Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Contents

Volume 1 Number 1

HIV Prevention Taken Seriously: Provision of Syringes in a Swiss Prison

Québec Court Finds Asymptomatic HIV Infection a Charter " Handicap ": Hamel v. Malaxos

Prisoners and HIV/AIDS

Australia

- Australian Federal Health Minister Calls for Needle Exchange in Prisons
- Prisoners Sue for the Right to Condoms

Tuberculosis

- TB/HIV Issues Receiving Increased Attention in Canada

Criminal Justice

- Ten Months' Imprisonment for Biting Police Officer
- Thirty Months' Imprisonment for Syringe Attack
- HIV+ Man Sentenced to Ten Years for Having Unprotected Sex
- Swiss Man Sentenced for Transmitting HIV
- Draft Legislation on HIV Transmission
- Sentencing News

Other Court News

- Mother Ordered to Cooperate with her Child's Physicians

Testing

- Mandatory Testing for Convicted Rapists in California
- Canadian Human Rights Tribunal Rules on Drug Testing

Blood and Blood Products

- First Canadian Ruling in a Tainted Blood Case: *Pittman v. The Canadian Red Cross Society*

Discrimination

- Sexual Orientation a Prohibited Ground of Discrimination in Alberta: *Vriend v. Alberta (Attorney General)*

Immigration

- Recent Developments in Immigration
- HIV+ Swimmer Faced Deportation

Canadian News

- Ontario Public Health Powers under Review
- The Federal Interdepartmental Committee on Human Rights and AIDS
- Legal Advocacy and Policy Development at CAS
- Law Students Provide Legal Services
- Universities Offer Courses on AIDS

Development Issues

- Aids, Denial and Development: ICAD's Response to the Epidemic

International News

- United Nations Focus on Ethics, Law and HIV

Upcoming Events

- 8th Annual British Columbia HIV/AIDS Conference on Youth

Top of this page

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

HIV Prevention Taken Seriously: Provision of Syringes in a Swiss Prison

While the Correctional Service of Canada has refused to carry out a pilot project to provide sterile needles to inmates, such a project was launched in a Swiss prison for women in May 1994.

"Our basic mandate is to enforce the sentence handed down by the courts. We are bound to observe the provisions of the Criminal Code, which sets out in article 46.2 that: 'In all institutions, the moral, cultural and physical needs of inmates shall be provided for; the measures necessary for this purpose shall be carried out in all institutions.' This article means, on the one hand, that we must help inmates free themselves from drug use, and thus to prevent drug use as far as possible. On the other hand, this article mandates us to ensure that the women in our care do not suffer any harm during their detention. The transmission of HIV or any other serious disease cannot be tolerated. Given that all we can do is restrict, not suppress, the entry of drugs, we feel it is our responsibility to at least provide sterile syringes to inmates. The ambiguity of our mandate leads to a contradiction that we have to live with."1

In 1991, a physician of the Hindelbank Institutions for Women in Switzerland polled inmates on drug use and needle exchange. He observed that almost all the women who were injection drug users had exchanged needles with other inmates. Armed with this information, he proposed, with the agreement of the director of the Institutions, launching a pilot project to provide sterile syringes to inmates in order to prevent HIV transmission. At first the project ran up against opposition, but was able to continue with the collaboration of the Federal Public Health Department (FPHD).

The aims of the pilot project, as set out in the 16 May 1994 press conference, are as follows:

- in the short term, to reduce the harms from drug use;
- in the short term, to prevent infection or reinfection by dangerous pathogenic agents (HIV, hepatitis B virus, hepatitis C virus, etc.); and
- in the medium or long term, to reduce the number of new drug users and of former users who relapse.

The methods used to achieve these goals are directed to all inmates and include demonstrations, group meetings that use exercises, role playing, consultations with the project director and his coworkers, a

hotline for discussion of problems, supplementary prevention measures, and written and audiovisual materials. The provision of sterile syringes is basic to the project. During their first interview with the project director or his coworkers, inmates receive a syringe, which may not, however, be used for injection purposes. The secretariat of the Institutions provides new inmates with such a syringe, together with instructions in their mother tongue, upon their arrival. With the help of this subterfuge (a real syringe without a needle), or with a syringe that has already been used, inmates can operate an automatic dispenser to get a sterile, readytouse needle. Automatic dispensers are installed in each of the six sections of the Hindelbank Institutions.

The prevention program will be assessed in terms of its implementation, outcomes, and the reactions of inmates and staff. On the basis of the results of this assessment, recommendations will be made concerning the introduction of effective measures for preventing drug use and AIDS.

At the press conference, Ms Zeltner, the Director of the Federal Public Health Department, emphasized the importance of the pilot project with respect to health policy, saying: “At first glance, the initiative may seem paradoxical: sterile needles and syringes are going to be provided to delinquent drug users who are serving time in prison, so that they can use their drug.... However, we should look reality in the face. It also happens that, behind the prison's walls, illegal drugs are being injected. In doing so, inmates are exposing themselves to the risk of contracting the AIDS virus or other pathogenic agents through the use of infected needles and syringes. The FPHD's mission is to stop the spread of the HIV epidemic in Switzerland. The FPHD is of the opinion that inmates should have the same possibilities as people outside prisons to protect themselves against HIV infection. Making sterile needles and syringes freely available is now part of AIDS prevention measures for injection drug users. The same rights + to have access to clean needles and syringes, and to counselling and medicosocial help + apply to inmates.” According to Mr Zeltner, the project is part of an attempt to fill a gap that still exists in the Swiss HIVprevention strategy. Moreover, its implementation is consistent with the WHO guidelines concerning the prevention of HIV infection and AIDS in penal institutions.2

In its expert report of July 1992,3 the Federal Department of Justice stated that the provision of sterile syringes in prisons in the context of pilot projects was judicially admissible and compatible with a responsible health policy. This report will be discussed in an upcoming issue of the *Newsletter*.4

- *Ralf Jürgens*

Top of this page

Return to Table of Contents

Return to Home Page

ENDNOTES

1 Martin Lachat, Interim Director of the Hindelbank Institutions for Women, chief organizer of the project and member of the committee monitoring it.

2 WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: WHO, 1993.

3 Federal Department of Justice. Provision of sterile syringes and of disinfectant: Pilot project in correctional institutions; judicial admissibility. Berne, 9 July 1992.

4 Most of this article is taken from an account of a pilot project for HIV prevention in the Hindelbank Penitentiaries for Women. Press conference, 16 May 1994, Information and Public Relations Bureau of the Canton of Berne.

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Québec Court Finds Asymptomatic HIV Infection a Charter “Handicap”

Hamel v Malaxos

In November 1993, a Québec court handed down the first decision of any Canadian court affirming that asymptomatic HIV infection qualifies as a handicap for the purposes of discrimination law.1

The plaintiff, a 25yearold man with asymptomatic HIV infection, succeeded in an action in small claims court against a dentist who allegedly refused to treat him because of his HIV infection. The decision is particularly interesting because (at least in Québec) it offers an alternative avenue of redress to the Human Rights Commission in some cases involving the discriminatory provision of services.

In December 1991, the plaintiff received dental treatment of a value of approximately $1,000. The following June he lost the tip of a tooth and was subsequently given an appointment, at which time the plaintiff claims he was told the tooth would be repaired without charge. The dentist later denied making this offer.

The plaintiff later learned that he was HIVpositive and so informed the receptionist when he arrived at the dental clinic to have the tooth repaired. The dentist then told him that he was not equipped to treat people with HIV and proposed to refer the plaintiff to NotreDame Hospital.

The plaintiff refused this offer and paid for treatment elsewhere. He then filed suit against the defendant on the following grounds:

- breach of contract, i.e., failure to honour the guarantee and repair the tooth free of charge;
- quasidelict; and
- discriminatory treatment, in breach of the Québec *Charter of Human Rights and Freedoms*.

