

CANADIAN

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Medical Prescription of Heroin – A Review

There are many problems associated with injection drug use, problems that affect both the users themselves as well as those close to them and the society in which they live.

Whether through complications associated with drug use (multiple infections, mental health problems, etc) or through the consequences on those close to them and on society (family dysfunction, crime, etc), the costs of illegal drug use are considerably greater than the costs of treating drug users.

One of the most effective treatments for opiate dependence is methadone maintenance treatment. Despite its effectiveness, in the best-case scenario this form of treatment reaches only 50 percent of the target population. In order to reach the most marginalized drug users who do not respond to traditional forms of treatment, many countries have prescribed heroin in the context of more comprehensive treatment that includes psychosocial services. Will Canada follow soon?

The first country to have prescribed heroin was Switzerland, where from 1994 until the end of 1996 a cohort of heroin-dependent people were treated. The results showed that there were benefits in many areas, including decreased use of heroin and cocaine, a decrease in crime, and an improvement in the indicators of physical and mental health. However, a number of scientists expressed reservations as to the validity of the results, given the research protocol used.

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The HIV/AIDS Pandemic and its Gender Implications

From 13-18 November 2000, the United Nations Division for the Advancement of Women, the World Health Organization, and UNAIDS convened an international meeting of experts in Windhoek, Namibia, to discuss the linkages between HIV/AIDS, gender, human rights, and human security.

On Monday, 13 November 2000, Windhoek radio reported that another person in Namibia had come out publicly as HIV-positive. A young woman who had just completed an AIDS counselor training course at Walvis Bay made the announcement to her peers and elders at the closing ceremony of the training course. In Namibia about one in five adults are HIV-positive, but stigma and shame have prevented all but a handful of people speaking out. It was a fitting context for a discussion of gender and HIV/AIDS.

The Expert Group Meeting was held in Windhoek at the invitation of the Namibian government. The meeting focused on the twin themes of human rights and human security from a gender perspective. For many years we have asked “where are the

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Comments?

We would like to hear your views and opinions regarding the Review, its content and format. We also encourage comments on or responses to individual articles, and letters to the editor.

CANADIAN HIV/AIDS POLICY & LAW REVIEW

The *Review* is a summary of developments in HIV/AIDS policy and law in Canada and abroad. Its aim is to educate people about and inform them of policy and legal developments and to promote the exchange of information, ideas, and experiences. It is published quarterly by the Canadian HIV/AIDS Legal Network.

Contributions are welcome and encouraged. Please contact Éric Nolet, Publications & Project Coordinator, at the following address to discuss your article and to obtain a copy of our style guide:

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Canadian HIV/AIDS Legal Network

The Network is a charitable organization engaged in education, legal and ethical analysis, and policy development. We promote responses to HIV/AIDS that

- implement the international Guidelines on HIV/AIDS and Human Rights;
- respect the rights of people with HIV/AIDS and of those affected by the disease;
- facilitate HIV prevention efforts;
- facilitate care, treatment, and support to people with HIV/AIDS;
- minimize the adverse impact of HIV/AIDS on individuals and communities; and
- address the social and economic factors that increase the vulnerability to HIV/AIDS and to human rights abuses.

We produce, and facilitate access to, accurate and up-to-date information and analysis on legal, ethical, and policy issues related to HIV/AIDS, in Canada and internationally. We consult, and give voice to, Network members and a wide range of participants, in particular communities of people with HIV/AIDS and those affected by HIV/AIDS, in identifying, analyzing, and addressing legal, ethical, and policy issues related to HIV/AIDS. We link people working on or concerned by these issues. We recognize the global implications of the epidemic and incorporate that perspective in our work.

The Network is based in Montréal. We welcome new members. For membership information, contact Anne Renaud at arenaud@aidslaw.ca.

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EDITORIAL

From February to June 2001, I participated as an observer representing Canadian non-governmental organizations on Canada's delegation to the United Nations General Assembly Special Session on HIV/AIDS. The aim of the special session was "to secure a global commitment to enhancing coordination and the intensification of national, regional and international efforts to combat the epidemic in a comprehensive manner." It resulted in the adoption of a Declaration of Commitment. While far from perfect, the Declaration represents a step in the right direction. But beyond the words, more and stepped-up action is needed to deal with the HIV/AIDS pandemic.

In Canada, the Canadian HIV/AIDS Network called for immediate action in 1999 to prevent the further spread of HIV among people who use injection drugs, and to provide better care, treatment, and support for those who are already infected

(see, Injection Drug Use and HIV/AIDS: Another Call for Action. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(4): 1, 13-19). Over 20 months later, as reported in this issue at page 86, Health Canada responded to our call not with action, but with more words. This is just one example of what has become a pattern of responding with indifference to the rising number of new HIV infections in Canada, and to the increasing number of people with HIV/AIDS. We cannot count on our governments to increase funding for HIV/AIDS nationally, although funding levels have remained at the same, woefully inadequate levels for nearly ten years. We cannot count on them to champion greater access to HIV/AIDS treatments internationally, and we cannot count on them to respond with innovative programs that have worked in other countries to reduce the spread of HIV among some of the populations hardest hit by HIV/AIDS – prisoners, injection

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drug users, Aboriginal people, young gay men, women, etc. Leadership is missing at a time when it is sorely needed to make the future different.

This is even more obvious at the international level. Canada's contribution to the global fight against HIV/AIDS remains far below what Canada should and could afford to do.

Kevin Osborne, a native South African and the HIV/AIDS Advocacy and Policy specialist at the Futures Group International in Washington, DC, recently challenged us to move beyond the rhetoric in the war on HIV/AIDS. In an article in *Global AIDSLink* (October/November 2001; 70: 11), he compared the response to the recent terror attacks in New York and Washington with the world's response to HIV/AIDS. This is what he had to say:

“Over the past two decades international and national leaders have declared war on HIV/AIDS. Everyone from Kofi Annan to Nelson Mandela, from AIDS activists to health care workers, have at some time reverted to a war analogy when talking about this epidemic. Cliched expressions ensuring that all ‘energies and resources will be mustered’ to win this ‘new struggle’ flow with relative ease. But this rhetoric of resolve is far too frequently not matched by sustained and dedicated action. By comparison the US response to date to the threats of terror aimed at the World Trade Center and the Pentagon has highlighted what it in fact means to declare war. ... In the first eighteen days since the attack more than half a billion dollars was raised in support of the victims; \$15 billion has been made available to support the airline industry; the United Nations supported a call for global action on terrorism; ... and every single American silently wondered what he or she could do to make a difference.

“But ... the war on AIDS is not being addressed with a similar resolve. While there

are fundamental differences between a war on terrorism and a war on AIDS, it is the striking similarities that head our attention. Both are unconventional in nature and will require perseverance, tenacity and commitment from all spheres. ... But ... in more than 20 years of

HIV/AIDS, after countless deaths, immeasurable suffering, a wave of AIDS orphans on the horizon and innumerable calls for a war on the epidemic, our global response lags far behind that of the global response for a war on terrorism. And the possible reasons for this are damning.

“While international HIV/AIDS resources have increased over the past few years, so too has the depth and the magnitude of the problem. Increasingly the ... inability to address the complexity of HIV/AIDS care needs in countries dwarfed by this epidemic has implications for stereotypical prevention and stigma reduction initiatives. For all too often international resources are intimately linked to the agendas of the specific donor rather than succinctly addressing the needs of the actual recipients. Yet on the HIV/AIDS battlefields in Botswana, Mexico and Cambodia everyday heroes are being cultivated but the global clarion call needs to be rung with greater passion and purpose. And this again begs the age-old question: Are the lives of those who live in developed countries of intrinsically more value than those who, simply by the fact of their birth, live in resource poorer countries?

“For in the shadow of the global war on terrorism is a ... silent war that claims more lives. And a war that is causing untold havoc to economies and development. Yet it seems that the idea of a global war on HIV/AIDS exists only in neatly carved words and politically expedient statements.

“I wish I was wrong.”

Are the lives of those who live in developed countries of intrinsically more value than those who, simply by the fact of their birth, live in resource poorer countries?

HIV/AIDS IN CANADIAN COURTS

This section presents a summary of miscellaneous Canadian court cases relating to HIV/AIDS or that may be of significance to people with HIV/AIDS. It features cases reported since the last issue, between December 2000 and July 2001. A search of Canadian electronic legal databases and some media sources yielded several cases in which reference was made to HIV/AIDS. However, only those cases dealing with HIV/AIDS or related litigation in any substantive way are reported here. (Readers aware of any unreported cases that would be of interest to the Network and to readers are asked to draw these to our attention.) The cases reported below deal with litigation against the government and the Red Cross for HIV infection through tainted blood or blood products, with medical marijuana, an HIV defamation suit, and various other areas. Criminal cases (both in Canada and other jurisdictions) and a case related to assisted suicide are summarized elsewhere in this issue.

Supreme Court Finds Red Cross Negligent in Screening Blood Donors

On 19 April 2001, the Supreme Court of Canada released its first judgments in litigation alleging the Canadian Red Cross Society was negligent for inadequately screening blood donors in the early 1980s. It upheld an order that damages in the amount of over \$2.5 million be paid to three individuals who contracted HIV between 1983 and 1985 from contaminated blood.¹

Background

In 1982, reports of AIDS-related pneumonia in hemophiliacs and an infant with possible transfusion-associated AIDS raised concerns that AIDS might be a bloodborne infection. The American Red Cross, the American Association of Blood Bankers, and the Council of Community Blood Banks released a Joint Statement on AIDS Related to Transfusion in January of 1983, recommending increased screening measures for AIDS symptoms in potential

blood donors. In March of 1983, a pamphlet containing references to groups at higher risk for AIDS as well as disease signs and symptoms was produced by the American Red Cross (ARC) for use at its donor clinics.

During this period, blood transfusion services in Canada were provided by the Canadian Red Cross Society (CRCS), a federally and provincially funded agency. The CRCS became aware of the above-

mentioned Joint Statement shortly after its release, and in March of 1983 issued a press release advising “members of groups identified as high risk of carrying Acquired Immunodeficiency Syndrome (AIDS) not to give blood.” In April of the same year, a decision was made not to ask potential donors symptom-specific questions, but rather to add to the existing donor questionnaire a “good health” requirement. It was not until May 1984 that the first reference to groups at higher risk for AIDS was made in CRCS donor information, and this document failed to contain a list of disease signs or symptoms. While the text advised sexually active homosexual and bisexual males to refrain from donation, past homosexual activity was not listed as a contraindication to donating blood until November of 1985. Not until May 1986 did the CRCS modify its questionnaire to question potential donors about the signs and symptoms of AIDS.

Facts of Cases before the Court

Between 1983 and 1985, the three plaintiffs (Alma Walker, Ronald Osborne, and AMM) received contaminated blood products at Ontario hospitals. All contracted HIV. Walker and Osborne later died as a result of developing AIDS.

In the Walker case, the plaintiff received a transfusion of HIV-tainted blood in October 1983. Before his death, the gay man who donated the blood she received indicated that at the time of donation he had not known of the emerging connection between the gay community and AIDS. The May 1984 CRCS pamphlet did not exist at the time of his 1983 donation, though it was in use by the time of his later donations. The donor testified he had never been presented with the document.

In the Osborne case, the plaintiff was given HIV-contaminated plasma in December 1984. The donor testified that although he had engaged in sex with other men, he had not done so since 1982. He did not recall seeing the May 1984 pamphlet, but indicated he would not have included himself in the category of “homosexual males who *have* multiple partners.” The donor believed himself in compliance with the “good health” requirement despite persistent lymph nodes in his neck, because these had been present since 1975 and did not appear to affect his overall health. The same donor donated blood in March 1985, from which AMM also received a transfusion.

Decisions in Lower Courts

All three actions (Walker, Osborne, AMM) were heard together.

In the AMM and Osborne cases, the trial judge found the Red Cross

had been negligent because it had not met the requisite standard of care.² The standard of care was established by comparing the responses of the ARC and the CRCS at that time. The March 1983 ARC pamphlet referred to the signs and symptoms of AIDS, as well as to groups at a higher risk for contracting the virus. The CRCS did not mention AIDS in donor literature until May of 1984, and failed to list AIDS-related signs and symptoms until 1986. The risk associated with past homosexual activity was not indicated until 1985. The trial judge also deemed the “good health” query to be based on an erroneous presumption, stating that “a donor could not know if he or she was in good health unless told what would constitute bad health in this context.” In this case, the donor’s swollen lymph nodes were listed as a possible symptom of AIDS in the pamphlet being used by the ARC, but not in the material used by the CRCS. Therefore, the trial judge found that the causal link had been established between the CRCS’s inadequate donor screening and the HIV contracted by both Osborne and AMM. The Ontario Court of Appeal upheld this decision.

However, Walker’s case was dismissed by the trial judge for “failure to show causation.”³ In the judge’s view, the donor would have donated blood regardless of whether or not the CRCS had provided the appropriate standard of care. The Ontario Court of Appeal overturned that decision, applying the principles from the earlier Supreme Court case of *Hollis v Dow Corning Corporation*.⁴ Given that the plaintiff has the burden of establishing causation, the Court held that, once Walker had shown the failure of the CRCS to properly screen

potential donors at the time of the donor’s tainted donation, the necessary causal link was “presumptively established,” and that the CRCS could therefore be found liable.

Supreme Court’s Decision

The Supreme Court upheld the decisions of the lower courts in the AMM and Osborne cases, agreeing that the CRCS had been negligent.

In the Walker case, however, the Supreme Court reversed the decision, ruling that the Court of Appeal had incorrectly used the *Hollis* case to establish causation on the basis of a presumptive causal link. In *Walker*, unlike *Hollis*, there was no “learned intermediary” through which duty of care was discharged. As it would be difficult or even impossible to determine what the donor might have done had proper screening measures been in place, the appropriate question as to the causal link between the CRCS’s actions and Walker’s HIV infection was whether the CRCS’s negligence had “materially contributed” to Walker’s infection with tainted blood. The Court found that it clearly did.

In addition to disagreeing with the Court of Appeal, the Supreme Court also disagreed with the trial judge on the question of causation. The question was not whether the donor would have refrained from giving blood in 1983 had he read a pamphlet such as the one that was eventually introduced in May 1984. Instead, the trial judge should have asked whether the donor would have refrained or been excluded from blood donation had the CRCS been using adequate screening measures comparable to those being used by the ARC at the same time, such as

the ARC's 1983 pamphlet. The causal link is thus established once the appropriate standard of care is applied.

The negligence verdict by the Supreme Court regarding the Canadian Red Cross Society tainted-blood scandal should act as an impetus for improved safety management and decreased bureaucratic blundering with respect to public health in general.

As a result, the Supreme Court found that the CRCS had been negligent in its donor screening in all three cases. It awarded total damages of over \$2.5 million dollars to the plaintiffs.

Commentary

During the late 1970s and early 1980s, approximately 2000 Canadians were infected with HIV through contaminated blood products. The Final Report of the Commission of Inquiry on the Blood System in Canada (the Krever Inquiry), released in 1997, refers to the tragedy as “a public health disaster that was unprecedented in Canada.”⁵ Many systemic problems were found to have played a part in the contamination of Canada's blood supply. When the Canadian Blood Committee was formed in 1981, it was assigned the responsibility of creating a national blood policy. The policy, however, was never created, and consequently no one was in charge of the safety of the Canadian blood supply. Further, because the Red Cross was provincially funded,

bureaucratic red tape prevented inter-provincial transfers of blood products during provincial blood shortages in the 1970s and 1980s. One result of this was the purchase of American plasma to counter chronic shortages in certain areas. The higher incidence of HIV in the United States, along with the American system of collecting plasma from prisoners, put those Canadians in need of plasma transfusions at a substantially increased risk for HIV contraction. Another result of the blood shortage was reluctance by the Red Cross to implement donor screening programs that may have further diminished the donor base.

Since the tainted-blood scandal, responsibility for blood operations has been turned over to the Canadian Blood Services (and, in Québec, its counterpart Hema-Québec). It was believed that unifying the nation's blood operations would remedy some of the bureaucratic problems encountered by the Red Cross. In 1999, however, the Canadian Hemophilia Society released a “report card” on the new blood system.⁶ Hema-Québec received grades of Bs and Cs, and Canadian Blood Services received mostly Ds, suggesting that the problems that brought about the tainted-blood tragedy may yet have to be fully sorted out.

The case also has important implications for Canadian public health at a more general level.⁷ Public health issues are largely invisible until crises present. This invisibility, combined with the current curative bias in medicine, make securing resources for public health a challenge. The tainted-blood tragedy, along with other recent public health disasters like the Walkerton, Ontario water-

related *E coli* outbreak, demonstrate the need for adequate funding and organizational restructuring to prevent calamities before they occur. The negligence verdict by the Supreme Court regarding the CRCS tainted-blood scandal should act as an impetus for improved safety management and decreased bureaucratic blundering with respect to public health in general, and blood operations specifically, in this country.

– Jennifer Gold

Jennifer Gold is a law student completing a summer internship at the Canadian HIV/AIDS Legal Network. She can be reached at jgold@aidslaw.ca.

¹ *Walker Estate c. York Finch General Hospital et al.* [2001] S.C.C. No 24 (QL) (jugement conjoint dans les affaires *Walker Estate c. York Finch General Hospital et al* et *Osborne c. Canadian Red Cross Society et al*).

² *Osborne c. Canadian Red Cross Society et al* (1997), 43 OR (3d) 461, 39 CCLT (2d) 1 (Cour de l'Ont., div. gén.), conf. par [1999] OJ No 644 (QL) (C.A.).

³ *Walker Estate c. York Finch General Hospital et al* (1997) 43 OR (3d) 461, 39 CCLT (2d) 1 (Cour de l'Ont., div. gén.), renv. par [1999] OJ No 644 (QL) (C.A.).

⁴ *Hollis c. Dow Corning Corp.*, [1995] 4 R.C.S. 634.

⁵ *Commission sur l'approvisionnement en sang au Canada. Rapport final.* Ottawa, ministère des Travaux publics et des Services gouvernementaux du Canada, 1997. Le Rapport final de la Commission Krever est disponible sur le site Web de Santé Canada, <www.hc-sc.gc.ca>.

⁶ CBC News Online, « Hemophilia Society Offers Little Praise for New Blood System », 6 octobre 1999 (consulté à <www.cbc.ca>, le 7 juin 2001).

⁷ Skirrow J., « Leçons de la Commission Krever – un point de vue personnel », *Bulletin canadien VIH/sida et droit*, 1999, 4(2/3) : 39-47.

Tainted-Blood Cases: Updates

Tainted-Blood Settlement Approved for pre-1986 and post-1990 Hepatitis C Infections

On 26 June 2001, an Ontario Superior Court judge approved a \$63 million partial settlement in a class action suit against the Canadian Red Cross Society (CRCS) on behalf of people who contracted hepatitis C through contaminated blood before 1986 and after 1 July 1990 (and those who became infected as a result of contact with a person infected through contaminated blood).¹ The necessary approval was also received from the Superior Court of Québec on 10 July 2001 (but reasons had not yet been released at the time of publication) and from the BC Supreme Court on 19 July 2001.² A class action on behalf of those infected between 1 January 1986 and 30 June 1990 had already been settled and received court approval in 1999.³

In Ontario, Justice Warren Winkler had rejected a previous settlement proposal in February 2001.⁴ However, in his view the revised offer was “fair, reasonable and in the best interests of the class [of plaintiffs] as a whole.”⁵ Victims stand to receive an initial sum of \$5000 which may increase to a 10-year total of \$7000 to \$8000. Under the plan, claimants who accept settlements will be proscribed from taking legal action against the CRCS or its associated bodies, as well as the other contributors to the settlement fund. However, the class action is proceeding against the federal government, who is not a party to the settlement.

The settlement is limited to people infected before 1986 and after 1 July 1990, who were excluded from the 1998 \$1.5 billion government compensation package approved by the courts in 1999. Canadian Hemophilia Society representative Mike McCarthy called for all levels of government to provide compensation for all victims of the blood tragedy, regardless of the date of infection. McCarthy indicated a \$3.8 billion lawsuit against the federal and provincial governments will go ahead if Health Minister Allan Rock refuses to reconsider the 1998 deal. Such a class action suit would be the largest in Canadian history.

No Charges Laid in Tainted Blood Scandal

After a four-year investigation, the RCMP decided not to lay charges against government officials who destroyed important documents relevant to the CRCS tainted-blood tragedy.⁶

It concluded that there was not enough evidence indicating “criminal intent” on the part of officials who ordered the destruction of all Canadian Blood Committee records from 1982 to 1989.⁷ The now-defunct Committee was a federal-provincial body that governed and funded the CRCS. The incident was uncovered during the Commission of Inquiry on the Blood System in Canada (the Krever Inquiry) in 1995.

Reacting to the revelation in a January 1997 report, then federal information commissioner John Grace said he was sceptical of the excuses of government

bureaucrats who described the destruction as an innocent “house-keeping” measure. He drew attention to the fact that the document-shredding coincided with concern over tainted-blood lawsuits. Grace’s report was passed on to the Solicitor-General, and the RCMP commenced a probe in February 1997. On 27

Canadian Hemophilia Society representative Mike McCarthy called for all levels of government to provide compensation for all victims of the blood tragedy, regardless of the date of infection.

February 2001, the RCMP indicated it would not lay charges. RCMP officers were unable to use the *Access to Information Act* to indict officials, as it did not contain sanctions against the improper destruction of records until 1999. The decision was met with anger and disappointment by those affected by the tainted-blood tragedy.

Winnipeg Negligence Suit Still Pending

In the spring of 1999, officials at St Boniface General Hospital in Winnipeg contacted nearly 2000 gastroenterology patients who had undergone either pH or motility testing at the hospital between 1992 and 1999.⁸ Patients were informed that the tubes used in these procedures had not been properly cleaned or sterilized over the course of seven years. A class-action suit has been launched against St Boniface, alleging the hospital was negligent in

allowing patients to be exposed to bloodborne diseases such as hepatitis C and HIV. A statement of claim was filed in March of 2000. More than 700 patients have been since tested for blood diseases, and so far three have been diagnosed with hepatitis C. The hospital insists the blame lies with one employee, a technician who was found to have been using sub-standard disinfectant, allegedly

against official hospital policy.⁹
Litigation is pending.

— Jennifer Gold

¹ *McCarthy v Canadian Red Cross Society*, [2001] OJ No 2474 (SCJ) (QL); Judge approves “tainted blood” settlement. CBC News Online, 27 June 2001. Accessed online at www.cbc.ca on 27 June 2001.

² *Killough v Canadian Red Cross Society*, 2001 BCSC 198, [2001] BCJ No 191 (QL).

³ See *Parsons v Canadian Red Cross Society* (1999), 49 CPC (4th) 151 (Ont Sup Ct); *Endean v Canadian Red Cross Society* (1999), [2000] VWR 688, 68 BCLR (3d) 350 (SC); *Honhon v Canada (Procureur général)*, [1999] JQ No 4370 (SC) (QL).

⁴ *McCarthy v Canadian Red Cross Society*, [2001] OJ No 567 (SCJ) (QL).

⁵ *McCarthy*, supra, note 1 at para 18.

⁶ Kennedy M. Mounties decide against tainted-blood charges: victims express anger and disappointment over wilfully destroyed documents. *The Vancouver Sun*, 27 February 2001.

⁷ Royal Canadian Mounted Police News Release. No charges in destruction of Canadian Blood Committee records. Accessed online at www.rcmp-grc.gc.ca on 27 June 2001.

⁸ O’Hallarn B. Trio spearhead St. B blood suit: others may join action on tainted tubes. *The Winnipeg Sun*, 18 April 2000.

⁹ Shifting the blame over sterilization mix-up. CBC News Online, 21 May 1999. Accessed online at www.cbc.ca on 27 June 2001.

Medical Marijuana and the Law: Recent Developments

Wakeford Awaits Decision on Safe Source of Medical Marijuana

Jim Wakeford, a Toronto man with AIDS, is currently awaiting judgment from the Ontario Court of Appeal in his effort to secure a safe source of marijuana for medicinal use.

In 1999, Wakeford was granted a constitutional exemption allowing him to possess and grow marijuana for personal, medicinal purposes. However, under the terms of this exemption, Wakeford is permitted to grow only seven plants. Wakeford’s lawyers have gone to court in an effort to force the federal government to provide Wakeford with a safe source of medicinal marijuana, arguing that it is unacceptable to force patients to manufacture their own medicines. Wakeford lost at the first level in May 2000, but appealed.¹ The Ontario Court of Appeal heard the case in March 2001 and has reserved judgment. No

decision had been reported at the time of writing.

In December 2000, Health Minister Allan Rock revealed that a five-year contract valued at nearly six million dollars had been awarded to Saskatoon-based Prairie Plant Systems Inc to provide Health Canada with a source of reliable and standardized marijuana for national medical and research needs.² The company will be responsible for producing over one million marijuana cigarettes, which will be used to conduct research on the drug’s harms and benefits, but also distributed to those Canadians who qualify for marijuana for medical reasons.³

In the meantime, the day after the Ontario Court of Appeal heard Wakeford’s case, police searched his property and found more than two hundred marijuana plants. Wakeford was charged with illegally growing and possessing marijuana for the purpose of trafficking. Wakeford grows the marijuana in order to help supply others who are terminally or

chronically ill and cannot obtain it on their own. The matter is still pending.⁴

Jury Finds in Favour of Man Who “Trafficked” Marijuana “Out of Necessity”

In a similar case, a Calgary jury has decided that Grant Krieger was justified in breaking the law.⁵

Krieger, who suffers from multiple sclerosis, was charged with possession of marijuana for the purpose of trafficking. An advocate of medicinal marijuana who operates the Universal Compassion Club, Krieger grows marijuana plants in order to provide the drug both for himself and for other chronically ill people in need. At trial, Krieger admitted he possessed marijuana for the purpose of trafficking. He emphasized, however, that he had broken the law “out of necessity.”

In December 2000, a jury in the Alberta Court of Queen’s Bench

dismissed charges of cultivating marijuana against Krieger. In July 2001, the Crown filed its appeal against the jury's decision, arguing that the trial judge erred in law in instructing the jury that they could find the defence of necessity applicable. Krieger has stated that he is prepared to fight the matter to the Supreme Court of Canada if necessary.⁶

New Regulations on Medicinal Marijuana

In July 2000, the Ontario Court of Appeal ordered the Canadian government to develop regulations governing the medical use of marijuana within one year, failing which the prohibition on marijuana (for any purpose) in Canadian criminal law would have become void by the Court's order.⁷

In response, on 7 April 2001 the federal government released draft Medical Marijuana Access Regulations for public comment over a 30-day period.⁸

There remain numerous concerns about unnecessary restrictions in the Medical Marijuana Access Regulations.

In a welcome development, the regulations recognize that persons legally authorized to use marijuana for medical purposes may require that others supply them with the drug. Therefore, the regulations contain provisions for designating another person to receive an authorization to grow marijuana for this purpose. However, many have raised concerns with the government about numerous unnecessarily and unjustifiably restrictive aspects of the

regulations.⁹ The final regulations were published in the *Canada Gazette* and came into force on 4 July 2001, with few substantial changes from the draft version. The Regulatory Impact Analysis Statement accompanying the regulations provides an overview of the current state of the law in numerous other countries, a summary explanation of the regulations, and indicates the government's rationale for, and interpretation of, the regulations.¹⁰

The regulations establish three categories of people who may legally possess the drug:

- those who are terminally ill and are expected to die within 12 months;
- those with symptoms (eg, nausea, weight loss, severe pain) associated with certain medical conditions (eg, cancer, HIV/AIDS, multiple sclerosis, epilepsy); and
- those suffering from symptoms who have other medical conditions.

However, there remain numerous concerns about unnecessary restrictions in the regulations. In particular:

- People with serious symptoms and conditions, but who are not expected to die within 12 months, require the support of a medical "specialist" rather than simply a licensed medical practitioner in order to get a licence to possess marijuana for medical use.
- The specialist must declare that all conventional treatments have been tried or at least considered and are medically inappropriate, creating an unwarranted restriction on the patient's informed and autonomous choice of medicine.
- While the government has indicated, in response to concerns raised, that photo identification cards issued to licence holders will not contain personal medical information, the regulations still state that a person must

show the full authorization issued to them (which does include this information) to a police officer "on demand," without any requirement for a warrant to obtain such confidential information.

- The government's interpretation of the regulations is that no single person can be designated a licensed producer of marijuana for more than one patient, and no licensed producer can produce marijuana in common with more than two other licence holders, meaning that "cannabis clubs" or buyer's cooperatives or even an individual cannot be legally licensed as a supplier to multiple patients. This wasteful requirement of duplicated effort presents an additional barrier to efficient access for patients who may wish to access the same supplier.
- The government also states, in its commentary accompanying the regulations, that it is up to hospitals and correctional institutions to determine whether they will allow a legally licensed patient to possess or grow marijuana in that facility, even though a decision to refuse this permission would discriminate against sick people based on their use of a particular medicine they have been given the legal authority to possess or produce.

Given the concerns that remain with the new regulatory regime, further litigation can be expected.

US Supreme Court Denies "Medical Necessity" Exception for Marijuana Distribution

While courts in Canada have repeatedly recognized the constitutional right to use marijuana as medicine, and the government has

been forced to address the issue, the US Supreme Court has recently unanimously ruled that federal law does not permit a “medical necessity” exception to the prohibition on marijuana distribution.¹¹

The case concerned a cannabis cooperative in California that supplied drugs to patients with AIDS, cancer, and other chronic and terminal illnesses. While the issue in the case was the legal status of distribution of medicinal marijuana and not its medical use by individual patients, many expect that the ruling will doom public distribution centres. As well, nine states currently have in effect policies governing the medicinal use of marijuana. The Supreme Court’s decision may have the effect of deterring other states from implementing similar policies.

The decision’s impact on the use of the medical necessity defence by individuals who cultivate or possess marijuana for personal, medicinal purposes is unclear. However, it does not bode well that, in its unanimous decision, the Court noted that the US Congress “has no currently accepted medical use” and “has no medical benefits worthy of an exemption” from criminal prohibition (outside government-approved research projects).

Non-Medicinal Marijuana: Supreme Court of Canada Will Hear Constitutional Challenge

Canadian appellate and trial courts have ruled that the prohibition on the medical use of marijuana is unconstitutional.¹² In response, the federal government has introduced new regulations on medicinal mari-

juana. However, it continues to insist on a prohibitionist approach to marijuana in general. Three men have been granted leave by the Supreme Court of Canada to challenge the constitutionality of Canada’s laws prohibiting recreational use of marijuana.¹³

In a two-to-one decision in June 2000, the British Columbia Court of Appeal upheld marijuana possession convictions against David Malmo-Levine and Randy Caine.¹⁴ The dissenting judge wrote that in order for the criminal justice system to rightfully intervene, the harm resulting from smoking marijuana should be considerable. In the Ontario case of Chris Clay, the trial judge who originally heard the case indicated that while he was persuaded that marijuana does not cause serious harm, it is the place of Parliament to determine its legality.¹⁵ The Ontario Court of Appeal was more equivocal, saying that “the jury is still out” on the actual and potential harm, and that it was open to Parliament to criminalize possession of marijuana for recreational purposes as long as there was a “reasonable basis” for concluding that harm will result. Malmo-Levine, Caine, and Clay are all appealing these decisions. The cases may be

heard by the Supreme Court of Canada by the end of 2001.

– Jennifer Gold & Richard Elliott

¹ *Wakeford v Canada*, [2000] OJ No 479 (SCJ) (QL).

² Health Canada. News release: Contract awarded for research-grade marijuana. 21 December 2000. Accessed online at www.hc-sc.gc.ca on 10 January 2001.

³ Basky G. Saskatoon firm wins country’s first contract to cultivate medical marijuana. *Canadian Medical Association Journal* 2001; 164(4): 535.

⁴ Pazzano S. Protect pot supplier, says AIDS patient. *Edmonton Sun*, 3 March 2001; Tyler T. Marijuana seized from Toronto AIDS patient: Grew own supply under constitutional exemption. *Toronto Star*, 3 March 2001; Clement M. Medicinal marijuana man burned. *Toronto Sun*, 3 March 2001.

⁵ Jury finds in favour of pot crusader. *Star-Phoenix*, 21 June 2001.

⁶ Crown appeals pot crusader acquittal. *Globe and Mail*, 20 July 2001:A7; L’acquittement du défendeur de la marijuana est porté en appel. *Le Soleil*, 20 July 2001; Alta Crown appeals acquittal of Krieger. *The Leader-Post* (Regina), 20 July 2001:A11.

⁷ *R v Parker* (2000), 49 OR (3d) 481, (2000) 146 CCC (3d) 193, [2000] OJ No 2787 (CA) (QL), summarized at R Elliott. Recent court rulings on medical and non-medical marijuana. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 9 at 10-12.

⁸ Available online via www.hc-sc.gc.ca.

⁹ The Canadian HIV/AIDS Legal Network’s comments on the draft regulations can be found online at www.aidslaw.ca/Maincontent/issues/cts/marijuana_submissions.htm.

¹⁰ SOR / 2001-227; also available online via www.hc-sc.gc.ca.

¹¹ *United States v. Oakland Cannabis Buyers Cooperative et al.* United States Supreme Court, 14 May 2000, Decision No. 00-151 (available online at <http://supct.law.cornell.edu/supct/html/00-151.ZO.html>).

¹² See the *Wakeford* and *Parker* cases summarized in Elliott, supra, note 7 at 9-12.

¹³ [2000] SCCA No 361 (QL); Supreme Court to hear challenge to marijuana laws. CBC News Online, 6 March 2001. Accessed online at www.cbc.ca on 27 June 2001.

¹⁴ *R v Malmo-Levine; R v Caine*, 2000 BCCA 335, 145 CCC (3d) 225, [2000] BCJ No 1095 (CA) (QL). For a summary see Elliott, supra, note 7 at 13.

¹⁵ *R v Clay* (2000), 146 CCC (3d) 276, 49 O.R. (3d) 577, [2000] OJ No 2788 (Sup Ct) (QL). For a summary, see Elliott, supra note 7 at 14.

Motion to Strike Claim Dismissed in HIV Defamation Suit

On 23 April 2001, the Ontario Superior Court of Justice issued the first Canadian ruling on the issue of whether words imputing that a person is HIV-positive or has AIDS can be the basis of a defamation action per se, in the case of *Serdar v Metroland Printing, Publishing and Distributing Ltd.*¹

In 1999, police constable Lorelle Serdar was bitten by a suspect during an arrest. Subsequent to the incident, a local newspaper published two articles and an editorial on the episode indicating that Serdar was “waiting in terror” to find

out if she had contracted HIV from the bite.

Serdar brought a defamation suit against the paper, the publisher, the editor-in-chief, the managing editor, and a reporter. She claimed that she had suffered damage to her reputation as a result of the articles, and that they had caused strain in her personal relationships with family and friends.

The newspaper brought a motion to strike out Serdar's statement of claim on the basis that there was "no reasonable cause of action" – in other words, they asked the court to rule that Serdar's lawsuit could not go forward because it had no legal basis. The newspaper made two arguments.

First, it argued that the words it published are incapable of being defamatory because they cannot be said to have damaged Serdar's reputation. The paper claimed that because its publications

made it clear that the incident giving rise to the statements took place while PC Serdar was carrying out her professional duties, the plaintiff's reputation cannot be said to have been damaged, as no average person could conclude from the facts that her condition resulted [from] some discreditable or "properly maligned" (to quote the phrase used by counsel for the ... defendants) conduct on her own part.²

Serdar argued, however, that as long as a statement would lower her in the estimation of others, or cause her to be shunned or avoided or exposed to contempt or ridicule, it can be found defamatory even if it does not necessarily attach any blameworthiness to her. In response, the newspaper argued that

[a] false statement that a person has an infectious disease is only capable of being defamatory where the tendency of the community to shun or avoid the plaintiff is linked to the social stigma resulting from the inference that the ordinary person could draw that there had been some blameworthy or discreditable conduct on the part of the plaintiff (such as drug use or sexual promiscuity). [The newspaper argues] that where the shunning and avoiding cannot possibly be said to have resulted from some properly maligned behaviour on the part of the plaintiff, there can be no damage to the person's reputation. The flip side of this argument is that it is only where the ordinary person could infer from the statement that the plaintiff had indulged in some discreditable or untoward conduct that an action in defamation can lie.³

The court considered other (primarily Canadian) cases in which courts had held that statements that falsely convey that a person has an infectious disease (including "venereal disease") can be defamatory.⁴ The court also considered commentary in the leading academic texts to the effect that, as a general rule,

words imputing a contagious disease are actionable per se [ie, they can be the basis for a defamation lawsuit in and of themselves]. The reason for this rule appears not to be the "wicked means" by which the disease may be acquired but the social ostracism resulting from the belief formerly held that all prudent persons will avoid the company of a person having such distemper. The effect of such an accusation, therefore, is "to exclude a person from the

social benefits of society." The rule is generally confined to diseases that are especially repugnant, lingering or chronic in character. The cases in Canada have been limited to venereal disease. Elsewhere, the rule has also been applied to leprosy, and it is suggested that typhoid and, possibly, scarlet fever or a plague would suffice, though not smallpox. An accusation that a person has AIDS is undoubtedly slanderous per se.⁵

The judge disagreed with Professor Brown's view that this rule is too entrenched to change through the judicial process. Rather, he noted that

the trial judge in this case will undoubtedly have to deal head on with the issue of whether words uttered in 1999 which falsely imputed that a person might have become HIV-positive or might contract AIDS are actionable per se. This is a legal issue which has not been determined expressly in a Canadian court and which should be determined in the context of a trial where the Court will have a full record before it.⁶

The judge concluded that it was not "plain and obvious" that a libel claim would fail in law, which is the applicable test set out by the Supreme Court of Canada⁷ for striking claims on the basis that there is "no reasonable cause of action," saying:

It is fair to say the law in this area is still developing.... This is an evolving area in which there have been significant changes in the public's attitude. It is a difficult area of law for that reason alone."⁸

The court was therefore unwilling to strike out Serdar's claim on this basis.

The newspaper's second argument was that the claim should be struck because its publications suggest only that Serdar *may* have been infected with HIV, and furthermore it also published a doctor's scientific opinion that the actual chance of being infected in the circumstances was "highly unlikely" and less than 0.3 percent. However, the court noted there was no legal authority for the newspaper's argument that it cannot be sued for defamation for simply stating that a person *may* be HIV-positive or contract AIDS. It held that a ruling on this argument should only be made after a full trial with a proper evidentiary record before it, not on a preliminary motion. In addition, even if the suggestion was only that she *may* become HIV-positive, and even if the newspaper reported that the chance of this was exceedingly low, the court held that this would really be relevant only to the number of people in the community who might shun or avoid Serdar, and is therefore really relevant to the issue of damages she could be awarded if she proved her case at trial.

In the end, the court was not convinced by either of the newspaper's arguments that it was "plain and obvious" that Serdar's claim would fail. It therefore dismissed the newspaper's motion and allowed her claim to proceed.

Commentary

Whatever the merits of the newspaper's arguments that it should not be held liable in defamation because it did not impute any conduct to Serdar that would discredit her in the eyes of others, its choice of language is problematic. There is certainly no doubt that HIV-related stigma exists and that, in the eyes of many, some peo-

ple with HIV are considered more "guilty" than others for their infection (particularly gay men, sex workers, and injection drug users). While such prejudices exist, it might indeed be defamatory to impute such conduct or characteristics (or even just HIV-positive status) to a person. As the judge noted, plaintiff's counsel argued that

whether we like it or not, we still live in a world where ordinary people and even some people who are reasonably knowledgeable about HIV and AIDS issues would want to avoid certain contact with a person about whom they have heard that he or she is HIV-positive.... He suggests that today there are still many individuals who would shun or avoid a person in certain circumstances if they thought that the person might be HIV-positive.⁹

This raises the age-old question of whether defamation law should accept widespread prejudices as a basis for deciding whether a statement is defamatory because in reality it might well expose a person to unjustifiable hatred, contempt or ridicule because of those prejudices, or whether it should take a more

principled approach in deciding whether the "reasonable person" would be guided by such prejudices in their view of a person to whom certain characteristics or conduct is imputed. But aside from this question, the suggestion by the newspaper in this case that a person with HIV could be "properly" maligned because their infection is due to sexual behaviour or use of drugs is unfortunate and should be abandoned.

