# Canadian HIV/AIDS Policy & Law Newsletter

## Volume 1 Number 2 - January 1995

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# Bill C-7: Implications for HIV/AIDS Prevention

**Existing Canadian drug legislation is irrational, confusing, and contains very severe penalties for drug possession and other drug offences. Bill C-7, introduced in February 1994 to reform that legislation, promises to exacerbate the irrationality, add to the confusion, and increase the severity of penalties in a number of cases. If the Bill is passed, the result will be continued misdirection of resources, continued emphasis on criminalization of drug users, and the unnecessary infection with HIV, and death, of many Canadians.**

Bill C-7, the Controlled Drugs and Substances Act, was first introduced in February 1994 by the Liberal government. The Bill very closely resembles Bill C-85, introduced by the Conservative government in June 1992 and at the time harshly criticized by the Liberals. Bill C-85 died with the Conservative government, but the Liberals resurrected it within months of coming to power. Bill C-7 is technically a "health" bill, tabled in the House of Commons by the Minister of Health. However, its punitive focus suggests that as a practical matter it is criminal law, normally a responsibility of the Minister of Justice. Following second reading in the House, Bill C-7 was referred for review to a subcommittee of the Standing Committee on Health. Hearings began in May 1994 and continued into June. As of January 1995, the Bill had not been passed, but its passage was expected soon.

Bill C-7 consolidates much of the existing drug legislation now set out in the *Narcotic Control Act* and the *Food and Drugs Act*. It repeals the *Narcotic Control Act* and parts of the *Food and Drugs Act*, creates a number of new drug offences, and extends the range of the law to include any drug with a "stimulant, depressant or hallucinogenic effect." It also adds new powers of search and seizure.

## Comments on Bill C-7

Members of Parliament who support Bill C-7 emphasize that it is not a policy document but simply a "housekeeping" bill directed exclusively at consolidating existing drug laws and bringing Canadian legislation into line with international drug treaties. However, although the Bill's preamble states that one purpose of the legislation is to meet Canada's obligations under international drug treaties, it can be argued that our international obligations do not require us to enact Bill C-7 or anything similar.1 It has also been suggested that Canada should first see to its own domestic needs, rather than give international drug treaties priority.2 Ironically, while claiming the need for compliance with international treaties, the Bill does not consider alternatives to conviction or punishment that are set out in these treaties.

The Bill should be recognized for what it is - a statement of drug policy, and bad policy at that. At the Health subcommittee hearings into Bill C-7, the vast majority of witnesses criticized the bill severely, and some even called for its complete withdrawal. Organizations expressing concern included the Canadian Bar Association, the Canadian Medical Association, the Canadian Police Association, the Canadian Centre on Substance Abuse, the Addiction Research Foundation and the Canadian Foundation for Drug Policy.

One much-criticized feature of the Bill is that it increases the maximum fine for cannabis possession and maintains the current seven-year maximum jail sentence for possession at a time when other countries are reducing or eliminating penalties for such possession. As with the current drug laws, the majority of people affected by the new legislation will likely be those caught for possession of small amounts of cannabis. More than 500,000 Canadians have criminal records for possession of cannabis. Because Bill C-7 creates new offences for possession of drugs the possession of which is not prohibited under current legislation (amphetamines, khat and hallucinogens), it will ensure that even more Canadians - primarily young Canadians - will be burdened with a criminal record.

Several critics have also pointed out that drugs are not scheduled rationally in the Bill; there is no relationship between the harms posed by drugs and the punishment. For example, cocaine is listed in Schedule I with drugs such as marijuana, whereas it should more properly be listed in Schedule II along with amphetamines, since their effects are almost identical. If it insists on proceeding with punitive drug legislation, the government should consult experts in pharmacology, law enforcement, epidemiology and other relevant areas when devising schedules.

The Bill has also been criticized because it preserves sweeping police powers of arrest, search and seizure. Some critics argue that, by unnecessarily increasing the powers of the state, the Bill seriously threatens fundamental human rights; they argue further that, under the guise of complying with international drug-control conventions, Canada will violate international human rights conventions and its own constitutional protections.

More importantly, rather than contributing to stop or at least reduce drug use, Bill C-7 promises to make drug use more dangerous, and would lead to more people being killed by adulterated drugs, by drugs of unknown potency or by conditions that promote the spread of HIV infection among drug users. The Bill will do nothing to address the multiple underlying causes of drug use or to help those who have become dependent on drugs. Rather, it will turn them into criminals, and sometimes force them to commit crimes to maintain their habits. The Bill thus betrays the vain belief that simple repression can solve a problem with complex roots. In addition, serious harms will result from the indirect effects of the Bill: because it explicitly exempts tobacco and alcohol, the Bill distracts attention from the much more serious harms associated with licit substances than with illicit ones.

## Bill C-7, drug policy and HIV/AIDS

There can be no question that drug and other social policies around the world have been catalytic in the spread of HIV and other drug-related harms.3 Current Canadian drug laws are contributing to the deaths of thousands of people through the preventable spread of HIV and other infections such as hepatitis and TB. One of the major criticisms of Bill C-7 is that it would continue and actually exacerbate these harms, for the following reasons:

Laws prohibiting drugs have encouraged users to ingest certain drugs (eg, cocaine, heroine) in more efficient ways, often by injecting. Injecting with contaminated equipment greatly increases the risk of HIV infection and other bloodborne infections.

Our drug laws have created a culture of marginalized people, driving them away from traditional social support networks such as non-using family members, friends and co-workers. Users may share syringes out of a sense of solidarity. It is difficult to reach marginalized communities with educational messages about safe drug-use practices or drug treatment.

Our drug laws have fostered a reluctance to educate both users and non-users about safe drug-use practices, for fear of condoning or encouraging the use of illegal drugs.

Our drug laws and the attitudes they have fostered toward Canadian citizens who use drugs have sometimes generated strong opposition to life-saving needle-exchange programs and other harm-reduction programs.

The highly inflated price of illegal drugs has forced some men, women and young people into high-risk forms of sex to pay for their habits. Condoms are not always used in these transactions, sometimes because clients offer more money for unprotected sex. This increases the risk of HIV infection for drug users, their clients, and unsuspecting contacts of both.

Drug users who fear being arrested for possession of illegal drugs, and fear having their syringes used as evidence against them, may forego using their own drugs and syringes. Instead, they may go to “shooting galleries” where they may be given syringes contaminated with HIV.

Our drug laws greatly increase the risk of spreading HIV in prisons because dependent users may have to commit acquisitive crimes to be able to pay the exorbitant illegal market price of drugs, a price that is the product of prohibition. Thus, drug laws are indirectly responsible for other crimes, and result in users being placed in prison environments where they will continue to use drugs but will likely have no means of protecting themselves against HIV infection. In prison they are unlikely to receive effective drug treatment, and because of drug-testing programs they may switch to injection drug use, thus increasing the risk of contracting HIV. Finally, prisons have become overcrowded with people charged with drug offences, making it more likely that HIV will spread in these institutions. In addition, a number of prisoners report using drugs and injecting for the first time in their lives when they are in prison -

perhaps because that is the only way they can cope with the oppression inherent in such institutional environments.

Our drug laws have fostered public attitudes that are vehemently anti-drug user. In this climate, it is difficult to persuade Canadians to care about what happens to their fellow citizens who use drugs.

Our drug laws have fostered attitudes to the effect that drug users do not care about their own lives, and that therefore society need not care about the lives of drug users.

Our drug laws and policies have focused too much attention on punishing Canadians who use drugs, thereby downplaying critically important issues such as why people use drugs and what can be done to help them stop unsafe drug-use practices.

## Bill C-7 and syringe exchange

Another criticism of Bill C-7 is that it criminalizes the possession of syringes containing small amounts of drugs. Syringe-exchange programs are often opposed because of legal concerns. In Canada, legal barriers to such programs are more perceived than real. For example, clean syringes are not considered drug paraphernalia under present law or under the law as it would stand if Bill C-7 were enacted. However, Bill C-7 would continue to create unnecessary confusion. The Bill states that “a reference to a controlled substance includes a reference to…any thing that contains or has on it a controlled substance and that is used or intended or designed for use…in introducing the substance into the human body” (section 2(2)(b)). This means that syringes containing drugs controlled by the Bill themselves become controlled substances. A used syringe would of course need to contain a detectable amount of a substance to qualify as a controlled substance, and the user would have to know that it contained an illegal drug. In practice, this provision may make users less willing to be caught with their own used syringes; if they want a fix, they may therefore be more likely to share someone else's injection equipment, with the risks for acquiring bloodborne infections that this entails.

Whether or not C-7 becomes law, users should ensure that the syringes they carry to syringe exchanges are as free of drug as possible. Washing out used syringes with water before taking them to the exchange would be one way to reduce the amount of residual drug. The most appropriate course of action, however, would be specific legislative exemptions for syringes containing small amounts of a drug.

## Conclusions

This should be a time to re-evaluate Canada's drug laws and to draft new ones based on public health and harm-reduction principles, not a time to repeat the mistakes of the past and make new ones which will increase rather than decrease the harms from drug use. We should move toward treating drugs as a health issue rather than address them through the criminal law, which has almost totally failed to decrease drug use and its harms. Rather than pass legislation such as Bill C-7, an independent committee should be created to identify and develop ways of dealing with drugs in a more enlightened, humane and effective manner that would better serve all Canadians.

