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# Canadian HIV/AIDS Policy & Law Newsletter

**Volume 2 Number 2 - January 1996**

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# Third HIV/AIDS Strategy Needed

**While Canada is still considering whether there should be a National AIDS Strategy, Phase III, Australian Prime Minister Paul Keating committed his government to a third, five-year HIV/AIDS strategy. Canada should follow step and end the uncertainty about the future of HIV/AIDS funding in the country.**

"It is clear to the government that there remains an overwhelming need for a national HIV/AIDS strategy," Keating said, adding that there would be "dedicated, secure and adequate funding" for the next five years.[1]

The current Australian strategy, which shapes Australia's response to the epidemic, will expire in June 1996. An independent evaluator, Prof Richard Feachem, was called in by the Australian health minister in October 1994 to advise on whether a third national strategy should be put in place when the current strategy expires. In September 1995, Feachem released a 232-page report entitled *Valuing the Past, Investing in the Future*.[2] The report provides a far-reaching assessment of Australia's response to the epidemic, ranging from treatment and care programs to financing and accountability. It concludes that Australia's second, three-year national HIV/AIDS strategy was a success and an efficient use of public health resources, and that the gains achieved over the years should be continued with a third national blueprint. Feachem emphasized that "unless a concerted effort is made in the third strategy to confront the continuing HIV epidemic ..., the gains and the investment to date may be lost." In particular, he expressed concern about the continuing HIV epidemic among men who have sex with men and among aboriginal populations in Australia. With regard to men who have sex with men, Feachem recommends that they remain the highest priority for the education and prevention programs of the national strategy, and that there be increased monitoring and accountability as part of the programs. With regard to aboriginal communities in Australia, Feachem warns that there is now "almost certainly" an epidemic of HIV in its early stages among them. He recommends that more money be allocated to education and prevention programs in aboriginal communities, stressing that these programs should be implemented in a way that enhances aboriginal ownership of the problem, and that the recognition of the diversity of aboriginal peoples "must be one of the starting points in all aspects of the response."

Community-based AIDS organizations in Australia welcomed the report, pointing out that the need for a third National HIV/AIDS Strategy was clear and that "neither the general community nor the communities at highest risk of HIV can afford any let up in the momentum already achieved in Australia's fight against the virus."[3]

**Law Reform**

The first Australian National HIV/AIDS Strategy, released in August 1989, already included an agenda for necessary law reform in light of the challenges HIV/AIDS presents to existing laws and traditional public health approaches. What followed was the establishment of a Legal Working Party of the Australian Intergovernmental Committee on AIDS, which released nine discussion papers between February 1991 and April 1992, distributed them widely, and invited public comment. Over 300 submissions were received, and the recommendations contained in the discussion papers were redrafted to reflect this input. A final report, released in 1992, contained numerous recommendations for law reform.[4] Both the recommendations and the process used are now serving as a model for the Canadian AIDS Society and Canadian HIV/AIDS Legal Network Joint Project on Legal and Ethical Issues Raised by HIV/AIDS.

Prof Feachem's report highlights the need for more work on implementing several unfinished aspects of the HIV/AIDS law reform agenda, such as provision of access to needles and syringes in prisons, reform of laws relating to prostitution, and improving aboriginal peoples' access to justice. In particular, the report recommends that "a body should be established to consider legal reform matters associated with HIV AIDS and other communicable diseases."

**Lessons for Canada**

In Canada, the Parliamentary Sub-Committee on HIV/AIDS tabled a report entitled *A Study of the National AIDS Strategy: Report of the Subcommittee on HIV/AIDS* on 4 December 1995. The report contains 23 recommendations dealing with the National AIDS Strategy, Phase II, and the role the federal government could or should be playing in responding to HIV/AIDS. Although the report touches briefly on the issues of poverty and discrimination, no recommendations are made dealing with either of these issues. Further hearings are planned to focus specifically on them. Attached to the report is a dissenting opinion issued by the Reform Party. Probably the most important among the recommendations is that Health Canada maintain an appropriate integrated AIDS Strategy with a corresponding budget.

Because the report was tabled in the House of Commons, and a response from the government requested, the government will be required to respond to the report, most likely in early April. It is hoped that at that point some further commitment will be made to the National AIDS Strategy, and that the Canadian government will soon end the uncertainty about the future of HIV/AIDS funding. The similarities between the situation in Australia and that in Canada are striking: both countries have adopted two national AIDS strategies, both have successfully prevented an explosion of HIV/AIDS cases, but both are faced with a continuing epidemic among men who have sex with men and an

increasing rate of infection in some populations, such as aboriginal people and, particularly in Canada, injection drug users and prisoners.