The dentist claimed that:

- the subsequent dental work required was unrelated to the prior work done by him;
- he had no ethical or legal obligation to treat the plaintiff; and
- his refusal to treat the plaintiff was not intentional discrimination, but was based on the desire to protect his clientele and himself from a deadly disease, as he was not equipped to treat people with HIV infection.

In arriving at his decision, Soumis J went beyond the arguments presented by the parties and familiarized himself with the substantial legal and medical literature on the subject. He concluded that there was insufficient evidence that the dental work was covered by warranty. The judge further noted that neither the *Act respecting health services and social services* nor the *Health Insurance Act* was applicable. Nor was there any obligation under contract law for the dentist to treat the plaintiff.

The Court noted the differing opinions of the professional associations regulating the medical and dental professions, and examined the Code of Ethics of each. The judge concluded that there was no binding obligation on doctors or dentists under their respective codes to treat seropositive patients in Québec.

Turning to the Québec *Charter of Human Rights and Freedoms*, the Court held that a contract for dental care falls within the ambit of section 12, being "a juridical act concerningBservices ordinarily offered to the public." The Court also observed that asymptomatic HIV infection should not be considered a period of "true biological latency" because a seropositive person experiences real disadvantages even at the asymptomatic stage of the disease. In particular, the judge noted that people with HIV are limited in their sexual relations because of the precautions that must be taken, and must live with the constant threat that their disease will enter the symptomatic phase.

The judge also addressed the argument that the subjective perception of handicap is sufficient enough a disadvantage as to come within section 10 of the *Charter*. The Court noted that the definition of "disability" in the *Americans with Disabilities Act* includes being *regarded* as having an impairment. It was further noted that US case law and legal commentators have generally accepted that asymptomatic HIV infection is a "handicap" or "disability." The Court also noted that the relevant definitions in the human rights acts of Ontario and Nova Scotia include the subjective perception of disability or handicap, and that the Canadian Human Rights Commission and human rights commissions in other provinces have made resolutions, statements or findings to that effect. The Court found that the defendant's perception of the plaintiff as being able to easily transmit a mortal illness constituted a handicap within the meaning of section 10, and noted that a similar conclusion had been reached by the British Columbian Human Rights Tribunal in *Biggs* v *Hudson* (1988), 9 C.H.R.R. D/5391.

The Court reviewed the evidence and the jurisprudence in light of the defendant's claim that such treatment would place him at risk of HIV infection, and concluded that such a risk was practically nonexistent. The Court thus found that the defendant, in refusing to treat the plaintiff because he was seropositive, had committed a discriminatory act contrary to the Québec *Charter of Human Rights and Freedoms,* and awarded the plaintiff $1,000 in damages.

- David Patterson

Top of this page

Return to Table of Contents

Return to Home Page

ENDNOTE

1 25 November 1993, no. 73032000370 929, Small Claims Court, Joliette, unreported.

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

PRISONERS AND HIV/AIDS

Australian Federal Health Minister Calls for Needle Exchange in Prisons

Australian federal health minister Carmen Lawrence has called for condoms, needles and syringes to be supplied in prisons as a measure against the spread of AIDS.1 This decision was made in response to a letter in the *Medical Journal of Australia* reporting the first documented case of HIV transmission in an Australian prison.2 Dr Lawrence said that the failure to introduce needle exchange programs to prevent the spread of HIV would be “igniting a time bomb which is likely to go off in the prisons and wider community.” Although she proposed that tight guidelines be introduced to monitor the distribution of needles in prisons, her plan met with opposition from state governments and prison officers' organizations.

ENDNOTES

1 Reported in the [Australian] *National AIDS Bulletin*, Vol. 8, no. 5 (June 1994).

2 *The Medical Journal of Australia*, Vol. 160 (6 June 1994).

A War on Drugs, But Not on AIDS: CSC's Response to ECAP's Report

The Expert Committee on AIDS and Prisons (ECAP) was created on 15 June 1992 by the Solicitor General of Canada. Its goal was to assist the Canadian government in promoting and protecting the health of inmates and of staff, and in preventing the transmission of HIV and other infectious agents in federal correctional institutions. In March 1994, the Correctional Service of Canada (CSC) released the Committee's Final Report.1 Among the Committee's many recommendations were that fullstrength household bleach be made available to inmates and that injection drug users have access to methadone. The Committee further concluded that making sterile injection equipment available in prisons “will be

inevitable," particularly because of the serious doubts that have recently arisen in relation to the efficacy of bleach in destroying HIV. It therefore recommended that research be undertaken "to identify ways and develop measures, including access to clean injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use."

The CSC has accepted many of the recommendations made by ECAP, and several projects are being developed in response to its recommendations. These include:

- an anonymous pilot project for HIV testing in a correctional facility in the Ontario Region of CSC;
- a research project on inmate highrisk behaviours related to HIV transmission in correctional facilities;
- a pilot project for distribution of bleach in one institution in the Pacific Region of CSC; and
- an inmate peer healthpromotion project at Dorchester Penitentiary.

These projects are jointly funded by Health Canada and CSC, and steering committees have been established to provide CSC with external advice in the preparatory phases of the projects. It is expected that all projects will be underway before the end of the year.

The Service has been praised for its decision to carry out these projects and, generally, for implementing many of ECAP's recommendations. However, it has been criticized for rejecting other critical parts of ECAP's plan. CSC will not make fullstrength household bleach available in all institutions, but for now only carry out a pilot project; will not provide methadone maintenance programs; and finally, will not pilottest needle exchange programs in prisons. Furthermore, although it accepted ECAP's finding that education about drug use is a very important element of efforts to prevent transmission of HIV, the Service is still holding back thousands of copies of educational materials developed for it. These materials were printed nearly a year ago and have not been distributed because they contain information on how to clean injection equipment. According to the Torontobased Prisoners with HIV/AIDS Support Action Network (PASAN), CSC "has chosen to ignore the issue of injection drug use and the high risk of HIV transmission through needle use within the prison context. How can CSC admit that there is a drug problem in the prisons and still refuse to even try a pilot needle exchange program for prisoners? This contradiction will cost lives." Similar criticism has come from organizations like the Canadian AIDS Society and the Kingston AIDS Project, and from physicians and representatives of the media. An editorial in the *Vancouver Sun* of 2 April 1994 called the "prison system guilty of AIDS complacency," and added that "[i]f any lesson should be learned from the continuing outcry over the Red Cross['s] sluggish response to the threat of AIDS transmission through the blood supply, it's that such attitudes [as expressed in CSC's response to the report] can be lethal."

Instead of making bleach available to inmates in all institutions, implementing methadone maintenance programs, and undertaking a pilot project for needle distribution in at least one institution, as recommended by ECAP, on 9 August CSC announced a "strategy to combat drugs in federal penitentiaries." As part of this strategy:

- the use of random urine testing for drug use will be increased “substantially” in federal institutions;
- searches of visitors will be undertaken more frequently;
- specially trained drugdetection dogs will be used;
- better training in drug detection and in the laws governing search and seizure will be undertaken;
- visitors attempting to bring drugs into institutions will not only risk facing criminal charges, but may be barred from further visits to federal penitentiaries;
- it will become “more likely” that charges will be laid against inmates engaged in the trafficking of drugs;
- steps will be taken to “draw to the attention of the judiciary the serious impact of drug trafficking and drug abuse in federal penitentiaries”; and finally,
- inmates will be offered better access to drug treatment programs.

Many of these measures are controversial at best. Whether they will help to reduce levels of drug use in prisons is at least questionable and remains to be seen. There is a wellfounded fear that, because of more frequent random urine testing and more severe penalties, inmates' drug use, rather than diminish, may shift from drugs (such as marijuana) that are detectable in urine for up to one month, to drugs (such as cocaine, heroin, PCP and LSD) that have much shorter windows of detection. As a result, injection drug use may increase, and with it the risk of HIV transmission and other harms from drug use. As stated by ECAP, measures such as those now being undertaken by CSC “may create risks or harms that outweigh the benefit being sought, namely the reduction of drug use.”