- *Diane Riley and Eugene Oscapella*

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ENDNOTES

1 S Usprich & R Solomon. A Critique of the Proposed Psychoactive Substance Control Act. *Criminal Law Quarterly* 1993; 35.

2 Canadian Foundation for Drug Policy. Presentation to the Parliamentary Sub-Committee on Bill C-7, 1994.

3 See E Oscapella. AIDS and Prohibition. Paper presented at the 8th BC HIV/AIDS Conference, Vancouver, November 1994; D Riley. *The Policy and Practice of Harm Reduction.* Ottawa: Canadian Centre on Substance Abuse, 1993; D Des Jarlais & S Friedman. AIDS and the Use of Injected Drugs. *Scientific American,* February 1994.

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# Ontario Court Rules on Notification of Blood Donors

First Reactions to the Judgement

*Canadian AIDS Society* v *Her Majesty the Queen in Right of Ontario, Dr Richard Schabas and the Canadian Red Cross Society*

In the course of the Commission of Inquiry on the Blood System in Canada, evidence revealed that between 1984 and 1985 the Canadian Red Cross Society (Red Cross) had, at its Toronto Centre, collected and stored samples of blood from donors who were not told that samples of their blood would be stored or tested for HIV antibodies. In fact, at the time the blood was donated there was no test for HIV antibodies.

As a result of this issue having been raised, the Red Cross struck an Expert Advisory Committee headed by Prof. Margaret Somerville of the McGill Centre for Medicine, Ethics and Law. The mandate of the Committee was to consider the legal, ethical and policy implications of testing the samples. The Canadian AIDS Society (CAS) was represented on the Committee.

The Committee recommended that, absent the informed consent of the donors, the samples be tested only for the purpose of notifying blood recipients. With regard to blood donors, the Committee expressed the view that obtaining the informed consent of each donor would be impractical. The Committee concluded that donors should only be told of their test results if they expressly requested it. According to the Committee, donors who did not expressly request their test results would not be notified of the results. In the Committee’s view, to notify donors who had not specifically requested it would, absent their informed consent, be tantamount to compulsory testing. The Committee’s final recommendation was that the Red Cross should not notify public health authorities of the test results, as this would also constitute compulsory testing.

The Chief Medical Officer of Ontario, Dr Richard Schabas, has since requested that the Red Cross report the test results to Public Health, including information that would identify the donors of the samples. He gave the Red Cross the alternative option of contacting and counselling the HIV-positive donors itself, but the Red Cross declined the option.

On 25 October 1994, CAS brought a motion for an interim interlocutory injunction prohibiting the Red Cross from notifying donors whose test results were positive, except at the donor's specific request. CAS also sought an order prohibiting the Red Cross from notifying public health authorities of the identity of the donors who tested positive for HIV antibodies. This order was granted and the hearing to decide whether the injunction should be made permanent was scheduled for 31 October 1994 at the instance of Mr Justice Douglas Carruthers, who issued the order, and not at the request of the parties.

Carruthers J of the Ontario Court (General Division) also heard this second application. At the hearing, intervener status was granted to The Canadian Hemophilia Society, the HIV-T Group (representatives of the recipients of the blood transfused), and the Hepatitis C Survivors Group. During the hearing, CAS advanced the following arguments:

- that HIV-positive blood donors have a privacy interest in the stored samples of their blood as well as in the information derived from the samples; and further, that this privacy interest is protected by the *Canadian Charter of Rights and Freedoms*;

- that HIV-positive blood donors had the right not to expect that their samples would be tested for antibodies to HIV or that their names and addresses would be reported to public health authorities without their express knowledge or consent;

- that the Red Cross could test the samples for HIV for the purposes of notifying recipients of any potentially infected blood units, notwithstanding the privacy interest of the donors, by arguing the defence of necessity; and, finally,

- that the privacy rights of the HIV-positive donors and the larger public interest required the Court to intervene to prevent the Red Cross from being compelled to release information to public health authorities in Ontario.

Carruthers J dismissed CAS's application in his decision released on 10 November 1994.1 He held that CAS did not satisfy the Court that the Red Cross fell within the concept of "government" within the meaning of section 32 of the *Canadian Charter of Rights and Freedoms* (according to s 32, the *Charter* is applicable only to the Parliament and government of Canada and the legislature and government of each province. In order to be able to claim that the Red Cross violated the donors' privacy interest, protected by the *Charter*, CAS had to convince the Court that the Red Cross is "government" within the meaning of that section). He further held that it was not possible to conclude that the HIV test now being done by the Red Cross was done without the consent of the donors, and that it therefore was not possible to conclude that releasing the names of infected donors violates their privacy. Carruthers J also found it difficult to reconcile CAS's argument that testing for the purpose of recipient notification was acceptable, whereas testing for the purpose of notifying the donors of the samples was not. In his view, the wording of the information provided to donors at the time of donation made it clear that the blood donation was a gift over which a donor could not reasonably be expected to retain control. He stated that donors could not validly complain that they have been subjected to compulsory testing when they have consented to their blood donation being tested for other diseases, and found that there was “implied consent” to HIV-antibody testing.

In Carruthers J’s view, any rights of the donors who tested positive to object to being told of their test results were outweighed by the need to do “whatever is necessary to prevent the spread of what has been described as an epidemic.”

Finally, Carruthers J held that there was no evidence before him to suggest that the Chief Medical Officer of Health would not act in the public interest. He stated that it was not within the power of the Court to interfere with the activities of the Chief Medical Officer of Health, especially in the prevention of a disease such as AIDS.

CAS is appealing Carruthers J’s decision. The grounds for appeal include Carruthers J’s failure to find that compulsory notification of the donors who tested positive is contrary to public policy and in violation of the donors’ rights under sections 7 and 8 of the *Charter*. (Section 7 states that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”; section 8 states that “[e]veryone has the right to be secure against unreasonable search or seizure.”) The appeal is to be heard in January 1995. This case raises important implications with respect to informed consent and HIV-antibody testing.

- *Patricia A. LeFebour and Douglas Elliott*

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ENDNOTE

1 [1994] O.J. No. 2789.

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## First Reactions to the Judgment

In a first reaction to Carruthers J’s decision, CAS stated that the ruling permits what is, in effect, compulsory testing for HIV. According to CAS, the donors, who gave blood in the Toronto area in 1984-85, “were never told their blood would be tested for HIV, or that the results would be reported to public health authorities. Today, blood donors are informed before they give blood that an HIV test will be done, and that the results will be given to local public health authorities where required by law.”1 David Garmaise, Executive Director of CAS, expressed his concern that the privacy and confidentiality of blood donors was violated, and stated that “[w]e know from experience that these violations do more harm than good in terms of efforts to stop the spread of HIV.” Garmaise was also concerned that individuals at risk for HIV will not come forward to be tested if the privacy and confidentiality of test results cannot be guaranteed. Russell Armstrong, the Society's Manager of National Programmes, further explained the Society's position by adding that CAS "absolutely agree[s] with the testing of the samples for the purposes of notifying recipients of HIV-infected blood units" and is not against donors knowing their status either. However, he added, "we believe that everyone should be able to choose when and where they find out this information. What will happen when the names are reported is that people will be forced to know, whether they want to or not."

The decision was heavily criticized in an editorial in the [Toronto] *Globe and Mail* of 14 November 1994.2 According to the editorial, the judgment "poses a serious threat to the privacy rights of all Canadians." Carruthers J's contention that notification of donors is necessary for the "health and well-being of our society" is flatly rejected: "Both sides agree the number of infected donors who have not yet developed AIDS is quite low, perhaps five to 16 individuals. In 1994, most of those individuals are probably taking precautions against spreading the disease. If they are not, telling them that they have the AIDS virus may not change their behaviour."

The editorial continued by saying that the benefit of telling blood donors seems small, especially when measured against the risks: "what is to stop government from requiring other risk groups to take the test? If we can test a group of blood donors without their consent, why should we not bring in all those who may have received transfusions of questionable blood and make them take the test?"

The *Canadian HIV/AIDS Policy & Law Newsletter* will report on further developments in this case.

- *Ralf Jürgens*

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ENDNOTES

1 Canadian AIDS Society Contends Ontario Court Wrong to Permit Release of HIV-Positive Blood Donor Names Without Consent. Canadian AIDS Society, press release of 10 November 1994.

2 Tainted Blood and Violated Privacy. Editorial in *The Globe and Mail*, 14 November 1994.

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# Should Canada Criminalize HIV Endangerment?

**This article addresses proposals to create a specific criminal offence in Canada for people who knowingly put others at risk of HIV infection through sexual intercourse.**

In a May 1994 article, “HIV/AIDS and the Criminal Law,” Prof. Winifred Holland of the University of Western Ontario concluded that there is a strong argument for amending the *Criminal Code* to prohibit HIV-infected persons from engaging in certain high-risk activities unless they inform their sexual partners of their HIV status beforehand.1

Cases involving the sexual transmission of HIV infection, or the risk of it, are coming increasingly before the courts. There have been at least ten such instances in which charges have been laid. High-profile cases, such as that of Charles Ssenyonga in Ontario,2 have focused media, public and judicial attention on the applicability and utility of the criminal law in such circumstances.

