

The statement reviews a number of studies of sero-discordant couples and rates of HIV transmission, with and without adherence to ART, by the person in the couple living with HIV. The authors concede that the evidence does not conclusively prove that effective ART prevents HIV transmission, because scientifically it is not possible to prove that an improbable event will not occur. But the authors make an analogy to the public statements in 1986 that HIV transmission could not occur through tongue-kissing — which, similarly, could not be scientifically excluded as a possibility, however remote.

After reviewing the scientific literature, the statement notes that “[a]n HIV-infected person on antiretroviral therapy with completely suppressed viremia” — also known as “effective ART” — “is not sexually infectious, i.e., cannot transmit the virus through sexual contact.” According to the statement, this position is valid provided that a person living with HIV:

- adheres to his or her HIV treatment and the effectiveness of that treatment is regularly evaluated by a doctor;
- has an undetectable viral load (<40 copies/ml) for at least six months; and

- does not have any other sexually transmitted infections.

According to the authors:

During effective antiretroviral therapy, free virus is absent from blood and genital secretions. Epidemiologic and biologic data indicate that during such treatment, there is no relevant risk of transmission. In the case of total suppression of the viral load, the residual risk of transmitting HIV in sexual activity without condoms is considerably below 1:100 000. Residual risk can not be scientifically excluded, but is, in the judgment of the Commission and the organizations concerned, negligibly small.²

After reaching this conclusion, the statement then went on to address the implications of such a position for physicians, people living with HIV/AIDS, HIV prevention programs, and the legal system (discussed below).

Raising concern

The statement drew immediate responses from organizations concerned that the position might undermine traditional public health messages about the importance of safer sex in preventing HIV infection. UNAIDS and the World Health

Organization (WHO) responded by observing that:

To prevent transmission of HIV, UNAIDS and WHO strongly recommend a comprehensive package of HIV prevention approaches, including correct and consistent use of condoms.... Research suggests that when the viral load is undetectable in blood the risk of HIV transmission is significantly reduced. However, it has not been proven to completely eliminate the risk of transmitting the virus.³

For its part, the Public Health Agency of Canada (PHAC) said that it “continues to emphasize that sexually active people should practise safer sex, which includes using condoms consistently and correctly with their sex partners.”⁴

The French advocacy group, Act Up Paris, observed that the statement would not affect the estimated 20 percent of people living with HIV/AIDS who are not on ART, nor an estimated 40 percent of people living with HIV/AIDS who are under treatment but who have a residual viral load despite close adherence to ART. The group also claimed that the statement is not applicable to homosexual relationships nor to situations involving anal sex due to bias in the scientific studies.⁵

The Swiss statement was also criticized for misreading the data of earlier studies and for overlooking recent research showing that undetectable viral loads in the blood do not correspond to undetectable viral in other bodily fluids, notably semen.⁶

Legal implications

While the situation is unclear and (legally) untested, some commentators suggest that the Swiss statement might assist a person accused of exposing another person to HIV to establish that he or she was not acting recklessly.⁷ The statement might be useful to establish that, in specific circumstances, unprotected sex did not pose a “significant risk” of HIV transmission to another person.

The statement itself notes that when evaluating liability in a case of HIV transmission, (Swiss) courts will have to take into account that HIV-positive people who are on ART and who do not have an STI cannot transmit HIV sexually. The statement makes clear that the Commission considers that unprotected sex between a person living with HIV/AIDS who is on ART and who does not have another STI, and an HIV-negative person, does not meet the criteria for the crimes of “an attempt at propagation of a dangerous disease” (Section 231 of the Swiss Penal Code) or of “an attempt to cause grievous bodily harm” (Sections 122, 123 or 125 of the Swiss Penal Code).⁸

—Richard Pearshouse

¹ P. Vernazza et al., “Les personnes séropositives ne souffrant d’aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle,” *Bulletin des médecins suisses* 89(5) (2008): 165–169. At www.saez.ch/html_f/2008/2008-05.html.

² P. Vernazza et al. at 167.

³ UNAIDS/WHO, *Statement: Antiretroviral Therapy and Sexual Transmission of HIV*, 1 February 2008. At www.who.int/hiv/mediacentre/080201_hivtransmission_en.pdf.

⁴ PHAC, *PHAC Continues to Emphasize Safer Sex for Preventing HIV Transmission*, statement on the PHAC website at www.phac-aspc.gc.ca/aids-sida/new-nouv-eng.html.

⁵ Act Up Paris, “Avis des médecins suisses sur la transmission du VIH: cherchez l’erreur,” news release, Paris, 30 January 2008.

⁶ S.R. Hosein, *Swiss Guidelines Take a Troubling Turn*, Canadian AIDS Treatment Information Exchange, March 2008. At www.catie.ca/catieneews.nsf/CATIE-NEWS.

⁷ See, for example, E.J. Bernard, “Swiss statement on sexual HIV transmission has major legal implications,” *Criminal HIV transmission blog*, 1 February 2008, at <http://criminalhivtransmission.blogspot.com/2008/02/swiss-statement-on-sexual-hiv.html>.

⁸ P. Vernazza et al., p. 168.

U.S.: PEPFAR reauthorization bills pass House, Senate committee

On 2 April 2008, the U.S. House of Representatives passed a bill (H.R. 5501) to reauthorize the President’s Emergency Plan for AIDS Relief (PEPFAR). The House bill would authorize the appropriation of US\$50 billion over the next five years — 40 percent more than the US\$30 billion requested by President George W. Bush.

President Bush introduced PEPFAR in his 2003 State of the Union Address, and Congress first funded the program in 2004 at US\$15 billion over five years. Under the current legislation, PEPFAR funding must be reauthorized every five years.

US\$9 billion out of the US\$50 billion would be allocated to efforts to fight malaria and tuberculosis, with the rest going to AIDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria would receive US\$2 billion annually. The United States

is currently the largest donor to the Global Fund, followed by France, Japan and the European Commission.

UNAIDS estimated in 2005 that over US\$22 billion would be required in 2008 for an effective response to AIDS in the developing world, with

half of the money needed for prevention efforts, a quarter for treatment and care, and a quarter for support of orphaned and vulnerable children.¹ However, in 2007, only US\$10 billion was pledged by governments, NGOs, and private donors.²

The U.S. Constitution requires both chambers of Congress to pass legislation before it can be implemented by the President. The Senate Foreign Affairs Committee approved a version of the PEPFAR reauthorization bill (S. 2731) on 13 March 2008, which is likely to come up for a vote before the full Senate in June 2008. The House and Senate bills are very similar.

Both the House and Senate bills would add Lesotho, Malawi and Swaziland to the 15 countries already participating in PEPFAR.³ In addition, both bills would also remove restrictions that, in previous years, required one-third of PEPFAR funding to be used for abstinence-only education.

The language in each bill requires “balanced funding for prevention activities for sexual transmission of HIV/AIDS ... including abstinence, delay of sexual debut, monogamy, fidelity and partner reduction...” Neither of the proposed bills explicitly mentions condom use as part of the balanced strategy.

In addition, the bills require the HIV/AIDS Response Coordinator in the U.S. Department of State to report and justify to Congress any program spending that uses less than 50 percent of funding for abstinence and fidelity programs. The House and Senate bill would ensure that organizations that have a “moral or religious objection” to any prevention program or activity “shall not be discriminated against in the ... issuance of grants.”

Travel restrictions for people living with HIV/AIDS

The Senate bill differs from the House bill on one major issue. Senator John Kerry (D-Mass.) included language in the Senate bill amending the *Immigration and Nationality Act*⁴ to remove restrictions on travel to the United States by people living with HIV/AIDS. The Act currently bars HIV-positive individuals from visiting or immigrating to the United States, but allows district-level officers in the U.S. Department of State to grant discretionary waivers on a case-by-case basis, as described in regulations issued by the U.S. Department of Homeland Security.

The House bill did not include a similar amendment. Representative Barbara Lee (D-Cal.) introduced a stand-alone bill (H.R. 3337) to overturn travel and immigration restrictions on HIV-positive individuals in August 2007, but did not attempt to include similar provisions as part of PEPFAR reauthorization, in order to ensure a fast approval of the PEPFAR bill on the House floor.

HIV/AIDS advocates, including non-governmental advocacy organizations such as Immigration Equality and the Gay Men’s Health Crisis, are concerned that if Congress does not amend the *Immigration and Nationality Act*, HIV-positive individuals may soon face even harsher restrictions on travel to the U.S.⁵

The Department of Homeland Security is currently considering a revision to its administrative rules that would allow U.S. consular offices around the world to make quicker decisions about HIV waivers, but that would also impose additional restrictions on travel.⁶ The proposed rules

would limit HIV-positive individuals to no more than two annual visits to the U.S., and would require them to prove that they have an adequate supply of antiretroviral medicines.

According to the European AIDS Treatment Group, twelve countries completely ban HIV-positive individuals from entering their borders for any length of time.⁷ The U.S. is one of 74 countries that restrict travel by HIV-positive individuals to some degree. The U.S. Department of State does not provide data on the number of individuals refused entry into the country because of their HIV status.

— Anna Dolinsky

Anna Dolinsky (ard32@law.georgetown.edu) is in her last year at Georgetown University Law Center. She completed her Masters in Public Health at Johns Hopkins Bloomberg School of Public Health.

¹ UNAIDS, news release, Geneva, June 2005, quoted at www.africafocus.org/docs05/hr0506.php.

² Ibid.

³ The fifteen PEPFAR-funded countries are Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.

⁴ 8 U.S.C. 1182(a)(1)(A)(i); (8 C.F.R. 212.4).

⁵ Immigration Equality, “Proposed regs tighten travel restrictions for HIV+ visitors,” news release, New York City, 15 November 2007.

⁶ Issuance of a Visa and Authorization for Temporary Admission into the United States for Certain Nonimmigrant Aliens Infected with HIV, 72 Fed. Reg. 62,593 (Nov. 6, 2007) (to be codified at 8 C.F.R. 212).

⁷ European AIDS Action Group, at www.eatg.org/hivtravel/.

HIV and human rights in U.N. drug control policy: making inroads, barely

Each year, U.N. member states gather for a week in Vienna at the Commission on Narcotic Drugs (CND), the central policy-making body within the U.N. system dealing with drug-related matters, “to exchange expertise, experiences and information on drug-related matters and to collaborate on a coordinated response to the global drug situation.”¹

The deliberations are framed by the three conventions on drugs, whose primary orientation is drug prohibition and control.² Ten years ago, at a 1998 Special Session on Drugs, the U.N. General Assembly adopted a declaration to guide global action to counter “the world drug problem”³ and to achieve what the U.N.’s drug control agency declared as the goal of a “drug-free world” within a decade.⁴

The 2008 session of the CND launched a year-long process of reviewing the past decade’s successes, culminating in decisions to be made at the 2009 CND session that will shape international law and U.N. policy and action on illicit drugs for years to come. Given the extent to which illicit drug use and human rights abuses against people who use drugs drive the HIV pandemic, it is critical that these be considered in assessing and defining global policy on drugs.