– Jennifer Gold & Richard Elliott

¹ *Serdar v Metroland Printing, Publishing, and Distributing Ltd.*, [2001] OJ No 1596 (SCJ) (QL).

² *Ibid* at para 9.

³ *Ibid* at para 13.

⁴ *French (Oscar) v Smith* (1922), 53 OLR 28; *Halls v Mitchell* (1926), 59 OLR 590 (CA) [note that this case was appealed to the Supreme Court of Canada on, among other things, the issue of medical confidentiality, but not on the issue of defamatory meaning]; *Peters-Brown v Regina District Health Board*, [1996] 2 WWR 337 (Sask QB), affirmed at (1996), 148 Sask R 248 (CA); *Southam Inc v Chelekis*, [1998] BC No 848 (SC) (QL) (summarized at *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 11); *Snipes v Mack* (1989), 191 Ga Ap 233 (Georgia Court of Appeals); *McCune v Neitzel* (1990), 235 Neb 754 (Supreme Court of Nebraska).

⁵ Brown RE. *The Law of Defamation in Canada*, 2nd ed, vol 1. Toronto: Carswell, 1999, at 8:45-46; see also *Gatley on Libel and Slander*. Milmo P. Rogers WV (eds). London: Sweet & Maxwell, 1998, 9th edition, No 8 at 22-23, 27-28.

⁶ *Serdar*, supra, note 1 at paras 26, 30.

⁷ *Hunt v Carey*, [1990] 2 SCR 959.

⁸ *Serdar*, supra, note 1 at paras 30, 32.

⁹ *Ibid* at para 30.

Couple Found Guilty in AIDS Scare

A Fredericton, New Brunswick city councillor and her husband were convicted by a jury in June 2001 of spreading a message with the intent to alarm, a seldom-used *Criminal Code* charge, for giving a woman the false impression that she had been exposed to the risk of HIV infection.

In a four-day trial in the New Brunswick Court of Queen's Bench, the Crown proved that Marilyn and Ron Kerton had phoned Wendy George and informed her they were both HIV-positive. Wendy George had a brief affair

with Ron Kenton. When it ended, she alleged that Marilyn called to tell her (falsely) that Marilyn and Ron had full-blown AIDS. Ron was said to have made a call shortly thereafter, “confirming” the bad news. George testified she had been devastated by the news and had contemplated suicide.

The offence of conveying a false message with intent to alarm carries a maximum sentence of two years in

prison. On 19 July 2001, each defendant was sentenced to a \$500 fine plus a \$75 victim surcharge, or 12 days in jail in default of payment, and the two were placed on probation for 10 months and ordered to perform 100 hours of community service within seven months. As a result of having a criminal record, Marilyn Kerton is no longer permitted to retain her seat on city council. Following the verdict, she has also

been suspended from her job as a social worker pending an investigation of her suitability for the job.¹

– Jennifer Gold

¹ Former mistress says she was suicidal. *CBC News Online*, 19 June 2001; City councillor faces jail for lying about AIDS. *CBC News Online*, 22 June 2001; Fredericton councillor found guilty of spreading false message about AIDS. *CBC News Online*, 22 June 2001; White A. Conviction costs councillor her seat in Fredericton. *New Brunswick Telegraph Journal*, 20 July 2001:A1.

Ontario Court of Justice Dismisses Police Negligence Case: HIV Infection a Factor

On 22 February 2001, the case of *Chartier v Greaves* was dismissed by the Ontario Superior Court of Justice.¹

In 1992, an altercation involving two police officers and two brothers left one brother dead and the other wounded. Frank and Jacques Chartier had been drinking and using drugs in an Ottawa apartment building, an incident that led to violence against their host and to vandalism of the apartment. The woman telephoned the police, and when requesting assistance warned the operator that the brothers were HIV-positive, were bleeding, and that there was “blood on the walls.” She also told them that Jacques Chartier had been violent and had threatened to kill her and her dog.

The officers who responded to the call were apprehensive about “the HIV issue” and put their uniform gloves on before entering. Upon encountering the brothers, the situation escalated and one of the officers drew his revolver and fired three shots. When asked why he used his gun, the officer testified that he was being charged by the two men, one of whom was wielding a fire hose as a weapon in a hallway with broken glass on the floor. He also said that he was concerned about getting cut or falling to the floor and landing in blood already there. Jacques Chartier was struck in the shoulder. Frank Chartier was fatally wounded.

Jacques Chartier and several relatives claimed that his injury, and the

death of his brother Frank, were wrongful, and had occurred as a result of unreasonable force. The judge dismissed the action, indicating the plaintiffs had failed to provide the court with reasonable alternatives the officers could have pursued. The officers were presented with an emergency, and the brothers posed a serious threat to the officers as well as to residents of the building. According to the judge, “the fear of contracting AIDS was a real one.” None of the defendants was found to have acted negligently; the case was dismissed.

– Jennifer Gold

¹ *Chartier v Greaves*, [2001] OJ No 634 (SCJ) (QL).

Woman Wins Claim for Tax Deductability of Complementary/Alternative Medical Expenses

On 30 April 2001, the Tax Court of Canada granted judgment in favour of a Victoria woman who claimed that she should be entitled to deduct from her taxable income, as legitimate “medical expenses,” her expenses for vitamin supplements and for rehabilitative therapies such as massage and therapeutic touch.¹

The claimant is a woman living with HIV/AIDS on a disability pension and had filed an appeal seeking a reassessment of her 1997 income tax after Revenue Canada denied her deduction for these items. She also claimed as a deduction various miscellaneous items such as cooler bags, books and reports related to her health-care needs as deductible medical expenses.

Teskey J considered the meaning of the applicable section of the *Income Tax Act*² allowing deductions for expenses “for drugs, medicaments or other preparations or substances” for use in diagnosis, treatment or prevention, and which are “prescribed by a medical practitioner” and “recorded by a pharmacist.” He ruled that this did not mean that only “prescribed prescription drugs” could be a deductible medical expense, but ruled

that, in this case, vitamin supplements were prescribed by a physician and should be allowed as a deduction from taxable income.

Teskey J also ruled that the woman’s expenses for travel to the US to receive therapeutic touch (also prescribed by a physician) at an institute staffed by medical doctors, nurses, and psychologists were eligible. He stated that “it is my duty to interpret medical expense cases, as well as medical disability cases, in a broad manner. The appellant said that she could receive the same type of treatment here in Victoria but not nearly the same quality.”³ He concluded the expense was deductible.

However, Teskey J did not allow the claim for periodicals, books and cooler bags as deductible medical expenses.

It should be noted that in at least two other cases, judges of the tax court have not accepted claims for deducting mineral and vitamin supplements or other herbal remedies, on the basis that they were not prescribed by a physician as is required under the *Income Tax Act*.⁴ The lesson for people living with HIV/AIDS is that physician prescription is likely required if there is to be any of hope of claiming these expenses as deductible from taxable income.

– Glen Bugg

¹ *Frank v Canada*, Court File No. 2000-3586(IT), Tax Court of Canada, Victoria, British Columbia, 30 April 2001 (per Teskey JTCC), on file.

² RSC 1985, 5th Supp. c. 1, s 118.2(2)(n).

³ *Frank*, supra note 1, at 6.

⁴ For example, see: *Bauman v Canada*, [2001] TC No 111 (QL); *Williams v Canada*, [1997] TC No 1346.

Federal Court Denies Asylum, Rejects Claim that Lack of Adequate Medical Care Is Persecution

On 9 May 2001, the Federal Court of Canada (Trial Division) rejected an HIV-positive man’s application for judicial review of a decision by the Immigration and Refugee Board (IRB) rejecting his claim for refugee status under the Geneva Convention. The question before the court was whether the unavailability of sophisticated medical treatment constitutes persecution?

Hassan Mare is a citizen of Burkina Faso. He fled to Canada out of fear for his safety: his father, the former chief of his primarily Muslim village, had converted to Christianity, and members of the village felt he would attempt to succeed his father as chief. Since arriving in Canada he has been diagnosed as HIV-positive. The IRB found that he lacked credibility concerning the usual grounds for fear of persecution. However, Mare also alleged a well-founded fear of persecution in his country of origin on the basis of his membership in a particular social group, namely individuals who are HIV-positive. He submitted that he should be found to be a Convention refugee, since he would not have sufficient funds to be treated for his illness in his home country, and even if he were treated, the treatment offered would not meet the standard in Ontario.

The IRB ruled that, although he was HIV-positive, he would not systematically be deprived of health care, which would amount to persecution. It also found that antiretroviral medication was available in Burkina Faso and was accessible through the Ministry of Health, although the cost was not subsidized. Even though Mare had no money, the IRB determined that he could return to his previous profession of cattle breeder and rely on his family. It concluded that the insufficiency of sophisticated and expensive treatment available in Burkina Faso could not amount to persecution.

Mare applied to the court for judicial review of this decision. The Minister of Citizenship and Immigration opposed his application, arguing that it was possible that withholding or denying health care could, in some circumstances, amount to persecution if done for a discriminatory reason or directed at a specific group, but that this was not the case with Mare. The government also argued that taking Mare's argument "to its logical conclusion would support the proposition that any person outside of Canada who did not have access to health care in his home country which is similar to that available in Ontario would be entitled to Convention refugee status."¹

Rouleau J of the Federal Court Trial Division rejected Mare's argument that the lack of medical care can amount to persecution:

I am satisfied that Burkina Faso, considering its wealth or lack thereof, is making available such medical resources as can possibly be achieved in a disadvantaged country. The state has taken its adherence to International Conventions to the highest standard of physical and mental health that it can economically afford.... To argue that refugee

claimants having inadequate medical care in disadvantaged countries equals persecution would create an unmanageable situation. To look to refugee boards to determine independently what standard should be applied throughout the world or in each country of origin is not their function, as well as is beyond their expertise. How can they be expected to determine the adequacy of medical care being offered?²

The judge therefore dismissed Mare's application for judicial review of the IRB's decision.

Mare's lawyer then suggested that there was a question of sufficient general importance that should be certified under the *Immigration Act*,³ which would allow the issue to be appealed to the Federal Court of Appeal. Rouleau J summarized the question as follows:

If a person is unable to access a reasonable level of medical care in their country of nationality, does that person thereby face a serious possibility of persecution?

Rouleau J was not convinced the question should be certified. He dismissed the request, stating: "There has not been any evidence or any submission that satisfies me that there is

any nexus established between poverty and unavailability of sophisticated medical care and the usual grounds underlying persecution."

It is to be hoped that this statement truly reflects the lack of adequate evidence before the court in this instance, as there can be little doubt that in many cases there is a very significant connection between discrimination on the one hand, and poverty and lack of adequate medical care on the other. However, the judge's decision not to certify the question for appeal means that the courts have avoided a very significant issue (for now). The *Mare* case directly raises the question of violations of economic and social rights, such as the right to the highest attainable standard of physical and mental health, as a basis for seeking asylum. But given the concern about "opening the floodgates," as raised by Citizenship and Immigration Canada and shared by the judge in this case, it will likely be a difficult claim to advance before Canadian courts.

— Richard Elliott

¹ *Mare v Canada (Minister of Citizenship and Immigration)*, 2001 FCT 450, [2001] FCJ No 712 at para 7 (QL).

² *Ibid* at para 11.

³ RSC 1985, c 1-2, s 83.

CRIMINAL JUSTICE

Criminal Law and HIV/AIDS: Update V

This regular column reviews new developments in the area of criminal prosecutions for HIV transmission or exposure, or developments that have come to our attention since the last issue. Canadian developments are the focus. Cases and legislation from other jurisdictions are only included if they represent a significant development in this area of the law or for the jurisdiction in question.

Canada

Nova Scotia: First case after *Cuerrier* to consider “lower risk” defence

In June 2001, a Nova Scotia trial court issued the first Canadian decision after the Supreme Court of Canada’s judgment in *Cuerrier*¹ that addresses the question of criminal liability for “lower risk.” On 14 June 2001, in the case of *R v Edwards*,² Goodfellow J of the Nova Scotia Supreme Court issued an oral judgment acquitting James Robert Edwards on charges of aggravated assault and sexual assault.

Facts of the case

The manner in which the case arose indicates how criminal charges may arise tangentially to other matters. Edwards met X at a Halifax gay bar, and they returned to X’s home. They performed oral sex on each other (without condoms) and at some point (the time was disputed by many hours), they had anal sex, with Edwards penetrating X. After Edwards left the next morning, X discovered he was missing a diamond ring. Concluding that Edwards likely stole it, he reported the theft to the police.

Edwards adamantly denied any knowledge of the ring to police. He cooperated fully with them, including readily agreeing to take a polygraph test at the station. The test concluded Edwards was being truthful in denying the theft. Upon learning this, X apologized to Edwards. However, before performing the polygraph, the operator inquired, in keeping with standard procedure, as to Edwards’s general and psychological health, including asking whether he was on any medication. Edwards said he was in good health other than the fact that he is HIV-positive. Having learned this information, the polygraph operator felt ethically compelled to advise X, who was reported to react with shock and fear.

X claimed that this anal sex was unprotected. Edwards admitted that he is HIV-positive and that he knew this when he had anal sex with X, but testified that a condom was used. Edwards was charged with one count each of aggra-

In June 2001, a Nova Scotia trial court issued the first Canadian decision after the Supreme Court of Canada’s judgment in *Cuerrier* that addresses the question of criminal liability for “lower risk.”

vated assault and with sexual assault. The matter went to trial in mid June 2001. (X continued to test HIV-negative at the time of trial, well beyond the window period for possible sero-conversion.)

Legal issues and judgment

This is the first reported case before Canadian courts that raises the issue of criminal charges against people with HIV for sexual activity other than unprotected penetrative vaginal or anal sex. In *Cuerrier*, the Supreme Court had suggested that HIV-positive partners might not be legally required to disclose their HIV status if the sexual contact were protected:

To have intercourse with a person who is HIV-positive will always present risks. Absolutely safe sex may be impossible. *Yet the careful use of condoms might be found to so reduce the risk of harm that it could not longer be considered significant* so that there might not be either deprivation or risk of deprivation [ie,

harm or risk of harm]. To repeat, in circumstances such as those presented in this case, there must be a significant risk of serious bodily harm before the [assault] section can be satisfied. In the absence of those criteria, the duty to disclose will not arise.³

Interestingly, the Crown conceded in this case that “unprotected oral sex is conduct at low risk that would not bring it within s 268(1) [the aggravated assault provision] of the Criminal Code and had only unprotected oral

There is still no firm statement of Canadian law on the question whether there is a duty to disclose HIV status if one engages in “safer sex” or sex that is lower risk than anal or vaginal sex without a condom.

sex taken place, no charges would have been laid.”⁴ This indicates the Supreme Court’s suggestion may have some impact on how some prosecutors exercise their discretion over whether to pursue charges against sexually active people with HIV/AIDS.

However, the Crown’s acknowledgment that unprotected oral sex without disclosure would not be a basis for criminal charges also means that there was no judicial commentary on the Supreme Court’s suggestion in *Cuerrier*. This means there is not yet any firm statement of Canadian law on the question whether there is still a duty to disclose HIV status if one engages in “safer sex” or sex that is lower risk than anal or vaginal sex without a condom.

The issue was thus the act of allegedly unprotected anal sex during which Edwards penetrated X. Goodfellow J reviewed the Supreme Court’s decision in *Cuerrier*, noting the ruling in that case that non-disclosure of HIV-positive status before unprotected (vaginal or anal) sex would be viewed as “dishonest” by a reasonable person, and could therefore amount to fraud that would vitiate (ie, render invalid) a person’s consent, making the sexual contact an assault under the law. In his view, a “reasonable person” would view engaging in unprotected (vaginal or anal) sex without disclosing one’s HIV-positive status as “selfish, despicable, and most importantly, criminal.”⁵

According to *Cuerrier*, the Crown bore the burden of proving that: (1) the men engaged in unprotected anal sex; (2) there was a “significant risk” of HIV transmission as a result, thereby “endangering the life of the complainant;” and (3) X would not have consented to sex with Edwards had he been forewarned that Edwards was HIV-positive.

On the first issue, Goodfellow J wrote:

What this case is about is whether or not the Crown has established beyond a reasonable doubt that “unprotected” anal intercourse took place between these two men. It is clear that X did not inquire of Mr Edwards nor did Mr Edwards inquire of X whether the other was infected with any disease and, in particular, if the other was HIV positive. While it is easy to suggest that such an inquiry would be particularly wise and very much appropriate in the gay community when anal sexual intercourse is anticipated, there is no such standard in law and human nature and circum-

stances, alcohol, passion, et cetera, dictate against such a standard. The standard to be applied in the gay community is the obligation of one who is infected to practice safe sex or make clear disclosure so that there can be informed consent if unprotected sex is to be pursued.⁶

X claimed the anal sex was unprotected. Edwards claimed a condom was used. Goodfellow J found the evidence of both X and Edwards “most convincing.” Therefore, he was left to conclude that there was a “reasonable doubt” on this issue, and he was therefore bound to acquit Edwards.

As to the question of X’s life being endangered, the judge noted the expert medical evidence before him that estimated the risk of transmission being 1 in 10,000 per incident of unprotected oral sex, 1 in 1000 per incident of unprotected vaginal sex, and 1 in 500 per incident of unprotected anal sex. The medical expert “indicated that the proper use of a condom reduces or renders the risk low; however, no statistical information or in depth assistance was given to the Court that would provide specific scientific or medical conclusions as to the degree of risk that remains when protected sex is engaged in.”⁷ The judge therefore concluded that the Crown had also failed to prove beyond reasonable doubt conduct that Edwards “endangered the life” of X.

Finally, with respect to the issue of X’s consent, the judge stated:

In situations such as presented in the case before me, it must be emphasized that the Crown is required to prove beyond a reasonable doubt that X would have refused to engage in protected sex with Edwards if he had been advised that Edwards was HIV positive.⁸

It should be noted that the judge's decision, as reported, refers to "protected sex," but the context and the law (eg, the *Cuerrier* decision) suggest that he actually meant "unprotected sex." Given that the decision was delivered orally, it seems likely that the judge misspoke or there was an error in transcription. Alternatively, it could be that Goodfellow J did in fact intentionally refer to "protected" sex: the Crown did not prove X's claim that the anal sex was unprotected, so the judge may have been suggesting that, assuming a condom was used, the Crown would have to prove that X would not have consented to anal sex, even with a condom, had he known Edwards's HIV-positive status. Given how short the oral judgment is, it is difficult to know. The important point is the need for the Crown to prove that X's consent to sex would not have been given had he known Edwards's HIV status.

In his closing comments, Goodfellow J noted the controversy over the notion of criminalizing even "safer sex":

It is not for a trial judge to expand what constitutes a criminal act. Such a determination is for the Legislature or the Supreme Court of Canada in its interpretation of legislation. The gay community and its leaders vigorously urge the practice of safe sex, not abstinence. If the failure to disclose a contagious disease before engaging in "protected" sex is to be a criminal offence, it is for the Legislature to so define such activity.⁹

Nova Scotia: Six years in prison for threatening with a syringe

In May 2001, Robert Arthur Harrison was sentenced to six years in prison after being convicted of threatening

security guards at a store with a syringe he claimed contained HIV-infected blood. The exact charges were not reported.¹⁰

Québec: Montréal man charged with aggravated assault

In April 2001, Montréal police announced three charges of aggravated assault against a 27-year-old homeless man who, it is alleged, is HIV-positive and had unprotected sex with three women. It was also reported that he was an injection drug user and worked as a prostitute in both Vancouver and Montréal, although none of the charges against him involve paid sex. One of the women, a 16-year-old, has tested HIV-positive, and it is alleged that he infected her; the other two were reported as waiting for test results. The infected woman learned of her status in November 2000 and was counseled by a social worker to contact police. During a five-month police investigation, Montréal police obtained warrants for the man's medical records, which they state showed he learned of his HIV infection in 1992.¹¹

Québec: Six-year sentence for transmitting HIV

On 6 June 2001, Mario Morin was sentenced to six years in prison for aggravated assault, having been convicted of infecting his former girlfriend with HIV through unprotected sex without having disclosed his status to her.¹²

Québec: Sentencing for man who spat blood at prison guards

On 6 June 2001, Jean-Roch Lefrançois, a prisoner with HIV, was sentenced on two counts of uttering threats, two counts of assault causing bodily harm, and two counts of attempted murder. He had been

charged following an altercation in December 1997 during which he spat blood at two prison guards at a Québec City detention centre (one guard was struck on the shoulder). He pleaded guilty to the charges of uttering threats at a preliminary hearing, and was convicted on the attempted murder and assault charges following a September 2000 trial. He was sentenced to one year in prison for the charges of uttering threats, five years in prison for the assault charges, and 14 years in prison for the attempted murder charges. The sentences are to be served concurrently.¹³

Alberta: Two cases of threats with syringes

In May 2001, a person wielding a syringe, who claimed that the syringe contained HIV-contaminated blood, robbed gas stations in Edmonton and Calgary. In the Edmonton robbery, the store clerk was sprayed in the face with blood. Eight charges, including possession of a weapon and aggravated assault, have been laid against a woman in this case. The man who robbed the Calgary station was not in police custody.¹⁴

Alberta: Acquittal in case of allegations of unsafe sex

On 27 March 2001, an Alberta trial court acquitted an HIV-positive man charged with aggravated sexual assault for not telling his girlfriend of his status before having unprotected sex. She testified that she and Fabion Dion Bear had unprotected sex many times between November 1999 and January 2000 after he told her he had no sexually transmitted diseases. She has since tested HIV-negative twice. Bear testified that he had told her he was HIV-positive and that they always used condoms. But he admitted he never told her he also has hepatitis C.

Trussler J of the Alberta Court of Queen's Bench said that she did not accept Bear's testimony and was unsatisfied with the evidence of other defence witnesses. However, in her view, there was reasonable doubt as to his guilt. She also described the alleged victim as not being "forthright," noting that she changed her testimony, lied under oath, and "had problems with drug and alcohol use." After acquitting Bear, the judge sharply criticized him, including for previously spitting on two police officers.¹⁵

British Columbia: Assault charges for spitting even though no risk of infection

In February 2001, an HIV-positive Victoria man was charged with assault for spitting on a bus driver. He had forgotten his bus pass and wanted to be allowed to ride for free. When the driver refused, he became angry and spat at the driver. The spit landed on the driver's pants. The man was arrested and charged with assault, and released the next day pending a court hearing. In the interim, he is banned from any public-transit bus and must surrender his bus pass. A BC Transit spokesperson told media that such an assault "instills a fear of disease" in the driver and driver's family, although there was no appreciable risk of infection as a result of spit landing on the driver's pants.¹⁶

British Columbia: Sentencing appeal for man charged with assaulting store security officer

In June 1999, John Perry was convicted of aggravated assault, assault with a weapon, and escaping lawful custody. The charges arose out of an altercation with security guards at a shopping mall, after Perry was

detained for shoplifting. In the course of the altercation, Perry hit one of the security guards repeatedly in the head with a hammer and bit him on the scrotum. Perry, an Aboriginal man living with both HIV and hepatitis C, claimed the altercation began after one of the guards made racist remarks about him and offensive comments about his wife, and that the security officer attacked him with the hammer.

He was sentenced to two five-year terms and a six-month term, all to run concurrently. In imposing the sentence, the trial judge noted:

His actions in striking the blows with the hammer and in biting the security guard, knowing that he was carrying the HIV and Hepatitis C viruses, could have left his victim with seriously permanent injury or worse.¹⁷

Perry appealed his sentence on a number of grounds, one of which was that the five-year term for the aggravated assault charge was excessive.

However, the BC Court of Appeal dismissed his appeal. Proudfoot JA, for the three judges, wrote:

This is a very serious assault and in view of the fact that the appellant has Hepatitis C and is HIV positive, the trauma involved for the victim must have been considerable. The victim was struck six times on the head with a hammer and required 17 stitches.... The five-year sentence is well within the appropriate range and should not be disturbed.¹⁸

It is not clear from the judgment how much weight was attached to Perry's HIV/hepatitis C status in relation to the severity of the injury done with the hammer. Neither the original sentencing judge nor the appellate court

seem to have considered the evidence regarding the low risk of transmitting HIV or hepatitis C via a bite (through clothing).

Ontario: Acquittal on allegations of unsafe sex

In March 2001, an HIV-positive man was acquitted in Timmins of charges of aggravated assault. A 25-year-old woman testified that she and Pierre Angnatuk-Mercier had sex at least three times without a condom, and that he had denied being HIV-positive. Angnatuk-Mercier insisted that he had used condoms and that she was aware he was HIV-positive. He testified that he had never had unprotected sex in the six years since his diagnosis. At the end of the trial, Karam J said it would be "unsafe to convict" the accused, given the number of inconsistencies in the complainant's testimony.¹⁹

Ontario: Spitting inmate requests at least two years in prison

On 19 December 2000, an HIV-positive inmate was sentenced to two years in a federal prison after pleading guilty to uttering death threats and assault causing bodily harm. Kenneth Ratte appeared in court on a rope leash, escorted by four guards wearing gloves, flak jackets, and protective eyewear. Ratte has a long criminal record, including crimes of violence. The most recent charges arise from an incident in September 2000, in which Ratte attacked a guard and spat at him. He pleaded "definitely guilty" to the charges and asked the court to give him a sentence of more than two years to ensure he was incarcerated in a federal institution, saying that he considered himself too dangerous an offender for a provincial institution.

A decade ago, he had been kept in solitary confinement for six months for repeatedly threatening to infect prison staff.²⁰

Concerns have been raised about the use of confidential medical information, obtained in the course of research studies, to gain a conviction in this case.

Newfoundland: Guilty plea to assault charges for unprotected sex

In January 2001, a St John's man pleaded guilty to two counts of aggravated assault for having unprotected sex with two women without disclosing his HIV-positive status.²¹ (Neither woman was infected.) Harold Williams is already serving a five-year sentence for a previous conviction in May 2000 on one charge of aggravated assault and one charge of common nuisance involving a third woman (who also was not infected). He is appealing both the conviction and sentence in that case.²² On 19 June 2001, Harold Williams was sentenced to an additional five years' imprisonment on these two new counts to be served after he finishes serving his first sentence, for total period of imprisonment of 10 years.²³

Newfoundland: Common nuisance charges dropped

In early July 2001, the Crown dropped a charge of "common nuisance" against an HIV-positive man in St John's, Newfoundland.²⁴ He had been charged in February 2000

after it was alleged that, in the course of working as a prostitute, he had engaged in unsafe sex without disclosing his status to a client.²⁵

United Kingdom

Scotsman sentenced to five years for HIV transmission

In February 2001, after a nine-day trial by a Glasgow court, Stephen Kelly was convicted of "culpable and reckless conduct" for having had unprotected sex with his ex-partner over a period of several months in 1993 and 1994 without disclosing his HIV status. On 16 March 2001, Kelly was sentenced to five years in prison. This was the first such case to be tried under Scottish law.²⁶

Kelly pleaded not guilty to the charge, testifying that he believed his ex-partner knew about his HIV status. She testified, however, that she only learned of his condition after she herself tested positive. She told the court that in March 1994, Kelly told her "a story" of how he had received a phone call from an ex-girlfriend who had AIDS and that he had gone for testing and received a positive result. However, once she tested positive, he later told her that he had been infected through sharing needles while in prison.

Kelly is a former heroin user and was in Glenochil prison when he was diagnosed with HIV in 1993. His ex-partner testified that she was aware he had been "promiscuous" in the past, had used heroin, and had spent time in prison. She testified that she had asked him about his HIV status, and that he told her he tested HIV-negative while in prison. There was an outbreak of hepatitis B and HIV in that prison, and Kelly was one of those who came forward for counseling and testing. However, a former nurse at the prison testified that Kelly

received his HIV-positive test results while in prison.

Concerns have been raised about the use of confidential medical information, obtained in the course of research studies, to gain a conviction in this case. Kelly had originally agreed to give a blood sample as part of the investigation into the outbreak of hepatitis B and HIV through needle sharing at Glenochil prison. Prisoners were told that samples were to be contributed confidentially and that test results would not be disclosed to anyone other than the outside research team without the prisoner's consent.²⁷ Kelly consented to his HIV-positive result being disclosed to prison medical authorities.

The police learned that Kelly was one of the prisoners infected in the outbreak. They also learned that a sample taken from his ex-partner, the complainant in the case, had been sent to a research project on the molecular epidemiology of HIV-1, and that her virus had been linked to the Glenochil virus. This information was used to help convict Kelly for having infected his partner.

During the course of the trial, Kelly's lawyer sought to prevent the results of the tests from being admitted into evidence. He argued that to allow the results as evidence would mean that prisoners would have to choose between authorizing disclosure of information that might end up being used as evidence against them in court or declining the opportunity of appropriate medical care. The court rejected this argument, noting that even before the research study had begun, Kelly had approached prison medical staff for an HIV test. The court also ruled that the samples taken in the context of the outbreak investigation were released to prison medical staff with his consent, and

that there is no absolute privilege that prevents such confidential medical information being revealed in a court proceeding.²⁸ Researchers have also raised a concern about the implications of such a development for their

An HIV-positive man had to serve a three-month jail sentence in a Vienna prison although he followed safer-sex guidelines issued by the Ministry of Health.

ability to conduct studies such as the one into the HIV and hepatitis B outbreak at Glenochil, or any other epidemiological research that links various clusters of HIV with personal identifying information.²⁹

United States

In April 2001, a man accused of transmitting HIV through unprotected sex to five women pleaded guilty to charges of aggravated assault with a deadly weapon. This is the first such case in Texas. Paul Hollingsworth was sentenced to nine months' probation because he is in the advanced stages of AIDS and was not expected to live long enough to face trial.³⁰

Austria

An Austrian gay/lesbian rights group reported in March 2001 that a 34-year-old HIV-positive man had been forced to serve a three-month jail sentence in a Vienna prison although he followed safer-sex guidelines issued by the Ministry of Health. The man was convicted in mid-1999, based on allegations that he had engaged in anal sex using condoms, and performed oral sex on another

man without the use of condoms. Although this conduct was in line with safer-sex guidelines, the court ruled that such acts were "conducive to the spread of a transmittable disease," which is prohibited under Article 178 of the Austrian Criminal Code.

One of the allegations was that he had oral sex on a man who was one month shy of his 18th birthday. Under Article 209 of the Austrian Criminal Code, the age of consent for gay male sex is 18 as opposed to 14 for heterosexual or lesbian sex. (International human rights groups such as Amnesty International and the International Lesbian and Gay Association have called upon Austria to repeal this discriminatory legislation, but such measures have not yet succeeded in the Austrian Parliament. Challenges to the law as unconstitutional and in violation of international human rights obligations are in progress.)

The court sentenced the man to a year in prison, but suspended eight months of the sentence. The man was jailed in March 2001.³¹

Denmark

In February 2001, the Danish Minister of Justice proposed amendments to the country's criminal law to support prosecutions against any person who "knowingly exposes" another to the risk of infection. The amendments would impose a penalty of up to four years in prison upon conviction. The proposal follows reports of a man who allegedly infected seven women in Denmark, Finland, Norway, and Sweden, and was charged after a Norwegian woman filed a complaint. He was not convicted because the Danish law against spreading a deadly disease defines "deadly" as one that causes death within 10 to 15 years.

Danish government officials said it was uncertain that this would still apply to HIV/AIDS, given treatment advances.³²

Germany

On 18 July 2001, a court in Stuttgart sentenced a 36-year-old man from the United States to 10 years in prison after finding that he had infected at least four women with HIV through sex without a condom or disclosure of his status. Although he disputed this and asserted he was innocent, the court found that Stoney Berly Gibbs knew he was HIV-positive when he arrived in Germany in 1999. He was found guilty of one count of rape, four counts of bodily harm, and 20 counts of attempted bodily harm. A 17-year-old girl brought the case to the attention of prosecutors when she tested HIV-positive and identified Gibbs as the source of her infection.³³

Zimbabwe

On 17 May 2001, the Parliament of Zimbabwe passed the *Sexual Offences Act*, which provides for stricter prison sentences of up to 20 years in prison for people convicted of knowingly infecting others with HIV/AIDS. Ordinarily, the maximum statutory penalty for rape is eight years' imprisonment. The new statute will also entitle women who are infected with HIV as a result of rape, and children born HIV-positive as a result of rape, to state health assistance.³⁴

Libya: Trial of Bulgarian health-care workers proceeds

Six Bulgarian health-care workers have pleaded not guilty to allegations that they intentionally infected 393 children with HIV at a Libyan hospital where they worked with blood

products contaminated with the virus. Nineteen health-care workers from Bulgaria were initially detained in February 1999 during an investigation into how the children were infected, but 13 were eventually released. Libyan state radio reported that prosecutors alleged that the infections were “part of a conspiracy of foreign intelligence forces aimed at undermining the security of Libya and its role in the Arab world.” Charges have reportedly also been laid against eight Libyans and a Palestinian. Defence lawyers have argued that the infections were the result of poor hygiene at the hospital, claiming that syringes were used repeatedly by Libyan staff. The prosecutor has called for the death penalty upon conviction.

The trial began on 7 February 2000, but further proceedings have been repeatedly postponed. In May 2001, the trial was postponed for a twelfth time in order to be able to question witnesses. In June 2001, the court denied the defence’s request to allow expert medical testimony, but also heard from two of the nurses that they had been tortured in custody. Defence counsel and groups such as Amnesty International and the International Lesbian and Gay Human Rights Association have also raised concerns that the “confessions” made by detainees have been obtained by torture, an accusation the Libyan government denies. The matter was also raised by Bulgaria at the recent UN General Assembly Special Session on HIV/AIDS in New York City, 25-27 June 2001. Media have reported that a verdict is expected in September 2001.³⁵

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¹ *R v Cuerrier*, [1998] 2 SCR 371, 127 CCC (3d) 1. Summarized at: Elliott R. Supreme Court rules in *R v Cuerrier*. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 1, 17-24. For in-depth analysis of the decision, including a discussion of a possible “safer sex” or “lower risk” defence to assault charges, see: Elliott R. *After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status*. Montréal: Canadian HIV/AIDS Legal Network, 1999 (available at www.aidslaw.ca/Maincontent/issues/criminalaw.htm).

² 2001 NSSC 80, [2001] NSJ No 221 (QL).

³ *Cuerrier*, supra, note 1 at para 129.

⁴ *Edwards*, supra, note 2 at para 6.

⁵ *Ibid* at para 14.

⁶ *Ibid* at paras 17-19.

⁷ *Ibid* at para 22.

⁸ *Ibid* at paras 20-21.

⁹ *Ibid* at para 25.

¹⁰ Nova Scotia: Blood threatener jailed. *Vancouver Sun*, 2 May 2001: A5.

¹¹ Bohn G. Vancouver warned of man charged with spreading AIDS. *Vancouver Sun*, 21 April 2001: B1; Cherry P. Suspect charged in HIV case: MUC police say alleged prostitute tried to infect three women with virus. *The Gazette* [Montréal], 21 April 2001: A3; Montrealeur charged with spreading HIV may have visited Toronto, Vancouver. *CP Wire*, 21 April 2001; Pigeon M. Il se disait “un gars propre”. *Le Journal de Montréal*, 20 April 2001: 4; Laroche M. Inculpation d’un sans-abri qui semait le VIH à tout vent. *La Presse* [Montréal], 20 April 2001: E2.

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¹⁵ Blais T. HIV lover not guilty of assault. *Calgary Sun*, 28 March 2001: 19; HIV-positive man acquitted of assault. *Globe and Mail*, 29 March 2001; Purdy C. Woman shocked that ex-sex partner had HIV, she tells court. *Edmonton Journal*, 27 March 2001: B4.

¹⁶ Westad K. Spitting results in charge of assault. *Times Colonist* [Victoria], 28 February 2001: B4.

¹⁷ *R v Perry*, 2001 BCCA 341, [2001] BCJ No 990 (QL) at para 9, citing the sentencing judge.

¹⁸ *Ibid* at para 14.

¹⁹ HIV-carrier tried for assault. *The Gazette* [Montréal], 6 March 2001: E8; Man with HIV always used protection during sex, Timmins assault trial told. *CP Wire*, 7 March 2001; Ontario: Man with HIV not guilty. *National Post*, 21 March 2001: A10; Personal communication with R. Carey, HIV & AIDS Legal Clinic – Ontario, 19 March 2001.

²⁰ Armstrong F. Con led into court on leash, asks judge for stiff sentence. *Kingston Whig-Standard*, 20 December 2000: 1.

²¹ Belec B. Man never told women he was HIV-positive. *Telegram* [St John’s], 20 January 2001: 3; Belec B. Scars will never go away for victim: Knowingly exposed to HIV by ex-boyfriend. *Telegram* [St John’s], 19 May 2001: 1.

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²⁶ See the following web-posted articles from the BBC News On-line (accessed 19 March 2001 at <http://news.bbc.c.uk>): HIV ‘infection’ trial begins, 13 February 2001; Boyfriend revealed he had HIV, 15 February 2001; Woman denies knowing man had HIV, 16 February 2001; Woman ‘did not condemn’ HIV man, 20 February 2001; Court hears HIV ‘admission’, 21 February 2001; ‘No crime’ claim in HIV trial, 22 February 2001; HIV man guilty of infecting girlfriend, 23 February 2001; Fears for sufferers after HIV verdict, 23 February 2001; HIV victim says justice done, 16 March 2001. See also: Scottish man jailed for passing HIV. *Associated Press*, 19 March 2001; Britain-AIDS: Man on trial over HIV infection, in legal first for Britain. *Agence France-Presse*, 14 February 2001.

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DISCRIMINATION & HUMAN RIGHTS

HIV/AIDS and Human Rights Revisited

In their article, Sofia Gruskin and Daniel Tarantola demonstrate how, as the number of people living with HIV and with AIDS continues to grow in nations with different economies, social structures, and legal systems, HIV/AIDS-related human rights issues are not only becoming more apparent, but also increasingly diverse. In the 1980s, the relationship of HIV/AIDS to human rights was only understood as it involved people with HIV or AIDS and the discrimination to which they were subjected. The concerns included mandatory HIV testing; restrictions on international travel; barriers to employment and housing, access to education, medical care, or health insurance; and the many issues raised by named reporting, partner notification, and confidentiality. Almost 20 years into the epidemic, these issues remain serious and most often have not been resolved. In the 1990s, however, there was increased understanding of the importance of human rights as a factor in determining people's vulnerability to HIV infection and their consequent risk of acquiring HIV infection and their chances of accessing appropriate care and support. And most recently, human rights have also come to be understood to be directly relevant to every element of the risk/vulnerability paradigm. Gruskin and Tarantola identify three situations and three levels of governmental obligations that should be considered when identifying the specific needs and related rights of individuals in the context of HIV/AIDS. They conclude that policymakers, program managers, and service providers must become more comfortable using human rights norms and standards to guide and limit government action in all matters affecting the response to HIV/AIDS; and that those involved in HIV/AIDS advocacy must become more familiar with the practicalities of using international human rights law when they strive to hold governments accountable.

Policymakers, program managers, and service providers must become more comfortable using human rights norms and standards to guide and limit government action in all matters affecting the response to HIV/AIDS.

Introduction

HIV continues to spread throughout the world, shadowed by increasing challenges to human rights both within countries and globally. The virus continues to be marked by discrimination against population groups: those who live on the fringes of society or who are assumed to be at risk of infection because of behaviours, race, ethnicity, sexual orienta-

tion, gender, or whatever social characteristics happen to be stigmatized in a particular society. In most of the world, discrimination also jeopardizes equitable distribution of access to HIV-related goods for prevention and care, including drugs necessary for HIV/AIDS care and the development of vaccines to respond to the specific needs of all populations, in both the North and the South. As the number of people living with HIV

and with AIDS continues to grow in nations with different economies, social structures, and legal systems, HIV/AIDS-related human rights issues are not only becoming more apparent, but also increasingly diverse.

The interaction between HIV/AIDS and human rights is most often illustrated through the impact on the lives of individuals of neglect, denial, and violation of their rights in

the context of the HIV/AIDS epidemics. This is equally the case, albeit in different ways, for women, men, and children infected with, affected by, and vulnerable to HIV.

