
Canadian HIV/AIDS Policy & Law Newsletter

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Focus on HIV/AIDS in Prisons

Although the prevalence of HIV among Canadian prisoners is at least ten times higher than in the general community, far from enough is being done to prevent the spread of HIV infection in prisons and to provide prisoners living with HIV or AIDS with adequate treatment, support and care.

Canada's First National HIV/AIDS and Prisons Workshop was held in Kingston on 18-20 August 1995. Two hundred prisoners and ex-prisoners, community workers and prison activists, health-care staff and correctional officers from federal and provincial prisons, and representatives from Health Canada and the Correctional Service of Canada (CSC) met to discuss the many issues raised by HIV/AIDS in prisons. The Workshop was organized by the Toronto-based Prisoners with HIV/AIDS Support Action Network (PASAN) and was made possible with contributions from Health Canada and CSC under the National AIDS Strategy.

The Editorial Committee decided to devote a major section of this issue of the *Newsletter* to the results of this Workshop and, generally, to the legal and policy issues raised by HIV/AIDS in prisons. We did this because the Workshop confirmed that, although provincial and federal prison systems have undertaken steps in the right direction, much more can and needs to be done. In particular, prisoners are still at an increased risk of contracting HIV in prisons, and those who are infected do not always receive the care, support, and treatment that would be available to them outside.

Living with HIV in Prisons: Living with Injustice?

To live with HIV or AIDS – or to be at risk of contracting HIV – in prisons means living with injustice.

Most people do not consider prisons as part of the community, but rather as a completely separate world with its own rules and regulations, where people are sent in order to be punished, not to be cared for. In reality, prisons should be seen as an integral part of the community, and everything that goes on in them

will have an impact on society in general: prisons house people temporarily, often for very brief periods, sometimes repeatedly. Prisoners live in the community before, after and between prison sentences. However, most of society does not seem to care about what happens to prisoners and how they are treated. When attention was first drawn to the problem of HIV/AIDS in prisons, people focused:

- • first, on determining HIV incidence and prevalence in the prison population;

  • then, on the fact that prisoners could spread HIV outside prisons after their release; and

  • only last, on the fact that prisoners themselves are at increased risk of being exposed to HIV in prisons and, when HIV-positive, of dying sooner.

Society still cares little about prisoners and more about what could happen if prisoners, infected and perhaps sick, are released into the community. In order to convince governments, prison systems, and the public that prisoners need to be provided with better care and the means to be able to protect themselves against contracting HIV infection, one has to argue that, unless we as a society do so, the public is at risk. In the eyes of many, prisoners do not seem to deserve care and compassion.

This lack of care for prisoners is wrong, unfair, and based upon prejudice. Prisoners, even though they live behind the walls of a prison, are still part of our communities and deserve to be cared for. They are in prison as punishment, and not for punishment. As the Australian Minister of Health pointed out, people are sentenced to prison, not to be infected. They deserve the same level of care and protection that people outside prison get.[1]

If governments and prison systems do not take proper steps, they "will stand condemned as irresponsible and morally negligent in the safekeeping of prisoners.[2] We owe it to the prisoners, and we owe it to the community, to protect prisoners from infection in prison: "This requires radical steps before it is too late. ... The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is ... unpalatable .... As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society."[3]

- *Ralf Jürgens*

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ENDNOTES

[1] Cited in I Malkin. The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody. See infra.

[2] M Kirby. WHO Global Commission, AIDS Recommendations and Prisons in Australia. In J Norberry, M Gaughwin, SA Gerull (eds). *No 4 HIV/AIDS and Prisons Conference Proceedings*. 1991, at 7, 19.

[3] Ibid.

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Methadone and HIV/AIDS

At the recent First National HIV/AIDS and Prisons Workshop, a vocal minority of participants vehemently opposed methadone maintenance programs in prisons as well as in the community.[1] This paper presents some of the arguments in favour of increasing access to methadone programs for opiate users. It pays particular attention to the ways in which methadone can contribute to reducing the spread of AIDS among and from injection drug users.

At present, the number of spaces in methadone programs is woefully limited, and existing programs tend to be restrictive and punitive. Suggestions are made for improving methadone programs, including expansion and liberalization.[2]

Introduction

Methadone is a synthetic alkaloid chemically similar to morphine. Its effects are like those of the other opiates; the main difference is that some of the effects of methadone last longer (24 hours or more) than those of morphine or heroin (4-6 hours). The duration of withdrawal symptoms following chronic use is also longer. Methadone can be given orally in the form of a syrup, thereby decreasing injection.

The opiates themselves appear to be relatively free from significant long-term physiological side effects. However, because most users are unable to obtain drugs that are pure, they can be harmed by any impurities that may be present in the drug. If users inject opiates, they can be harmed by infections transmitted through contamination of needles and other parts of their drug paraphernalia. A majority of methadone users report a history of injection drug use and needle-sharing.

Drug legislation (the 1961 *Narcotic Control Act*) permits the use of opioids for the treatment of narcotic-dependent persons. In 1963, Dr Robert Halliday of the Narcotic Addiction Foundation of British Columbia began the first methadone maintenance program in Canada and possibly in the world. In 1988, an advisory committee reviewed the federal guidelines pertaining to use of drugs in the treatment of

opioid dependency. New guidelines came into effect in January 1993.[3] These guidelines are unnecessarily restrictive and pose a barrier to vital treatment. Furthermore, each province imposes its own guidelines on methadone distribution and the licensing of physicians. At present, the number of places in methadone programs is woefully small and the majority of programs are restrictive and punitive in nature, although methadone, in conjunction with other interventions, is considered to be the most effective means of treatment for people with opiate-related problems.

The need for expansion of methadone programs is urgent: currently there are only approximately 2600 persons in methadone treatment for opiate dependency in Canada, almost half of whom have been in treatment for more than 10 years. Not every province provides methadone treatment. Levels of HIV and hepatitis are rising rapidly in injection drug users, but the number of places in programs is small. In Metropolitan Toronto, for example, an estimated 14,000 people are in need of treatment for heroin addiction, and heroin use is rising. Nevertheless, there are less than 600 methadone spaces and only 40 physicians licensed to prescribe methadone. Waiting lists for methadone maintenance programs range from one month to over a year. The situation is slightly better in British Columbia, where 1500 users are in methadone treatment, and 170 physicians are licensed to prescribe. As a result of the recent BC Coroner's Report[4] this number is expected to increase substantially.

Methadone and the Reduction of Drug-Related Harm

Injection drug use is one of the major risk factors in new HIV cases in Canada and now accounts for more than 70 percent of new HIV cases in the US. Many injection drug users are users of opiates. In particular, there has lately been a marked increase in heroin use in North America, due to increased availability of high grade, less expensive heroin. It is estimated that 80 percent of heroin users in New York and San Francisco are HIV-positive. In Canada, rates of HIV positivity among injection drug users are lower, but have reached 20 percent in Montréal.[5]

The primary advantage of methadone is that it can reduce users' contact with crime, the black market, and contaminated drugs, at a time when opiates are prohibited by law.[6] Methadone brings users back into the community rather than treating them like outsiders or criminals. This allows not only for rehabilitation of users and linkage with HIV/AIDS services, but also breaks the drugs-and-crime cycle.

Another very important advantage of methadone is that, because it is many opiate users' treatment of choice, high retention in treatment has been observed, whereas there is a high discontinuance rate with other forms of treatment. Methadone also assures that the patient is more stably addicted than when on heroin. Flexible treatment programs, where multiple options exist for each patient, appear to be the most effective in keeping users away from illegal drugs, and the most successful at retaining clients.

The AIDS pandemic has further highlighted the significance of methadone as part of a harm-reduction approach to drug use. Because of its long-lasting effects, methadone can help keep users stabilized: they will decrease the frequency of drug use. This is particularly important for those who inject heroin. With

the help of methadone, they can either stop injection or at least decrease its frequency, thereby reducing the spread of HIV and other infections.[7] Evidence suggests that heroin users enrolled in methadone maintenance programs may have lower HIV seroprevalence than users who are not enrolled in treatment.[8] While on methadone, persons living with AIDS are able to live with their friends or families rather than on the streets, as many injection drug users do. Further, methadone has not been found to significantly affect the immune system, and, aside from naltrexone, all current licensed and experimental agents for clinical use with HIV-related disorders can be used as safely with methadone-maintained patients as with drug-free patients.

Recommendations

If methadone programs are to be truly cost-effective, some changes are needed to attract and retain more clients, and to keep them from using other drugs. For example, since methadone syrup does not provide a "buzz," some clients look for this experience elsewhere. Sufficiently high levels of methadone syrup, capable of producing the "buzz," could be provided to prevent relapse to injection. Supplying injectable methadone ampoules, with plenty of clean injection equipment, or cigarettes injected with a drug (reefers) might be other solutions. Such approaches are working successfully in Merseyside, England and now, on an experimental basis, in Switzerland.[9] However, they have met with little approval in Canada, where progress in methadone treatment is most often equated with low doses of methadone used by the patient, rather than with the patient's overall adjustment regardless of dose level.

Canada can and should learn from what other countries do. For example, in Amsterdam, methadone is provided with a minimum of impediments – low-threshold programs – in order to contact as many heroin users as possible, stabilize, detoxify, and treat them. A "methadone bus" program is used to distribute methadone throughout the drug-using community, but no take-home dosages are provided. Clients are also assisted with problems concerning housing, financial and legal matters, and are provided with regular medical examination. One of the main reasons why the methadone bus program has proven effective in getting people into treatment is that it requires no urine samples and no mandatory contact with counsellors. The number of people entering drug-free treatment and resocialization programs in Amsterdam has more than doubled since the introduction of the methadone buses and the needle-exchange schemes.

In Australia, measures introduced to combat the spread of HIV included the marked expansion of methadone programs. The criteria for admission to these programs were made less stringent, and many more spaces were allowed for maintenance of clients with little motivation to change drug-using behaviour. These changes have been supported by a change in governments' drug policy toward seeing the prevention of the spread of HIV as its highest priority. This pragmatic response has been successful and has resulted in low levels of HIV infection among Australian drug users.

In contrast, some Canadian federal guidelines for methadone maintenance are harsh and unrealistic. For example, frequent checking of urine for traces of other drug use – and the recommendation that positive urine tests lead to mandatory review of treatment and consideration of withdrawal of methadone – may

only serve to deter users from treatment, increasing the likelihood that they will go back to using other drugs and infected injection equipment. Research has shown that the rigidity of programs is positively related to rates of crime, other drug use, and exposure to infection.[10]

What we need to do in Canada is to expand and liberalize our methadone programs. This is particularly pressing in light of the spread of AIDS. It does not mean that treatment standards should be lowered; inadequate programs do not reduce injection drug use. Similarly, no attempt should be made to reduce resources for abstinence-based treatment programs. As the World Health Organization has recommended, a greater diversity of programs should be provided, including programs with less ambitious goals and objectives for those injection drug users who may not be willing or able to enter other programs.[11]

The suggested expansion and liberalization of methadone programs would require some changes to both federal and provincial guidelines:

• because the vast majority of studies suggest that rigid, inflexible protocols have deleterious effects on the recruitment and retention of otherwise compliant patients, there should be introduction of "low-threshold" programs with less stringent criteria for admission and no urine screening;

• because the data suggest that the benefits of carries (take-home dosages) outweigh the risks of diversion, carry privileges should be expanded;

• because physicians report that regulatory accountability, related to licensing, monitoring, reporting and practice standards require an undesirably high degree of control over their patients and represent a significant barrier to provision of maintenance services, regulations should be relaxed;

• because there is little reason for physicians to take on the extra work involved with methadone maintenance clients, incentives should be provided for private practitioners to become qualified to prescribe methadone.

Broader changes to improve provision of methadone in Canada would involve:

• increased training in methadone maintenance and provision of education on harm reduction to all detoxification and treatment centres and to physicians;

• a thorough review of existing legislation, policies and practices regarding methadone programs;

• an examination of the ways in which unnecessary costs could be reduced (eg, reduction of urine testing, replacing physician contact with counsellor contact);

• increased public awareness of the harms associated with heroin use and education about the benefits and cost-effectiveness of harm-reduction approaches;

• provision of methadone programs in prisons and the offering of methadone treatment as an alternative to imprisonment;

• experimentation with alternatives to methadone, including the prescribing of heroin (as is already done in the UK and in Switzerland, and planned in Australia, Germany, and the Netherlands. British Columbia is currently considering the feasibility of an experimental program); provision of smokable preparations of heroin substitutes should be considered as an option for some users;

• ready access to sterile syringes in all methadone programs, including services provided by physicians, as well as AIDS education and counselling for users, their partners and concerned others;

• closer links between methadone clinics and general hospitals and AIDS clinics to ensure a more efficient response to the present and future needs of HIV-positive drug users. Staff in methadone programs and physicians with clients on methadone should be trained to deal with the special needs of HIV-infected clients and clients with AIDS;

• encouragement of the development of self-help, mutual support and advocacy groups of former and current heroin users.

Conclusion

Implementing these recommendations would do much to reduce the harms from drug use in Canada. Moreover, it would help to reduce the spread of HIV infection among drug users and to the public. Effective methadone programs were important before the advent of HIV. They have now become an urgent, pressing need. Finally, because one of the main factors underlying drug-related harms is the fact that they are prohibited by law, it is imperative that we consider changes to our drug laws. If we don't, many of our "solutions" will remain merely band-aid approaches. Bill C-7, the proposed new Canadian drug law, comes back to the House for third and final reading this fall.[12] If it passes, it will do nothing to diminish drug-related harms and will only serve to continue and even exacerbate these harms. What Canada needs is not Bill C-7, but a thorough and independent review of Canadian drug policy and laws.

- *Diane Riley*

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ENDNOTES

[1]See infra, Results from the First National HIV/AIDS and Prisons Workshop.

[2]For a more detailed review, see D Riley. The Role of Methadone in the Treatment of Opiate Dependence. Ottawa: CCSA, 1991; D Riley. The Policy and Practice of Harm Reduction. Ottawa: CCSA, 1993.

[3]Health Protection Branch. The Use of Opioids in the Management of Opioid Dependence. Ottawa: Health and Welfare Canada, 1992.

[4]Task Force into Illicit Narcotic Overdose Deaths in British Colombia. Report. Burnaby, BC: Ministry of Attorney General, 1994.

[5]For a review of HIV infection levels, see Second National Workshop on HIV, Alcohol and Other Drug Use. Proceedings. Ottawa: CCSA, 1995.

[6]C Fazey. Heroin Addiction: Crime and Treatment. In: PA O'Hare, R Newcombe et al (eds). *The Reduction of Drug-Related Harm*. New York: Routledge, 1992, 154-161; M Schuckit. Methadone Maintenance: Is it Worth the Price? *Drug Abuse & Alcoholism Newsletter* 1992; XXI(4):1-3.

[7]M Schuckit, supra, note 6; for a detailed review, see Riley, 1991 and 1993, supra, note 2.

[8]World Health Organization (WHO). The Uses of Methadone in the Treatment and Management of Opioid Dependence. M Gossop, M Grant, A Wodak (eds). Geneva: WHO, 1989; WHO. The Content and Structure of Methadone Treatment Programmes: A Study in Six Countries. M Gossop, M Grant (eds). Geneva: WHO, 1990. See also D Riley, 1991 and 1993, supra note 2, for a review.

[9]D Riley, 1993, supra note 2; E Nadelmann. Switzerland's Heroin Experiment. *National Review*. 10 July 1995, at 46-47.

[10]E Buning. AIDS-related Interventions among Drug Users in the Netherlands. *The International Journal of Drug Policy*; 1990(1):10-13; E Springer. AIDS Prevention with Drug Users Supplanted by The War on Drugs or What Happens When You Don't Use Harm Reduction Models. *The International Journal of Drug Policy*; 1990(2):18-21.

[11]See WHO, supra note 8.

[12]See D Riley, E Oscapella. Bill C-7: Implications for HIV/AIDS Prevention. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 2 (1995) at 1, 11.

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Criminal Law and HIV/AIDS

Whether or not the criminal law should be used to deal with the behaviour of HIV-positive persons who put others at risk of contracting HIV is a hotly debated topic and has received much attention in the media and from policy- and law-makers.

As Patterson reported in a previous issue of the *Newsletter*,[1] Canada has so far resisted the temptation to amend the *Criminal Code* to contain a provision specifically dealing with HIV transmission or endangerment of transmission. However, Federal Minister of Justice Allan Rock declared in January 1995 that he was considering a *Criminal Code* amendment to make it a crime to "knowingly communicate" HIV.[2] In the absence of an offence to "knowingly communicate" HIV, there have been at least 11 cases in which existing *Criminal Code* provisions have been used to deal with HIV transmission or endangerment thereof. In most of these cases, prosecutions have been successful and have resulted in terms of imprisonment of up to 11 years.

The following is the first part of a review of these cases. The second part and a review of the literature on criminalization of HIV transmission will be published in the next issue of the *Newsletter*.

Common Nuisance

Section 180 of the *Criminal Code* provides that a person who does an unlawful act or fails to discharge a legal duty, thereby endangering the lives, safety or health of the public, or causes physical injury to any person, commits a common nuisance.