This year’s session of the CND (10–14 March 2008) was to be the occasion for expert assessment and debate about the past decade’s successes and the way forward. Unfortunately, but unsurprisingly, most states did little more than reiterate national positions and recite ostensible “successes” in their national responses, focussed primarily on enforcement of various legal

provisions prohibiting drug-related activities.

However, the 2008 session of the CND was notable for the attention that human rights and public health considerations received during the session, as well as the unprecedented involvement of NGOs. The U.N. Office on Drugs and Crime (UNODC), the lead U.N. agency in this area and one of the UNAIDS co-sponsors, issued a paper on “reducing the adverse health and social consequences of drug abuse.”⁵

In his opening speech, UNODC Executive Director Antonio Maria Costa declared that health is a basic human right and a basic principle of the drug control system. He noted that implementation of the drug conventions “must proceed with due regard to human rights.”⁶ He also declared that harm reduction must be part of the way forward.

However, the ambivalence of this commitment was evident: Rather than explicitly endorsing various evidence-based interventions that protect and promote the health of people who use drugs, and that are normally considered as signature elements of harm reduction programming (e.g., needle exchange programs, substitution treatment and supervised injection facilities), Costa declared that “everything we do at UNODC” amounts to harm

reduction, including law enforcement. In barely veiled criticisms of harm reduction advocates, he urged: “Let us not shy away from this jargon — harm reduction — just because it has been appropriated by a vocal minority that has given to it a narrow and controversial interpretation.”⁷

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While the president of the International Narcotics Control Board (INCB), Philip Emafo, did not mention supervised injection sites in his address to the member states, the INCB’s 2007 report, issued just days before, again criticised Canada for allowing such a site (Insite in Vancouver’s Downtown Eastside) — a criticism rejected by Canadian

NGOs as based on wilful ignorance of the evidence of the U.N.'s own legal advisors.⁸

On the first day of the CND session, a well-attended side event on drug control and human rights was held to launch *Recalibrating the Regime*,⁹ a new report outlining the legal basis for a human rights-based approach to international drug policy. Speakers from the International Harm Reduction Association (IHRA, the Canadian HIV/AIDS Legal Network and Human Rights Watch highlighted such human rights concerns as the death penalty for drug offences;¹⁰ and how strict enforcement of criminal laws against drugs undermine HIV prevention and treatment efforts and lead to other human rights abuses, such as the wave of extrajudicial killings by state agents during Thailand's 2003 intensified war on drugs. Numerous representatives of the Thai delegation attended the session to react publicly to the criticisms.

The NGO presence was also felt in the plenary sessions. Numerous NGO statements were delivered in the plenary, highlighting human rights and health concerns, and including a statement on behalf of the International Network of People Who Use Drugs (INPUD).¹¹ A day-long official NGO forum was hosted by the Vienna NGO Committee, as a venue to hear reports back from numerous regional consultations with civil society from around the world that constitute a parallel process to the governments' year-long review.

A follow-up NGO forum ("Beyond 2008") in July 2008 will be a venue for civil society organizations to debate and develop three proposals to states for their consideration in charting the future course of U.N. drug policy.

Finally, member states at the 2008 session of the CND adopted the first-ever resolution making reference to human rights in relation to the U.N.'s drug control machinery and policy.¹² Major proponents of the resolution were the United Kingdom, Switzerland, Argentina, Uruguay and Bolivia, but the resolution was drastically weakened through the combined efforts of countries such as China, Japan, Pakistan, Thailand, Nigeria, Canada and the U.S.

In the face of blatant and repeated obstructionism by China, Uruguay briefly broke with the rule that no resolutions can be adopted except by consensus among all member states, calling instead for the human rights resolution to be put to a vote. However, in the end, a deal was brokered that allowed the much-weakened resolution to pass by consensus.¹³

While the resolution ultimately says little of substance about the relationship between drug control policy and human rights, it does at least officially open the door to collaboration between the UNODC and the U.N.'s human rights bodies (e.g. the Office of the U.N. High Commissioner for Human Rights), providing an opportunity for further efforts to advance human rights-based analyses of drug policy.

— Richard Elliott

Richard Elliott (relliott@aidslaw.ca) is the Executive Director of the Canadian HIV/AIDS Legal Network. A more detailed report on the 2008 CND session has been prepared by the International Drug Policy Consortium (IDPC): www.idpc.info/php-bin/documents/IDPC_BP_08_RptProceedings2008CND_EN.pdf. Video clips of events at the CND, including

interviews with NGO representatives, were prepared by the Hungarian Civil Liberties Union and are available via www.drogriporter.hu.

¹ "Commission on Narcotic Drugs," www.unodc.org/unodc/en/commissions/index.html.

² *Single Convention on Narcotic Drugs, 1961*, 520 UNTS 204 (as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs, 1961, 976 UNTS 3); *Convention on Psychotropic Substances, 1971*, 1019 UNTS 175; *Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988*, U.N. Doc. E/CONF.82/15 (1988), reprinted in (1989) 28 ILM 493; all available via www.unodc.org.

³ U.N. General Assembly, *Political Declaration* ("Declaration on the Guiding Principles of Drug Demand Reduction, Resolution"), U.N. Doc. A/Res/S-20/2 (1998).

⁴ P. Arlacchi, Executive Director, U.N. Office for Drug Control and Crime Prevention. "Towards a drug-free world by 2008: we can do it," *UN Chronicle* 1998; 35(2). At www.un.org/Pubs/chronicle/1998/issue2/0298p4p.html.

⁵ At www.unodc.org/documents/prevention/Reducing-adverse-consequences-drug-abuse.pdf.

⁶ A. Costa, UNODC Executive Director, remarks to opening plenary, U.N. Commission on Narcotic Drugs, 51st Session, 10 March 2008. At www.unodc.org/india/cnd_ed_remarks.html.

⁷ *Ibid.*

⁸ Canadian HIV/AIDS Legal Network, "Latest report from United Nations drug control body misses the mark," news release, Toronto, 4 March 2008, available via www.aidslaw.ca/media.

⁹ D. Barrett et al., *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy*, Beckley Foundation Drug Policy Program, 2008. Available via www.aidslaw.ca/drugpolicy or at www.idpc.info/php-bin/documents/BFDPP_RP_13_Recal_Regime_EN.pdf.

¹⁰ See R. Lines, *The Death Penalty for Drug Offences: A Violation of International Human Rights Law*, International Harm Reduction Association, 2007. At www.ihranet/uploads/downloads/NewsItems/DeathPenaltyforDrugOffences.pdf.

¹¹ See all NGO statements at www.idpc.info/php-bin/documents/ngo_statements2cnd2008.pdf.

¹² The text of the resolution is available on the website of the UNODC via www.unodc.org/unodc/en/commissions/CND/session/51.html.

¹³ For a more detailed description of the process by which the resolution on human rights was gutted, see "The life of a human rights resolution at the UN Commission on Narcotic Drugs," 22 April 2008, (at www.ihrablog.net/2008/04/life-of-human-rights-resolution-at-un.html); and the summary description in the IDPC's report of the proceedings at the 2008 CND session, pp. 9–11 (at www.idpc.info/php-bin/documents/IDPC_BP_08_RptProceedings2008CND_EN.pdf).

In brief

Russia denies HIV treatment to prisoner

Vasily Aleksanyan was a senior lawyer for Yukos, the Russian petroleum company. Senior executives of the company, Mikhail Khodorkovsky and Platon Lebedev, were arrested in 2003 on charges of large-scale fraud and tax evasion.¹ In March 2006, Aleksanyan was appointed executive vice-president of the company and a month later was detained on charges of embezzlement and money laundering.

On 7 April 2006, Aleksanyan's request for pre-trial release on bail was denied. His pre-trial detention was extended on a number of occasions. In September 2006, Aleksanyan was found to be HIV-positive. His health deteriorated considerably as he suffered from a number of AIDS-related conditions. In December 2007, doctors concluded he had most likely contracted tuberculosis while in prison. In February 2008, Aleksanyan was diagnosed with non-Hodgkins lymphoma.

Despite recommendations from doctors that he undergo in-patient examination and treatment in the Moscow AIDS Centre, prison authorities denied antiretroviral treatment and other forms of medical care and treatment to Aleksanyan. Aleksanyan claimed that he was denied treatment because he had refused to testify against his former Yukos bosses.²

The European Court of Human Rights (ECHR), in an interim measure issued on 27 November 2007, requested the Russian government to "secure immediately ... the in-patient treatment of the applicant in

a hospital specialised in the treatment of AIDS and concomitant diseases."³ On a number of occasions in December 2007 and January 2008, the ECHR reiterated this request, but it was ignored by Russian prison authorities.⁴

Aleksanyan's trial was scheduled to commence on 5 February 2008, although it was suspended due to his ill health. The court refused to release Aleksanyan on bail.⁵ On 8 February 2008, he was transferred from pre-trial detention facilities to Moscow's City Clinical Hospital No. 60 to receive medical care. Media report that he was under 24-hour surveillance and was handcuffed to his hospital bed for a week after being transferred.⁶

– Richard Pearshouse

California: Governor vetoes another prison condom bill, but leaves door ajar

In October 2007, California Governor Arnold Schwarzenegger vetoed a bill that would have permitted the distribution of condoms and other safer sex devices in that state's prisons. The measure, Assembly Bill 1334, was sponsored by Sandre Swanson (Democrat) and was similar to Assembly Bill 1677 that Schwarzenegger had vetoed a year previously.⁷

However, in his veto message, Schwarzenegger stated that "condom distribution in prisons is not an unreasonable public policy and

it is consistent with the need to improve our prison healthcare system and overall public health." He requested the California Department of Corrections and Rehabilitation "to determine the risk and viability of such a program by identifying one state prison facility for the purpose of allowing non-profit and health agencies to distribute sexual barrier devices."⁸

A *New York Times* editorial accused the Governor of a lack of political courage, noting that "[a] small, exploratory program falls far short of the mass distribution effort that the system clearly needs."⁹

– Richard Pearshouse

Australia to legislate to remove same-sex discrimination

On 30 April 2008, Australia Attorney-General Robert McClelland announced the government's intention to introduce legislation to remove same-sex discrimination from a range of Commonwealth legislation and programs.¹⁰

According to the Attorney-General's news release, areas where discrimination will be removed include tax, superannuation, social security, health, aged care, veterans' entitlements, workers' compensation and employment entitlements. The government will begin to introduce the legislation in May 2008, and foresees that all measures should be implemented by mid-2009.

The commitment follows a national inquiry by the Human Rights and Equal Opportunities Commission and the launch of the report *Same Sex: Same Entitlements* in 2007.¹¹

However, the changes will not allow people in same-sex relationships to marry. When he announced the government's intention, McClelland stated, "The government believes that marriage is between a man and a woman so it won't amend the *Marriage Act*.... But in all other areas that we've identified, the issue of discrimination against same-sex couples will be removed."¹²

On this particular issue, the current (Labor) Government's policy overlaps with that of the previous (Liberal) Government under John Howard. Prior to 2004, marriage was not defined in the *Marriage Act* (1961). The *Marriage Legislation Amendment Act* (2004) inserted a definition into Section 5(1) of that Act to read: "Marriage, means the union of a man and a woman to the exclusion of all others, voluntarily entered into for life."