There can be no doubt that national strategies such as the HIV/AIDS strategies of Australia and Canada have their problems. At the same time, they have been crucial in securing dedicated, secure and adequate funding for HIV/AIDS programs, without which coordinated efforts to fight the epidemic would be made much more difficult. As Canada evaluates its National AIDS Strategy, Phase II, and makes a decision about whether there should be a third phase, it should take into consideration that there are continuing and emerging HIV/AIDS epidemics in our country, and that unless a concerted effort is made to confront them, the gains and the investment to date may be lost. A National AIDS Strategy, Phase III, can be an efficient use of public resources. Cutting AIDS funding now would only, if at all, have short-term budgetary benefits. In the long term, it would result in the preventable infection and death of many Canadians, and entail enormous human and financial costs.

- *Ralf Jürgens*

**For a copy of *A Study of the National AIDS Strategy: Report of the Subcommittee on HIV/AIDS*, contact Nancy Hall, Clerk of the Sub-Committee, at (613) 992-1775.**

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[1] As reported in: Independent Evaluator Recommends Third National HIV AIDS Strategy. [Australian] National AIDS Bulletin 1995; 9(6): 8-11 at 8. Parts of the following text are taken from this article.

[2] Valuing the Past, Investing in the Future: The Evaluation of the National HIV/AIDS Strategy, 1993-94 to 1995-96. Canberra: Australian Government Publishing Service, 1995.

[3] Ibid. Statement of the national president of the Australian Federation of AIDS Organisations, Bill O'Loughlin.

[4] Intergovernmental Committee on AIDS, Legal Working Party. The Final Report of the Legal Working Party of the Intergovernmental Committee on AIDS. Canberra: Department of Health, Housing and Community Services, 1992.

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# HIV-Specific Criminal Offence Proposed

**Reform MP Garry Breitkreuz (Yorkton-Melville) introduced a private member's bill (C-354) that, if adopted, would create two new criminal offences "related to wilful or reckless acts by a person infected with HIV or who has AIDS." The bill received first reading on 25 October 1995.**

**Summary**

The proposed bill "creates two new offences related to wilful or reckless acts by a person infected with HIV or who has AIDS. If the act results in infection by HIV, the offence is criminal infection punishable by imprisonment for life, and, if infection is not proven, the offence is reckless infective behaviour punishable by imprisonment for up to seven years." According to the summary that precedes the text of the bill, "[c]onsent may be an issue in prosecutions under other provisions of the *Code*. The problematic questions of whether consent was clouded by duress or emotional stress and whether the consent was properly informed as to outcome and risk are avoided as the bill provides that consent is not a defence to the two new offences."

Bill C-354: An Act to amend the Criminal Code

The bill provides for the amendment of the *Criminal Code* by adding the following after section 221 (according to s 221, "every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years"):

(2) Every one who knows or should reasonably know that he is HIV positive or has AIDS and who wilfully or recklessly commits an infecting act is

> (a) if the infecting act is shown to have resulted in the transmission of HIV to another person, guilty of the offence of criminal infection and liable to imprisonment for life; and
>
> (b) if the infecting act is not shown to have resulted in the transmission of HIV to another

person, guilty of the offence of reckless infective behaviour and liable to imprisonment for a term not exceeding seven years.

(3) The consent of a person to an infecting act being carried out by a person charged under subsection (2) is not a defence to the charge.

Under s 221.1(1) of the proposed bill, "infecting act" in this section means "any of the following acts, whether or not carried out using measures that may or do reduce the risk of infection:

(i) sexual intercourse.

(ii) any form of physical contact, whether or not sexual, whereby a body fluid of a person may be transmitted to the blood stream of another person.

(iii) the donation of blood or any other body fluid, body substance or organ.

(iv) a person using a thing and subsequently permitting another person to use the thing in a manner whereby a body fluid or the HIV infection of the person may be transmitted to the other person, or

(v) any other act that the court considers the person knew was capable of transmitting HIV to another person."

**Comment**

If adopted, the bill would come close to criminalizing the status of being HIV-positive. For example, any kind of sexual intercourse with an HIV-negative person engaged in by a person who knows or "should reasonably know" that he or she is living with HIV/AIDS would constitute a criminal activity, regardless of whether appropriate precautions were taken and regardless of whether the HIV-negative person, knowing that his or her partner is HIV-positive, consented to sexual intercourse. Apart from this, a whole range of other activities, including "any other act that the court considers the person knew was capable of transmitting HIV to another person," would constitute a criminal activity if undertaken by a person who knew or "should reasonably know" that he or she was living with HIV/AIDS.