In fact, the existing law may already be adequate to deal with sexual conduct leading to HIV transmission as a result of a “wanton and reckless disregard for life or safety.” Convictions have been obtained in two such cases under section 221 of the *Criminal Code*, which addresses criminal negligence causing bodily harm.3 However, it should be noted that in both these cases the accused pleaded guilty, and hence the sufficiency of *mens rea* was not addressed by the Court. Ssenyonga pleaded not guilty, but died, and the case lapsed before the verdict could be handed down.

The more important question concerns what to do about those who have sexual relations while knowing themselves to be HIV-positive and do not either inform their partners or take protective measures such as using a condom. In some cases such behaviour might clearly be considered “criminal negligence” in the sense noted above. However, in the absence of harm, criminal negligence is not an offence under the *Criminal Code*.

It is at precisely this point that the positivist mind-set of the criminal lawyer fails us. Rather than ask, first, how a person arrived at the point at which he (and I use the masculine pronoun deliberately) appears so uncaring of his sexual partner as to risk infecting her (or him) with a deadly virus, the criminal lawyer sees the problem as one of addressing such behaviour *within the limited framework of the criminal law*. Yet before the admittedly "rough instrument" of the criminal law is invoked, we should raise our sights and consider what others have to say about this problem.

The 1990 Canadian national HIV/AIDS strategy makes no mention of criminal law and the sexual transmission of HIV.4 The National Advisory Committee on AIDS (NAC-AIDS) recommended that "[i]n the very small number of cases where involuntary measures are reasonably and demonstrably essential, the use of carefully controlled involuntary public health measures is generally to be preferred over criminal sanction."5

The Canadian Public Health Association (CPHA) has noted: "When a person who is HIV positive is unwilling or unable to change his or her behaviour, public health is challenged to determine the most appropriate intervention. These situations, while extreme and small in number, are both difficult and challenging.... Public health officials must endeavour to keep interventions in difficult cases within public health law unless a criminal act, such as a sexual assault, is involved."6

Thus, NAC-AIDS and the CPHA propose that the criminal law is to be considered in limited cases only after other options have been tried and have failed. What are these other options, and have they been fully explored?

It is generally agreed that adequate and appropriate pre- and post-test counselling is essential in helping a person diagnosed with HIV infection to come to terms with both the foreshortened lifespan and the infectious state. Prof. Holland asserts that "some form of counselling is invariably provided" when HIV testing is carried out. Is such counselling always adequate or are we trying to cut corners, with disastrous results? In *R* v *Kreider*, the accused was charged with "common nuisance" (s 180) after he had unprotected sexual intercourse three times without informing his partner that he was HIV-positive (she was not subsequently infected). The defence argued that the accused was in a state of denial. The Court rejected this argument and sentenced the accused to one year in prison (upheld on appeal).7

Nowhere in the judgment is there a discussion of the adequacy of the counselling he received, or of whether other measures such as a public health order were considered or were even possible; not even the appropriateness of the charge was considered. Yet the "common nuisance" provision was rejected by the Court as inappropriate to such circumstances in a preliminary hearing of the charges against Charles Ssenyonga (28 May 1992, O.J. No. 1154).

Since the Ssenyonga case first came to the attention of the public health authorities in Ontario, there has been an ongoing debate concerning the amendment of the *Health Protection and Promotion Act* to permit compulsory counselling or, as a last resort, confinement in such circumstances;8 it would, indeed, seem prudent to at least consider this option before proposing a new criminal offence.

In the single case of a criminal prosecution involving two males, the accused was charged with having anal intercourse with a minor (s 159). The accused knew he was HIV-positive at the time and took no precautions, and the young man was infected during the encounter. The complainant's HIV infection was considered an aggravating factor in sentencing. Curiously, the prosecutor noted that, had it not been for his age (he was seventeen-and-a-half years old at the time of the offence), the matter would not have come before the Court at all!9 Did the prosecutor recognize the general inappropriateness of the criminal law in such circumstances, or is there a double standard here, depending upon whether the sexual act was homosexual or heterosexual?

## Experiences outside Canada

How have other jurisdictions handled this challenge? In the United States, a 1988 presidential commission recommended HIV-specific statutes that would require disclosure, consent *and* precautions.10 It has been argued that such proposals run the risk of leading to arbitrary prosecutions and harassment of sexual minorities, and to practical problems of proof.11

The opposite approach has generally been taken in Australia. The 1989 *National HIV/AIDS Strategy*12 addresses the issue squarely, proposing counselling and, in the final resort, isolation, under public health legislation. Only three of the eight state and territorial jurisdictions have general offences of reckless endangerment. No legislature has moved to introduce or amend the criminal law relating to endangerment in the absence of bodily harm. Public health legislation in some states requires disclosure before intercourse. The penalty is a fine.

There has been an ongoing process of community consultation on HIV policy and law. In the state of Victoria, a protocol has been developed between police and public health authorities to handle those cases of endangerment that come to the attention of the police. A stepped intervention under public health legislation, rather than the criminal law, is considered. Similar guidelines have been published in New South Wales.13

## Consultation and consensus

The HIV pandemic calls for a multidisciplinary approach. Before we propose new policies, jurists must consult with doctors, psychologists, public health officials *and people living with HIV disease*. Before invoking the criminal law, medical practitioners would do well to consult with criminologists about the problems of *mens rea*, proof and, indeed, the deterrent effect – if any – of criminal sanctions in such intimate circumstances. Clearly, there needs to be further public debate involving all affected communities. The Canadian government could advance the discussion by commissioning a background paper and bringing together all interested parties.

Criminalizing HIV endangerment will do little to stop the spread of the virus. Worse, it gives the appearance of decisive action while distracting attention from the solutions that work. The whole thrust of our response to this issue should not be determined by a handful of hard cases. A good indication of the worth of any proposal claiming to limit the spread of HIV infection is the range of different parties and disciplines consulted during its formulation.

*- David Patterson*

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ENDNOTES

1 W Holland. HIV/AIDS and the Criminal Law. *Criminal Law Quarterly* 1994; 36(3):279.

2 *R* v *Ssenyonga*, [1992] O.J. No. 1154 (Ont. Ct. (Prov. Div.)), 21 C.R. (4th) 128, 81 C.C.C. (3d) 257 (Ont. Ct. (Gen.Div.)). See C Johnston. AIDS and the law: Do courts have a place in the bedrooms of the nation? *Can Med Assoc J* 1992; 146(11):2065.

3 *R* v *Wentzell*, C.R. No. 10888 (Halifax County Ct., Nova Scotia, 8 December 1989), unreported; *R* v *Mercer* (1993), 84 C.C.C. (3d) 41.

4 *HIV and AIDS: Canada's Blueprint*. Ottawa: Minister of Supply and Services, 1990.

5 *HIV and Human Rights in Canada*. Ottawa: National Advisory Committee on AIDS, 1992 at 15.

6 *HIV & AIDS: A Public Health Perspective*. Ottawa: Canadian Public Health Association, 1993 at 20, 21.

7 *R* v *Kreider* (1993), 140 A.R. 81.

8 See L Stoltz. Ontario Public Health Powers under Review. *Canadian HIV/AIDS Policy & Law Newsletter* 1994; 1(1):10.

9 *R* v *Langlois* (25 January 1991), Québec 200-01-010507-907, J.E. 91-954 (C.Q.).

10 *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic*. Washington: United States Government Printing Office, 1988 at 131.

11 L Gostin & WJ Curran. The Limits of Compulsion in Controlling AIDS. *Hastings Center Report* 1986; 24 at 29. See, generally, DH Hermann. Criminalizing Conduct Related to HIV Transmission. *Saint Louis University Public Law Review* 1990; 9:351.

12 Canberra: Australian Government Publishing Service, 1989.

13 *Guidelines on the management of people with HIV/AIDS who knowingly place others at risk of infection*. Sydney: NSW Department of Health, 1990.

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## THANKS

The Network would like to thank Montréal film producer Rock Demers, who on 1 December 1994 (World AIDS Day) invited the Network to distribute information and collect donations from people attending the Montréal première of his film “Voilà le Cinéma (The Life of Charles Pathé).” Sincere thanks also to Québec MNAs François Beaulne and Pierre Bélanger for their generous donations.

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### NOTE

## Joint Network/CAS Project on Legal Issues Raised by HIV/AIDS

**The Canadian HIV/AIDS Legal Network and the Canadian AIDS Society have decided to undertake a joint three-month project on legal issues raised by HIV/AIDS in Canada. Funding is being sought from the AIDS Care and Treatment Unit, Health Canada.**

The project is intended to lay the groundwork for the production of a comprehensive set of resource documents addressing critical legal and ethical issues raised by HIV/AIDS in Canada. Such materials do not currently exist in Canada, and many have expressed a need for extensive, targeted resource materials on these issues in order to adequately respond to the needs of people living with HIV or AIDS and those otherwise affected by the disease. Key legal and ethical issues will be assessed and prioritized, and existing resources researched and documented. A literature review and annotated bibliography will be produced and made widely available. Partnership support from other NGOs, institutions and professional associations will be sought.

If you are interested in this project or would like to receive further information, please contact the Project Coordinator, Ralf Jürgens. Phone: (450) 451-5457 Fax: (450) 451-5134.