People *infected* with HIV may suffer from violations of their rights when, for example, they face government-condoned marginalization and discrimination in relation to access to health, education, and social services.¹ In this context, the realization of rights by people living with HIV would require non-discriminatory access within a supportive social environment. People are *affected* by HIV/AIDS when their close or extended families, their communities and, more broadly, the structures and services that exist for their benefit are strained by the consequences of the pandemic and as a result fail to provide them with the support and services they need. These negative effects of the HIV epidemics on people's lives may be compounded by marginalization and stigmatization on the basis of such attributes as race, migrant status, behaviours, or kinship that may be perceived as risk factors for HIV infection.

Violations of many of the rights of people affected by HIV may involve restricted or denied access to health services, education, and social programs.² People affected with HIV may progress toward the realization of their rights and better health if the personal, societal, and other impacts of the HIV epidemics on their lives are alleviated. This requires policies and programs designed to extend support and services to affected families and communities. Children orphaned by HIV/AIDS illustrate this need.

Vulnerability to HIV is the lack of power of individuals and communi-

ties to minimize or modulate the risk of exposure to HIV infection. Even in populations where HIV has not spread widely, some individuals may be more *vulnerable* than others with regard to HIV. For example, gender differentials may impose on a monogamous woman that she engage in unprotected sex with her spouse, even if he is engaging in sex with others. Adolescent girls and boys may be vulnerable to HIV by the mere fact that they are denied access to preventive information, education, and services. A truck driver's vulnerability to HIV may be enhanced by peer pressure to engage in multiple unprotected sexual encounters. Sex workers may be at greater vulnerability to HIV if they cannot access services able to diagnose and treat sexually transmitted infections, particularly if they are afraid to come forward because of the stigma associated with their occupation. Vulnerability is enhanced by the denial of such rights as the rights to information, education, association, or to essential care. To reduce vulnerability requires actions that enable individuals and communities to make and effectuate choices in their lives and thereby effectively modulate the health risks to which they may be exposed.

The effects of discrimination, particularly in the forms of racism, gender-based discrimination, and homophobia, continues to exacerbate the impact of the pandemic on the lives of individuals and populations around the world. It is increasingly recognized that realization of human rights is critical to protecting the rights and dignity of those infected and affected by HIV/AIDS, and to decreasing the relative vulnerability of individuals and communities.

Recognition of the Relationship Between Human Rights and HIV/AIDS

In the 1980s, the relationship of HIV/AIDS to human rights was only understood as it involved people infected with HIV and AIDS and the discrimination to which they were subjected.³ For HIV-infected people and people with AIDS, the concerns included mandatory HIV testing; restrictions on international travel; barriers to employment and housing, access to education, medical care, or health insurance; and the many issues raised by named reporting, partner notification, and confidentiality. These issues are serious, and almost 20 years into the epidemic they have not been resolved. In some ways, the situation has become even more complicated, as old issues crop up in new places or present themselves in new and different ways. For example, in certain settings, access to employment used routinely to be denied to people infected with HIV. Even in places where this situation has improved, HIV-positive individuals now run the risk of finding themselves excluded from workplace health insurance schemes, with considerable impact on their health and, therefore, on their capacity to work. There are also new issues, with tremendous human rights implications, that have been raised for HIV-positive people in recent years, including the large and growing disparities and inequities regarding access to antiretroviral therapies and other forms of care.⁴

The 1980s were extremely important in defining some of the connections between HIV/AIDS and human rights. In fact, by the end of the

decade the call for human rights and for compassion and solidarity with people living with HIV/AIDS had been explicitly embodied in the first WHO global response to AIDS.⁵ This approach was motivated by moral outrage but also by the recognition that protection of human rights was a necessary element of a worldwide public health response to the emerging epidemic. The implications of this call were far-reaching. By framing this public health strategy in human rights terms, it became

The importance of bringing HIV/AIDS policies and programs into line with international human rights law is generally acknowledged but, unfortunately, rarely carried out in reality.

anchored in international law, thereby making governments and inter-governmental organizations publicly accountable for their actions toward people living with HIV/AIDS. The groundbreaking contribution of this era lies in the recognition of the applicability of international law to HIV/AIDS – and therefore to the ultimate responsibility and accountability of the state under international law for issues relating to health and well-being.⁶ The strong focus in the 1980s on the human rights of people living with HIV/AIDS helped pave the way for increased understanding in the 1990s of the importance of human rights as a factor in determining people's vulnerability to HIV infection and their consequent risk of acquiring HIV infection and chances

of accessing appropriate care and support.⁷ It is only very recently, however, that human rights have also come to be understood to be directly relevant to every element of the risk/vulnerability paradigm.

Government Responsibilities for Human Rights in the Context of HIV/AIDS

Given the reality of violations that continue to occur in the context of HIV/AIDS, it is useful to consider the specific human rights responsibilities of governments. Governments are responsible for not violating rights directly, as well as for ensuring the conditions that enable people to realize their rights as fully as possible. It is understood that, for every human right, governments have responsibilities at three levels: they must respect the right; they must protect the right; and they must fulfill the right.⁸ As an illustration, consider governmental obligations in the context of HIV, using one right – the right to education.

- **Respecting the right** means that states cannot violate the right directly. This means that the right to education is violated if children are barred from attending school on the basis of their HIV status.
- **Protecting the right** means that a state has to prevent violations of rights by non-state actors – and offer some sort of redress that people know about and have access to if a violation does occur. This means that a state has to ensure, for example, that groups motivated by extremist ideologies are not successful when they try to stop adolescents from accessing reproductive-health education.
- **Fulfilling the right** means that states have to take all appropriate

measures – legislative, administrative, budgetary, judicial, and otherwise – toward fulfilling the right. If a state fails to provide essential HIV/AIDS prevention education in enough languages and mediums to be accessible to everyone in the population, this in and of itself could be understood to be a violation of the right to education.

In most countries, resource and other constraints can make it impossible for a government to fulfill all rights immediately and completely. The mechanisms responsible for monitoring governmental compliance with human rights obligations recognize that, in practical terms, a commitment to the right to basic education is going to require more than just passing a law. It will require financial resources, trained personnel, facilities, textbooks, and a sustainable infrastructure. Therefore, realization of rights is generally understood to be a matter of making steady progress toward a goal. This principle of “progressive realization” is fundamental to the achievement of human rights. This is critical for resource-poor countries that are responsible for striving toward human rights goals to the maximum extent possible; but it is also important because it imposes an obligation on wealthier countries to engage in international assistance and cooperation.⁹

Using human rights concepts, one can look at the extent to which governments are progressively respecting, protecting, and fulfilling their obligations for all rights – civil, political, economic, social, and cultural – and how these government actions influence the patterns of who is getting infected and what is being done about it.¹⁰

HIV/AIDS, Public Health, and Human Rights in Practice

Advocacy and accountability

Governments are responsible for promoting and protecting both public health and human rights. None of the human rights treaties specifically mentions HIV or the rights of individuals in the context of HIV/AIDS, yet all the international human rights mechanisms responsible for monitoring government action have expressed their commitment to exploring the implications of HIV/AIDS for governmental obligations. This may be of critical importance for bringing HIV/AIDS and human rights together in practical and concrete ways. In addition, governments have made political commitments at international conferences such as the Cairo International Conference on Population and Development and the UN Fourth World Conference on Women, stating their responsibility for ensuring the rights of individuals in the context of HIV/AIDS.¹¹ Resolutions of the UN Commission on Human Rights and the 1998 International Guidelines on HIV/AIDS and Human Rights provide both advocates and policymakers with useful tools for helping to ensure increased attention to both HIV/AIDS and human rights.¹² The Declaration of Commitment that came out of the UN General Assembly Special Session on HIV/AIDS in June 2001 may become a critically important document for advocacy and accountability in relation to HIV/AIDS and human rights.

Human rights in HIV/AIDS policy and program design

Recognizing human rights in the design, implementation, and evaluation of health policies and programs can help point the way toward more effective action. Human rights are governmental obligations toward individuals; because these obligations include the protection of public health, they are relevant to the design, implementation, and evaluation of health policies and programs.¹³ Based on these obligations, governments can be understood to be legally responsible for instituting policies and programs that can reduce the spread and impact of HIV/AIDS.

Examining public health through a human-rights lens means looking not only at the technical and operational aspects of public health interventions but also at the civil, political, economic, social, and cultural factors that surround them.¹⁴ These factors may include, for example, gender relations, religious beliefs, homophobia, or racism. Individually and in synergy, these factors may influence the extent to which individuals and communities are able to access services or to make and effectuate free and informed decisions about their lives and, therefore, the extent of their vulnerability to HIV/AIDS, including accessing needed care and support once HIV infection has set in.

HIV/AIDS policies and programs can be improved by a systematic review of how and to what extent interventions are both respectful of human rights and of benefit to public health. The following questions can be used by policymakers and public health and other government officials to help in the development, imple-

mentation, and evaluation of more effective HIV/AIDS policies and programs. They can also be used by nongovernmental organizations and other concerned actors as an advocacy tool to hold governments accountable for the ways they are and are not in compliance with their international legal obligations to promote and protect both public health and human rights. They are intended only to serve as a starting point:¹⁵

- What is the specific intended purpose of the policy or program?
- What are the ways and the extent to which the policy or program may impact positively and negatively on public health?
- Using the international human rights documents for guidance, what and whose rights are impacted positively and negatively by the policy or the program?
- Does the policy or program necessitate the restriction of human rights?
- If so, have the criteria/preconditions been met?
- Are the health and other relevant structures and services capable of effectively implementing the policy or program?
- What steps are being taken to progress toward the optimal synergy between the promotion and protection of health and rights in relation to the issue?
- What system of monitoring, evaluation, accountability, and redress exists to ensure that the policy or program is progressing toward the intended effect and that adverse effects are acted upon?

A Framework for action

An agenda for action can be created by recognizing the convergence of the three situations in which people

TABLE 1 *Governmental Obligations with Respect to People in the Context of HIV/AIDS*⁶

	People infected with HIV	People affected by HIV/AIDS	People vulnerable to HIV/AIDS
Respect	Government to refrain from directly violating the human rights of people living with HIV/AIDS on the basis of their HIV status.	Government to refrain from directly violating the rights of people affected by the HIV/AIDS pandemic.	Government to refrain from directly violating human rights that impact on vulnerability.
Protect	Government is responsible for preventing rights violations by non-state actors against people living with HIV/AIDS and for providing some legal means of redress.	Government is responsible for preventing violations by non-state actors that would increase the burden of HIV/AIDS on affected people, and for providing some legal means of redress.	Government is responsible for preventing rights violations by non-state actors that may increase people's vulnerability to HIV/AIDS, and for providing some legal means of redress.
Fulfill	Government to take administrative, legislative, judicial, and other measures toward the realization of the rights of people living with HIV/AIDS.	Government to take administrative, legislative, judicial, and other measures toward the realization of the rights of people affected by HIV/AIDS.	Government to take administrative, legislative, judicial, and other measures toward the realization of the rights of people in order to minimize their vulnerability to HIV/AIDS.

live in a world with HIV/AIDS – infected, affected, and vulnerable – and the three levels of government obligations that exist for every right: respect, protect, and fulfill. This approach has the power to bring about the incorporation of human rights promotion and protection into the diversity of responses designed to bring the pandemic under control and mitigate its impact. Table 1 summarizes the three situations and three levels of obligation that should be considered when identifying the specific needs and related rights of individuals in the context of HIV/AIDS.

Conclusion

People living with HIV/AIDS, their friends and relatives, their communities, national and international policy- and decision-makers, health professionals, and the public at large all, to varying degrees, understand the fundamental linkages between HIV/AIDS and human rights. The importance of bringing HIV/AIDS policies and programs into line with international human rights law is

generally acknowledged but, unfortunately, rarely carried out in reality. Policymakers, program managers, and service providers must become more comfortable using human rights norms and standards to guide and limit the actions taken by or on behalf of governments in all matters affecting the response to HIV/AIDS. This requires genuine attention to building their capacity to recognize and promote the synergy between health and human rights, and to more fully appreciate the gains to be achieved when health interventions are guided by human rights principles. Those involved in HIV/AIDS advocacy must become more familiar with the practicalities of genuinely using international human rights law when they strive to hold governments accountable. For human rights to remain relevant to legal and policy work in HIV/AIDS, the contact between the conceptual work being done on the linkage between HIV/AIDS and human rights and the realities being faced by those working in advocacy and in policy and

program design must be constant. It is the mutually supportive – although occasionally mutually challenging – interaction between these that will help keep this work vital and useful.

– *Sofia Gruskin and Daniel Tarantola*

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⁴ See, for example: Statement from the community AIDS movement in Africa, presented at the meeting on the international partnership against HIV/AIDS in Africa. New York, UN Headquarters, 6-7 December 1999.

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⁹ International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp NO. 16, at 49, UN Doc. A/6316 (1966), Article 2.

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¹² See, in particular: Office of the United Nations High Commissioner for Human Rights and the Joint United Programme on HIV/AIDS. *HIV/AIDS and Human Rights: International Guidelines*. UN Doc HR/PUB/98/1 (1998).

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¹⁴ Gruskin, supra, note 10.

¹⁵ International Federation of Red Cross and Red Crescent Societies and François-Xavier Bagnoud Center for Health and Human Rights. The public health-human rights dialogue. In: *AIDS, Health and Human Rights: An Explanatory Manual*. Boston, 1995. WHO/UNAIDS. Partner Notification and Disclosure of HIV and/or AIDS Serostatus to Others. Geneva, June 1999.

¹⁶ Adapted from Tarantola D, Gruskin S. Children confronting HIV/AIDS: charting the confluence of rights and health. *Health and Human Rights* 1998; 3(1): 70.

Measuring Legal Implementation of the International Guidelines on HIV/AIDS and Human Rights

With over 36 million people now living with the virus and over 21 million people dying of AIDS in the last two decades, HIV/AIDS is a global health and security problem. These shocking figures eclipse the human toll of many wars, and reveal in themselves that human rights are not being respected, protected, or fulfilled, either through negligent omissions or violations.

A human rights approach to the epidemic was advocated early by advocates such as Jonathan Mann, who recognized that infections thrived in conditions of inequality.¹ This approach was crystallized in the International Guidelines on HIV/AIDS and Human Rights that were developed at the Second International Consultation in 1996 convened by UNAIDS and the Office of the High Commissioner for Human Rights.² The Guidelines cover three main areas: improving governmental responses in terms of multisectoral responsibility and accountability; widespread law reform and legal support services; and supporting increased private sector and community participation in effective responses to the epidemic. This article focuses on the half of the twelve Guidelines that concern rights that are justiciable and amenable to law reform. It highlights the responsibilities of States Parties to human rights treaties, as they bear the principal burden of the obligations to implement.³

Some work has been done to promote the Guidelines, such as a Handbook for Legislators that was launched in 1999, but not enough to make a real difference.⁴ David Patterson noted in an earlier article that dissemination of the Guidelines has been inadequate, despite work from pioneering NGOs such as the International Council of AIDS Service Organizations (ICASO).⁵ The response from governments, including Canada, to the Guidelines has been dis-

appointing, but Patterson calls on developed countries to take a leadership role in implementing the Guidelines.⁶ The UN Commission on Human Rights considered a report on promotion and implementation of the Guidelines in April 2001 that was more comprehensive than previous ones, and documented 36 responses by national governments, international and regional agencies, and NGOs.⁷

There has been recent criticism that the Guidelines are overly legalistic.⁸ However, this article takes the approach that instead of being seen as a limitation, law reform is a necessary but not sufficient measure – it cannot be used alone in order to achieve far-reaching social change in huge areas such as poverty reduction. Legislative expression of rights does not guarantee actual compliance with international standards, nor does it discount extra-legal forms of administrative implementation. However, law is a vital tool in struggles that have taken place in some countries in relation to human rights, including

economic and social rights such as health – for example, increasing access to treatment in countries like Brazil by legislative provisions.⁹

Public shaming at the domestic and international levels is a key method of improving compliance with legitimate international human rights norms.

ICASO has reported on human rights research initiatives, and is currently conducting a project in several countries on implementation of Guideline 6, which requires the provision of safe and effective medications at affordable prices.¹⁰

Many countries are thought not to be complying with the binding human rights norms contained in the Guidelines, but the extent to which this occurs is unknown. A monitoring and evaluation approach has recently been taken to increasing the effectiveness of integrated and coordinated AIDS interventions (such as the AIDS Program Effort Index developed by the Futures Group International/POLICY Project).¹¹ At the XIII International AIDS Conference held in Durban in 2000, one of several important issues raised and discussed was measuring the empirical effect a human rights environment has on the epidemic.¹² This article recommends taking a measurement approach to health and human rights by using a Legal Rights Implementation Measuring Instrument to evaluate the extent to which countries have implemented the Guidelines, by conducting

systematic audits of legislation and the common law (where applicable).

The Instrument was designed for the Australian National Council on AIDS, Hepatitis C and Related Diseases in 1999.¹³ It has been piloted by the author in early 2001 at the State/provincial level in Australia, with input from NGOs. The process is important in putting participation rights into meaningful practice, as well as capitalizing on local expertise and knowledge of detailed and often complex legislation.

The social-science methodology used attempts to be as transparent as possible, without compromising technical accuracy.¹⁴ The Instrument consists of 10 indicators in the areas of public health (including informed consent to HIV testing, due-process protections, availability of condoms, needle and syringe exchanges, and a safe blood supply), anti-discrimination, privacy and confidentiality, sexual offences, the sex industry, prisons, employment, legal equality of vulnerable populations, regulation of professionals and ethical research, therapeutic goods, and media. Questions in the indicators are as specific and structured as possible so that subjectivity in scoring the legal effect of relevant provisions is minimized.

These 10 areas of the Guidelines have been selected as significantly impacting on the determinants of health in order to prevent infection and reduce the social impact of infection. These indicators are not precisely equivalent to each other because the nature and relative weights of the rights being analyzed vary. Scoring is divided into four quadrants for each indicator – minimal, partial, significant, and substantial implementation.

Measurement using numerical scores of these qualitative features attempts to give a comprehensive overview of legal responses that may be compared over time and between jurisdictions to show whether the situation has improved or deteriorated with reform. The Instrument needs to be applied individually to State/provinces in federal systems before a composite national score can be achieved. It is hoped that following the pilot, Australia will embark upon a comprehensive application of the Instrument in all jurisdictions, as this has already occurred in another area (mental health).¹⁵

It is intended that the Instrument may be used internationally, especially as an accountability tool through the UN human rights treaty bodies that States Parties are required to report to regularly.¹⁶ Public shaming at the domestic and international levels is a key method of improving compliance with legitimate international human rights norms. Political commitment by governments facilitating the process is important, but not crucial, to its success, as the exercise could be simply carried out by NGOs in compiling “shadow reports” to accompany official government reports.

The Instrument attempts to make evaluation more objective, and thus the arguments based on its results more convincing and digestible to legislators and policymakers. NGOs in countries such as the UK have already begun using the Guidelines and the Instrument to prod government into action. The National AIDS Trust has described the Guidelines as “an authoritative audit and advocacy tool that focuses the mind on the full

breadth of policy that requires being scrutinised against human rights benchmarks.”¹⁷ The UK All-Party Parliamentary Group on AIDS conducted an inquiry in early 2001 to consider the extent to which the government is in compliance with the Guidelines.¹⁸

The Instrument is only designed to cover legal implementation as a discrete first step, and later projects may measure the equally important issues of measuring the gap between formal law and actual practice, as well as administrative and other more fluid means of implementing human rights. All and any of these forms of measurement that are statistically manipulable may then be linked with epidemiological data to provide solid evidence of whether the intuitive link between health and human rights is borne out empirically.

A major challenge is to make this work relevant to developing countries, where 95 percent of the epidemic is concentrated.¹⁹ Particularly concerning is the recognition that unprecedented political and legal equality can coexist with spiraling infection rates as the epidemic grows exponentially in countries such as South Africa.²⁰ This is not a reason, however, to abandon law reform, but

instead to refocus efforts into complementary means of addressing inequalities that are determinants of the epidemic.

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¹ Mann J, Tarantola D. Responding to HIV/AIDS: a historical perspective. *Health and Human Rights* 1998; 2: 5.

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³ Including the International Bill of Rights, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment.

⁴ UNAIDS and the Inter-Parliamentary Union. *Handbook for Legislators on HIV/AIDS and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact*, UNAIDS/99.48E.

⁵ International Council of AIDS Service Organizations. *NGO Summary and Advocate's Guide on the International Guidelines on HIV/AIDS and Human Rights*, 1997.

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¹¹ Stover J, Rehnstrom J, Schwartlander B. Measuring the Level of Effort in the National and International Response to HIV/AIDS: The AIDS Program Effort Index (API), paper presented to the XIII International AIDS Conference, Durban, 2000. See also UNAIDS. *National AIDS Programmes: A Guide to Monitoring and Evaluation*, June 2000, UNAIDS/00.17E, at 31.

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¹³ Watchirs H. *A Rights Analysis Instrument to Measure Compliance with the International Guidelines on HIV/AIDS and Human Rights*. Australian National Council on AIDS, Hepatitis C and Related Diseases, 1999.

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¹⁹ UNAIDS. *AIDS Epidemic Update*, December 2000.

²⁰ Albertyn C. Using Rights and the Law to Reduce Women's Vulnerability to HIV/AIDS. Discussion Paper produced for the Satellite Symposium, Putting Third First – Critical Legal Issues and HIV/AIDS, XIII International AIDS Conference, Durban 2000; see www.aidslaw.ca/durban2000/e-durban-women.htm.

CANADIAN NEWS

Ontario to Develop a Viatical Industry

On 4 October 2000, Bill 119 (or the Red Tape Reduction Act, 2000) was introduced and received first reading in Ontario's provincial legislature. Like many of the other similarly titled bills the Harris government has introduced, Bill 119 proposes to change a long list of existing statutes in an effort to make Ontario more business friendly. Schedule G of Bill 119 sets out a mechanism whereby a viatical industry in Ontario would be made legal if a licensing scheme is first put in place by the Ministry of Finance.

Viatical settlements involve the sale of a life insurance policy by a dying insured (called a "viator") to a third party. The insured signs an irrevocable designation that ensures the purchaser will be paid the proceeds of the policy upon the insured's death. The purchaser gives the insured a lump sum in exchange. In Ontario, that amount is usually a maximum of 50 percent of the value of the policy upon the insured's death.

Since at least 1980 in Ontario, viatical settlements have been illegal unless the purchasing of the policy involved is done by an insurance company.¹ The penalty for a conviction is a fine of not more than \$100,000 for a first offence, and a fine of not more than \$200,000 for each subsequent offence.² In fact viatical settlement companies are illegal in most jurisdictions in Canada, with the exception of Québec, Saskatchewan, New Brunswick, and Nova Scotia.³ Despite the illegality of the practice, viatical settlements by private interests (excluding insurance companies) have occurred in Ontario without prosecution, albeit not in large numbers.⁴

The experience of the HIV & AIDS Legal Clinic (Ontario) has been that the primary problem with

the illegality of the small viatical industry is the common-law rule concerning illegal contracts. Consider the situation in which a person with HIV/AIDS enters into a contract that says they will sign an irrevocable designation of the proceeds of their life insurance policy in exchange for three payments of \$10,000 each, which shall be made on days one, two, and three. The designation is executed on day one and \$10,000 is paid. If the viatical settlement company refuses to make payments on days two or three, there is a breach of contract. However, when an illegal contract is breached, the normal response of any court asked to help enforce the contract is that it will not enforce an illegal contract. As a result, people with HIV/AIDS are not going to be able to obtain judgment for the missing \$20,000. Instead, they can only apply to a court for a declaration that the contract is unenforceable, and the court will order the viator to return the \$10,000 to the party in breach and void the irrevocable designation. This is not the response to the problem that people with HIV/AIDS want, and they probably do not have the \$10,000 anymore to return to the other party.

As stated above, viatical settlements entered into by insurance

companies are not illegal in Ontario. Despite the legality of insurance companies entering into the viatical business, they have not chosen to do so in Ontario. Instead, beginning in 1988, insurers in Ontario have allowed insured people with HIV/AIDS access to "living benefits" if it is clear that their life expectancy is less than two years. Living-benefit schemes, unlike viatical settlements, are not sales. Rather, they are loans against the face value of the policy. The insured receives a fraction of the value of the policy and the insurance company charges administrative fees or interest against the rest of the

A Canadian viatical industry is highly unlikely to resemble that of the US.

value of the policy until the policy is exhausted, or the insured dies. If, upon the death of the insured, there is any remaining value to the policy, it passes to the named beneficiary.

Bill 119 was debated in the provincial legislature at second reading on the 11th, 12th and 16th of October 2000. The legalization of viatical settlements was not raised as part of the debate at that time. After second reading was moved and

passed, the Bill was referred to the Standing Committee on General Government on 17 October 2000 for consideration. The Standing Committee elected to hold public hearings. The Hansard for the Committee shows that there was only one person who appeared before the Committee to discuss the issue of the legalization of viatical settlements. That was Mark Daniels, a representative of the Canadian Life and Health Insurance Association (CLHIA). He appeared on 1 November 2000.

The CLHIA represents approximately eighty life and health insurers in Canada. Their membership holds some 90 percent of the life and health insurance in force in Canada. Their submission to the Standing Committee relied heavily on horror stories about the viatical industry in the United States – 137 pages of articles about the industry in the US over a six-month period were submitted to the Standing Committee.⁵ The dangers of a viatical industry are fairly obvious. Because the purchaser of the policy is gambling that the insured will die soon, realizing the investment means tracking the health of the insured, and can involve calling to see if the insured has died yet. Such purchasers have a direct, financial interest in early deaths, which creates an industry that is repugnant to many people. Investors in viatical companies in the US have a similar interest in knowing personal-health information about the viators whose deaths they are eagerly awaiting. As a result, serious privacy issues arise in protecting viators from unscrupulous investors. The CLHIA also raised the concern that people with terminal illnesses would have a motive to commit fraud and obtain policies they could then sell.

A Canadian viatical industry is highly unlikely to resemble that of the US, primarily because the motive for most viators in selling their life insurance is to obtain funding for medical treatment and food and shelter, and because the potential volume of trading in viatical settlements available in any given province would be comparatively small. In the US there are approximately 70 viatical companies dealing in an estimated \$500 million in viatical settlements annually.⁶ Over 30 US states have laws regulating viatical settlements, many of them based on a draft model created by the American insurance industry. Extensive information about the US model law can be found on the website of the National Association of Insurance Commissioners at www.naic.org.

The position of the CLHIA before the Standing Committee was that Schedule G of Bill 119 should not be passed, suggesting instead that separate legislation be created after careful consideration of how such an industry should be regulated in the best interests of all parties involved. The CLHIA recommended the draft model used in the US be looked at as a starting point. In the alternative, it recommended that Schedule G not be proclaimed in force until stringent regulations could be drafted and reviewed by the Standing Committee.

On 15 November 2000, the Standing Committee met to discuss what recommendations it would make regarding Bill 119. With regard to Schedule G, it was decided to recommend to the Minister of Finance that the new provisions not be proclaimed until the insurance industry was given a chance to examine and comment on the regulations that

would govern the licensing of the new viatical industry. With that promise in place, Schedule G of Bill 119 was approved by the Standing Committee and the Bill was returned to the legislature for third reading and debate.⁷

On 4 December 2000, Bill 119 received third reading. There was no substantive debate about the benefits and dangers of creating a private viatical industry in Ontario. Rather, most of the debate focused on the omnibus nature of the Bill and the massive changes to many pieces of legislation that were to take place with little opportunity for debate or comment. On 5 December 2000, Bill 119 passed by a vote of 46 to 38.

That said, Schedule G of Bill 119 has not been proclaimed as of the date of writing, and so has not come into effect. Mark Daniels of the CLHIA indicates that it is expected that, prior to proclamation, the draft regulations concerning how viatical settlement companies will be licensed and regulated will be distributed to the insurance industry for comment.⁸ Clearly it would also be in the best interests of people with HIV/AIDS to play a role in commenting on any draft regulations, particularly to ensure that the regulation of a viatical industry in Ontario truly addresses the privacy and enforcement issues of viators.

The text of Bill 119, including Schedule G, can be accessed online at www.ontla.on.ca/Documents/StatusofLegOUT/b119ra_e.htm.

– Ruth Carey

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NOTES

¹ *Insurance Act*, RSO 1990, c 1-8, s 115 provides: "Any person, other than an insurer or its duly authorized agent, who advertises, or holds himself, herself or itself out as a purchaser of life insurance policies or of benefits thereunder, or who trafficks or trades in life insurance policies for the purpose of procuring the sale, surrender, transfer, assignment, pledge or hypothecation thereof to himself, herself, or itself or any other person, is guilty of an offence."

² *Ibid*, ss 447(3) and (4).

³ Canadian Life and Health Insurance Association Inc. Submission to the Standing Committee on General Government of the Legislative Assembly of Ontario regarding Bill 119, Red Tape Reduction Act, 2000 (Toronto: October 2000), at 5.

⁴ This information is contained on file with the HIV & AIDS Legal Clinic (Ontario).

⁵ Both documents are available on the CLHIA website at

www.clhia.ca/.

⁶ Joseph Spina, MPP for Brampton Centre, as reported in Hansard, 37th Parliament, Session 1, 4 December 2000, at 2100.

⁷ Standing Committee on General Government, Hansard, 37th Parliament, Session 1, 15 November 2000.

⁸ Personal communication with the author.

SEX WORK

Alberta Law Confining Child Prostitutes Upheld

The Alberta Court of Queen's Bench has determined that the Alberta Protection of Children Involved in Prostitution Act is not in violation of the Constitution.¹ This decision overturns the ruling of the Provincial Court, which held that the Act infringes the rights articulated in sections 7, 8, and 9 of the Charter.²

The controversial Act was created to protect underage child prostitutes based on the presumption that such children are victims of abuse.

Under the Act, law enforcement and child welfare officials can apply for an order that permits the apprehension of a minor where there are "reasonable and probable grounds to believe the child is in need of protection." The child is either returned to his or her guardian or is taken to a safe house where they may be confined for 72 hours and examined by child welfare authorities. The apprehension of a child *without an order* is also permissible, provided that, within three days of the apprehension, the

director of child welfare justifies the action before a provincial court judge.

The Provincial Court had ruled that the Act violated the young person's rights not to be deprived of liberty and security of the person except in accordance with the principles of fundamental justice (s 7 of the Charter), because of the lack of a procedure that would allow every child apprehended to appear before a judge, with the assistance of counsel, to challenge the evidence of child welfare authorities, and to present their own evidence. The Provincial Court also ruled that the Act violated s 8 of the Charter by authorizing unreasonable warrantless searches of premises, because the law failed to ensure that a judge will scrutinize the "reasonable and probable grounds" that police or child welfare authorities say justify their entry without a warrant onto premises. Finally, the Provincial Court found that the Act breached the right to be free from arbitrary detention or imprisonment (s 9 of the Charter), saying that the protection against state

action was inadequate because the Act failed to provide for a review in every case of the belief that a child is in need of protection of the police or child welfare officer who apprehend and confine them.

The Provincial Court judge found that these infringements of Charter rights were rationally connected to the very important objective of protecting children and youth from sexual abuse, but concluded that they did not impair those constitutional rights as little as possible. Therefore, the infringements could not be justified under s 1 of the Charter.

The Court of Queen's Bench disagreed. While it did agree that there was a deprivation of liberty of children and youth apprehended under the legislation, it was guided by the Supreme Court of Canada decisions in *B(R) v Children's Aid Society of Metropolitan Toronto*³ and *Winnipeg Child and Family Services v KLW*⁴ in its assessment of what principles of fundamental justice are required in the context of child welfare legislation.

The Court concluded that these decisions have affirmed that a deprivation of liberty does not contravene the principles of fundamental justice where there is a fair and prompt hearing after the apprehension, in cases in which authorities have reasonable and probable grounds to believe that a child is at serious risk of harm. The Court also noted that the child's right to life and health must be weighed in the balance. Ultimately, the fact that they are minors weighed heavily in the Court's view, allowing this infringement of their liberty:

While these are not young children that we are dealing with at bar, they are still children in the eyes of the law. Ultimately, because they are children, their right to liberty must give way to

the overriding interest of protecting their general welfare as long as the procedures employed to do so are fair.⁵

Considering the specific provisions of the Act, the Court felt that the appropriate balance had been struck and that, while the legislation could perhaps be improved, the procedure it authorized for apprehending and confining a child without prior judicial authorization was constitutionally defensible because consistent with the principles of fundamental justice as required by s 7 of the Charter. Furthermore, it did not provide legal authority for an "arbitrary" detention, because confinement was not automatic, and was required to meet certain criteria. The Court therefore concluded that the Act did not violate s 9 of the Charter.

In the event that it was wrong on these points, and that the Act did in fact infringe Charter rights, the Court also undertook an analysis of whether these infringements could be justified under s 1. It took the view that detention for up to 72 hours was not a "major impairment" of the constitutional rights of children/youth when balanced against the need for protection, and that the impairment was proportional to the substantive objective.

– Jennifer Gold &
Glen Bugg

¹ *Alberta v KB*, [2000] ABQB 976 (QL).

² *Alberta v KB & MJ*, [2000] AJ No 876 (Prov Ct Fam Div) (QL).

³ [1995] 1 SCR 315.

⁴ 2000 SCC 48, [2000] SCJ No 48 (QL).

⁵ *Supra*, note 1 at para 69 (QL).

ASSISTED SUICIDE AND EUTHANASIA

Court Dismisses Constitutional Challenge to Ban on Assisted Suicide

On 6 February 2001, the Ontario Superior Court of Justice dismissed a constitutional challenge by Jim Wakeford, a Toronto man with HIV/AIDS and an advocate for access to medical marijuana, to the sections of the *Criminal Code* that outlaw assisted suicide in Canada.¹

Section 241 of the *Criminal Code* states that every person who "coun-

sels" a person to commit suicide, or "aids or abets" a person to commit suicide, is guilty of an indictable offence, whether suicide ensues or not, and faces imprisonment for up to 14 years. Furthermore, section 14 of the Code provides that "no person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death

may be inflicted on the person by whom consent is given."

In his statement of claim issued in September 1999, Wakeford stated his physicians have advised him he likely has only two or three years to live. Having witnessed the devastation and loss of dignity and autonomy that accompanies the final states of death because of AIDS, Wakeford states he does not wish to experience an

agonizing death or impose the mental suffering on friends and family that will accompany it. Rather, he “wishes to end his life by his own act, with dignity and with medical assistance, to ensure death is as painless as possible, effective, and will not be interrupted or prevented by public authorities.”²

He therefore sought a declaration that sections 14 and 241 of the Code discriminate against him on the basis of disability, contrary to the equality guarantee in section 15 of the *Canadian Charter of Rights and Freedoms*. He asked the court to strike down these sections as unconstitutional, or in the alternative, to at least grant him and a medical practitioner of his choice a constitutional exemption from these *Criminal Code* provisions.

The major hurdle for Wakeford was the decision of the Supreme Court of Canada in the 1992 *Rodriguez* case, in which a woman with amyotrophic lateral sclerosis (ALS) challenged the same provisions, arguing that they violated her rights under the Charter. The Supreme Court rejected her lawsuit. A majority found there was no violation of her right to liberty and security of the person and not to be deprived thereof except in accordance with the principles of fundamental justice (s 7). None of the judges accepted that her right not to be subjected to cruel and unusual punishment (s 12) had been infringed. With respect to the equality rights claim (s 15), the majority declined to decide whether there was an infringement, but found that, assuming there was an infringement, it was justifiable under the Charter

(s 1). Two judges, including the then Chief Justice, dissented on this point, finding that the infringement of Sue Rodriguez’ equality rights was not constitutionally defensible.

Based on the *Rodriguez* decision, the Attorney General of Canada brought a motion to have the court strike out Wakeford’s claim, arguing that he had no case that could be sustained in law (“no reasonable cause of action”). In order to get Wakeford’s claim struck out, the government had to show that it was “plain and obvious” that it would not succeed.³

Wakeford conceded that the facts of his case are similar, but argued that the decision in *Rodriguez* is not determinative because the legislative facts that underpinned that decision have changed, and that the Supreme Court of Canada has on occasion been known to overrule past decisions. In particular, he relied on a 1995 report of the Senate Special Committee on Euthanasia and Assisted Suicide, *Of Life and Death*, in which the committee determined that there was no social consensus in Canada about making changes to the law on assisted suicide, and made no recommendation for changing the law.

Wakeford argued that, given the contents of the report, the federal government can no longer support the validity of the criminal prohibition on assisted suicide. In the *Rodriguez* case, the Supreme Court majority ruled that Parliament should be given some flexibility in dealing with this “contentious” and “morally laden” issue, as long it could show it had a “reasonable basis” for concluding that its legislation “minimally

impaired” the constitutional rights in question. Wakeford submitted to the court that the lack of a social consensus on assisted suicide, as found by the Senate committee, is an unacceptable basis for the government to defend discrimination under the Charter: “majoritarian sentiment is never a basis for justifying discrimination.”

Wakeford also pointed to the Committee’s findings on the insufficient level of palliative care in Canada, arguing that this is an additional reason to reconsider *Rodriguez* because it shows the extent to which constitutional equality rights are infringed.

Swinton J of the Ontario Superior Court of Justice was reluctant to overrule a Supreme Court decision, and was not persuaded by Wakeford’s arguments that there are any significant developments suggesting the *Rodriguez* decision is open to reconsideration. In particular, she noted that in the *Rodriguez* decision the majority expressly commented on the lack of social consensus on assisted suicide and concluded that in order to protect human life and vulnerable individuals, a blanket prohibition was justified, given the difficulty of building in adequate safeguards. She concluded that it was “plain and obvious” that Wakeford’s claim had no sustainable legal basis and dismissed his action.

– Richard Elliott

¹ *Wakeford v Canada (Attorney General)*, [2001] OJ No 390 (QL).

² Statement of Claim, *Wakeford v Attorney General of Canada*, Court File No 99-CV-175987, Ontario Superior Court of Justice; reported earlier at Elliott R. Criminalization of assisted suicide challenged. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 5(1): 12-13.

³ *Hunt v Carey*, [1990] 2 SCR 959.

LEGAL CLINICS

New Developments at the University of Ottawa Community Legal Clinic

This is another in our series of articles about Canadian legal clinics that provide specialized services to people with HIV/AIDS.¹ Vanessa Gruben describes new trends in legal issues observed by the University of Ottawa Community Legal Clinic since the last article by the Clinic in 1999,² as well as other programs and projects undertaken by the Clinic over the last year.

The Legal Clinic

The University of Ottawa Community Legal Clinic (UOCLC) provides legal services in French and English to people of modest income and to historically disadvantaged groups in the Ottawa-Carleton community. It also provides services to University of Ottawa students and, since 1999, to Carleton University students through a fixed-satellite office at Carleton. Services offered include legal representation, summary legal information, referrals, public legal education, advocacy, and law reform in the areas of landlord-tenant, criminal, and civil law. Legal services in three specialized divisions dealing with women, Aboriginal people, and people with HIV and AIDS are also offered. The UOCLC is part of Legal Aid Ontario and is affiliated with the Faculty of Law at the University of Ottawa. Services are provided by law students who are supervised by staff lawyers.

HIV Legal Services

HIV legal services is run by the UOCLC in partnership with the AIDS Committee of Ottawa (ACO) and Oasis, both community-based organizations that serve people living with or at risk of contracting HIV. The UOCLC, ACO, and Oasis work

together to make the legal system more accessible for people with HIV and AIDS. Members of HIV legal services take on individual casework, make presentations to various members of the community, and research areas of the law important to people with HIV and AIDS.³

Another Year of Growth

This past year has marked another year of growth for HIV legal services in a number of different areas. Once again, the number of caseworkers has grown, from four to five. This is the result of the division's work at Oasis, a satellite intake project started by the division in February 2000. Oasis is one of many programs run by the Sandy Hill Community Health Centre and works to enhance the health and well-being of people with HIV or AIDS, especially those who are under-served. Oasis provides a wide range of medical and social services, including access to a nurse and doctor, shower and laundry facilities, and a needle exchange program. HIV legal services are provided two afternoons a week; the work at Oasis has complemented our ongoing presence at the ACO.

As a result of our presence at Oasis and involvement in other endeavours

discussed in more depth below, the types of file managed by the division have broadened. Our current caseload ranges from the traditional landlord-tenant case to the drafting of wills and powers of attorney to human rights issues.