- *Ralf Jürgens*

ENDNOTE

1 The report comprises three documents: *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*; *HIV/AIDS in Prisons: Summary Report and Recommendations*; and *HIV/AIDS in Prisons: Background Materials*. It can be obtained through the Health Care Services Branch of the Correctional Service of Canada, 340 Laurier Avenue West, Ottawa, Ontario K1A OP9. Tel: (613) 9955058; Fax: (613) 9956277.

Australia: Prisoners Sue for the Right to Condoms

At the same time that reports in two Australian states, New South Wales (NSW) and Queensland, indicate that inmates have contracted HIV while in prison, a civil action has been undertaken in the NSW Supreme Court on behalf of 52 inmates from two prisons, against the state of NSW over its refusal to permit prisoners to have access to condoms.1 The prisoners are applying for a mandatory injunction to force the government to reform its policies. The application seeks:

- an order that the state of NSW, through the Commissioner of Corrective Services and the Director General of the Department of Corrective Services, be restrained from refusing to permit the plaintiffs and other male prisoners in NSW prisons to possess and use condoms;
- a declaration that the decision not to supply or permit the possession or use of condoms by male prisoners was made in breach of the duty of care owed by the state of NSW to the plaintiffs; and
- an order that the state of NSW supply and permit the possession and use of condoms by the plaintiffs and other male prisoners in NSW prisons.

Counsel for the prisoners argued that it "is no proper part of the punishment of prisoners that their access to preventive means to protect their health is impeded," and said that the case was being brought with the support of "major medical people" in Australia.

In Queensland, the Corrective Services Commission was criticized for its decision to refuse to issue condoms to inmates, while at the same time teaching them how to practice safe sex.2 Prisoners have reportedly been using plastic wrap instead of condoms for protection.

In Canada, condoms are made available to prisoners in the federal and in many provincial prison systems. However, with the exception of some federal institutions and provincial institutions in British Columbia, condoms are nowhere easily and discreetly available; and in provincial prisons in Newfoundland, Nova Scotia, Prince Edward Island and New Brunswick condoms are not made available at all.

- *Ralf Jürgens*

ENDNOTES

1 Reported in the Australian *National HIV/AIDS Legal Link*, Vol. 5, no. 1 (April 1994), Australian Federation of AIDS Organisations.

2 Reported in the [Australian] *National AIDS Bulletin*, Vol. 8, no. 3 (April 1994).

Top of this page

Return to Table of Contents

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

TUBERCULOSIS

TB/HIV Issues Receiving Increased Attention in Canada

TB/HIV and the Law

TB/HIV Issues Receiving Increased Attention in Canada

A *National Workshop on Tuberculosis: HIV and Other Emerging Issues* was held in Toronto on 35 May 1993. The (bilingual) proceedings of the Workshop, which was sponsored by the Health Protection Branch, the Health and Social Programs Branch and the Medical Services Branch of Health Canada, are now available from the Office of Special Health Initiatives, Laboratory Centre for Disease Control, Tunney's Pasture, Ottawa, Ontario K1A 0L2.

The proceedings were prepared from notes for and summaries of the plenary presentations, panel discussions and workshop discussions, and contain sections on: TB/HIV, the global situation; TB in the US; epidemiology of TB in Canada; TB prevention and control; occupational safety and laboratory advances; research priorities; and workshop reports.

In January 1994, the Canadian AIDS Society (CAS) initiated a oneyear national project to raise community awareness of issues related to the dual infection of HIV and TB. The project is funded by the AIDS Care and Treatment Unit of Health Canada. Its objectives include:

- researching and collecting materials on work done on HIV and TB in Canada and other countries;
- developing and implementing educational “train the trainer” workshops for both the HIV and broader healthcare communities;
- developing community positions on public health issues raised by TB and HIV/AIDS; and
- developing guidelines for workplace policies on TB for communitybased groups, including hospices and hostels.

For more information about the project, contact the project coordinator, Elisse Zack, at: Canadian AIDS Society Project on HIV and TB, c/o AIDS Committee of Toronto, Box 55, Station “F”, Toronto, Ontario M4Y 2L4. Tel: (416) 3402437, ext. 233; fax: (416) 3408224.

In March 1994, the Canadian Public Health Association (CPHA) held a TB/HIV Consensus Workshop supported by the AIDS Care and Treatment Unit of Health Canada. Representatives from regional, provincial/territorial and national organizations, as well as community groups, discussed their concerns about the dual infection of TB and HIV. The Workshop issued eleven recommendations that provide a framework for a coordinated strategy for TB/HIV control in Canada. A bilingual *Report of the TB/HIV Consensus Workshop* is now available from the CPHA AIDS Program, National AIDS Clearinghouse, 4001565 Carling Avenue, Ottawa, Ontario K1Z 8R1. Tel: (613) 7253769; fax: (613) 7259826.

The September/October 1994 issue (Vol. VII, no. 6) of *Canadian AIDS News* will deal with issues raised by HIV/AIDS and TB. For free copies of *Canadian AIDS News*, contact The Editor, *Canadian AIDS News*, CPHA AIDS Program, at the above address.

TB/HIV and the Law

US - A Superior Court judge in the US state of Georgia ordered a person living with AIDS to be indefinitely confined to his house because his drugresistant TB could be contagious.1 On 11 April, Judge Dan Cousey refused to overturn a DeKalb County Board of Health petition ordering the person living with AIDS to remain in “respiratory isolation” in his home. The person tested negative three times on the standard tests to determine whether a TB patient is contagious. However, the judge accepted the Board of Health's testimony that the tests were invalid because his TB is drugresistant.

This case provides but one example of the many legal and policy issues raised by the dual epidemic of HIV and TB. According to Bayer et al.,2 it is the tension between voluntary approaches to public health and compulsion that will inform the debate over the central questions posed by TB. These questions include: What are the obligations of the state to develop programs that will identify individuals with TB? When may the state compel an individual to undergo care or face the prospect of isolation? How much effort must be made to encourage patients to undergo treatment until cure before more restrictive measures are adopted?

Future issues of the *Newsletter* will comment on the legal, ethical and policy issues raised by TB.

- *Ralf Jürgens*

Top of this page

Return to Table of Contents

Return to Home Page

ENDNOTES

1 Reported in *AIDS Reference Guide*, May 1994, Atlantic Information Services, Washington, DC.

2 Bayer R. et al. The dual epidemic of tuberculosis and AIDS. *The Journal of Law, Medicine & Ethics* 21:34 (Fall/Winter 1993) at 27778.

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Criminal Justice

Ten Months' Imprisonment for Biting Police Officer
30 Months' Imprisonment for Syringe Attack
HIV+ Man Sentenced to 10 Years for Having Unprotected Sex
Swiss Man Sentenced for Transmitting HIV
Draft Legislation for on HIV Transmission
Sentencing News

Ten Months' Imprisonment for Biting Police Officer

Québec - In a decision rendered on 28 January 1994, Judge LouisMichel Hétu of the Court of Québec in Joliette sentenced an HIVpositive man to 10 months in prison for a charge of aggravated assault against a police officer (file no. 7050133851939, Court of Québec, Joliette).

Richard Taylor, who bit a police officer on 3 June 1993 following his arrest on suspicion of drunk driving, was not found guilty of attempted murder since the Crown could not prove beyond a reasonable doubt that there was intent to kill. But after admitting evidence of a similar act performed in December 1991, Judge Hétu concluded that there was sufficient evidence of the requisite intent for the charge of aggravated assault.

- *Bruno GuillotHurtubise*

---

30 Months' Imprisonment for Syringe Attack

Québec - A woman was sentenced to 30 months in prison on charges of uttering death threats and of aggravated assault after she stabbed another woman with a syringe possibly infected with HIV (file no.