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## PRISONERS AND HIV/AIDS

# Alarming Evidence of HIV Transmission in Prisons

**Little data from scientific studies are available on how many prisoners become infected while in prison. However, a recent study undertaken in a prison for adult male offenders in Scotland has provided definitive evidence that outbreaks of HIV infection can and will occur in prisons unless HIV prevention is taken seriously.**

To date, no studies on HIV transmission in prisons have been undertaken in Canada. In the only controlled study undertaken in the US, 0.3 percent of a sample of over 2,300 initially seronegative male inmates in Illinois had seroconverted after spending one year in prison.1 Several other US studies found annual seroconversion rates of less than 0.5 percent. In the Federal Bureau of Prisons, 52 cases of seroconversion had been identified as of early 1993. However, all but four of these occurred during the first six months following intake testing, suggesting that at least some of the individuals had been infected, but were in the “window period” when they entered the prison system.

The results of these studies have sometimes been used to argue that HIV transmission in prisons is rare, and that consequently there is no need for increased prevention efforts. However, as pointed out by Hammett et al, “[r]egardless of the rates of HIV seroconversion documented in studies, it is clear that sex and drug use continue to occur in prisons…and that they represent high-risk activities for transmission of HIV.”2 Many would agree that the documented cases of HIV transmission reveal but the tip of the iceberg. Anecdotal evidence that HIV transmission in prisons is occurring is abundant. For example, a Louisiana inmate who tested positive for HIV in 1989 reported he was infected through sexual intercourse and/or needle-sharing with a cellmate during an eight-month period in which they did “every unsafe thing you could do.”3 In a survey conducted by a German community AIDS organization, about 17 percent of HIV-positive participants stated that they believe they acquired HIV infection while in prison. The author of the study commented: “Probably many justice ministries will say that this is a subjective opinion not supported by hard evidence. I ask myself, however, why these prisoners should give false testimony.”4

In 1994, a study undertaken in Glenochil prison for adult male offenders in Scotland provided evidence that an outbreak of HIV infection had occurred in the prison. Of 43 inmates who admitted having injected at some point in their lives, but not in Glenochil, 34 were tested. Of these, none tested positive. In contrast, 12 of 27 inmates who admitted having injected in Glenochil tested positive, 7 tested negative, and the remaining 8 tested negative but had recently been exposed to the risk of transmission. Certain characteristics of the positive test results showed that in most if not all cases the infection had been acquired in prison.5

That transmission of HIV can occur on such a large scale in prisons should not come as a surprise. It is well known and acknowledged by prison administrations that injection drug use is a reality in prisons and that it would be unrealistic to assume that it could ever be eradicated. While a number of studies have found that injection drug use decreases in prisons among inmates who were injection drug users on the outside, they have also shown that inmates are more likely to inject in an unsafe manner when they do inject. Those who inject in prison often do not have a choice but to share unclean equipment with others because sterile injection equipment or even bleach to clean equipment is not provided to them. The studies therefore all concluded that imprisonment increases the risk of contracting HIV infection.6

This raises important policy and legal considerations. Prisoners are in prison as punishment, not for punishment. Their human rights must be respected, except for those limitations demonstrably necessitated by the fact of incarceration. In particular, prisoners are entitled to protection from contracting diseases. In Canada, the National Advisory Committee on AIDS, the Royal Society, the Parliamentary Ad Hoc Committee on AIDS, the Federal/Provincial/Territorial Advisory Committee on AIDS, the Prisoners with AIDS/HIV Support Action Network, and the Expert Committee on AIDS and Prisons have all issued recommendations aimed at reducing the spread of HIV infection and the harms from drug use in prisons. As early as 1988, making condoms and bleach available to inmates was recommended. As stated by the Honourable Justice Michael Kirby, Chairman of the International Commission of Jurists and a former member of the WHO Global Commission on AIDS, "[w]hat needs to be done to address the problems of HIV/AIDS in prisons is, by now, dazzlingly clear. Those with responsibility have to take the same courageous steps in prisons that were earlier taken by politicians of all parties to protect the general…community. Life is precious. Infection with HIV (or hepatitis C) is life threatening. Of course, there are some risks in the strategies which the experts urge. But there are terrible risks of infection and cross-infection if those strategies are not adopted."7

Nevertheless, in many Canadian prisons condoms are still not – or not easily and discreetly – available to prisoners, bleach is not made officially available, and proposals to provide prisoners with clean needles are rejected. Will prisoners have to wait until an outbreak of HIV infection such as that in the Scottish prison occurs in Canada, before they gain access to the means of protection that are available to people outside? Unless governments and prison administrations act without further delay, they could be held legally or, at least, morally responsible for the spread of HIV infection and hepatitis C among inmates and, ultimately, the public. The fact that prisoners put themselves at risk of contracting HIV by engaging in sexual activity and drug use, both prohibited in prisons, is not a sufficient excuse for not acting. This has been understood outside prisons, where needle exchanges have been set up with government approval and funding. It is to be hoped that governments and prison administrations will finally act upon the experts' recommendations, and that courts or a commission such as that currently examining the safety of the blood supply will never have to study the lack of HIV prevention in prisons and its consequences for prisoners and the general public.

- *Ralf Jürgens*

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ENDNOTES

1 T Hammett et al. 1992 Update: AIDS in Correctional Facilities. Washington, DC: The National Institute of Justice, 1994.

2 *Ibid*.

3 *Ibid*.

4 *HIV/AIDS in Prisons: Background Materials*. Ottawa: Minister of Supply and Services Canada, 1994 at 60.

5 A Taylor et al. Outbreak of HIV Infection in a Scottish Prison. Paper presented at the Xth International Conference on AIDS, Yokohama, 1994.

6 *Ibid*. See also PJ Turnbull et al. Prison Decreases the Prevalence of Behaviours but Increases the Risks. Poster abstract no PoC 4321, VIIIth International Conference on AIDS, 1992; D Shewan et al. *Drug Use and Scottish Prisons – Full Report*. Scottish Prison Service Occasional Paper, no 6, 1994.

7 M Kirby. HIV in Australian Prisons. [Australian] *National AIDS Bulletin*, vol 8, no 6 (July 1994) at 10.

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## TESTING AND REPORTING

# Bank’s Drug Testing Program: Not Discriminatory, but Intrusive

**A Canadian Human Rights Tribunal held recently that a Toronto Dominion Bank mandatory drug-testing program is not discriminatory and therefore does not violate the *Canadian Human Rights Act*.1 This decision may have disappointed those involved in the protection of workers’ rights and of civil liberties in the workplace. However, the verdict should not be interpreted as a clear confirmation of the legitimacy of mandatory drug testing in the workplace. Indeed, while this particular drug-testing program was not held to be discriminatory, the Tribunal made, *in obiter*, some sharply critical remarks on the Bank’s policy that indicate a concern as to the legitimacy of conducting such tests.**

The Tribunal ruled only that the drug-testing program was neither directly nor indirectly a discriminatory practice on the basis of disability (perceived drug dependence) under the *Canadian Human Rights Act*. It did not discuss whether the program violated the *Canadian Charter of Rights and Freedoms*. It has been argued that compulsory drug-testing programs may violate the right to life, liberty and security of the person, protected under section 7 of the *Charter*. They may also constitute unreasonable search or seizure, prohibited under section 8 of the *Charter*, and therefore infringe upon the right to privacy.2 The Human Rights Commission had invoked these arguments, but the Tribunal concluded that the *Charter* did not apply, the Bank not being part of the federal government or under direct government control. Statements by the Tribunal about the intrusiveness of the drug-testing program suggest that, were the *Charter* to be applicable, the outcome of this case would have been different.

The Tribunal also confirmed that the existence of criminal laws prohibiting drug possession and other drug-related crimes does not suspend the protection of the human rights of people using drugs. It contended that “[i]t is not for the employer to be the trier of fact and the enforcer of the criminal law.”

Furthermore, the Tribunal could have been satisfied with its conclusion that the drug-testing program was not discriminatory. Nevertheless, it examined the question of whether the drug-testing program, if discriminatory, could have been justified as a Bona Fide Occupational Requirement (BFOR). A discriminatory requirement may, under the *Canadian Human Rights Act*, be upheld if it is reasonably necessary to ensure a safe and efficient working environment. The Tribunal qualified the mandatory urinalysis for employees as so intrusive that it “could only be seen as reasonable in the face of substantial evidence of a serious threat to the Bank’s other employees and the public.” According to the Tribunal, such evidence was lacking. It was not convinced of the existence of a serious drug problem at the Bank, nor did it accept the argument of a causal link between crime and drug use. Accordingly, the drug-testing program was not found to be necessary to avoid criminal activity, as had been argued by the Bank. At the same time it was conceded that, even if the practice had had indirect discriminatory results, the testing program could have been upheld because the Bank accommodated drug-dependent people. The Tribunal held that the counselling, free treatment and rehabilitation offered by the Bank fulfilled the requirement of reasonable accommodation in the case of indirect discrimination.

Two observations should be made about this decision:

First, the Tribunal pointed out that the Bank’s drug-testing program was disproportionately invasive and unnecessary for the protection of the workplace against crime. It nevertheless accepted that the elimination of illicit drugs from the employee population is a legitimate aim because of the impact of drugs on job performance. This statement should have been clarified. The precise impact of drug use on work performance is disputed. While studies indicate that there is a connection between positive drug-test results and higher absenteeism rates, their results cannot be generalized and do not establish a direct, causal link between job performance and drug use. Indeed, these studies may say more about the general attitudes of people who use drugs, in particular toward disciplined labour, than about the effect of the drugs themselves. This may in fact be the hidden reason why some employers are so keen to use drug tests as an employee-selection mechanism. Further, drug tests only indicate past drug use, sometimes from several days previous to the test; they do not provide evidence of current impairment and are therefore more a form of attitudinal testing. Considering the intrusiveness of the tests and the unclear relation between drug use and work performance, it should be questioned whether the elimination of illicit drug use is a legitimate aim for employers. Less intrusive and more direct methods could be used to verify current impairment or attitude toward work.