The "common nuisance" charge is traditionally used to punish people who inconvenience the general public by activities such as blocking a road or public street. Recently, however, this charge has been used in at least four cases involving persons living with HIV/AIDS who put others at risk of contracting

HIV. The use of s 180 in these cases has been criticized as inappropriate. As Shekter pointed out, "[i]n the pre-AIDS context, it has been held that a common nuisance must be directed to the public generally and cannot be utilized to support a conviction where the accused's activity is directed to specific individuals as opposed to the public at large."[3] According to Shekter, it is therefore "very much an open question whether specific acts of sexual intercourse can every [sic] constitute a "common nuisance" as that term is defined in the *Criminal Code*." This is consistent with the ruling by Livingstone J in the case of Ssenyonga.[4] He found that the fact that Ssenyonga had engaged in unprotected sexual intercourse with three women, all of whom later tested HIV-positive, was no evidence of endangerment of public health: "Unlike the situation of donation of infected blood ... there was no evidence that Ssenyonga offered himself to the general public. The evidence was of sexual relationships with specific individuals with whom he had developed relationships and they could not be said to represent the community as a whole."[5] In contrast, in the case of *Napora*, the Court of Queen's Bench of Alberta held that there was enough evidence "of a public aspect of the transmission of HIV."[6]

R* v *Summer[7]

Summer was a bisexual men with an extensive criminal record dating back to 1981. Between 1987 and 1989, he engaged in unprotected sex with a number of persons, knowing that he was HIV-infected. He did not advise his partners of his status or use any type of protection.

Summer pleaded guilty to the charge under s 180 and was sentenced to one year of imprisonment plus three years' probation. Dinkel J relied on the principle of deterrence to justify sending a strong message to the accused and the general public that this type of offence would not go unpunished. He did not accept the defence's proposition that such a sentence might drive underground those who might otherwise come forward to public authorities to seek help. In addition, he relied on the issue of public health-care costs, noting that those who contribute to the spread of HIV must be made accountable for the substantial costs associated with its treatment. Finally, Dinkel J expressed strong reservations about the chances that the accused might actually modify his behaviour in the future.

An appeal from the sentence was dismissed. The Alberta Court of Appeal noted that the case was a serious one, although not the worst of its kind. It stressed that anyone who knowingly exposes another person to the risk of contracting HIV must expect to receive a substantial period of imprisonment.

R* v *Thornton[8]

Thornton had donated blood, knowing that he was HIV-infected. He pleaded guilty to a charge under s 180(2) of the *Criminal Code*. He testified that he had donated blood as a form of blood-letting, and that he had hoped that by getting rid of some of his contaminated blood, his chances of developing AIDS would be reduced. He further testified that he thought that the Red Cross blood-screening process was foolproof and that his blood would not "get through the system." The Ontario District Court did not accept his testimony. It held that Thornton was aware that he should not donate his blood and risk causing serious damage to the general public; he was convicted to 15 months' imprisonment.

Thornton appealed from the conviction and sentence. The Court of Appeal of Ontario confirmed that his conduct amounted to a failure to discharge a "legal duty" under s 180(2). While the Court noted that there is no statutory duty to refrain from donating HIV-infected blood, it emphasized that the common law recognizes a duty to refrain from conduct that it is reasonably foreseeable could cause serious harm to others. It held that donating blood that one knows to be HIV-infected clearly constitutes a breach of such a duty, and rejected Thorton's appeal.

On appeal to the Supreme Court of Canada, the conviction and sentence were upheld. The Court held unanimously that Thorton breached his duty of care by not disclosing that he was HIV-positive, thus endangering the life, safety and health of the public (82 CCC (3d) 530, 21 CR (4th) 215, [1993] 2 SCR 445).

R* v *Kreider[9]

The accused entered a guilty plea to a charge of committing a common nuisance. He had tested HIV-positive in February 1991 and subsequently had unprotected sex with the complainant on three occasions, without telling her that he was HIV-positive. However, he later did tell her, and both sought medical advice together, at which time the accused was described as being "tearful and extremely remorseful over what he had done." The complainant tested negative six months after the last occasion of unprotected intercourse, and subsequently had protected sex with the accused.

In the Court's opinion, the accused's guilty plea confirmed that he was genuinely remorseful about what he had done. Although he clearly knew that he should not have had unprotected sex with the complainant, the evidence revealed that he might have been going through a period of temporary denial at the time of the offence. According to the Court, this evidence was not sufficient to completely exonerate the accused. However, it held that the other mitigating factors, including the fact that there was only one victim, did not make this a case deserving the harshest sentence. Nevertheless, the Court noted the gravity of the risk to the victim and stated that an unequivocal message must be sent to other HIV-positive persons who might put their partners at risk. The accused was sentenced to one year of imprisonment.

R* v *Napora[10]

Napora, a former male prostitute, tested positive for HIV in 1989. He was charged with two counts of common nuisance for engaging in consensual anal intercourse with another men, without using a condom, knowing that he was HIV-positive.

Napora was found not guilty. The evidence established that his partner could well have been already infected at the time of the instances of unprotected sexual intercourse at issue in this case.

Although consent was not a legal issue in the trial, the Court noted that – if it had been an issue – it

would have held that "the informed consent of a person to have unprotected high risk sexual activity would not relieve the HIV infected person from criminal responsibility." The Court said that it would not "allow a person to expose others to the risk of contracting a fatal disease."

Criminal Negligence

Under s 219 of the *Criminal Code*, a person is criminally negligent who in doing anything – or in omitting to do anything that is his or her duty to do – shows wanton and reckless disregard for the lives or safety of other persons.

This section has been used in at least two cases involving transmission of HIV.

R* v *Wentzell[11]

This was the first Canadian criminal case to deal with the issue of HIV transmission. Wentzell was diagnosed HIV-positive in January 1988 and was advised that he should be practising safe sex. In July and August 1988, without disclosing his status, Wentzell had unprotected sex on about 40 occasions with a woman who was six months pregnant at the time. The woman was later diagnosed HIV-positive. It was not known at the time of the judgment whether the baby had also contracted HIV.

Wentzell pleaded guilty to criminal negligence causing bodily harm. The Court noted that he was not guilty of deliberately transmitting the virus. However, by having engaged in 40 incidents of unprotected sexual activity with the complainant, he had shown wanton and reckless disregard for her life. The Court acknowledged that a reduction in the spread of HIV can only be achieved through education and awareness, and that the criminal law has only a minor role to play in this respect. However, it invoked the principle of deterrence to justify sentencing Wentzell to three years imprisonment, coupled with a recommendation that he receive all necessary treatment and counselling in prison. The Court concluded that a clear and unequivocal message must be sent that a serious crime had been committed.

R* v *Mercer[12]

Mercer pleaded guilty to two charges of criminal negligence causing bodily harm through transmission of HIV. He was convicted at trial to 27 months of imprisonment. The Crown appealed the sentence.

In April 1991, Mercer was identified by a medical officer as having been the partner of an HIV-infected woman. He was told that he might have been infected and was asked to submit to a test. Mercer was also warned and counselled about the risks of transmission. In June 1991, prior to receiving the result of his test, he had unprotected sex with a 16-year-old girl without informing her that he might be HIV-positive. The girl requested that a condom be used, but Mercer refused telling her that there was no risk.

In July 1991, Mercer received the result of his test. He was found to be HIV-positive and again he was counselled about the risks involved in unprotected sexual intercourse. When asked about his recent

partners, he failed to mention the 16-year-old girl. Mercer continued to have unprotected sex with the girl, who later tested HIV-positive. In July of 1991, he also had unprotected sex with another woman, who consequently contracted HIV.

On appeal, the sentence was increased to 11 years and three months. The Court emphasized the magnitude of the harm done and the deliberate nature of the acts and concluded that a much longer sentence was warranted. It dismissed the argument that imposing such a long sentence on a person who, knowing that he was HIV-positive, had unprotected sex without informing his partners about his serostatus, might dissuade other people to seek testing. The Court chose to send a strong message, in order to deter others from committing such acts. It concluded by saying that any degree of compassion over the fact that this sentence might well be equal to a life sentence must cede to the imperative of public protection.

- *Bruno Guillot-Hurtubise*

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ENDNOTES

[1] D Patterson. Should Canada Criminalize HIV Endangerment? *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 2 (1995) at 1, 14-15.

[2] As reported in *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 3 (April 1995) at 6.

[3] RH Shekter. The Criminalization of AIDS in Canada. In: Canadian Bar Association-Ontario (Continuing Legal Education). *AIDS*. Toronto: The Association, proceedings of a workshop held on 24 October 1992.

[4] *R* v *Ssenyonga* (1992), 73 C.C.C. (3d) 216 (Ont Ct, Prov Div), preliminary inquiry before Livingstone J.

[5] WH Holland. HIV/AIDS and the Criminal Law. *Criminal Law Quarterly* 1994; 36: 279-316 at 306.

[6] Unreported decision of 27 February 1995 (Court of Queen's Bench of Alberta, Judicial District of

Edmonton). See *infra*.

[7] (1989), 73 CR (3d) 32, 99 AR 29, 69, 69 Alta LR (2d) 303 (CA).

[8] (1991), 3 CR (4th) 381, 1 OR (3d) 480 (CA).

[9] (1993) 140 AR 81 (Alta Prov Ct), [1993] AWLD 560.

[10] See supra, note 6; for a more detailed summary, see R Jürgens. HIV-Positive Man Acquitted of Two Counts of Common Nuisance. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 3 (April 1995) at 9.

[11] File No CR 10888 (December 8, 1989, NS Co Ct).

[12] (1993), 84 CCC (3d) 41, 110 Nfld & PEIR 41 (CA), leave to appeal to SCC refused, SCC Bull, 4 March 1994, at 348.

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PROSTITUTION

Individuals and groups consulted during phase I of the Joint Canadian AIDS Society / Canadian HIV/AIDS Legal Network Project on Legal and Ethical Issues Raised by HIV/AIDS suggested that the Project should examine whether prostitution should be decriminalized or legalized to empower those in the sex trade.[1] The following is a shorter version of a literature review undertaken as part of the Project.[2] The next issue of the *Newsletter* will feature an in-depth article on current issues raised by prostitution and HIV/AIDS.

Prostitution and HIV/AIDS: A Literature Review

Generally, women and men working in the sex trade have been considered as vectors of transmission rather than persons who for many reasons, including legal reasons, are vulnerable to contracting HIV: "All over the world, prostitutes are being made the scapegoats for heterosexual AIDS."[3]

This scapegoating is taking place "in the context of a general viewing of women as vectors for transmission of the disease to their male sex partners ... and their babies."[4] Laws were "introduced to protect the interests of prostitutes' clients, considered to be potentially innocent victims of AIDS, at the expense of prostitutes, on whose side guilt is deemed to lie."[5] The media has also responded with hysteria, blaming prostitutes for the transmission of AIDS among the heterosexual population. As stated by Brock, by blaming prostitutes, "we forget that they are working women and men who attempt to maintain as much control over their working conditions, including hygiene, as possible."[6]

Government Responses to Prostitution and AIDS

It has been stated that there are two main governmental responses to the issue of prostitutes and AIDS: mandatory testing backed up with quarantine, or nothing at all.[7] This is reflected in the literature, where much attention is devoted to the issue of whether prostitutes should be mandatorily tested for

antibodies to HIV.[8] Most articles reject mandatory testing and other compulsory measures directed at "controlling" prostitutes, and suggest alternative ways of reducing the spread of HIV among prostitutes and to their clients. The policy of the AIDS and Civil Liberties Project of the American Civil Liberties Union (ACLU) points out that, as a purely practical matter, "targetting prostitutes for forced testing simply won't work as a prevention strategy," saying that "[i]f there is any group which will be driven underground by such a policy, it is prostitutes."[9] Generally, the rationale behind compulsory measures, which focus exclusively on prostitutes, but not on clients, is criticized. Alexander suggests that "governments are more interested in blaming prostitutes, and thereby appearing to do something to control the spread of AIDS, than they are in actually developing workable programs to help people protect themselves."[10] Laws under which prostitutes may be required to refrain from specific conduct, undergo specified treatment or counselling, submit to supervision, undergo treatment while detained, or, if infected with HIV, be detained during the operation of the order, may be counterproductive: "Prostitutes will not come forward for public testing for HIV infection. Clients are absolved of any responsibility for using safe sex methods because the effect of the legislation leads them to assume that working prostitutes will be 'clean'."[11] Bowleg suggests that any HIV prevention programs for women must also involve men.[12]

Alternative Strategies

Rather than coercive measures, interventions are proposed that would give prostitutes the means to protect themselves against HIV transmission and would empower them to use them. For example, Cohen et al advocate the development of educational strategies for reaching prostitutes, giving them accurate information about the ways of preventing transmission, and supporting them in their efforts to utilize these measures consistently.[13] Leigh recommends disability payments to prostitutes who may be infected, and provision of income and job-training alternatives for those who wish stop working in the sex business.[14] Similarly, the English Collective of Prostitutes has issued a list of "demands," including provision of "money and other resources, including raising Child Benefit, Supplementary Benefit and other welfare payments, so that women aren't forced into prostitution by economic need, and for women who want to get off the game."[15]

Current Laws Regulating Prostitution

According to Neave, laws that affect the sale and purchase of sex fall into three main classes: laws that punish those who work as prostitutes; laws that punish those involved in the management of prostitution; and, much more rarely, laws that punish those who buy sex.[16] Many articles criticize current laws,[17] pointing out that discrimination against and vilification of prostitutes enhances the vulnerability to infection of prostitutes themselves, their clients and others in the wider community. Among other things, it is argued that:

- • by criminalizing prostitutes, information about their experiences of AIDS, its prevention and its treatment are suppressed; and

- that prostitution laws should be changed on the basis of questions of civil liberty and prevention of exploitation, and that this would protect public health.

According to Kirby, "there is a legitimate community interest in regulating, and in some places controlling and prohibiting, public solicitation to the offence of the neighbourhood. But these concerns apart, there is a real question as to what business it is for the law to be attempting to stamp out consensual adult sexual activity. Such laws will never succeed. In the attempt, they will arm police and a whole host of officials and others with powers of oppression, intimidation, blackmail, humiliation and harassment. They will tend to drive the sex industry underground. They will promote oppression of sex workers. And they will impede the struggle against HIV."[18] As Loff points out,"[g]ood health cannot be achieved in an environment where people feel stigmatized and fearful."[19] AIDS compels us to re-examine traditional methods of responding to commercial sex: it is a much bigger threat to society than prostitution.[20]

Decriminalization

Decriminalization has been defined as "the removal of all prostitution specific laws and no government regulation of the trade;" in contrast, decriminalization "with controls" means legal recognition with government regulation of some aspects of prostitution.[21] Many authors support decriminalization of prostitution and some kind of regulation of the sex trade: "If this happened, working conditions could be controlled and condoms could be provided at all times. A prostitute could then get health insurance, workers' compensation, social security, and disability insurance like other workers, making it possible to stop working when sick or injured."[22] ACLU suggests that decriminalization of prostitution would decrease the problems of furtiveness and auxiliary criminal activity associated with it,[23] and a representative of the Canadian Organization for Prostitutes' Rights points out that the "laws that prevent prostitutes from working legally also prevent education about safer prostitution." In her view, prostitution in Canada "must be decriminalised" in order to effectively promote safer prostitution, and "[p]eople involved in outreach to prostitutes must make decriminalisation a priority."[24]

The importance of examining existing laws on prostitution was also recognized by the World Health Organization, which recommended that a meeting be organized to address issues such as "laws which impinge on social, economic, and legal rights of prostitutes and therefore impede HIV prevention efforts."[25]

The most comprehensive analysis of legal issues pertaining to sex workers and HIV/AIDS, in particular the impact of laws regulating and/or penalizing prostitution on efforts to prevent HIV infection, can be found in the report of the Australian Intergovernmental Committee on AIDS' Legal Working Party.[26] The report proposes the following public health objectives that should guide a reform of prostitution laws:

- ❍ • removing provisions that make it difficult for sex workers and their clients to take steps to protect themselves against infection;

- encouraging responsible behaviour by workers and clients;

- alleviating the stigma associated with the industry;

- promoting conditions within the culture of the sex industry to permit and encourage safer sex activities; and

- improving working conditions within the industry.

The report contains a list of "preferred options" for law reform, which includes decriminalization of prostitution and state regulation of working conditions.

Opposition to Legalization

While many support decriminalization, they emphasize that soliciting for the purpose of prostitution should not be legalized (legalization is defined as the legal recognition of prostitution with full government control). One Canadian lawyer stated: "I'd like to see women being able to work out of their own homes. That would be the ideal situation, both for safety and for dignity. But I don't want to see prostitution legalized." In her view, in every jurisdiction where prostitution has been legalized, "control has been taken away from the women and they experience oppressive working conditions."[27] The English Collective of Prostitutes also opposes legalization "on the grounds that prostitute women should be allowed to advertise and get into touch with clients legally, without interference and pimping by the State."[28] According to Overs, "[u]nconditional removal of all relevant criminal law and the introduction of regulations based on an accurate understanding and analysis is required," not partial legalization whose "intended consequence is to provide a pool of infection free women."[29]

Conclusion

The approach taken by those who seek law reforms should combine removal of criminal penalties against those who work as prostitutes with efforts to empower those who work in the business, minimize prostitution, and prevent young people from exploitation.[30] All women need to be convinced that prostitution law reform is their concern: "The real purpose of laws which punish prostitutes is to reinforce male values about sex, uphold the double standard, and discipline and divide women by treating some as respectable wives and others as whores. Women need to stand up against this process, and recognise that they, as well as their stigmatized sisters are affected by laws which criminalize those who sell sexual services."[31]

- *Ralf Jürgens*

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ENDNOTES

[1]For more details, see R Jürgens. Joint Project Identifies Priority Legal and Ethical Issues Raised by HIV/AIDS. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 4 (July 1995) at 7-9.

[2]The full version can be found in R Jürgens. Legal and Ethical Issues Raised by HIV/AIDS: Literature Review and Annotated Bibliography. Montréal: Canadian AIDS Society and Canadian HIV/AIDS Legal Network, 1995.

[3]P Alexander. Response to AIDS: Scapegoating of Prostitutes. San Francisco, CA: National Task Force on Prostitution, 1988.

[4]Ibid.

[5]AE Wills. Public Health, AIDS and Sex Workers in New South Wales. [Australian] *National AIDS Bulletin* November 1991:39-43.