50001475944, Court of Québec, Montréal). Sylvie Trudeau, who is HIVpositive, stabbed Georgette Plouffe after the latter refused to supply her with drugs. It is not known if the victim was infected with the virus. Sylvie Trudeau, who pleaded guilty to the charges laid against her, was sentenced on 26 April 1994 by Judge JeanPierre Bonin of the Court of Québec in Montréal.

- *Bruno GuillotHurtubise*

HIV+ Man Sentenced to 10 Years for Having Unprotected Sex

US - A man who in 1988 was found to be HIVpositive while serving a prison term in New Jersey, USA, was sentenced to 10 years in prison for having unprotected sex with three teenage girls from September 1992 through July 1993, without telling them that he was HIVinfected. Two of the girls, one of whom is pregnant, have been infected with HIV. The man pleaded guilty to charges of sodomy, statutory rape, indecent liberties, and two cases of attempted murder. (*Virginia* v *Webb*, Petersburg Cir. Ct., No. F79693, 5/11/94, reported in *AIDS Policy & Law*, Vol. 9, no. 10 (27 May 1994)).

Swiss Man Sentenced for Transmitting HIV

Switzerland - A man accused of having transmitted HIV has been given a suspended sentence of eighteen months by the Supreme Court of the canton of Aarau. Although he knew since 1985 that he was seropositive, the accused continued to have unprotected sexual relations with a number of women, infecting two of his partners. (reported in the AIDES ÎledeFrance *Bulletin juridique national*, No. 1, September 1994).

Draft Legislation on HIV Transmission

Denmark - Draft legislation on HIV transmission will soon be put forward for adoption by the Danish parliament, where it seems assured of a large majority. According to the bill, a seropositive person who does not warn his or her partner may be sentenced to anything from a fine to four years in prison. The bill was tabled after the Supreme Court of Denmark acquitted + absent an article in the Criminal Code giving grounds for sentencing + a seropositive man who had had unprotected sexual relations with 25 women and who had been sentenced to 18 months in prison without parole by the trial court. (reported in the AIDES ÎledeFrance *Bulletin juridique national*, No. 1, September 1994).

Sentencing News

Québec - An HIVpositive man accused of trafficking cocaine was returned to prison on 23 February 1994 by Judge Dionysia Zerbisias of the Superior Court in Montréal (file no. 70501702946, Superior Court, Montréal). Daniel Mandanici, 36, had obtained a conditional release on 14 February 1994 from Judge Maurice Parent of the Court of Québec. Judge Parent considered that Mandanici's HIVpositive status warranted that he be released from prison until sentencing could take place. Mandanici's release was immediately appealed by the Crown. Zerbisias J was of the opinion that he was not entitled to special treatment because of his medical condition. Mandanici, who pleaded guilty to charges of possession of drugs for the purpose of trafficking, was scheduled for sentencing on 22 September 1994.

- *Bruno GuillotHurtubise*

US - The New Jersey Appellate Division ruled on 11 May in *State* v *E.R.*, 1994 WL 240772, that a trial judge had appropriately granted an amended judgment resentencing a previously sentenced defendant to five years' probation instead of seven years in prison. The defendant had pleaded guilty to criminal charges involving cocaine distribution and the possession of pipe bombs. One month after his prison sentence was rendered, he petitioned for reconsideration based on medical developments. The trial judge decided, based on more detailed medical information than had been available at the original sentencing, that imprisonment would entail “excessive hardship” for the defendant. The Appellate Division noted that the record showed serious illness and repeated hospitalization of the defendant. Dissenting, Judge Brochin argued that New Jersey law did not authorize judges to grant “clemency” in such situations. (reported in *Lesbian/Gay Law Notes*, Summer 1994.)

Top of this page

Return to Table of Contents

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Other Court News

Mother Ordered to Cooperate with Her Child's Physicians

US - The Alabama Court of Civil Appeal ruled on 10 June 1994 that a mother who insisted that her child was not HIVinfected could be ordered to cooperate with physicians in administering AZT to the child (*A. D.H.* v *State Department of Human Resources*, 1994 WL 248155, reported in *Lesbian/Gay Law Notes*, Summer 1994). Despite the physicians' insistence that the child was HIVinfected, and the failure of the child to gain weight, the mother refused to believe that the child was infected. Also, the family expressed concerns about the side effects of treatment with AZT. The Court formulated the issue on appeal as "whether the State may require a mother to submit her minor child to treatment for HIV, when the mother objects to that treatment." The Court stated that it would normally hesitate to overrule a parent's reasoned objection to a particular course of medical treatment for a child. However, it held that "[t]he mother's adamant belief at trial that her child was not infected with HIV leads us to conclude that she was incapable of making a wellreasoned, rational decision regarding treatment that was in the best interest of the child," and affirmed the trial judge's order.

Top of this page

Return to Table of Contents

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Testing

Mandatory Testing for Convicted Rapists in California

US - Under a law signed by California governor Pete Wilson on 1 July 1994, persons convicted of sexual assault will have to undergo mandatory HIV testing. Prosecutors are to refer victims of sexual assault to health professionals to be informed of the test result and receive counselling. The law was passed in response to the case of a man who was convicted of several counts of sexual assault committed in 1991 and 1992, and was subjected to HIV testing in prison. Under California law, persons convicted of sexual assault could be forced to be tested in prison, but the victims of the assault were not entitled to learn the results of the test. However, several of the victims were advised to be tested for antibodies to HIV (reported in *Lesbian/Gay Law Notes*, Summer 1994).

Canadian Human Rights Tribunal Rules on Drug Testing

On 16 August 1994, a Canadian Human Rights Tribunal ruled that the Toronto Dominion Bank's practice of using urine tests to detect drug users is not discriminatory under the *Canadian Human Rights Act* and is therefore not illegal. The Bank's policy had been challenged by the Canadian Civil Liberties Association as denying employment to people with a disability + perceived drug dependence. Under the policy, bank employees must undergo urine testing within 48 hours of accepting a job. Those who test positive do not lose their job, but are offered treatment or rehabilitation at the Bank's expense. Only those who refuse to undergo testing or treatment or who test positive a third time after treatment are dismissed. The Tribunal found that “the ultimate dismissal is not based upon a perceived disability (drug dependence) but upon the persistent use of an illegal substance even though in some instances that may include a drugdependent person.” The Tribunal added that, even if the tests were discriminatory, the Bank still made a reasonable effort to accommodate drugdependent employees by keeping them on the payroll and paying for treatment. It concluded that “[t]o expect the bank to continue beyond this treatment schemeBwould be unreasonable andBwould create undue hardship.”

Despite the outcome, Mr Max Yalden, the Chief Commissioner of the Canadian Human Rights

Commission, called the ruling an “outright condemnation” of mandatory drug testing (as reported by S. Bindman of Southam News, *The [Montreal] Gazette*, 17 August, p. A7). In particular, the Tribunal said that the Bank's policy was based on some “very impressionistic assumptions” about the correlation between drug use and crime, and that there was no evidence that drug testing was necessary to protect other employees or the public. According to the Tribunal, “[i]f mandatory testing were reasonably necessary as a means to assure job performance, employee health or freedom from criminal activity, then surely it would be necessary on a regular basis for all employees, not just once in the career of some employees when they first accept employment.”

On 7 September the Canadian Human Rights Commission announced its intention to appeal the Tribunal's decision. A forthcoming issue of the *Canadian HIV/AIDS Policy & Law Newsletter* will feature a detailed commentary on this important case.