Second, and although this was not accepted by the Tribunal, the argument that the testing program constitutes indirect discrimination is not so far-fetched. According to the Tribunal, the program is not discriminatory because it affects occasional users as much as it does drug-dependent people. Under the testing program, people who test positive are submitted to a second and a third test. If they test positive a second time, they are submitted to an assessment, and treatment is eventually provided. Only in the case of a third positive result is employment terminated. The Tribunal therefore found “that the dismissal is not based upon a perceived disability (drug dependence) but upon the persistent use of an illegal substance,” whether as an occasional user or a drug-dependent person. However, classifying drug dependence as a disability implies that one accepts that it is a more or less permanent or long-term condition characterized by compulsive use. If that is the case, one should also acknowledge that drug-dependent people are less able than occasional users to abstain from drug use and are therefore more affected by the testing program than occasional users; they are more likely to be dismissed as a result of the testing program.

However, even if the drug-testing program had been considered indirectly discriminatory by the Tribunal, this would not have changed its final decision. Following a policy statement of the Human Rights Commission,3 the Tribunal argued that the free treatment and counselling provided by the Bank in cases of posi-tive test results constituted “reasonable accommodation.” It is questionable, however, whether this is the only – or indeed a good – way to accommodate drug-dependent people in the workplace. The criterion for drug-dependent as for any other disabled people should, rather, be whether they are capable of performing their job efficiently and safely and, if not, whether there is a reasonable alternative within the workplace for them. Offering free treatment and counselling in the workplace is laudable, but submitting employees to intrusive drug tests and then forcing them into treatment programs under threat of dismissal is perhaps not something we should allow employers to do.

- *Trudo Lemmens*

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ENDNOTES

1 See R Jürgens. Canadian Human Rights Tribunal Rules on Drug Testing. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 1 (October 1994) at 7-8.

2 See, for example, the Report on Drug and Alcohol Testing in the Workplace. Ontario Law Reform Commission, 1992.

3 Canadian Human Rights Commission, Policy 88-1, Drug Testing. Ottawa, 1988.

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### DISCRIMINATION

## Daycare Centres: Another Area of Concern

**The expulsion of "Baby J" from Les Petits Lutins Daycare Centre in Côte-St-Paul, Québec, in January 1994 is yet another illustration of the problems of discrimination and exclusion that people with HIV infection or AIDS are facing.**

The facts are as follows: "Baby J", a two-year-old girl, was expelled when it was discovered that her serostatus was positive. Although "Baby J" had to take an unidentified syrup every six hours, her mother had not disclosed her daughter's state of health. When the daycare centre's management discovered that the medication in question was AZT, they almost immediately expelled the child.

Three reasons were considered by the daycare centre's management as fully justifying "Baby J"'s expulsion: (1) "Baby J"'s mother's silence, which gave rise to the unfortunate situation in which both mother and child found themselves; (2) the risk that the presence of a seropositive child entails in a daycare environment, which, according to the centre's management, is "unacceptably high"; and (3) the Centre's obligation to accede to the demands of their customers, parents who have paid to ensure that appropriate services are provided to their children.

The disclosure of "Baby J"'s serostatus raised the whole issue of the confidentiality of a person's state of health, and of the right to the respect of a person's inviolability and private life. Reference may be made in particular to sections 1, 4 and 5 of the Québec *Charter of Human Rights and Freedoms*1 (Québec Charter) and Art. 10 of the *Civil Code of Québec*, which conflict with sections 17 and 19(2) of the *Regulation respecting day care centres*.2 These sections of the Regulation require that any medication administered to children in daycare centres must be duly prescribed and identified. It is clear, on the one hand, that it is easy to make the correlation between AZT and AIDS, and on the other, that the disclosure of this correlation necessarily destroys the confidential nature of the child's state of health, with disastrous results for the child and his or her family.

Many daycare centres claim that they do not have at their disposal the means enabling them to meet the needs of seropositive children. Despite the many information sessions offered by hospitals and community organizations to those staffing daycare centres, and despite the material on the subject that has been made available, many daycare centres still refuse seropositive children access to the services they provide. Because the risk, although infinitesimal, is real, and the consequences irreversible, parents and daycare centre staff are not prepared to ignore it, even if this very often leads to a denial of the rights of infected children and their parents that irremediably condemns them to being abandoned by the system. The parents of the other children, as well as the daycare centre staff, also invoke respect for their rights to justify the refusal to receive an infected child. However, the recent report submitted by the working group on the control of blood-transmissible diseases in child daycare centres3 (the “Report”) has stressed that seropositive children who are asymptomatic, as in "Baby J"’s case, do not require special care. Moreover, the Report states that:

- daycare centres must use the customary universal precautions;

- the activities that take place in daycare environments do not expose the children or the daycare staff to the risk of contracting HIV. It should be emphasized that no cases of HIV transmission in daycare centres have ever been reported;4

- even in cases where biting occurs – situations that particularly worry parents and staff – the risk is insignificant. In order for the virus to be transmitted, the bite would have to involve a break in the skin, there would have to be blood in the mouth of the HIV-infected child, and there would have to be contact with an open sore or the blood of an uninfected child. It should be noted that aggressive children known to be biters are subject to increased supervision and that acts that lead to blood wounds are rare.5

It should also be recognized that, judging by the legislation, the obligation of daycare centres to provide a service accessible to all is not without limitations. Whereas section 2 of the *Act respecting child day care*6 provides that “[e]very child is entitled to receive good, continuous, personal day care until the end of primary school,” the third paragraph of this section limits the scope of these rights by setting out that “such rights shall take into account the organization and the resources of the bodies providing day care… as well as the right of a person holding a permit…to receive or to refuse to receive a child.” However, daycare centres cannot invoke this paragraph to refuse access to an HIV-infected child solely on the ground that the child is infected.

It should be noted that AIDS is a handicap, and constitutes an illegal ground of discrimination. In the Québec Court decision in *Hamel* v *Malaxos*,7 where the issue concerned a dentist’s refusal to treat a seropositive patient, Mr Justice Soumis concluded that HIV infection is also a handicap and that the infected person could therefore rely upon section 10 of the Québec Charter. The decision also held that section 1 of the Québec Charter could not be invoked to justify discriminatory conduct because Mr Malaxos did not prove that he had reason to fear for his life.

Faced with the increasing number of HIV-infected children and the almost total ignorance concerning AIDS, it is not unreasonable to think that daycare centre staff will be confronted with similar cases for a long time to come. However, it should be noted that the Office des services de garde à l'enfance circulated a text to daycare centres and supports the Report's recommendation that a child should not be refused access on the ground of HIV infection where universal precautions are observed. This is consistent with the results of the intervention project in Montréal Daycare centres, which the McGill AIDS Centre and Batshaw Youth and Family Centres carried out from October 1993 to March 1994. For more information about the project, as well as a copy of *A guide to developing policy for children and daycare workers who are infected with HIV*, contact Anne Renaud, McGill AIDS Centre, Jewish General Hospital, Lady Davis Institute, Room 318, 3755 chemin Côte-Ste-Catherine, Montréal QC H3T 1E2. Tel: (514) 340-7536; Fax: (514) 340-7537.

Furthermore, Health Canada has recently provided funding to the Canadian Child Care Federation (CCCF) for the development of educational material for parents, daycare staff, and primary school teachers. This material will be made available at the CCCF National Conference, to be held in May 1995.

- *Kathleen Beaugé*

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ENDNOTES

1 RSQ, c C-12.

2 RRQ, c S-4.1, r 2.

3 Department of Health and Social Services, Public Health Directorate, in collaboration with the Provincial Committee on Infectious Diseases in Daycare Centres, April 1994.

4 T Norton. Developing Centre Policies Regarding HIV Infection. *The Early Childhood Educator* 8(Sept-Oct 1994).

5 Ibid.

6 RSQ, c S-4.1.

7 Québec Court (Small Claims Division), Joliette, 25 November 1993, no. 730-32-000370-929, unreported.

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## WOMEN AND HIV/AIDS

# Bulletins Such As *Stronger Together* Can Help Lawyers and Policy-Makers

**The following article points to legal and policy issues raised in the September 1994 issue of *Stronger Together*, the Bulletin produced by CAS's National Women and HIV Project, written for and by HIV-positive women about their experiences in creating change. The personal stories contained in the Bulletin make the practical importance of, and the need to develop policies that respond to, these issues very clear.**

A dominant theme running through the issues raised in the Bulletin is the unequal, and sometimes abusive, relationship between physicians and their HIV-positive women clients. Some HIV-positive women may not be aware of their right to informed consent, or may feel too isolated to enforce it. Any concern to obtain the informed consent of his patient is absent from the story told by a 15-year-old whose doctor "took a bunch of blood tests and told me I have HIV. So, he told me I had to have an abortion and I did. I cried. I didn't want to kill the baby." He would now seem to be pressuring her to be sterilized [see *Stronger Together*, page 6].