[6]D Brock. Prostitutes are Scapegoats in the AIDS Panic. *RFR/DFR* 1989; 18(2):13-16.

[7]Alexander 1988, supra note 3.

[8]See, eg, P Alexander. Mandatory Testing of Prostitutes Will Not Prevent AIDS. In: CC Abt, KM Hardy (eds). *AIDS and the Courts*. Cambridge, MA: Abt Books Inc, 1990, at 132-139; L Bowleg. Unjust Punishments: Mandatory HIV Testing of Women Sex Workers and Pregnant Women. Washington, DC: Center for Women Policy Studies, National Resource Center on Women and AIDS, 1992; J Cohen, P Alexander, C Wofsky. Prostitutes and AIDS: Public Policy Issues. *AIDS & Public Policy Journal* 1988; 3(2):16-22; C Leigh. No Mandatory Testing! A Feminist Prostitute Speaks Out. *On the Issues* 1988; 10:10,24.

[9]AIDS and Civil Liberties Project, American Civil Liberties Union Foundation. Mandatory HIV Testing of Female Prostitutes: Policy Statement of the American Civil Liberties Union. In: M Blumberg (ed). *AIDS. The Impact on the Criminal Justice System*. Columbus, OH: Merrill Publishing Company,

1990.

[10]Alexander 1988, supra note 3.

[11]Wills, supra note 5.

[12]Bowleg, supra note 8.

[13]Cohen et al, supra note 8.

[14]Leigh, supra note 8.

[15]English Collective of Prostitutes. Prostitute Women and AIDS: Resisting the Virus of Repression. San Francisco, CA: US PROStitutes Collective, 1988 (US edition).

[16]M Neave. In: Sex Industry and the AIDS Debate '88. Report and Conference Papers from the First National Sex Industry Conference, Melbourne, Australia, 25-27 October 1988. St Kilda, Victoria: Prostitutes Collective of Victoria, 1988.

[17]See, eg, B Loff. AIDS Legal Workshop. Criminal Laws Impeding HIV/AIDS Prevention. [Australian] *National AIDS Bulletin*, July 1990, at 18-20; M Plant. Sex Work, Alcohol, Drugs, and AIDS. In: M Plant (ed). *AIDS, Drugs, and Prostitution*. London and New York: Tavistock/Routledge, 1990, at 1-17.

[18]M Kirby. Sex, Drugs and the Family. [Australian] *National AIDS Bulletin* 1994; 7(12):20-22.

[19]Loff, supra note 17.

[20]M Plant. Conclusions and Strategies. In: Plant M (ed). *AIDS, Drugs, and Prostitution*. London and New York: Tavistock/Routledge, 1990, at 198-204.

[21]P Rogan. In: Sex Industry and the AIDS Debate, supra note 16.

[22]Alexander, 1990, supra note 8.

[23]ACLU, supra note 9.

[24]V Scott. In: Sex Industry and the AIDS Debate, supra note 16.

[25]Global Programme on AIDS and Programme of STD. Consensus Statement from the Consultation on HIV Epidemiology and Prostitution (Geneva, 3-6 July 1989). Geneva: World Health Organization,

1989.

[26]Intergovernmental Committee on AIDS, Legal Working Party. *Legal Issues Relating to HIV/AIDS, Sex Workers and Their Clients*. Canberra: Department of Health, Housing and Community Services, 1991.

[27]A Derrick, cited in S Fraser. Defending the Right to Do the Work They Do. *Atlantic Insight* June 1988:14-19.

[28]Supra note 15.

[29]Overs. In: Sex Industry and the AIDS Debate, supra note 16.

[30]Neave, supra note 16.

[31]Ibid.

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TESTING AND REPORTING

The following article is an update on the Ontario case concerning the notification of blood donors of their HIV-positive status.

As reported in issues 2 and 3 of the *Newsletter*, many months into the Commission of Inquiry into the Blood Supply in Canada (the Krever Inquiry) it was discovered that the Canadian Red Cross Society (Red Cross) had 175,000 frozen blood samples. The samples were taken from donors at the Toronto Red Cross Centre between 1 December and 31 October 1985. In late 1994 and early 1995 they were tested for HIV; the purpose was to enable the Red Cross to trace the tainted samples to the recipients of the tainted blood. Steps have since been taken to advise the recipients. Testing revealed that there were 22 HIV-positive donors; of these, nine had been previously identified because they were repeat donors who had donated blood after testing and notification procedures were implemented in the fall of 1985. The remaining 13 HIV-positive donors were not previously known to the Red Cross. The question was: should these 13 donors be notified of their HIV status and reported to the Ontario Ministry of Health?

In its action, the Canadian AIDS Society (CAS) attempted to prevent such disclosure, arguing that only donors who specifically requested their results should be informed that the HIV test performed without their consent was positive.

Carruthers J of the Ontario Court (General Division), in a judgment released on 10 November 1994, dismissed CAS's application for an injunction prohibiting the Red Cross from releasing the names of HIV-positive donors.[1] CAS immediately appealed this decision. On 18 January 1995, the Court of Appeal ordered a rehearing of the application, and CAS obtained an interim injunction to preserve the status quo preventing reporting of the test results to Public Health pending the rehearing of the application. Only a week before the appeal hearing was scheduled, the Red Cross revealed that although the initial testing of the donor samples was done at various Red Cross blood centres, the confirmatory testing was done at the federal Laboratory Centre for Disease Control (LCDC) in Ottawa. In light of this new information, the Court of Appeal referred the matter back to the Ontario Court (General Division)

for a rehearing of the original application.[2] The new hearing began on 5 June 1995.

Further Update on Blood Donor Notification Case

Canadian AIDS Society v *Ontario*

On 4 August, the Ontario Court (General Division) released its decision, dismissing CAS's application.[3]

The first issue before the Court was whether the provisions of the *Health Protection and Promotion Act of Ontario*, RSO 1990, c H.7 (the HPPA) or the *Laboratory and Specimen Collection Centre Licensing Act*, RSO 1990, c L.1 (the LSCCLA) apply to require donors and public health authorities to be notified of the donors' positive HIV status. CAS sought a declaration that they do not apply because the confirmatory testing was conducted by the Laboratory Centre for Disease Control (LCDC). The Society argued that the LCDC is not subject to the provincial reporting requirements because it is a federal laboratory. Alternatively, it argued that the application of the reporting provisions of the Acts in these circumstances contravenes the rights of the donors pursuant to ss 7 and 8 of the *Canadian Charter of Rights and Freedoms*.

The Issue of Standing

The Court first had to consider whether CAS had standing to bring this application on behalf of the donors (a court has discretion to grant "standing" to a party so that it may take a position on behalf of the public interest, although that party need not be actually prejudiced by the law in issue). Applying the three-part test used by the Supreme Court of Canada,[4] it concluded that CAS had standing:

- • CAS was "clearly acting for a group of unidentified individuals to contest a justiciable issue;"

  • it had a "genuine interest" in the determination of the issue; and

  • were it not for CAS's application, there would be no other way for the issue to be brought before the Court.

Reporting Issues

The Court agreed that there is no obligation on the LCDC to report positive test results because the provincial legislation cannot bind the federal Crown.[5] But it held that there is an obligation on the Red Cross to report pursuant to the HPPA, notwithstanding that the second-step confirmatory testing was done at the LCDC. The facts were as follows:

- • Red Cross laboratories conducted ELISA tests on the blood samples;

  • the Red Cross requested the LCDC to perform confirmatory testing on repeatedly reactive ELISA samples;

  • the LCDC performed further ELISA screen tests, and confirmatory Western Blot and RIPA tests;

  • it then communicated the results of the testing to the Red Cross originating lab in coded form;

  • the Red Cross matched the coded test results with donor names.

The Court had to address two questions: (1) Does the Red Cross have an obligation to report the test results of the LCDC under the above circumstances? (2) Alternatively, does the positive ELISA test result trigger a reporting obligation by the Red Cross, without the need for confirmatory testing?

(1) Section 29 of the HPPA requires "an operator of a laboratory to report ... a positive medical finding" to the officer of the local health unit. The Court held that the Red Cross screening facility qualifies as a laboratory, and that the Red Cross, by linking the positive test result with the donor's identity, made a "positive medical finding" that triggers the reporting obligation pursuant to the HPPA.

(2) The Court held that a finding of repeatedly reactive ELISA test results alone would not trigger the obligation to report: because the ELISA test results are too inaccurate, they do not constitute a "positive laboratory finding in respect of a reportable disease."

Informed Consent

CAS submitted that the donors did not, at the time of their donations, provide informed consent to have their blood tested for HIV antibodies. At that time, the Red Cross was not screening blood donations.

Was Informed Consent Necessary?

While CAS argued that informed consent was necessary, the Province of Ontario argued that by donating blood the donors gave a "gift of life" and relinquished all rights to their blood, in particular their right to object to future testing and public reporting.

The Court held that when the donors made the "gift of life," they "freely and generously gave their blood to be used by the Red Cross for transfusion and life sustaining purposes." However, "[t]he retaining of personal information and testing of the Samples [sic] ten years later could not have been contemplated as part of the gift. Donors were specifically told when the blood was given that there was no test available to test for AIDS." The Court acknowledged that a finding of positive HIV status can have

"devastating personal consequences for an individual," and concluded that the "gift of life" did not include the right to conduct a test upon the sample of blood ten years later.

Was There Informed or Implied Consent to the Testing?

The question was: Could consent be inferred from the circumstances at the time? The Court held that donors had not given consent, express or implied, to the storage and testing of the samples donated.

Charter of Rights and Freedoms

CAS submitted that the reporting requirements of the Acts in the unique circumstances of this case infringe privacy rights protected by ss 7 and 8 of the *Charter*.

Section 7 of the *Charter*

Section 7 provides 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."

The Court held that there had been a breach of the donors' s 7 right to security of the person. It found that the disclosure of the donors' names to the public health authorities would "cause psychological stress to some donors, and in particular gay donors. The donors may be unaware of their HIV positive status. They were told by the Red Cross over ten years ago that HIV tests could not be conducted on their blood. Since that date, awareness of AIDS and the HIV virus [sic] has increased dramatically. At that time, and continuing unfortunately to this day, there is considerable stigma attached to HIV seropositive status."

The Court then had to decide whether the "principles of fundamental justice" had been breached. The Court balanced the state's goal of promoting public health and the rights of the individual. Giving great weight to the state objective of "promoting public health for the safety of all," it concluded (1) that CAS had failed to show that the HPPA is not in accordance with principles of fundamental justice; and (2) that, consequently, CAS had failed to prove a breach of s 7.

Section 8 of the *Charter*

Section 8 provides that "[e]veryone has the right to be free from unreasonable search or seizure."

CAS alleged that the donors' right against unreasonable search and seizure has been violated by using the information contained in the donors' blood samples without the donors' consent. The Court agreed that there had been a seizure that violated donors' expectations of privacy. However, it concluded that the seizure was not unreasonable, finding that the importance of public health objectives outweighed the individual's right to privacy.

Section 1 of the *Charter*

Although the Court concluded that a breach of the donors' rights under ss 7 or 8 could not be proved, it went on to outline what its conclusions would have been under s 1 of the *Charter* (according to s 1, the *Charter* "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society"). It concluded that, even if the donors' rights had been infringed, this would have been justified under s 1. In particular, the Court held that the provisions of the HPPA are "reasonable, and infringe rights as little as possible. As well, the effects of enforcement are not harmful in relation to the benefits of compliance with the reporting requirements of the HPPA." The Court emphasized that it was possible "with the cooperation of the donors that are still alive today that lives may be spared," and added that the "health of partners, and the partners of partners is at stake." It concluded:

- This is not simply a case about 13 well informed, possibly deceased members of the gay community. Sadly, the deadly web of this disease has likely spread much further. The important privacy rights of the 13 men who altruistically donated their blood over ten years ago must yield to the more compelling public objectives of public safety.

  It is the submission of the applicant that the HIV positive donors have the right not to know their status. This somewhat narrow view ignores the right of the HIV positive donors to this vital health information. Through an odd chain of events the Red Cross is in possession of information that may change an HIV positive individual's life. It is acknowledged that there are a minority of the 13 HIV positive donors that are asymptomatic today. Many of the 13 may be dead. There may be here an individual, or individuals who are unknowingly infecting loved ones. The donors' right to know the truth about their health appears to have been ignored by the applicant. As important as the public reporting aspect of the case may be, in my view of equal importance is the donors' right to this devastating but vital information. Compliance under the reporting provisions of the HPPA will ensure that the donors receive this information, and obtain counselling.

Appeal

The decision is being appealed.

- *Patricia A LeFebour and R Douglas Elliott*

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ENDNOTES

[1] [1994] OJ No 2789 (QL). See PA LeFebour, D Elliott. Ontario Court Rules on Notification of Blood Donors. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 2 (January 1995) at 1, 13-14.

[2] See PA LeFebour. Update on Blood Donors Notification Case. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 3 (April 1995) at 4-5.

[3] *Canadian AIDS Society* v *Ontario*, Ontario Court of Justice (General Division), 4 August 1995, court file no 4581/94, as yet unreported.

[4] *Finlay* v *Minister of Finance of Canada*, [1986] 2 SCR 407.

[5] *Alberta Government Telephone* v *Attorney General of Canada* (1989), 61 DLR (4th) 193 (SCC).

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CAS's Reaction to Judgment in Blood Donor Case

According to the Canadian AIDS Society (CAS), the court decision requiring the Red Cross to report the names of HIV-positive blood donors will make HIV prevention more difficult.[1]

Brian Huskins, president of CAS, noted that CAS is very disappointed with the judgment: "People who never consented to be tested for HIV in the first place will have their names reported to the state. Reporting their names will not serve the public good when it comes to HIV prevention because forced disclosure has the effect of discouraging people from coming forward for testing."

According to Huskins, the decision will make AIDS prevention more difficult: "We know from a lot of experience that offering people a supportive, voluntary environment for HIV testing is the only way to encourage long term prevention. We're concerned about the precedent this sets for other HIV testing and, indeed, for non-consensual testing for other purposes."

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ENDNOTE

[1]CAS. Ruling on Blood-Samples Setback for HIV Prevention, Says AIDS Society. Ottawa: The Society, news release dated 8 August 1995.

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United States: Testing of Juveniles Accused of Sexual Assault

Fuentes J of the New Jersey Superior Court recently held that a state law requiring HIV testing of juveniles charged with sexual assault was unconstitutional.[1]

Fuentes J found that testing violated the defendants' rights of privacy and was not justified by any medical needs of the victims, crediting expert testimony that "the HIV status of the alleged assailant or even the actual assailant would provide no useful information to a physician in his/her attempt to diagnose the victim of the assault." Furthermore, the judge held that testing the assailant might be harmful to the psychological health of the victim, since "a positive test from the assailant would not necessarily mean the victim is positive, and the victim would then have to be tested repeatedly, thinking she is at risk for AIDS when she may not be." The judge concluded that testing the victim is the best approach to dealing with the victim's health concerns.

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ENDNOTE

[1] *State in the interest of J.G., N.S. and J.T.*, 1995 WL 251592 (NJ Superior Ct, Chancery Div, Family Part, Hudson County). Reported in *Lesbian/Gay Law Notes* Summer 1995, at 110.

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EUTHANASIA

Whether or not euthanasia and assisted suicide should be legalized is one of the most hotly debated legal and ethical issues. Most AIDS community groups have supported legalization, arguing that terminally ill persons have a right to choose to end their life at the time they themselves choose. Previous issues of the *Newsletter* have dealt extensively with arguments in favour of legalizing euthanasia and have printed some of the position statements adopted by Canadian AIDS-community groups. In the HIV/AIDS movement, arguments against legalization are seldom made. The following article offers a variety of such arguments, and will hopefully stimulate much-needed discussion, which we will reproduce in future issues of the *Newsletter*.[1]

Legalizing Euthanasia

Proponents of legalizing assisted suicide and euthanasia often defend their case by mixing two types of argument. One is based on social policy; the other is related to individuals – their liberty, dignity, pain and suffering.

Some of these arguments are, in my view, flawed, and are inadequate to justify the legalization of assisted suicide and euthanasia. Legalization could have grave consequences, especially for those who deserve support and protection because of their vulnerability. Although AIDS advocacy groups frequently argue in favour of euthanasia and assisted suicide, I am concerned that people living with HIV/AIDS could be seriously harmed by the legalization of mercy killing.

The "New Realism"

The social-policy argument reflects a form of "new realism" that has been invoked successfully in discussions of HIV/AIDS. Thus, Ogden argues in a previous issue of this *Newsletter*[2] that the euthanasia prohibition forces people to commit acts of euthanasia or assisted suicide in appalling "conditions akin to those of back-street abortions." It could be expressed this way:

- euthanasia is prohibited;
- the prohibition forces people to commit "backstreet" acts of euthanasia;
- therefore, it should be abolished.

In other words, because euthanasia is actually practised, it should be legalized so that control can be exercised on the manner by which people are put to death.

This "realistic" approach is not new. It has been a key element in the campaign to control the spread of HIV/AIDS. Lifting many of the taboos on sexuality was necessary to inform people about how they could prevent transmission of the virus. Needle-exchange programs and the distribution of bleach are also clear acknowledgments of previously hidden practices. Against those who opposed bleach and needle distribution, it was argued that the advantages of preventing the spread of HIV/AIDS outweigh any objection to drug use.

Does this argument make sense in the context of euthanasia? As an ethical argument, it is not solid. It is a well-established ethical principle that the end does not justify the means. Although avoiding back-street acts of euthanasia is a valuable goal, it is dangerous to argue that euthanasia should *therefore* be legalized. Needle distribution can be justified, but not just because its goal is valuable. It is more justifiable than allowing euthanasia, because using drugs is not the same as killing a person or asking others for assistance in suicide. For example, the suffering and death of young girls during back-street surgical removals of the clitoris is not a reason to legalize the practice and allow physicians to perform it in "ideal circumstances." A practice can be unacceptable, independent of its goal. This can be due to the revolting character of the act, but can also be due to the social consequences of legalization.