- *Ralf Jürgens*

Top of this page

Return to Table of Contents

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Blood and Blood Products

First Canadian Ruling in a Tainted Blood Case

Pittman v *The Canadian Red Cross Society*

In the first Canadian ruling in a "tainted blood" case,1 **the Ontario Court of Justice awarded the estate of a man who died of complications from AIDS, his widow and four children the sum of $515,075 in compensation for the tainted blood received by the deceased in 1984.**

Kenneth Pittman received a blood transfusion in November 1984 while undergoing cardiac surgery at the Toronto Hospital. The donor's blood had not been tested for HIV. In November 1985, the Canadian Red Cross Society tested a subsequent blood donation from the same donor and learned that it was infected with HIV. In June 1987, the Red Cross traced the potentially infected 1984 donation to the Toronto Hospital.

It was only in February 1989 that the Hospital, which by then had established an operational traceback procedure, traced the 1984 donation to the transfusion received by Mr Pittman. In April 1989, the Hospital contacted Mr Pittman's family physician, Dr Stanley T. Bain, and informed him that his patient might have been infected with HIV. In light of Mr Pittman's heart condition and Dr Bain's belief that Mr Pittman was not engaging in sexual relations with his wife, Dr Bain never informed him of the potential infection.

Mr Pittman died of AIDSrelated pneumonia in March 1990, never knowing that he had been infected with HIV, a fact that was only confirmed by a postmortem investigation. In September 1990, Ms Pittman learned that she had been infected by her husband. Expert testimony indicated that she had most probably been infected in late 1989, or after Dr Bain had been informed by the Toronto Hospital of the potential infection.

Rochelle Pittman filed two claims totalling $2 million against the Canadian Red Cross Society, the Toronto Hospital and Dr Bain. One suit was on behalf of the estate of her deceased husband, and the

other for herself and the couple's four adult children. The two suits were heard in one trial, presided by Judge Susan Lang.

The Pittman family alleged that the Red Cross fell below the appropriate standard of care in failing to adequately screen blood donors and in failing to test donated blood for possible infection. They further alleged that the Hospital, on the basis of an implied contractual warranty, was liable for the provision of the tainted blood. Both defendants were also sued for negligence for failing to implement, in a timely manner, a program to trace potential recipients of tainted blood donations. With respect to Dr Bain, the Pittmans alleged that he fell below the requisite standard of care in deciding to withhold information concerning the potentially infected donation.

In her decision of 14 March 1994, Lang J emphasized that her findings were based solely on the particular facts of the case. She ruled that the Red Cross had not been negligent in collecting the infected blood in November 1984. Examining the methods and standards of that period, Lang J concluded that the Red Cross met the standard of care to which they could be held at that time. She stated:

The importance of avoiding hindsight is critical in this case, which involves not only conflicting medical theories and practices, but also changing levels of knowledge and understanding of both rapid and controversial developments in medical and scientific knowledge. The procedures of the Red Cross should be reviewed and judged according to the state of knowledge as it prevailed at the relevant time and not at some later date when such knowledge has increased, advanced and developed.

She also concluded that the plaintiffs had failed to establish that the hospital was liable under a common law implied warranty of fitness.

However, Lang J did find both the Red Cross and the Hospital negligent in their failure to notify the deceased more rapidly of the potentially tainted transfusion. Had Mr Pittman been informed and tested, he could possibly have survived two more years by benefiting from treatment. Furthermore, had he been informed of his status, he could have notified his wife and taken precautions to avoid her becoming infected.

Lang J also found Dr Bain's conduct negligent in two respects: first, his failure to verify that Mr Pittman's heart condition precluded him from receiving bad news and, second, his failure to verify that Mr Pittman was not engaging in any sexual activity with his wife. Dr Bain also failed to monitor the health of his patient carefully in the final months of his life, when he knew that he could well have been infected with HIV. On these findings, Lang J split liability on the basis of 40 percent to Dr Bain and 30 percent each to the Red Cross and the Toronto Hospital.

The estate of Mr Pittman was awarded $8,000 as compensation for his pain and suffering. Ms Pittman was awarded $461,318 and her children the sum of $45,759 collectively.

The office of Mr Kenneth Arenson, lawyer for the Pittman family, confirmed in midAugust 1994 that

the judgment had not been appealed by any of the parties involved.

- *Bruno GuillotHurtubise*

Top of this page

Return to Table of Contents

Return to Home Page

ENDNOTE

1 Ont. Ct., nos. 21487/91U, 21488/91U, 3/1/94; [1994] O.J. No. 463.

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Discrimination

Sexual Orientation a Prohibited Ground of Discrimination in Alberta

Vriend* v *Alberta (Attorney General)

In a case decided on 12 April 1994,1 **Russell J of the Alberta Court of Queen's Bench ruled that "sexual orientation" be read in as a prohibited ground of discrimination under Alberta's *Individual's Rights Protection Act*.**

In doing so, Russell J relied heavily on the reasoning of Krever J.A. in *Haig & Birch* v *Canada (Attorney General)* (1992), 9 O.R. (3d) 495 (C.A.), the case that construed the *Canadian Human Rights Act* as including "sexual orientation" as a prohibited ground of discrimination. In both cases, the courts accepted the applicant's argument that the exclusion of sexual orientation as a prohibited ground of discrimination constituted an unjustified breach of the *Canadian Charter of Rights and Freedoms'* section 15(1) guarantee of equality.

In 1991, Vriend was dismissed from his position at King's College in Edmonton after he admitted to a superior that he was gay. The sole reason given for his termination was his noncompliance with the policy of the College with respect to homosexuality. The Alberta Human Rights Commission advised Vriend that it could not accept his complaint against his former employer because sexual orientation was not a prohibited ground of discrimination.

Russell J began by taking judicial notice of discrimination against homosexuals, characterizing such discrimination as "an historical, universal, notorious, and indisputable social reality... the subject of much judicial and social comment, and... the subject of provincial legislation elsewhere in Canada." He then addressed the issue of whether the omission of sexual orientation under the *Individual's Rights Protection Act* violated section 15(1) of the *Charter*. In *Vriend*, the Attorney General of Alberta refused to concede that sexual orientation was an analogous ground of protection from discrimination under section 15(1), thus departing from the established practice of other attorneys general in *Haig & Birch*, supra, *Egan* v *Canada (Attorney General)* (1993), 103 D.L.R. (4th) 336 (F.C.A.), and *Brown* v *British Columbia (Minister of Health)* (1990), 66 D.L.R. (4th) 444.

Applying the reasoning in *Andrews* v *Law Society of British Columbia*, [1989] 1 S.C.R. 143, Russell J was of the view that not including sexual orientation as a prohibited ground of discrimination was discriminatory within the meaning of section 15(1) of the *Charter*. She found that, "[r]egardless of whether there was any intent to discriminate, the effect of the decision to deny homosexuals recognition under the legislation is to reinforce negative stereotyping and prejudice thereby perpetuating and implicitly condoning its occurrence." The omission of sexual orientation under the *Individual's Rights Protection Act* could not be saved under section 1 of the *Charter* since, under the first part of the *Oakes* test, there was no evidence of a legislative purpose of pressing and substantial concern justifying the limitation. In fact, the exclusion of sexual orientation was found to be inconsistent with the statement of principle of the legislation itself, which recognizes the "inherent dignity and the equal and inalienable rights of all persons."

Following the reasoning in *Haig & Birch*, Russell J determined that reading "sexual orientation" into the *Act* was the appropriate remedy in the circumstances. Addressing the issue of judicial concern for legislative intent, it was assumed that the legislature would have preferred a statute that included sexual orientation to no statute at all. Further, the budgetary impact associated with such an addition was found to be not so significant as to change the nature of the scheme of the legislation. The Crown had argued that reading in "sexual orientation" would substantially conflict with the legislative intent, given that successive Alberta governments had been opposed to amending the *Act* in order to prohibit discrimination against lesbians and gays. Russell J dismissed this objection out of hand, stating that "[i]f evidence of Government support were required before the court could read in a provision in underinclusive legislation, the remedy would seldom be available or necessary."

The decision in *Vriend* has been appealed; if it is upheld, only three Canadian jurisdictions remain that do not afford lesbians and gays legal protection against discrimination: Newfoundland, the Northwest Territories and Prince Edward Island.