However, the current Government does support the development of a national register of same-sex relationships.¹³

– Richard Pearshouse

ILO publishes digest of good legislative practices in Africa

The ILO recently published a *Digest of Good Legislative Practices Relating to HIV/AIDS in Selected African Countries*.¹⁴ The Digest examines a number of laws — not

just special AIDS statutes or labour codes — in a series of national monographs from 14 English-, Portuguese- and French-speaking African jurisdictions.¹⁵ The Digest is designed to enhance compliance with legal frameworks relating to HIV/AIDS in the world of work.

The good practices identified in the Digest use as a benchmark the relevant international labour standards — in particular, the *Discrimination (Employment and Occupation) Convention, 1958* (No.111), and the ILO's *Code of Practice on HIV/AIDS and the World of Work* (2001). In addition, the Digest is rich in gender-sensitive assessments of the texts.¹⁶

Most national monographs note the general influence of the international human rights instruments that guarantee equality and freedom from discrimination. According to the Digest, one approach adopted by certain states has been to introduce a dedicated law on the subject (e.g., HIV-specific legislation) that includes a chapter or division reflecting the specific needs of the world of work (e.g., Benin and Togo).

Another marked trend is to include specific HIV/AIDS-related provisions in the general labour or employment law (e.g., Botswana, Lesotho, Mozambique, South Africa and those French-speaking states that will follow the proposed Uniform Labour Law currently being developed by the *Organisation pour l'harmonisation du droit d'affaires*).

Another identified approach for establishing a legal framework in favour of people living with HIV/AIDS, especially in the absence of specific HIV/AIDS provisions, is a constitutional provision prohibiting discrimination on the basis of "disabil-

ity" or "other status" (e.g., Malawi, Mozambique and South Africa).

Five of the monographs refer to gender inequalities as requiring a legislative response in the context of the customary legal traditions. Some monographs highlight the particular vulnerability of young women and girls to forced unprotected sexual relations with male relatives and hence to HIV/AIDS infection, as imposed by customary rules (e.g., Botswana, Lesotho and Malawi). Others report that customary rules help mitigate the impact of the disease on persons living with HIV/AIDS (e.g., Ethiopia and Democratic Republic of Congo).

Where labour laws includes provisions on HIV/AIDS, most ban work-related testing or screening, protect against dismissal based on real or perceived HIV status, establish a duty to provide information and awareness-raising, and provide the right to care and support for employees living with HIV.

The Digest notes, however, that while such statutory protection should amount to a serious deterrent to HIV-related acts of stigma or discrimination, very few legal complaints have been observed in the countries involved (Botswana, Burkina Faso, Democratic Republic of Congo, Malawi, South Africa and Zimbabwe). Fear of stigma attached to the revelation of HIV status, as well as the lack of realistic legal remedies, may be responsible for this situation.

– Jane Hodges

Jane Hodges (hodges@ilo.org) is a Senior Labour Law Specialist with ILO.

U.N. Secretary-General calls for an end to criminal law approaches to vulnerable populations

On 26 March 2008, U.N. Secretary-General Ban Ki-moon called for increased respect for the health and human rights of people living with HIV, sex workers, men who have sex with men and young people who inject drugs in Asia. He stated:

[W]e will never see equitable progress if some parts of the population are still denied basic health and human rights — people living with HIV, sex workers, men who have sex with men, and young people who inject drugs. I look to Asian Governments to amend outdated laws criminalizing the most vulnerable sections of society, and take all the measures needed to ensure they live in dignity.¹⁷

His comments were made in response to the launch of a report by the Commission on AIDS in Asia. The report calls for, among other things, increased access to harm reduction measures to prevent HIV transmis-

sion to people who use drugs and the decriminalisation of sex work.¹⁸

— Richard Pearshouse

¹ In May 2005, Khodorkovsky and Lebedev were found guilty and sentenced to ten and eight years in prison, respectively. See www.khodorkovsky.info.

² D. Nowak, "Aleksanyan to stay in custody," *The St. Petersburg Times*, 7 March 2008.

³ A copy of ECHR correspondence referring to the interim measure can be found at www.mka-london.co.uk/documents/ronald_60B12.pdf.

⁴ Human Rights Watch, *Letter to President Vladimir Putin: Denial of HIV treatment Endangering Russian Prisoner's Life*, 8 February 2008. Available via www.hrw.org.

⁵ M. Scwartz, "Ill Russian's plea to leave prison: 'I will not go anywhere but to the grave,'" *The New York Times*, 7 February 2008.

⁶ S. Osadchuk, "Ex-Yukos executive kept in handcuffs," *The Moscow Times*, 19 February 2008; D. Nowak, "Aleksanyan to stay in custody," *The St. Petersburg Times*, 7 March 2008.

⁷ R. Pearshouse, "California: Governor vetoes prison condom bill" *HIV/AIDS Policy and Law Review* 11 (2/3) (2006): 38.

⁸ The veto message is available online at <http://gov.ca.gov/pdf/press/AB%201334%20veto%20message.pdf>.

⁹ "Reality and denial in California prisons," *The New York Times*, 19 October 2007.

¹⁰ Attorney-General for Australia, "Rudd government moves on same-sex discrimination," news release, Canberra, 30 April 2008. At www.attorneygeneral.gov.au/www/ministers/robertmc.nsf/Page/

[MediaReleases_2008_SecondQuarter_30April2008-RuddGovernmentmovesonsame-sexdiscrimination](http://www.media.gov.au/mediareleases/2008/SecondQuarter_30April2008-RuddGovernmentmovesonsame-sexdiscrimination).

¹¹ Human Rights and Equal Opportunities Commission, *Same Sex: Same Entitlements — National Enquiry into Discrimination Against People in Same-Sex Relationships: Financial and Work-Related Entitlements and Benefits*, May 2007. At www.hreoc.gov.au/Human_Rights/samesex/report/pdf/SSSE_Report.pdf.

¹² "Govt excludes same-sex marriage from law changes," *ABC News*, 30 April 2008. At www.abc.net.au/news/stories/2008/04/30/2230972.htm.

¹³ "National register for gay couples, says Kevin Rudd," *news.com.au*, 16 December 2007. At www.news.com.au/story/0,23599,22932717-2,00.html.

¹⁴ The full text of the Digest can be downloaded at www.ilo.org/public/english/dialogue/ifpdial/downloads/papers/digest.pdf. The Digest forms part of a (Swedish) Sida-funded program aimed at mitigating the effects of HIV/AIDS in sub-Saharan Africa. Further information about this project can be found at www.ilo.org/public/english/dialogue/ifpdial/tech/hiv aids.htm.

¹⁵ Benin, Botswana, Burkina Faso, Cameroon, the Democratic Republic of the Congo, Ethiopia, Lesotho, Malawi, Mauritius, Mozambique, Nigeria, South Africa, Togo and Zimbabwe.

¹⁶ The research feeds into the International Labour Conference debate in 2009 and 2010 on a new instrument on the subject: See the background report *HIV/AIDS and the World of Work*, 98th Session of the ILC, Report IV(1). Available in several languages at www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_090177.pdf.

¹⁷ The Commission on AIDS in Asia, "AIDS remains the leading cause of death and lost days in the most productive age groups in Asia," news release, New York City, 26 March 2008. At http://data.unaids.org/pub/PressRelease/2008/20080326_pr_asiacommissionreport_en.pdf.

¹⁸ The Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response*, March 2008. At http://data.unaids.org/pub/Report/2008/20080326_report_commission_aids_en.pdf.

HIV/AIDS IN THE COURTS – CANADA

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

Court strikes down restriction in Ottawa's medical marijuana program

On 10 January 2008, the Federal Court struck down a key restriction in Ottawa's medical marijuana program.¹ The ruling grants approved medical marijuana users more freedom in picking their own grower, and allows growers to supply the drug to more than one patient.²

In 2004, licensed medical marijuana users, who use marijuana to treat chronic pain, seizures and other ailments, sought a judicial review of Health Canada regulations regard-

ing the growing of the drug and its distribution. Under Health Canada's regulations, licensed producers were only permitted to grow marijuana for one patient at a time. Therefore,

authorized users who could not grow their own marijuana were forced to rely on either a licensed private producer, if they could find one willing to produce only for them, or the gov-

ernment, which buys the plants from a Manitoba-based company.³

This restriction effectively established Health Canada as the country's sole legal provider of medical marijuana. According to Alan Young, lawyer for the medical marijuana users, Health Canada was providing an expensive yet ineffective drug that didn't meet the needs of many patients. Young also said that there are providers who want to supply various strains of marijuana at a lower cost for medical use.⁴

In the Federal Court's view, the one-to-one ratio for growers and patients violated the *Canadian Charter of Rights and Freedoms*. In his decision, Justice Barry Strayer said that the provision was unconstitutional and arbitrary because it "caused individuals a major difficulty with access."⁵

Justice Strayer held that the liberty and security of the person interests in section 7 of the *Charter* conferred on the applicants a right to choose, on medical advice, to use marijuana for treatment of serious conditions, and that that right implied a right of access to such marijuana and a right not to have one's physical liberty endangered by the risk of imprisonment from having to access marijuana illicitly.

Moreover, Justice Strayer observed that while the government had argued that medical users who couldn't grow their own marijuana could obtain it from the government, fewer than 20 percent of patients actually used the government's supply. The judge said that "it is not tenable for the government, consistently with the right

established in other courts for qualified medical users to have reasonable access to marijuana, to force them either to buy from the government contractor, grow their own or be limited to the unnecessarily restrictive system of designated producers."⁶

Health Canada's restriction on medical marijuana producers arose as the result of a government policy that was implemented following a 2003 Ontario Court of Appeal ruling that struck down as unconstitutional certain rules that limited access to medical marijuana.⁷ In response, Health Canada amended several aspects of its policy but retained the limits on production.⁸

Lawyers for the medical marijuana users hailed the Federal Court's ruling as a "nail in the coffin" of the one-to-one ratio restriction, which they believe will allow patients to choose whether to buy from the government or "to create small the small collectives of patients that go to an experienced and knowledgeable grower."⁹

Health Canada has appealed the Federal Court decision.

In the case before the Federal Court, the medical marijuana users had also asked the Court to retain supervisory jurisdiction over Health Canada's creation and implementation of a new process for allowing multiple patients to designate a single designated producer. This would require Health Canada to submit periodic reports on the status and progress of the new process. Justice Strayer denied the request and the medical marijuana users have cross-appealed that decision.

On 19 March 2008, the Federal Court of Appeal granted an interim stay of the Federal Court decision pending the outcome of the appeal and cross-appeal.¹⁰

¹ *Sfetkopoulos v. Canada (Attorney General)*, 2008 FC 33 (CanLII).