Pain and Pain Relief

Is it true that the euthanasia prohibition is the cause of back-street killings? Euthanasia is necessary, it is claimed, because many patients are in agony and pain and are forced into life-prolonging treatments. But people are not forced to undergo treatment. It is perfectly legitimate in Canada to refuse treatment even if this clearly hastens death. It is also legitimate to refuse food and liquids. Euthanasia is not the only method of relieving pain; adequate relief is possible for most patients, including those in the terminal phase of illness. However terrible the idea of starving to death might be, those who choose to refuse food and liquids can be kept comfortable without major problems. For the approximately five percent of patients who do not respond to traditional pain-relief treatment, total sedation can be practised.

This does not mean that pain relief is always provided. Health-care professionals frequently do not provide adequate pain relief from an unfounded and often absurd fear of drug addiction. The solution is not to legalize euthanasia but to educate people, including health-care professionals, about treatment refusal and pain relief. This alone would solve many problems of suffering patients. The Special Senate

Committee on Euthanasia and Assisted Suicide, which rejected legalization, recommended making palliative care a priority and improving pain-control training for all health-care professionals.[3]

Loss of Dignity

Proponents of euthanasia argue that the measures discussed above do not mitigate the loss of dignity that dying patients might experience. Why, they ask, should society have to impose a way of dying? Both arguments are based on the idea that legalizing euthanasia is a neutral policy that allows people to choose their way of dying. Consent, in this view, would be an adequate safeguard. As I argue elsewhere, though, legalizing euthanasia does more than offer a free choice.[4]

Words such as "dignity" and "dehumanization" are not neutral, objective terms. "Dignity" refers essentially to the way others perceive us. If we feel "undignified," it is because we are so in the eyes of others around us. What constitutes dignity is culturally determined. For example, dependence on others is considered "undignified" in a society that values independence and self-determination. However, we are all confronted with loss of autonomy. We are dependent as children, and count on others when we can no longer work and take care of our own. This need not be experienced as degrading – unless it is assumed that we lose our dignity when we are physically dependent or economically useless; the latter can be fostered by a legal system.

The Message Behind Legalization

Legalizing euthanasia sends a message: when physical and mental impairment undermine autonomy, dignity is indeed lost and life is no longer worth living. Societal approval of death as a solution to dependence and loss of autonomy might, in the long run, have a serious impact on the way people perceive themselves. Laws are not neutral statements of facts; they express specific values. They also re-establish, reinforce and slowly change values. Allowing physicians to ask patients if they want to terminate their life is not tantamount to offering a choice. It shows that the lives of patients have already lost value.

A Burden to Society?

Other arguments invoked to support the legalization of euthanasia reveal growing pressure on all those who have become dependent because of age or mental and physical disability. Financial cost, not to mention the emotional cost of seeing beloved ones "without dignity," are often mentioned in support of euthanasia. Cuts in the health-care system result in less support for the sick and their relatives. This increases social pressure, making it more and more difficult to accept the idea that disability and dependence do not deprive life of value. Again, the solution is not to encourage people to choose to be killed, but to increase their psychological, medical and financial support. People should not believe that they are a burden to those around them. On the contrary, they should believe that they are owed respect and support. One British study, reported in the British Medical Journal, should ring an alarm bell. It reveals that relatives (except spouses), friends, neighbours and health-care officials are keener on

euthanasia than patients.[5] It was also concluded that, rather than being in pain, fear of being dependent and being a burden to relatives was most likely to be the reason for requesting euthanasia.

The "Value of Life"

Obviously, there are situations in which "the value of life" can seem trivial. If one is close to death, many would argue, one hour, one day or even one month does not matter if staying alive means enduring physical and mental decline, or involves a nearly vegetative existence that causes suffering to loved ones. There is no valid argument against this feeling, which depends on personal beliefs. Does it mean that in the name of liberty, we must give legal approval to killing or assisted suicide? Liberty is necessarily restricted by merely living in society. There will always be reasonable limits to the exercise of liberty.

Consequences of Legalization: The Slippery Slope

Before allowing individuals to request the assistance of others to kill themselves, we should consider the potential consequences. Slippery-slope arguments must be placed in this context. Legalizing euthanasia and assisted suicide could be the first step on that slope. I have mentioned the influence this might have on our perception of what constitutes a valuable life. We might all be forced to acknowledge that dependence and physical decline diminish human dignity.

As the New York State Task Force on Life and the Law suggested, "[o]nce assisted suicide and euthanasia are integrated into medical practice, the criteria now proposed as safeguards will prove elastic and unstable."[6] In its report on assisted suicide and euthanasia, it indicated that safeguards such as "consent," "terminal illness" and "unbearable pain or suffering" are likely to be challenged and gradually transgressed. For example, if the relief of suffering is an important aim, it seems unreasonable to limit it to those who are able to consent. "Once euthanasia becomes an accepted 'therapy,'" the New York Task Force warned, "the expansion to include those who are incapable of consenting would be a logical, if not inevitable progression."[7] Then, too, "unbearable pain and suffering" are inherently subjective terms and are unlikely to remain limited to physical suffering. Finally, what does "terminal illness" mean? How certain are medical diagnoses? Many people survive their diagnosis by many months or years.

The difficulty in keeping euthanasia within limits, once it is accepted as an exceptional procedure, is already clear in the Netherlands. There, physicians are not prosecuted for euthanasia or assisted suicide where guidelines are respected. They can perform euthanasia on explicit request if patients are forced to endure unbearable physical and/or mental suffering without any prospect of improvement. But studies indicate that between 0.8 and 1.6 percent of all deaths in the Netherlands involve cases of termination of life *without patients' consent*.[8] The New York Task Force calculated that, if the same were to occur in the US, this would amount to 16,000 cases of involuntary euthanasia a year. Moreover, the Dutch Supreme Court held in the 1994 *Chabot* case that euthanasia or assisted suicide are available options for people suffering from depression. Chabot, a psychiatrist, gave a depressed woman, who was not his patient, lethal medication after having seen her over a period of one month. The Supreme Court judged

that he should have asked the opinion of a second physician but accepted the idea that euthanasia or assisted suicide may be performed on patients who are "suffering unbearably" from depression. The Dutch policy, so often praised as a model, shows that the danger of a slippery slope is real.

Conclusion

Is everything then going smoothly under the Canadian system? Clearly not. "Back-street killings" are a concern. The suffering of patients is not helped by locking up the physicians and relatives who assist them in dying. Laws cannot predict all possible situations, but they should not treat all killings alike. It should be possible to be more lenient toward those who act in despair or out of mercy.[9] But this does *not* mean that we should give legal approval to killing. When we refuse to collaborate in suicide, we must, though, reassure people that they are not a burden to us and that we will relieve their suffering. It implies appropriate pain relief, palliative care, and adequate support of relatives and friends. This should not be forgotten when decisions about the future of health care are made.

- *Trudo Lemmens*

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ENDNOTES

[1] See the articles by R Ogden in issues 1 and 2, the British Columbia Persons with AIDS Society Position Statement on Euthanasia in issue 1, and the Position Statement on Assisted Suicide of the AIDS Committee of Toronto in issue 4.

[2] R Ogden. The Uncloseting of AIDS-Related Euthanasia. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 1 (October 1994) at 14-15.

[3] *Of Life and Death: Report of the Special Committee on Euthanasia and Assisted Suicide*. Senate of Canada, 1995.

[4] T Lemmens. Euthanasia and the Good Life. *Perspectives in Biology and Medicine* 1995 (forthcoming).

[5] L Dillner. Relatives Keener on Euthanasia than Patients. *British Medical Journal* 1994; 309(29 October):1107.

[6] The New York State Task Force on Life and the Law. *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*. New York: The Task Force, 1994, at 132.

[7] Ibid. at 133.

[8] Ibid. at 134.

[9] See *Of Life and Death, Report of the Special Committee on Euthanasia and Assisted Suicide*, supra note 3.

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Oregon's Measure 16 Declared Unconstitutional

A federal district judge of Oregon declared on 3 August 1995 that Oregon's Measure 16, legalizing physician-assisted suicide, is unconstitutional.[1]

Measure 16 had been approved by a 51 to 49 percent majority of the popular vote during the 1994 federal election. It allowed physicians to prescribe lethal doses of medication to competent, adult patients whose life expectancy is less than six months. Procedural safeguards were built in to avoid abuses and ensure choice:

- • confirmation of the diagnosis by a second physician was necessary;
- • the patient had to produce one written and two oral requests;
- • the written request had to be signed by two witnesses;
- • waiting periods of 15 days from the first oral request and 48 hours from the written request had to be respected; and
- • treating physicians had to refer patients who were depressed or suffering from another psychological disorder to a specialist.

Oregon Measure 16 never entered into effect as a result of a preliminary injunction, granted by the same court some months ago. Some terminally ill patients with histories of depression, including one patient with AIDS, claimed that the measure violated the constitutional Equal Protection and Due Process clauses of the US Constitution and the *American with Disabilities Act* and that it infringed on the freedoms of association and exercise of religion. In relation to the Equal Protection clause, they argued that, as terminally ill patients, they were not as well-protected against suicide as other people in the state. Judge Hogan, who dealt only with the Equal Protection Clause, ruled that the measure arbitrarily

"withholds from terminally ill citizens the same protection from suicide the majority enjoys." He stressed that a treating physician was not qualified to evaluate potential mental impairments of suicide applicants. "With state-sanctioned and physician assisted death at issue," the judge warned, "some 'good results' cannot outweigh other lives lost due to unconstitutional errors and abuses."

- *Trudo Lemmens*

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ENDNOTE

[1] *Lee* v *Oregon* [Civ No 94-6467-HO] 1995 WL 471792; 471797 (D Or).

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Criminal Justice

United States: HIV-Positive Rapist's Conviction Upheld

A Maryland appellate court ruled that a man who had committed a sexual assault knowing that he was HIV-positive may be convicted of attempted murder or assault with intent to murder.[1]

While incarcerated in 1991, appellant Smallwood was diagnosed HIV-positive and said that he would practise safe sex in order to avoid transmitting the virus. In 1993, Smallwood and an accomplice robbed a woman at gunpoint; according to the facts, Smallwood then sexually assaulted the woman, causing "slight penetration," without a condom. Convicted in a bench trial, Smallwood received concurrent sentences for armed robbery and attempted rape. Based on his HIV status, Smallwood also received concurrent sentences for attempted murder, assault with intent to murder, and reckless endangerment. Smallwood argued that the evidence could not support a conviction of attempted murder or assault with intent to commit murder.

The appeals court, per Bishop J, upheld the convictions. It cited cases from other jurisdictions upholding convictions where HIV-positive defendants were convicted of attempted murder for spitting,[2] biting,[3] and otherwise assaulting their victims,[4] and stated that Smallwood knew he could transmit a lethal virus by committing rape without a condom. It ruled that the trier of fact could infer that he had intended the foreseeable consequences of his actions.

Dissenting, Bloom J argued that the evidence supported two contradictory inferences as to Smallwood's mental state: specific intent to murder, which would support the convictions; and the wanton, reckless indifference that would support a conviction for the lesser crime of reckless endangerment. Bloom added that the second presumption was more convincing because, if Smallwood had intended to kill, he would have used his gun rather than relying on the speculative chance of transmitting HIV.

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ENDNOTES

[1] *Smallwood* v *State of Maryland*, 1995 WL 411379 (Ct Special App of Md, 13 July 1995). Reported in *Lesbian/Gay Law Notes* September 1995, at 126-127.

[2] *Weeks* v *State*, 834 SW 2d 559 (Tex Ct App 1992).

[3] *State* v *Smith*, 621 A.2d 493 (NJ Superior Ct App Div, 1993).

[4] *State* v *Haines*, 545 NE 2d 834 (Ind Ct App, 1989).

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HUMAN RIGHTS

Advocating for International Human Rights

The International Gay and Lesbian Human Rights Commission (IGLHRC) was founded in 1991 to fight abuses of human rights based on sexual orientation or HIV status. It advocates for a world in which the fundamental rights of gay men, lesbians, bisexuals, and persons living with HIV/AIDS will be respected and accorded the protection of international human rights law.

IGLHRC monitors and documents human rights violations, exposing the most egregious cases and mobilizing urgent responses to them. Since 1993, IGLHRC has had a presence in Canada through its Canadian Working Group, a network of individuals committed to furthering the work of IGLHRC by working with government agencies, human rights NGOs and gay and lesbian groups in Canada.

IGLHRC combines traditional human rights monitoring, documenting, advocacy, and lobbying techniques with grass-roots organizing and support, including the distribution of material aid to groups in developing countries. Despite an increasing international consensus that the rights of sexual minorities belong on the agenda of the human rights movement, IGLHRC remains the only organization solely dedicated to advancing their human rights.

In the area of HIV/AIDS, articulating the link between human rights and health status is a challenge that few have responded to. Policy makers and opinion shapers often ignore connections between health and human rights. It is therefore important that human-rights groups emphasize that human rights abuses related to HIV status are not only a violation of human rights, but also a threat to public health. For example, an IGLHRC campaign directed against threats and acts of violence against an AIDS hospice in Bogota was targeted at the Colombian Ministry of Justice, but also at the Ministry of Public Health. In another case, a campaign emphasized that denial of legal registration to a gay AIDS NGO in Tegucigalpa was an infringement of freedom of association and a barrier to effective disease-control efforts.

Such actions force us to build powerful and sometimes unexpected coalitions; at the same time, they allow us to multiply the fora and institutions before which we can seek redress for the injustices suffered. The emancipation of and full societal integration of sexual minorities is in and of itself a desirable goal. Because of HIV/AIDS, it has become indispensable to the public's health in regions where there is an elevated risk for HIV infection: mobilizing the resources necessary to fight AIDS is impossible to muster where gay men, injection drug users, sex workers, and other socially marginalized groups are denied their full rights and privileges as civic, cultural, and social agents.

Divisions between AIDS work, gay and lesbian work, and human rights work need to be overcome. IGLHRC applies this principle to its own work and tries to be active in all three areas.

- *Jorge Cortiñas*

To find out more about IGLHRC's Canadian Working Group, contact: Canadian Working Group, 1-21 Graham Ave, Ottawa ONT K1S 1X2. To contact IGLHRC's head office, or to subscribe to its publication *Emergency Response Network* (available in English, French or Spanish), contact IGLHRC, 1360 Mission Street, Suite 200, San Francisco, CA 94103, USA. Tel: (415) 255-8680; fax: (415) 255-8662; e-mail: iglhrc@igc.apc.org.

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Drug Policy

Canadian Foundation for Drug Policy Seeks New Members

The Foundation is a non-profit organization founded in 1993 by several of Canada's leading specialists in drug policy.

Its aims are:

- • to act as a forum for the exchange of views among those interested in reform of policies relating to drugs, both legal and illegal;

  • to serve as a vehicle for sharing those views and for discussing significant drug policy issues with government, the public, other organizations and the media;

  • to gather experience about innovative drug policies from around the world and share this information with Canadians;

  • to examine the extent to which drug laws and policies succeed in their objectives;

  • to examine the consequences of drug laws and policies on individual Canadians, their communities and Canadian society as a whole;

  • to examine the interplay between international and Canadian drug policies; and

  • where necessary, to recommend alternatives that will make Canada's drug laws and policies effective and humane.

The Foundation does not encourage harmful drug use.

Those interested in learning more about the Foundation or in becoming a member, please write, fax or send an e-mail to the address: 70 MacDonald Street, Ottawa, Ontario K2P 1H6; e-mail: eoscapel@fox.nstn.ca; fax: (613) 238-2891. More information about Foundation activities can also be accessed through its Internet Web site: http://fox.nstn.ca/~eoscapel/cfdp.html.

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Canadian News

Developing an International HIV/AIDS Strategy for Canada

On 5-6 October 1995, 30 representatives from Canadian governmental and non-governmental organizations, and researchers involved in HIV/AIDS work, will attend a forum organized by Health Canada. They will discuss what an international HIV/AIDS Strategy for Canada should look like.

In 1993, Canada announced Phase II of its National AIDS Strategy. Among many other things, the Strategy includes a focus on international activities. However, Canada has so far not adopted its own, independent international AIDS Strategy. Work on such a strategy started in April 1995, when the National AIDS Secretariat brought together a small group of individuals (who had previously worked together in preparing for the Paris Summit on AIDS in December 1994) to start developing a "Framework for Action" intended to help develop Canada's international AIDS Strategy. This Strategy is intended to foster a more cogent approach to Canada's response to the global HIV/AIDS pandemic by:

- • initiating collaboration among the various Canadian organizations active in international HIV/AIDS work;

  • coordinating program interventions;

  • focusing the allocation of resources; and

  • integrating Canadian health and development strategies addressing the international HIV/AIDS situation.

Participants in the forum – over one-third of whom will be representatives of international development NGOs and persons living with HIV/AIDS – will be provided with the "Framework for Action," which

suggests objectives, priorities, and a common strategy for partnership among Canadian government departments, non-governmental organizations, and people living with HIV/AIDS. Participants will have an opportunity to make recommendations regarding the contents of the Strategy, and a mechanism for its implementation will be suggested. It is anticipated that the Strategy will be finalized in the fall, and that its active implementation could start immediately thereafter. The AIDS Secretariat of Health Canada will continue to provide logistical and administrative support for its coordination.