One response of the National Women and HIV Project to this problem is the dissemination of information on treatment issues. It is difficult to make an informed decision when relevant information is difficult to obtain. For example, an important issue for many women at the moment is whether or not to use AZT during pregnancy in order to reduce the risk of transmitting the virus to the fetus. The Bulletin [page 7] urges women to inform themselves as much as possible before making such treatment decisions, and raises some important questions: does exposure to AZT while in the womb have any long-term effects on the child? how much AZT is necessary to prevent transmission? when should AZT be started – mid-term, or later in pregnancy?

Another important action is the publication in the Bulletin of women's personal accounts of their situation. It is crucial that lawyers and policy-makers be aware of some of the contextual factors that make the exercise of informed consent more difficult, even where information on treatment is available. These factors are evident in several of the stories in the Bulletin. Social isolation is a major problem for many of the women interviewed: one woman describes the [TRANSLATION] "loss of friends and the feeling of isolation that overcame me. I had the impression that I was the only seropositive woman in Québec" [page 3]. Consequently, members of the medical team may be among the few people whom some women see regularly, and their influence with respect to treatment decisions may not be counterbalanced by other opinions.

A recurrent theme is the extreme guilt many women feel because their children are infected and/or will be left motherless: "[s]ometimes I look at her and I feel so damned guilty. How could I have given this disease to her?… Like I gave her a death sentence…. I can understand me getting AIDS. I asked for it, I guess but my daughter didn't and you know, if it meant me dying tomorrow to get rid of the HIV in her, I would gladly, but that's not an option" [page 1]. It may therefore be particularly difficult for HIV-positive (prospective) mothers to refuse treatments presented to them as being in the interests of their children. In addition to these factors, many of the women interviewed spoke of having experienced rape or/and sexual abuse. The experience of violence may be very disempowering, and may undermine the self-confidence necessary to enforce one's rights.

The Bulletin thus raises issues of fundamental importance for lawyers and policy-makers. If informed consent is not to be an empty concept for HIV-positive women, lawyers must be aware of, and policy-makers must address, the circumstances that make women's enforcement of their rights so difficult. It is therefore of great importance that the perspectives of the women themselves be included in the policy-making process. Without them, policies and projects will be inadequate. The publication of bulletins such as *Stronger Together* is an important part of this process.

- *Sarah Wilson*

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## INTERNATIONAL NEWS

# The Global Programme on AIDS: What It Is, What It Does

Building up the national response: technical assistance

**Since 1987, when the World Health Organization (WHO) established its Global Programme on AIDS (GPA), WHO has worked directly with countries to help them set up and run effective and ethical national AIDS programs. Along with financial assistance to national programs, technical assistance accounts for about half of GPA's budget.**

Over the years, GPA's technical assistance has evolved to meet the changing needs and nature of national AIDS programs. From small-scale programs based mainly in the health sector, they have become coordinators of a wide range of activities carried out by many different participants and sectors – a major challenge. GPA has accordingly allocated considerable resources to strengthening national AIDS program management, including program planning and reviewing, monitoring, and evaluation of impact. Among the many tools developed is a 10-day program management course, which has already benefited senior management from over 50 developing countries – many of whom have begun to train fellow nationals. GPA also continues to have consultants or multidisciplinary teams stationed in most developing countries to provide on-the-spot technical assistance in key areas, such as condom promotion, home-based care of AIDS patients, and HIV/AIDS surveillance. A further service to national AIDS programs is the procurement of low-cost condoms and HIV test kits through bulk purchasing.

### AIDS/STD prevention and care: old tools and new

Ensuring that national AIDS programs have the best possible tools at their disposal requires research and development. From its global vantage point, GPA helps assess the prevention and care approaches being tried out around the world, and adapts the effective ones for use in developing countries, where 90 percent of the world's HIV-positive people live. GPA also funds, coordinates and undertakes research of its own to find improved ways of challenging AIDS.

When it comes to biomedical research, GPA's top priorities are vaccines and vaginal microbicides. A candidate vaccine that emerged successfully from safety trials in the USA has just entered a safety/ immunogenicity trial in Thailand, with strong GPA support. The Programme began laying the groundwork for such trials in 1992, when it started training local researchers and otherwise building up the research infrastructure in trial sites in Brazil, Thailand, Uganda and Rwanda,1 and providing vaccine developers with HIV strains circulating in developing countries.

A long-neglected area is the development of vaginal microbicides, which GPA has put squarely on the agenda of international agencies and the pharmaceutical industry. An interagency working group established by GPA recently agreed on guidelines for international safety trials, which have now begun. Safety is a critical issue. Though some products long marketed as spermicides show anti-HIV activity in the test tube, repeated vaginal application can cause lesions – too small for the woman herself to detect, but potential entry-points for HIV. The next stage in the search for female-controlled barrier methods will be efficacy trials.

Social and behavioural research can provide invaluable insights for prevention and for reducing discrimination against seropositive people. GPA-supported research in developing countries is exploring male-female relations in the area of sexual negotiation, and household and community responses to HIV/ AIDS.

A major product nearing completion is GPA's prevention planning manual, bringing together methods suitable for the variety of population groups, including sex workers and their clients, men who have sex with men, and injection drug users. It should help NGOs, district health officials and national AIDS program planners to tailor prevention activities while maximizing local opportunities and resources.

In the past year GPA has devoted considerable attention to the conventional sexually transmitted diseases (STDs). A major public health problem in their own right, with 150 to 300 million curable cases a year worldwide, STDs also multiply the risk of HIV transmission; an individual with an untreated STD is perhaps 5-10 times more likely to acquire or pass on HIV during sex. GPA's new *STD management guidelines* include an innovation in the care of sexually transmitted diseases: syndromic case management. Briefly, this enables patients to be examined, diagnosed and treated in one visit without any need for laboratory tests – which are expensive and often unavailable in developing countries.

To date, about 50 percent of all HIV infections have been among teenagers and young adults under 25. A recent GPA analysis suggests that, in mature African epidemics, the proportion is as high as 75 percent. Clearly, young people need to know the facts about HIV transmission and acquire life-saving skills, such as how to refuse unsafe sex and drug use. The culmination of years of work, GPA's 284-page resource package for curriculum designers, teachers and students, entitled *School health education to prevent AIDS and STDs,* is about to be published with UNESCO. For young people who do not attend school, GPA helped develop a prevention guide in collaboration with the Commonwealth Youth Programme.

## Advocacy

The prevention of AIDS hinges on educational messages and policy decisions that, many people feel, condone or even encourage disapproved-of behaviour. So, for example, if GPA's curriculum package and its intervention planning manual are to be used, those in charge first need reassurance that school AIDS education does not lower the age of first intercourse. (A GPA review of existing studies shows that, if anything, it does the opposite.) They need evidence that needle-exchange programs reduce seroconversion without increasing the number of drug users, and so on.

GPA thus invests a great deal of time and resources in advocacy – through international conferences and meetings, the Executive Director's visits to countries to meet with political leaders, day-to-day contacts with local officials and community groups, the Programme's quarterly newsletter *Global AIDSnews* and its new advocacy book *AIDS: images of the epidemic*. GPA advocates not only rational approaches to AIDS prevention but compassionate care and support of those living with HIV and AIDS, and close collaboration with the communities most affected, such as gay men. It argues for the empowerment of women, millions of whom are unable to negotiate safe sex or leave a relationship that puts them at risk. GPA advocates *against*, too: against coercive measures such as AIDS-related restrictions on travel and mandatory HIV testing, which not only flout human rights but threaten to make the epidemic worse by driving people away from prevention and care programs. Advocacy of this kind is done in close collaboration with AIDS and human rights organizations, including the human rights bodies in the United Nations system.

## The years ahead

This brief listing of GPA activities and achievements in the past year can do no more than hint at the scope of action of the Programme – from forecasting trends in the pandemic to human rights monitoring at country level; from humanitarian and technical assistance in the Rwanda emergency to the development of methods for costing AIDS prevention, care and impact. Increasingly, activities are carried out jointly with other agencies and organizations in the United Nations system, such as joint projects with the World Bank in Southeast Asia and West Africa.

In the years ahead, the breadth of action is bound to expand still farther with the creation of a joint and cosponsored United Nations Programme on HIV/AIDS, toward which WHO has been working hard along with the other cosponsors – UNDP, UNESCO, UNFPA, UNICEF and the World Bank – and with NGO partners as well. The joint program, which is to be fully operational by January 1996, will build on the capacities and comparative advantages of the six cosponsors to provide a unified UN system response to the pandemic. The first such venture in the UN system, the joint program is expected to provide a firm base on which communities worldwide can rely for support in the years ahead as they strive to reduce the spread of HIV (currently over 6000 new infections a day) and soften the pandemic's harsh impact on those already affected.

- *Suzanne Cherney*

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ENDNOTE

1 The trial-site infrastructure in Rwanda has been destroyed by the civil war.

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## DEVELOPMENT ISSUES

# Programming for a Positive World: Women, Development, and Cultural and Social Change

**This two-day workshop was held in Ottawa (21-22 October 1994) by the Interagency Coalition on AIDS and Development. The workshop was attended by representatives of several NGOs and donor organizations with projects to help HIV-positive women or to prevent the transmission of HIV infection to women.**

The description of the workshop made it sound highly ambitious: an examination of the problems of why women are susceptible to HIV infection; their problems coping with their own illness and that of their children and their immediate and extended families; discussion of examples of constructive responses to these issues; and the identification of strategies for getting women and AIDS on the policy and program agendas of governments, NGOs, and AIDS and other service organizations. The focus was on developing countries, but the Canadian context was also discussed. The following is a personal account of the issues raised by the workshop.