- *Glenn Betteridge*

Top of this page

Return to Table of Contents

Return to Home Page

ENDNOTE

1 12 April 1994, no. 9203/04252, Alberta Queen's Bench, Edmonton, unreported.

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Immigration

Recent Developments in Immigration Law

Reform Party MP Art Hanger will introduce a private member's bill before Parliament on 23 September. The bill would require all prospective immigrants to be tested for HIV infection and excluded if the test is positive. While this is unlikely to become law, new medical inadmissibility regulations with important implications for prospective immigrants with HIV infection or AIDS are being developed by the Department of Immigration to implement new provisions under the *Act to amend the Immigration Act*.

On 14 August 1993, draft amendments to the Regulations were published for public comment in the *Canada Gazette, Part I*. These regulations have not yet become law; the old regulations therefore still apply. Under the current regulations, people with AIDS or HIV infection must be excluded if, in the opinion of the Designated Medical Officer, their admission would place “excessive demands” on health and social services.1

The draft regulations propose to define the notion of “excessive demands” more precisely, to respond to criticisms of the vagueness of the present system. According to the regulatory impact analysis statement [*Canada Gazette*, Part I, Vol. 127, no.33, p. 2561], Designated Medical Officers “must bear in mind that excessive demands are caused when the total costs of health and any required prescribed social services, in the five years immediately following assessment, exceed by more than five times the average per capita expenditures for health and social services in Canada.”

At present, the Department is working on developing a costing methodology and on an overhaul of testing requirements for the routine medical examination required of all prospective immigrants. These new requirements are likely to be announced by the Minister, Sergio Marchi, in the fall.

How might the new system apply to prospective immigrants with HIV infection or AIDS? It is unlikely that the Department will require mandatory blood tests of all prospective immigrants, as in Australia and the United States. (It should be noted that, at present, the Designated Medical Officer may require any immigration candidate to take an HIV test. If the candidate refuses, he or she will be excluded from Canada.) However, people who show clinical manifestations of AIDSrelated conditions will be

excluded. In theory at least, the same is not true of candidates who are found, by whatever means, to be HIVpositive, since the fiveyear window in the proposed “excessive demands” test could allow a person recently infected to enter Canada.

Obviously, however, these developments raise many questions. First, many HIVpositive people would in practice find it difficult, if not impossible, to show that they were recently infected, particularly if they come from a country where medical recordkeeping is less developed than it is in Canada. Second, should the decision whether or not to allow someone with AIDS or HIV infection to immigrate to Canada be determined entirely by financial considerations, or should humanitarian concerns such as family reunification be taken into greater account? How will the regulations be applied where an HIVpositive person has tuberculosis? On what basis will the Department determine whether or not a person is likely to remain healthy for five years? How will the Department try to ensure that the proposed regulations, which may appear more equitable and transparent on paper than the current regulations, will be applied in a nondiscriminatory manner when enacted? These and other questions raised will be addressed in future issues of the *Newsletter*.

[Editors' Note: On 23 September, shortly before this issue went to press, the Canadian AIDS Society reported that progress had been made on the issue of shortterm visitors with HIV entering Canada. The *Newsletter* will report on this in its next issue.]

- *Sarah Wilson*

ENDNOTE

1 See section 22 of the Regulations made under section 19(1)(a)(ii) of the *Immigration Act*.

HIV+ Swimmer Faced Deportation

US - Shaun Mellors, an HIVpositive swimmer from Cape Town, South Africa, decided to attend Gay Games IV in New York City without applying for the special waiver from the ban on HIVpositive visitors announced by US Attorney General Reno in May. He told US Embassy officials that he had tested negative for HIV, and he was admitted to the US. Once in New York, he announced that he was HIVpositive. According to a report in the *Washington Post* of 22 June 1994 (p. C2), an Immigration Service spokesperson told reporters that Mellors faced deportation because he obtained his visa fraudulently, but she stated that she did not know what action would be taken in light of the short duration of the Games.

The following paragraph, cited from the February 1994 list of “Known HIVRelated Entry Restrictions

Introduced by Other Countries" issued by the British Foreign and Commonwealth Office, briefly summarizes the US policy visàvis HIVpositive people seeking to enter the US:

Applicants for immigrant visas, refugees and aliens already in the US seeking permanent residence status, who are found, in the qualifying medical examination, to have AIDS or to be HIV positive, will not be granted permanent residence. Although there is no compulsory screening of applicants for nonimmigrant visas, those discovered to be HIV positive will be refused admission. Those planning to attend conferences, receive medical treatment, visit relatives or visit on business may apply for a waiver allowing them to enter the United States. Tourism is not counted as grounds for the granting of a waiver, except in exceptional circumstances (eg children, haemophiliacs).

- *Ralf Jürgens*

Top of this page

Return to Table of Contents

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Canadian News

Ontario Public Health Powers under Review
The Federal Interdepartmental Committee on Human Rights and AIDS
Legal Advocacy and Policy Development at CAS
Law Students Provide Legal Services
Universities Offer Courses on AIDS

Ontario Public Health Powers under Review

The AIDS Committee of the Canadian Bar Association + Ontario (CBAO) is an ad hoc committee that was struck by the Executive Committee of the CBAO to consider legal reform in relation to a very specific issue: the need to designate AIDS as a “virulent” disease under Ontario's public health legislation, the *Health Protection and Promotion Act* (HPPA).

The HPPA provides for the categorization of transmissible diseases (including, for example, foodborne illnesses and sexually transmitted diseases) as “communicable,” “reportable” and “virulent.” With the exception of smallpox, all diseases designated as “virulent” diseases are also designated as “communicable” and “reportable.” The significance of their additional designation as “virulent” is that medical officers of health are extended a wider range of coercive powers by the HPPA with which to respond to a risk of transmission from one person to another.

Under the HPPA, AIDS is currently designated as a “communicable” and “reportable” but not “virulent” disease. The issue of its redesignation came before the CBAO for discussion as a result of a well-publicized case in which one man was identified by Ontario public health authorities as having transmitted HIV to at least three women during unprotected sexual intercourse despite counselling provided to him regarding his HIV status and the necessity of adopting safer sexual practices. The Chief Medical Officer of Health of Ontario made a public call for the redesignation of AIDS as a virulent disease so that greater powers would be available to public health authorities to address situations in

which individuals with HIV are identified as either unwilling or unable to comply with recommendations that they take precautions to minimize the risk of HIV transmission to others. In support of his position, the Chief Medical Officer of Health relied upon a recommendation contained in an earlier CBAO report, Committee to Study the Legal Implications of Acquired Immunodeficiency Syndrome (AIDS), released by the CBAO on 25 April 1986.

Membership of the CBAO AIDS Committee included authors of the 1986 report, as well as a number of new members with relevant legal expertise and community experience.

During its deliberations, the Committee sought and obtained submissions from representatives of the following:

- the medical and scientific community, to provide current information about the causes of AIDS, its routes of transmission, epidemiological trends, modes of treatment and prognosis;
- the traditional community of public health-care providers, including medical officers of health and public health nurses from across Ontario, to provide the Committee with their perceptions of the nature of the identified problem and the measures that should be considered to address the problem;
- community-based organizations providing counselling, resources and other services to people with HIV disease and people at high risk of HIV infection, to provide the Committee with their perceptions of the nature of the problem and the measures that should be considered to address the problem (the Committee expected these to differ from the perceptions and proposals of the traditional community of public health-care providers);
- legal academics from Canada and from the United States with an interest in public health issues raised by HIV disease, to provide the Committee with their insights into the appropriate role and direction of legal reform in this area; and
- public health-care providers and representatives and advocates of community-based organizations from US jurisdictions with high rates of HIV infection, to provide the Committee with their insights into how this concern had been addressed (if at all) in these other jurisdictions.