The forum is a timely initiative. Current "international best practice" in addressing HIV/AIDS is characterized by an emphasis on a coordinated multi-sectoral approach to AIDS and closer cooperation between governments and NGOs. Experience has shown the importance of forging partnerships with those most vulnerable to HIV infection – the poor, women, sexual minorities, sex workers, and migrants – in order to address:

- • the social and cultural factors that fuel individual vulnerability to HIV infection; and

- • the limited capacity of governments to work directly with these groups.

According to historian Dennis Altman, "wherever it is possible, there will be grassroots responses to the demands of the epidemic, and no government or international agency programme can be effective if it does not co-operate with and support such responses."[1]

Most major international AIDS stakeholders increasingly reflect this understanding in their international HIV/AIDS work. UNAIDS, the new Joint United Nations Programme on AIDS, which brings together six agencies, is by definition multi-sectoral. Recently, the World Bank has recognized the importance of NGOs in addressing AIDS and has committed itself to strengthening the community response to HIV/AIDS.

The forum, which brings together representatives from a range of government and non-government sectors, is consistent with this increased emphasis on multi-sectoral, collaborative efforts in addressing HIV/AIDS. It provides important opportunities:

- • to mobilize Canadian support for the community-based response to HIV/AIDS in the resource-poor countries of the developing world; and

- • to develop a more coherent approach to Canada's international HIV/AIDS work.

While the latter is generally well-regarded, overall, it does not consciously build on the lessons learned from the first decade of the pandemic: to date, Canada's international HIV/AIDS program and research priorities have been decided by government departments, universities, and NGOs on a somewhat ad hoc basis. In the best-case scenario, individual departments, universities and organizations have policies in place to guide their international HIV/AIDS work. In the worst-case scenario, policies are outdated, limited by a view of HIV/AIDS as only a health issue, or are simply non-existent.

The absence of a stated collective commitment to a multi-sectoral approach based on government and non-government collaboration has tended to be to the detriment of support for:

- • initiatives in the developing world undertaken by NGOs, community-based groups, and persons living with HIV/AIDS; and

- • Canadian groups who want to work in solidarity with groups in the developing world.

Canadian NGOs, community-based and persons living with HIV/AIDS groups do not carry as strong a political voice as the universities or health institutions that have been well-funded to undertake international HIV/AIDS work. The bulk of Canada's international HIV/AIDS spending – over $100 million since 1985 – has either been through bilateral channels (with Canadian universities and health institutions acting as executing agencies), or through multilateral channels. At the same time, the NGO/ community sector has remained underfunded: organizations such as the International Council of AIDS Service Organizations (ICASO) and the Interagency Coalition on AIDS and Development (ICAD) have received some support, but that support is in danger of being withdrawn. Other organizations such as Global Network Plus and the International Community of Women have not received any government funding. Many Canadian international development NGOs are struggling for survival because of cuts in overall government support for NGOs.

The development of Canada's international AIDS Strategy will, one hopes, provide at least two things: formal recognition of the important role of the community sector in the fight against HIV/AIDS, and greater financial support to enable NGOs to participate in a meaningful way in supporting community-based responses to HIV/AIDS all over the world.

- *Áine Costigan*

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ENDNOTE

[1] D Altman. *Power and Community: Organizational and Cultural Responses to AIDS*. Taylor and Francis Ltd, 1994, at 166.

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International News

China: New Marriage Law

China has introduced a new law under which persons living with HIV/AIDS may be barred from marrying. The law took effect on 1 June 1995.[1]

The *Maternal and Infantile Health Law* requires couples planning to wed to pass a series of medical tests. People with sexually transmitted diseases, including syphilis and AIDS, may be barred from marrying; violators would be punished. The law also prevents people with serious hereditary diseases from marrying unless they are sterilized or take long-term contraception. Fetuses with hereditary diseases or severe defects are to be aborted.

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ENDNOTES

[1] Reported in the [Australian] *HIV/AIDS Legal Link*, vol 6, no 2 (June 1995) at 24.

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United Kingdom: New Disability Discrimination Bill

The British government has agreed to include persons suffering from symptomatic HIV/AIDS within the terms of the new Disability Discrimination Bill, now before Parliament.[1]

The Bill is intended to outlaw discrimination against persons with disabilities. The All-Party Parliamentary Group on AIDS has received assurances from the government that when Parliament resumes in October, it will put forward an amendment to include persons suffering from symptomatic HIV/AIDS within the terms of the Bill, so that they would get the same benefits and safeguards as other persons with disabilities: for example, they would be able to sue for unfair dismissal if they were dismissed from their jobs, and insurance firms would no longer be able to cancel life insurance policies of people who later develop AIDS.

The move is likely to prove controversial with some Conservative Mps, who have expressed the view that "AIDS is not like other disabilities and is frequently contracted as a result of behaviour."

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ENDNOTE

[1] See G Jones. UK: AIDS Victims Protected by Disabled Bill. London: *The Telegraph*, 1995.

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Publications Reviewed

Legal and Ethical Issues Raised by HIV/AIDS

As part of the Joint Canadian AIDS Society / Canadian HIV/AIDS Legal Network Project, a 200-page Literature Review and Annotated Bibliography has been prepared.

The Literature Review focuses on the eight issues that were identified as priority legal and ethical issues by the over 60 individuals and organizations consulted throughout the project:[1]

- Access to Care and Treatment for Persons Living with HIV/AIDS
- Criminalization of HIV Transmission
- Discrimination
- Drug Laws and HIV/AIDS
- Gay and Lesbian Legal Issues
- Legal Issues Raised by HIV/AIDS in Prisons
- Laws and Policies Regulating Prostitution and HIV/AIDS
- Testing and Confidentiality

It also includes a chapter on "HIV/AIDS, Law, and Ethics," which reviews the role of the law and ethics in responding to HIV/AIDS, and a chapter on "Women and HIV/AIDS."

The Bibliography contains not only short annotations on hundreds of books, articles, and reports, but also short summaries of most of the Canadian case law on HIV/AIDS to date.

For a copy of the Literature Review and Annotated Bibliography, in English or French, contact Ralf Jürgens, Canadian HIV/AIDS Legal Network
484 McGill Street
4th Floor
Montréal, Québec
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Phone: (514) 397-6828 Fax: (514) 397-8570
e-mail: info@aidslaw.ca
While stocks last, copies are free.

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ENDNOTE

[1] See *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 4 (July 1995) at 7-9.

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Upcoming Events

International Conference on AIDS-Law and Humanity

The conference will take place in New Delhi, India, on 6-10 December 1995. The draft program includes:

• objectives and strategy for AIDS-control programs and law;

• AIDS and socio-economic development programs;

• AIDS, industries and law;

• public health issues;

• public health and human rights law;

• economic implications of AIDS and law;

• family culture and HIV;

• customary law;

• population, AIDS and law;

• women and children;

• insurance issues; and

• communication and information systems.

The McGill Centre for Medicine, Ethics and Law in Montréal is one of the co-sponsors of the conference. For more information, contact: The Indian Law Institute, Bhagwan Das Road, New Delhi, 110 001 India. Tel: (91-11) 338-7256; fax: (91-11) 378-2140; e-mail: ILLINDLAW@aXcess.net.in

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Results from the First National HIV/AIDS and Prisons Workshop

The Workshop's goal was not to develop new recommendations. Participants agreed that the 88 recommendations in the Final Report of the Expert Committee on AIDS in Prisons,[1] and the comprehensive strategy proposed by PASAN in 1992[2] contain the elements necessary for an effective HIV/AIDS prevention and care strategy in prisons. The problem, as pointed out by them, is that recommendations are not being implemented at all, or are being done so slowly and unevenly.

Participants therefore called upon provincial and federal governments to act immediately to implement all recommendations put forward by ECAP and PASAN. At the same time, they acknowledged that some positive initiatives – such as condom and bleach distribution, a peer education and support pilot program, and availability of anonymous testing for HIV – are being undertaken or planned.

The following is a brief summary of some of the main issues discussed at the Workshop.

Testing and Confidentiality

Participants supported CSC's recent decision to make anonymous testing for HIV available to prisoners in federal prisons.[3] They pointed out that this will allow inmates who have so far been reluctant to be tested because of concern that test results will not remain confidential to come forward for testing. At the same time, participants emphasized that testing offered by prison health-care staff also needed to be made more accessible and acceptable to prisoners. This could be done by offering them the option of non-nominal testing, by training prison health-care staff in the delivery of pre- and post-test counselling, and by better protecting the confidentiality of medical information.

Educational Programs for Inmates

Participants heard about a successful education program in British Columbia, where a health educator,

contracted jointly to federal and provincial correctional services, provided education for inmates and staff in all prisons. They also heard about a peer education and support pilot program in one institution in New Brunswick,[4] and saw a video presentation by a group of inmates at Matsqui Institution who have been providing peer education and health promotion to their fellow inmates for several years. However, the importance of peer education programs still does not seem to be fully understood by provincial and federal correctional services. This was evidenced by the testimony of one inmate, who submitted a proposal for developing a peer educator training curriculum at Frontenac Institution. His proposal was refused because the institution did not "see the need for any inmate to be employed in a full-time capacity doing this type of work with his peers. Our focus is on Core Programming, which includes literacy, Living Skills Programs, Substance Abuse Programs and Mental Health Treatment for those who are in need.... This is not an appropriate time for us to consider creating a new job."[5] It became evident that staff and prison administrators need to be informed and educated about the importance of peer education efforts, pointing out that they are cost-efficient and potentially life-saving programs. A plan needs to be developed to ensure that the New Brunswick initiative is reproduced wherever possible, and that institutions are provided with the means that will allow them to create paid inmate peer educator positions.

Preventive Measures for Inmates

Condoms, Dental Dams, Lubricant

Participants were outraged that some provincial prison systems in Canada still do not make condoms, dental dams, and lubricant available to prisoners. Even where they are imprisoned for short periods of time, some inmates in provincial prisons nevertheless engage in sexual activity and are at risk of contracting HIV infection. Participants further criticized the fact that in many provincial and some federal prisons, condoms, lubricant, and dental dams for female prisoners, although available, are difficult to obtain. They called upon all prison systems and individual wardens to make condoms, dental dams, and lubricant easily and discreetly available through a variety of distribution channels, as has been recommended by ECAP and PASAN.

Bleach

Participants welcomed CSC's recent decision to make bleach easily and discreetly available in all institutions.[6] They called upon CSC to issue clear directives to ensure that bleach distribution is implemented quickly and evenly in all institutions. They further urged that all provincial systems follow suit and make bleach available.

Sterile Needles

Most participants agreed that sterile needles should be made available in prisons. Rather than discuss whether they should be made available, participants – including prison staff – therefore focused on how this should be done. They felt that Canada could learn much from the Swiss experience, where sterile

needles are being made available as part of a pilot project.[7] They suggested that CSC and provincial systems face the inevitable: sterile needles need to be made available in prisons in the interest of prisoners, staff, and the public. Therefore, as recommended by ECAP and PASAN, prison systems and governments should start putting in place the measures that will make needle distribution possible. According to participants, these include: broad consultation with prison staff and the unions; the drafting of legal opinions, as was done in Switzerland;[8] education of the public about (1) the fact that making needles available in prisons does not mean condoning drug use or giving prisoners the right to use drugs; (2) the benefits to society from making needles available: prevention of the spread of HIV among prisoners and to society, and avoidance of health-care costs related to it. While they generally agreed that needles can and should be made available to prisoners who inject drugs, participants conceded that in some prisons this may not be possible because of security problems, or may not be necessary because of low rates of injection drug use.

Methadone

A vocal minority of participants at the workshop vehemently opposed making methadone available to prisoners and to people using drugs outside prisons. They argued that "methadone does not really help people to get off drugs" and that "those in methadone maintenance programs only exchange one sort of dependence, that on narcotic drugs, against another, that on methadone." Those in favour of making methadone available emphasized that this was a pragmatic measure necessary to reduce injection drug use and the resulting risk of HIV infection. In other words: methadone maintenance may not be completely harmless, but its possible harms are insignificant when compared to the much bigger harms resulting from injection drug use. Participants pointed to ample data supporting the effectiveness of methadone maintenance programs in reducing the risk of HIV infection.[9] They stressed that people who are forced to withdraw from methadone because they are incarcerated usually return to narcotic use, often within the prison system, and often via injection. They concluded that methadone maintenance programs need to be established in prisons, particularly for those already in a program at the time of their incarceration. They also called upon federal and provincial health authorities to increase the availability of such programs on the outside.

Tattooing Equipment

Participants criticized CSC's response to ECAP's and PASAN's recommendations with regard to tattooing. They felt that tattoo equipment and supplies should be classified as hobby-craft equipment and authorized for use in the institutions, particularly in view of the fact that 54% of respondents in the survey undertaken by Trudy Nichol, Project Coordinator of the pilot bleach distribution program at Matsqui Institution, admitted having received tattoos in prison.[10]

Protective Measures for Staff

Most of the staff present agreed that they did not need more protective equipment and that, in order to protect themselves, they did not need to know who in the institution is living with HIV, but needed to

use available precautions with all inmates. They further agreed that measures to reduce HIV infection among inmates were also in their own interest. For example, at Matsqui Institution inmates are told to clean injection equipment with bleach before and after use. Correctional officers pointed out that the risk of suffering a needle-stick injury with a contaminated needle was thus significantly reduced by making bleach available. Similarly, in the Swiss needle distribution pilot, measures have been undertaken to ensure that correctional officers are in less danger of accidental needle-stick when searching prisoners' cells: prisoners are allowed to keep only one syringe in their cell, and only in a glass in a cupboard.

Health Care

It was agreed that most prison health-care services do their best to provide inmates living with HIV or AIDS with optimal care, and that often inmates are referred to outside specialists for HIV-specific diagnosis and treatments. However, concern was voiced about a marked increase in the number of sick inmates. It was pointed out that prisons are not equipped to deal with inmates who require long-term, ongoing care and treatment. It was further pointed out that prisoners with HIV or AIDS continue to find it difficult, if not impossible, to access investigational drugs or nonconventional therapies – although in its response to ECAP's *Final Report* CSC promised to facilitate inmates' access to specialized or experimental treatments. Another concern was the difficulty of obtaining narcotics routinely given for pain relief to patients on the outside. In prison, it was said, these narcotics are often denied even to those in severe pain.[11]

Compassionate Release

Participants were told about some inmates dying in prison or being released just before they died, to their deathbed. They insisted that more needs to be done to ensure that inmates with progressive life-threatening diseases who do not represent a threat to public safety be released earlier in the course of their disease.

Women Inmates

Participants felt that not enough has been done in response to ECAP's recommendations regarding the needs of female inmates, although CSC had accepted the recommendations. Apart from pointing to the need for education and prevention programs specifically designed for female inmates, most participants agreed that society and prison systems were generally failing the needs of women in Canadian prisons, many of whom have suffered a history of abuse.

Aboriginal Inmates

As with women inmates, participants felt that not much has been done to respond to the needs of aboriginal inmates. They also expressed concern about the hyperincarceration of aboriginals in Canadian provincial and federal prisons.

Young Offenders

It was pointed out that many young offenders are at high risk of contracting HIV, but that little is done by provincial prison systems to address this risk. PASAN presented a first draft of a comprehensive AIDS strategy for young offenders and is seeking input into it.[12]

Inmates' Voices

Participants regretted that only few inmates had been granted day passes to attend the Workshop. They felt that prisoners living with HIV or at risk of contracting HIV in prison are the real experts we need to listen to and can learn from. It was generally agreed that prisoners and ex-prisoners who attended, or who had prepared video presentations, made an invaluable contribution to the Workshop.

Staff's Voices

Although many more staff than prisoners attended the Workshop, it was still felt that more health-care staff, correctional officers, administrators, and other staff could and should have benefited from and participated in the discussion. Staff's voices need to be heard, because changes to prison policies can only be made with, not against, them.

Legal and Ethical Issues

One of the plenaries was organized by the Joint Canadian AIDS Society and Canadian HIV/AIDS Legal Network Project on Legal and Ethical Issues Raised by HIV/AIDS.[13] Two presentations were devoted to an analysis of some of the legal issues raised by HIV/AIDS in prison.[14] They addressed questions of access to condoms, bleach, clean needles, and methadone in prisons: Do prisoners have a right to the means that would allow them to protect themselves against contracting HIV and other diseases in prisons? Can prison systems be forced to provide condoms, bleach, and needles? Can and should the law be used to achieve changes in policies?

Drug Policy

One of the presentations at the Workshop critically reviewed Canada's drug policy and its impact on the spread of HIV in prisons. Participants agreed that many of the problems raised by HIV/AIDS in prisons are the result of Canada's drug policy which, instead of providing drug users with much-needed treatment, care, and support, criminalizes their behaviour and puts many of them in prison. The financial and human costs of this policy are enormous, and prison systems are burdened with a problem society fails to deal with, and that they are even less equipped to deal with.

Conclusion

Not surprisingly, the Workshop revealed the need for more action from federal and provincial governments and prison systems: many of ECAP's and PASAN's recommendations – including some recommendations CSC agreed with in its response to ECAP's report – have not been implemented. Participants criticized the lack of action that clearly puts many – prisoners, staff, and members of the public – at risk of their lives, and called upon governments and the prison systems to finally act upon ECAP's and PASAN's recommendations. Unless they do so, courts or a commission such as that currently examining the safety of Canada's blood supply may one day have to explore why not enough was done to prevent HIV infection in prisons, although everyone was aware of the risks and knew the measures that could be taken to reduce them. At the same time, participants acknowledged that the situation with regard to HIV/AIDS in prisons in Canada has improved over the last years, and expressed their willingness to work together and learn from each other to make further necessary changes possible. Finally, because they felt that the Workshop had provided them with much-needed information, participants said that the event should be repeated in 1997.