Trends in Legal Issues

Ontario Disability Support Program

This year has been marked by an increase in the number of ODSP-related files, as a person's HIV-positive status is no longer a guarantee that an individual will receive ODSP and related benefits. The majority of these problems have arisen as a result of (1) "rushed" medical reports (these reports are crucial in the application stage); (2) the fact that social workers have considered roommates as spouses despite the client stating otherwise during the review stage; or (3) administrative problems at the local social services office.

Wills and powers of attorney

We have also seen an increase in requests for wills and powers of attorney. A common concern that has recently arisen in will-making has been the care of children and the

desire to place them with family other than the biological father. Concerns expressed in powers of attorney most often relate to the extent of treatment during the later stages of the disease, as well as the type of care preferred by the client.

Landlord–tenant issues

As the housing market in Ottawa has exploded, landlord–tenant issues have become increasingly difficult to

In a private conversation with a manager, D disclosed his HIV-positive status. He was fired three days later.

resolve. Clients who are facing possible eviction have few options if eviction becomes a reality. Moreover, many of our clients' housing is subsidized by bodies who will refuse to continue subsidization following an eviction. As a result, clients are often forced to settle disputes to prevent the very real possibility of homelessness.

Human rights

Human rights files continue to predominate in the HIV division. The following is an example of a typical human rights file in the division. Client D was employed by a well-known restaurant chain. In 1998, he suffered harassment and sexual harassment at work at the hands of co-workers. This took the form of displays of sexually offensive pictures, graffiti and materials left in his workplace locker, verbal abuse, physical assault, and touching of a sexual nature. Despite complaints to the management and various superiors, the employer refused to take any action on D's behalf. In a private con-

versation with a manager, D disclosed his HIV-positive status. He was fired three days later, under a questionable charge of malfeasance, after 11 years of employment. D decided to file a complaint of discrimination based on race, disability, and sexual orientation with the Ontario Human Rights Commission. Within eight months of being retained, the UOCLC negotiated a favourable settlement with the restaurant chain, for an amount of over \$40,000. At this time, D was receiving ODSP benefits. In order to prevent D losing these benefits, substantial additional work was required to successfully ensure that the settlement received was characterized as an award for "pain and suffering."

Law Reform Projects

The UOCLC as a whole has shifted a great deal of emphasis onto the law reform aspect of the Clinic. As a result, the HIV division has investigated a number of possible law reform projects, including investigation into complications with the *Personal Health Information Protection Act*. The implications of such legislation may affect an individual's ability to keep their health information, such as their HIV status, private. Also, UOCLC is presently gathering information and resources to anticipate the repercussions of Bill 68 (Brian's Law, which came into force in Ontario in December 2000).⁴ As the effects of the relaxed prerequisites for involuntary assessments, hospitalization, and treatment orders have not yet been fully realized, it is of the utmost importance for the UOCLC and other service providers to be prepared for the consequences. Undoubtedly, these law reform initiatives will spur more growth in the division over the next few years.

Positive Law: A Symposium on HIV Legal Issues for Service Providers

On 3 November 2000, the division hosted its biannual conference on "Positive Law." The day was a great success. Topics discussed included the medical use of marijuana, Aboriginal people and HIV, the rights of prisoners with HIV/AIDS, and the common law duty to warn. Dr Donald Kilby from the University of Ottawa Health Services and Rick Reimer, a lawyer from Pembroke currently using marijuana legally for treatment of his multiple sclerosis, spoke to the process and issues surrounding the legalization of marijuana for medical use. This was especially interesting to our caseworkers who have worked on two applications for the medical use of marijuana to treat HIV/AIDS-related symptoms.

Ralf Jürgens of the Canadian HIV/AIDS Legal Network and Art Zocole, the Executive Director of the Canadian Aboriginal AIDS Network (CAAN), gave a presentation on HIV/AIDS in Aboriginal communities. They noted the steady rise of HIV cases among Aboriginal people in Canada. Concrete solutions were suggested, including: increased political leadership; addressing issues of homophobia; increasing on-reserve programming and treatment as well as increased education and information regarding prevention and control strategies.

Following a presentation by a person with HIV about the reality of living with the disease, Ruth Carey, the Director of the HIV/AIDS Legal Clinic of Ontario (HALCO) spoke to the numerous issues that affect inmates with HIV and AIDS. The most pressing issues she identified

were better access to medication and physicians and access to needle exchange programs in prisons.

Finally, Michel Landry, the Executive Director of the UOCLC, delivered a presentation on the common law duty to warn.

Conclusion

The HIV division continues to be committed to providing a high level of legal representation and information to people with HIV and AIDS. As such, we are committed to growing and adapting to better meet our clients' needs. This includes an

increased participation in law reform projects, working more closely with the Aboriginal division to address some of the HIV/AIDS-specific issues among this population, as well as maintaining a presence within the Ottawa community to ensure that the rights of people with HIV/AIDS in our community are protected.

– Vanessa Gruben

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¹ See also Carey R. Provision of legal services to persons with HIV or AIDS: barriers and trends. *Canadian HIV/AIDS Policy & Law Newsletter* 1997/98; 3(4)/4(1): 9-11, available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/winter9798/08CAREYE.html; Leroux J. The Montréal legal clinic for people with HIV/AIDS. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 15-17, available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/clinics.htm.

² Duff JM. The University of Ottawa Community Legal Clinic. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 5(1): 41-43, available at www.aidslaw.ca/Maincontent/otherdocs/Newsletter/fallwin99/clinics.htm.

³ For more information about the UOCLC in general, or the HIV division in particular, see Duff, *ibid*.

⁴ For more information, see the text of the Bill at www.ontla.on.ca/Documents/StatusofLegOUT/b068ra_e.htm; and a Government of Ontario question-and-answer sheet at www.gov.on.ca/health/english/pub/mental/faq.html.

POLITICAL COMMITMENT

Political Commitment, Governance, and HIV/AIDS

In July 1992, the Organization of African Unity adopted the Declaration on the AIDS Epidemic in Africa, in which the assembled heads of states gave their “fullest political commitment to mobilising society as a whole for the fight against AIDS.” These leaders declared that by the end of 1992, each one of them “would be publicly recognized as the leader of the fight against AIDS” in their respective countries. At that meeting, Africa’s leaders endorsed a six-point AIDS action agenda that could have averted much of the present infection and impact in the region.

In December 1994, 42 governments met in Paris to renew their commitment to the struggle against AIDS. Speeches and pledges were made, and the Paris AIDS Summit Declaration was signed. In September 1999 the prime ministers, vice-presidents, and ministers of health of 10 African countries met in Lusaka and signed another Declaration on the HIV/AIDS Epidemic, which also promises action on AIDS.

Governments have a unique and crucial role in the national response to the AIDS pandemic. In most industrialized countries and a few developing

countries – notably Brazil, Senegal, Thailand, and Uganda – governments have taken concrete action to address HIV and AIDS. In many other countries something is clearly missing.

Government failure, particularly in those countries worst affected, has generated calls for greater “political commitment,” yet we do not have a common or clear understanding of what this elusive factor is or how it might be increased. This article explores the difficulties of focusing on political commitment and questions the usefulness of this concept for programming and advocacy. It concludes

that a focus on better governance would be more useful than simple exhortations for greater political commitment.

We reprint this article with the permission of the Interagency Coalition on AIDS and Development (ICAD). It is followed by a commentary by Justice Michael Kirby of the High Court of Australia, entitled “HIV: Getting Action from Our Political Leadership.”

Political Commitment – A Confusing Euphemism?

In one view, it is the role of government leaders to motivate the private sector and civil society to take action on AIDS.

Perhaps most important in the global battle against HIV/AIDS is political commitment. Leaders at the national, provincial, and local levels of government must speak out about HIV/AIDS and encourage businesses and non-governmental organizations to commit to work against the disease. (David Satcher, MD, Surgeon General of the United States of America and Assistant Secretary, Department of Health and Human Services)

In another view, the initiative comes from the ground up – it is communities that must advocate for national action by politicians and bureaucrats.

Communities should share their experiences with other communities, knowing that success is possible and that the threat of HIV/AIDS can be controlled. Front-line workers should share their experiences with their peers, who face similar problems under different conditions. The local response support teams should encourage these

exchanges, structuring the process so that political decision makers also have access to the documented experiences. This should lead to greater political commitment and a more vigorous and coherent national response. (UNAIDS, undated)

These two points of view reflect broader tensions between a “professional” or “bureaucratic” approach to AIDS, and an approach that views community action as the impetus for the governmental response. In countries with recorded successes against AIDS there is often a continuing dialogue between government and community. In other countries, leaders at all levels of government appear deaf to calls for action, and sometimes actively oppose policies that have been shown to work.

Calls for greater political commitment direct responsibility for action on AIDS to government leaders, but without benchmarks for progress the response may be as insubstantial as the concept itself. The following additional difficulties arise with the concept of political commitment.

Sustained political commitment is uncommon, and fragile

In the developing world, three examples are commonly given: Thailand, Uganda, and Senegal. In each country, strong political commitment is cited as a factor in its response. In 1986, Uganda’s President Yoweri Museveni publicly acknowledged the country’s AIDS problem and established the Uganda AIDS Commission within the Office of the President. In Senegal, where HIV prevalence has remained relatively low, the government responded early by permitting and promoting extensive NGO activity, by including HIV

in sex education for school-aged children, and by integrating STD care into regular primary health services. In Thailand, following a rapid rise in HIV infection in the late 1980s, concerted lobbying led to the 1991 nationwide prevention program, which included the following key elements:

- each key ministry had its own AIDS plan and budget;
- all provincial governors led the AIDS program in their respective provinces through the provincial development planning system; and
- the business community, people living with HIV/AIDS, religious leaders and other community leaders became very involved in contributing to policy dialogue and resource mobilization (Sittitrai, 2000).

More recently, as a result of decisive government action, Brazil now leads the developing world in the provision of antiretroviral therapy, with a government policy of universal access supported by local manufacture or bulk importation of key drugs. This has resulted in reduced morbidity due to AIDS, and most likely reduced the spread of HIV as well.

To remain effective in the longer term, political commitment must be consistent. Even those countries with early successes could face rapid reversals if commitment wavers. For example, in Uganda, despite early support for AIDS NGOs, the government has refused to “register” the national coalition of NGOs (Human Rights Watch, 2000). Yet a vibrant civil society is essential to the national response. In Australia, the government funded the creation of a national network of AIDS groups, and community representatives often

sit alongside bureaucrats on government policy bodies (Altman, 1994).

Political commitment for development assistance for both prevention (including vaccine research) and care cannot be taken for granted. Political commitment, and hence funding, may quickly evaporate if the world economy becomes less buoyant, or if the domestic political climate becomes more hostile to foreign aid.

A lack of political commitment is a common theme in related policy areas – but few solutions are evident

The focus on political commitment can also be found in related development areas such as poverty and reproductive health. In 1991 the UN Development Programme's *Human Development Report* concluded that the lack of political commitment, not of financial resources, is often the "real cause" of human neglect (UNDP, 1991). Echoing the Report, an independent expert on human rights and extreme poverty appointed by the Commission on Human Rights noted in 2000 that the lack of political commitment, rather than a lack of financial resources, was the "real obstacle" to poverty eradication (Lizin, 2000).

At the 1994 International Conference on Population and Development, the governments of the world committed themselves to a comprehensive Program of Action. Yet by 1999, in another failure of political will, only one-third of the funds pledged by donors had been provided (Klitsch, 1999). In short, political commitment has also been identified as crucial in achieving progress in other development areas, but few ways have been identified to directly achieve it.

The determinants of political commitment are complex and difficult to identify

An initially attractive model is that of the "AIDS champion" – a government leader with charisma and determination who pushes necessary policies through a stolid or hostile bureaucracy. President Museveni is sometimes characterized as a leader of this type. In another demonstration of commitment, the then head of state of Zambia, President Kenneth Kaunda, opened international conferences on AIDS in Montréal (1989) and Florence (1991). He had lost a son to the epidemic.

The dangers of reliance on this model are obvious: such champions are rare, the momentum will quickly fade if they find another priority or leave office, or they may champion ineffective or dangerous policies. President Museveni was reluctant to permit widespread condom distribution in the early days of the epidemic in Uganda.

Even if the initial push comes from above, research has shown that policies are adopted more quickly when a broad consultative process is undertaken. In Ethiopia, it took over a decade to get a national AIDS policy in place. The process entailed repeated internal government review involving relatively few people and almost no community involvement. In South Africa, when civil society was able to flourish following the transition to democracy, a national policy was debated and adopted in the space of two years (Stover & Johnston, 1999). It is worth remembering that the frank and heated discussion in the South African media over that government's AIDS policies could probably not have occurred in any other country in the region.

Political commitment is more likely if government leaders must face the consequences of non-action. In a full democracy this could mean losing office, but this is less likely in many of the partial democracies in the developing world. Early research by Jonathan Mann and colleagues on the determinants of political will showed that many countries whose heads of state had remained silent on HIV/AIDS ranked lower on the UNDP's Human Freedom Index (Mann et al, 1992). The lower the respect for civil and political rights, the less likely it is that government leaders will speak out on HIV/AIDS. Nor can communities easily challenge ineffective or dangerous policies in such circumstances.

A free and active media sector is essential. The distinguished economist Amarty Sen observed long ago that famines did not exist in countries where a free press was allowed to operate. According to Sen, it is not the lack of food in the aggregate that gives rise to famines, but the lack of access to food by the poor in famine regions. A free press exposes these problems; once exposed, the failure to act is absolutely intolerable (Stiglitz, 1999). There are evident parallels with AIDS.

Former World Bank Vice-President and Chief Economist Joseph Stiglitz identified the key ingredients in a successful development strategy as *ownership* and *participation* (Stiglitz, 1998). World Bank Institute research into governance (defined broadly as "the traditions and institutions by which authority in a country is exercised") shows that there is a strong causal relationship between better governance and better development outcomes. Indicators used to measure

good governance include political process, civil and political rights, media independence, civil service independence and competence, rule of law, and corruption (Kaufmann et al, 1999).

In 1999, Kenya rated poorly on the World Bank Institute governance indicators. In mid-2000, because the Ministry of Health could not account for missing funds, UNICEF suspended its government AIDS funding and instead provided funds directly to NGOs and community-based organizations (Etieyibo, 2000). It is reasonable to conclude that better governance will also lead to more effective AIDS programs.

Finally, in some of the worst-affected parts of the world there is no realistic expectation of adequate government capacity, at least within the time frame needed for an effective response to the epidemic. In cases where NGOs and international agencies provide the only effective services, an undue emphasis on governance in the short term could be counterproductive (Altman, 1999).

Political commitment is difficult to measure

In order to know whether efforts to generate political commitment are successful, it would be useful to have tools for measuring it. The following indicators have been proposed to assess the degree of political commitment to addressing AIDS:

Budget allocations to prevention and care

In 1998, UNAIDS released a study of 64 countries that analyzed the level of national and international contributions to national AIDS programs. The study established baseline contributions for the national response for

1996 (UNAIDS, 1998). To be useful, further work should be done to determine funding patterns over time.

A protocol for the measurement of spending from national accounts has been developed by SIDALAC in Latin America (UNAIDS, 2000). One problem identified with this protocol, however, is that low national spending may not be a fair indication of a government's commitment to fighting AIDS. If international contributions are already significant, a government may choose to devote national resources to other priorities for which less development assistance is available. Further, if a true multisectoral approach is adopted, funding to national AIDS programs alone will not adequately reflect the government response.

Measures of AIDS program activity

The AIDS Program Effort Index, developed by the Policy Project, is a composite index designed to measure political commitment and program effort. The index is based on a questionnaire completed by key informants from diverse backgrounds, and includes components measuring political support and organizational structure (including a multisectoral approach) (Stover et al, 2000). Because the Index is subjective, it may be more useful in assessing a particular government's response over time than in comparing different national responses.

Indicators of compliance with the International Guidelines on HIV/AIDS and Human Rights

The Guidelines provide a basis for a broad policy and legal response. A protocol developed at the Australian National University measures legislative recognition of the international

norms set out in the Guidelines (Watchirs, 2000). Although law reform is perhaps easier to assess than spending, it is clear that, without education and accessible and effective enforcement, law reform alone may have little impact. More work is needed on this aspect of the national response, including the establishment of goals and deadlines.

Because there are no easy ways to measure political commitment, it is difficult to know whether efforts to increase political commitment have

Is there political commitment to deal with the epidemic? Is it openly expressed? Is it reflected in adequate staffing of a national program or otherwise?

any impact on the AIDS epidemic. A focus on improved governance provides concrete and measurable programming options to increase government effectiveness in the response to AIDS, which may also increase visible government commitment as well.

How Can We Improve Governance?

The following practical measures are offered for consideration.

- *Strengthen civil and political rights to permit and encourage community discussion and advocacy.* In countries where freedom of speech and association are restricted, leaders are less likely to tackle difficult issues such as AIDS. Without open debate, government policies are more likely to be ineffective or dangerous. International and regional intergovern-

mental organizations can have a strong impact here, as can be seen as Eastern European countries amend their laws and practices in preparation for joining the European Union.

- *Build skills of affected communities and support links with more experienced advocates.* Projects to enhance community advocacy skills, and to partner AIDS groups with legal and advocacy organizations, can achieve marked success. The Fact Sheet “HIV/AIDS, Human Rights, and Development” gives examples of rights-based programming in different countries and contexts (ICAD, 2000).
- *Include AIDS advocacy groups in technical and financial support for improved democracy, governance, and participation.* Donors often support the development of civil society organizations in the context of democracy building. Organizations supported could include AIDS advocacy or patients’ rights groups that can lobby government for effective prevention and care services. In Kenya, AIDSCAP (USAID) assisted the Kenya AIDS NGOs Consortium (KANCO) to hold a series of district and provincial workshops in 1996 and 1997 to solicit the views and experiences of NGO personnel, religious leaders, civil servants, and policymakers. Designed to build consensus among diverse groups, these workshops gave those working in HIV/AIDS prevention and care opportunities to identify common concerns and problems and to develop advocacy strategies for advancing priority issues (AIDSCAP, undated).
- *Include all levels of government in advocacy efforts.* Experience in

South Africa has demonstrated that national, provincial, and local levels of government must be targeted. Advocacy efforts at all levels must be matched with constant monitoring to ensure that government promises for action on AIDS do not evaporate (Hatane & Kariem, 2000). Donors should appreciate that this is a costly and time-consuming, but essential, role for civil society.

- *Encourage transparency and accountability.* Data on the national response should be accessible, which requires good monitoring and evaluation as well as a data dissemination plan (UNAIDS, 2000). Establish intersectoral structures with community representation. Require concrete outcomes to facilitate monitoring and evaluation. Train and fund local groups to monitor progress.
- *Prioritize financial and technical support to countries that demonstrate commitment.* The UNAIDS Board has endorsed an approach to the allocation of certain resources that in part reflects the likelihood of a strengthened national response. Questions to assess competing requests for assistance will include: “Is there political commitment to deal with the epidemic? Is it openly expressed? Is it reflected in adequate staffing of a national programme or otherwise?” (UNAIDS, 1999). In circumstances in which government commitment is lacking, other options such as supporting community advocacy, as noted above, should also be explored.
- *Include support for the office of ombudsman and national human rights institutions.* Such offices must be independent, and immuni-

ty guaranteed for those who dare to bring complaints (Jenkins, 2000). Office staff must also be trained to be sensitive to HIV/AIDS-related issues.

Political pressure from governments, and particularly larger donors, should

Calls for greater political commitment should be accompanied by concrete support for better governance.

also continue. In March 1999, the US Department of State launched a diplomatic initiative to raise the profile of the global HIV/AIDS epidemic and foster political commitment overseas. The initiative instructs ambassadors and high-level US officials to encourage foreign leaders to increase attention and resources in combating HIV/AIDS. The State Department also works with international organizations, other governments, and the public and private sectors to draw greater attention and resources to the HIV/AIDS epidemic (Department of State, 1999). Such advocacy efforts should continue alongside concrete action to improve governance, and hence governments’ responses to AIDS.

Conclusion

Although there appears widespread agreement that political commitment is an important factor in the successful response to the AIDS epidemic, it remains an elusive concept. It is unclear whether a focus on greater political commitment alone will have a significant impact on the course of the pandemic. Worse, it ignores the

complex reasons why government leaders act, or fail to act, on AIDS.

On the other hand, research has shown a strong causal relationship between better governance and better development outcomes. It is reasonable to conclude that better governance will also lead to more effective AIDS programs.

A policy focus on improved governance offers a range of practical options for programming, based on experience in different areas of development. It is recommended therefore that calls for greater political commitment be accompanied by concrete support for better governance, which is more likely to have a greater impact on the course of the AIDS pandemic.

– David Patterson

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In this commentary on David Patterson's article on "Political Commitment, Governance, and HIV/AIDS," Justice Michael Kirby of the High Court of Australia reflects on how HIV/AIDS mobilized him and others in positions of power. He concludes that we are engaged not in a war, but in a great civil struggle, and that we have a moral duty to do what we can in this struggle.

In his article on political commitment to the struggle against HIV/AIDS, my fellow countryman, David Patterson, has touched on many of the relevant dilemmas and impediments.

We were lucky in Australia when AIDS came along in the early 1980s. The Federal Minister and his Opposition counterpart showed great courage, wisdom, and willingness to listen to NGOs. Inevitably, at that time most of the NGOs were from the gay community. Recently the Minister, now in retirement, has disclosed a long-term gay relationship. It was a fluke that he was in office at the time. He was supportive of bold strategies. He was articulate and persuasive. Without him, the Australian response would have been much slower. Chances like that cannot be counted on in most countries.

The attention span and true commitment of politicians all too often varies with the most recent pressure applied to them.

Yet the arrival of the HIV/AIDS epidemic has mobilized a lot of silent people. The loss of friends, lovers, and family has propelled people into activism. This happened to me. It drove me into public involvement, which judges would not normally engage in. I spoke at conferences of gays, commercial sex workers, and at meetings with injection drug users. I still do. Eventually this momentum coaxed me into disclosure of my own homosexuality. In the face of HIV/AIDS, shame and silence seemed absurd.

The same things are happening around the world. In developing countries, HIV is not primarily a "gay disease." It is attacking the sons and daughters, wives and friends of political leaders, and sometimes those leaders themselves. Sadly, many will be silenced by shame and ignorance. But a few will speak out and take the lead. Their voices are precious. They must be identified, supported, encouraged, and promoted. Putting well-known faces to the campaigns for HIV awareness is part of the strategy we need to encourage. It is a bit like "coming out" for gays and lesbians. When a few people do it, it becomes easier for others. It is less of an ordeal.

Unfortunately, as David Patterson's article shows, political mobilization is a complex thing. The attention span and true commitment of politicians all too often varies with the most recent pressure applied to them. In the struggle against HIV, the experience of many countries teaches that there is a need for:

- institutional responses in the bureaucracy;
- civil society actions to spread the message; and

- constant follow-up and auditing to ensure effectiveness.

From 1993 to 1996 I served as UN Special Representative in Cambodia. At that time, according to tests in the blood supply, HIV was a small problem. I put HIV at the top of my agenda, as a priority target. I got the support of King Sihanouk. I explained to everyone who would listen how it was a vital human rights issue. The NGOs generally gave support, especially women's groups. But the male politicians, by and large, reacted with indifference or giggles.

When eventually large public posters with rudimentary AIDS warnings were put up, the city council, under pressure from residents, pulled them down. Instead of instituting condom distribution to the brothel district near Phnom Penh, as I recommended, the brothels were raided by police and closed. The commercial sex workers were scattered, beyond support and health

messages. Hypocritically, the leaders blamed "foreign girls" who were spreading the virus. Now Cambodia has very high rates of HIV. If only I could have been more effective.

What did it require? It needed radical changes to the fabric, culture, and economic organization of society to inform and empower people to protect themselves. It needed a community more responsive to activist groups with little political clout. It needed vision to perceive the priorities. It needed a change of spiritual values and an end to xenophobia. All of these represented a big task. There was no time to get such changes. There was no equivalent to our Health Minister in Australia, Mechai Viravaidya in Thailand, or the incomparable Jonathan Mann of WHO. As a result, tens of thousands in Cambodia are now living with HIV and many will die.

The moral of this story is that effective agents of change with

achievable strategies are needed to break the cycle of ignorance and powerlessness that feeds off silence. Politicians have a role to play. Key health bureaucrats can be mobilized. Activist NGOs can try to grab the attention of whatever media will listen. National and international bodies must do what they can to teach the lessons that have been learned by the countries that went before.

This is not a war. It is a great civil struggle. Only someone who has not sat at the bedside of a suffering human being is indifferent. We who know must spread the news and do what we can. This is self-protection. It is also a moral duty.

– *Michael Kirby*

Michael Kirby is a Justice of the High Court of Australia, a former member of the WHO Global Commission on AIDS, and a UN Special Representative for Human Rights in Cambodia from 1993 to 1996. Comments should be directed to the Editor at ralfj@aidslaw.ca, who will forward them to Justice Kirby.

PATENTS AND PRICES

In the last issue of the *Review*, we noted that Canadians and others concerned with the human rights of people with HIV/AIDS needed to develop “trade literacy” in order to understand and respond to the implications of international trade agreements on access to adequate and affordable care, treatment, and support. In this field, as in no other, it is crucial that we appreciate the connection between the rights of people with HIV/AIDS in Canada (and all Canadians with a stake in accessible health care) and the rights of people with HIV/AIDS elsewhere, particularly in developing countries. International trade agreements – from the North American Free Trade Agreement (NAFTA) and the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to the General Agreement on Trade in Services (GATS) and the Free Trade Agreement of the Americas (FTAA) currently being negotiated with the active support of the Canadian government – present one of the most profound and sustained threats to the health and well-being of people with HIV/AIDS since the epidemic began. This regular column in the *Review* is intended as a means of raising the consciousness, and building the capacity, of individuals and civil-society organizations to respond.

International Trade and Canadian Patent Law

Canada Amends Law to Comply with WTO Deadline

In a ruling issued at the end of February 2001, a World Trade Organization (WTO) arbitrator ruled that Canada had until 12 August 2001 to implement changes to its laws, as required under a previous WTO ruling.¹ In May 2000, a WTO panel ruled that Canada was in violation of TRIPS for failing to provide 20 years of patent protection for inventions under its *Patent Act*.² That ruling was upheld by the WTO Appellate Body in September 2000.³ These decisions have been summarized in previous issues of the *Review*.⁴

The Panel Report, as upheld by the Appellate Body, was adopted by the WTO’s Dispute Settlement Body (DSB) on 12 October 2000. On 23 October 2000, Canada informed the DSB that it would implement the ruling and require a “reasonable period of time” to do so, as provided for in the WTO’s Understanding on Rules and Procedures Governing the Settlement of Disputes (the “Dispute Settlement Understanding,” or DSU). However, Canada was unable to reach an agreement with the US, which had originally brought the complaint, as to the “reasonable” period of time required to implement the ruling; the US requested that the matter be decided by binding arbitration under the DSU.

Canada argued that it should have until 14 December 2001, the last day Parliament is scheduled to sit before the holiday recess, to make the necessary changes. Canada argued that complying with the ruling would require amendments to its *Patent Act*, and that the domestic “contentiousness” of the matter should be considered, as well as the “inherent necessity of providing adequate time for debate when legislative choices need to be made in a democratic sys-

tem of government.” One choice for the government, put forward by the Canadian Drug Manufacturers Association (representing companies

The required amendment to the *Patent Act* will have an impact on Canada’s health care system.

manufacturing generic drugs), is to ensure that if the patent term is amended to 20 years from the date of filing, it must apply to *all* patents. This would mean extending the term for some existing patents but reducing it for others. Such a proposition would, of course, be opposed by brand-name pharmaceutical companies, who seek the maximum protection possible for each and every patent, even if this requires inconsistent application of the law.

One of the principal points made by the government of Canada was that it will have to “manage carefully the legislative process” before and

during the debate in Parliament over these amendments. It should be noted that there was no suggestion by the Canadian government, which has a majority in Parliament, that it would be making any choice other than to implement the amendments “required” by the WTO. This is despite Canada’s submission to the WTO arbitrator that

the required amendment to the *Patent Act* will have an impact on Canada’s health care system. Therefore, it can be expected that there will be significant debate on the amendments that the government will propose. The debate, which is likely to be divisive, will affect the amount of time required by Parliament to process the legislative proposal.

This acknowledgment by the Canadian government that implementation of the WTO ruling will affect Canada’s health-care system should be recalled when ministers of the federal government negotiate other trade agreements with similarly clear and foreseeable effects, such as the FTAA and further expansion of the GATS.

In contrast, the US argued that six months was sufficient time for the legislative amendments, and that if Canada is permitted to delay implementation, “thousands of patents will continue to expire ‘prematurely,’ causing irreparable harm to patent owners that are United States nationals.” (Canada’s position was that between the hearing date and December 2001, only 12 of these “term-deficient” patents that will expire have any commercial value.) The US also argued that the existence of domestic controversy over the amendments is irrelevant, and that Canada is required to comply in

“the shortest period of time possible.” In support of this position, it cited the arbitrator’s ruling in a previous case against Canada dealing with pharmaceutical patents.⁵ The US pointed out that the Liberal Party has a controlling majority in Parliament, and that legislative procedural rules only require an average of one mandatory sitting day each for the first reading, second reading, committee consideration, and third reading for final approval.

The DSU provides, as a general guideline for arbitrators, that the reasonable period for implementing “recommendations” from a panel or the Appellate Body should be a maximum of 15 months from the date the report of the panel or Appellate Body is adopted. However, the length of this period may be shorter or longer, depending on the circumstances. The arbitrator in this case noted earlier arbitrator rulings had established that the reasonable time period should be the “shortest period possible within the legal system” of the country, but that this does not require the country to use an “extraordinary” legislative procedure in every case.

The arbitrator found that the commercial value of the expiring patents was not relevant to determining what the shortest possible period was, within the Canadian legal system, to amend the *Patent Act* as required. However, he also found that in requiring a minimum term of patent protection of 20 years from the filing date, Article 33 of TRIPS “leaves no room for any legislative discretion or legislative choices.” The contentiousness of the issue within Canada is “outside the strict boundaries” of the implementation of WTO rulings and recommendations.

In the arbitrator’s view, giving

only six months would mean the deadline would fall in the middle of the spring 2001 session of the House of Commons, but this would be unreasonably short. However, postponing the deadline for implementation to mid December 2001 would be an unreasonably long period, and would not reflect Canada’s obligation of “prompt compliance.” He therefore concluded that a period of 10 months, ending 12 August 2001, would be appropriate.

On 20 February 2001, the Canadian government introduced in Parliament for first reading Bill S-17, *An Act to amend the Patent Act*, which contains the planned amendments to the *Patent Act* to bring Canadian law into compliance with the WTO ruling. The bill was introduced in the Senate, rather than the House of Commons. It passed both chambers, and received royal assent on 14 June 2001.⁶

PhRMA Still Gunning for Canada

In February 2001, the Pharmaceutical Research and Manufacturers of America (PhRMA), the US association representing the pharmaceutical industry, included Canada among the 13 countries on its annual “priority watch list.” PhRMA is urging the US government to place Canada on its “Special 301” Priority Watch list for 2001.⁷

Under the “Special 301” provisions of its Trade Act of 1974, at least annually the Office of the US Trade Representative (USTR) identifies foreign countries that, in its view, deny “adequate and effective” protection of intellectual property rights or “fair and equitable” market access for US companies. The Act expressly states that a country can be

found to deny adequate or effective protection for intellectual property rights even where it is in compliance with TRIPS. If a country is designated by the USTR as a “priority foreign country,” then USTR may further “investigate.” The investigation may then lead to retaliatory measures. For example, in 1997 the US withdrew tariff benefits from Argentina because of its “delay in providing adequate patent legislation, particularly for pharmaceutical products.”⁸ USTR has reported that it has used similar measures “to motivate improved intellectual property rights enforcement or to strengthen legal protections” in countries such as Honduras, Panama, Paraguay, and Turkey.⁹ In many other cases, the mere threat of such measures, such as placing a country on the US “watch list,” has been a key part of US strategy in pressuring other countries to amend their laws to satisfy the demands of US industry.

It should be noted that one of the very premises of TRIPS, and indeed of the whole WTO system, was supposedly to prevent countries from engaging in unilateral retaliation such as that proposed by USTR, but rather to establish a multilateral regime for settling disputes as to whether a country is or is not complying with its obligations under the WTO-administered treaties. This has not stopped the brand-name pharmaceutical industry, which was the chief lobbyist for TRIPS, from continuing to push the US government to engage in such unilateral threats, nor has it restrained the US government from acquiescing in the industry’s demands.

Although PhRMA notes with satisfaction that Canada’s defence of its “stockpiling” regulations before the

WTO was rejected, PhRMA’s complaints about Canadian patent law go considerably further. PhRMA alleges that Canada is a “WTO scofflaw” and “continues to fall short of its TRIPS requirements” and its requirements under the NAFTA. PhRMA is urging the US “to take aggressive action to remedy these violations, including the consideration of WTO dispute settlement if necessary.”

PhRMA complains about “the failure of Canadian regulatory authorities to provide effective data exclusivity.” It alleges that:

Although Canada has statutory data protection, recent judicial decisions have rendered those protections meaningless. Canadian authorities allow parties other than the right holder to gain marketing approval in direct reliance of [sic] protected confidential data. This violates TRIPS Article 39.3 as it eliminates the TRIPS requirement to prevent “unfair commercial use” of protected data.

PhRMA also alleges that Canada fails to provide “expeditious remedies” to prevent infringements of patents and to deter further infringements:

Systemic inadequacies in Canada’s administrative and judicial procedures call into question whether Canada is meeting its TRIPS and NAFTA obligations with respect to pharmaceutical patents. These inadequacies allow generic versions of patented medicines to be approved by Health Canada, to be listed for use by doctors and use or even mandatory substitution by pharmacists, and to reach or be ready to reach the market in commercial quantities while valid patents are still in force.

This can occur under the *Patented Medicines (Notice of Compliance) Regulations*, the so-called “linkage regulations” administered by Health Canada, and as a result of how patent infringement claims are treated in the Canadian courts.

PhRMA is displeased that, under the “linkage regulations,” generic manufacturers can apply “at any time” for approval of their generic medicines by Health Canada: “Such generic medicines are assessed for safety and efficacy against data and clinical trials relating to previously approved patented medicines. These regulations extend significant advantages to generic companies.”

It should be noted that the *Patented Medicines (Notice of Compliance) Regulations*, about which PhRMA complains, provide that any generic drug manufacturer who challenges a brand patent is automatically prevented from obtaining regulatory approval for a generic version until it wins its litigation under the regulations. This is a perverse linking of regulatory approval (the focus of which is the safety and efficacy of a medicine) with the issue of patent infringement – a linking that allows patent-holding pharmaceutical companies to hold up the approval of a generic drug, even if it has been shown to be pharmacologically sound, by alleging patent infringement. It should be noted that generic drug companies have unsuccessfully challenged these regulations as being beyond the jurisdiction of the federal government.¹⁰

Contrary to PhRMA’s assertions, these regulations actually privilege brand-name patent-holding pharmaceutical companies. A fairer and more sensible system would be to

divorce the regulatory approval process from the patent system. If a generic drug is safe and effective, it should be approved for sale in Canada. The *Patent Act* prohibits the sale (and, as a result of the WTO decision, even the stockpiling) of that drug before the patent holder's patent expires. If evidence of such patent infringement exists, a patent-holding company should be able to initiate legal proceedings to prevent this (including the obtaining of an injunction where it can show "irreparable harm" if the generic drug continued to be sold during the course of the litigation).

PhRMA's complaint that generic drugs are assessed for safety and efficacy against data submitted for the approval of previously patented medicines is a clear indication that PhRMA is concerned only with maximizing monopoly profits that result from strong patent protection, and wishes to ignore the key reason why patents are recognized in the first place – namely, to ultimately benefit society as a whole by sharing innovative information. This is why, in exchange for receiving a patent (ie, a monopoly) on an invention, the patent holder must disclose to the public the information that will allow society to benefit from the innovation, including competition from like products based on that know-how.

This tradeoff is expressly reflected in TRIPS: Article 29 provides that WTO member countries require that an applicant for a patent disclose the invention in a sufficiently clear and complete manner that a person skilled in the art can replicate it; and countries may even require the applicant to indicate the best mode known to the inventor for carrying out the invention. It is this tradeoff that

PhRMA seeks to avoid through its selective application of TRIPS, taking only the benefits, with none of the corresponding obligations.

PhRMA's complaint suggests that any subsequent producer's product should not be measured against previously known data regarding medicines, and that each and every time, a producer would need to conduct full clinical trials to generate the evidence to support its claims of safety and efficacy. Not only would this amount to wasteful duplication of resources that impedes scientific advances and delays ultimate benefit to patients who need medicines (especially those who cannot afford high-priced medicines); it would also hinder the ability of government regulators in discharging their obligation to protect the public and consumers by limiting the available evidence base for assessing new products submitted for approval.

But PhRMA's concern is not for government's role in protecting public interests. This is clear from its unsurprising opposition to government interference in the "free" market in relation to medicines. PhRMA's "watch list" for 2001 continues its campaign against the Patented Medicines Prices Review Board (PMPRB), the quasi-judicial body established in the early 1990s by the federal government under Bill C-91, as a compromise gesture to mollify concerned Canadians while completely abolishing any system of compulsory licensing for pharmaceuticals. The PMPRB is mandated to monitor prices for patented medicines, and has the authority to order a patent holder to reduce its prices if the Board considers them "excessive," based on statutory criteria and a set of guidelines it has developed.

PhRMA's concern is that recent reports emerging from the Federal/Provincial/Territorial Pharmaceutical Issues Committee "suggest the likelihood of increased collaboration among different levels of government toward more stringent, non-market based interventions." PhRMA objects to the PMPRB's mandate to establish price ceilings based on price comparisons with other countries, even though those used for comparison are all wealthy, industrialized countries. PhRMA wants prices to be set by what the market will bear. It also asserts that price controls in Canada "prevent innovators from covering their costs" and that this will

Among developing countries, Brazil has attracted much praise for its bold response to the HIV/AIDS epidemic, including a commitment to manufacturing generic drugs that it can provide cheaply to the majority of Brazilians with HIV/AIDS.

"impede biomedical innovation and can jeopardize high quality health-care for future patients." The concern is misplaced: the pharmaceutical industry has been identified as the most profitable in the world despite such market interventions.

PhRMA's "trade watch" list, and pressures on the US government, should be of concern to Canadians, and should also signal to Canadians the important connection between current events in developing countries and their implications for Canada. PhRMA is open about why

it is attacking Canada over allegedly inadequate protection for pharmaceutical patents:

The concerns of pharmaceutical patent owners are serious and have important implications beyond economic losses in Canada. If a major developed country such as Canada is failing and continues to fail to comply with the spirit and letter of TRIPS, this will set a negative example for developing countries. Canadian practices that create a dangerous precedent should be addressed before they are adopted in other jurisdictions.... PhRMA requests that the U.S. Trade Representative place high priority to [sic] remedying this situation.

PhRMA places Brazil, the Dominican Republic, and the Philippines on the same “priority watch list” as Canada, and places even higher priority for action on countries such as Argentina and India.

PhRMA and Developments in Other Countries

Brazil

Among developing countries, Brazil has attracted much praise for its bold response to the HIV/AIDS epidemic, including a commitment to manufacturing generic drugs that it can provide cheaply to the majority of Brazilians with HIV/AIDS, drastically reducing the death rate and realizing considerable savings in health-care expenditures (including hospitalizations). In fact, PhRMA expressly refers to AIDS drugs by opposing the legislative measures taken in Brazil that would allow

compulsory licensing of drugs in situations of national emergency or where a patent holder fails to produce a patented drug domestically in Brazil (ie, “local working” of the patent).