In addition to receiving the submissions mentioned above, members of the Committee prepared their own analyses of those areas of the law related to this debate. These analyses will serve as background papers to the recommendations contained in the Committee's final report.

The Committee anticipates release of its final report in the fall of this year, following submission of the report to the Executive and Council of the CBAO [Editors' Note: *Canadian HIV/AIDS Policy & Law Newsletter* will provide a summary and analysis of the final report in a forthcoming issue]. Release of the report will be timely, as the Ontario Advisory Committee on HIV/AIDS (which serves in an advisory capacity to the Ontario Ministry of Health) is currently considering the same issue with a view to making recommendations to the Minister of Health.

- *Lori Stoltz*

The Federal Interdepartmental Committee on Human Rights and AIDS

As part of Phase II of the National Strategy on AIDS announced in March 1993, and following a recommendation made by the National Advisory Committee on AIDS, Justice Canada and Health Canada agreed in the summer of 1993 to establish an Interdepartmental Committee on Human Rights and AIDS. The Department of Justice chairs the Committee, with the centre of responsibility being the Public Law Sector, Human Rights Law Section. The AIDS Secretariat at Health Canada also plays an important role in helping to set the agenda of the Committee.

The Committee draws on the expertise of all federal departments with an interest in how public health policy relating to HIV/AIDS and human rights develops. At present, the Committee includes representatives from the following departments: Justice, Health, Canadian Heritage, Human Resources Development, Citizen-ship and Immigration, Solicitor General, Status of Women, National Defence, Treasury Board, Privy Council Office, and Foreign Affairs.

The Committee studies complex human rights issues relating to HIV/AIDS on the basis of government priorities. To date it has examined and helped revise the Treasury Board policy on HIV/AIDS in the workplace and has examined the question of HIV-antibody testing of persons accused or convicted of sexual assault. It is now further studying the human rights issues relating to the use of criminal law to deal with HIV/AIDS-related behaviours. The results of these studies may be used by interested departments in the development of government policy. The studies by the Committee are advisory only, do not represent the views of the government, and are not intended for general publication.

- *Oonagh Fitzgerald*

Legal Advocacy and Policy Development at CAS

The Canadian AIDS Society (CAS) is a national coalition of more than 100 community-based AIDS organizations across Canada. Its role is to speak as a national voice and to act as a national forum for a community-based response to HIV infection and AIDS. CAS also acts as an advocate for people affected by HIV/AIDS and as a resource on HIV/AIDS issues for its member organizations, and coordinates community-based participation in a national strategy to combat HIV and AIDS.

One of the ways in which CAS carries out its national role is through legal advocacy and policy development. Over the past year this work has taken some new and important directions.

In February, CAS joined with the Canadian Disability Rights Council and the Council of Canadians with

Disabilities to intervene in the appeal of *Thwaites* v *Canadian Armed Forces*. This was the first time that CAS has participated as an intervener in a legal proceeding. Working as part of a coalition of interveners also helped CAS develop a strong, collaborative relationship with other disability rights organizations.

In November, CAS will intervene in another legal case, along with the Coalition for Lesbian and Gay Rights in Ontario (CLGRO) and Justice for Children and Youth (JCY). *R.* v *Carmen M.* involves section 159 of the *Criminal Code* and the different ages of consent for various kinds of sexual activity. CAS, CLGRO and JCY will support the respondent's position that the different ages of consent constitute discrimination on the basis of age, marital status and sexual orientation. CAS will also argue that the higher age of consent for anal sex is an obstacle to effective AIDS prevention education targeted at gay youth.

On the policy front, CAS released a discussion paper on euthanasia and assisted suicide at the beginning of July. This paper documents the results of a survey among CAS member groups. Most of the respondents, and all of the people living with HIV/AIDS who participated, supported legal changes to permit assisted suicide. Most, however, also thought that safeguards need to be incorporated into any new law. The paper was presented to the Special Senate Committee on Euthanasia and Assisted Suicide on 5 July.

More policy papers and discussion documents are in preparation. Topics include mandatory testing of sexual offenders and mandatory HIV screening for new immigrants. Also, watch for news about CAS' Legal Issues Committee. Calls for nomination to this newly created advisory committee should be ready in September 1994.

- *Russell Armstrong*

Law Students Provide Legal Services

In Vancouver, the Law Students Legal Aid Program (LSLAP) will be offering a wide range of legal services at the British Columbia Persons with AIDS Society (BCPWA). Under the supervision of a practising lawyer, law students will draft wills, living wills, and health-care directives. LSLAP will also assist with landlord+tenant disputes, small claims, criminal matters and general legal advice. Appointments can be made by calling the BCPWA at (604) 681-2122. (reported in *BCPWA News*, No. 79, August/September 1994).

Universities Offer Courses on AIDS

A course on AIDS and the Law will be offered again during the 1994-95 winter term at the Faculty of Law of McGill University. The course, which was offered for the first time during the 1993-94 winter term, is the first course at a Canadian university focusing exclusively on the legal, social and ethical

issues raised by AIDS. Another course, a multidisciplinary undergraduate course on the social, cultural and scientific aspects of HIV/AIDS, will be offered at Montréal's Concordia University in 1995. In the United States, a growing number of universities are also offering courses on legal and social issues raised by AIDS.

Top of this page

Return to Table of Contents

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Development Issues

AIDS, Denial and Development: ICAD's Response to the Global Epidemic

Established in 1989, the Interagency Coalition on AIDS and Development (ICAD) is a network of Canadian organizations concerned about AIDS and development issues. ICAD's membership includes international development agencies, AIDS service organizations, and communitybased organizations. While there are counterparts in the United Kingdom, the Netherlands and Australia, ICAD is the only coalition of its kind in North or South America.

ICAD's mission is to educate its constituency about AIDS and development issues, to promote the adoption of policies by domestic and international stakeholders, and to ensure a greater and more appropriate response to AIDS in the developing world.

The need for Canadian organizations to respond to the international AIDS crisis cannot be overstated. Canadians are familiar with the devastating emotional, health, social and economic consequences of AIDS in Western countries, but may be unaware of the much greater suffering in developing countries. Unequal distribution of health care, severe poverty, the subordination of women, civil wars, famine, human rights abuses and unscreened blood supplies are just some of the realities facing the poorest countries; each is a daunting obstacle even *without* the complicating factor of AIDS.

AIDS is now an additional cause of underdevelopment in countries struggling with these myriad problems: it kills adults in their most productive years; decreases school attendance; overburdens individual, family and community support systems; overtaxes inadequate health care; reduces the availability of labour; and lowers the productivity of many sectors, including agriculture, transportation and mining.

Statistically, the situation is bleak:

- the largest numbers of HIVinfected people are in subSaharan Africa, where 12 million individuals are infected, half of them women;
- in Asia (which was thought by many to be “immune” to AIDS just a few years ago), an estimated

3.7 million are now HIVpositive, while India and Thailand have the fastestgrowing epidemics in the world;
- cumulatively, 19.5 million people are infected with HIV, 89 percent of them in developing countries;
- Western countries spend 93 percent of the funds allocated worldwide to AIDS prevention and care.1

The Canadian Public Health Association's Southern Africa AIDS Training Program, a $9 million project, helps strengthen local organizations so that they can better serve communities vulnerable to HIV and AIDS in nine southern African countries. World Vision Canada has contributed $2.7 million to AIDS programming in Uganda and has programs in Tanzania, Ethiopia and Thailand.

CUSO has developed a progressive and comprehensive AIDS in the Workplace Policy for its Canadian and overseas employees and cooperants (volunteers) and has placed an AIDS educator cooperant in South Africa. Oxfam Canada has supported the South African AIDS prevention group, Puppets Against AIDS. It has also established a partnership between a Namibian AIDS organization and AIDS Vancouver Island to develop educational workshops and kits. Many other Canadian development agencies have also launched programs.