Many speakers raised issues that constantly recur in discussions of social problems that concern women. What made this workshop different was the personal and thus powerful way in which their experiences were communicated. Many participants expressed their own despair, anger and grief, as well as the knowledge they had gained and their experiences of trying to effect change. The enormous scale of the problems in many countries of the developing world was emphasized; nevertheless, certain parallels between the experience of infected and affected women in the developing world and in Canada, for example in terms of their relative economic and social power, were also clear.

### Approaches to social and cultural change

Renée Sabatier raised many issues in her comparison of a survey of the priorities, with respect to HIV prevention, that southern African women identified and ranked for themselves, with the priorities set by many organizations working in the area. The women surveyed emphasized the lack of information they had received on AIDS, the need for improving communication regarding sexuality with men through the use of parallel information systems for men, and for improving their social and economic position. The (short-term) technical solutions emphasized by many organizations – female-controlled contraception methods, proper STD and reproductive care, and the male condom – although not ignored, were considered much less important.

The relationship between the priorities identified by the women, and questions of equality and social and economic power, is obvious. Gaining greater control over one's life requires information; improving women's social and economic power will improve their negotiating power with their husbands – an important issue, given that the women identified by many speakers as being at greatest risk were married women. It is clear, however, that achieving these objectives will require long-term and far-reaching cultural change.

The speakers at the conference emphasized the problems raised by cultural practices that affect the economic and social position of women, but also cultural sexual practices. Priscilla Mishairabwi (Zimbabwe) and Felicia Sakala (Zambia), for example, both identified dry sex (practices for keeping the vagina dry, leading to vaginal lesions), sexual cleansing (widows having intercourse with members of her late husband's family), and sugar daddies (men who have intercourse with younger girls in the belief that the girls are free from HIV infection) as problems.

They emphasized the need for legal reforms and other interventions to help change these practices. Felicia Sakala favoured the use of discussion groups for, and led by, young women, as well as approaching community leaders to raise awareness of the problems. She also emphasized the need to view such interventions as a process rather than as part of the imposition of a fixed model of reform. Such process-oriented interventions illustrate how change may be effected from within a culture, using structures and networks of relationships already existing in the local context, rather than through attempts to impose a model of change developed outside that context.

This process-oriented approach is particularly noteworthy (for lawyers), given that it is often assumed or claimed that re-creating cultural practices verges on the impossible and does not respect local cultures. Furthermore, such process-oriented interventions better reflect the way culture, which can never be static or impervious to internal criticism, evolves within a particular context. Thinking about culture in terms of process avoids the rigid dichotomy – often constructed in legal discussions of cultural change – between the preservation of culture on the one hand, and the promotion of human, and in particular women's, rights on the other. This dichotomy may create a barrier to thinking about possible reforms, and denies some groups – for example, women activists – their moral and political agency: they become cultural objects rather than subjects.

Finally, this issue also provides an illustration of an important theme of the conference, namely the deleterious effects of the unequal relationship between donors in wealthier nations and the recipients of their aid in developing nations. Priscilla Mishairabwi spoke forcefully of how her organization's agenda was too driven by the needs of donors to be shown "concrete results" for their money. For example, donors might be impressed by the distribution of leaflets that, in her opinion, do not work, but not by the more intangible effects of the advocacy work she feels to be necessary. In terms of the question of promoting cultural change, this analysis indicates that while outside organizations should not shy away from supporting programs that promote social and cultural change – and the designation of a practice as "cultural" should not be a means of disregarding criticism of that practice from within the society where it is practised – they should not try to determine the content of that change or the methods by which such change is effected. As the survey discussed by Renée Sabatier indicates, those in a better position to determine policy (infected and affected women, local organizations) need to participate fully in the decision-making process if subsequent interventions are to be effective.

For more information, or to obtain a copy of the workshop report, contact the Interagency Coalition on AIDS and Development, 100 Argyle Street, Ottawa, Ontario K2P 1B4. Tel: (613) 788-5107; fax: (613) 788-5052.

- *Sarah Wilson*

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## EUTHANASIA

# Euthanasia Law and Policy

The issue of euthanasia receives abundant attention in relation to various medico-legal and philosophical arguments, but to date little serious consideration has been given to policy models for safeguarding euthanasia decisions. In the event that euthanasia or assisted suicide becomes legal in Canada, it is vital that careful consideration be given to ensuring that the implementation of such legislation is socially responsible.

In Canada, three private member's bills have attempted to address various aspects of euthanasia and end-of-life decision-making. Each has failed to pass through Parliament:

- Bill C-203:1 Relieves physicians of the legal obligation to administer treatment against a patient's expressed wishes. Brings the *Criminal Code* into balance with the existing common law right to refuse treatment, and "would also protect a physician who administers pain killing treatment to a patient even though the effect of that treatment will hasten death."

- Bill C-261:2 Would legalize euthanasia and protect physicians in situations where pain-killing treatment simultaneously hastens death. Also clarifies concerns raised by the Law Reform Commission of Canada about criminal liability for not initiating or withdrawing treatment at the request of a patient.

- Bill C-215:3 Introduced by MP Svend Robinson. Proposes the decriminalization of physician-assisted suicide for terminally ill persons.

In the United States, ten legislative euthanasia models have been introduced since 1990. The latest, Measure 16, or the *Oregon Death With Dignity Act*,4 recently passed in a referendum held on 8 November 1994. This law is called a "prescribing bill" because it permits physicians to prescribe lethal doses of drugs to terminally ill adults. Injections are specifically prohibited, but physicians and other persons are permitted to attend the suicide of patients who self-administer lethal drugs. The Act has been hailed for being a conservative proposal that would allow patients to die in "a humane and dignified manner." However, the act of ingesting lethal quantities of drugs has been shown to contribute to botched assisted deaths in conditions likened to back-street abortions.5 A key problem with the Oregon law is that it places full responsibility on the patient to self-administer the lethal medication and prohibits the direct assistance of other parties. Persons with disabilities that prevent self-administration of medications (eg, Sue Rodriguez) are ineligible. No other form of health care has ever been so restrictive. In the event that complications arise in the assisted-death process, physician and family members may risk putting themselves in legally compromising positions if they provide assistance in emergency situations.

Individuals and organizations dedicated to AIDS advocacy have been in the forefront of a lobby for some form of legalization or regulation of euthanasia or assisted suicide.6,7 The BC Persons With AIDS Society (BCPWAS) issued a position paper that was the result of several months of discussion among its members. The paper, *Choices*,6 called upon the federal government to allow individuals to "choose medically assisted euthanasia as an option, and give the individual the right to appoint a 'proxy' to exercise such decisions should they become unable to do so themselves." The BCPWAS also called for professional counselling to ensure informed decision-making by individuals seeking euthanasia.

In early 1995 the Special Senate Committee on Euthanasia and Assisted Suicide is expected to make its report available; it may contain recommendations for law reform regarding euthanasia. The Committee has received numerous submissions from interest groups, medical and health-care professionals, legal scholars, and other individuals. Although many have argued for some relaxation of the legal status quo, few have made specific recommendations for law reform and policy implementation.

Earlier this year I wrote a policy proposal intended to introduce euthanasia policy to the thus far theoretical discourse of opposing legal and ethical viewpoints.8 The proposed Aid-in-Dying/Euthanasia Act is grounded in the principles of equality of justice, self-determination, and respect for individual autonomy. It outlines model legislation respecting the cessation and withholding of medical treatment, and active voluntary euthanasia. Competent patients or their proxies who apply for euthanasia are required to meet with an Aid-in-Dying Counsellor whose purpose is to educate the applicants and ensure that they fully understand the implications of an assisted death. The counsellor determines whether the patient is being coerced, assesses capacity for informed health-care decision-making, and explores treatment alternatives with the patient, including palliative care. Recommendations are forwarded to an Aid-in-Dying Board, which reviews the application. Its purpose is to ensure that all provisions of the Act have been met, as well as to assess, approve or refuse Aid-in-Dying applications.

The proposed legislation contains a provision for proxy decision-making. In accordance with the principles of adult guardianship law, patients may appoint a surrogate to make treatment decisions, including euthanasia in the event that the patient becomes incompetent. A number of legislative safeguards are part of the policy:

- voluntary participation for applicants and physicians;

- Aid-in-Dying boards;
- counselling regarding decision-making and treatment alternatives;
- assessment of informed consent;
- time-limited Aid-in-Dying licences;
- restrictions on who may request euthanasia;
- medical supervision of assisted deaths;
- independent third party witnessing of applications;
- reviews by the Minister of Health.

It is almost certain that there is a potential for abuse and error in any policy area. This concern is paramount when it comes to policy that regulates euthanasia. Nonetheless, it has been shown that the current prohibition against assisted death is not working and that acts of euthanasia and assisted suicide are occuring with and without the assistance of physicians.5 Although these situations sometimes come to the attention of the authorities, they almost never result in criminal charges. Given the failures of the existing law, a compromise that permits a form of regulated euthanasia is worthy of consideration.