² M. Babbage, "Federal Court strikes down regulation limiting growers of medical marijuana," *Canadian Press*, 10 January 2008.

³ M. Fitzpatrick, "Ottawa loses medical marijuana challenge," *National Post*, 11 January 2008.

⁴ "Medical marijuana restrictions unfair; lawyers contend," *Canadian Press*, 4 December 2007.

⁵ "Court strikes down regulation limiting growers of medical marijuana," *CBC News*, 22 January 2008.

⁶ *Ibid.*

⁷ *Hitzig v. Canada* (2003), 231 D.L.R. (4th) 104.

⁸ P. Lucas, "Regulating compassion: an overview of Canada's federal medical cannabis policy and practice," *Harm Reduction Journal* 5:5 (2008). Available via www.harmreductionjournal.com.

⁹ M. Fitzpatrick.

¹⁰ *Canada (Attorney General) v. Sfetkopoulos*, 2008 FCA 106 (CanLII).

Refugee claimant's identity as cross-dresser must be considered in assessing adequacy of state protection

On 11 December 2007, the Federal Court allowed Jose Hernandez's application for judicial review of a November 2006 decision by the Refugee Protection Division of the Immigration and Refugee Board, which found that the applicant was neither a Convention refugee nor a person in need of protection.¹ Hernandez had requested that the Board's decision be set aside and the matter referred back to a newly constituted panel of the Board for re-determination.

Hernandez, a Mexican citizen, sought refugee status on the basis of his sexual orientation. He had been ejected from his home by his family and physically assaulted on a number of occasions as a result of his being gay. On one occasion, he was assaulted while he was "dressed as a woman."

Hernandez moved to Canada in 2003 and was diagnosed with HIV in 2005. In June 2006, Hernandez's immigration hearing took place, during which he disclosed that he feared danger in returning to Mexico because he is gay and is a cross-dresser.

According to the Board, the determinative issue in Hernandez's particular claim was whether state protection was available to him in Mexico. The Board was persuaded by the documentary evidence on Mexico that while there continues to be strong homophobic attitudes among the general public, the government had adequately addressed the issue of sexual orientation and health care; and that in recent years, there had been substantial political and legal gains for sexual minorities.

The Board found it unreasonable for Hernandez not to have made efforts to seek police protection or protection of other state authorities, and held that he had an obligation to first seek protection in his country of origin. With regards to Hernandez's claim of protection on the basis of his HIV-positive status, the Board noted that the HIV/AIDS program in the City of Mexico provides full antiretroviral treatment for all persons living with HIV who could not otherwise afford treatment. The Board concluded that having considered all of the evidence, Hernandez was not a Convention refugee, nor was he a person in need of protection.

The Federal Court held that with regards to the issue of adequacy of state protection, the appropriate standard of review is reasonableness. In its review of the Board's decision, the Court concluded that there was no consideration of Hernandez's full identity, "despite ample evidence before the Board to alert them to the fact that the applicant's identity was not only a homosexual man, but also a cross-dresser and transgender

individual." The Court held that in failing to assess Mexico's ability to adequately protect such individuals, the Board had erred.

¹ *Hernandez v. Canada (Minister of Citizenship and Immigration)*, [2007] F.C.J. No. 1665 (QL).

Case of disclosure of HIV status helps to clarify privacy law in Ontario

A judge in the Ontario Superior Court of Justice has dismissed a breach of privacy suit on the basis that the plaintiff failed to prove that the disclosure of his HIV status had caused him harm. The judgment set out guidelines for how future claims of breach of privacy should be addressed.¹

In 2005, the HIV & AIDS Legal Clinic of Ontario (HALCO) was contacted by a man whose aunt had disclosed his HIV status to his parents without his consent. His aunt had revealed the man was HIV-positive while having an argument with his mother and another aunt. He was not there at the time and discovered the disclosure one month later. With the assistance of HALCO, the man sued his aunt for breach of privacy and intentional infliction of mental distress.

At the time, breach of privacy cases were relatively new in Ontario's courts. While there had been cases in which plaintiffs had won damages for breach of privacy, these had not clearly established the necessary criteria to prove this claim.

The trial took place in February and June 2007. Both the plaintiff and the defendant provided their legal arguments in writing. On 4 October 2007, the judge released her judgment, holding that the plaintiff could not prove that his aunt's disclosure to his parents caused him harm in view of a number of other stressful circumstances in his life at the time.

While the judge found that the aunt had disclosed the plaintiff's HIV status, she stated that the plaintiff could not recover damages without making a direct link between the disclosure and the harm that he suffered, and

without proving that his aunt intended to harm *him* and not his mother.

Nevertheless, the case established a framework for future breach of privacy cases. In her decision, the judge provided that in order to determine a breach of privacy case, a court should answer the following questions:

1. Is the information acquired, collected, disclosed or published of a kind that a reasonable person would consider private?
2. Has the plaintiff consented to the acquisition or collection of the information?
3. If not, has the information been acquired or collected for a legal process or public interest reason? If so, what is that reason?
4. Has the plaintiff consented to the disclosure or publication of the information?
5. If not, has the information been disclosed or published for a legal process or public interest reason? If so, what is that reason?
6. Is the legal process or public interest reason put forward for acquisition, collection, disclosure or publication one that a reasonable person would consider outweighs the interest of the individual in keeping the information private?

In addition, the judge held that a person whose privacy has been

breached must prove that she or he suffered some harm as a result of the privacy breach. This contrasts with legislation in British Columbia, Saskatchewan, Manitoba and Newfoundland, which stipulate that a person can sue for breach of privacy without needing to prove damages, and which the judge chose not to be guided by.

There may be scope in a future breach of privacy claim to argue that proof of harm should not be determinative of a case. In the meantime, this case has provided greater clarity for privacy law in Ontario and for people intending to sue when their HIV status is disclosed without their permission.

– *Renée Lang*

Renée Lang (langr@lao.on.ca) is a staff lawyer at HALCO and represented the plaintiff in the above case.

¹ *Caltagirone v. Scozzari-Cloutier*, [2007] O.J. No. 4003 (QL).

HIV-positive woman's appeal for absolute discharge dismissed on grounds of public safety

On 7 December 2007, the Nova Scotia Court of Appeal dismissed an appeal from a June 2007 order of the Nova Scotia Review Board providing that an HIV-positive woman, "K.A.S.," be discharged with conditions to reside in hospital-approved premises, to continue with recommended mental health treatment, and to abstain from alcohol and illicit drug use because she continued to present a significant risk to the safety of the public.¹

K.A.S. had sought an absolute discharge on the grounds that her psychosis had been controlled with medication, and that the restrictions on her liberty are intended to address her drug addiction and HIV status, which are community health issues and not properly the subject of continuing proceedings under the *Criminal Code*.

In February 2004, K.A.S. was found to be "not criminally responsible" by reason of mental disorder in relation to two charges of communication for the purposes of prostitution. K.A.S. had undergone a psychiatric assessment prior to her trial and was found to suffer from chronic schizophrenia. K.A.S. had reported to the examining psychiatrist that at the time of the offences that she believed she was an undercover police agent posing as a sex worker who was incapable of transmitting or contracting sexually transmitted infections.

As a result of the verdict, K.A.S. fell under the jurisdiction of the Nova Scotia Review Board, which ordered that she be detained at the East Coast Forensic Psychiatric Hospital. During her detention in the hospital and in transitional group homes where she was periodically dis-

charged, K.A.S. went absent without leave on a number of occasions and tested positive for cocaine use upon her return.

Although her psychosis was controlled with medication, K.A.S.'s diagnosis of chronic schizophrenia remained unchanged and the Review Board found that she continued to pose a significant risk to the safety of the public because of her drug use, which could cause her delusions to return.

The Court of Appeal observed that in making a decision to grant an absolute discharge, a conditional discharge, or detention in hospital custody, the Review Board must take into consideration "the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused."

The Court said that the Review Board could order an absolute discharge only if, in its opinion, the accused is not a "significant threat to the safety of the public." In the Court's view, the Review Board's conclusion that the potential that K.A.S. would infect a sexual partner through her failure to disclose her HIV status rendered her a significant

threat, and the Review Board's consequent order, were not unreasonable.

The Court held that while, as K.A.S. argued, the risk that she would infect another with HIV is a public health risk, the Board's finding that K.A.S. presented a significant threat to the safety of the public because she may commit an assault on a member of the public due to her failure to disclose her HIV status was "evidence-based, predicted criminal conduct which is squarely within the jurisdiction of the Review Board."

¹ *R. v. K.A.S.*, [2007] N.S.J. No. 504 (Q.L).

Criminal law and HIV transmission or exposure: seven new cases

Québec woman convicted for non-disclosure of her HIV-positive status

A Québec woman, D.C., was found guilty on 14 February 2008 of sexual assault and aggravated assault for failing to inform her sexual partner, J.L.P., that she was HIV-positive before they had sex.¹ In the judgment, both the accused and the complainant were referred to only by their initials because their identities were suppressed as the result of a publication ban.

D.C. was diagnosed with HIV in 1991. She met the complainant J.L.P. in 2000 and began a sexual relationship with him shortly afterwards. In earlier proceedings, D.C. successfully brought charges of assault against J.L.P. following the breakdown of their relationship in 2004, for which J.L.P. received an unconditional discharge.²

During the trial, Justice Bisson noted that J.L.P. had waited four years before bringing charges against D.C., and observed in him a “certain vengeance [towards her] for the fashion in which their relationship ended. The bitterness is palpable.”³

J.L.P., who had not been infected with HIV, alleged during trial that he had unprotected sex on multiple occasions with D.C. and that she did not disclose her HIV-positive status to him beforehand. D.C. maintained that she only had sex with J.L.P. once before she informed him of her HIV-positive status and that a condom had been used.

The Court found J.L.P.’s evidence on this point unreliable and concluded that D.C. only had sex with him once before she informed him of her HIV-positive status. At issue was whether a condom had been used on that occasion.

In his decision, Justice Bisson specifically stated as a finding of fact that in the initial sexual encounter between D.C. and J.L.P., a condom had not been used. Justice Bisson relied in part on the evidence of D.C.’s physician, who testified that notes in her medical chart indicated that D.C. had consulted with her about the risk of HIV transmission if a condom broke.

This was contrary to various newspaper reports that D.C. had only had “protected sex” with her partner.⁴ Given this finding of fact, the case does not address the issue of disclosure obligations when condoms are used, the so-called “condom defense,” an issue which remains unaddressed in Canadian jurisprudence.

D.C. is expected to return to court in July 2008 for sentencing.