As reported previously, in late May 2000 the US filed a complaint against Brazil at the WTO alleging that Brazil was in violation of its obligations under the TRIPS Agreement and the 1994 General Agreement on Tariffs and Trade (GATT).¹¹ In response, Brazil filed its own complaint against the US. Provisions in the US Patents Code state that “no small business firm or non-profit organization” which has title to a patented invention shall give anyone an exclusive right to use or sell the invention in the US unless it will be “manufactured substantially” in the US. The US law also says that any person licensed to use or sell a “federally-owned invention” in the US must agree that any product that embodies the invention, and any product produced through the use of the invention, will be “manufactured substantially” in the US.¹²

Following widespread criticism of the US,¹³ at the time of the UN General Assembly Special Session on HIV/AIDS in late June 2001, the US and Brazil announced that they had reached a settlement of this dispute.¹⁴ The US agreed to terminate its WTO panel proceeding, but without prejudice concerning its interpretation of the contentious section in Brazil’s legislation, in exchange for a commitment by the Brazilian government “to hold prior talks” with the US government should Brazil deem it necessary to apply the provision to grant a compulsory licence on a patent held by a US company. The

US also expected Brazil to not proceed with its complaint about provisions in the US Patents Code.¹⁵

The settlement is welcome. But it remains to be seen how it will play out in practice: should Brazil decide at some point to grant a compulsory licence because a patent-holding pharmaceutical company is failing to produce their product locally, will the US manage to prevent or significantly delay the issuing of a compulsory licence and the lowered drug prices it will generate?

Dominican Republic

PhRMA asserts that the Dominican Republic has adopted “the worst new patent law in the Western Hemisphere,” and calls on the US government to initiate WTO proceedings against it. As in Brazil, the law requires “local working” of the patent, in the form of domestic manufacture. It also allows compulsory licences to be granted in cases where the patent holder does not exploit the patent or abuses the patent by engaging in non-competitive practices, or where it is in the public interest. The law also requires the disclosure of data filed by the patent holder for getting regulatory approval to market a medicine, and allows this data to be used by others when necessary to obtain health approval for their own similar product before it can be sold. This is similar to the provisions of Canadian law in this regard, which, as noted, PhRMA also opposes.

Philippines

PhRMA is also targeting the Philippines, which has in the past year engaged in “parallel importation” of pharmaceutical products from India. According to the former

Minister of Health of the Philippines, this measure yielded significant savings for the government in fulfilling its constitutional duty to “make essential goods, health and other social services available to all the people at affordable cost” (Article 13.11). Parallel importing is perfectly permissible under the TRIPS Agreement. PhRMA, however, says that parallel importing necessarily involves “unfair reliance” on confidential test data or other information supplied by the patent-holding company to get marketing approval for its own patented drug.

India

PhRMA is even more incensed about India and Argentina, which it has identified to the US government as “priority foreign countries” for action. PhRMA urges that “strong action ... be taken against India, which stands as the greatest unchallenged opponent of intellectual property protection for pharmaceutical products” and “urges USTR to initiate a WTO dispute settlement process as soon as possible.”

India has been critical of the WTO and the TRIPS Agreement as tools for maintaining the power of industrialized countries (and their industries) over developing ones. As with Canada, PhRMA opposes India’s system of drug-price controls and is pushing for “market-based pricing” only. And as with Canada, PhRMA is also concerned about the example India sets. According to PhRMA, “the Indian regime has become a ‘model system’ for opponents of strong intellectual property protection systems,” and Indian generic pharmaceutical companies “aggressively export their products to third countries where intellectual

property laws are similarly lax.” Finally, PhRMA has targeted India because of its proposal, made at the WTO in mid-2000, to amend the TRIPS Agreement “to serve as a lever for technology transfer to developing countries,” even though this is supposedly only one of the “objectives” of the Agreement, Article 7 of which states:

The protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations.

Argentina

With respect to Argentina, PhRMA asserts that it “remains the worst expropriator of the intellectual property of the research-based pharmaceutical industry in the Western Hemisphere, and one of the worst in the world.” As with Canada, PhRMA complains that data submitted in support of applications for marketing approval are able to be used by others in developing competing products, which PhRMA calls “unfair commercial use” even though, as explained, this is one of the key obligations imposed in exchange for lengthy market monopolies. And as with Brazil, PhRMA is particularly upset by proposed legislation that would force companies to produce patented products locally as a condition of enjoying full patent rights. Again, this is a form of ensuring technology transfer, one of the supposed objectives of the TRIPS

Agreement, but one that is strongly opposed by PhRMA. In response to lobbying by PhRMA, the US has filed a WTO complaint against Argentina.¹⁶

What happens to developing countries at the WTO is of direct relevance to Canada’s ability to implement policies that take into account public interests such as the human right to affordable health care.

Conclusion

PhRMA continues to press for the abolition of “non-market based government interventions” such as “abusive price controls, reference pricing, monopsonistic purchasing practices, ... unreasonable restrictions on listings in government-established formulations ..., and other non-market-based practices or measures which have the effect of distorting trade.” PhRMA fails to acknowledge that patents themselves, which grant extensive monopolies, are distortions of the “free” market, and that the TRIPS Agreement, in contrast to other trade agreements, is principally about restricting the free operation of market forces. Monopsony situations – where there is a single, or at least one dominant, purchaser of goods (such as government) – are a counterbalance in the market to the monopoly of the patent-holding pharmaceutical company. Canadians should be particularly interested in PhRMA’s attacks on government intervention in the health-care market because mechanisms for price control such as the

Patented Medicines Prices Review Board, and policies by provincial governments to cover only lowest-cost versions of drugs, are fundamental aspects of Canada's public health-care system that PhRMA seeks to abolish.

Canada's experience to date at the WTO signals danger for developing countries with even fewer resources to defend against US/PhRMA pressure and even more extensive HIV/AIDS epidemics. And what happens to developing countries at the WTO is of direct relevance to Canada's ability to implement policies that take into account public interests such as the human right to affordable health care, not just the private interests of an industry that seeks to maximize profit and opposes any efforts to ensure that advances in scientific know-how are in fact of public benefit to those whose situation is the most dire.

— Richard Elliott

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¹ *Canada – Term of Patent Protection*. Arbitration under Article 21.3(c) of the Understanding on Rules and Procedures Governing the Settlement of Disputes, 28 February 2001:WT/DS170/10.

² *Canada – Term of Patent Protection*. Report of the Panel, 5 May 2000:WT/DS170/R.

³ *Canada – Term of Patent Protection*. Report of the Appellate Body:WT/DS170/AB/R, 18 September 2000.

⁴ See Elliott R. Canada loses appeal of WTO panel ruling on minimum patent terms. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 25-26.

⁵ *Canada – Patent Protection of Pharmaceutical Products*, WT/DS114/13: Award of the Arbitrator under Article 21.3(c) of the Understanding on Rules and Procedures Governing the Settlement of Disputes, 18 August 2000 at para 60.

⁶ *An Act to amend the Patent Act*, SC 2001, c 10 (available via www.parl.gc.ca).

⁷ Letter dated 16 February 2001 from Shanon SS Herzfeld, Senior Vice President (International Affairs), Pharmaceutical Research and Manufacturers Association of America, to J Papovich, Assistant US Trade Representative for Services, Investment & Intellectual Property, and PhRMA Special 301 Submission, 20 February 2001 (available online at www.pharma.org/intnatl/news/2001-02-20.40.pdf).

⁸ US Trade Representative. Monitoring and Enforcing Trade Laws and Agreements [fact sheet], 1 May 2000. Office of the USTR, Washington DC (available online via www.ustr.gov).

⁹ *Ibid.*

¹⁰ *Apotex v Canada (Attorney General)* (2000), 188 DLR (4th) 145; [2000] FCJ No 634 (CA) (QL), leave to appeal dismissed by the Supreme Court of Canada on 22 February 2001, [2000] SCCA No 379 (QL).

¹¹ Brazil – Measures Affecting Patent Protection, complaint by the United States:WT/DS1999, 8 June 2000 (available via www.wto.org). Summarized at: R Elliott. US Files WTO complaints against Brazil over requirement for “local working” of patents. *Canadian HIV/AIDS Policy & Law Review* 2000; 5(4): 28.

¹² United States – US Patents Code: Request for Consultations by Brazil:WT/DS224/1, 7 February 2001, available via: www.wto.org.

¹³ For example, see: Médecins Sans Frontières. Press release: US Action at WTO Threatens Brazil's Successful AIDS Programme. 1 February 2001, available via www.accessmed-msf.org.

¹⁴ United States Trade Representative. Press release: United States and Brazil agree to use newly created Consultative Mechanism to promote cooperation on HIV/AIDS and address WTO patent dispute. 25 June 2001, available via www.ustr.gov.

¹⁵ Brazil – Measures Affecting Patent Protection. Notification of Mutually Agreed Solution, WT/DS199/4, 19 July 2001, available via www.wto.org.

¹⁶ See previous summary of this complaint by Elliott R. Complaint against Argentina over protection of patents and test data. *Canadian HIV/AIDS Policy & Law Newsletter* 2000; 5(4): 29.

Canadian Court Upholds Glaxo's Patent on AZT

In October 2000, the Federal Court of Appeal issued the latest ruling in the ongoing dispute over the validity of Glaxo's Canadian patent for AZT,¹ upholding Glaxo's patent but narrowing the scope of the claims it could validly make. The decision is now on appeal to the Supreme Court of Canada.

The case involved appeals and cross-appeals from the March 1998 decision of the Federal Court of Canada Trial Division in the matter.² In that judgment, Wetston J ruled that Glaxo's patent on AZT was valid; that certain of its patent claims were valid and others invalid; and that generic drug manufacturers Apotex and Novopharm had infringed Glaxo's valid patent claims. As a result, he issued an injunction preventing these companies from importing, manufacturing, using, advertising, promoting, offering for sale, and selling AZT in pharmaceutical dosage form, and ruled that Glaxo should be awarded damages against Apotex and Novopharm.

Apotex and Novopharm appealed from this decision, arguing that Glaxo's patent is invalid for a number of reasons, and that alternatively, even if the patent were generally valid, certain of Glaxo's claims are invalid. Glaxo

defended the validity of its patent generally, and cross-appealed from the trial judge's findings, which narrowed the scope of its patent claims. The Federal Court of Appeal dismissed most of the appeals and cross-appeals, generally affirming the validity of Glaxo's patent but narrowing its claims for the use of AZT beyond treatment or prophylaxis against HIV.

Background

AZT was synthesized in 1964 as a potential cancer treatment. At the time, Glaxo had also been researching the drug for its possible use as an antibacterial treatment, but decided not to pursue the drug beyond some initial testing. No patent protection for AZT was sought at that time for

any use. However, some time before November 1984, Glaxo decided to test AZT, a nucleoside analogue, against mouse retroviruses similar to HIV, as a potential treatment for HIV/AIDS. Glaxo scientists discovered that AZT had “completely eradicated” the mouse retroviruses against which it had been tested, and the trial court found that, on 19 November 1984, a Glaxo scientist formed the idea that AZT could be used to treat HIV. In December 1984, Glaxo started working on developing AZT for clinical trials in humans, and in January 1985 began to prepare its patent application.

On 4 February 1985, Glaxo sent what it knew to be AZT to two scientists at the US National Institutes of Health, to be tested against HIV in a laboratory human cell line they had developed, because Glaxo suspected AZT would be effective against HIV but did not have the facilities required to test compounds against actual HIV. Neither of the two NIH scientists knew the name or chemical compound of AZT at the time or that it was a nucleoside analogue. On 21 February 1985, the NIH scientists advised Glaxo that the compound showed anti-HIV activity *in vitro*. Glaxo then submitted its final patent application to the UK Patent Office, with a “priority date” of 16 March 1985. (Glaxo disputed any suggestion that it was waiting for the NIH results before applying for its patent. Its draft patent application was completed on 6 February 1985, containing a complete description of a new use for the old AZT compound, including dosage details, and this draft was virtually identical to the final application filed in the UK on 16 March 1985.) Glaxo filed its Canadian patent application just under a year later, on 14 March

1986, with a claimed priority date of 16 March 1985, based on its filing in the UK. Glaxo was granted the Canadian patent on AZT on 21 June 1988.

The litigation in both the US and Canada began a few years later. In May 1991, what was then Burroughs Wellcome (since subsumed into GlaxoWellcome, now the merged corporation GlaxoSmithKline) filed suit in the US against Barr Laboratories (an affiliate of Apotex) for infringing its US patents, and later filed suits against Novopharm and the US National Institutes of Health. These US actions were consolidated into one, which Burroughs Wellcome (Glaxo) eventually won.³ In Canada, Apotex and Novopharm started an action in May 1991, seeking a declaration that Glaxo’s Canadian patent was invalid, and that the generic products proposed by Apotex and Novopharm would not infringe the patent. In October 1991, Glaxo sued Apotex for infringement of its Canadian patent. Two years later, it also began a similar action against Novopharm. All three of these actions were consolidated and tried together, eventually resulting in Weston J’s decision in March 1998 in the Trial Division of the Federal Court of Canada that was the subject of the most recent appeal to the Federal Court of Appeal.

The key substantive issues raised by the generic companies and by Glaxo are summarized below. Technical issues are omitted, although readers may refer to the court’s judgment for these.

The Issues: Claims by Apotex and Novopharm

The generic drug manufacturers advanced a number of arguments in their efforts to have Glaxo’s AZT

patent declared invalid, either wholly or partially. All but one of their arguments were dismissed.

Issue 1: inventorship

Only the five Glaxo scientists were named as inventors of AZT as an HIV treatment or prophylaxis in both the UK and Canadian patents. The two scientists at the US NIH were not named as co-inventors. Apotex and Novopharm argued that this amounted to a “material misrepresentation” that invalidates Glaxo’s patent. However, the Federal Court of Appeal disagreed. Upon reviewing the law, it concluded that

an inventor is that person (or those persons) whose conception or discovery gives rise to the invention for which a patent is sought. It should thus be equally clear that a person who does not conceive the idea or discover the thing is not an inventor. Where a person is directed to engage in a purely mechanical act for the purpose of testing whether an invention will work, in circumstances where “the whole train of ideas put into motion ... were those of others,” the person is not to be treated as an inventor.⁴

Accordingly, the Court found that the two NIH scientists were not “inventors” in law: they did not think to use AZT to treat AIDS, but merely carried out testing on behalf of the Glaxo scientists who did. The Court noted that these scientists have never asserted they were co-inventors of the use of AZT against HIV (although they do hold patents on suramin, ddC and ddI for the treatment of HIV).

The Court also found that, even if the two NIH scientists were legally co-inventors of AZT for the treatment of HIV, the failure to mention

them in the patent application is not a “material allegation” that invalidates the patent under Canada’s *Patent Act* (s 53).

Issue 2: completion of invention

Apotex and Novopharm argued that a pharmaceutical compound cannot be an invention until it is tested on living humans, and that absent this testing, there can be no “sound prediction” of its pharmacological utility sufficient to establish invention.

Glaxo could not have known, by the date of 16 March 1985 when it filed its UK patent application, that AZT would be effective in the treatment or prophylaxis of HIV in humans.

Therefore, because testing showing its utility was not complete, it did not have an invention at that time that could be the subject of a valid patent.

The Court disagreed, citing its earlier decision in *CIBA-Geigy AG v Commissioner of Patents*⁵ in ruling that

even where an invention constitutes a speculation as of the priority date claimed in the patent, the patent will not be invalid if it turns out that the speculation is valid at the time the patent is attacked. In other words, so long as an inventor can demonstrate utility or a sound prediction at the time a patent is attacked, the patent will not fail for lack of utility.... [To conclude otherwise] would require a Court to close its eyes to continuing scientific advancements, and would disentitle patentees to rely on the instinctive sparks that so often engender great discoveries.⁶

The FCA ruled that cases supporting the rule that all pharmaceuticals must always be tested on living humans before the priority date claimed on the patent in order for the patent to

be valid, did not apply to this case, because those cases dealt with situations in which a few claimed compounds are tested but many are still untested even at the time the patent is attacked. That was not the situation

International trade agreements may be invoked to limit the ability of the Canadian government to differentiate between different kinds of inventions.

here, because by the time Apotex and Novopharm attacked Glaxo’s patent, further evidence following Glaxo’s patent application had established that AZT is indeed useful in treating HIV.

Another aspect of the Court’s decision should be noted. Although unnecessary for its ruling, the Court rejected any suggestion that pharmaceutical products should be held to a higher standard of utility than other kinds of inventions, saying that cases such as *CIBA-Geigy* were no longer valid in this respect because they preceded the North American Free Trade Agreement (NAFTA) and the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The Court ruled that both these agreements, incorporated into domestic law, prohibit discrimination based on field of technology, and therefore courts may not hold pharmaceutical inventions to a higher standard of utility than other classes of inventions.⁷

This point is significant, and should be worrisome for people with HIV/AIDS and for other Canadians. It confirms that international trade agreements may be invoked to limit

the ability of the Canadian government to differentiate between different kinds of inventions. It weakens the ability to reflect, in Canadian law, that inventions may be qualitatively different from one another, such that in some cases other considerations and interests must be balanced against intellectual property rights. This is particularly true in the area of medicines, which are qualitatively different from inventions such as cars or can openers. Indeed, this difference had, for decades before these trade agreements, been reflected in Canadian law and the law of many other countries, in that the ability to patent medicines was non-existent or limited. This is precisely the situation that brand-name pharmaceutical companies sought to change through international trade agreements such as NAFTA and TRIPS. Notwithstanding the complaints by the industry reported elsewhere in this issue, it would appear that their efforts are now bearing fruit in Canadian courts as well.

Issue 3: obviousness and novelty

Apotex and Novopharm argued that Glaxo’s patent is invalid because the use of AZT to treat HIV was “obvious” and lacked “novelty.” However, the Court dismissed both these arguments.

With respect to obviousness, the Court cautioned that, in weighing the evidence, it must “guard against the danger inherent in hindsight analysis that an invention may appear obvious after the fact which was not obvious at the time of invention.” Furthermore, an appeal court should only overturn the finding of the trier of fact on this issue if it is “manifestly wrong” on the evidence. That was not the case here. With respect to novelty, the Supreme Court of

Canada had already ruled in the *Shell Oil*⁸ case that the discovery of a new use for a known compound is patentable. In this case, the Court ruled that Glaxo could validly claim, under its patent, the new use of AZT, an old compound, as treatment or prophylaxis for HIV.

Issue 4: ambiguity

Apotex and Novopharm argued that the term used to describe AZT in the patent (3'-azido-3'-deoxythymidine) is either overly broad or ambiguous because either (i) a person skilled in the art who read this could not know the structure of the chemical compound so described, and/or (ii) this term could apply to two specific compounds. The Court dismissed these claims, finding that the trial judge who considered the evidence made no palpable and overriding error in finding that the term only applied to one compound, and that someone skilled in the art could read the material disclosed in the patent and be able to synthesize AZT.

Issue 5: sufficiency of disclosure

Apotex and Novopharm argued that, in the patent, Glaxo did not disclose sufficient information for a medical practitioner to treat patients with AZT, nor sufficient information regarding the mechanism of action of AZT to support a claim for its use as a prophylaxis. Again, the Court felt that the trial judge was correct in his finding that the patent did in fact give sufficient information for persons skilled in the art to work the invention. He was correct in finding that, in prescribing drugs, physicians do not refer to the drug patents, but rather rely on product monographs, medical literature, and experience; therefore the patent did not have to contain detailed prescribing informa-

tion in order to be valid. Furthermore, the patent did specify the method of making formulations for administering AZT as a prophylaxis, so the trial judge was correct in finding the patent valid on this basis.

Issue 6: medical treatment

Apotex and Novopharm argued the patent is invalid because it is for a medical treatment and therefore cannot be patented. The Court rejected this argument, noting that in the *Shell Oil* case the Supreme Court ruled that the distinction between what is and what is not patentable is based on whether the subject matter is related to professional skills on the one hand, or to trade, industry, or commerce on the other. (It should be queried whether this distinction is really so clear, particularly in the “information age” and information-

“What is new is the specific use of AZT against HIV. That is what was invented in 1985. It is only that use of the pharmaceutical formulation that is patentable.”

based economies.) The Court found that what was invented by Glaxo was a new use for a known compound – a saleable product “clearly related to trade, industry and commerce” – and not a method of medical treatment.

Based on all these considerations, the Court rejected the attempts by Apotex and Novopharm to have Glaxo’s entire patent ruled invalid. In the alternative, the generic companies argued that certain of Glaxo’s patent claims were invalid, on two grounds.

Issue 7: claims unrelated to use

First, Apotex and Novopharm argued that AZT is not a new compound, and that Glaxo could not validly claim a patent for any use other than the use against HIV, because any other claims do not constitute an invention by Glaxo. This was the only argument by Apotex that the Court accepted. The Court explained that, in law, “when a new compound is invented, the inventor is entitled to a patent over that compound for all uses. However, where the compound is not new, the patent will be limited to the new use invented for the compound.”⁹ The Court found that to allow Glaxo’s exceedingly broad patent claim for “a pharmaceutical formulation comprising an active ingredient (ACT) and a pharmaceutically acceptable carrier therefor” would be tantamount to granting Glaxo a patent for a compound that was not new, since its pharmaceutical use had been known since 1964: “What is new is the specific use of AZT against HIV. That is what was invented in 1985. It is only that use of the pharmaceutical formulation that is patentable.”¹⁰

Issue 8: prophylaxis claims

Second, Apotex and Novopharm argued that Glaxo’s claims for the use of AZT as a prophylaxis were ambiguous and not described in its patent disclosure. The Court, however, felt that there was no ambiguity in the term “prophylaxis,” meaning a “preventative measure against disease” (HIV infection in this case). Furthermore, any disagreement among experts as to the efficacy of AZT in preventing mother-to-child transmission, or infection following a needlestick or unprotected sex, does not mean that Glaxo’s patent claim for the use of AZT as a prophylaxis

is ambiguous. Even if the use of AZT as a prophylaxis was not known by Glaxo scientists when they filed this patent claim in 1985, at the time the

The end result is that the Court affirmed the validity of Glaxo's patent on AZT for use as treatment or prophylaxis for HIV infection, but only this use.

patent was challenged, there was evidence of its utility in preventing mother-to-child and needlestick transmission, and that this was therefore sufficient.

The Issues: Claims by Glaxo

In addition to defending the validity of its patent generally, Glaxo cross-appealed three aspects of the trial judge's decision.

Issue 9: scope of patent claim

First, Glaxo argued that its claims for the use of AZT in the treatment or prophylaxis of *all* human retroviral infections was valid. The trial judge had found this claim overbroad. Glaxo argued that he had erred in this finding, because there was cogent evidence of its usefulness for all such infections. Glaxo pointed to a paper written by one of the NIH scientists who had tested AZT on

human cell lines for Glaxo, in which he stated that AZT had the potential to function as an antiviral agent against human retroviruses in addition to HIV. However, the Federal Court of Appeal dismissed this argument, saying that the trial judge did not ignore this evidence, and that he made no palpable and overriding error in finding that human retroviruses other than HIV were not good candidates for treatment using AZT.

Issue 10: ambiguity of AIDS-related claims

Second, the trial judge ruled that Glaxo's claims for the treatment or prophylaxis of "an AIDS infection" were invalid because they were ambiguous. Glaxo argued this was an error. However, the Federal Court of Appeal agreed with the trial judge that this is an ambiguous claim, because the term "an AIDS infection" might refer to HIV infection itself or to an opportunistic infection. The Court upheld the trial judge's finding that there is "nothing in the patent disclosure or the claims that suggest [sic] the drug will assist in treating those opportunistic infections associated with the disease."¹¹

Conclusion

In the end, the Court dismissed all of Glaxo's cross-appeals and all but one of the appeals by Apotex and Novopharm. The end result is that the Court affirmed the validity of Glaxo's patent on AZT for use as

treatment or prophylaxis for HIV infection, but only this use. It ruled that Glaxo could not claim a broader patent for the use of AZT in the treatment of opportunistic infections in people with HIV/AIDS, nor could it claim the use of AZT for treatment of human retroviruses other than HIV. It awarded damages for patent infringement to Glaxo (to be assessed by the trial court), as well as pre- and post-judgment interest on those damages, and its legal costs for defending against the appeals by Apotex and Novopharm (but none of the costs for its own unsuccessful cross-appeals).

On 15 March 2001, the Supreme Court of Canada granted leave to appeal.¹² Absent any extensions, Glaxo's patent in Canada for the use of AZT as HIV treatment or prophylaxis expires in 2005.

— Richard Elliott

¹ *Apotex Inc v Wellcome Foundation Ltd*, [2000] FCJ No 1770 (CA) (QL) (hereinafter *Apotex*, online via www.fct-cf.gc.ca).

² See Elliott R. Court rules on patent dispute over AZT – appeal still outstanding, *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 11-12, summarizing: *Apotex Inc v Wellcome Foundation Ltd* (1998), 79 CPR (3d) 193; 145 FTR 161; [1998] FCJ No 382 (TD) (QL).

³ *Burroughs Wellcome v Barr Laboratories Inc*, 828 F Supp 1208 (EDNC 1993), largely affirmed on appeal at 40 F 3d 1233 (CAFC 1994).

⁴ *Apotex*, supra, note 1 at paras 32-33.

⁵ (1982), 65 CPR (2d) 73 (FCA).

⁶ *Apotex*, supra, note 1 at paras 50-52.

⁷ *Ibid* at para 54, citing NAFTA Art 1709(7) and TRIPS Art 27.

⁸ *Shell Oil Co v Commissioner of Patents*, [1982] 2 SCR 536.

⁹ *Apotex*, supra, note 1 at para 81.

¹⁰ *Ibid* at para 83.

¹¹ *Ibid* at para 108.

¹² [2000] SCCA No 610 (QL).

Generic Drug Maker Wins Right to Sue for Anti-Competitive Practices

In December 2000, the Ontario Court of Appeal upheld the right of generic drug manufacturer Apotex Inc to sue three name-brand pharmaceutical companies for allegedly anti-competitive practices.¹ Apotex's claim had been struck out by a lower court, but the appellate court overturned this judgment and allowed the suit to proceed. The facts alleged by Apotex, if eventually proved true, could support a court finding that the name-brand companies were in fact liable.

Apotex claimed that the practices of Hoffman LaRoche, Pharmacia & Upjohn, and Glaxo Wellcome, and the marketing corporation ("AltiMed") they created, violated the *Competition Act*, and amounted to the common law torts of conspiracy and unlawful interference with economic relations. Apotex's claim centres on the marketing of "pseudo-generic drug products":

These products are manufactured on the same production lines and are identical in composition to the name-brand drug products, save for being labeled as originating from AltiMed. They are sold at much lower prices. The plaintiff claims that the name-brand defendants make these drug products available for distribution by AltiMed under agreements that only allow the pseudo-generic product to be sold immediately before a competing generic product is about to enter the market, thereby capturing critical market share and harming competition.²

Apotex claimed that the name-brand companies mislead consumers by:

- marketing drug products at prices substantially in excess of identical products in the same pharmacies across Canada; and
- failing to provide physicians, pharmacists, and consumers with material information about the source of their products, and thereby permitting misleading representations to be made about their products and pseudo-generic drug products, such that consumers pay premiums on name-brand products without receiving any corresponding benefit.

The federal *Competition Act* says that "no person shall, for the purpose of promoting ... the supply or use of a product or for the purpose of promoting ... any business interest, by any means whatever, knowingly or recklessly make a representation to the public that is false or misleading in a material respect."³ The Court of Appeal found that, if Apotex proves that the name-brand companies represent that the drugs originate with AltiMed, or that they permit AltiMed to make this representation, this would amount to a false representation.

Furthermore, assuming it were true that the name-brand companies made such representations in order to promote the sale of their name-brand products to uninformed consumers at higher prices, the Court said that this would be a representation made "to promote a business interest." Finally, the Court said that this could be a "material" representation, if it was shown that it is "so pertinent,

germane or essential that it could affect the decision to purchase." Apotex alleged that "the majority of consumers are unaware that pseudo-generics exist and are identical to name brand products, and would choose the lower-priced version of a prescription drug if presented with the informed choice between two identical brands."

Apotex also alleged that the name-brand companies were violating the *Food and Drugs Act*, which prohibits labeling, packaging, selling, or adver-

Apotex alleged that "the majority of consumers are unaware that pseudo-generics exist and are identical to name brand products, and would choose the lower-priced version of a prescription drug if presented with the informed choice between two identical brands."

tising any drug "in a manner that is false, misleading or deceptive or is likely to create an erroneous impression regarding its character, value, quantity, composition, merit or safety."⁴ While the Court expressed doubt as to whether this section was intended to prohibit the kind of conduct complained of by Apotex, it was possible that it might apply to AltiMed. Therefore, since it was not "plain and obvious" that Apotex's claim must fall – the test for whether or not to dismiss the claim at the outset⁵ – the claim were allowed to proceed.

The Court found that these possible breaches of the *Competition Act* and the *Food and Drugs Act* could

also be the “unlawful purpose” necessary for Apotex to prove the common law tort claims of both conspiracy and unlawful interference with economic relations. Therefore, these claims were also allowed to proceed.

Apotex is claiming damages for lost sales as a result of these practices. Apotex’s lawyer promises to call evidence at trial to show this, pointing out that the name-brand companies “wouldn’t do this unless there was a point to it.”⁶

– Richard Elliott

¹ *Apotex Inc v Hoffman La-Roche Ltd*, [2000] OJ No 4732 (CA) (QL).

² *Ibid* at para 3.

³ RSC 1985, c C-34, s 52(1).

⁴ RSC 1985, c F-27, s 9(1).

⁵ *Abdoal v Anaheim Management Ltd* (1995), 21 OR (3d) 453 (Div Ct).

⁶ Saxe C. Appeal court concludes “pseudo-generic” drugs may be cause of action. *Lawyers’ Weekly*, 12 January 2001; 20(33): 1, 3 at 3.

Canadian Court Dismisses Pfizer Attempt to Prevent Approval of Generic Fluconazole

On 10 January 2001, Pfizer lost its bid before the Federal Court of Appeal to prohibit the federal Minister of Health from issuing approvals for two generic versions of the drug fluconazole.¹

Fluconazole is an antifungal drug used to treat yeast infections such as “thrush” (oesophageal candidiasis), as well as the fatal cryptococcal meningitis to which people with compromised immune systems are susceptible.

Pfizer holds the patent on the drug, which it markets under the brand name Diflucan. In June 1995, two generic drug manufacturers, Apotex Inc and Nu-Pharm, issued notices under Canada’s *Patented Medicines (Notice of Compliance) Regulations*² (the NOC Regulations), alleging that their processes for making these generic versions would not infringe any pertinent patent claim of Pfizer’s. Pfizer disagreed, and started legal proceedings, seeking an order prohibiting Health Canada from issuing a “notice of compliance” to the companies. A “notice of compliance” (NOC) is required in order to legally market a drug in Canada.

Pfizer’s applications were dismissed in 1998, and the Minister of Health issued notices of compliance to both Apotex and Nu-Pharm in October 1998. Pfizer appealed the dismissal of its applications to the Federal Court of Appeal, and sought

an order granting its original request for prohibition and revoking the NOCs issued to Apotex and Nu-Pharm until Pfizer’s patent expires.

The Federal Court of Appeal agreed with the generic companies that the appeal was moot, since once the Minister had issued the NOCs, proceedings to prohibit the issuance were foreclosed. This conclusion was warranted because of the particular, summary nature of this kind of proceeding under the NOC Regulations.

The Court pointed out that “prohibition proceedings under the Regulations are not similar to patent infringement proceedings.” The regulations give patent-holding companies a “special method” of protecting their patents from possible infringement. Just by applying for an order prohibiting the Minister from issuing a NOC to a competitor, on the basis that this will infringe its patent, the patent-holding company automatically gets what is essentially a temporary injunction preventing the NOC from being issued for at least 30 months. This is markedly different from the standards a court would ordinarily apply in deciding whether to issue an injunction, and the patent

holder gets this benefit simply by alleging that the competitor’s product will infringe its patent.

In the Court’s view, “this unique benefit conferred upon patentees has as its corollary that Parliament intended [these] proceedings be dealt with expeditiously by way of summary application for judicial review.”³ Therefore, applying one of its earlier decisions, the Court ruled that once the Federal Court Trial Division dismisses a prohibition application, the Minister is entitled to issue a NOC. And once the Minister has done so, any appeal from the decision to dismiss an application is moot.

The Court pointed out that Pfizer could still sue Apotex and Nu-Pharm for patent infringement if they wished.

Pfizer applied on 12 March 2001 to the Supreme Court of Canada for leave to appeal the Federal Court of Appeal’s decision.⁴

– Richard Elliott

¹ *Pfizer Canada Inc v Apotex Inc*, [2001] FCJ No 17 (CA) (QL).

² SOR/93-133.

³ *Supra*, note 1, at para 19 (QL).

⁴ [2001] SCCA No 11 (QL).

Court Dismisses Eli Lilly's Case against Generic Drug Makers

In December 2000, the Federal Court of Appeal ruled that generic drug manufacturers Novopharm Ltd and Apotex Inc could market generic versions of the patented antidepressant drug Prozac (fluoxetine) in capsules with a colour, size, and shape similar to the brand-name drug.¹

The case is significant for people with HIV/AIDS because it means one less barrier that brand-name pharmaceutical companies can erect to competition

from generic drugs in the market, competition that lowers prices of medicines.

Eli Lilly & Company hold the Canadian patent on Prozac. Eli Lilly had sued Novopharm and Apotex, alleging they passed off their generic drugs as Eli Lilly's brand-name Prozac because they had the same size, shape, and colour as Prozac capsules. Eli Lilly sold its product in 20mg capsules that are half green and half cream, and in 10mg capsules that are half green and half pale grey, with the words "Prozac" and "Lilly" stamped on the side.

When its patent on fluoxetine expired in March 1996, Eli Lilly began to market its own generic version of the drug as well as continuing to sell capsules under the trademarked name Prozac. Eli Lilly's own generic version was identical in size, shape, and colour to its brand-name version, with only the wording stamped on the pills being different. The appearance of a product is known, in intellectual property law, as its "trade dress" or "get up."

The day after Eli Lilly's patent expired, Eli Lilly obtained temporary injunctions preventing Apotex and Novopharm from adopting "trade dresses" for their products that were the same as or similar to the Prozac trade dress. While these injunctions were in place, the generic companies sold their drugs in capsules that

looked different from Eli Lilly's. But in September 1996, the injunction was overturned by the court, and they began marketing their products in a trade dress similar to Prozac (with minor differences). A few weeks later, Eli Lilly's lawsuit went to trial.

The trial court received 51 expert reports and heard from 62 witnesses, including doctors, pharmacists, and Prozac users. Apotex and Novopharm testified that they chose to copy the appearance of Eli Lilly's capsule for marketing reasons. The trial judge noted that this has been standard practice for decades in Canada's pharmaceutical industry.

The trial judge found that consumers associated a drug's appearance with the medicine contained in it and its therapeutic effect, not with the company that manufactured it. Eli Lilly had not proved that the appearance of its capsules had acquired a "secondary meaning" (ie, consumers

associating the appearance of the Prozac capsules with either Eli Lilly or any other particular source). The trial judge also found there was no evidence before her of actual confusion on the part of patients as a result of the generic companies using the same appearance as brand-name Prozac, and that Eli Lilly had not proven any significant likelihood of such confusion. She therefore dismissed the claim.² Eli Lilly appealed.

The Federal Court of Appeal found there was no "palpable and overriding error" in the trial judge's findings of fact and that the trial judge had correctly applied the law. It therefore upheld her decision, affirming that Eli Lilly could not claim any "trade-mark" with respect to the size, shape, and colour of their Prozac capsules. On 21 June 2001, the Supreme Court of Canada dismissed without reasons Eli Lilly's application for leave to appeal the decision.³

– Richard Elliott

¹ *Eli Lilly & Co v Novopharm Ltd*, [2000] FCJ No 2090 (CA) (QL). See also Naiberg R. Trade dress not passing-off [op-ed], *Lawyers' Weekly* 12 January 2001; 20(33): 4, 8.

² (1997), 73 CPR (3d) 371; [1997] FCJ No 488 (FCTD).

³ [2001] SCCA No 100 (QL).

BioChem Pharma Wins Patent Dispute over 3TC

In December 2000, the US Board of Patent Appeals and Interferences, a branch of the US Patent and Trademark Office (USPTO), upheld BioChem Pharma's claim to hold the patent on 3TC.

The drug, lamivudine, is marketed under the brand name Epivir, and BioChem claims it is the world's most widely prescribed drug for HIV/AIDS treatment. Emory University in Atlanta had also claimed to hold a patent. On this basis, it

filed a patent infringement suit in a US district court in Georgia against BioChem and its licensee, Glaxo Wellcome. (Under a licensing agreement, BioChem receives royalties from Glaxo Wellcome on the sale of 3TC, and Glaxo has the right to develop, manufacture, and sell the drug

worldwide, except in Canada, where the two companies have a commercialization partnership.) BioChem obtained a stay of Emory's lawsuit until the patent appeals board ruled on the validity of Emory University's patent claim. Patent offices in numerous countries have previously rejected

Emory University's claim. It is unknown whether Emory University will appeal the decision.¹

¹ BioChem Pharma Inc. News release: US Patent Office Invalidates Emory University's Patent for 3TC/Epivir; 21 December 2000 (available online via www.biochem-pharma.com); BioChem wins patent battle. *The Gazette* [Montréal], 23 December 2000: C2.

PUBLICATIONS REVIEWED

HIV-Related Knowledge and Stigma – United States, 2000

This report¹ describes the results of three questions on HIV/AIDS in a national public opinion survey of households, conducted in the United States through the internet from August to September 2000.

One question measured HIV stigma. Respondents who strongly agreed or agreed with the statement “People who got AIDS through sex or drug use have gotten what they deserve” were considered to have a stigmatizing attitude toward people with HIV/AIDS. The two remaining questions measured knowledge about HIV transmission. Persons who responded that it was very unlikely or impossible to become infected through sharing a glass or being coughed or sneezed on were considered informed; those who stated that it was very likely, somewhat likely, or somewhat unlikely, were considered misinformed.

Out of the total sample of 7493 adults aged 18 and over, 5641 (75.3 percent) answered the question on HIV stigma. Of these, 18.7 percent had a stigmatizing attitude. Stigmatizing responses were more common among men (21.5 percent), whites (20.8 percent), persons aged 55 and over (30 percent), those with only a high school education (22.1 percent), those with an income of less than \$30,000 (23.4 percent), and those in poorer health compared with others (23.6 percent). Approximately 40 percent of respondents were misinformed about the possibility of HIV transmission through sharing a glass or being coughed or sneezed on. Approximately 25 percent of those who were misinformed had a stigmatizing attitude, compared with approximately 14 percent of those who were informed.

These results suggest that there has been only a modest improvement in attitudes and knowledge related to HIV/AIDS in the United States over the past

decade. A 1990-1991 survey of 538 adults found that 20.5 percent had a stigmatizing attitude (agreeing that “People who got AIDS through sex or drug use have gotten what they deserve”), while 47.8 percent were misinformed about the possibility of HIV transmission through sharing a glass and 45.4 percent were misinformed about being coughed or

There has been only a modest improvement in attitudes and knowledge related to HIV/AIDS in the United States over the past decade.

sneezed on.² The 2000 survey confirms that a substantial minority of the population continues to stigmatize people with HIV/AIDS, and that a large proportion of the population is misinformed about HIV transmission.

The editors of the *Morbidity and Mortality Weekly Report* observe that

reduced HIV stigma would contribute to increased HIV testing, entry into health care, and adoption of safer behaviours.³ But while greater understanding of HIV transmission may reduce the level of stigmatizing attitudes, other factors are at work in HIV-related stigma, as the editors note. Attitudes toward gay people and injection drug users significantly influence attitudes toward HIV/AIDS and people with HIV/AIDS.⁴

In Canada 30 to 40 percent of the estimated number of people with HIV/AIDS – 15,000 out of 40,000, according to estimates made in 1996 – are unaware of their HIV status.⁵ The Canadian Strategy on HIV/AIDS is considering how to increase public

knowledge about preventing HIV transmission and how to increase levels of HIV testing.⁶ Repeated general population surveys of knowledge of HIV transmission, attitudes toward people with HIV/AIDS, and HIV testing behaviours would be an important adjunct to any such efforts.⁷

– reviewed by Theodore de Bruyn

Theodore de Bruyn is the author of *HIV/AIDS and Discrimination: A Discussion Paper* (Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1998). He can be reached at tdebruyn@cyberus.ca.

¹ DA Lentine et al. *Morbidity and Mortality Weekly Report* 49(47): 1062-1064.

² GM Herek, JP Capitanio. Public reactions to AIDS in the United States: a second decade of stigma. *American Journal of Public Health* 1993; 83(4): 574-577 at 575.