All experts have recommended against the passage of such sweeping legislation.[1] Although it's aim is supposedly to protect the public from the spread of HIV infection, it creates a whole new class of criminals - persons living with HIV/AIDS - and distracts attention from the solutions that work.

- *Ralf Jürgens*

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[1] See, eg, Justice Minister Considers Introducing HIV/AIDS-Specific Criminal Offence. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(3): 6, with many references. See also in this issue: Joint Project on Criminalization of HIV Transmission; and Criminalization of HIV Transmission: A Literature Review.

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# Interventions in Perinatal HIV Transmission

**The debate about the testing of pregnant women for HIV has been renewed in light of the results of ACTG 076 and other recent studies relating to perinatal transmission. This article discusses the implications of these studies for HIV counselling and testing of pregnant women.**

## What ACTG 076 Proved

ACTG 076 was a randomized, multi-centre, double-blind, placebo-controlled clinical trial sponsored by the National Institutes of Health in the United States.[1] Begun in April 1991, ACTG 076 enrolled 477 HIV-positive pregnant women and 421 infants. The trial was stopped in December 1993, when interim analysis showed that AZT administered to a selected group of HIV-positive pregnant women and their infants reduced the risk of perinatal transmission by approximately two-thirds.

Those eligible to enter the trial were HIV-positive pregnant women with CD4 counts above 200 at their time of entry, who were between 14 and 34 weeks pregnant, who had received no anti-retroviral therapy during their current pregnancy, and who had no clinical indications suggesting that they should start treatment with AZT immediately after testing pregnant.

ACTG 076 consisted of three stages: (1) AZT administered orally beginning at 14-34 weeks gestation and continued through the pregnancy; (2) during labour, intravenous AZT to the point of delivery; and (3) AZT administered to the infant for six weeks after birth.

The trial found that observed toxicity attributable to AZT was minimal among women in this trial. Evaluations of fetal growth and amniotic fluid volume showed no differences between pregnancies in those women receiving AZT and those receiving the placebo. Birth parameters, birth weights, and major and minor congenital abnormalities were approximately the same in both groups. Infants tolerated AZT well. Lower hemoglobin levels and mild, transient anemia were noted, but both conditions resolved themselves after the therapy was completed. It should be noted, however, that a trial known as ACTG 152, which compared AZT to ddI to an AZT/ddI combination in HIV-positive infants, was discontinued

early because of toxicities in those who were receiving only AZT.[2]

**What ACTG 076 Did Not Prove**

The results of ACTG 076 are applicable only to HIV-positive women with the same characteristics as the women who entered this clinical trial. This means that the efficacy of AZT is not known for:

pregnant HIV-positive women with advanced disease;

those who have previously used anti-retrovirals; and

those who have an AZT-resistant strain of HIV.</blockquote`

It should also be noted that:

use of AZT in ACTG 076 did not stop, although it did reduce, perinatal transmission - in some cases, transmission occurred despite anti-retroviral therapy;

it is not known what part of the AZT protocol played the most important role in reducing transmission; the long-term risks to infants associated with AZT exposure in utero and in early childhood are not yet known (a registry has been established to track children exposed to anti-retroviral drugs through age 21); and

the implications for the efficacy of anti-retroviral therapy for both HIV-positive women and HIV-positive infants later on in their disease progression is unknown. Serious short-term effects for both mother and infant may become evident with more widespread use.

**Viral Load: A Predictor of Perinatal Transmission**

ACTG 076 did not gather information about maternal viral load, the presence of anti-retroviral resistance among either women or infants, or cell-culture phenotypes (syncytial inducing or non-syncytial inducing). ACTG 076 does not predict whether an individual pregnancy is associated with HIV transmission.

However, a more recent study by the New York State Department of Public Health and SUNY at Stony Brook found that researchers could predict, based on maternal viral load, which HIV-positive pregnant women were most likely to transmit HIV to their infants.[3] In this study of 19 mother/child pairs, six of the women were classified as having a high viral load (defined as greater than 125 HIV-1 infectious units per 106 peripheral blood mononuclear cells). Of these, four women (67 percent) transmitted HIV to their infants. Of the 13 women with a low viral load,

only one transmitted HIV to her infant. In other words, of the women who transmitted the virus to their children, 80 percent had a high viral load. Maternal load is therefore effective in identifying HIV-positive women who are at high risk for perinatal transmission. (The study also determined that women's viral load is unaffected by pregnancy; in the 19 mother/child pairs who participated, clinical and immunologic markers varied widely.)