Commentary

Significantly, the Court interpreted *R. v. Cuerrier*, the first Supreme Court of Canada decision dealing with non-disclosure of HIV status before unprotected sex, to require HIV-positive individuals to disclose their HIV status and reduce as much as possible the risk of exposure during sex.⁵ This interpretation is seem-

ingly inconsistent with the Court’s ruling in *Cuerrier*, which requires disclosure of HIV status if there is a significant risk of exposure and not in circumstances where safer sex is practiced.⁶

As the Court in *Cuerrier* suggested, “the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant...”⁷ The requirement of disclosure of HIV status *in addition to* practicing safer sex is unnecessarily burdensome on people living with HIV, particularly given that they may face stigma, discrimination and fear of rejection in their personal relationships.

Cases in which women have been charged for failing to disclose their HIV-positive status to their sexual partners are relatively rare in Canada. While women, particularly those in abusive relationships or those involved in sex work, may have limited control over whether safer sex is practised with or by a partner, and may be more likely than men to face sexual and physical violence if they reveal they are HIV-positive, the impact of the criminal prosecution of non-disclosure of HIV status on women has not been sufficiently studied.

Some groups have contended, however, that Justice Bisson’s decision deters HIV-positive women living in abusive relationships from bringing charges of abuse against their sexual partners for fear of retribution.⁸

Leone given 15 consecutive sentences for aggravated sexual assault

On 4 April 2008, Carl Leone was sentenced in the Ontario Superior Court of Justice to 49 years imprisonment for 15 consecutive sentences of aggravated sexual assault, a term that was ultimately reduced to 18 years after Justice Joseph Quinn took into account the “principle of totality.”⁹

According to Justice Quinn, when an individual receives consecutive sentences, the principle of totality requires judge to ensure that the aggregate sentence is not unduly long or harsh. In his judgment, Justice Quinn indicated that Leone’s age, his lack of a criminal record and the fact that he pleaded guilty to spare the complainants the trauma of testifying in court were all factors in his decision.

In April 2007, Leone had pleaded guilty to 15 counts of aggravated sexual assault for having unprotected sex with 20 women between 1997 and 2004 without disclosing his HIV status.¹⁰ Five of the 20 women had since tested positive for HIV.¹¹ Leone was arrested by Windsor police in June 2004, seven years after he had tested HIV-positive at the Windsor Essex County Health Unit.

Leone will be eligible for parole in six years. The Crown’s application to have Leone declared a dangerous offender did not succeed, because Justice Quinn held that the Crown had not proven beyond a reasonable doubt that Leone would commit similar offences in the future. Had Leone been declared a dangerous offender, he would have faced an indefinite prison term subject to review every seven years.

The Crown’s application to have Leone declared a long-term offender was also unsuccessful. As a long-term offender, Leone would have been subject to a period of supervision of up to ten years after his eventual release from prison.¹² However, Leone will be required to surrender a DNA sample and his name will be added to Ontario’s sex offender registry for life.

Lifetime sex offender registration for man who failed to disclose his HIV status

On 27 March 2008, Ryan Handy was sentenced to eight months’ incarceration and two years’ probation for failing to disclose his HIV-positive status before having unprotected sex twice with the same man.¹³ Handy had been convicted of aggravated sexual assault in November 2007.

During his trial at the Ontario Superior Court of Justice, Handy had testified that at the time he first had unprotected sex with the complainant, he was experiencing a mental breakdown and believed he was the Messiah and had sweated out the virus. After they had unprotected sex again, Handy testified that he had a moment of clarity, realized he had the virus and immediately contacted the man and told him he was HIV-positive. The complainant, who was not ultimately infected, had testified that he would not have participated in sex had he known Handy was HIV-positive.¹⁴

During Handy’s sentencing, Justice Williams Jenkins acknowledged that Handy’s mental illness

affected his judgment. While Justice Williams Jenkins could not agree with the conditional sentence the defence had requested, he called the three-year jail term requested by the Crown “crushing.”¹⁵

Handy’s conditions of probation include continuing his treatment for mental illness, abstaining from illegal drug use, disclosing his HIV status to all sexual partners and abstaining from unprotected sex. In addition, Handy was ordered to provide a DNA sample, and his name was added to the sex offender registry for life. Because Handy was convicted of aggravated sexual assault, which carries a maximum life sentence, lifetime registration on the sex offender registry is automatic.

Court dismisses motion for leave to bring a Section 15 Charter claim

In December 2007, the Ontario Superior Court of Justice dismissed Johnson Aziga’s motion for leave to bring a Section 15 *Canadian Charter of Rights and Freedoms* application to stay proceedings against him or, alternatively, to exclude evidence based upon a violation of one or more of his *Charter* rights.¹⁶

Aziga is charged with two counts of first-degree murder and 13 counts of aggravated sexual assault for having unprotected sex with 13 complainants without disclosing his HIV-positive status. Seven of the complainants subsequently became HIV-positive and two of the complainants died as a result of complications associated with their HIV infection.

In his motion, Aziga argued that the criminalization of HIV exposure in Canada criminalizes a “physical disability,” which violates his right to be free from discrimination as a result of his membership in an identifiable group.

Aziga, who was born in Uganda, also argued that he was discriminated against on the ground of race, because the Crown had introduced evidence regarding the statistical probability of the source of the complainants’ HIV infection being an African and in particular, a Ugandan. Aziga contended that the statistical analysis based on race, national origin or ethnicity amounted to racial profiling which was offensive to the right of every individual to be free from discrimination on the basis of race, national origin or ethnicity, and a breach of his rights under Section 15 of the *Charter*.

Justice Lofchik held that Aziga had failed to establish an evidentiary foundation or a factual basis to support an assertion that there has been a violation of his rights pursuant to Section 15 of the *Charter*. In Justice Lofchik’s view, the Crown’s evidence merely indicated that Aziga and the infected complainants share a particular virus which is “a rare clone in Canada but prevalent in Africa,” and did not amount to racial profiling.

Furthermore, Aziga was not being prosecuted because he is HIV-positive, but because “he engaged in unprotected penetrative sexual activity with the 13 named complainants, knowing he was HIV-positive and failing to disclose to them that he was HIV-positive, thereby exposing them to serious bodily harm.” Aziga’s trial has been scheduled to begin in October 2008.

Admission of consensual sex leads to dismissal of criminal charge

On 4 February 2008, the Ontario Superior Court of Justice dismissed a charge of attempted aggravated sexual assault against Mark Hinton for allegedly having unprotected sex with a man in 2006 without disclosing his HIV-positive status.¹⁷ The man subsequently discovered he was HIV-positive.

Hinton’s original charge of aggravated sexual assault had been reduced to attempted aggravated sexual assault because the Crown could not prove definitively that Hinton had infected the complainant.

The trial ended after the complainant testified that HIV was not a concern for him before he engaged in “moderately high-risk” unprotected sex with previous partners. According to the Crown, this admission of consent substantially weakened the Crown’s case to prove the allegation beyond a reasonable doubt. After the case was dismissed, Hinton claimed he had never had sex with the complainant and was being used as a scapegoat for the man’s HIV status.

B.C. man sentenced to over four years for failing to disclose HIV-positive status

In November 2007, the Prince George Provincial Court sentenced “J.M.L.” to four years and eight months for failing to disclose his HIV-positive status to a woman with whom he had unprotected sex.¹⁸

J.M.L. had pleaded guilty to a charge of aggravated assault against

the woman, who he had met in an online chat room and with whom he had unprotected sex with from November 2004 until March 2005. A concerned housemate of the man allegedly told the complainant about J.M.L.’s HIV status, at which point she immediately went for HIV testing and was given post-exposure prophylaxis for several months. At the time of his sentencing, the complainant had tested negative for HIV.

Since J.M.L. had already served 16 months in custody, which counted as double that time when applied to his sentence, he was required to serve an additional two years to complete the sentence.

Guilty plea in case of sexual assault in Ontario prison

On 28 February 2008, Lee Wilde pleaded guilty in the Ontario Court of Justice to sexually assaulting a fellow prisoner who is HIV-positive.¹⁹ Wilde was charged with sexually assaulting the male complainant, who was incarcerated with him at the Central North Correctional Centre in Penetanguishene, Ontario in March 2007. Wilde was sentenced to 20 months imprisonment and his name will be placed on the provincial sex offender registry.

This was the second trial for Wilde. In December 2007, Wilde was tried before Justice Jon-Jo Douglas in the Ontario Court of Justice (Central East Region). A new trial was ordered after the judge removed himself from the trial following some questionable conduct on his part.

For further discussion of the first trial, see the “Canadian Developments” section of this issue.

¹ *R. v. D.C.* (14 February 2008), Longueuil 505-01-058007-051 (C.Q.).

² “Woman who hid HIV infection from partner faces jail,” *CBC.CA News*, 5 May 2008.

³ *R. v. D.C.* at para. 153.

⁴ “Quebecer guilty of assault for failing to tell boyfriend she was HIV-positive,” *Canadian Press*, 14 February 2008.

⁵ *R. v. D.C.*, para. 92.

⁶ For further discussion on this issue, see R. Elliott, *After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status*, Canadian HIV/AIDS Legal Network, 2002.

⁷ *R. v. Cuerrier*, [1998] 2 S.C.R. 371 at para. 129.

⁸ See for example, COCQ-Sida, “Are Judges and Prosecutors Guilty of Discrimination Against People Living with HIV?,” news release, Montréal, 15 November 2007.

⁹ C. Alphonso, “Man gets 18 years for spreading HIV,” *Globe and Mail*, 5 April 2008.

¹⁰ D. Schmidt, “Plea ends HIV trial; Leone admits guilt in 15 sex assaults,” *The Windsor Star*, 28 April 2007, p. A1.

¹¹ D. Schmidt, “Positive HIV test drove Leone to tears, trial told,” *The Windsor Star*, 17 April 2007, p. A3.

¹² C. Alphonso.

¹³ J. Sims, “HIV positive man spread virus, jailed 8 months,” *The London Free Press*, 28 March 2008, p. B5.

¹⁴ J. Sims, “HIV accused claims mental breakdown,” *The London Free Press*, 21 September 2007, p. B1.

¹⁵ J. Sims, “HIV positive man spread virus,” p. B5.

¹⁶ *R. v. Aziga*, [2007] O.J. No. 4965 (QL).

¹⁷ J. Sims, “Charge dismissed against HIV-positive man,” *The London Free Press*, 5 February 2008, p. B.1.

¹⁸ S. Freeman, “HIV-positive man jailed after deceiving partner about infection; Court hands down four-year, eight-month sentence for aggravated assault,” *Vancouver Sun*, 5 November 2007, B.1.

¹⁹ J. Friesen, “Odd HIV assault trial ends abruptly,” *United Press International*, 29 February 2008.

In brief

Case of HIV-positive gay transvestite referred to new refugee panel for re-determination

On 7 February 2008, the Federal Court set aside a decision of the Refugee Protection Division of the Immigration and Refugee Board rejecting Orlando Quiros Cascante’s claim for refugee status, and referred the matter back for re-determination before a differently constituted panel.¹

Cascante, who is from Costa Rica, claimed protection on the basis of his fear of persecution as a gay transvestite who is HIV-positive. A central feature of his claim was whether he could receive state protection in Costa Rica from persecution with respect to his identity as a gay transvestite who is HIV-positive, including with respect to the three attributes on an accumulated basis.