³ Editorial note to DA Lentine et al. HIV-related knowledge and stigma – United States, 2000. *Morbidity and Mortality Weekly Report* 2000; 49(47): 1062-1064 at 1064.

⁴ GM Herek, JP Capitanio. AIDS stigma and contact with persons with AIDS: effects of direct and vicarious contact. *Journal of Applied Social Psychology* 1997; 26(1): 1-36. GM Herek, JP Capitanio. AIDS stigma and sexual prejudice. *American Behavioral Scientist* 1999; 42(7): 1130-1147. JP Capitanio, GM Herek. AIDS-related stigma and attitudes toward injecting drug users among black and white Americans. *American Behavioral Scientist* 1999; 42(7): 1148-1161. For a review of this special issue of the *American Behavioral Scientist* on AIDS and stigma in the United States, see T de Bruyn, *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 5(1): 50-51.

⁵ Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada. HIV testing among Canadians: 15,000 current HIV infections may not be diagnosed. *HIV/AIDS Epi Update* April 2000.

⁶ Canadian Strategy on HIV/AIDS. Draft meeting report. Canadian Strategy on HIV/AIDS Annual Direction-Setting Meeting, October 29-November 1, 2000. December 7, 2000, at 12-13 and 27.

⁷ The National Population Health Survey, a bi-annual survey of the general population in Canada, has limited data. The 1994-1995 survey asked: "Has your blood ever been tested for HIV?" The 1996-1997 survey asked: "Have you started being tested for STDs (in the past 2 years)?" There were no questions in the 1998-1999 survey.

AIDS Doctors: Voices from the Epidemic¹

Last summer I was speaking with a novelist who lives down my street about my personal and professional experiences as an AIDS doctor. He strongly recommended that I publish, with other AIDS physicians, a record of our experiences or else risk losing a part of medical history. A few days later the *Canadian Medical Association Journal* sent me a review copy of *AIDS Doctors: Voices from the Epidemic*. The idea for this wonderful book had arisen in the early 1990s, during a dinner conversation in which the editors were made privy to the private reminiscences of three AIDS physicians. My novelist neighbour's suggestion came nearly 10 years too late.

AIDS Doctors is an oral history based on the recollections of 76 front-line AIDS physicians in the United States, including those who first detected and reported on the epidemic in June 1981. Canadian "AIDS people" (a designation assigned to the first wave of AIDS physicians in the US) will recognize themselves in this book, no matter what their background or experience.

The editors remark on the atypical demography of the physicians interviewed: 40 percent gay and lesbian, just under 50 percent Jewish, 30 percent women, and 90 percent white. A leftist political philosophy, deeply held religious beliefs, a sense of moral duty, and the excitement of a new dis-

ease motivated and sustained AIDS physicians through the first terrible 15 years of the epidemic. But it was gay physicians who rallied to the side of their dying friends and lovers in numbers "out of all proportion" to their representation in the medical profes-

AIDS Doctors provides a blow-by-blow account of the bewilderment and shock felt by physicians who first encountered an unknown killer of young gay men.

sion. Many openly declared their homosexuality, almost in defiance of the deadly epidemic sweeping their community.

AIDS Doctors provides a blow-by-blow account of the bewilderment and shock felt by physicians who first encountered an unknown killer of young gay men. Physicians, some reluctantly, were quickly connected to communities of HIV-infected people with whom they shared no common experience or values: injection drug users, the poor, and (for heterosexual physicians) the gay community. It was a struggle – described in brutally frank interviews – to overcome the barriers between mostly middle-class physicians and dying, destitute patients. And it was their helplessness in witnessing the march of their patients to death that impelled most AIDS physicians to return to the most noble traditions of medicine: kindness, compassion, and availability. Death and dying also forced these physicians to cede power in relationships that they traditionally dominated. HIV-infected people demanded participation in all decision-making, whether at the level of patient care or of public policy, leading to a so-called “more democratic” medicine.

The epidemic profoundly affected the lives of AIDS physicians who, as one of them put it, became “gripped.” Fear of infection, occasionally to a near-paranoid degree, tested a centuries-old ethical conflict between the values of self-interest and of self-effacement. Requests for assisted suicide, the demands for unapproved and unconventional therapies, and the need to enrol poverty-stricken patients in clinical trials as a means of securing medical care regularly confronted American AIDS physicians. The dumping of AIDS patients by physicians who refused to treat them, institutional antagonism

toward AIDS doctors, and professional isolation produced clusters and networks of AIDS physicians who relied on each other for mutual support.

The traditional separation between doctors and patients collapsed, particularly in the gay community, in the throes of death. For heterosexual physicians the bonds of family life were severely strained as they poured their energies into all aspects of the epidemic. One highly visible doctor recounted a conversation in which his young child stated, “I don’t want to see a TV Daddy; I want to see the real Daddy.”

The intimate revelations published in *AIDS Doctors* will resonate with many AIDS physicians: the “illicit sense of exhilaration” at engaging with a new disease with its myriad manifestations, “tak[ing] chances and work[ing] on limited data,” the “state of chronic depletion, sadness and fatigue” and the disappointment and exasperation of the zidovudine (AZT) monotherapy saga.

The assimilation of AIDS into mainstream medicine (the “normalization” of AIDS) has been wrought in part by the spectacular success of new treatments and the rise of early AIDS doctors into positions of professional prominence. But the goodwill and commitment of the earlier years is no longer sufficient. The complexity of highly active antiretroviral therapy (HAART) requires expertise held by relatively few. The “ties and identities that so defined the lives of AIDS doctors” have broken down, and the solidarity has dissipated. One AIDS pioneer stated, “I would really prefer being on the frontlines again, doing something that’s unique.”

The subjective experience of Canadian AIDS physicians is accurately reflected in *AIDS Doctors*, with some noteworthy exceptions. Canadian physicians were not participants in the detection and initial description of the AIDS epidemic in North America. Canada’s health-care system guaranteed, in contrast to the US system, access to HIV care for patients regardless of socioeconomic status. The existence of a well-developed system of primary care meant that Canadian family physicians, particularly gay physicians, found themselves on the front lines of the AIDS epidemic in Canada.

AIDS Doctors provides for both medical and lay readers an intimate glimpse into the dramatic struggles of the relatively few physicians who first confronted an epidemic of catastrophic proportions. It stands as a testament to the lives of physicians “gripped” by the AIDS epidemic.

– reviewed by Philip B Berger

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Reprinted with permission from *Canadian Medical Association Journal* 2000; 163(11): 1486-1487.

¹ Ronald Bayer and Gerald M. Oppenheimer. New York: Oxford University Press 2000, 310 pp. US\$ 27.50 (cloth) ISBN 0-19-512681-5.

Principles for Model Sex Industry Legislation

Intended for use as a lobbying tool for sex industry law reform in Australia, Principles for Model Sex Industry Legislation¹ is a critical read for anyone interested in or working with sex workers' rights organizations, HIV/AIDS policy, and law reform in the context of prostitution and sex work in many countries and regions. The document lays out ten principles for model sex industry legislation, provides a skills-building scheme for dealing with politics and bureaucracies, and an easy-to-use media lobbying kit.

The principles set out in the document address a number of policy and human rights issues raised by HIV/AIDS in the context of sex work, including: decriminalization; sex work as legitimate employment; choice of employment within the sex industry; occupational health and safety;² public health and mandatory testing; local planning laws and zoning; community attitudes toward sex work; discrimination and human rights; sex slaves and foreign sex workers; and myths regarding the prevalence of drug use, coercion by pimps, and minors in the sex industry.

The model for sex industry legislation presented attempts to “ensure a balance of stakeholders needs” (at 1). For example, it underlines the importance of respecting sex workers' human rights in all policymaking. Mandatory HIV testing is seen as

“perpetuating stereotypes of sex workers as diseased” (at 20). To single out workers in the sex industry is a discriminatory practice that “harms sex workers in both their professional and personal lives” (at 32) and “infringes the Universal Declaration of Human Rights to grant freedom of discrimination to sex workers on the basis of employment” (at 34).³

In order to assist the reader in developing a balanced response to sex industry legislation, the Australian political system is explained and various media lobbying strategies are listed. For the Scarlet Alliance and the Australian Federation of AIDS Organisations, “Involvement and liaison with the relevant arms of political power – including the parliament, its committee structures and the bureaucracy – are essential to influencing policy, decision making and legisla-

tive changes so that they reflect sex workers needs” (at 44). Frameworks for submissions to government, petitions, press releases, letters to the Editor, and talkback radio, may be helpful for sex worker organizations and their advocates for influencing decisions in Canada.

For a copy of the document, contact the Australian Federation of AIDS Organisations (AFAO) at PO Box 876, Darlinghurst NSW 1300, Australia (tel: 61 2 9281 1999; fax: 61 2 9281 1044; email: afao@rainbow.net.au). For consultation only, the document is also available at the Legal Network's Resource Centre (contact Thomas Haig at thaig@aidslaw.ca).

– reviewed by Maria Nengeh Mensah

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¹ Banach L, Metznerath S. *Principles for Model Sex Industry Legislation*. Sydney: Scarlet Alliance and Australian Federation of AIDS Organisations, 2000.

² The Scarlet Alliance and the Australian Federation of AIDS Organisations also recently produced *A Guide to Best Practice. Occupational Health and Safety in the Australian Sex Industry* (2000). This publication is a detailed model of how the implementation of occupational health and safety standards can assist both sex workers and legislative bodies in decreasing health risks as well as improving social justice.

³ A parallel is made with other industries where no such “draconian measures” are applied. “For example, the food industry is responsible for the death and intoxication of large numbers of people every year, yet food handling workers in restaurants are not required to be compulsorily tested for various communicable diseases” (at 21).

HIV/AIDS IN PRISONS

Inquest into the Death of a Prisoner Co-Infected with HIV and Hepatitis C: How Many More Will There Be?

Michael Joseph LeBlanc probably became infected with HIV and Hepatitis C while incarcerated in a federal penitentiary. On 18 November 1999, he died at the Regional Hospital in Kingston Penitentiary of complications relating to hepatitis C. Mr LeBlanc died inhumanely, in extreme physical, psychological and emotional distress. His death raises the issues of transmission and prevention of HIV and hepatitis C, compassionate release, and health care and palliative care in federal prisons. An Inquest under the Coroners Act¹ was held in Kingston, Ontario from 30 January to 1 February 2001. These same issues had been raised previously at the October 1997 coroners inquest into the death of William Bell, a person living with AIDS who died while incarcerated in another federal penitentiary.²

Introduction

Michael Joseph LeBlanc was incarcerated in federal penitentiaries for most of his adult life. He was 45 years old when he died and was serving a sentence of 10 years. The cause of death was “acute bronchopneumonia and diffuse alveolar damage in a patient with end stage hepatic cirrhosis.”³ Mr LeBlanc was co-infected with HIV and hepatitis C and had been receiving antiretroviral therapy for his HIV infection for a number of years prior to his death. He was scheduled to be released into the community in September of 2000.

In Ontario, a coroner, a legally qualified medical practitioner, must hold an inquest whenever an inmate of a correctional institution dies.⁴ The

inquest is conducted in the presence of a jury composed of five persons selected from the community in the same manner as a jury is selected for a criminal trial.⁵ A Crown attorney acts as legal counsel to the coroner throughout the proceedings⁶ and serves as the guardian of the public interest, although in the case of an inquest into the death of a prisoner, the office of the Crown Attorney is adverse to the interests of prisoners, an interest that needs to be represented.⁷

The purposes of a coroner’s inquest are twofold: first, the inquest shall inquire into the circumstances of the death and determine who the deceased was and how, when, where

and by what means the deceased came to his or her death.⁸ Second, the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.⁹ Courts have referred to this second function as the dominant, public interest function of the modern inquest.¹⁰

In keeping with the public interest function, any person, before or during an inquest, may make an application for standing at the inquest and the coroner shall designate the person as a person with standing if the coroner finds that the person is substantially and directly interested in the inquest.¹¹ A person with standing can be represented by counsel or an agent, call and examine witnesses and present arguments and submissions, and conduct cross-examinations of witnesses relevant to the interests of the person with standing.¹²

At the inquest into the death of Mr LeBlanc, the Kingston-based AIDS service organization HIV/AIDS Regional Services (HARS) was designated as a person with standing, as was Correctional Service of Canada (CSC). In the months prior to his death, HARS met with and advocated on behalf of Mr LeBlanc. In its application for standing, HARS took the position that while Mr LeBlanc’s death from hepatitis C and AIDS-related causes might have been inevitable, he did not have to die in prison because he was eligible for consideration for compassionate release. HARS

also argued that CSC's inaction unnecessarily compromised Mr LeBlanc's quality of life immediately preceding his death and that had proper care been provided he might have lived longer and would have died under more dignified and humane circumstances.¹³

Arguably, CSC did not fulfil its purpose or its legal responsibilities in its treatment of Mr LeBlanc. The *Corrections and Conditional Release Act* (CCRA)¹⁴ governs institutional and community corrections and conditional release, detention, and long-term supervision in federal prisons. The purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful, and safe society by carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders, and to assist in rehabilitation of offenders and their reintegration into the community through the provision of programs in penitentiaries and in the community.¹⁵ CSC's statutory responsibilities include the care and custody of inmates and the preparation of inmates for release, including matters relating to parole.¹⁶

Transmission and Prevention of HIV and Hepatitis C

Dr Peter Ford, Clinical Director of the Clinical Immunology Outpatient Clinic at Kingston General Hospital and Mr LeBlanc's HIV primary care physician from 1995 until his death, testified at the inquest that Mr LeBlanc possibly contracted HIV and probably contracted hepatitis C in prison through sharing contaminated injection drug equipment. CSC knew, prior to Mr LeBlanc testing positive for hepatitis C, that he was

an injection drug user and explicitly recognized that he likely engaged in illicit drug use causing further harm to his health and possibly spreading communicable disease. Health records also show that the doctors from the Clinical Immunology Outpatient Clinic recommended to the physician in charge at Kingston Penitentiary as early as February 1998 that Mr LeBlanc be put on methadone maintenance therapy to treat his heroin addiction and as a harm-reduction measure. CSC never evaluated Mr LeBlanc for methadone maintenance therapy.

The jury heard evidence about the crisis posed by HIV and hepatitis C in penitentiaries both from Dr Ford and Ralf Jürgens, Executive Director of the Canadian HIV/AIDS Legal Network. Both experts testified that CSC has done very little to stop the spread of HIV and hepatitis C, even in the face of reports such as the 1994 report of the Expert Committee on AIDS and Prisons (ECAP)¹⁷ and the 1996 report by the project on legal and ethical issues raised by HIV/AIDS, *HIV/AIDS in Prisons: Final Report*.¹⁸ Both reports detailed the extent of the crisis and proposed recommendations for action. As a budgetary item, the prevention of HIV and Hepatitis C and health promotion are woefully under-funded especially in light of the inordinate amount of resources dedicated to the so-called "war on drugs" in prisons.¹⁹

Mr Jürgens said that CSC is ethically required to spend more money on preventing the transmission of HIV and hepatitis C and that CSC was acting immorally and negligently by failing to take appropriate action. Dr Ford characterized current drug programs as "ineffective" and

CSC's failure to provide inmates with the means to protect themselves from HIV and hepatitis C infection as "immorality of a rare degree." An alternative, health promotion and harm-reduction approach, including anonymous testing, distribution of bleach, distribution of sterile needles, and access to methadone maintenance therapy (MMT) wherever clinically indicated, was described by Mr Jürgens. As detailed in the report of the Expert Committee on AIDS in Prisons, in *HIV/AIDS in Prisons: Final Report* and elsewhere,²⁰ harm-reduction measures have been successful in a number of Western European prisons, resulting in lower rates of transmission of HIV and hepatitis C and safer working conditions for correctional staff.

HARS asked the jury to recommend that CSC adopt a harm-reduction strategy to prevent the transmission of HIV and hepatitis C, as follows:

- CSC should make anonymous HIV testing, including pre- & post-test counseling, available to all inmates.
- Peer education programs must be established in all CSC institutions.
- A pilot needle exchange program needs to be put in place immediately.
- CSC must provide methadone maintenance therapy to every inmate who requests it, where it is medically indicated. This includes providing MMT to inmates who were not on MMT in the community.
- CSC must work toward a greater role for outside agencies that are able to provide expertise and services in the area of HIV/AIDS, hepatitis C, and harm reduction.

Compassionate Release

Mr LeBlanc need not have died in prison. Under the CCRA, parole may be granted at any time to an offender who is terminally ill, whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement or for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced.²¹ CSC must also take into consideration a prisoner's state of health and health-care needs in all decisions affecting the prisoner and in the preparation of the prisoner for release.²² The National Parole Board has final authority over matters relating to parole and conditional release and is guided, among other considerations, by the principle that the protection of society is paramount and that the Parole Board should make the least restrictive determination consistent with the protection of society.²³

In 1994, CSC explicitly accepted ECAP's recommendation that prisoners with diseases like HIV be released on parole before their condition deteriorated to the terminal stage.²⁴ The circumstances of Mr LeBlanc's death demonstrate that CSC has not implemented an effective compassionate release policy. Compassionate release was never discussed with Mr LeBlanc. On 9 November 1999, nine days before he died, CSC staff held a multi-disciplinary case management meeting to determine if they could support an application for compassionate release. By that date, Mr LeBlanc's health had deteriorated to the point that he was no longer competent to understand information or make decisions regarding parole, compas-

sionate release, and placement in the community.

Research concerning compassionate release of prisoners in another jurisdiction has suggested that the main obstacles impeding the program's effectiveness are overly restrictive eligibility criteria, a cumbersome review process resulting in extensive delays, and the availability of a hospice program providing correctional staff with an alternative to release.²⁵ With the exception of the availability of hospice programs, the anecdotal evidence arising out of the LeBlanc inquest indicates that the same obstacles are at work in Canada's federal prisons.

In response to ECAP's recommendation released in 1994, CSC stated that it would provide education and training for staff on discharge planning to ensure continuity of care and access to resources after release.²⁶ Patricia McGuirk, HARS' Prison Support Co-Ordinator who worked with Mr LeBlanc, testified concerning CSC's failure to provide appropriate pre-release planning or "aftercare" for Mr LeBlanc. As of the date of the multidisciplinary case management meeting, Mr LeBlanc's plan called for him to be released to the Kingston, Ontario community, despite the fact that appropriate residential hospice care was not available in that community.

HARS asked the jury to recommend that CSC put in place a compassionate release case management plan. "CSC is responsible, primarily through the parole officer, for developing pre-release plans and making parole applications on behalf of inmates. Where inmates have progressive, life-threatening illnesses, they must have the option of making an application for compassionate

release within a realistic time frame. CSC must be proactive. Inmates must be advised of the option of compassionate release as early on in their illness as possible. Parole officers must then be prepared to make compassionate release the focus of the inmate's case management plan."

Health Care and Palliative Care

CSC has a legislative obligation to provide every inmate with essential health care that conforms to professionally accepted standards.²⁷ Practically, this legislative obligation has been interpreted by CSC to mean that inmates should have access to

On at least three occasions the Correctional Service of Canada interrupted Mr LeBlanc's HIV antiretroviral medications without clinical justification or Mr LeBlanc's consent.

the same level of health-care service available in the community.²⁸

Dr Ford's testimony concerning the health care provided to Mr LeBlanc exposed the systemic barriers that HIV primary care physicians contracted by CSC face in caring for incarcerated clients. Dr Ford testified that on at least three occasions CSC interrupted Mr LeBlanc's HIV antiretroviral medications without clinical justification or Mr LeBlanc's consent. The actual number of interruptions may have been higher, but sections of the medication administration records were incomprehensible. The interruption of one or more HIV antiretroviral medications may

have profoundly harmful effects on the health of an HIV-positive individual and those with whom they engage in high-risk activities. Such interruption can lead to drug resistance and these drug-resistant strains of virus may eventually be transmitted to other individuals. In addition, CSC health-care staff did not routinely undertake the blood work (viral load and lymphocyte studies) that Dr Ford relied upon to monitor the clinical course of Mr LeBlanc's HIV disease.

Dr Ford testified that, when compared with HIV-positive people in the community, his ability to control HIV infection in the prisoners he treats is only half as good. This disparity in outcomes is due to a number of factors: prisoners are less compliant with the complex anti-retroviral drug regimes used to treat HIV infection, failure on the part of CSC staff to ensure that the medications used to treat HIV infection are available and administered, failure on the part of CSC staff to test blood for markers of HIV infection in a timely manner, and failure on the part of CSC staff to ensure that HIV-positive prisoners are discharged with a sufficient supply of antiretroviral medications.

Despite the fact that Dr Ford is an authority on the treatment of HIV disease and has a great deal of experience treating HIV-infected individuals who have substance abuse issues, he testified that his professional opinion as to the appropriate course of treatment for individual prisoners is "often" overridden. This is particularly the case when Dr Ford orders prescription medications to help prisoners manage the symptoms of withdrawal associated with stopping illicit drug use. In his opinion,

he cannot properly treat HIV infection without addressing the other health conditions that his patients suffer. CSC health-care staff did not assess Mr LeBlanc for methadone maintenance therapy despite requests by both Dr Ford, Dr Wobeser, and

Mr LeBlanc's health care records revealed that he was transferred to the palliative care room at the Regional Hospital in Kingston Penitentiary less than 12 hours before he died and that his pain was never brought under control.

another physician to do so and despite the strong suspicion among staff that, until shortly before his death, he was discharging himself from the Regional Hospital to engage in illicit drug use.

Mr LeBlanc's health-care records revealed that he was transferred to the palliative care room at the Regional Hospital in Kingston Penitentiary less than 12 hours before he died and that his pain was never brought under control. Marilyn Duphney, a nurse specializing in palliative care employed at Hospice Kingston, reviewed Mr LeBlanc's medical records and determined that he had suffered from anxiety and panic attacks for months prior to his death and that these conditions were never appropriately treated. Ms Duphney testified that insufficient pain medication was administered to Mr LeBlanc in the final hours of his life and that her review of his chart revealed that in the two months preceding his death a standard pain

measurement scale had only been used once. Moreover, Mr LeBlanc exhibited anxiety, restlessness, and panic behaviour in his final hours and his family members were upset by the experience of watching him die in such circumstances.

Ms Duphney gave evidence of what a real palliative care program should look like, based on standards and guidelines developed by the Canadian Palliative Care Association,²⁹ and spoke about existing prison palliative care programs and resources in Canada³⁰ and the United States.³¹

HARS asked the jury to recommend that CSC develop a palliative care program based on the Canadian Palliative Care Association's standardized principles of practice and drawing on existing community resources. HARS also recommended that CSC Health Care Services be accredited by an independent agency, like hospitals in the community, to evaluate whether CSC health services are providing care that meets objective and identifiable standards. Finally, HARS recommended that CSC permit outside specialist physicians the authority necessary to determine the appropriate course of care for their inmate patients.

Jury Recommendations

The jury made one recommendation to address the "key issue" surrounding Mr LeBlanc's death: "That the Regional Hospital at Kingston Penitentiary seek outside accreditation by an independent agency as is done for other public hospitals in Canada." The jury listed a number of other "issues that concerned the jury and which should be of ongoing concern to CSC, such as the prevalence of HIV/AIDS and hepatitis C under-

lying the need for both prevention and harm reduction methods through proactive strategies and pilot programs, the need for continued work on palliative care at Kingston Penitentiary in conjunction with outside agencies, and the need for CSC to develop clear and well-publicized guidelines around compassionate release.”

Conclusion

In 1996, a prisoner with AIDS named William Bell died alone at Millhaven Institution, “like a dog in a back kennel.”³² In 1997, the jury in the Bell inquest made detailed and specific recommendations about what CSC needed to do to prevent the “unfortunate and regrettable circumstances surrounding Mr. Bell’s death”. The recommendations of the Bell inquest jury went much further and were much more concrete than the recommendations made by the LeBlanc inquest jury. CSC has ignored the jury recommendation

There will undoubtedly come a point in time where CSC will be required to take both moral and legal responsibility for its inaction and the resulting harms – in a court of law

from the Bell inquest and many of the crucial recommendations for action in the two comprehensive studies,³³ both of which CSC funded in part. CSC has failed to take the action required to stem the transmission of HIV and hepatitis C, to provide health care and palliative care that meets professionally accepted

standards to prisoners living with HIV, or to fulfil its obligation (and public commitment) to make compassionate release a viable option for terminally ill inmates.

The *Coroner’s Act* explicitly prohibits any finding of legal responsibility or any conclusions of law relating to the circumstances of death.³⁴ CSC has had detailed knowledge of the crisis posed by HIV/AIDS and hepatitis C in federal correctional institutions since at least 1994, with the release of the ECAP Report. The LeBlanc inquest demonstrated once again that CSC has consistently failed to deal with the issues raised by HIV/AIDS, hepatitis C and injection drug use in federal prisons. There will undoubtedly come a point in time where CSC will be required to take both moral and legal responsibility for its inaction and the resulting harms – in a court of law. The failure of the Canadian Red Cross and the federal government to take timely action to protect the Canadian blood supply stands as the obvious precedent for such action.

– Jonathan Glenn Betteridge

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¹ RSO 1990, c. C. 37.

² For an account of the inquest into the death of William Bell see: Lines R. Death exposes treatment of prisoners living with HIV/AIDS. *Canadian HIV/AIDS Policy & Law Newsletter* 1998; 3/4(1).

³ Verdict of Coroner’s Jury, Inquest into the Death of Michael Joseph LeBlanc (February 1, 2001). On file with author and available from the Office of the Chief Coroner – Eastern Region, 51 Heakes Lane, Kingston, ON, K7M 9B1, (613) 531-5737.

⁴ *Supra*, note 1, s 10(4).

⁵ *Ibid* at s 3(1), 33.

⁶ *Ibid* at s 30(1).

⁷ *People First of Ontario v Porter* (1991), 5 OR (3d) 609 (Ont Ct Gen Div – Div Ct) at 620.

⁸ *Supra*, note 1 at s 31(1).

⁹ *Ibid* at s 31(3).

¹⁰ See, eg, *Kingston Penitentiary (Range Representative) v Regional Coroner* (1989), 33 OAC 241 (Ont Ct Gen Div – Div Ct) at 249; *Faber v The Queen*, [1976] 2 SCR 9 at 30.

¹¹ *Supra*, note 1 at s 41.

¹² *Ibid* at s 41(2).

¹³ All documents relating to the application for standing of HARS are on file with the author.

¹⁴ SC 1992, c 20.

¹⁵ *Ibid* at s 3.

¹⁶ *Ibid* at s 5.

¹⁷ Expert Committee on AIDS and Prisons. *HIV/AIDS in Prisons: Final Report of The Expert Committee on AIDS and Prisons* (Ottawa: Correctional Service of Canada, February 1994).

¹⁸ Jürgens R, *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, September 1996.

¹⁹ See *Ibid* at 22, where it is reported that in the year 1995-1996 CSC spent a combined \$2.2 million on urinalysis and the other components of its Drug Strategy but only \$175,000 on its AIDS Program at the national level.

²⁰ See a number of recent articles, eg, Menoyo C, Zulaica D, Parras F. Needle exchange programs in prisons in Spain. *Canadian HIV/AIDS Policy & Law Review* 2000;5(4): 20-21; Stöver H. Evaluation of needle exchange pilot projects show positive results. *Canadian HIV/AIDS Policy & Law Newsletter* 2000; 5(2/3): 60-64; and a publication review, Greig A. Harm Reduction: A New Direction for Drug Policies and Programs. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(4) 72-75; Zeegers Paget D. Needle distribution in the Swiss prison setting: a breakthrough? *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3) 60-61, as well as many other previous articles in the *Canadian HIV/AIDS Policy & Law Newsletter*.

²¹ *Supra*, note 14 at s 121.

²² *Ibid* at s 87.

²³ *Ibid* at s 101 (1) (a) & (d).

²⁴ Backgrounder: CSC Response to the Expert Committee on AIDS and Prisons (ECAP). Ottawa: CSC, Health Care Services Branch, 24 March 1994.

²⁵ Beck J. Compassionate release from New York State prisons: why are so few getting out? *Journal of Law, Medicine & Ethics* 1999; 27: 216 at 216, 231.

²⁶ *Supra*, note 24.

²⁷ *Supra*, note 14 at s 86.

²⁸ CSC. Commissioner’s Directive 800, *Health Services*. 22 December 1997.

²⁹ *Palliative Care: Towards Consensus in Standardized Principles of Practice*. Ottawa: Canadian Palliative Care Association, 1995.

³⁰ Staff and inmates at Mountain Institution, a federal penitentiary in British Columbia, have developed a program of care, details of which are available at www.csc-scc.gc.ca/text/pblct/duoweb/229/care_e.shtml.

³¹ Information on prison hospice and palliative care programs in the United States is available from the National Prison Hospice Association at www.npha.org and The Grace Project (Guiding Responsive Action in Corrections at End-of-Life) at www.graceprojects.org.

³² *Supra*, note 2.

³³ *Supra*, notes 17 and 18.

³⁴ *Supra*, note 14 at s 31(2).

Correctional Officers and Prevention of HIV Transmission among Prisoners

The problem of HIV transmission in prisons in Québec and elsewhere is increasingly urgent and requires the attention of federal and provincial authorities. Prison officers are among the key players who should be kept in mind when preventive measures are being developed.

We reprint the executive summary of a study conducted in federal and provincial prisons in Québec.¹ The goal of the study was to identify the factors influencing prison officers, with respect to whether they would agree or refuse to make accessible the tools needed for the prevention of HIV transmission among inmates (ie, condoms, bleach, tattooing equipment, and needles). Among the factors studied are officers' perceptions and beliefs as well as their attitudes, perceived social norms, emotions, and perceived barriers with respect to making preventive tools accessible.

Study Sample

The target population of the study consisted of correctional officers working in all correctional institutions in the province of Québec when the data were collected. Of those solicited, 42.8 percent agreed to participate in the study. This means that a total of 957 officers (23 percent women and 77 percent men) from 28 Québec correctional institutions (48 percent under federal jurisdiction and 53 percent under provincial jurisdiction) completed and returned the questionnaire.

Results

The results indicate that a majority of correctional officers in Québec institutions are not in favour of implementing the distribution of all preventive measures necessary for the prevention of HIV transmission in prisons (condoms, bleach, tattooing equipment, and sterile needles). Only 21.4 percent of respondents said they agreed with making *all these preventive tools* accessible. The responses to whether each of these tools should be made available revealed that intentions varied in light of the degree to which the proposed tool was perceived as dan-

gerous. In other words, the intention to agree to making the tools available increases where the tools are perceived as less dangerous.

Officers' intentions to agree to make all such tools accessible are related to individual workplace-related variables. Thus, women, single people, and people working in federal institutions generally have a significantly higher-than-average intention to agree to make such tools available. Also, managers and people who work with women prisoners seem more favourable to the idea of making preventive tools accessible. However, officers who have undergone training on a subject dealing with AIDS and those who report having been personally exposed to a risk of HIV infection in the course of their duties displayed a lower level of intention to making such tools accessible.

Four factors were identified to explain why officers were not in favour of making preventive tools accessible to inmates.

1. With respect to barriers, officers perceived certain factors that negatively influenced their decision:
 - a lack of training on the subject;

- the fear that a syringe could be used as a weapon;
 - the presence of a rule forbidding drug use in prison;
 - doubt as to whether these measures will work; and
 - the fear of an increase in workload.
2. With respect to their role, officers do not see themselves as "AIDS-prevention officers": making HIV prevention tools accessible to inmates is not perceived as one of their duties.
 3. With respect to perceived social pressures, officers believe that the members of their social network (mainly work colleagues and family members) would disapprove of their agreeing to make preventive tools accessible to inmates.
 4. On an emotional level, officers expressed negative feelings (fear, stress) at the idea of making preventive tools accessible to inmates.

Recommendations

The data indicate that it is not currently realistic to think of setting up accessibility programs for *all* AIDS-prevention tools in Québec prisons. However, according to prevention programs planning experts in the health field, and considering this study's identification of factors influencing officers' intentions, we think the three following recommendations should be considered with regard to preventing HIV in prisons.

1. Prison authorities (Correctional Service of Canada and the Québec

Ministry of Public Security) should provide clear instructions on how to apply preventive measures that involve access to preventive tools.

2. A training program based on the four factors identified in the preceding section should be developed and made available to all prison staff. Officers should be involved in the development of the contents and activities of any such program.
3. Access programs should be developed and program strategies should be set up in collaboration with the officers.

– Gaston Godin, Michel Alary,
Michel Morissette, Lina Noël

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1 Godin G, Alary M, Morissette M, Noël L. Correctional Institution Officers' Intention of Agreeing or Refusing to Make Accessible the Tools Needed for the Prevention of HIV Transmission among Inmates. Research Report. Québec, December 2000. [in French]

Irish Prison Guards Call for Expansion of Methadone Access

In many Western countries, including Canada, seroprevalence rates in prisons have reached epidemic levels, with infection rates among prisoners many times higher than among people outside prisons.

The situation is no different in Ireland.¹ As in Canada, the correctional system has reacted to the HIV and HCV crisis in a piecemeal fashion. While the Canadian and Irish correctional systems have a mandate to provide standards of health care comparable to those in the community, each system has chosen to implement HIV programs and services in an incremental and far from comprehensive manner.

Almost half of injection drug users reported injecting while in prison, with 58 percent of them admitting to sharing injecting equipment while incarcerated.

In Canada, community advocates have been at the forefront of demanding institutional change to address the HIV and HCV crisis in prisons, although trade unions representing correctional workers have been among the most vociferous opponents of extending essential health-care programs to prisoners.

While Irish prisons and prisoners struggle with many of the same issues as their Canadian counterparts, recent actions by the union representing Irish prison guards demonstrate that HIV- and HCV-prevention programs

need not be seen as antithetical to staff needs. In fact, in the case of methadone maintenance therapy, the union has clearly articulated that extending methadone access to all prisoners is in keeping with their workplace needs and the Irish correctional mandate.

HIV and HCV in Irish Prisons: An Overview

The most recent and comprehensive survey of HIV and HCV infection in Irish prisons was conducted in November 1998 by researchers from Trinity College in Dublin.² Over 1200 prisoners participated in the study, which examined seroprevalence rates and risk behaviours among Irish prisoners.

The Trinity College study revealed HCV infection rates of 37 percent and HIV infection rates of two percent. These statistics closely mirror the currently available Canadian figures. In a 1998 study conducted by Dr. Peter Ford, the HCV infection rate was found to be 37 percent and the HIV infection rate was 1.7 percent among prisoners at Joyceville Penitentiary in Kingston, Ontario.³

When these results were analyzed by gender, the Trinity College survey revealed that incarcerated Irish women have slightly higher infection rates than men: 47 percent HCV-positive and two percent HIV-positive. These findings are in keeping with

several Canadian studies that show higher seroprevalence rates among incarcerated women.⁴

As is the case in Canadian prisons, injection drug use was identified as a significant risk behaviour among Irish prisoners. The Trinity College researchers found that more than 43 percent of study participants reported injecting at least once in their lives, with 20 percent of this group stating that they first injected inside prison. Almost half of injection drug users reported injecting while in prison, with 58 percent of them admitting to sharing injecting equipment while incarcerated.⁵

In Canadian prisons, the high rates of HIV and HCV infection and injection drug use have spurred ongoing calls for prison health-care reform. Groups such as the Prisoners' HIV/AIDS Support Action Network, the Canadian HIV/AIDS Legal Network, the Canadian AIDS Society, and the Expert Committee on AIDS and Prisons have demanded the introduction of effective harm-reduction programs for prisoners. One of the key harm-reduction measures identified and promoted by these organizations is methadone maintenance treatment (MMT).

MMT in Prisons

MMT is internationally recognized as an effective replacement therapy for opiates, and an important harm reduction option for injection heroin and morphine users.⁶

In the Canadian federal prison system and in some provincial systems, MMT is available on a limited basis.⁷ Community advocates have generally been critical of the restricted nature of MMT implementation in prisons, and have called on correctional services to expand access to all opiate-dependent

prisoners requesting the treatment.

In Ireland, similarly high rates of HIV and HCV infection and injection drug use have recently moved the government to implement a new policy that makes MMT available to prisoners in selected Irish prisons.

The change in Irish policy originated in a recommendation of the July 2000 *Report of the Steering Group on Prison Based Drug Treatment Services* by the Irish Prisons Service. The Service explained its decision to expand the availability of MMT to prisoners on the basis that:

The Prisons Service must replicate in prison to the maximum extent feasible the level of medical and other supports available in the community outside.⁸

The report proposed Mountjoy Men's Prison in Dublin as the primary location for prisoners accessing MMT. The report also recommended that MMT be made available in three other institutions in the Dublin area.

Although not explicitly stated in the report, the selection of these prisons is not surprising. Dublin has the highest levels of injection drug use, primarily heroin, in Ireland. Since the mid 1990s, the national government has identified the Eastern Health Board region (the Dublin area) as *the* priority area for the development and implementation of harm-reduction initiatives such as needle exchange and MMT. Much of the local infrastructure and experience necessary to introduce methadone into prisons is readily available in Dublin. This is not the case in other regions of Ireland, where MMT programs are much smaller in scale and are in many cases reliant on Dublin-based expertise.

Mountjoy Men's Prison, with a population of approximately 500, is

also the largest of Ireland's 13 prisons. At present, the institution houses the majority of prisoners with HIV/AIDS.⁹

While the new Irish Prisons Service MMT policy represents an important step forward in dealing with the HIV and HCV epidemics in prisons, it suffers from several of the

While unions representing prison guards in Canada have been vocal opponents of HIV prevention and harm-reduction measures, their Irish counterparts have publicly criticized their government for not going far enough to make MMT accessible to people in prison, and have called for an expansion of the methadone program.

problems illustrated by Canadian federal and provincial prison policies on access to MMT.

First, MMT will only be available to Irish prisoners already on the therapy prior to incarceration.¹⁰ This is similar to the current policy in most Canadian systems that provide access to MMT, although the Canadian federal system has a policy that allows prisoners to start MMT in prisons under "exceptional circumstances" and is currently preparing to expand access to MMT. In most prisons, however, heroin users are not allowed to initiate MMT inside. MMT is therefore eliminated as an option for the majority of opiate-using prisoners

because they are not allowed to begin the therapy while incarcerated.

Second, the MMT policy will be implemented only in those prisons falling within the geographic boundaries of the Eastern Health Board (basically the city of Dublin and its environs). These four institutions – Mountjoy, Cloverhill (remand), Dochas Centre (Mountjoy Women’s Prison), and St Patrick’s (for males aged 16-21) – house only half Ireland’s total prison population of approximately 2200. In Canada, disparate access to HIV-prevention programs from one institution to another is common, despite policies demanding the same standard of care across the system as a whole. This reality often reflects varying levels of enthusiasm for these programs by staff and administration in different prisons. However, under the Irish policy, disparate access has been incorporated into the policy itself.

Irish Prison Officers’ Association Reacts

From a Canadian perspective, one of the biggest surprises of the new Irish Prisons Service methadone policy has been the reaction of the Prison Officers’ Association (POA), the union representing Irish correctional officers. While unions representing prison guards in Canada have been vocal opponents of HIV prevention and harm-reduction measures, their Irish counterparts have publicly criticized their government for *not going far enough* to make MMT accessible to people in prison, and have called for an expansion of the methadone program.

In a deposition before the government’s *National Drug Strategy Review*, the Prison Officers’ Association stated that

The Irish Prison Service has an aspiration to provide similar medical treatment for drug abusers in Prisons, as exists in the community at large.

Unfortunately this aspiration has been and continues to be an aspiration.¹¹

The POA further accuses the Irish Prisons Service of setting up a “two-tiered” system, denying MMT to a large number of people who might benefit from the program. In a separate communication with the *National Drug Strategy Review Group*, the POA stated

It is imperative that the national [MMT] policy be reviewed immediately and the proposals which are contained in the groups [sic] report should be made available to all Prisoners regardless of what geographic location or what Health Board area the Prison they are incarcerated in is located....