- *Ralf Jürgens and Julia Barnett*

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ENDNOTES

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Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 1 - October 1995

Governments' Responsibility in Preventing Prisoners' Exposure to HIV in Prisons

Do prisoners have a right to the means that would allow them to protect themselves against contracting HIV and other diseases in prisons? Can prison systems be forced to provide condoms, bleach, and sterile needles? Can and should the law be used to achieve change in prison HIV/AIDS policies?

The following articles by Ian Malkin and Richard Elliott discuss these questions. Malkin analyzes whether the tort of negligence can be used to prevent prisoners' exposure to HIV, and Elliott discusses whether denying prisoners access to sterile needles and/or to bleach constitutes a violation of their rights under the *Canadian Charter of Rights and Freedoms*.

The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody

It is no secret that prisons detain a large number of injecting drug users, gay men, lesbians, and individuals who identify as "straight" but who engage in same-sex activities. These individuals are among the most marginalized and disadvantaged in the community, and imprisonment heightens their marginalization. Because many prisoners engage in unsafe activities, they run the risk of contracting HIV/AIDS: this risk, and the spread of the virus, could be diminished substantially if it were not for the negligent conduct and choices of governments and prison administrators.

It is unreasonable for a prison authority to assert that because it does not want to be seen to encourage same-sex or drug-use activity in prison, it can pretend that it does not occur, and not provide measures to contain its spread. Because administrators manifestly cannot guarantee an environment free from the danger of infection, there is not only a moral duty to face up to that danger and address it, but a legal one as well. Its non-fulfillment amounts to negligence.

Recent developments highlight the importance of putting the search for legal redress on the legal and political agenda:

- • The possibility of seroconversion in prisons has become a documented reality: Dolan reported Australia's first confirmed case of custodial seroconversion, warning that "a disturbingly high number of HIV transmissions might have occurred," and adding that, "given the prevalence of infection and the prevalence of risk behaviour it would appear that the potential [for further seroconversions] is enormous."[1] Also in 1994, Scottish researchers documented as many as eight cases of custodial seroconversion.[2]

  • There is evidence of the rapid spread of hepatitis B and C in prisons and, by extension, of the potentially rapid transmission of HIV:

  • From January to July 1995, 200 new cases of active hepatitis C and 18 new cases of hepatitis B were reported in federal prisons in Canada.[3]

  • Three studies undertaken in Canadian prisons revealed hepatitis C seroprevalence rates of between 28 and 40 percent: (1) in the first study, undertaken at Prison for Women in Kingston, 39.8 percent of the 86.9 percent of inmates who participated tested positive;[4] (2) in the second study, undertaken at Joyceville Institution, a federal medium security federal penitentiary near Kingston, 27.9 percent of the 408 participating prisoners tested positive;[5] (3) a third study of male inmates in British Columbia showed a prevalence of 28 percent.[6]

  • Similar figures are reported from other prison systems. For example, in prisons in Victoria (Australia), 39% of 3627 prisoners tested had been exposed to hepatitis C; 46% had a history of injecting drugs. Prevalence of hepatitis is as high as 50% in prisons in New South Wales (NSW).[7]

  • Fifty prisoners launched a legal action against the State of NSW for non-provision of condoms.[8] Their lawyer noted that "[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded".[9]

  • A prisoner who seroconverted while in a maximum security institution in Queensland, Australia, has launched an action for damages for negligence against the Queensland Corrective Services Commission.[10]

These developments leave no room for complacency and, combined with the threat of legal actions by prisoners contracting HIV and other infections in prison, may provide the catalyst necessary to the institution of long-recommended changes and reasonable responses to HIV by prison authorities.

The Potential Usefulness of a Legal Action in Negligence

Given the increasing dangers posed by HIV and hepatitis in prisons, brought into focus by cases of seroconversion in custody, there is more reason than ever to utilize a legal approach involving an old, somewhat flexible proceedings in the attempt to achieve substantive change in correctional policy: prisoners may be able to demonstrate the need for changes in prison authorities' and governments' behaviour by instituting an action in negligence. Canadian prisoners could also raise important constitutional law arguments based on *Canadian Charter of Rights and Freedoms* violations.[11]

The tort of negligence gives rise to a private action or civil claim. An action in negligence is initiated by the aggrieved individual (not by the police or the Crown, if a particular act can be characterized as criminal in nature) who alleges that she or he has a cause for complaint. The complainant, or plaintiff, contends that she or he suffers harm or damage that was caused by a wrongful, careless, or unreasonable act or omission of another person, entity, or institution (the defendant in the proceedings).

The law of negligence is about balancing interests – a defendant's conduct on the one hand, and the rights of those affected by that conduct on the other. During the last several years, the law of negligence has struggled to resolve disputes in contexts far removed from those traditionally seen to be the site of careless activity, such as transportation accidents. It has taken on the role of ombudsman[12] and standard-setter, in an attempt to formulate and shape desirable behaviour. It can also act as educator, deterrer and compensator, and is being used increasingly by various elements of the community who otherwise have nowhere to turn to seek redress. At the very least, these marginalized, disenfranchised individuals are using the law of negligence to make significant public statements.

In the prison context, the primary objective is not necessarily one of securing damages for a prisoner whose seroconversion is causally linked to a prison authority's negligence, but a means through which institutional improvements can be effected. The law of negligence can provide a check on how well (or badly) duties are fulfilled, and gauge whether behaviour ought to be changed. This is particularly important in the prison context, where the relationship of dependence – respecting a prisoner's every need – is fundamental to existence and survival. Prison authorities have in fact been found negligent in several cases.[13]

Elements of the Tort of Negligence

In order for an action in negligence to succeed, the plaintiff needs to prove that he or she was owed a duty of care by the defendant, that the standard of care owed was not met, and that the breach caused actual harm.

Duty of Care

Without question, prison authorities owe a duty of care to those in their custody, based on the proximate relationship of custodian and detainee. There is, however, one possible stumbling block, which is

dependent on the court's characterization of the specific decision under consideration: the authorities may argue that prisoners' complaints concern policy or planning decisions of government, dictated by resource implications or politics, and that therefore no duty is owed. Although this arose in the *Prisoners* case in NSW, it was not fatal to the claim.[14]

Breach of the Duty of Care

Establishing a breach of duty – a failure to exercise the degree of care that is reasonable in the circumstances – may be difficult. The central question is: What constitutes reasonable behaviour on the part of prison authorities? Answering it requires authorities to abandon arguments drawn from moralizing, compelling them to engage in a dialogue embracing notions of responsibility, practicality, and confrontation of harm.

The measures currently in place to contain the spread of HIV in Canadian prisons are as follows: all systems provide some educational programs, and offer voluntary HIV testing to prisoners; most provide condoms, but rarely are they easily and discreetly accessible; in some systems, condoms are not available at all; lubricant is often not available even where condoms are available; some systems provide bleach; no system provides syringes or sterile needles. The issue is: could prison authorities be held liable in negligence for failing to comply with the standard of reasonable care expected of them, if they persist in refusing to provide access or easy access to condoms, dental dams, lubricant, bleach, and sterile needles in prisons?

Unlike previous HIV-related litigation, where claims focused on what hospitals and blood banks ought to have known at particular dates in the past, in this context there is no doubt that prison authorities have not only for several years been able to foresee the likely harm of their policies, but in fact *have known* of the existence of HIV/AIDS and how it is transmitted in prisons. The issue, then, relates not simply to the prison authorities' knowledge of the risk of transmission, but to their actual conduct, which seems premised on wilful blindness to these recognized dangers. This should all weigh quite heavily in a prisoner's favour.

On the one hand, in determining whether conduct is negligent or not, immeasurable values such as community concepts of justice, health, life, and freedom of conduct are taken into account: they favour a prisoner's contention that she or he has been wronged. On the other hand, the authorities may contend that the need to manage institutions effectively – embracing fears of labour-related strife – justifies their inaction. However, the seriousness of the risk of not providing effective, inexpensive measures favours a finding of carelessness: its gravity dictates that a strong public health, harm-reduction approach must be taken as the only reasonable response to the risk of transmission.[15]

A court's ultimate finding cannot be predicted with confidence. Knowledge of measures used elsewhere, as well as the recommendations of bodies such as the World Health Organization, can be helpful in assessing what constitutes a reasonable response. Regard would be had to the fact that many prisons worldwide provide access to condoms and to bleach, and that provision of sterile needles is being

successfully piloted in Switzerland. The latter is particularly important: the success of the Swiss program demonstrates that provision of sterile needles in prison is not merely the product of the imagination of pie-in-the-sky, ivory-tower academics or committees who could be said to have little appreciation of the actual difficulties associated with implementing such a measure. We now know that a sterile needle-distribution program in prison can realistically and successfully be implemented.[16] In fact, because some concern has been voiced regarding use of bleach[17], the only reasonable response to the risk of transmission from IV drug use may be the one that seems hardest to swallow: do on the inside what is done on the outside – provide clean needles. The fact that most systems do not provide syringes is an inadequate response to an allegation of carelessness: while examples of similar conduct may be helpful, they do not determine findings of fault. Poor practices do not excuse failures to do what a reasonable enterprise ought to do.

Has the Claimant Suffered Harm?

Traditionally, claimants have to have suffered actual harm before they can bring a negligence action; the "gist of the action" is damage. The relief granted has always been in the form of damages. However, in the NSW claim, Dunford J made some remarkable comments that dramatically affect the nature of the action: there appears to be no reason why the court should not grant an injunction in an appropriate case, even without proof of damage.[18] This approach is certainly appropriate whenever preventative measures are demanded. As the plaintiffs' lawyers argued, "[i]f the plaintiffs contract HIV or hepatitis in consequence of the continuing breach of the duty of the defendant, their losses will be irreparable, and damages will scarcely be a suitable alternative remedy. The plaintiffs ought not wait until they have compensable injury before they can take action in respect of the defendant's continuing breach of the duty of care."[19]

Causality: Is the Harm the Result of the Breach?

A court certainly has the opportunity to resolve causality in the plaintiff's favour, depending on the facts of the particular case. However, the potential stumbling blocks should not be underestimated. Were it not for the failure to provide a prisoner with sterile needles, bleach, dental dams, or condoms, depending on the nature of the behaviour in a particular instance, would a prisoner have contracted the virus? No. Of course, a negative response assumes there is evidence that the prisoner was HIV-negative prior to incarceration for a period longer than the six-month "window period" and that the infection occurred in prison. From a litigation perspective, the prisoner recently identified as having seroconverted while in prison would obviously be the plaintiff best able to litigate successfully. The argument that the measures might not have been used has been raised: however, this does not address making them *available* – thereby empowering the individual prisoner to make the decision to use or not use them (rather than the authorities). Authorities also may argue that the true cause of infection is the plaintiff's own behaviour, especially where education addressing risk reduction is provided; in response, it may be contended that the provision of education programs without providing condoms, bleach, and needles is inadequate.

Defences

Even if a plaintiff can establish a cause of action to the satisfaction of the court, the defendant still has the opportunity to negate the plaintiff's case by raising one of the following defences:

Voluntary Assumption of Risk

The most troublesome hurdle in a plaintiff's case may be the authorities' expected argument that the sufferer "voluntarily assumed the risk" of injury. However, this defence is not insurmountable, and courts have been loath to give effect to it because of its harshness in result. For example, whether a plaintiff "freely and willingly" ran the particular risk is contentious. If a drug-dependent prisoner shared an unclean needle, it could hardly be argued that she or he "voluntarily assumed the risk" of infection. In situations involving consensual, unprotected sexual activity, the issue is far more complex, but courts have in the past been prepared to recognize the complexity of human will and the importance of a broad understanding of the circumstances in which decisions are made. Of course, the authorities and perhaps the public and courts may have little "sympathy" for a plaintiff who engages in risky behaviour. But no one is asking for sympathy; rather, the demands are for reasonable, responsible conduct on the part of custodians. Further, a detainee's vulnerability in comparison to the power enjoyed by prison management cannot be ignored where the plaintiff's "free and willing" behaviour is at issue.

Contributory Negligence

The authorities may argue that a prisoner's own act of practising unsafe sex or using injecting drugs with unclean instruments should be considered a failure to take care with respect to her or his own safety. The courts may hold the prisoner contributorily negligent and apportion damages. To do so, however, would be to unrealistically assess the true dynamics of prison life: because of imprisonment, there is less opportunity for prisoners to truly take care of their own safety, as they are virtually totally dependent on the authorities for their care.

Illegality

Because drug use and sexual activity are prohibited in prison, it might be argued that a prisoner's illegal conduct defeats her or his claim. This defence should fail: unless the infringed law itself states (or implies) that a civil claim cannot be brought for an injury sustained while committing the prohibited act, the mere fact that the prisoner acted illegally does not disallow the action. Prison regulations are intended to serve institutional management efforts rather than to preclude civil recovery. The Supreme Court of Canada narrowly circumscribed the availability of illegality as a defence: "Its use is justified where allowing the plaintiff's claim would introduce inconsistency into the fabric of the law, either by permitting the plaintiff to profit from an illegal or wrongful act, or to evade a penalty prescribed by criminal law. Its use is not justified where the plaintiff's claim is merely for personal injuries sustained as a consequence of the negligence of the defendant."[20] Here, a prisoner neither profits from infringing the regime's rules, nor evades penalties in doing so; the illegal conduct is legally irrelevant. As Jürgens states: "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."[21]

The Value of the Common Law – and Its Limits

"Will the complainant succeed?" Possibly. But success in the traditional sense is not entirely the issue in these circumstances. Even if a prisoner fails, the expenses facing the authorities in having to defend claims of this nature may prove to be a factor weighty enough to tip the balance in favour of changed policies. Of course, this is not intended to minimize important factors in all HIV-related litigation: "a person who is actually suffering from AIDS ... may not have the physical or emotional strength to instruct counsel, attend discovery proceedings and be subjected to the rigour of a trial".[22] A prisoner's opportunity to enforce "common law duties is curtailed by limited access to legal aid, and probably by their own reluctance to become involved in legal disputes with their custodians. In the case of prisoners with HIV/AIDS it may be additionally unattractive because of the stresses associated with involvement in legal proceedings".[23]

However, in order to make a statement, some individuals may be willing to endure the rigours of litigation. And while legislation would certainly be a far better means by which to institute harm-reduction measures than court action, litigation and the threat of it may provide a reason for legislators' effecting improvements. The action, by and of itself, cannot compel the introduction of the necessary legislative initiatives; however, in conjunction with other strategies it may fuel reform. Regardless of actual outcomes, policies may change as a result of embarrassing publicity: it is because of the publicity generated by the prisoners' condom case in NSW that some politicians have hinted that change may be forthcoming. For example, the Australian federal health minister criticized prison authorities' resistance to providing preventative measures, stating that "[p]eople are sentenced to jail, not to be infected," and that "they deserve the same level of care as people outside get."[24]

The non-provision of sterile needles and the often difficult access to other harm-reduction measures in prisons in Canada and in other countries cannot be justified: compliance with the conduct of other prison systems does not excuse culpable, careless behaviour. If a negligence action can help demonstrate to the public and authorities the need to respond to the risk of the spread of HIV and hepatitis in prisons, then instituting proceedings will have proven worthwhile. However, as noted earlier, one of the problems with using the law of negligence as it is traditionally understood, and not as suggested by Dunford J, is that damage must have occurred. In Australia and Scotland, with the recognition of documented cases of custodial seroconversion, this requirement has been satisfied; an after-the-fact remedy can now be pursued, if the sufferers wish to do so. A case has already been instituted by a prisoner who contracted HIV while in prison in Queensland, Australia.[25] It seems inevitable that other cases will soon be instituted by prisoners, in Canada or elsewhere, who have seroconverted while in prison and who would have used condoms or bleach or syringes had they been available. They will sue the authorities for their failure to satisfy the reasonable level of care owed to them by refusing to provide preventative measures. The problem is real. Only the most irresponsible authorities and governments would persist – at their potential legal peril – in refusing to provide measures that would prevent the grave harm of custodial

seroconversion. Courts are now in a position of being able to legally condemn the authorities' inaction.

- *Ian Malkin*

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ENDNOTES

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Canadian HIV/AIDS Policy & Law Newsletter

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Prisoners' Constitutional Right to Clean Needles and Bleach

Despite evidence that sharing of contaminated needles in order to inject intravenous drugs is frequent among prisoners, the Correctional Service of Canada (CSC) and all provincial prison systems still deny prisoners access to clean needles; many systems even deny access to bleach. Can the argument be made that denying prisoners access to clean needles and/or bleach is a violation of their constitutional rights?

Arguably, three sections of the *Charter* may provide a home for prisoners' right to protection, and might be used to seek the implementation of needle exchanges and distribution of bleach kits in prisons.

Section 7: Rights to Life and Security of the Person

Decisions in two major cases by the Supreme Court of Canada suggest that prisoners' right to protect against HIV infection could be framed as an aspect of the right to "security of the person" (under s 7 of the *Charter*, "[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").

In *Singh* v *Minister of Employment and Immigration*, [1985] 1 SCR 177, Wilson J held that s 7 encompasses freedom from the threat of physical punishment or suffering as well as freedom from the punishment itself, and cited with approval the finding in *Collin* v *Lussier*, [1983] 1 FC 218 (TD) that security of the person is infringed not only by an actual impairment of health but also by a likelihood that health would be impaired.

In *R* v *Morgentaler*, [1988] 1 SCR 30, she held that state interference with bodily integrity offends the right to security of the person, and Dickson CJC also ruled that s 7 "extends to state-imposed limitations upon the ability of persons to obtain beneficial medical treatment where those limitations do not adequately take into account the needs, priorities and aspirations of those persons." Beetz J concurred that s 7 is violated where such a limitation endangers a person's life or health.

In light of these cases, the argument could be made that the denial of access to clean needles and/or to bleach violates prisoners' security of the person by increasing the likelihood of HIV infection. (The violation of the right to life is simply an extension of this argument, given that HIV infection is held to be ultimately fatal.) Evidence would have to be advanced to establish the requisite link between the denial of needles and bleach and this increased risk; research demonstrating this link abounds.