While the Board found that Cascante was who he claimed to be, it chose to follow a precedent regarding the treatment of gay individuals in Costa Rica and, as the Federal Court held, “without critical evaluation, found that the precedent applied to the Applicant’s claim.” Since the precedent only spoke to treatment of gay individuals in Costa Rica and did not address state protection with respect to transvestites and persons who are HIV-positive, the Court held that the Board’s application of the precedent constituted a reviewable error.

Furthermore, on the state protection issue, the Board introduced evidence of Costa Rica’s alleged protection of transvestites, which, when examined, did not support such a claim. The Federal Court said that by relying on this evidence to reject Cascante’s application for refugee status, the Board’s actions were

“capricious” and the Board’s decision was patently unreasonable.

Application for judicial review denied for HIV-positive refugee applicant from Mexico

On 23 January 2008, the Federal Court denied an application for judicial review of the Immigration and Refugee Board’s decision to reject Flores de la Rosa’s claim for protection, having found that part of his story was not credible, that he had an “internal flight alternative” in Mexico City, and that state protection was available.²

The applicant, a citizen of Mexico, claimed protection based on his HIV-positive status and on abuse, including physical assault, from his estranged boyfriend, Bernardo. The applicant alleged that Bernardo

had tried to find him when he tried to hide in another city, and that Bernardo had friends in the federal judicial police who would assist Bernardo in finding him. The Board rejected the applicant's protection claim on credibility grounds, and on the basis that both an internal flight alternative and state protection were available.

The Federal Court found that even if the Board's credibility findings were suspect, the findings regarding state protection and an internal flight alternative were a complete answer to the applicant's claim. In the Court's view, there had been numerous decisions of the Federal Court upholding the Board's findings that Mexico City is an internal flight alternative for most gay and lesbian individuals in Mexico.

On the finding of state protection, it was open to the Board to conclude that the applicant had provided insufficient evidence to rebut the presumption of state protection. The Court observed that "Mexico was found to be a democratic state with a functioning government. On a general level, there was nothing to suggest that Mexico could not provide protection." Furthermore, the Court held that it was open to the Board to conclude that the applicant had not sufficiently attempted to engage state protection to be able to sustain the argument that it was not available to him personally.

Court rules that defamation not proved because reputation not "materially affected"

On 16 January 2008, the Ontario Superior Court of Justice (Toronto

Small Claims Court) dismissed Jennifer Murphy's claim for defamation arising from a Toronto Sun newspaper article published in November 2005 which claimed Murphy "tried to pass on HIV."³ At the time the article was published, Murphy had just pleaded guilty to aggravated sexual assault for failing to disclose her HIV-positive status to a man she had unprotected sex with.

Murphy argued that the Toronto Sun headline and article were defamatory because there was no evidence that she had deliberately attempted to infect the man with HIV, although she may have been reckless in not disclosing her HIV status. Murphy also argued that the failure of the Toronto Sun to report certain facts and the misrepresentation of other facts contributed to the defamation of her reputation.

While Justice Godfrey held that the Toronto Sun had incorrectly claimed that Murphy deliberately tried to infect the man she had unprotected sex with, he said that the real issue to be determined was whether the statements were "material" statements or mere "errors in detail."

In Justice Godfrey's view, the "reasonable person" would conclude that Murphy "had a callous disregard for the health and safety of others regarding the transmission of the HIV virus" and that there was "no substantial difference between a person deliberately attempting to infect their sexual partner with HIV virus, and a person acting with total disregard whether they might infect their sexual partner." Accordingly, Justice Godfrey found that the inaccuracy reported did not materially affect Murphy's reputation.

Final charges against former director of Canadian Red Cross withdrawn

Six criminal nuisance charges against Dr Roger Perrault, the former director of the Canadian Red Cross, were withdrawn on 18 January 2008 after Crown attorney John Pearson told the court there was no "reasonable prospect of conviction."⁴

The common nuisance charges stemmed from an allegation he endangered the public for failing to properly screen blood donors, implement testing for blood-borne viruses, and warn the public of danger regarding both hepatitis C and HIV.⁵

The decision comes less than four months after Perrault, two other Canadian health officials and an American pharmaceutical company representative were acquitted by the Ontario Superior Court of Justice of four charges of criminal negligence causing bodily harm and common nuisance related to the infection of hemophiliacs with HIV in 1986 and 1987.⁶ During that trial, Madam Justice Benotto concluded that the accused had acted professionally and reasonably in the face of a public health problem.

In withdrawing the charges, Crown attorney Pearson told the court that it would be "irresponsible," no matter how strong the public interest in continuing with the prosecution, to ignore Madam Justice Benotto's findings in the earlier trial, which included the finding that Perrault acted "carefully and responsibly" in his role as head of blood transfusion services at the Canadian Red Cross.

Perrault's lawyer, Eddie Greenspan, indicated Perrault would consider his

next steps, including a possible lawsuit against the government.

¹ *Cascante v. Canada (Minister of Citizenship and Immigration)*, [2008] F.C.J. No. 208 (QL).

² *De La Rosa v. Canada (Minister of Citizenship and Immigration)*, [2008] F.C.J. No. 98 (QL).

³ *Jennifer Murphy v. Sun Media (Toronto) Corporation, David Swail and Tracy McLaughlin*, (16 January 2008), Toronto Small Claims TO 32468/06.

⁴ J. Huber, "Crown cancels blood charges," *Winnipeg Free*

Press, 19 January 2008.

⁵ G. Bonnell, "Charges dropped against former director of Canadian Red Cross," *Winnipeg Free Press*, 18 January 2008.

⁶ *R. v. Armour Pharmaceutical Co.*, [2007] O.J. No. 3733 (QL).

HIV/AIDS IN THE COURTS - INTERNATIONAL

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

European Court of Human Rights rejects prisoner's plea for prison needle exchange

On 4 January 2008, the European Court of Human Rights declared inadmissible an application from prisoner John Shelley alleging a violation of his rights under the *Convention for the Protection of Human Rights and Fundamental Freedoms* (European Convention).¹

Shelley, a U.K. national, was serving a sentence of imprisonment in H.M.P. Long Lartin (near Evesham) when in 2004 he commenced judicial review proceedings against the British Home

Secretary, arguing that the failure to introduce a trial of prison needle exchanges (PNEPs) into English and Welsh prisons violated Articles 2 (right to life), 3 (prohibition of

torture) and 8 (right to respect for private and family life) of the European Convention.

Shelley claimed that prisoners who use drugs are at risk of contracting

blood-borne viruses such as HIV and hepatitis if they do not have access to sterile needles for injection. He also claimed that disinfecting tablets, which the U.K. government had proposed to make available throughout prisons, were not as effective as sterile injection equipment.

The Royal Courts of Justice (Administrative Court Division) dismissed the application for judicial review on the basis that the steps taken by the Secretary of State to protect the health of prisoners were not unreasonable, given that the provision of syringes would remove one of the disincentives to prisoners injecting themselves and that the effect of a decision to introduce a policy of distributing disinfecting tablets had yet to be assessed.²

In a renewed application to the Court of Appeal, Shelley again claimed that the U.K. government's failure to provide PNEPs violated Articles 2, 3 and 8 of the European Convention.³ In November 2005, the Court of Appeal dismissed the renewed application for judicial review and upheld the decision of the lower court.⁴

In 2006, Shelley lodged a complaint with the European Court of Human Rights. Relying on the same legal provisions, Shelley alleged that U.K. authorities had failed to take steps to prevent the spread of blood-borne viruses in prison and the known and immediate risk to his life, his health and well-being through their refusal to introduce PNEPs.

In this connection, he also invoked Article 14 (prohibition of discrimination) of the European Convention, complaining that, as a group, prisoners were treated less favourably than people in the community. The Canadian HIV/AIDS Legal Network

and the Irish Penal Reform Trust were jointly granted leave to intervene in the proceeding,⁵ and the National AIDS Trust (U.K.) was also granted leave to intervene separately.⁶

In its decision, ruling the case inadmissible, the Court acknowledged that drug use was common in prison, that HIV and hepatitis C (HCV) infection rates were substantially higher among the prison population than the general population, and that cleaning syringes with disinfectant such as bleach did not sufficiently reduce the risk of infection.⁷ The Court further acknowledged that the Prison Service has a responsibility to ensure that prisoners have access to health services broadly equivalent to those in the community, that needle exchange programs have been recognized as the most effective harm reduction method in the community, and that the Department of Health did not consider that disinfectant tablets were an adequate response to risks of HIV and HCV transmission for the general public.

The Court noted the evidence provided by the Canadian HIV/AIDS Legal Network and the Irish Penal Reform Trust, which showed that in the prisons where needle exchange programs operated, they reduced needle-sharing, reduced drug overdoses, led to a decrease in abscesses and injection-related infections and facilitated referrals of users to treatment programs. Moreover, the Court agreed that PNEPs have not been demonstrated to result in an increase in drug consumption, drug injection or in any incidents of intentional use of needles as weapons or accidental needle-stick injuries.⁸

Nevertheless, the Court noted that Shelley had not specified that, due to his own personal circumstances, he

was at any real or immediate risk of becoming infected through unclean or shared needles, nor had he claimed to use drugs himself. In the Court's view, the "general unspecified risk, or fear, of infection as a prisoner"⁹ was not sufficiently severe as to raise issues under either Articles 2 or 3.

The decision of the Court is arguably amiss, for a number of reasons.

With respect to Shelley's Article 8 complaint, the Court held that Shelley could not point to any authority that placed any obligation under Article 8 on a Contracting State (a state that has ratified the European Convention) to pursue any particular preventive health policy. As the Court observed, while "it is not excluded that a positive obligation might arise to eradicate or prevent the spread of a particular disease or infection," matters of health care policy were in principle within the margin of appreciation of the domestic authorities who were best placed to assess priorities, use of resources and social needs.¹⁰

The Court said that Shelley had not suffered any directly negative effect on his private life, nor was he being denied any information or assistance concerning a threat to his health for which the authorities were directly or indirectly responsible.

According to the Court, giving "due leeway to decisions about resources and priorities and to a

legitimate policy to try to reduce drug use in prisons, and taking account of the fact that some preventive steps had been taken (disinfecting tablets) and that the authorities were monitoring developments in needle exchange programmes elsewhere,” the U.K. government had not failed to respect Shelley’s private life, and so that part of the application was declared inadmissible.

The arguments invoking Article 14 were similarly dismissed. In its assessment, the Court provided that

the risk of infection primarily flows from conduct by the prisoners themselves which they know, or should know, is dangerous to their own health, a situation that can be contrasted with damage to health flowing from conditions for which the authorities themselves are directly responsible.¹¹

While the Court noted that prisoners do not forfeit the protection of their fundamental rights and freedoms guaranteed under the European Convention, and was prepared to assume that prisoners could claim to be on the same footing as the community as regards to the provision of health care, it held that the difference in treatment with respect to needle exchange programs fell within the State’s margin of appreciation and could be regarded as being proportionate and supported by objective and reasonable justification.