Important as these initiatives are, Canadian development agencies' AIDS programming just begins to address the problem. One could draw a parallel and say that the response of Western countries today to AIDS as a *global* issue is comparable to the insignificant response of the United States, Canada and European countries to AIDS in the early 1980s as a *domestic* issue. For example, in Canada, which funds most of the world's international development work, the federal government's Canadian International Development Agency (CIDA) has not increased AIDS funding since 1991 and eliminated its AIDS specialist position in 1993.

In light of the severity of the problems, why is the response inadequate? *Denial* is of course one explanation. Denial has touched every aspect of the struggle against AIDS since the beginning of the epidemic, and has often seemed as strong as the virus itself. Unfortunately, the international development arena is just as guilty of denial as other sectors. Considering the multitude of problems in the developing world, denial is a defence against admitting that there is yet another formidable crisis to confront. One of the greatest challenges facing ICAD is overcoming denial within governments and development and funding agencies.

Another explanation lies in *the limited resources available to Canadian development agencies*. Because of decreasing government support, combined with the need to raise funds in an increasingly competitive and economically weak environment, development agencies already face cutbacks and closures in existing programs.

Canada has been a leader in the provision of development assistance to many countries. Given the enormity of the AIDS crisis in the developing world, Canada must step up its efforts through increased

funding and programming. To reach this goal, the Interagency Coalition on AIDS and Development is redoubling its efforts to confront the ravages of AIDS in developing countries and to overcome ignorance and denial at home.

For more information, write to the Interagency Coalition on AIDS and Development, 100 Argyle Street, Ottawa, Ontario K2P 1B4, or call Áine Costigan, Coordinator of ICAD, at (613) 7885107 (fax: (613) 7885052).

- *Daniel J Peiser*

Top of this page

Return to Table of Contents

Return to Home Page

ENDNOTE

1 Data from J.M. Mann, D.J.M. Tarantola, T.W. Netter (eds.). *AIDS in the World*. Cambridge: Harvard University Press, 1992.

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

International News

United Nations Focus on Ethics, Law and HIV

In an attempt to widen the dialogue on AIDS law and policy, the United Nations Development Programme (UNDP) is initiating a series of national legal networks on ethics, law and HIV in developing countries. The networks comprise legal professionals, workers in nongovernmental AIDS service organizations, government policy advisers, people living with HIV/AIDS and others seeking to influence HIV/AIDS public policy.

The first meeting of the representatives of networks in the Asia and Pacific region was held in Cebu, the Philippines, in May 1993. The proceedings of this meeting have been published and are available from the UNDP. A similar consultation for the subSaharan region was held in Dakar, Senegal, in June 1994. A planning meeting to establish networks in Latin America and the Caribbean is to be held in Caracas, Venezuela, in October 1994.

Although the nature of each national network will vary according to local conditions, all are characterized by the desire to marry the expertise of legal professionals with the experience of people living with HIV/AIDS and those working closely with them. There is a twoway flow of information. In one respect, advocates, legal academics and the judiciary learn not only basic epidemiology, but also come to wrestle with specific social and cultural factors that must inform appropriate legal and policy reforms. In another, people living with HIV/AIDS and those working in nongovernmental AIDS, women's rights, development and human rights organizations learn more of the legal process and of ways in which abuses of rights can be addressed. Everyone benefits from the ensuing ethical, legal and human rights input into HIV/AIDS policy formulation and from legal advocacy.

None of us will see the end of the devastation caused by the HIV/AIDS pandemic. The response to date of even the most educated and those most in a position to bring about change has seemed painfully slow. Yet momentum is developing, and the necessary infrastructures are being established. National and regional networks on law, ethics, human rights and HIV/AIDS reflect this momentum and are an important part of the response.

For more information, and for details of regional offices, contact the United Nations Development Programme, HIV and Development Programme, 304 East 45th Street, New York, NY 10017. Tel: (212) 906 6978; fax: (212) 906 6336.

- *David Patterson*

Top of this page

Return to Table of Contents

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 1 Number 1 - Fall 1994

Upcoming Events

8th Annual British Columbia HIV/AIDS Conference: "Focus on Youth" (Vancouver, 68 November 1994)

The Division of Interprofessional Continuing Education at the University of British Columbia hosts a major conference on AIDS for healthcare professionals each fall in Vancouver. This event brings together resource people from across North America to exchange the latest information on the spread of AIDS, its prevention, counselling and treatment for people with AIDS, those at risk for AIDS and their families. Although the focus of the conference is not on legal issues, many of the workshops will address legal, ethical and policy issues raised by HIV/AIDS.

The British Columbia HIV/AIDS Conference: A Historical Note

Once upon a time, a long time ago (1986), when we still thought that the heterosexual spread of HIV could only happen in Africa because of special circumstances there and terrible cofactors, a wellknown and dedicated hematologist, Dr Hillary Waas, of St. Paul's Hospital, the University of British Columbia Division of Continuing Medical Education, and Dr Michael Rekart, representing the British Columbia Ministry of Health, collaborated to put on the first BC AIDS Conference in November 1987. I was asked to join in order to foster the image of an interdisciplinary approach. The Department of National Health and Welfare and the BC Ministry of Health were generous in their financial support.

Our first conference was held in an atmosphere of tension (how many people would come?) and anxiety (how would we handle the press, which we perceived to be largely hostile and sensationalist?). In fact 700 people came, from all over Canada and the United States and even from Europe. As members of the planning committee, we were thrilled. (We had actually had the audacity to bill the first few conferences as "international.") We locked the press out of conference sessions because we felt we needed a safe place for participants to discuss difficult issues. A lot of energy went into questions about transmission + *no, mosquitoes do not transmit the virus*. How well I remember a Swedish physician raising a question from the floor, imploring us to think of our adolescents and their high rates of chlamydia. *They are vulnerable to HIV*, he pleaded. But the audience was not convinced and grew restless as he tried harder and harder to have his point heard.

In those days we relied on our San Francisco colleagues to provide clinical leadership for the plenary sessions. Our audiences loved Dr Constance Wolfsy and Dr Don Abrams, and have since complained about their absence. However, leaders in the Canadian world have made important contributions to the conference: Dr David Roy, Dr Peter JepsonYoung, Dr Catherine Hankins and Dr Michel Morissette, to name a few.

In recent years the planning committee has become truly multidisciplinary, with the full participation and support of the community: the CoChair, Rick Marchand, is also Executive Director of AIDS Vancouver.

In 1994 the Conference very nearly did not take place. When the provincial AIDS Secretariat received $7.3 million in requests and had $1.75 million to distribute, tensions rose and the communitybased AIDS coalition decided to boycott both the BC AIDS Conference and the 1996 International meeting. After direct dialogue with the premier's office and visible movement on the subject of an AIDS strategy for the province, the boycott of the BC Conference was lifted.

This year we are offering 10 concurrent sessions, probably the maximum for a conference that typically attracts from 350 to 500 people. The sessions range from primary care to issues in prisons, harm reduction, safe hot sex for adolescents, palliative care, and the reality of euthanasia. The planning committee no longer pretends that it knows the field, and relies on a call for abstracts and on experts to orchestrate the concurrent sessions on prisons and harm reduction. The need to provide more in less time, and to provide AIDS 101 to targeted audiences, has lead us to establish Saturday Satellites. This year there are three: an introduction to AIDS and issues in nursing care, an intermediatelevel satellite for those involved in counselling, and a communitybased workshop sponsored by AIDS Vancouver for those interested in training for advocacy roles.

The planning committee, with financial assistance from Health Canada, AIDS Care and Treatment Unit, is consciously striving to turn this meeting into the national conference on prevention and care. What could be more appropriate for a city that has the highest incidence of AIDS in Canada?

For further information, please contact Continuing Education in the Health Sciences, University of British Columbia. Tel: (604) 8222626 (in BC 18006630348); fax: (604) 8224835.

- *Irene Goldstone*

Top of this page

Return to Table of Contents

Return to Home Page