Section 7 offers a "preventative" legal remedy. It may be invoked to prevent future harm resulting from state action (eg, future transmission among prisoners of HIV or other bloodborne diseases, such as hepatitis C). Granted, the decision in *Operation Dismantle Inc* v *R* (1988), 45 CCC (3d) 57 (SCC) establishes that s 7 does not impose a duty on the government to refrain from any act that *might* lead to consequences that deprive or threaten to deprive individuals of their life and security of the person. Yet Dickson J was careful to note that remedial action by the courts remains an option where "the link between the action and the future harm alleged" is capable of proof. Therefore, the success of this argument will depend heavily on the evidence presented to establish the relationship between IV drug use, needle-sharing and HIV transmission in prisons, and to establish that denying access to clean needles and bleach directly contributes to the risk of HIV infection.

Once the connection is established between the impugned state action and the increased risk of HIV infection, the next step will be to show that this infringement of the rights to life and security of the person is not "in accordance with the principles of fundamental justice." What exactly those principles are is rather unclear, although the Court said in the *B.C. Motor Vehicle Reference*, [1985] 2 SCR 486 that they "are to be found in the basic tenets of our legal system." If those principles are intended to promote the dignity and well-being of the individual and society – and presumably this is a fundamental purpose of constitutional rights such as liberty and security of the person – how could the state justify a policy that not only precludes people from protecting themselves against infection with a deadly virus, but in fact contributes to the likelihood of its spread? Could denying people the right to self-preservation be consonant with notions of "fundamental justice"?

Section 12: Cruel and Unusual Punishment

There is also an argument to be made that denying prisoners clean needles and/or bleach constitutes "cruel and unusual treatment or punishment" (under s 12 of the *Charter*, "[e]veryone has the right not to be subjected to any cruel and unusual treatment or punishment"). According to the Supreme Court of Canada in *Miller and Cockriell* v *The Queen*, [1977] 2 SCR 680, a punishment violates s 12 if it is "so excessive as to outrage standards of decency." This test of "gross disproportionality" between the effect of a punishment and what would have been appropriate has been affirmed in subsequent cases.

In *R* v *Smith*, [1987] 1 SCR 1045, it was held that a punishment violates s 12 of the *Charter* if it either (a) "outrages the public conscience" or is "degrading to human dignity," or (b) goes beyond what is necessary to achieve a valid social aim, "having regard to the legitimate purposes of punishment and the adequacy of possible alternatives." In the subsequent case of *R* v *Goltz* (1991), 67 CCC (3d) 418 (SCC), the Court noted that the nature and conditions of a sentence, and not merely its duration, must be

considered in determining whether it is cruel and unusual.

The case could be made that denying prisoners the right to protect themselves against HIV infection satisfies the test of "cruel and unusual": it is degrading to human dignity, it goes beyond what is necessary to achieve the social aim of reducing IV drug use, and it is not a legitimate purpose of punishment. Furthermore, research suggests that alternative approaches to dealing with IV drug use among prisoners, based on a harm-reduction model, are more rational and effective than a blanket denial of access to clean injection equipment. The prohibition appears even more excessive in light of the federal *Corrections and Conditional Release Act*, which states that the correctional system's operating premises include the protection of inmates, the safe and humane care of offenders, and the provision of programs to achieve these ends. The *Act* also affirms that offenders retain the rights and privileges enjoyed by all members of society, except for those necessarily restricted as a consequence of their sentence. Those on the outside can access needle exchange programs; why should denying prisoners access to such programs be a necessary consequence of imprisonment?

Section 15: Equality Rights

This last argument is closely related to a potential equality rights argument: does it constitute "discrimination" within the meaning of s 15 of the *Charter* to deny prisoners access to protective methods that those on the outside can access? Under s 15(1), "[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." In order to succeed, it would have to be shown that the status of being incarcerated is a prohibited ground of discrimination analogous to those enumerated in s 15. The case law interpreting s 15 indicates that this would require showing that not only are prisoners treated differently than non-prisoners, but that this distinction imposes disadvantages on prisoners or denies them benefits available to others.

There is a distressing trend in recent decisions to limit the protection of s 15 only to "discrete and insular minorities" or to groups or individuals who can demonstrate some sort of stereotyping, vulnerability to prejudice, or historical disadvantage apart from the distinction being challenged. Such an interpretive approach in effect renders s 15 static, allowing the courts to address past discrimination but precluding the recognition of new target groups or new categories of discrimination. Such a result stands in opposition to numerous statements that the interpretation of s 15 must be "context-dependent" and that all *Charter* rights need to be interpreted generously and purposively.

However, there is still room to argue that these conditions are not necessary requirements for concluding that a distinction is "discriminatory" within the meaning of s 15, but merely "indicia of discrimination" (in the words of Wilson J in *R* v *Turpin*, [1989] 1 SCR 1296 at 1333) that assist in the interpretive task. Even if s 15 is interpreted narrowly so as to necessarily require evidence of historic disadvantage in order to find a given legal distinction "discriminatory," evidence could be put forward showing that prisoners do constitute such a group.

Section 1: The State's Justifications for Violating Prisoners' Charter Rights

If a breach of one of the above rights can be established, the state will seek to justify the prohibition on needles and bleach under s 1 of the *Charter*, most likely arguing that its goal is to prevent IV drug use in prisons and to protect the safety of correctional officers and inmates (according to s 1, the *Charter* "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society").

In order to rebut these claims, evidence will be needed to establish that there is no "rational connection" between the policy of prohibiting needles and bleach and the goal of preventing drug use (as required by the Supreme Court in *R* v *Oakes* (1986), 24 CCC (3d) 321). This evidence can be provided. First, studies indicate that, despite the lack of clean equipment, drug use continues among prisoners, and needle-sharing increases because of the shortage of injecting equipment. Second, implementing a needle-exchange program will not threaten the safety of guards: (1) If needles were exchanged one-for-one (one used against one sterile needle), there would not be a net increase in the number of needles in the prison population. In fact, such a needle-exchange program would likely improve correctional officers' safety, reducing their chances of suffering a needle-stick injury with a contaminated needle. (2) Even if provision of needles resulted in a net increase in the number of needles in the possession of inmates, rules could be established to safeguard staff safety, as demonstrated in the Swiss pilot project.[1]

Furthermore, it should be pointed out that denying prisoners access to clean needles and bleach may not satisfy the *Oakes* requirement that constitutional rights be impaired "as little as possible": placing captive persons at increased risk of HIV infection is hardly a minimal impairment of the right to protection, be it framed as a claim under s 7, s 12, s 15, or all three. In *McKinney* v *University of Guelph* (1990), 76 DLR (4th) 545 (SCC), it was held that courts must turn to available knowledge, including social science evidence, in assessing the question of minimal impairment: again, evidence of the effects of prohibiting the possession of clean needles and/or bleach can be presented to establish the seriousness of the violation being challenged.

While the *Charter* offers a "preventative" legal remedy, and litigation could be used as a way to prevent future cases of HIV transmission, it seems that the strongest test case in which to advance the above *Charter* arguments would be one brought by a prisoner who was infected through needle-sharing while incarcerated. In such an instance, a court would be faced with an existing harm that is alleged to flow, at least in part, from the state's prohibition – as opposed to being asked to strike down government policy because of its potential for future harm.

Finally, regardless of which *Charter* provision(s) is/are invoked to advance the arguments, it is important to stress that the constitutional interest being litigated is not a "right" of prisoners to inject IV drugs, but the right of prisoners to protect themselves against HIV infection, given the reality – acknowledged by correctional systems – that drug use and needle-sharing occur in prisons.

- *Richard Elliott*

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ENDNOTE

[1] See supra, Jürgens and Barnett. Results from the First National HIV/AIDS and Prisons Workshop.

Canadian HIV/AIDS Policy & Law Newsletter

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HIV Transmission and Advocacy for Harm Reduction in US Prisons and Jails

In the US, the number of people in state and federal prisons and city or county jails continues to increase at record-setting levels. In 1994, state and federal prisons had over 83,200 new entrants – the second largest increase in history – and almost 1.5 million people were behind bars on any given day.[1]

The so-called War on Drugs has been a boon to the US prison industry: in 1994, over 25 percent of state and federal inmates served time for drug-related crimes, compared to eight percent in 1980.[2] Minorities are vastly over-represented: African-Americans represented over 50 percent, and Hispanics 14 percent, of the total sentenced inmate population in 1993.[3]

At the same time, the AIDS epidemic in the US is increasingly an epidemic of injection drug users (IDUs) and their sexual partners. Very high rates of HIV-infection among prisoners are the result of wide-scale incarceration of IDUs, many of whom are living with HIV/AIDS, on drug-related and other crimes. Conservative estimates indicate that the median AIDS incidence rate in correctional facilities for 1992-93 was 20 times higher than in the general population.[4]

In prisons and jails, high-risk sex and drug use are commonplace. Prisoners and their advocates, and correctional staff and officials, have known this for some time. Recently, the extent of high-risk activities and the ensuing risk of HIV transmission has been confirmed by researchers:

- • Mutter and colleagues identified 556 prisoners in the Florida Department of Corrections who had been continuously incarcerated since 1977. The medical records of these prisoners were reviewed to determine whether they had been tested for HIV and, if tested, whether the results were positive. Eighty-seven of the 556 prisoners had undergone testing for HIV infection. Of these, 18 (21 percent) were found to be HIV-positive, providing strong evidence for transmission of HIV in prison.[5]

• I conducted a focus-group study in New York, in which prisoners and former prisoners reported frequent and tragic instances of unprotected sex and often-desperate injection drug use with used injection equipment being used behind bars.[6]

Nevertheless, not much is being done to prevent HIV infection among prisoners. Although the White House Office on AIDS/HIV Policy endorsed the distribution of condoms and dental dams behind bars,[7] only five jurisdictions – New York City, Philadelphia, Washington, DC, Vermont and Mississippi – distribute condoms to male prisoners.[8] Only two – San Francisco and the District of Columbia – distribute dental dams and condoms to female inmates.[9] Bleach is nowhere officially made available to inmates in the US. In contrast, prisoners have access to latex barriers and bleach in many countries where HIV rates among inmates are lower than in the US.[10]

In correctional systems in the US where latex barriers are available to prisoners, access to them was made generally possible by the determination and persistence of individual service providers and local departments of health. Working in partnership, prison advocates and public health officials approached correctional officials and requested changes in or exceptions to correctional regulations that would allow for HIV education and prevention. For prison advocates everywhere, this attests to the necessity of seeking out public health and correctional officials as potential allies.

Largely because of mounting anti-prisoner sentiment in the US, distribution of latex barriers and other harm-reduction devices – such as bleach and sterile needles – in prisons and jails has become an increasingly difficult goal to achieve. As in many other countries, the legislative and judicial branches of the US government grant correctional officials wide discretion in operating prisons and jails. In jurisdictions where correctional officials themselves will not consider distribution of harm-reduction devices, advocates face substantial and perhaps insurmountable opposition.

Litigation is one potential means of challenging correctional officials' resistance to the introduction of harm-reduction devices into prisons and jails. Since 1964, when the US Supreme Court first declared that prisoners have constitutional rights, litigation – particularly claims under the Eighth Amendment to the US Constitution, which prohibits correctional officers from imposing "cruel and unusual punishment" on prisoners – has been the major avenue for reform in correctional polices and conditions in the US. Over the last few years, however, prisoners' access to federal courts has been under siege. Those who propose restricting prisoners' access to courts often refer to the large numbers of meritless claims filed by prisoners, yet in a strikingly high number of instances prisoners prevail at the bar. It suffices to say that prisons and jails in at least 24 states are currently under court order for violations of the health-care standards mandated by the US Supreme Court in *Estelle v Gamble* in 1976.[11] In that case, the Supreme Court recognized a prisoner's right to health care, declaring that "deliberate indifference" to an inmate's "serious medical needs" violated the Eighth Amendment.

Prisoners seeking the introduction of harm-reduction devices could file suit against correctional officials. Such a case would most appropriately be framed as an Eighth Amendment claim, alleging that correctional officials had been "deliberately indifferent" to prisoners' safety by denying them access to

HIV risk-reduction tools. A similar suit was filed by prisoners in New South Wales, Australia in 1994. [12]

For the potential suit in US courts to prevail, plaintiffs would have to meet the formidable test for Eighth Amendment prison conditions claims. As currently interpreted by federal courts, this standard has two prongs:

- • the objective requirement, which dictates that the challenged conditions must pose a "substantial risk of serious harm" to prisoners; and

  • the subjective requirement, under which plaintiffs must prove that the correctional official personally knew of and disregarded an excessive risk to inmate safety.

A full analysis of a potential Eighth Amendment claim is beyond the scope of this article. However, it is unlikely that the claim would prevail, due to two factors:

- • the increasingly conservative trend in courts' rulings on Eighth Amendment claims;

  • the enormity of the plaintiffs' burden in proving that the correctional officials had personal knowledge of the risk of infection.

Moreover, given the strong anti-prisoner sentiment in the general public and the increasingly limited scope of the Eighth Amendment, the viability and political wisdom of such a suit must be questioned. In the current climate, filing an Eighth Amendment claim could cause a backlash against prisoners, prison advocates and prison legal services, which are already under political and economic siege.

Rather than through litigation, advocates for the introduction of HIV risk-reduction tools in prisons and jails in the US should pursue their goal through coalition-building, in particular with public health authorities. Results of research on incidence and prevalence of high-risk behaviour behind bars, and examples of successful harm-reduction programs in prisons in other countries (such as Canada, Switzerland and Australia), will be invaluable for any advocacy efforts. Indeed, the need for international collaboration cannot be overestimated: arguments often made by correctional officials against the introduction of harm-reduction devices – such as that prisoners will use them as weapons – can best be refuted with examples of successful prison-based harm-reduction programs, programs that have not had any negative consequences with respect to safety and security in the institutions, and are supported by prisoners, staff, prison administrations, and the public.

- *Nancy Mahon*

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ENDNOTES

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[6] N Mahon. High Risk Behavior for HIV Transmission in New York State Prisons and City Jails. *American Journal of Public Health* 1995 (forthcoming).

[7] Oral remarks of Ben Merrill, Special Assistant to the Director, White House Office of AIDS Policy. Presented at the First National AIDS/HIV in Prison Roundtable, 15 October 1993. San Francisco, CA.

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[11] 429 U.S. 97, 97 S. Ct. 285 (1976). See also N Mahon. Where Medical Treatment is Criminal. *The New York Times*. Op-Ed, 2 July 1994.

[12] *Prisoners A to XX inclusive* v *New South Wales*, 1994. See also I Malkin. The Role of the Law of

Negligence in Preventing Prisoners' Exposure to HIV While in Custody, supra; and *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, nos 1 and 3.

Canadian HIV/AIDS Policy & Law Newsletter

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Inmates' Voices

Unfortunately, only a small number of inmates were able to attend the First National HIV/AIDS and Prisons Workshop. Michael Linhart, a prisoner living with HIV in a federal institution in British Columbia, was one of the few who could participate. He prepared a video presentation that was screened at the opening plenary. We reprint this presentation in slightly edited form. It is evidence of how important inmates' participation is: inmates are, without doubt, the real experts who know better than any other person what goes on in prisons.

HIV/AIDS in Prisons: A Prisoner's View

Four years ago, when I first became involved with HIV/AIDS issues, there was little more than a Commissioners' Directive on the Management of Inmates with HIV/AIDS[1] and PASAN's recommendations.[2]

Shortly afterward, the Expert Committee on AIDS and Prisons was formed. The Committee produced a report that, in my opinion, contains good, solid, and well-founded recommendations on how to address the problem of HIV/AIDS in prisons.[3] With PASAN's recommendations and ECAP's report, the Commissioner of the Correctional Service of Canada (CSC) has at his disposal all the recommendations necessary to implement an effective plan to reduce the spread of HIV/AIDS within prisons and to those who will be in contact with prisoners during or following their release.

Unfortunately, there is currently a great deal of apathy on the part of both Correctional Service officials and inmates. No recommendations, however well thought-out and realistic, will be effective against

apathetic minds. If there is any hope in reducing the spread of HIV/AIDS in our prisons, a way needs to be found to motivate both CSC employees and inmates to work together to fight HIV.

To be fair, not all inmates and staff are apathetic: there are many inmates and more than a few staff who are concerned and are advocating for necessary change. However, they often feel frustrated about the attitude of the many around them who do not seem to care. We need to find a way to make it clear to everyone – the administration, staff, prisoners, and the public – that more needs to be done to prevent the spread of HIV and to care for those already infected, and that doing more is in everyone's interest, not only that of prisoners.

Perhaps of greatest concern to me lately has been that CSC has accepted many of ECAP's recommendations and publicly states that condoms are available in institutions, that bleach is made available in one institution officially and in others unofficially, and that confidentiality of medical information is respected. The untold truth, however, is altogether different: for example, in many institutions condoms are available only occasionally, and no water-based-lubricant is available. With regard to the issue of confidentiality, there is much I could say; frankly, I have grown tired of repeating how the importance of keeping medical information confidential does not seem to be understood, and how often and in how many ways confidentiality is not respected.

It frustrates me greatly that only those of ECAP's recommendations were accepted that are considered to be "politically correct" and would upset as few politicians and public sentiments as possible. I do not believe that the decision-makers considered the lives of those who would be most affected by their decisions, many of whom will be infected as a result of the refusal to accept the other recommendations.

If there is to be any hope of reducing the spread of HIV in prisons, it will be necessary to reconsider the decisions made. As a recovering addict, it is hard for me to advocate a needle- exchange program for anyone, in particular prisoners. However, when I consider the amount of needle sharing that I have witnessed over the years spent in prison, and how many new infections they may have caused, I find myself more concerned with the human lives than the "correctness" of providing needles to prisoners. Perhaps the following will help illustrate my concern.