Commentary

The decision of the Court is arguably amiss, for a number of reasons. The Court chose to ignore the Article 2 (right to life) and 3 (prohibition of torture) arguments, yet gave an unconvincing rationale as to why these rights were not engaged. In its view, the fact that Shelley had not specified

whether he personally used drugs led it to conclude that his risk of infection was not “sufficiently severe” to raise issues under Articles 2 and 3. However, irrespective of whether Shelley injects drugs in prison, he is still directly at risk from the use of infected needles, given the numerous possibilities for disease transmission, including needle-stick injuries, associated with a closed prison environment.

Further, the Court’s deference to U.K. prison authorities in terms of health care policy was misplaced, given that the Court conceded the principle of equivalence with regards to the provision of health care; and given that the U.K. Health Department had, as the Court noted, determined that disinfecting tablets were not an “adequate response to risks of HIV and HCV transmission for the general public.”¹²

Rather than refer to the evidence demonstrating that PNEPs had not led to an increase in drug consumption or drug injection, the Court deferred to the U.K. prison authorities’ untested assertion that “the best policy is to encourage” prisoners to give up drugs on entering prison, “rather than to put the emphasis on ensuring access for such prisoners to clean needles.”¹³

Moreover, the Court’s deference to the U.K. government’s claim that it was “monitoring developments in needle exchange programmes elsewhere”¹⁴ (which then provided a basis to rule the case inadmissible) was unreasonable in light of the U.K.’s preceding claim that it was not aware of any Contracting State that had introduced needle exchange programs throughout their prison system.¹⁵

This had been refuted by the Canadian HIV/AIDS Legal Network and the Irish Penal Reform Trust,

which described the positive outcomes of needle exchange programmes operating in a significant number of the prisons of Spain, Luxembourg and Moldova, all Contracting States of the Council of Europe.¹⁶

Correspondingly, the Court overlooked evidence regarding the introduction of state-funded syringe exchange programs outside of prisons in countries across the Council of Europe, in a legislative context where drug possession or use remains illegal. As the Canadian HIV/AIDS Legal Network and the Irish Penal Reform Trust argued, the doctrine of margin of appreciation should not be used to justify inaction on PNEPs which contradicts the broad international consensus on prisoners’ equal right to health and the positive obligations of states under international human rights and health standards.¹⁷

– Sandra Ka Hon Chu

Sandra Ka Hon Chu (schu@aidslaw.ca) is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network, and editor of the HIV/AIDS in the Courts — Canada section of the *Review*.

¹ *Shelley v. the United Kingdom* (4 January 2008), Application No. 23800/06.

² *Ibid.*, p. 4.

³ *Ibid.*, p. 4.

⁴ *The Queen on the Application of John Shelley v. Secretary of State for the Home Department* [2005] EWCA Civ 1810.

⁵ Irish Penal Reform Trust and Canadian HIV/AIDS Legal Network, *Shelley v. the United Kingdom: Submissions of the Intervenor the Irish Penal Reform Trust and the Canadian HIV/AIDS Legal Network to the European Court of Human Rights*, 19 January 2007. Available via www.iprt.ie and www.aidslaw.ca/prisons.

⁶ National AIDS Trust, *Shelley v. the United Kingdom: Submissions of the Intervenor the National AIDS Trust to the European Court of Human Rights*, 5 February 2007. Available via www.nat.org.uk.

⁷ *Shelley v. the United Kingdom* (4 January 2008), Application No. 23800/06, p. 6.

⁸ For an overview of Canadian and international research on PNEPs, see R. Lines et al, *Prison Needle Exchange: Lessons from A Comprehensive Review of International Evidence and Experience*, Second edition, Canadian HIV/AIDS Legal Network, 2006. Available via www.aidslaw.ca/prisons.

⁹ *Ibid.* at 10.

¹⁰ *Ibid.* at 11.

¹¹ *Ibid.* at 14.

¹² *Ibid.* at 7.

¹³ *Ibid.* at 14.

¹⁴ *Ibid.* at 11.

¹⁵ *Ibid.*, p. 8.

¹⁶ Irish Penal Reform Trust and Canadian HIV/AIDS Legal Network, *Shelley v. the United Kingdom: Response of the Intervenor the Irish Penal Reform Trust and the Canadian HIV/AIDS Legal Network to the Observations of the United Kingdom on Admissibility and Merits*, 9 February 2007. Available via www.iprt.ie and www.aidslaw.ca/prisons.

¹⁷ See, e.g., Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, concerning the right to the highest attainable standard of health; World Health Organization (WHO), *Guidelines on HIV Infection and AIDS in Prisons*, 1993; UNAIDS and the Office of the U.N. High Commissioner on Human Rights, *International Guidelines on HIV/AIDS and Human Rights*, 2006 (consolidated version); and U.N. Office on Drugs and Crime, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response*, 2006.

South African High Court defends the right to water

The High Court of South Africa (Witwatersrand Local Division) ruled in April 2008 that the City of Johannesburg's system for providing water in Phiri, Soweto is unconstitutional and unlawful.¹

The application was brought by five residents of the Township of Phiri, supported by the Centre for Applied Legal Studies (CALS). The Centre on Housing Rights and Evictions (COHRE) submitted an amicus brief.

In 2001, the City of Johannesburg and Johannesburg Water (Pty) Ltd. agreed to provide every household (or account holder) in Johannesburg with six free kilolitres of water per month (25 litres per person per day). For residents of Phiri, the water would be dispensed by a prepayment meter system. Once the six free kilolitres were dispensed, the water supply would be automatically shut off.

The account holder would need to purchase water credits to have

any additional water until the next month's six free kilolitres became available.² For the applicants, this meant that they went without water for the last 15 days of each month.

The Court found that the prepayment meter system infringes national standards, including the requirement that no consumer be without water for more than seven days per year, and violates procedural fairness. In particular, the Court highlighted the manner in which the prepaid meters were introduced, characterizing the process as "a vain attempt on the part of Johannesburg Water to make the process appear reasonable and fair."³

The Court further ruled that the prepayment meter system is dis-

criminatory. Other residents of Johannesburg are given notice if they fall into arrears and have the opportunity to make arrangements to settle their arrears. Residents of Phiri, a poor and predominantly Black area, are not given the same opportunity. The Court found this distinction to be unreasonable, unfair, inequitable, and also discriminatory (i.e., based solely on colour).⁴

The Court also noted that many domestic chores are performed by women and many households in poor areas are headed by women. Taking into consideration that one of the applicants had to travel three kilometres to access water on behalf of her household, the Court held that pre-

payment meters discriminate unfairly against women on the basis of their sex.⁵

The Court accepted that a minimum standard for free basic water is understandable, given South Africa's resource challenges but that, depending on resources available and the needs of the residents, the city may need to provide more than the minimum.⁶

In the case of Phiri, the Court found that the applicants did indeed need more than the minimum and that the city had the resources available to provide more. The Court therefore ordered the city to provide the applicants and other similarly placed residents of Phiri Township with free basic water supply of 50 litres per person per day and the option of a metered supply installed at the cost of the city.⁷

In its analysis, the Court considered the social and economic situation of residents of poor townships. For example, it noted that the average household in Phiri consists of 16 persons, that there are more informal settlers in yards than members of households, and that there are over 100 000 indigent households in Phiri.⁸ The Court characterized the residents of Phiri as mainly poor, uneducated, elderly, sickly and ravaged by HIV/AIDS,⁹ and considered what this meant in terms of their water needs and their ability to engage in the city's process.

Justice Tsoka quoted extensively from expert evidence adduced with respect to the water needs of persons

living with HIV/AIDS (PLWHAs). PLWHAs require more water on a daily basis than non-HIV infected individuals. Additional water is required to meet enhanced hygiene requirements, to prevent dehydration in those susceptible to frequent bouts of diarrhoea, to prepare formula for bottle-feeding infants born to HIV-positive mothers, and to meet nutritional needs (by growing vegetables in kitchen gardens). As well, water is needed for frequent laundering of soiled clothing and bedding for patients in advanced stages of AIDS.¹⁰ In the words of the judge:

To expect the applicants to restrict their water usage to compromise their health by limiting the number of toilet flushes in order to save water, is to deny them the right to health and to lead a dignified lifestyle. It is common cause that the people suffering from HIV/AIDS need more water than those not afflicted by the illness. Such persons require water regularly to wash themselves, drink, wash their clothes, and cook. Their caregivers are also constantly expected to wash their hands. In this context water-borne sanitation is a matter of life and death.¹¹

Commentary

Drawing extensively on international and comparative law, as well as a contextual analysis of the lived realities of the poor and people infected with HIV, the Court has held the City of Johannesburg accountable for the progressive realization of the right to water. This decision is an excellent

example of the justiciability of economic and social rights, and sends a clear message to government bodies in South Africa and more broadly that they have real and unequivocal duties with respect to the right to water.

– Alison Symington

Alison Symington (asymington@aidslaw.ca) is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network, and editor of the Canadian Developments section of the *Review*. The decision, a summary of the case, and COHRE's amicus curiae brief are available at www.cohre.org/watersa. The submissions of the applicants and respondents are available at www.law.wits.ac.za/cals/phiri/index.htm.

¹ *Lindiwe Mazibuko & Ors v. The City of Johannesburg & Ors*, Case No. 06/13865.

² *Ibid.*, para. 3.

³ *Ibid.* at para. 111.

⁴ *Ibid.*, para. 94.

⁵ *Ibid.*, para. 159.

⁶ *Ibid.*, para. 126.

⁷ *Ibid.*, para. 183.5.

⁸ *Ibid.*, paras. 166, 168.

⁹ *Ibid.*, para. 169.

¹⁰ *Ibid.*, para. 172–3.

¹¹ *Ibid.* at para. 179.

Court says French government's refusal to authorize adoption violates woman's human rights

On 22 January 2008, the European Court of Human Rights held that there had been a violation of the *Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention)* in the case of *E.B. v. France*, concerning a refusal by the French authorities to grant E.B.'s request to adopt a child, allegedly on account of her sexual orientation.¹

E.B., a French national, had been living with another woman since 1990. In 1998, E.B. applied to the Social Services Department for authorization to adopt a child. During the adoption procedure, she mentioned her sexual orientation and her stable relationship with another woman. On the basis of the reports drawn up by a social worker and a psychologist, the adoption board recommended that the application be rejected. The reasons given were the absence of a paternal reference, and the ambiguous nature of E.B.'s partner's commitment to the adoption plan.

A series of appeals were lodged, which ultimately led to E.B.'s application to the European Court of Human Rights in December 2002. In her application, E.B. alleged that she had suffered discriminatory treatment based on her sexual orientation, and that the state had failed to respect her private life. E.B. invoked Article 14 (protection from discrimination) and Article 8 (the right to respect for private and family life) of the European Convention.