As Canadians wrestle with the extraordinary issues posed by euthanasia, it is imperative that sober attention also be given to policy areas. Without this discussion, there is significant risk that a recognition of the right to die may assume the perverse form of law that has materialized in Oregon. There, a terminally ill patient now has the right to a lethal prescription that must be taken without assistance. Such forms of coat-hanger euthanasia are risky and subject to unintended consequences. There must be a lesser evil.

- *Russel Ogden*

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## ENDNOTES

1 Bill C-203. (1991). House of Commons of Canada, 3rd Session, 34th Parliament.

2 Bill C-261. (1991). House of Commons of Canada, 3rd Session, 34th Parliament.

3 Bill C-215. (1994). House of Commons of Canada, 1st Session, 35th Parliament.

4 *Oregon Death With Dignity Act* (1994). Portland: Oregon Right to Die.

5 R Ogden. *Euthanasia*, *Assisted Suicide & AIDS*. New Westminster: Peroglyphics, 1994.

6 BC Persons With AIDS Society. Choices: A position paper on euthanasia. Vancouver: The Society, 1994. See *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 1 (October 1994) at 15.

7 C Neron & R Armstrong. Euthanasia, assisted suicide and people living with HIV/AIDS. Submission to the Special Senate Committee on Euthanasia and Assisted Suicide. Ottawa: Canadian AIDS Society, 1994.

8 R Ogden. The right to die: A policy proposal for euthanasia and aid-in-dying. *Canadian Public Policy* 1994; 20 (1):1-25.

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## HISTORY

**In May 1991, the World Health Organization had already counted 583 laws and regulations from various countries that directly concern HIV infection and AIDS. To these, more than 170 US state laws had to be added. Since then, many more laws have been passed. The following article provides an account of the beginnings of HIV/AIDS legislative and regulatory history.**

# AIDS: Toward a Regulatory History

In keeping with its traditional function of monitoring, processing, and disseminating information on all aspects of health legislation, WHO's Health Legislation Unit in Geneva has been carefully following all significant international, national, and subnational developments in the field of HIV/AIDS legislation, and in this article I propose to briefly comment on the major legislative and regulatory developments that occurred in the year 1983 (WHO's Health Legislation Unit is unaware of any legislation of any sort during the first 18 months following the first case reports from California in the early summer of 1981).1 The table below lists what appear to be the key events.

### Reporting/notification

The first item of legislation communicated to WHO on this key aspect of AIDS control consisted of Swedish Regulations of 8 March 1983, in which the National Board of Health and Welfare stated, inter alia, that "it is matter of urgency to survey suspected and confirmed cases [of AIDS] in order to provide the information necessary to decide whether preventive measures are required." Subsequently, WHO became aware of earlier regulations on the subject issued in British Columbia and in California.

### Blood safety

As far as WHO has been able to ascertain, France was the first jurisdiction to draw attention to what was then described as "the possible transmission of AIDS through blood transfusions." The particular Circular was issued by the Directorate-General of Health on 20 June 1983; three days later, on 23 June, the Committee of Ministers of the Council of Europe issued Recommendation No. R. (83) 8) on the blood safety issue. Governments of the Member States of the Council of Europe were recommended to, among other things, provide all blood donors with information on AIDS, so that “those in risk groups will refrain from donating.” It is noteworthy that on 20 January 1984, the European Parliament adopted a resolution on “an emergency Community programme of research into and measures to combat AIDS disease”; this included a call on what was then known as the Commission of the European Communities to translate the Council of Europe’s non-binding recommendations into binding Community law. No information is available to the Health Legislation Unit concerning the matter of whether or not this particular request was dealt with substantively within the Commission.

### Human rights

By far the most significant event in this sphere in 1983 was the adoption, by the Parliamentary Assembly of the Council of Europe on 23 November, of Resolution 812 (1983) on AIDS. While the term “human rights” does not actually appear in the text of the resolution, one of the preambular paragraphs reaffirms the Assembly’s “unshakeable attachment to the principle that each individual is entitled to have his privacy respected and to self-determination in sexual matters.” The Assembly recalled a recommendation and resolution, both adopted in 1981, that addressed the issue of discrimination against homosexuals, and expressed its concern at the “inaccuracy in the information circulated on AIDS by some of the media, whose sole concern is sensational news.” It emphasized that “campaigns of this kind establish a link between AIDS and homosexuality, so spreading anti-homosexual reactions.” This particular text, which appears to have received relatively little attention at the time, was of course the precursor to many subsequent developments, culminating in the Declaration adopted by the Paris AIDS Summit on 1 December 1994.

### Health-care workers

As early as 16 March 1983, the Austrian Federal Ministry for Health and Environmental Protection issued a decree containing a series of precautionary recommendations addressed to health and laboratory personnel. Corresponding provisions were introduced in Greece by a circular of 14 July 1983.

### Research and funding

As early as 30 July 1983, the State of New York amended its *Public Health Act* by the insertion of provisions setting up an Acquired Immune Deficiency Syndrome Institute within the Department of Health. Its powers and duties demonstrated considerable foresight as to the future dimensions of AIDS. For example, the Institute was charged with, among other things, developing and promoting an outreach campaign directed toward targeted high-risk populations, and promoting the availability of support services for affected persons. Particular emphasis was laid on the preservation of confidentiality with respect to personal data. This statute included provisions on funding. On 15 October 1983, a research program covering various aspects of AIDS was established in Germany by a notice issued by the Federal Minister for Research and Technology in conjunction with the Federal Minister for Youth, Family Affairs and Health.

## Conclusions

It is not possible in the course of a short article to comment substantively on the developments described here. It will be up to the social-policy historians of the future to analyze the extent to which information on regulatory issues was shared among the limited number of governments, and limited number of international organizations, then concerned with what was to become perhaps the major pandemic of the twentieth century.

- *Sev S. Fluss*

The views expressed in this article are those of the author and not necessarily those of the organization he works for.

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1 Virtually all the legal instruments covered in this article have been reported in the WHO quarterly journal, the *International Digest of Health and Legislation*.

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## PUBLICATIONS REVIEWED

## Two New Guides on HIV/AIDS in Prisons

**Canada** – Two guides, one for inmates with HIV infection or AIDS and the other for community-based HIV/AIDS workers in the Canadian federal penitentiary system, were released in the summer of 1994.

*FINDING OUT: What you need to know – A guide for inmates living with HIV* is published by the Correctional Service of Canada (CSC) and is part of a larger HIV/AIDS education program being developed for inmates in federal correctional institutions. The book, which was researched, written and produced by Andréa R. Toepell, is written for federal inmates living with HIV or AIDS. It provides inmates with information about how to live and cope with HIV infection or AIDS inside and outside prison, and one of its chapters deals with legal issues relating to HIV.

For more information about the guide, which is also available in French under the title *APPRENDRE: Ce qu'il faut savoir*, contact CSC's Health Care Services Branch at 340 Laurier Avenue West, Ottawa, Ontario K1A 0P9. Tel: (613) 995-5058; fax: (613) 995-6277.

*The Virus in the Steel: HIV/AIDS in Prisons* is a practical guide to assisting community-based HIV/AIDS workers within the Canadian federal penitentiary system. Written by Cheryl White, Education Coordinator and formerly Prison Outreach Coordinator at the Kingston AIDS Project, the guide contains a "voice from inside" (the views and reflections of an HIV-positive prisoner serving time in a federal penitentiary); an overview of the situation in Canadian federal institutions with regard to HIV/AIDS; an analysis of the political issues that inform prison AIDS work, including the philosophies and principles that have guided the author's work and the political barriers that can hamper health-oriented programs in prisons; a description of the administrative tasks involved in setting up prison HIV/AIDS outreach work; and, finally, a description of the projects and services provided by the prison outreach coordinator.

For a copy of the guide, please contact the National AIDS Clearinghouse, 400-1565 Carling Avenue, Ottawa, Ontario K1Z 8R1. Tel: (613) 725-3769; fax: (613) 725-9826. For more information about the project, write to Prison Outreach, Kingston AIDS Project, P.O. Box 120, Kingston, Ontario K7L 4V6.

- *Ralf Jürgens*

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## First Issue of French HIV/AIDS Legal Bulletin Published

Issue number 1 (September 1994) of the *Bulletin juridique national* has been produced by the Legal Group of AIDES Île-de-France. In his editorial, Pierre Lascoumes, editor of the publication and president of AIDES Paris and Île-de-France, writes that “to fight against the HIV epidemic is also to fight for the defence of rights... For ten years, the law has in fact been one of our most important weapons.” The *Bulletin* is considered to be a new working tool in the fight against various forms of discrimination.

Like its Canadian counterpart, the French *Bulletin* intends to provide a quarterly account of legal news, new texts, innovative legal judgments, the state of current litigation, and will take an in-depth look at certain topical issues. The first number, with a circulation of 1,000 copies, contains articles on businesses and AIDS, medical confidentiality, AIDS in prisons, the Criminal Code and the fight against AIDS, and insurance and the risk of excessively high death rates. For further information or to submit articles, contact: AIDES Île-de-France, *Bulletin juridique national*, groupe Juridique, 247, rue de Belleville, 75019 Paris. Tel: (33) 1-44.52.33.43; fax: (33) 1-44.52.02.01.

- *Ralf Jürgens*

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