Recently, I became aware that an HIV-positive inmate was sharing needles with other inmates. The inmates sharing with him did not know he was infected. Bleach was sometimes used; some inmates, however, were not using bleach because they just did not think about it or because of the amount of time it takes and the increased risk of being caught injecting. The HIV-positive inmate did not want to tell the other inmates about his positive serostatus, because then he would not have had any way of injecting his drugs, the number of needles available being so limited as to force inmates to share.

It is very easy for politicians with no first-hand knowledge of the prison environment to decide the kind of treatment that should be given to prisoners. All too often, they will fail to consider that prisoners will, in most cases, be released. For those individuals who are irresponsible enough to share needles without bleaching, can it be reasonable to expect that they will use a condom when they have their first post-

release sexual experience? I strongly doubt that they will! Prisoners who contract HIV in prison will in all likelihood transmit it to others upon release. If those with the power to implement needle exchanges, methadone programs and other means of providing risk-reducing initiatives, are not prepared to consider the prisoners in their charge, then perhaps they could consider those at risk of contracting HIV/AIDS from prisoners.

There are no magic answers to any of the issues I have raised, but there is one thing I am certain of: as we move toward the next century, prison administrators, staff, and prisoners will have to put aside old differences and work together to aggressively fight against the spread of HIV. Community-based organizations will also have to get more involved, work with us, continue to monitor the efforts undertaken, and provide support and assistance. Unless everyone concerned begins to work together for the common good, all the reports, studies, and initiatives will prove to be no more effective than they have been to date. As a person living with HIV, and greatly concerned with the effects it has on prisoners and their families, it is my most fervent hope that we will overcome divergencies in opinion, understand that we work for our mutual benefit, and are able to work together.

- *Michael Linhart*

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Health-Care In Prisons

In the following article, Dr Sally Ford, Clinical Associate at the HIV/AIDS Clinic at Kingston General Hospital, describes her personal experience as the physician responsible for care of patients with HIV/AIDS in federal prisons in the Kingston area.

Health Care for Prisoners Living with HIV/AIDS

The situation with regard to HIV/AIDS in prisons is changing. Until recently, most prisoners with HIV were in early stages of the disease. Lately we are seeing more and more prisoners – both newly admitted and long-term – with advanced stages of HIV disease.

This reflects the evolution of the HIV/AIDS epidemic in Canada, mirroring the rise of infection rates among intravenous drug users (IVDUs) observed since the mid 1980s: an increasing number of IVDUs, many of whom spend at least part of their lives in prison, are developing AIDS and becoming sicker.

Prisoners in early stages of the disease normally do not require anything other than monitoring of the progression of their disease and psychosocial support. For many, imprisonment has resulted in an improvement of their general health status, due in large part to reduced drug consumption, better nutrition resulting in weight gain, and ready access to medical and dental facilities.

Now, in the mid 1990s, prison health services are increasingly faced with having to deal with further-advanced stages of the disease and their manifestations. While the numbers are rising, they are still relatively small: in the Kingston area, where there are about 4500 prisoners, there are presently less than 10 prisoners with CD4 counts under 200. This means that the prison physicians who provide services for them are still relatively inexperienced. The resulting problems are managed if they recognize that they cannot provide the necessary specialized services and treatment, and refer prisoners early enough to the Kingston General Hospital HIV/AIDS Clinic, which provides HIV-specific care for prisoners with HIV/AIDS.

However, problems are sometimes not recognized. Most prisoners are regarded as relatively fit young persons, with drug dependency as their only health problem. While nurses and doctors who work with prisoners deal well with well-demarcated chronic illnesses such as diabetes, cancer, arthritis, or easily recognized emergencies such as acute myocardial infarction or trauma, the HIV-positive patient with a low CD4 count, who may look well but not be well, is a challenge. For example, it is difficult for health-care staff to appreciate that the headache of a well-looking prisoner, still able to lift weights, is due to a life-threatening cryptococcal meningitis. This difficulty is enhanced by the fact that some prisoners have a tendency to try to manipulate health-care staff, who as a result can be more reluctant to "believe" the inmate and to intervene immediately by, for example, making referrals or prescribing medication. Problems are likely to increase in the years to come because, unfortunately, the rise in the number of seriously ill patients – with other serious infectious diseases and/or with HIV – coincides with cuts to health-care budgets.

There are other serious problems as well:

- • **Getting Things Done**: In prisons, the bureaucratic machine often works slowly and communication errors may also occur. Sometimes I only find out when I see a patient again that something I suggested should be done has not been done.

  • **Access to Drugs**: The Kingston area CSC pharmacy has made it very easy for prisoners to access accepted drugs, even expensive ones not available under the Ontario Drug Benefit Plan. However, it has not been possible to obtain investigational drugs such as 3TC, which is being widely used by persons living with HIV/AIDS outside prisons. It is unclear what would happen if a prisoner on such a drug was admitted to the system. Further, it is almost impossible for prisoners to obtain access to nonconventional therapies.

  • **Pain Medication**: On the outside, it is often difficult for health-care staff to accept that drug users in pain will not automatically abuse narcotics given for pain relief. In prisons it can be even more difficult. It is also hard to convince staff that a patient with no easily demonstrable physical signs may still have excruciating pain. Unless a prisoner is in the regional hospital, there is no mechanism for giving adequate pain relief. But not all who require pain relief also require hospitalization: a patient with chronic meningitis in our clinic needed narcotics for the last 15 months of his life, during which time he led an active life. I am very concerned about how prisoners requiring pain relief are being dealt with.

What can be done to improve the situation? A few suggestions follow:

- • **education of staff**: "classroom" education is needed, but is no substitute for hands-on experience;

• **education of patients**: should be part of the solution, although because of the sometimes adversarial relationship between prisoners and staff, it will be of limited value;

• **accelerated parole**: because offering patients with advanced disease accommodation in the regional hospital or palliative care unit is not an acceptable alternative for the patient, we spend much time trying to obtain early release for patients with AIDS. However, because of the public's concern over violent crime, and because it is feared that prisoners with AIDS, once released, may spread the disease, this is often difficult. Of five applications concerning my patients, only two have been successful; three applications were turned down because of security concerns and because the prisoners were not terminally ill. So far, three of my patients have died in custody: two died shortly after their admission to prison, and the third committed suicide.

- *Sally Ford*

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Pilot Inmate AIDS Peer Education Project Underway in New Brunswick

The precise number of inmates with HIV-infection in Canadian federal and provincial prisons remains unknown. However, in July 1995 almost one in every 100 federal inmates was known to be living with HIV/AIDS, a 25 percent increase over a period of just over one year, and rates of infection continue to increase in all regions.[1]

In prisons, unsafe sex, sharing of needles for injecting drugs, piercing, tattooing, and injecting steroids are behaviours that pose a high risk for the transmission of HIV.

Traditionally, HIV-related education in federal penitentiaries has been passive, and has included audiovisual materials, brochures, information sessions, and conversations with Correctional Service Canada (CSC) Health Care staff.[2] Such education has frequently been criticized as lacking comprehensiveness[3] and being ineffective[4]. Because most HIV-related risk activities constitute institutional offences or are illegal in prisons, inmates have understandably been reluctant to discuss the associated risks with correctional staff.

Recommendations for inmate AIDS peer-education approaches have been made in several documents, and were repeatedly echoed at the First National Workshop on HIV/AIDS and Prisons.[5] In March 1994, the Expert Committee on AIDS and Prisons (ECAP) recommended, among many other things, that inmates "be assisted in delivering their own peer education, counselling and support programs," and that "in each institution, CSC should create or designate one or more inmate job positions as peer health counsellors and provide for appropriate training, support and evaluation."[6] The need for peer-led AIDS programs had also been stressed in the brief prepared by the Prisoners with AIDS/HIV Support Action Network (PASAN).[7]

In response to ECAP's report, CSC agreed to pilot-test a program of paid inmate peer-health promotion.[8] AIDS New Brunswick (AIDS NB) had already undertaken education and support work at Dorchester Penitentiary, a medium-security federal penitentiary housing approximately 400 male inmates in eastern

New Brunswick, and submitted a proposal for the pilot project. The proposal was approved for funding, and work started in February 1995.

The 15-month "CAN" Project (Cons AIDS Network Peer Education Project) is aimed at developing, implementing and evaluating a sustainable peer-education and support model in which inmates provide their fellow-inmates with the necessary information, motivation and skills to prevent HIV and other communicable diseases and provide support to those living with HIV/AIDS. The program is the first of its kind to be pilot-tested in Canada, and, if effective, may be adapted for use in prisons throughout the country.

It involves developing and implementing an AIDS-related training curriculum for inmates interested in becoming peer educators. These inmates will participate in a four-week training program that will be delivered in an interactive and prisoner-centred format. Following this program, participants will be assessed in terms of their interest and suitability for becoming peer educators or the program coordinator. The inmate hired as coordinator will receive four additional weeks of one-on-one support and training. He will play a strong supervisory role, and will be responsible for the coordination, ongoing education and supervision of peer educators.

An evaluation of the program will be conducted through the administration of a knowledge, attitudes and behaviour (KAB) questionnaire administered prior to and three months following the implementation of the program. A training manual will also be prepared to provide other community-based organizations and prisons with guidelines regarding the setting up, implementation, evaluation and sustaining of peer education and support programs within correctional facilities. In addition to suggested facilitation strategies, the manual will include a number of overheads, hand-outs and exercises developed specifically for inmate AIDS peer education.

A critical component of this project is the involvement of a number of key players. The project coordinator is working with a national advisory committee consisting of representatives of CSC, Health Canada, the John Howard Society, various AIDS-service organizations, and inmates. A Dorchester advisory committee has also been formed, with representation of staff from health care, case management, psychology, personal development, security, and of inmates. HIV-positive and HIV-negative inmates have and will continue to play an instrumental role throughout all phases of the project.

For many reasons, education by peers has been held to be particularly effective in preventing the spread of HIV/AIDS in prisons:

- • It is generally easier to speak openly about HIV-related risk behaviours – which often involve illegal or forbidden behaviour – to other inmates than to staff.

  • Inmates do not often trust correctional staff; HIV-related information from peers is not viewed with the same suspicion.

• Peers may be the only people who truly understand the prison culture and inmate code, along with strategies that work in the prison setting.

• Because they reside in the same setting, peers are able to respond both formally and informally to educational needs in an ongoing manner.

Conclusion

Effective and comprehensive inmate AIDS education strategies are needed to prevent transmission of HIV and other transmissible diseases, such as hepatitis, in Canadian prisons. Inmate peer education programs, successfully adopted in various prisons worldwide, are an important part of these strategies, and offer the most promise of success.

For further information, contact Caroline Ploem, AIDS New Brunswick, at 1-800-561-4009 or (506) 459-7518.

- *Caroline Ploem*

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A Comprehensive Young Offender HIV/AIDS Policy

The Toronto-based Prisoners with HIV/AIDS Support Action Network is in the process of drafting a comprehensive young offender HIV/AIDS policy and has issued a "communities call for response."

According to the draft document, the recommendation for the development of a comprehensive young offender HIV/AIDS policy is aimed at both the provincial and federal governments: "At the provincial level, we propose that a joint ministerial task force, including members from the Ministries of Community and Social Services, of Health and of Corrections, be formed to consult with young offenders, community groups, and custody staff's unions while implementing our recommendations. We also propose the same process be undertaken at the federal level with the Solicitor General's Office, Correctional Services Canada and the Ministry of Health and Welfare. We urge these federal ministries to coordinate their response to our recommendations with the provincial task force."

The document contains information about: (1) who is in young offender custody facilities; (2) why they are in custody; (3) why youth are at risk for HIV; and (4) why there is concern for young offenders with regard to HIV/AIDS. It concludes that there is no need for HIV seroprevalence studies to know that HIV/AIDS is threatening young offenders' lives: "HIV/AIDS has already reached the adult institutions. Youth are at risk whether they are in young offender facilities or out on the street."

PASAN is seeking input into the document. For copies, contact PASAN at 517 College Street, Suite 327, Toronto ON M6G 4A2. Tel: (416) 920-9567; fax: (416) 928-2185; toll free: 1-800-263-9534 (PASAN accepts collect calls from prisoners).

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International Prison News

United Kingdom: Report on HIV/AIDS in Prisons

In June 1995, the Prison Service of England and Wales released its "Review of HIV and AIDS in Prison."[1]

The report has a long history that began in December 1991. The then Minister of Prisons announced that a review of HIV in prisons would take place, and invited concerned individuals and organizations to make submissions on HIV in prisons to the AIDS Advisory Committee of the Prison Service of England and Wales. Nearly four years later, the results of the Advisory Committee's work have been published.

One of the fundamental assumptions of the review is that prison-based work on HIV prevention and care constitutes a significant contribution to public health. Therefore, the Prison Service's strategy on HIV was developed within the context of the British government's general health strategy.

In a letter accompanying the release of the report, Rosemary J Wool, Director of the Health Care Service for Prisoners, emphasizes that HIV/AIDS is a "phenomenon which all in the Prison Service need to consider. For this reason the report addresses a broad audience including policy-makers, managers, practitioners and operational staff."

The report contains 39 recommendations in the areas of research, staff and prisoner education, prevention, risk reduction and harm minimization, counselling, psychological and social care, and medical aspects of HIV in prison. Among other things, it recommends that cleansing agents (washing-up liquid and Milton sterilizing tablets), and condoms, dental dams, and lubricant be made easily accessible to prisoners.

All of the Committee's recommendations have been accepted, with one surprising exception: condoms will not be made easily accessible, but will remain available only on prescription "if in the clinical

judgment of the doctor there is a risk of HIV infection." At a time when many prison systems world-wide make condoms easily accessible to inmates – and when experience has shown that this can be done without creating any problems and with support from management, staff, and prisoners – this is hardly understandable.

The report places emphasis on multidisciplinary teamwork to address the issues raised by HIV/AIDS in prisons. It is evidence of the existing international consensus with regard to HIV/AIDS in prisons. Many of its recommendations are the same as, or at least similar to, those previously issued by other committees and by the World Health Organization, with one exception: it does not recommend setting up needle-exchange programs in prisons in England and Wales. The report fails to convincingly deal with this issue: the Committee considered recommending the setting up of needle-exchange schemes, but "felt that such an approach would be fraught with difficulty and would fit uneasily with the duty of prison authorities and staff to detect the smuggling of drugs into prison and to prevent drug misuse during custody. The conflict between encouraging prisoners to use an exchanges scheme and detecting illicit drug use would have no easy resolution." However, and in complete contradiction to this argument, the Committee goes on to say that "the probability of HIV infection amongst drugs users in prison is such that the Prison Service should make available to clandestine injectors the means of effectively sterilising needles." Admittedly, making sterile needles available in prisons is more difficult than making bleach available, but in terms of the conflict invoked by the Committee there is no difference between making needles and bleach available: both are an acknowledgment that drug use occurs in prisons, and both create a conflict between the prison system's mandate to prevent drug use and its responsibility to prevent the spread of HIV. Many committees, in Canada and internationally, have been more consistent than the English report and have recommended that both bleach and sterile needles be made available, holding that prevention of the spread of HIV needs to be the foremost priority.

Copies of the Report are available on request from the Committee Secretary, DHC, Cleland House, Page Street, London SW 1N 4LP, England.

- *Ralf Jürgens*

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ENDNOTE

[1]AIDS Advisory Committee. *The Review of HIV and AIDS in Prison.* London, England: HM Prison Service of England and Wales, 1995.

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Australia: A Community Policy on Bloodborne Diseases

A number of community groups in New South Wales (NSW) have joined forces and produced a policy on the prevention and treatment of bloodborne diseases, such as HIV and hepatitis C, in the prison system.[1]

The policy was launched on 18 September 1995. It reflects the interests of a wide range of community-based organizations, including the AIDS Council of NSW (ACON), a drug-user association, the Hepatitis C Council of NSW, a prisoners action group, and a group of transgender persons. According to Geoffrey Bloom, Policy Advisor for ACON, all measures proposed in the policy "must be implemented before NSW can say that it is doing all that it can to fight the epidemics."[2]

Among many other things, the policy recommends that:

- • all prisoners have "free, confidential access to new injection equipment on a strict exchange basis"; drug equipment be "excluded from communal spaces within the prison, except for transport to and from a point of exchange"; prisoners be provided with information and education about the correct use of injecting equipment; prisoners "known to have this equipment should not be subject to discriminatory treatment or harassing cell searches";

  • prisoners have access to bleach, and to sterilization equipment of a clinical standard for tattoo guns and body-piercing equipment;

  • there be no limit to the number of prisoners who have a history of opiate use having access to the prison methadone program;

  • positive prisoners be given information about and access to all existing treatments, complementary therapies, and alternative and natural therapies available outside prison;

• requests from seriously ill positive prisoners for compassionate early release be considered promptly.

The policy also addresses an issue that underlies many of the problems raised by HIV/AIDS in prisons: current drug laws that result in many drug users being sentenced to prison, where they continue using and run an increased risk of contracting HIV. In order to decrease the number of drug users sentenced to prison, it recommends a variety of changes to drug laws.

To obtain a copy of the policy, contact Geoffrey Bloom, ACON, PO Box 350, Darlinghurst, NSW, 2010, Australia. Tel: (61-2) 206-2042; fax: (61-2) 206-2069.

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ENDNOTES

[1] The AIDS Council of NSW et al. Prisons and Blood Borne Communicable Diseases. The Community Policy. Darlinghurst: The Council, September 1995.

[2] G Bloom. The Community Policy: Prisons and Blood Borne Communicable Diseases. [Australian] *HIV/AIDS Legal Link*, vol 6, no 2 (June 1995) at 14-15.