In its decision, the Court said that while French law and Article 8 of the European Convention do not guarantee either the right to found

a family or the right to adopt, the concept of "private life" within the meaning of Article 8 is a broad one which encompasses a certain number of rights.

With regard to E.B.'s allegation of discrimination based on her sexual orientation, the Court held that it was sufficient for the facts of the case to fall "within the ambit" of Article 14, as E.B.'s case did, since French legislation expressly granted single persons the right to apply for authorization to adopt and established a procedure to that end. Consequently, the Court said, the State could not take discriminatory measures when it came to applying that right.

The Court said that while it was legitimate for the authorities to ensure that all safeguards were in place before a child was taken into a family, it questioned the merits of one of the grounds for rejecting the application — i.e., that there was a lack of a paternal referent in the household — because the application had been made by a single person and not a couple.

The Court said that this ground served as a pretext for rejecting E.B.'s application on grounds of her sexual orientation, a finding that was

reinforced by the fact that E.B.'s sexual orientation had featured significantly in the reasoning of the domestic authorities. The Court concluded that the decision refusing E.B. authorization was a violation of Article 14 of the European Convention, taken in conjunction with Article 8, and the Court awarded E.B. 10,000 euros (about CAN\$15,800) in respect of non-pecuniary damage and 14,528 euros (about CAN\$22,954) for costs and expenses.

– Sandra Ka Hon Chu

¹ *E.B. v. France* (22 January 2008), Application No. 43546/02.

In brief

ECHR: Ukraine held responsible for inhuman and degrading treatment of HIV-positive prisoner

The applicant, Oleg Yakovenko, was a Ukrainian national. The applicant died while proceedings before the European Court of Human Rights were ongoing and his case was continued at the wish of his mother.¹

In June 2003, Yakovenko was arrested on suspicion of burglary and placed in police custody. He was convicted and sentenced to three years and six months' imprisonment. He was detained for most of the period of imprisonment at a pre-trial detention facility in Simferopol.

Between June 2003 and April 2006, Yakovenko spent about a year in total in the Sevastopol Temporary Detention Centre, a facility that was constantly overcrowded, unclean, and poorly lit and ventilated. He suffered from tuberculosis. No staff at the Centre were medically trained.

Yakovenko was transported on a regular basis between two detention facilities in prison vans and trains that were severely overcrowded, dimly lit and poorly ventilated, for a journey that took some 36 to 48 hours. Prisoners were not provided with food or drink.

In February 2006, Yakovenko was diagnosed HIV-positive although he claimed he was not informed of the diagnosis until three months later. His health deteriorated. Despite repeated medical opinions that he required hospitalization, prison

authorities agreed to hospitalize him only after Yakovenko's mother lodged a complaint with the prosecutor general.

The Court found violations of Article 3 (prohibition of inhuman or degrading treatment) and Article 13 (right to an effective remedy) of the *European Convention of Human Rights*. It held that the conditions in the Sevastopol Temporary Detention Centre amounted to degrading treatment, as did the means of his transportation between detention facilities.

The Court also accepted that the prison administration's failure to provide the applicant with appropriate medical treatment for his HIV and tuberculosis infections in a timely fashion amounted to inhuman and degrading treatment.

Finally, the Court found that the applicant was not provided with an effective and accessible means to complain about his conditions of detention. The Government of Ukraine was ordered to pay 434 euros (about CAN\$686) in respect of pecuniary damages and 10,000 euros (about CAN\$15,800) in respect of non-pecuniary damages.

– Richard Pearshouse

Richard Pearshouse (rpearshouse@aidslaw.ca) is the Director of Research and Policy for the Canadian HIV/AIDS Legal Network, and editor of the International Developments section of the *Review*.

Sweden: Man found guilty of infecting two women with HIV

Christer Merrill Aggett, a British citizen, was sentenced to 14 years in jail

by a Swedish court in February 2008, after having unprotected sex with 16 girls, two of whom contracted the virus.

Aggett was found guilty by Solna District Court in November 2007 of two charges of serious assault, 13 charges of attempted assault, six charges of sexual exploitation of a minor, one minor narcotics offence and two charges of driving without a licence.² He was also ordered to pay damages of 2.7 million kronor (about \$425,000) to the 16 complainants, including 850,000 kronor (about \$133,000) to each of the girls who were infected with HIV.³

Allegedly, Aggett contacted girls through internet chat sites. Some of the complainants were under 15 years of age — the legal age of consent in Sweden — when they had sex with Aggett.⁴ He was convicted of serious assault for the encounters with girls who became infected with HIV, and attempted assault for having unprotected sex with girls who did not become infected.⁵

Sentencing was delayed until Aggett underwent a court-ordered psychiatric analysis. Had he been found to suffer from a psychiatric disorder, Aggett could have been sentenced to psychiatric care rather than prison.⁶

– Alison Symington

Nepal: Supreme Court makes landmark decisions on LGBTI rights and the right to confidentiality

On 21 December 2007, the Supreme Court of Nepal issued directive orders to the Government of Nepal to end discrimination against lesbian,

gay, bisexual, transgender and intersex (LGBTI) people and to ensure their equal rights within Nepal.⁷

In April 2007, four LGBTI organizations had filed a writ petition demanding protection of the legal rights of LGBTI people, by recognizing the civil rights of transgender people without requiring them to renounce one gender identity for another, creating a new law to prevent discrimination and violence against LGBTI communities, and requiring the state to make reparations to LGBTI victims of state violence or discrimination.

The writ was heard by the Supreme Court of Nepal in November 2007. In its directive, the Court ordered the Nepalese government to ensure LGBTI people's right to life according to their own identities, introduce laws providing equal rights to LGBTI people, and amend all discriminatory laws against LGBTI people.

On the issue of same-sex marriage, the Supreme Court of Nepal also issued a directive order to the Nepalese government to form a committee comprised of a representative appointed by the Nepalese government, an advocate from the LGBTI community and representatives from the police, National Human Rights Commission, Health Ministry, Law Ministry and Ministry of Population and Environment to conduct a study on other countries' practice regarding same-sex marriage. The Nepalese government is expected to legislate in this area, based on the committee's recommendations.

Significantly, in December 2007, the Supreme Court of Nepal also ruled that persons, including those from the media, who reveal the identity of HIV-infected individuals,

women and children involved in the judicial process will be subject to one-year imprisonment for contempt of court.⁸ The ruling was issued by the Court while handing down a set of guidelines for courts, government agencies and the media, outlining how the judicial process in sensitive cases involving persons living with HIV/AIDS, women and children should be dealt with to maintain confidentiality.

In addition to the possibility of one-year's imprisonment, violators would also have to pay a 10,000 rupees (about CAN\$160) fine. The guidelines are to be in effect from 24 January 2008 until the Nepalese government enacts the necessary legislation ensuring the confidentiality of individuals involved in such sensitive cases.

– Sandra Ka Hon Chu

U.S.: Texan man acquitted in medical marijuana case

On 25 March 2008, Tim Stevens, a man who uses marijuana to treat the symptoms of HIV, won an acquittal on marijuana possession charges based on a “necessity defence.”⁹ Stevens, who was diagnosed with HIV in 1986, was arrested in October 2007 while smoking marijuana in front of his residence.

Jurors deliberated for less than 15 minutes before acquitting Stevens, who was required to establish that an otherwise illegal act was necessary to avoid imminent harm more serious than the harm caused by breaking the law. His attorney argued that Stevens' cannabis use was necessary

to treat nausea and vomiting associated with HIV, a condition so severe that it has required hospitalization in the past.

Texas is not one of the twelve states in the U.S. that have legalized the medical use of marijuana.

– Sandra Ka Hon Chu

Egypt: Court convicts men for “debauchery”

In April 2008, an Egyptian court sentenced five men to three years in prison following their conviction on charges of “the habitual practice of debauchery,” an offence under Egyptian law purportedly used to prosecute men who have sex with men. Four of the men are alleged to be living with HIV.¹⁰

According to human rights groups, these arrests are part of a widening crackdown on men suspected of being HIV-positive that started in October 2007. Since then, police have arrested and charged 12 men, four of whom were sentenced to one year in prison prior to the latest sentencing.¹¹ All of the men arrested have allegedly been forced to undergo HIV testing without their consent.

In addition, human rights organizations have reported that some of the men were handcuffed to hospital beds or desks at the police office, and some were forced to undergo forensic anal examinations.¹²

An attorney for the Egyptian Initiative for Personal Rights has appealed the ruling to Egypt's Court of Cassation, the country's highest appellate court.¹³

– Alison Symington

Indian court rules HIV is a ground for divorce

Reports from November 2007 indicate that the Delhi district court granted a man permission to divorce his HIV-positive wife. The couple was married in October 2000. She was found to be HIV-positive during a prenatal screening test several months after the marriage.¹⁴

Reportedly, the judge stated that “marriage without sex is anathema” and that “[t]he disease being sexually communicable, the petitioner cannot be reasonably expected to live with her and lead a happy married life.”¹⁵

The court also found the petitioner’s wife guilty of not disclosing her HIV-positive status prior to

the marriage. In 1998, the Supreme Court held that people who are HIV-positive must so inform their future spouses.¹⁶

– Alison Symington

¹ *Yakovenko v. Ukraine*, Application no. 15825/06, Judgment, 25 October 2007. The case is available via www.echr.coe.int/ECHR/EN/Header/Case-Law/HUDOC/HUDOC+database/.

² “HIV Brit gets 14 years,” *The Local*, 1 February 2008.

³ *Ibid.*

⁴ “British man found guilty of infecting women with HIV in Sweden,” *International Herald Tribune*, 15 November 2007.

⁵ “HIV Brit found guilty of infecting girls,” *The Local*, 15 November 2007.

⁶ *Ibid.*

⁷ S. Pant, “Great victory of Nepalese LGBTI!” *International Gay and Lesbian Human Rights Commission* 21 (December 2007). Available via www.iglhrc.org.

⁸ “Courts to punish disclosure of HIV affected,” *The Kathmandu Post*, 27 December 2008. Available via www.fwld.org.

⁹ M. Hess, “Acquittal of a medical cannabis user in Texas,” Associated Press, 27 March 2008.

¹⁰ C. Johnston, “Egypt court jails five men for debauchery,” Reuters, 9 April 2008.

¹¹ Human Rights Watch, “Egypt: New indictments in HIV crackdown: persecuting people living with HIV/AIDS feeds the epidemic,” news release, New York City, 11 March 2008.

¹² *Ibid.*

¹³ “Egyptian court convicts suspected HIV-positive men on charges of ‘debauchery,’” Kaiser Daily HIV/AIDS Report, 11 April 2008.

¹⁴ “HIV ground for divorce: Court,” *The Times of India*, 2 November 2007.

¹⁵ B. Sinha, “Court allows ‘HIV’ divorce,” *Hindustan Times*, 2 November 2007.

¹⁶ “Indian court lets man divorce HIV positive wife,” Agence France Presse English, 2 November 2007.