[A]ll drug abusers and drug addicts who are committed to prison should be assessed for suitability for Methadone Maintenance Drug Treatment Programmes. The availability of such programmes should not be prejudiced by whether or not a drug addict/drug abuser was in receipt of a drug treatment programme before his committal to prison.¹²

While the language is strong, the Prison Officers’ Association’s critique of the limitations of the current Irish Prisons Service MMT policy is *not* guided by a harm-reduction philosophy. Rather, the POA’s arguments come from a “zero tolerance” treatment-oriented perspective, in which the ultimate goal is to “reha-

bilitate” prisoners by weaning them from drugs, not to increase health options for users. The POA maintains that

[m]any who are now committed to Prison offend in the community because they are feeding drug habits. Is it not total negligence on all our behalves [sic] if we do not make at least some effort to try to rehabilitate and reform them from their drug abuse while we have them in the custody and care of the state?¹³

Such zero-tolerance positions would resonate with those of many correctional officials and workers in Canada.

Unlike many correctional workers’ unions in Canada, the POA has made a pragmatic assessment of the situation, and concluded that expanded methadone access is in fact good policy not only for prisoners but for union members and the broader community as well. Thus, there are important lessons both for Canadian correctional systems and for prisoner HIV/AIDS advocates in the Irish case.

The Irish POA critique provides three key contrasts with the current thinking of both Canadian correctional services and unions representing Canadian prison staff.

- (1) The POA locates the problem of drug use in prison within broader patterns of drug use in society. This perspective informs their support for the introduction of successful community programs such as MMT into prisons.
- (2) The POA recognizes that providing MMT as an option for all prisoners may reduce the number of people injecting drugs in prison, and thereby *increases*

workplace safety for their membership (by reducing the risks of needlestick injuries, reducing drug-related violence, and lessening the negative impacts of the illegal drug trade on the prison subculture, etc).

- (3) The POA asserts that making MMT accessible to all prisoners who wish to access it is in keeping with the mission of the Irish Prisons Service.

In its strong critique of the new Irish MMT policy, the POA demonstrates that the needs of prison staff are not inherently antithetical to the needs of prisoners. This is indeed an important lesson for Canadian correctional workers' unions.

For community advocates the lessons are equally compelling. The POA submission clearly articulates that the extension of HIV and HCV prevention and care can both increase workplace safety and support the correctional mandate. These are important elements that must

continue to be incorporated into advocacy on HIV and HCV issues in prisons.

While it is essential that advocacy efforts to expand prison HIV and HCV services be based on fundamental rights of prisoners to care and treatment, it is strategically important that the positive effects of such programs for staff not be overlooked. Examples such as the Irish case should be remembered in Canada when responding to concerns of correctional staff about expanding HIV and HCV programs in prisons.

– Rick Lines

Rick Lines was employed as the Prison Outreach Coordinator for the Toronto-based Prisoners with HIV/AIDS Support Action Network (PASAN) from 1993 to 2000. He is currently on a one-year leave of absence from PASAN and is working on a drug and alcohol program and policy issues in Ireland. He can be reached at ricklines@yahoo.com.

¹ In this article, the term "Ireland" and "Irish" refer to the 26 counties of the Republic of Ireland, and do not include the six counties in Northern Ireland. The figures cited in this article are drawn solely from the 26 counties, and do not incorporate figures from Northern prisons.

² Department of Community Health and General Practice, Trinity College, Dublin. *Hepatitis B, Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk*. Report prepared for the Minister of Justice, Equity and Law Reform (1999).

³ Ford P. HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 52-59.

⁴ Canadian HIV/AIDS Legal Network. HIV/AIDS and Hepatitis C in Prisons: The Facts. HIV/AIDS in Prisons: Info Sheet 1 (2nd ed, 2001).

⁵ Department of Community Health and General Practice, supra, note 2 at 16-18.

⁶ Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. Montréal: The Network, 1999, at 85 et seq, with many references.

⁷ For an overview, see Canadian HIV/AIDS Legal Network. *Prevention and Treatment: Methadone*. HIV/AIDS in Prisons: Info Sheet 7 (2nd ed, 2001).

⁸ Irish Prisons Service/ Seirbhís Phriosúin na hÉireann. *Report of the Steering Group on Prison Based Drug Treatment Services*. July 2000, at 2-3.

⁹ Although formal segregation of prisoners with HIV/AIDS was ended in January 1995, most openly HIV-positive prisoners are still housed in Mountjoy because the prison has been allocated resources to provide a higher standard of specialized care.

¹⁰ While the Irish Prisons Service report acknowledges the need to make methadone available to detox opiate users entering the prison system, under the current policy only those with a prior prescription will be allowed to continue methadone therapy.

¹¹ Prison Officers' Association. Submission to Mr Tony Bass, Secretary to the National Drug Strategy Review, Department of Tourism, Sport and Recreation. 6 June 2000.

¹² Larry Buggy, Assistant General Secretary, Prison Officers' Association. Letter to Mr Tony Bass, National Drug Strategy Review Group, Department of Tourism, Sport and Recreation. 7 September 2000.

¹³ Supra, note 11.

INTERNATIONAL NEWS

Pharmaceutical Companies Abandon Case against South Africa: Victory for People with HIV/AIDS

On 19 April 2001, 39 pharmaceutical companies bowed to worldwide condemnation and pressure, and completely abandoned their court action against the South African government over legislation that could be used to make essential drugs affordable for millions of South Africans.

Background

In 1997 the South African Parliament enacted the *Medicines and Related Substances Control Amendment Act* (Act 90 of 1997).¹ The purpose of the legislation was to facilitate access to cheaper medications in both the public and private health sectors of the country. These measures enabled parallel importation of patented medications, drug price control (with a transparent pricing system overseen by a Price Committee), mandatory generic substitution of off-patented medicines, exclusion of pharmaceutical industry employees from the Medicines Control Council, and international tendering for state medicine purchase contracts.

In February 1998, the Pharmaceutical Manufacturer's Association (PMA), the umbrella body in South Africa for the multinational, brand-name pharmaceutical industry, attempted to prevent the South African government from implementing these measures.² The government agreed not to proceed with implementation pending outcome

of the court case. The arguments advanced by the PMA were that:

- the legislation violated their constitutional right to equality by unfairly discriminating against innovator companies in favour of generic manufacturers;
- the legislation would allow their property (ie, patents) to be expropriated without compensation;
- pharmacists' constitutional right to practise their profession was being violated;
- parallel importation is in violation of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS); and
- the provisions were vague and gave the Minister of Health unfettered power to act.

The PMA also argued that the provisions would not lead to price reductions benefiting a significant number of people, but would lead to the pharmaceutical market being flooded with pirate, fake, dangerous drugs.

This was a transparent attempt by the PMA to conflate generic with pirate drugs.

TAC's Intervention

By means of marches, letters, petitions, and meetings with the PMA, the Treatment Action Campaign (TAC) had been pressuring the PMA for two years to drop the case, but the PMA finally set the matter down for hearing on 5 March 2001. No notice was given to TAC, which then requested permission to intervene as an *amicus curiae* (friend of the court). The court papers at that stage dealt only with intellectual property issues and there was no mention of the HIV/AIDS epidemic or access to affordable treatment to avert the effects of the epidemic on South African society. Despite opposition from the PMA, the court allowed TAC standing as an intervener, stating that TAC was bringing to the matter a vital perspective absent from the papers filed by the PMA and the government as the principal parties.

TAC focused its intervention on three aspects of the legislation: section 15C, dealing with parallel importation; section 22F, dealing with mandatory generic substitution; and section 22G, dealing with a single exit price and a pricing committee to ensure transparency of drug prices. The main arguments put forward by TAC were based on the provisions of the Bill of Rights of the South African Constitution relating to the rights to equality, human

dignity, life, and access to health care, as well as the rights of children.

TAC argued that the new laws did not infringe upon the rights of the pharmaceutical companies, but that if they did, the limitation of the companies' rights to make (further) profits was justifiable, given the scale of the HIV/AIDS epidemic. While the PMA argued that the legislation would benefit "only" a small number of people in the private sector, TAC submitted evidence showing that the legislation would benefit both the public and private health-care sector. In addition, TAC pointed out that even if the PMA's allegation was true, according to the PMA's own calculations there would still be a benefit to approximately 500,000 people with HIV/AIDS.

TAC also argued that the provisions were compliant with South Africa's obligations under TRIPS, but in the alternative, if the Court found that they contravened TRIPS, the government's obligations under the South African Constitution trump its obligations under TRIPS. In any event, South Africa is also signatory to other international treaties such as the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Rights of the Child. All of these impose positive obligations on the state to take measures to promote the health of South Africans, and these should take precedence over obligations under a treaty like TRIPS.

Resources were mobilized in South Africa and around the world to fight the case, both in the courts and outside the legal system. Local and international experts in the fields of health economics, the South African

health-care system, medical economics, drug pricing, and international law willingly assisted by providing legal advice and affidavits for TAC's

The result was worldwide protests and media coverage that precipitated an unconditional capitulation by one of the most powerful and profitable industries in the world.

submissions to court, and ALP worked with expert senior counsel to prepare TAC's brief and its oral argument to the court.³

Médecins Sans Frontières (MSF) successfully organized a campaign to collect 250,000 signatures from around the world on a petition calling on the PMA to drop the case. The AIDS Consortium, an umbrella body of about 300 HIV/AIDS non-governmental organizations and service organizations in South Africa, held weekly briefings at their offices. TAC prepared a fact sheet that was distributed to journalists at all major newspapers in the country. The result was worldwide protests and media coverage that precipitated an unconditional capitulation by one of the most powerful and profitable industries in the world. The PMA withdrew from the action on 19 April 2001 and agreed to pay the legal costs of the South African government.⁴

The Current Situation

If implemented appropriately, the new legislation will save both the government and the private medical sector millions of rands in drug

costs. The current price of triple antiretroviral therapy from innovator companies is about R10,000 a year in South Africa. On 4 June 2001, the government released draft regulations that would implement the provisions of the Act, with public comments due by September 2001.⁵

Despite the victory, the South African government has not moved to make antiretroviral therapy more affordable. At the press conference following the withdrawal of the action, the Minister of Health emphasized that the government would not be making antiretroviral therapy available to people with HIV/AIDS. She offered the following reasons: the high cost of the drugs; infrastructure problems; the cost of testing, counseling, and diagnostics; and the "toxicity" of the drugs.

TAC will continue to demand access to affordable treatment for people with HIV. In the battle against the PMA, TAC fought alongside the South African government to defend valid and necessary legal measures for realizing the right to health of South Africans. But the battle ahead will see them ranged on opposing sides.

– Anita Kleinsmidt

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For more information on the issue of access to treatment in developing countries, see the resources on the following websites: Treatment Action Campaign (www.tac.org.za); AIDS Law Project, South Africa (www.hri.ca/partners/alp); and the Canadian HIV/AIDS Legal Network website, which has a page listing key resources on this issue (www.aidslaw.ca/Maincontent/issues/cts/selectedresources.htm).

NOTES

¹ The text of the legislation can be found on the government of South Africa website (www.gov.za).

² *Pharmaceutical Manufacturers' Association of South Africa and Others v The President of the Republic of South Africa, the Hon. Mr NR Mandela and Others*, Case No 4183/98, High Court of South Africa (Transvaal Provincial Division). Many of the court documents are online at the TAC website (www.tac.org.za).

³ TAC's main affidavit replying to the PMA's arguments, most of the supporting affidavits, TAC's legal brief, and a TAC statement on the court case can be viewed on the TAC website at www.tac.org.za

⁴ The text of the settlement between the PMA and the South African government can be found at www.aidslaw.ca/Maincontent/issues/cts/agreementSA.htm.

⁵ The draft regulations can be found on the government website (www.gov.za): click on "Documents, reports & forms," then click on either of "consultative documents" or "reports and other documents."

Nigeria – Judge Denies Woman with HIV Access to Courtroom

In February 2001, a judge in the Ikeja High Court in Nigeria barred an HIV-positive woman from entering her courtroom out of concern for transmission of the virus.¹

District Court Justice Caroline Olufawa was hearing a lawsuit brought by Georgina Ahamefule, a woman with HIV, who alleged that her former employer, a hospital, had engaged in unconstitutional discrimination and unlawful dismissal when it fired her in 2000. Ahamefule had brought the lawsuit with the assistance of the Social and Economic Rights Action Centre (SERAC), a Nigerian human rights organization. This is the first HIV discrimination lawsuit in the country.

At the hearing on 22 January 2001, Justice Olufawa expressed her aversion to having Ahamefule present in her courtroom, stating to her lawyer: "Please do not bring your client to this court. Let her stay away." At the next hearing date, on 5 February 2001, she ruled that before she allows Ahamefule into the courtroom, she required expert evidence to provide assurances that neither she nor others in the courtroom would become infected with HIV as a result. The judge ignored oral arguments to the effect that HIV is not casually communicable and that denying Ahamefule access to her own court

proceeding was unconstitutional discrimination and infringed her constitutional right to a fair hearing.

On 16 February 2001, SERAC filed an appeal of the judge's decision with the Court of Appeal, alleging that she had erred in law and was in flagrant violation of the Nigerian Constitution and the African Charter on Human and People's Rights. Ahamefule is seeking a declaration that she is a person under the Constitution and entitled to the full enjoyment of her fundamental human rights regardless of her HIV-positive status. She is also seeking a declaration that denying her access to the courtroom based on her HIV status is unconstitutional and that the judge's order is null and void, and that she is not required to produce expert evidence regarding HIV transmission before being able to attend the court sessions. She is also seeking to have her lawsuit assigned to another judge for trial. Her appeal is scheduled for October 2001.

Following widespread condemnation of her decision denying Ahamefule access to the courtroom, Justice Olufawa summoned two jour-

nalists to appear before her at the end of March 2001 to show cause why they should not be committed to prison for contempt for publishing her ruling. As a result, one journalist published a retraction. However, the other challenged the court's jurisdiction to summon him. Justice Olufawa also threatened charges, on undisclosed offences, against SERAC's executive director, Ahamefule's solicitor.

Unexpectedly, before the journalist's challenge could be heard, the court struck out the contempt charges. But the court also struck out Ahamefule's entire lawsuit, citing "undue publicity" as the reason, notwithstanding that a valid notice of appeal had been filed challenging the court's previous orders. Justice Olufawa also attempted to block Ahamefule's access to official court records and certified copies of court orders, releasing the file only after SERAC petitioned the Chief Judge of Lagos State, giving notice of its intent to seek an order compelling release.

This case first came to SERAC's attention in the course of its nationwide research to determine the nature and extent of human rights infringements experienced by people living with HIV/AIDS, as well as the attitudes of the general public. Mrs Ahamefule's decision to seek judicial remedy against her former employer is testimony to her great courage and selflessness in an environment ripe with misconceptions about and prejudice toward persons living with HIV/AIDS.

This case has garnered global attention because of its far-reaching public interest dimensions. The fact that a high court judge can be so profoundly ignorant of the nature of HIV/AIDS as to employ the coercive power of the state to demonstrate the “correctness” of her flawed premise points to the enormity of the tasks

that must be accomplished if Nigeria is to overcome the threat posed by the HIV/AIDS pandemic and to secure basic human rights for people living with HIV/AIDS.

– Felix Morka

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Ahamefule. He can be reached at Seracnig@aol.com, or c/o SERAC, 16 Awori Crescent (off Coker Rd/Obokun St), Ilupeju-Lagos, Nigeria.

¹ *Ahamefule v Imperial Medical Centre & Molokwu* (Suit ID #1627/2000), Notice of Appeal, Court of Appeal (Lagos), 16 February 2001 (on file); Communication from F Morka, Solicitor, Social and Economic Rights Action Center (SERAC), 21 February 2001 and 30 July 2001.

US: Court Refuses to Order Disclosure of HIV Status to Police

In February 2001, Massachusetts’ highest court ruled that a man whose blood was splattered on police officers during his arrest is protected under that state’s law from having to reveal his HIV status.

While responding to a call about a domestic disturbance, police officers shot Luis Ortiz, and in the ensuing struggle eight officers came into contact with his blood. Initially, a district court judge ruled that Ortiz must disclose his HIV status to police, but he filed an emergency appeal to postpone the order. Gay & Lesbian Advocates & Defenders (GLAD), a public interest legal organization, filed an *amicus*

curiae brief, and the AIDS Action Committee of Massachusetts argued against the court order that mandated disclosure of HIV status.

On 15 February 2001, Justice Martha Sosman of the Supreme Judicial Court, sitting as a single justice, overturned the district court’s order. She noted in her decision that “state law prohibits the disclosure of anyone’s HIV status unless the person

allows it,” that the state legislature repeatedly voted against proposals to allow police or other public safety officials to supersede the law, and that absolute confidentiality of HIV status is the best way to protect public health. Justice Sosman pointed out that in cases where an individual is concerned about possible exposure to HIV, there is little or no medical utility in knowing the source person’s HIV status; rather, the exposed person should follow established medical protocols for HIV testing and counseling.¹

¹ *Massachusetts v Luis Ortiz*, 15 February 2001, Supreme Judicial Court of Massachusetts (per Sosman JJ); Gay & Lesbian Advocates & Defenders (GLAD). Press release: Supreme Judicial Court Affirms HIV Privacy Rights. 15 February 2001 (accessed at www.glad.org on 27 July 2001).

China – Chengdu Passes Legislation Discriminating against People with HIV/AIDS

In February 2001, the city of Chengdu, capital of Sichuan province, enacted legislation banning HIV-positive people from marrying or working as surgeons or kindergarten teachers. The law requires that police impose mandatory testing on sex workers, drug users, and people belonging to

other so-called “high risk” groups within five days of the person being arrested. It also mandates segregation of HIV-positive inmates in jails, and HIV testing for any resident who has been out of the country for over a year. UNAIDS, the joint AIDS program of seven UN-affiliated organiza-

tions, criticized the legislation as counterproductive and infringing on human rights. The Chengdu Workers Daily also criticized the law.¹

¹ Wockner R. Chinese city bans marriage for HIV-positives. *International News* #354, 5 February 2001.

HIV/AIDS AND THE LAW

We continue our special section on HIV/AIDS and the law, which has thus far included articles presenting developments from five countries: Australia, Switzerland, England and Wales, India, and the United States.¹

HIV/AIDS and Legal Developments in Germany

Case law has helped to define the legal environment for people infected and affected by HIV/AIDS in Germany. This article describes court decisions in three areas that may be of interest to Canadian readers: criminal law, confidentiality, and the use of illegal drugs to control pain. It also describes the situation of refugees with HIV/AIDS.

Criminal Law

In the area of criminal law, several rulings by high-level courts have dealt with the issue of HIV-positive people having unprotected sex without disclosing their HIV status, and with the use of the defence of valid consent.

Unprotected sex with failure to disclose HIV-positive status

In 1988, in a case that has some similarities to the *Cuerrier* case in Canada,² the Federal Supreme Court (*Bundesgerichtshof*) upheld the conviction of an HIV-positive American soldier of attempted aggravated assault for engaging in sexual acts without taking adequate precautions and without informing his partners of his HIV status.³

The defendant tested positive for HIV in 1986 and was twice counseled by his physician on the precautions he needed to take in future, including the use of condoms when engaging in vaginal, anal, or oral intercourse even where these acts did not lead to orgasm. Nevertheless, the defendant subsequently engaged in several

instances of unprotected anal intercourse and oral sex with other men without informing his partners about his HIV-positive status. The testimony revealed that the defendant always put on a condom right before reaching orgasm, but not prior to that. It was not possible to confirm whether HIV transmission occurred during any of the sexual acts in question. Some of the partners were tested and were found to be HIV-negative, but other partners were not available for testing. Under German law, to be convicted of attempted aggravated sexual assault, it is not necessary to show that the lives of the sexual partners were actually endangered.⁴

The Court found that the defendant had intentionally put his partners at risk in order to satisfy his sexual urges.⁵ It said that the defendant had acted with limited intent (*bedingter Vorsatz*), meaning that although he may not actually have wanted to injure his partners, he had willfully ignored the facts that were known to him.⁶

The Court said that it might have treated the defendant more harshly were it not for the fact that he tried to minimize the risk to the other men involved by interrupting the sexual act and putting on a condom before reaching ejaculation. In addition, it pointed out that the majority of the acts in question involved oral sex, which, if performed without ejaculation, is objectively less dangerous than unprotected anal intercourse not resulting in ejaculation.⁷

In commenting on the question of valid consent on the part of the defendant's sexual partners, the Court referred to the legal concepts of "acting at one's own risk" and "intentionally entering a risk."⁸ However, the Court concluded that these legal concepts are not applicable in this case, because of the defendant's "superior knowledge."⁹ The Court said that no one can consent to entering a risk without knowing all the facts that constitute the risk in question, particularly (in this case) the fact that the defendant had tested HIV-positive. The Court also said that the fact that the sexual partners belonged to a so-called "high-risk group" (men who have sex with men) did not reduce the defendant's burden of minimizing the risk of infecting other people.¹⁰

In another case in 1989, the Federal Supreme Court upheld the conviction of a man on charges of aggravated assault but threw out a

charge of attempted aggravated assault involving the same victim.¹¹ The evidence showed that the defendant (D) had tested HIV-positive in 1985. In 1987, he met C, with whom he became sexually intimate. Before engaging in sex, C told D he was “clean,” meaning that sex with him would not endanger D’s health. Since D did not reply, C assumed D was also “clean.” They engaged in unprotected anal intercourse on two occasions, with C acting as the passive partner. The Court found that on one of these occasions, D transmitted HIV to C. It was impossible to establish the exact date of infection. The Court said that D committed attempted aggravated assault (the lesser crime) during one of the acts and aggravated assault (the more serious crime) during the other. However, the Court said, the lesser crime was subsumed by the more serious crime, and thus the defendant should not receive an additional sentence.¹²

Defence of valid consent

In 1989, the Bavarian Superior Appellate Court (*Bayerisches Oberstes Landesgericht*) upheld a lower-court acquittal of a man charged with attempted aggravated assault on the ground that the defendant’s sexual partner had consented to the acts in question.¹³

The evidence showed that the defendant (D) had tested HIV-positive. Later, D met a 16-year-old woman (H). H had learned about D’s infection from a third party. On several occasions, D talked to H about the illness, the possible lethal outcome of HIV infection, and the risks attached to unprotected sex. Nevertheless, H insisted on having unprotected vaginal sex with D. D initially declined but later agreed.

Unprotected sexual intercourse took place on several occasions. H tested HIV-negative after the relationship had ended.

The Court ruled that H had engaged in the acts at her own risk¹⁴ and that the acts of the defendant were not illegal because H had provided valid consent.¹⁵ The Court said that the necessary conditions for valid consent are that: (a) the defendant is not the only one who has control over the actions taking place; (b) the sexual partner is comprehensively informed about the risks attached; and (c) the sexual partner is mature enough to sufficiently evaluate the risks involved.¹⁶ The Court said that all three conditions were met in this case.¹⁷

Confidentiality

A more recent court decision may perhaps clarify what physicians should do when faced with a conflict between the need to protect the confidentiality of patients and the duty to warn partners of HIV-positive patients.

The legal situation for physicians in Germany is rather awkward. The Code on Sexually Transmitted Diseases (STDs) requires that physicians report anonymously to health authorities any sexually transmitted diseases that they diagnose in their patients.¹⁸ However, because they have taken a professional oath to protect the confidentiality of their patients, physicians are prohibited by the German Criminal Code (GCC) from notifying the partner of a patient of any such STDs. Thus, physicians could not be prosecuted if they chose to obey their professional oath in a situation where their patient insisted on not telling anyone about the infection.¹⁹

The Court ruled that in some cases physicians have to inform the partner of a person with HIV/AIDS of the person’s HIV status if the person is obviously insensitive to the needs of their partner and expressly prohibits the physician from informing the partner.

In 1999, however, in a case before the Appellate Court of Frankfurt,²⁰ the Court ruled that in some cases physicians have to break their professional oath and inform the domestic partner of a person with HIV/AIDS if this person *is obviously insensitive to the needs of their partner and expressly prohibits the physician from informing the partner*.²¹ The Court also said that if both partners are patients of the same physician, there is a clear obligation to inform the partner; to do otherwise, the Court said, would constitute acute endangerment of human life.²²

The facts of the case are as follows. A young woman had sued her late boyfriend’s physician (who was also her physician) for damages because the physician had not informed her about her boyfriend’s HIV infection. Right until the end, she had believed that her partner was only suffering from cancer. As a result, she had had unprotected sexual intercourse with him, which resulted in her own infection with HIV. The complainant argued that she would not have continued a sexual relationship with her partner had she known he was HIV-positive.

In its ruling, the Court cited Paragraph 34 of the GCC (*Rechtfertigender Notstand*, ie, justification through necessity), which deals with situations in which one has to decide between two legally valid obligations.²³ Any conflict between protected interests has to be resolved by weighing one protected interest against the other. In this case, the Court ruled that the health and life of the young woman outweighed the protection of personal information.²⁴

The Court said that in other cases the facts could lead to different conclusions. The physician might not have a duty to warn the partner if (a) the partner is not also a patient of that physician and (b) the physician has good reason to think that the patient will inform their sexual partners about the infection.²⁵

In this particular case, the young woman was not granted the damages that she sought since it was impossible to prove whether she became HIV-positive before or after the physician learned about her boyfriend's HIV status.

The Federal Supreme Court refused to hear the woman's appeal.

Use of Illegal Drugs to Control Pain

Another case involved an HIV-positive man who used marijuana and hashish for medical reasons. Possession of these drugs is illegal in Germany. The man (D) had smuggled the drugs from the Netherlands for his own use. The amounts in question were 142 grams of marijuana and 19 grams of hashish, which together contained 7.7 grams of tetrahydrocannabinol (THC). D, who has been HIV-positive since 1984 and ill with AIDS since 1990, used

the drugs to numb pain caused by AIDS-related complications. THC had positive results for him.

A lower court found D guilty of possession and sentenced him to six months probation. In 1999, D's lawyers appealed the case to the Appellate Court of Cologne (*Oberlandesgericht Koeln*),²⁶ on the grounds that the lower court had failed to take into account the fact that the act was justified under Paragraph 34 of the GCC (justification through necessity). Paragraph 34 states that an act is not deemed illegal if it is committed in order to fight a present danger (such as a danger to one's health). The danger must not be preventable in any other way and the two interests in question must be weighed against each other. The interest protected by the act must considerably outweigh the interest that has been interfered with.²⁷

In the case in question, this meant that D's physical pain could not be preventable in any other way, and that D's well-being must considerably outweigh the nation's interest in maintaining a drug-free environment in order to protect public health.²⁸ There are some doubts about the first condition, since artificial THC is available in Germany and was previously prescribed to D by his physician.

Because it lacked some factual information, the Appellate Court sent the case back to the lower court for reconsideration²⁹ and instructed that court to hear the arguments brought forward by the defence.³⁰ The Appellate Court also said that even if the lower court rejected the use of Paragraph 34 in this case, it should consider as a possible defence the fact that D's actions may constitute a "legally valid error."³¹

The Treatment of Refugees with HIV/AIDS³²

Citizens of countries that are members of the European Union (EU) are entitled to live and work freely in Germany for as long as they want. With respect to immigrants and refugees from countries outside the EU, Germany used to have a rather liberal policy compared to other Western countries. In 1993, however, largely because of problems with the reunification of East and West Germany, the then Christian Democrat government, with some support from Liberals and Social Democrats, adopted a more restrictive policy and enshrined it in the Constitution.

Currently, the right to political asylum is limited by a number of exceptions, the most important of which is the so-called "third state rule." This rule states that if a person seeking political refuge travels to Germany via a country that Germany considers to be "safe" in terms of how it treats political refugees, the person is sent back to that country. These safe countries are listed in legislation approved by the German Parliament. This leads to situations like the following: if an Iraqi Kurd seeks refuge in Germany, and has to fly via a Turkish airport to Germany, authorities will send him or her back to Turkey because that country is considered to be safe.

Each case is decided on an individual basis, and refugees have the right to appeal against decisions made by the authorities. However, very few of these appeals ever succeed. Despite these restrictions, Germany still allows more people to remain than many other European countries.

A significant proportion of people with AIDS in Germany come from other countries (22 per cent, up from 13 per cent in 1994, according to the Robert Koch Institute). They face a difficult and uncertain situation.

In Germany, the *Länder* (the equivalent of Canadian provinces or US states) are responsible for providing accommodation to people seeking asylum. Most *Länder* do not impose mandatory HIV testing on refugees. In 1988, the Conference of the Ministers and Senators of Health of all *Länder* concluded that mandatory testing would not improve the epidemiological or hygienic situation of refugee accommodation in any way.³³

Asylum seekers with HIV/AIDS have only limited access to social or medical benefits.

Nevertheless, Bavaria, Germany's largest and wealthiest *Land*, with a population of approximately nine million and a long-standing ultra-conservative government, does test potential refugees for HIV. Furthermore, the testing is done without proper informed consent and with little support or counseling for persons testing positive. In the absence of adequate psychological support from the state, much of the follow-up work is done by the local HIV/AIDS organizations and volunteers. They have identified a number of problems experienced by refugees living with HIV/AIDS, including fear of being deported from the country; shame and discrimination within the community; lack of knowledge about the medications

they are taking; and (unjustified) fears of infecting their own children.³⁴

Due to their inferior residence status, asylum seekers with HIV/AIDS have only limited access to social or medical benefits. Only very basic medical treatment is provided and does not meet the many complicated physical and psychological needs of people with HIV/AIDS. Asylum seekers are not allowed to move freely within the whole of the German territory and their right to work is extremely restricted. It is not uncommon to see a person trained as a physician or a professor work as a maid or a cleaning person.³⁵

Being HIV-positive does not automatically entitle a potential refugee to remain in Germany. German law and European human rights instruments protect people from being deported if they face the death penalty, torture, or inhumane treatment in their country of origin.^{36,37} Also, recent court decisions have affirmed that potential refugees with serious illnesses cannot be deported if their illnesses cannot be adequately treated in their country of origin.³⁸ However, each case is decided on an individual basis, so deportation of HIV-positive refugees is still possible. An important factor is where the infection was acquired: the German state takes more responsibility if an infection occurs on its territory.³⁹

Even if a potential refugee is granted asylum status, such status can still be taken away under certain circumstances until the asylee becomes a German citizen. The constant uncertainty that refugees face is one of the greatest hardships they have to endure.

– Olav Kratz

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¹ See *Canadian HIV/AIDS Policy & Law Newsletter* 2000; 5(2/3): 1, 70-86; and 2000; 5(4): 38-41.

² *R v Cuerrier*, [1998] 2 SCR 371.

³ BGHSt (ie, Entscheidungen des Bundesgerichtshofs in Strafsachen, decisions of the Criminal Law Section of the Federal Supreme Court), vol 36 at 1 et seq.

⁴ *Ibid* at 9.

⁵ *Ibid* at 2, 3.

⁶ *Ibid* at 11.

⁷ *Ibid* at 19.

⁸ *Ibid* at 16.

⁹ *Ibid* at 17.

¹⁰ *Ibid* at 18.

¹¹ *Ibid* at 262 et seq.

¹² *Ibid* at 268, 269.

¹³ BayObLG (ie, Bayerisches Oberstes Landesgericht, Bavarian Superior Appellate Court), in: NJW 1990, at 131 et seq.

¹⁴ *Ibid* at 132.

¹⁵ *Ibid*.

¹⁶ BGHSt in: NJW 1989, at 785.

¹⁷ BayObLG in: NJW 1990, at 132.

¹⁸ Troendle in: Troendle/Fischer. *Kommentar zum Strafgesetzbuch und Nebengesetzen*. 49th edition, Munich, 1999.

¹⁹ Laufs, Prof. Dr. iur. Dr. h. c. Adolf and Reiling, Assessor Emil in *Rechtsfragen zu HIV – Infektion und AIDS – Erkrankung*. Frankfurt, 1995, at 12.

²⁰ OLG Frankfurt (Appellate Court at Frankfurt), court order of 8 July 1999, file code 8 U 67/99.

²¹ *Ibid* at 6.

²² *Ibid* at 7.

²³ *Ibid*.

²⁴ *Ibid*.

²⁵ *Ibid* at 8.

²⁶ OLG Koeln, court order of 26 February 1999, file code Ss 51/99 – 23, in: StaFo 1999, at 314 et seq.

²⁷ See Troendle's *Commentary to the Criminal Code*, 48th edition, para 34, s 5; and BGHSt vol 39 at 137.

²⁸ OLG Koeln in StrFo 1999, at 315.

²⁹ *Ibid*.

³⁰ *Ibid*.

³¹ *Ibid*.

³² For additional reading, see Narimani P. PatientInnen und KlientInnen zweiter Klasse darf es nicht geben. *Quilt*

1999; 5: 4; Hölzcl M. Die Gründe für Flucht und Migration liegen in den Industrieländern. Interview with Gisela Seidler, attorney. *Quilt* 1999; 5: 5-6; Gütschow B. Who is who. *Quilt* 1999; 5: 6.

³³ Entschliessung der 59. Konferenz der fuer das Gesundheitswesen zustaendigen Minister und Senatoren der Laender am 17./18. November in Berlin.

³⁴ See Narimani, *supra*, note 32.

³⁵ See Seidler, *supra*, note 32.

³⁶ BverwG 9. Senat decision of 27 April 1997, file code 9 C 13/97.

³⁷ Auslaendergesetz, para 43, s 4, in connection with Art 3, European Human Rights Convention.

³⁸ BverwG, decision of 15 April 1997; BverwG 9, Senat decision of 27 April 1998, file code 9 C 13/97.

³⁹ See para 53, s 206.2 in: *Gemeinschaftskommentar zum Auslaenderrecht*, Luchterhand, vol 3.

DRUG POLICY

Natural Helpers: A Community Approach to Harm Reduction

This paper, by Jennifer Taylor and Theresa Jaspersen, looks at a successful harm-reduction initiative developed by Streetworks, a needle exchange program in Edmonton, Alberta. The Natural Helpers initiative provides and enhances the skills, knowledge, resources, and support that people who use injection drugs need in order to take care of others in their community. The evolution of the project, from its inception to the present situation, is described.

Introduction

Injection drug use is an ongoing and growing concern in Canada. Rates of HIV and hepatitis C among injection drug users are very high, and overdose deaths and several opportunistic infections have historically adversely affected people who use injection drugs.

Working with people who use injection drugs has never been easy. They are often viewed as difficult and non-compliant. Natural Helpers, a community-development initiative based on the principle of harm reduction, creates avenues to allow the injection-drug-user community to work with service providers. Not only do service providers gain information, but injection drug users have the opportunity to express their needs and contribute to the creation of a safer and healthier community.

History

Boyle Street Community Services Co-operative is an agency that attempts to fill many of the gaps that exist for people living in poverty in Edmonton's inner city. Services include but are not limited to adult outreach, adult literacy, a school, and a drop-in centre.

Thirty years' experience have helped staff to recognize that there are people in the community who have a natural inclination to help their friends and family. Some are leaders in the community, although many have received little or no recognition for the work they do. To acknowledge the important role these people play in the community, the term Natural Helpers was coined.

Edmonton's needle exchange, Streetworks (which has one of its sites at the Boyle Street Co-op), has been

in operation for over 10 years. Its services are based on a harm-reduction model, with the focus on relationship-based programming. Streetworks defines harm reduction as providing the skills, knowledge, resources, and support people need in order to live safer and healthier lives. Streetworks focuses on community development and on building strengths of the people it serves. The concept of Natural Helpers was thus a perfect fit.

The staff began to identify people in the injection-drug-user community who felt a need to help their friends and family. The goal of the project was to work with Natural Helpers to enhance the skills, knowledge, resources, and support they need to be able to do their "job" better. Funding for the project was obtained through Health Canada.

A nurse was hired to bring together a group of Natural Helpers so that they could explore what would be most helpful to them in their role. After the initial challenges of bringing a group of injection drug users together and trying to gain an understanding of their ideas, the group decided to collect the knowledge and experiences

that members shared in order to develop a booklet on safer injecting. In six months a *Vein Care Handbook* was published.

The novelty of having a group of injection drug users together, who were stable enough and willing enough to talk, quickly gained attention. There were many requests from various people to meet with the group in order to gain some firsthand knowledge from those who had “been there,” not just from those who work with them. The Natural Helpers themselves decided whether they would meet with a particular person or group. Streetworks staff encouraged those who wanted to meet with the Natural Helpers to consider paying them a consultation fee.

The success of the initial project opened the doors to additional funding, granted by the Edmonton Community Lottery Board. The Natural Helpers continued to meet and new members were added as needed. A new booklet, *Street First Aid: ‘Cause You Just Never Know*, was developed, and goes beyond issues directly related to injection drug use, dealing with how people can best provide first aid on the streets. Most recently, the Natural Helpers completed work on a “germ book,” which focuses on prevention of infectious diseases.

Forming the Group

Streetworks hired a nurse and appointed another staff member to be facilitators of the Natural Helpers project. The facilitators closely observed members of the injection-drug-user community who used the needle exchange, and identified those who took care of others in the community. They asked questions like:

How many people do you exchange for? Why do you exchange for others? How do you take care of others? and What would you need to help you do what you are doing better? One member of the injection-drug-user community who had previously developed a strong relationship with Streetworks was included in the group. Once people were identified, a meeting place and time were set, and those identified were asked to attend. Group size was limited to 10 members initially, although it later grew to 14. In terms of gender, race, type of drug use, and age, the group was representative of the drug-user community that accesses Streetworks. Natural Helpers were paid \$10 an hour for three reasons: the facilitators of the project were being paid; the Natural Helpers were considered legitimate consultants; and it was recognized that poverty is a social issue that affects the Natural Helpers’ lives.

Group Structure

Meetings were held one or two times a month. An environment in which community members felt safe and comfortable served as the meeting place. The meetings were two hours long, with two fifteen-minute breaks. Most Natural Helpers had limited experience with formal group meetings, so an effort was made to provide a relaxed and informal environment. The facilitators recorded the minutes of the meetings, during which the members were encouraged to brainstorm and talk about issues they face. In order to prevent hunger from distracting the group’s focus, food was provided. Eventually, the group meetings developed their own dynamic.

Group Process

Safer injection, first-aid skills, infectious diseases, and grieving on the street were just a few themes that came out of the brainstorm session. The funding obtained after the completion of the *Vein Care Handbook* allowed for an extended time frame that enabled those involved to work on future projects. The group members and facilitators decided to create a street-level first-aid manual, describing situations in which first aid is needed. For example, “Buddy” passed out in an empty lot in the hot sun after drinking all day. “Buddy” was at risk for sunstroke. In a step-by-step process, the Natural Helpers chose characters and scenarios that reflected street life. The facilitators contributed the first-aid skill and knowledge, and the group members contributed street-life knowledge. The group was involved in every step of the project’s development. Each paragraph was read and critiqued by the Natural Helpers. Care was taken to use language realistic to the targeted population. Professionals with substantial knowledge in first aid reviewed draft copies of the book. Final approval came from the Natural Helpers.

Benefits of the Project

Building on strength

The facilitators recognized the strength and skill that injection drug users with 20-year addictions have to live with, and still remain relatively healthy and able to take care of others in their community. The Natural Helpers project provided and enhanced these skills. The group members were respected for their expertise and their confidence grew. Evidence of this confidence was

expressed through their sharing of ideas around the first-aid book.

Mutual sharing of information

Working closely with the Natural Helpers, the facilitators obtained invaluable insight into the lives of people who use injection drugs. The group members disclosed information openly as the trust level within the group increased over time. At the same time, the Natural Helpers were learning first-aid skills they brought into the community.

Advocacy

The Natural Helpers advocated for their community both directly and indirectly. They spoke on behalf of people who use injection drugs to professional groups such as hospital consultants and medical students who want to access this population. The group members hosted a poster presentation at a provincial harm-reduction conference and fielded questions. One Natural Helper approached eight pharmacies and asked if they would display the first-aid book. The facilitators were mem-

The facilitators recognized the strength and skill that injection drug users with 20-year addictions have to live with, and still remain relatively healthy and able to take care of others in their community.

bers of various committees as part of their work with Streetworks. Having gained insight into the lives of injection drug users, they were able to advocate for them.

Community involvement in harm reduction

Natural Helpers honed their skills and adopted new harm-reduction strategies. One member purchased a first-aid kit to help out injection drug users in need of first aid as he rode around downtown on his bike. This member also collected used needles from areas in the inner city.

Reaching a hidden population

Although widely accepted among Edmonton's injection-drug-user population, Streetworks is aware that not all users in the city access its program, but it is able to reach this population in various ways. For example, one Natural Helper started an informal needle exchange in the rooming house where he lived. He collected used needles and exchanged them for clean ones with Streetworks. People who did not access Streetworks could still obtain clean needles and other supplies.

Potential to improve the health of the entire community

By better understanding injection drug users, the facilitators were able to adapt their practice to meet the needs of this population more effectively. The facilitators also made presentations concerning the project to a number of agencies, organizations, and learning institutions, in the hope that such service providers would become sensitive to the needs of people who use injection drugs.

Staff Role

Initially, the facilitators took a lead role. They provided a safe environment and encouraged dialogue about injection drug use and the issues that surround it. The minutes were reviewed regularly to monitor

progress. When the facilitators recognized that the group was taking ownership of the project, efforts were made to back off. As the group progressed, it realized that some rules were necessary. For example, the group did not expect members to attend either sober or straight. Some members attended the meetings but were nodding out and therefore not participating. The Natural Helpers decided to add the stipulation that members need to be productive if they attend meetings.

Evaluation

The facilitators constantly evaluated the process. They asked questions such as: Are we maintaining the focus? Are we on schedule? Is the group progressing? Do we need more group members? Are group members taking ownership? and Do group members feel listened to? The facilitators evaluated the outcomes of the process by answering such questions as: Did the group complete the project? What unexpected outcomes occurred? Did the group accomplish what you expected it to? Did the group accomplish what the group expected it to? What could have been done differently?

Unexpected Outcomes

Some community members involved with Streetworks' Natural Helpers made positive changes in their lives. Four members dealt with their addictions and took steps to quit. Three members took steps to attend education programs. One member started a new job as a parking attendant. Being involved in the Natural Helpers project provided the support and stability that another member needed to make changes in her life that benefited her family. She

stopped using drugs and worked hard to get back her children, who were removed from her home by child welfare authorities. She was granted weekend visits with them, and has been clean for almost two years. Over time, the group members bonded and acted as support for each other outside the meetings. Group members started meetings by asking everyone around the table how things were going. As people discovered their skills and expertise, they became more able to take control over their lives and health, and they underwent positive personal changes.

Future Possibilities

The focus of Natural Helpers was mainly on resource development.

This was due to many factors, especially the group's need to have something tangible to focus on, and project-funding requirements. As the group grew closer, it considered future possibilities, such as mutual support, consultation with the community at large, and creating a political voice for a seldom-heard segment of the population. Any of these could be expanded on with potentially powerful results. Streetworks realized the value in the Natural Helpers project and has now included this work in its core programming.

The benefits the group members and the organization experienced could easily be transferred to other marginalized groups in society. The needs and knowledge of previously

recognized cultural groups are unique and should be explored. Some potential groups might include: injection-drug-using youth, sex-trade workers, street-involved transsexuals, and women whose partners are injection drug users. The potential for positive health impacts on individuals and communities is enormous.

– Jennifer Taylor, Theresa Jaspersen

For more information about the Natural Helpers project or copies of the materials produced, contact Jennifer Taylor RN, BScN, Nurse Educator, or Theresa Jaspersen RN, BScN, Nurse Educator, at Streetworks, 10116 – 105 Avenue, Edmonton, AB T5H 0K2. Tel: 780 424-4106 ext 210; fax: 780 425-2205; email: jtaylor@boylestco-op.org or tjaspersen@boylestco-op.org.

Health Canada Commits to Strengthening Efforts with Respect to Injection Drug Use and HIV/AIDS

On 31 August 2001, over 20 months after the release of the Canadian HIV/AIDS Legal Network's report on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*,¹ Health Canada responded to the report by making a commitment to both "strengthening and expanding efforts with respect to injection drug use."²

Health Canada's Response

In its response to the Legal Network's report, Health Canada acknowledges that "injection drug use is first and foremost a health issue" and that "fundamental changes are needed to existing legal and policy frameworks in order to effectively address IDU [injection drug use] as a health issue."

Health Canada also makes several important commitments, including:

- "working with other partners to ensure a compassionate, comprehensive and effective response to IDU" (at i);
- "initiating a dialogue with other federal departments about the impact of current drug laws on people who use injection drugs" (at 5);

- working with key partners to enhance the implementation, accessibility and effectiveness of needle exchange programs and to reduce the barriers to such programs in Canada (at 6); and
- "both strengthening and expanding efforts with respect to IDU" (at 12).

In addition, Health Canada's response explicitly recognizes that

- the problems associated with injection drug use have reached critical proportions and require urgent attention (at 1 and 12);
- injection drug use is an issue for all Canadians (at 1);

- Canada will not be able to turn the situation around without doing more (at 2);
- people who inject drugs must be treated as respected members of society who need and deserve support and assistance, not as criminals who should be isolated from others (at 2);
- innovative harm reduction measures must be developed, piloted, evaluated and, where found to be effective, implemented in Canada, as they have been in other countries (at 2);
- the involvement of drug users and drug user networks in reducing the harm associated with injection drug use is crucial (at 8, 9, 12);
- provision of services should not be contingent upon an individual's entry into drug treatment (at 8);
- it is important to support a strengthened and integrated research agenda related to IDU, illegal drugs, and HIV/AIDS (at 10);
- there is a need for expanded, more effective harm reduction and addictions treatment services in all settings across Canada (at 11); and
- increased collaboration is needed with the Correctional Service of Canada to improve interventions aimed at reducing the harm associated with IDU in prisons (at 11).

The Legal Network Reaction

The Network prepared an in-depth review of Health Canada's response to the Network's report, entitled *Injection Drug Use and HIV/AIDS: The Canadian HIV/AIDS Legal Network Reacts to Health Canada's Response to the Network's 1999 Report on Injection Drug Use and HIV/AIDS*.³ The review, released on

the same day as Health Canada's response to the Network's report, applauds Health Canada for making the above-noted commitments and for acknowledging that injection drug use is first and foremost a health issue. However, it is critical of several other aspects of Health Canada's response.

The Failure to Address the Impact of Drug Laws and Policies

In particular, the Network notes that Health Canada's response acknowledges that changes are needed to existing legal and policy frameworks – both national and international – in order to effectively address injection drug use as a health issue, but then totally skirts the issue (as did the Federal/Provincial/Territorial Committee on Injection Drug Use paper entitled *Reducing the Harm Associated with Injection Drug Use in Canada*).⁴

Both Health Canada's response and the F/P/T Committee paper explicitly recognize the importance of undertaking a close examination of Canada's drug laws, regulations and policies related to injection drug use and to drug use in general. They point out that a large number of reports have identified some aspects of Canada's drug laws as contributing to the harms associated with injection drug use and have established the need for changes to drug policy in Canada. But both papers fail to deal with this fundamental issue in a meaningful way and tiptoe around it.

According to the Network, it may be justifiable to focus on immediate initiatives that can be undertaken within the existing legal framework, but it is not justifiable to not at all

deal with the issue of the impact of existing laws and policies on prevention and on our ability to provide adequate care, treatment, and support to drug users. The Network points out that during the preparation of the Consultation Report on *Care, Treatment, and Support for Injection Drug Users Living with HIV/AIDS*,⁵ people providing services to injection drug users emphasized that they "know what to do, but ... are not able to do it for a variety of reasons," chief among them the barriers created by the legal status of drugs and drug use. As a result, it has been persuasively argued that "it is unethical not to consider alternatives to drug laws and policies."⁶

No Response to Some Recommendations

The Network also criticized Health Canada for failing to respond to a number of the concrete recommendations in the Network's report that were directed at Health Canada, choosing to make general statements on larger issues rather than to make commitments or even take action on specific recommendations. In addition, it noted that some of the commitments made are quite vague and do not get to the level of detail that would make them meaningful, and that would enable accountability. According to the Network, this is disappointing, particularly because Health Canada took over 18 months to prepare the response to the Network's report.

The Network recognizes that Health Canada's response to the Network's report must be read together with the recommendations in the paper by the F/P/T Committee on Injection Drug Use. As stated in Health Canada's response, both

“documents reflect this Government’s view that Canada’s response to injection drug use requires both improved interventions and the promotion of a supportive, non-discriminatory environment in which these interventions are offered.”⁷ However, while the F/P/T Committee’s paper does contain more specific actions than Health Canada’s response, the Network noted that many of its recommended actions also leave too much room for interpretation or do not go far enough.⁸

Urgent Action, Not Words, Is Needed

Health Canada’s response does acknowledge that “urgent attention” (at 12) is required to the many issues related to injection drug use and HIV/AIDS and hepatitis, that Canada’s response to this urgent health issue requires both “improved interventions with individuals who use injection drugs and fundamental changes to the environment in which such interventions are offered” (at i), and that “more needs to be done” (at 2). However, the Network notes that the commitments made do not respond to the need for urgent action expressed in 1999 in the Network’s report (and in many other reports). In particular, it points out that the public health tragedy of HIV/AIDS and hepatitis C among people who use injection drugs has been underway for many years, and at least some of it could have been prevented had governments moved from meetings and further consultations to actually doing something about the problems at hand. According to the Network, in some ways the situation resembles that of the blood tragedy in the 1980s, when decision-makers did

exactly what is still being done to a large extent today with regard to injection drug use: meet, consult, and act too late. As Jan Skirrow, former

“In addressing this issue, we must look beyond the negative labels we attach to people who inject drugs. We must acknowledge that being in the grip of an addiction does not make a person any less entitled to a decent response. It means remembering that every one of those statistics is a human being, is someone’s son or daughter – sister or brother.”

- Allan Rock, Minister of Health, 2001

Deputy Minister of Community and Occupational Health of Alberta, has said:

A marginalized community (in this case injection drug users) is experiencing an epidemic of death and disease resulting not from anything inherent in the drugs that they use, but more from the ineffective and dysfunctional methods that characterize our attempts to control illicit drugs and drug users. There is the same unwillingness to carefully analyze the problem or to depart from traditional methods and conventional thought that was integral to the blood tragedy. There is a struggle for power and control over the issue between law enforcement and public health. There is a profound lack of understanding among decision-makers and many health professionals regarding

the nature of the community and individuals at risk.

... Our committees meet, the media reports the political rhetoric and the disagreements of experts, and effective program responses remain in limbo as we try to sort out what are in essence power and control issues. Yet people continue to die in alarming numbers, and no one seems to notice or care very much.⁹

The Network concludes by saying that the commitments in the paper are welcome, but long-overdue action must not be further delayed.

A Step in the Right Direction, But ...

Despite its many shortcomings, Health Canada’s response to the Network’s report on HIV/AIDS and injection drug use, together with the F/P/T Committee on Injection Drug Use paper, is an important and significant step in the right direction. The federal and provincial/territorial governments have made important acknowledgments and commitments. It remains to be hoped that action will follow the words. As the Network has said before, thus far the inaction has been

striking, particularly if one considers that those responsible for it – and particularly the federal, provincial, and territorial governments, and public health authorities across Canada – should know better and should have learned their lessons from the Commission of Inquiry on the Blood System in Canada (the Krever Inquiry). But the lessons from that Inquiry – many directly applicable to the HIV/AIDS epidemic among injection drug users ... seem to be forgotten, or

are applied whenever convenient, and otherwise neglected. Thousands of injection drug users have been infected with HIV and hepatitis C virus in the last years, many as a direct result of inaction. Their infections were preventable. And many more will become infected in the years to come unless immediate action is taken.¹⁰

On 26 September 2001, federal, provincial and territorial health ministers publicly released the F/P/T Committee on Injection Drug Use paper at their meeting in St John's.¹¹ They "provided support for the continuing work to establish conditions under which a multi-site, scientific, medical research project on supervised injection sites in Canada could be undertaken, including the development of a legal and regulatory framework, further focused consultations with stakeholders, and identifi-

cation of the potential scope of this project; and provided support for the continued collaborative work of federal/provincial/territorial officials in developing a framework for reporting regularly and monitoring progress to address the critical issue of injection drug use."¹²

More nice words, but once again no concrete commitments?

— Ralf Jürgens

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¹ Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. Montréal: The Network, 1999. The report is accompanied by a series of 11 info sheets and by a volume of background papers. All documents are available online at www.aidslaw.ca/Maincontent/issues/druglaws.htm and at the Canadian HIV/AIDS Clearinghouse (email: aids/sida@cpha.ca).

² Health Canada. *Injection Drug Use and HIV/AIDS: Health Canada's Response to the Report of the Canadian HIV/AIDS Legal Network*. Ottawa: Health Canada, 2001. Available online at www.aidslaw.ca/Maincontent/issues/druglaws.htm. All subsequent quotes are taken from this text, unless otherwise indicated.

³ Canadian HIV/AIDS Legal Network, Montréal: 2001. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm.

⁴ Reducing the Harm Associated with Injection Drug Use in Canada. Working Document for Consultation. March 2001. Available at www.aidslaw.ca/Maincontent/issues/druglaws.htm, together with an extensive comment prepared by the Legal Network.

⁵ McAmmond D. Ottawa: Health Canada, March 1997.

⁶ Roy D. *Injection Drug Use and HIV/AIDS: An Ethical Analysis of Priority Issues*. In: *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues, Background Papers*. Montréal: Canadian HIV/AIDS Legal Network.

⁷ Health Canada's Response, supra, note 1, "Message from the Minister of Health."

⁸ See the Network's comments on the F/P/T Committee report, supra, note 4.

⁹ Skirrow J. Lessons from Krever - a personal perspective. *Canadian HIV/AIDS Policy & Law Newsletter* 1999; 4(2/3): 35-41, at 40-41.

¹⁰ Enough Is Enough (editorial). *Canadian HIV/AIDS Policy & Law Review* 1999; 4(4): 3-4.

¹¹ Health Canada. Health ministers move forward on improving health care in Canada. 26 September 2001 (press release no 2001-103). Available at www.hc-sc.gc.ca/english/fpc2001/

¹² Correspondence received from Michael Smith, Health Canada, on 4 October 2001. On file.

A Review of A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver¹

A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver leaves the author of this review, Jan Skirrow, seriously conflicted. According to Skirrow, the *Framework* is a useful document and reflects well on those who prepared it, but skips over the hard issues by agreeing that drugs are the problem, and then moving on to repackaging the failed program approaches of the past. This, Skirrow says, is not the fault of those who participated in the planning exercise leading to the *Framework*. Rather, it results from a lack of courage on the part of society's policy-makers.

Vancouver is a major seaport, driven by the boom and bust cycles of British Columbia's resource-based economy. Over the past century or more, its skid row has been home to opium users, alcoholics, and heroin users. During the 1960s and 1970s, Vancouver became a destination of choice for mobile, often drug-using, youth from across Canada.

Recent province-wide economic problems have led many poorly educated and somewhat marginalized people to migrate to Vancouver's inner city in search of opportunity. The inevitable social problems have

been exacerbated by downtown redevelopment and gentrification, reductions in affordable housing, and the decanting onto the street of people with often serious mental health problems.

British Columbia was an early innovator in responding to the wave of youthful drug use that began in the 1960s. Methadone maintenance and addiction treatment programs were established around this time. Compulsory treatment was considered, but not implemented. Coordinated law enforcement has had some prominence over the years.

Yet for the most part these efforts are widely judged to have been ineffective. As with BC politics in general, measures to contain drug use have been characterized by shifting priorities, ad hoc organizational arrangements, complex interagency conflict, and frequent changes in program structure, philosophy, and direction.

Major factors providing impetus for a more determined approach to drugs have included the extreme level of overdose-related deaths recently, and AIDS, with its accompanying risk of needle-transmitted infection. Previous methods of drug control, which emphasized abstinence-oriented treatment and criminal justice sanctions, are seen by many to be fundamentally unworkable, based as they are on erroneous notions of who drug users are, and what drug use is all about.

The pressure to abandon stereotypical views of drug users has in the recent past led British Columbia to implement harm-reduction initiatives, such as needle exchanges, that would have been previously unthinkable. While worth doing, this kind of “Band-Aid” approach seems unlikely to do more than simply ameliorate

the worst consequences of some kinds of drug use. Substantial government and private resources have flowed into what appear to be the most affected Vancouver communities, but thus far the results have been disappointing.

A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver (Framework) reflects the latest effort toward a coordinated attack on Vancouver’s drug problem. It draws together a vast network of individuals and agencies, both government and non-government, concerned with the problems of inner-city residents in general, and drug users in particular.

Framework summarizes available data describing the extent of drug problems in Vancouver, and sets these within a provincial, national, and international context. It includes a detailed action plan based on what appear to be positive programs in use here and elsewhere in the world, and assigns tentative responsibility for further planning and development.

The proposed coordinated response is based on four areas of activity (the title’s four pillars). These are Prevention, Treatment, Enforcement, and Harm Reduction. Each of these areas is discussed in terms of basic concepts, principles and approaches, barriers to effective action, and potential benefits. In an attempt to reduce the interagency conflict that has hampered previous efforts, an overall coordinating, monitoring and evaluation process is also proposed, but almost as an afterthought.

I am seriously conflicted by *Framework*. It is a solid proposal to take concerted action against a serious social and health problem, even

to the point of being prepared to attract strong criticism for what are still considered radical programs in Canada: safe injection sites, heroin maintenance, and so on. The effort needed to achieve the degree of consensus reflected in *Framework* must have been enormous. Yet despite these good qualities, the document is flawed, probably due to the process that generated it.

Consensus appears to be an unquestioned necessity for action on

Framework tiptoes around such issues as the degree to which the consequences of drug use result to a significant degree from our legal response to drugs; or that the consumption of potentially harmful drugs is something virtually everyone does at some point in their lives; or that drug use is not the same as drug addiction.

modern problems. Yet different people and agencies have fundamentally different views of the central issues, often mandated by broad institutional or public policy determined elsewhere. These artificial, yet ultimately binding, constraints make meaningful consensus unachievable.

However, with sufficient effort, a kind of consensus can be forced, but only if basics are never critically examined. *Framework* tiptoes around such issues as the degree to which the consequences of drug use result to a significant degree from our legal response to drugs; or that the consumption of potentially harmful drugs is something virtually every-

one does at some point in their lives; or that drug use is not the same as drug addiction; or that people who develop serious drug problems are often dysfunctional in many ways, with this dysfunction usually preceding their introduction to drugs. It is safer, and very much easier, to skip over the hard issues, agree that drugs are *the* problem, and then move on to repackaging the failed program approaches of the past. This is not the fault of those who participated in the planning exercise. It results from a lack of courage on the part of society's policymakers.

Combined with this process issue is our conceptualization of the core matter to be addressed. We have chosen to place drugs at the centre – rather than, say, economic opportunity, educational attainment, family dysfunction, risk-taking behaviours, or any of the other determinants of whether or not someone uses drugs, and whether or not a serious problem results from that use. This is one of the reasons that harm-reduction ideas are so attractive. They provide a humane and necessary response to people in serious trouble, without the need to consider how they got there.

I suspect that those most closely involved with the effort to produce *Framework* would roll their eyes at these remarks and say – “Of course, we know that. First we must deal with the casualties, and then we’ll have the luxury of time to do more basic work.” In my 30 years in the addiction field, I have heard this refrain so many times. But at the end of the day, we do other things because prevention is really really hard. In fact, true prevention rarely gets done, not least because the

resources – talented people and money – are hoovered up by the treaters and enforcers.

The compelling need to act, and the controversial aspects of the generally useful *Framework* proposals, shouldn't be allowed to obscure the broad roots of the drug problem. Prevention, to get us out of this mess, must focus on the many factors that start people on this path in the first place. Few of these have much to do with drugs themselves. True prevention will focus on how to better prepare all young people for the challenges of our complex, dangerous, and often unforgiving society. It will develop much better ways of dealing with the mentally ill, and with the unique economic and social problems that Aboriginal peoples face. Surely it is more sensible to deal with these matters upstream, from the streets of Vancouver.

In the end, our success in dealing with any problem, and certainly with drugs, depends on the clarity of our understanding, and our courage. If we take the core problem, and layer on it the vested-interest needs of the many concerned parties, coat it with the iron limitations of our determination to see drug use as a criminal justice issue, attempt to make everyone part of “the solution,” we are unlikely to achieve anything. The danger in government-sponsored planning is the emphasis on consensus among people of opposing views. That ensures that thinking outside the box formed by dysfunctional yet well-established perceptions and policies is simply not going to happen. The lowest common denominator will emerge instead.

Framework is a useful document and reflects well on those who prepared it. But while it proposes a few courageous activities, it doesn't tackle the underlying insanity of how we as a society deal with drug use. But so long as our leaders demand consensus, even from those who have a duty to see the basic problem differently, nothing much will happen. They abrogate their responsibility as leaders and policymakers and expect those in the trenches to somehow make it work. An insistence on consensus means that basic issues and disagreements are never explored, much less resolved. One can only hope for better. But that would require a kind of leadership that is increasingly rare.

The specifics of *Framework* may have little relevance beyond the Vancouver area. However, it is worth reading for a number of reasons, not least of which is the way in which, perhaps inadvertently, it reveals much about why the drug problem has proven so intractable.

– reviewed by Jan Skirrow

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¹ Draft Discussion Paper. Written by D MacPherson, Drug Policy Coordinator, City of Vancouver. City of Vancouver, 21 November 2000. Available at www.city.vancouver.bc.ca/commsvcs/planning/dtes/VanAgree/frameworkforaction.pdf. A revised version of the discussion paper (24 April 2001) is now available at www.city.vancouver.bc.ca/commsvcs/planning/dtes/VanAgree/Framework2.pdf.

Medical Prescription of Heroin – A Review

(cont'd from page 1)

In 1998, the Netherlands undertook a randomized clinical study, the results of which will be known in 2002. Preliminary observations indicate that there have been no problems to date with respect to security and public order, something that had already been noted in Switzerland. Several countries are awaiting the approval of research protocols that are designed to assess the effectiveness of heroin prescription as a treatment alternative for heroin-dependent populations.

In North America, researchers have developed a protocol (North American Opiate Medications Initiative) aimed at assessing the effectiveness of heroin prescription with respect to attracting and retaining those resistant to conventional treatments. This randomized clinical study will include a control group receiving oral methadone, while the experimental group will receive an injectable opiate (heroin or hydromorphone) with or without oral methadone. The two groups will be offered extensive psychosocial services, such as individual or group therapy, help with job seeking or returning to school, and housing placement. The study will last two years and the experimental treatment one year. The protocol is awaiting approval.

Introduction

Opiate and, in particular, heroin use remains a significant health problem in North America. It is estimated that approximately 60,000 to 90,000 people in Canada are opiate-dependent,¹¹

including 15,000 in Vancouver,²³ 14,000 in Toronto,¹² and approximately 5000 in Montréal.

Use of opiates causes many problems and affects both those who are opiate-dependent as well as society as a whole. It is well known that the morbidity and mortality rates of drug users are higher than those in the general population who are of the same age.⁵ In British Columbia in 1998, one death a day was reported as being associated with injection drug overdose.²³ Meta-analyses in recent studies indicate an annual mortality rate of 1 to 2.5 percent in the untreated injection drug user population.^{27,36}

Drug injection is also an important risk factor in the transmission of infectious diseases, particularly HIV and hepatitis, and is also a risk factor for endocarditis, abscesses, and tuberculosis. The increased prevalence of these infections in this population is due to the sharing of injection equipment, unhealthy living conditions, and contacts with infected people.^{19,3} In Canada, HIV prevalence in the injection drug user population is estimated at 20 to 25 percent or more in cities such as Vancouver and Montréal.^{31,14,28} The prevalence of hepatitis C in Canada varies from 55 percent to 88 percent, while hepatitis B varies from 25 percent to 35 percent.^{23,31,12} Finally, injection drug users also present with multiple mental health problems.¹⁷ They tend rarely to consult the health-care system for their problems and receive less treatment than the general population but, paradoxically, they visit emergency

clinics more often than the general population.¹²

The problems related to drug use are not limited to the users themselves. Dysfunctional family relationships, violence, and crime are all complications associated with illegal drug use.¹⁰ The social costs related to such use are estimated to be 0.2 percent of the Gross National Product,³⁰ using such common indicators as loss of productivity, and health and legal costs, a recent study estimates that the social costs for one untreated opiate-dependent person amount to \$49,000 a year.³⁷

Treatment

There are many kinds of treatment for opiate-dependent people, ranging from abstinence-oriented treatments to treatments that seek to reduce use and associated complications through substitute medications. Methadone is the most commonly used form of substitute medication in North America. Introduced in the 1960s, it has demonstrated its efficacy in many respects: reduction of the use of illegal opiates and other drugs; reduction

Methadone is the most commonly used form of substitute medication in North America. Introduced in the 1960s, it has demonstrated its efficacy in many respects.

in crime associated with drug use; stabilization or improvement of mental and physical health; reduction in drug injection and secondary reduction in transmission of infectious diseases; and improvement in social and family interactions.^{22,24,26,25,8,7,29} A number

of features of methadone maintenance programs are associated with such results, including adequate methadone dosage, access to high-quality psychosocial services, duration of treatment, and acceptance by patients of the rules of the program.^{20,1,6} The costs of methadone maintenance treatment are estimated to be from \$3000 to \$5000 a year per person, and are thus clearly less than the \$49,000 mentioned above.³⁷

Despite its efficacy, many factors limit the potential of methadone maintenance treatment, the first being access to treatment. It is estimated that only about 15 to 20 percent of opiate-dependent people receive the treatment in Canada.¹³ In Québec before 1999, about 700 people had access to methadone maintenance treatment. Since then, as a result of a provincial government decision, the number of available openings for methadone maintenance has grown considerably, reaching close to 2000 people. By 2002, this is likely to rise to between 2500 and 3000 people.

However, even when it is widely and easily available, methadone maintenance treatment would only reach 50 percent of the opiate-dependent population, as the Le Dain Commission concluded.¹⁶ This is confirmed by data from European countries such as Switzerland and the Netherlands.^{4,32} Opiate-dependent people have expressed their reluctance to participate in methadone maintenance programs, voicing concerns about the pharmacological qualities of the substance itself, and their difficulties in complying with the rules and requirements of the programs. A series of studies has also demonstrated that methadone maintenance programs lose about a

third of their participants in the first 12 months and another third in the following 24 months. Overall, long-term retention rates range from 30 to 60 percent.^{25,18,1}

The Medical Prescription of Heroin

The idea of prescribing opiates to people resistant to standard treatment is not new. Since the early 1970s, the Vera Institute of Justice in New York has been a proponent of this idea, along with the Le Dain Commission in Canada.^{34,16} In England, the prescription of injectable heroin has been practised for many years,

The idea of prescribing opiates to people resistant to standard treatment is not new.

although it has not been systematically assessed.^{21,2,15} In 1994, the Swiss Federal Office of Public Health undertook a large-scale study of the efficacy of prescribing heroin in the treatment of heroin-dependent people who were not responding to traditional treatments. At that time, the prevalence of heroin dependence was assessed at 4000 per million of the population; moreover, methadone maintenance treatment was widely available, with about 50 percent of heroin-dependent people receiving it.

The Swiss Study

The Swiss study is in fact made up of many studies, some of which were randomized or double-blind, but the majority of which consisted in an evaluation of cohorts of patients before and after the administration of treatment, which involved the pre-

scription of an opiate as part of a complete program that included medical, psychiatric, and psychosocial services. In the majority of cases, the opiate was pharmaceutical heroin. Some studies also assessed the efficacy of injectable morphine and injectable methadone. The study was carried out in 12 cities, for a total of 18 sites, one of which was in a prison: 1151 people participated in the study, and there are complete data on 1035 of the admissions.³³

To be able to participate in the study, people had to be at least 20 years old, to have been heroin-dependent for more than two years, and not have responded to conventional treatments. On average, participants went to the clinic three times a day to inject heroin under the supervision of nursing staff. If participants so wished, oral intake of methadone could be added to their treatment.

The results (Table 1) demonstrate that heroin-dependent people who had failed to respond to traditional treatments and who had difficulty in

Heroin-dependent people who had failed to respond to traditional treatments have been more effectively reached by heroin prescription programs than by standard treatments.

maintaining their health and their ability to function in society have been more effectively reached by heroin prescription programs than by standard treatments. With respect to drug use, there was a rapid decrease in illegal heroin and cocaine use, as well as a decrease, albeit slower, in benzodiazepine use. There was no

significant change in alcohol and cannabis use. There was improvement with respect to work and mental health, and a decrease in criminal activities. Of participants who left the study, 63 percent sought other forms of treatment, including 83 subjects in abstinence-oriented treatments.

Table 1. Results from the initial cohort of the Swiss study*

	Initial	18 months
Heroin**	81 percent	6 percent
Cocaine **	29 percent	5 percent
Benzos **	19 percent	9 percent
Employment	14 percent	32 percent
Contacts ***	40 percent	18 percent
Illegal income	70 percent	14 percent
Criminal activities	69 percent	10 percent
Mental illnesses	48 percent	18 percent

* taken from Uchtenhagen et al, 1999

** taken almost every day

*** with the drug world

The Swiss study had many strengths, such as the large number of subjects recruited on many sites, and the fact that benefits were measured using a broad range of outcomes. It also demonstrated the feasibility of such programs, particularly with respect to security and public order. Moreover, no overdose deaths were reported. It also benefited from both national and international (World Health Organization) oversight.

On the other hand, there were certain major scientific weaknesses that limited the scope of the results. The lack of randomization meant that no determination could be made as to whether the observed benefits were attributable to heroin itself; they could equally well have been attributable to the fact that participants were enrolled in a treatment program that included psychosocial interventions and frequent therapeutic contacts.⁹ Research design differed from site to site, resulting in heterogeneous cohorts of subjects and making the interpretation of results difficult. Finally, illegal heroin use was assessed on the basis of information given by the subjects; this made it impossible to distinguish between pharmaceutical heroin and illegal heroin in urine tests.

Table 2. Design of Dutch study^{35*}

Group	Phase I	Phase Iia	Phase IIb	Phase III
	4-8 weeks	6 months	6 months	6 months
A	Methadone	Methadone	Methadone	Methadone + heroin
B	Methadone	Methadone + heroin	Methadone + heroin	Most appropriate treatment
C	Methadone	Methadone	Methadone + heroin	Most appropriate treatment

* two identical designs, one for injected heroin, the other for smoked heroin

The Netherlands

There are about 24,000 heroin-dependent people in the Netherlands. Of this total, 17,000 are in treatment, 12,500 of them on methadone maintenance. Unusually, heroin is smoked rather than injected in this country.³⁵ In 1998, following a government decision, a research protocol was introduced, the results of which should be published in 2002. The objectives of this randomized study are to assess the efficacy of combined heroin and methadone treatment compared with methadone-only treatment. The target population is heroin-dependent people who are resistant to traditional treatment and whose state of health and social functioning are precarious. The design used is illustrated in Table 2. The subjects have to be at least 25 years old, and to have been under methadone maintenance treatment within the 12 months preceding entry into the study. Heroin will be offered by injection for those already using this means of administration, or by inhalation for those who are used to smoking.³⁵

The study will be carried out in two phases, the first having begun in July 1998, in two cities (185 subjects). The second began in November 1999, six units (440 subjects) having been added.

To date, there have been no problems with patient recruitment, randomization, or data collection, and there have been no public-order problems or serious medical adverse events.

The Dutch study illustrates the advantage in scientific terms of a randomized study with a single design that will be applied on several sites. The results will also be assessed according to several outcomes (drug use, state of health, and social functioning) and will benefit from

national and international oversight.

On the other hand, the design that was used (delayed entry in the treatment of heroin) may artificially inflate retention in Phase I, where subjects receive methadone only.

Heroin treatment is of short duration (six months on average). As with the Swiss study, measures will be taken on the basis of information provided by subjects, which is a weakness of the study, particularly with regard to illegal heroin use. However, as explained above, it is difficult to avoid this problem in this field of research.

Many protocols have been developed in various countries. A randomized study project has been approved by the German government and should begin in 2002. Two projects are awaiting approval in Spain, one in Belgium, and a non-randomized study has been approved in the United Kingdom.

NAOMI (North American Opiate Medications Initiative)

Since 1998, North American researchers with expertise in various fields (epidemiology, treatment, pharmacology, sociology, users, etc) have worked together to develop a scientifically and ethically rigorous protocol.

The primary objective is to assess whether the percentage of injectable heroin-dependent users who are attracted to and retained in a prescribed heroin treatment program (with or without complementary oral methadone) will be higher than those attracted and retained to receive oral methadone treatment only. The secondary objective is to evaluate whether the two therapy arms are equally effective, given that equiva-

lent psychosocial services will be offered to both treatment groups.

Study Population

The target population is people responding to opiate-dependence criteria (DSM-IV). Subjects must be at least 25 years old, with an opiate dependence of at least five years, a one-year injection history, and a treatment history of methadone maintenance at least twice in their past. People who present with a severe medical or psychiatric condition for whom the administration of opiates would be contraindicated, pregnant women, and people incapable of signing an informed consent to participate in the research protocol are ineligible.

Experimental Design and How the Study Will Be Conducted

After a three-week period during which the eligibility criteria (medical, treatment centre, criminal, and other records), those who agree to take part will be randomized into one of two experimental groups – either a group taking an injectable opiate with or without methadone, or a group receiving oral methadone only. Of the 470 subjects needed for the study, 260 will be randomized in the injectable-opiate group and 210 in the methadone-only group. Of the 260 subjects who are to receive an injectable opiate, 50 will receive hydromorphone (Dilaudid™) and 210 will receive heroin. Neither the subjects nor the researchers and clinicians will know which of the two opiates will be administered (double blind). Unlike pharmaceutical heroin, hydromorphone can be distinguished from illegal heroin through urine tests. It will therefore be possible to verify whether or not the information

given by this subgroup of subjects concerning illegal heroin use is reliable. Hydromorphone has pharmacological features similar to those of heroin and would be acceptable to the subjects. Any subject who cannot participate or who refuses to will be offered a reference to the most appropriate treatment centre.

On entry into the study, the subjects will all undergo a medical and psychiatric examination, blood tests, and urine screening. They will also be assessed using questionnaires such as the Addiction Severity Index and a quality-of-life questionnaire. They will be examined regularly by clinicians, and every three months by a research team that will carry out data collection for the duration of the study. This team will remain separate from the clinical team, with respect to both personnel and workplace, in order to avoid any potential bias and to protect the confidentiality of the information collected. Treatment will last 12 months and data collection will continue for another 12 months. The study will take place in three cities – Vancouver, Toronto, and Montréal.

Services Provided

Other than medical and pharmacological treatment, all subjects will have access, on request, to psychosocial services that will be site-specific but equivalent for each treatment arm (individual or group therapy, help with job seeking or returning to school, housing placement, etc). The clinical team will ensure the treatment of co-morbidities (for example, HIV and hepatitis) and will provide references where needed. In order to screen early for pregnancies and to avoid any harm to the fetus, women participating in the study will

regularly undergo pregnancy tests, and those who are pregnant will be offered appropriate care and will be transferred to a methadone maintenance treatment program, which is currently the only recommended treatment in such circumstances.

Measures

The following outcomes will be measured at 12 months: retention in the study, drug use, and illegal/criminal behaviour. Other outcomes will also be measured at 12 and 24 months: social functioning (employment, family relationships, education, and housing), and physical and mental health. Costs and benefits will also be measured.

Study Limitations

Given the target population – that of heroin-dependent people resistant to conventional treatments – the results may not be generalizable to the population of heroin-dependent people as a whole. There will also be some variation between the three sites, so that as far as possible there must be rigour in establishing standards between treatments, particularly at the psychosocial level. Since the population recruited will, by definition, be resistant to methadone maintenance treatment, the subjects assigned to the group that is to receive methadone only might leave the study in greater numbers; the results must take this factor into account.

Public Health Implications

If the results of the study prove conclusive, it may be possible to increase treatment options to opiate-dependent people, in particular to those who do not respond to traditional treatments. The fact of being able to attract and retain such people in treatment should reduce the burden on health services (infectious diseases, emergency room visits, etc), reduce criminal behaviours and the use of the criminal justice system, and improve chances of social rehabilitation.

Ethical Considerations

Many ethical problems are raised by such studies, and particular attention has been paid to them. For example, problems related to confidentiality, risks to the community, and legal liability have been assessed, and all possible measures will be applied. At the local level, community advisory committees will be created to advise researchers as to the implementation of the protocol and to public order and ethical issues. One problem nonetheless remains: what will happen to subjects who have received injectable-heroin treatment and who at the end of the study have demonstrated a notable improvement in terms of the measured parameters? All subjects will be informed that the heroin treatment can only be offered for a 12-month period, and that there is no guarantee at the present time

that this kind of treatment will be available after the study. This problem cannot, however, be resolved by the research team alone: it involves decisions that need to be taken at a societal level. It is nevertheless the responsibility of the researchers to try to convince policymakers that this kind of treatment should be pursued if it proves effective.

The NAOMI protocol has been submitted to the scientific and ethical committees of several institutions, and has been approved by the Johns Hopkins School of Public Health, the New York Academy of Medicine, and the University of British Columbia. It has been reviewed by a panel of international experts and has received their approval. Funding is now being sought; if the response is favourable, the project could get underway in the months to come.

– Suzanne Brissette

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(cont'd from page 1)

women?" in development programming. A gender-sensitive analysis of the responses also questions "where are the men?" Responses that focus solely on women's vulnerability will fail because they ignore the constraints men face in making the changes necessary to reduce the spread and impact of HIV/AIDS.

Wars and other conflicts increase the vulnerability of women and girls to HIV/AIDS, including through systematic rape and other war crimes. Girls are particularly vulnerable to abuse, both as civilians and as child soldiers. In post-conflict situations, local women and girls are at increased risk as they barter or sell sex for survival to occupying or peacekeeping forces. (In January 2001, the UN

Security Council again addressed the issue – the fourth time in a year.)

Six experts attended the consultation, from North America, Europe,

Responses that focus solely on women's vulnerability will fail because they ignore the constraints men face in making the changes necessary to reduce the spread and impact of HIV/AIDS.

Africa, and Asia, as well as over thirty observers from local and international

NGOs, the Commonwealth Secretariat, and UN system organizations. The expert papers are on the web at www.un.org/womenwatch/daw/csw/hivaids/index.html, so only four are mentioned briefly here.

Sam Page's gender analysis of HIV in poor rural communities in Zimbabwe identified the differential impact of HIV/AIDS, and gave feasible alternatives to expensive medications to promote longevity in HIV-positive mothers. Page noted that extremely toxic pesticides are often applied by rural women and children in many African countries, and that while male farmers are afforded some degree of protection through the wearing of overalls and gumboots, women and children are not usually protected at all. This is because children are too small to wear protective clothing and women do not wear overalls for cultural reasons. Page has demonstrated that pesticide-free farming and cheap nutrient supplements to address local

soil deficiencies can help to keep HIV-positive parents healthy longer. In this way they are able to raise their children to the point where they can farm the land themselves.

Cathi Albertyn provided a gender perspective on the human rights and HIV/AIDS analysis, noting that the only comprehensive international statement – the UN International Guidelines on HIV/AIDS and Human Rights – places excessive responsibility on governments, largely ignores other centres of power, is overly reliant on the law and legal frameworks, and prioritizes individual over social rights. She gave a list of preconditions for effective human rights approaches to HIV/AIDS.

Peter Aggleton noted that although women are systematically denied access to economic, political, educational, and other resources to achieve their potential, an approach that ascribes women's misfortunes to men alone is seriously deficient. Factors such as poverty, age, class, caste, race, and sexuality also affect women's and men's vulnerability. Aggleton stressed that women also play a role in creating and continuing their disadvantage through, for example, their role in the ways in which both girls and boys are raised.

Geeta Rao Gupta noted that some HIV/AIDS prevention campaigns

reinforce damaging sexual and gender stereotypes, which foster predatory, violent, and irresponsible images of male sexuality, while women are seen as powerless victims or repositories of infection. She urged approaches that empower women in six areas: information and education; skills; access to services and technologies; access to economic resources; social capital; and the opportunity to have a voice in decision-making at all levels.

These and other diverse contributions from the experts and observers generated a week of rich discussion and reflection. It emerged, however, that few of the participants were familiar with the International Guidelines on HIV/AIDS and Human Rights, which would surely be a basic document for any discussion on the subject (see Patterson D. The International Guidelines on HIV/AIDS and Human Rights – three years on. *Canadian HIV/AIDS Policy and Law Newsletter* 1999; 5(1): 30-31). As a result, some time was lost going over old ground (eg, the need for a multisectoral approach) rather than further strengthening our understanding of the intersection of gender, rights, and security. For the moment, we can only speculate as to why it is poor young HIV-positive women, such as

the Walvis Bay AIDS counselor, who are often the first to speak out in some heavily infected communities.

– David Patterson

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