The information gathered from both ACTG 076 and the New York study provides HIV-positive women and their health-care providers with (1) a tool for assessing individual risk of perinatal transmission and (2) an intervention to minimize transmission.

**Vitamin A: A Predictor Suggesting Intervention**

A study in Malawi involving a core of 338 HIV-positive pregnant women examined the relationship between serum levels of vitamin A and perinatal transmission.[4] Women were stratified into four groups based on the level of vitamin A in their blood serum. An adequate vitamin A level was defined as more than 1.05 micromoles of vitamin A per litre. Perinatal transmission rates were much higher in women who were vitamin-A deficient. The study did not rule out other micronutrient deficiencies as co-factors in transmission, suggesting the role that adequate nutrition and supplementation may play in reducing perinatal transmission.

**Other Factors in Perinatal Transmission**

Many other factors are associated with an increased risk of perinatal transmission. These include low CD4 counts, p24 antigenemia, placental membrane inflammation, increased intrapartum exposure to maternal blood, premature rupture of membrane, premature delivery, breastfeeding, HIV-positive father, and poor maternal nutrition. Knowledge of these factors can be used to minimize risks for maternal transmission or to make an individualized risk assessment that would assist an HIV-positive pregnant woman in decisions regarding her pregnancy.

Interventions for decreasing perinatal transmission include birth-canal cleansing, cesarean sections, and good prenatal care.

**Implications for HIV Counselling and Testing of Pregnant Women**

ACTG 076 provides a proven, albeit problematic, intervention to reduce perinatal transmission, namely the administration of AZT during pregnancy for at least some women. As a result, legislators and policy-makers across North America and

beyond are debating how to offer HIV counselling and testing to pregnant women. Three options have been considered:

Routine counselling, voluntary testing, and free choice as to intervention

Currently, HIV-informed health-care providers routinely advise pregnant women of the option of HIV testing and leave the decision of whether to test to the woman. Should the woman request to be tested and in fact test positive, the choice of how to proceed with her pregnancy is her own. Options include abortion and interventions to reduce the risk of perinatal transmission. The decision the woman makes about testing and her response(s) to a positive test result should in no way affect the quality of health care she subsequently receives.

Critics of this approach argue that, in practice, it is only women who are perceived by health-care providers to be at risk for HIV who are "routinely" informed of testing options; those perceived to not be at risk remain uninformed. This has spurred calls for mandatory counselling.

Mandatory counselling, voluntary testing, and free choice as to intervention

Mandatory counselling would oblige all health-care providers to inform all pregnant women about the option of HIV testing. Ideally, guidelines for prenatal HIV counselling would be developed. Counselling would be delivered in a non-coercive manner, and would respond to the woman's linguistic, cultural and educational background. Pre- and post-test counselling guidelines specific to pregnancy would be developed. The decision to test or not to test would not affect the quality of health care received by the woman. If a woman requested to be tested for HIV and if she tested positive, she would be given choices as to how to proceed with her pregnancy, including whether to abort or to pursue interventions aimed at reducing the risk of perinatal transmission.

Mandatory counselling, testing, and intervention

In the US, the debate about whether newborn infants and/or pregnant women should have to undergo HIV testing has been ongoing for years. Legislative initiatives involving mandatory testing, particularly of newborns, have been pursued both at the state and federal levels. In New York State, the state with the highest number of HIV-positive women and infants in the US, Governor Pataki recently agreed to introduce new procedures governing HIV-testing of newborn infants (see infra, New York Policy on HIV-Testing of Newborns). At the federal level, several attempts have been made to push legislation to mandate disclosure to the infants' parents or other legal guardians of test results collected during an

anonymous HIV testing program for newborn infants. (As of May 1995, health departments in 45 states, the District of Columbia, Puerto Rico and the Virgin Islands were randomly screening blood specimens from newborns in a "blind" study that the Centers for Disease Control and Prevention (CDC) began in 1988. In the summer of 1995, federal officials announced that the anonymous HIV-testing program would be halted, just as a congressman was pushing legislation that would have required unblinding the results.)

Opponents of mandatory testing and treatment believe it is a woman's right to control her body. It is up to the woman to decide if she wants to be tested for HIV during pregnancy, if she wants to take AZT should she test positive, and if she wants her newborn tested. These decisions should be made after the woman is made aware of all her options, and the risks and benefits associated with each option. Opponents of mandatory testing believe that individualized counselling and information are the answers, and that when women are properly informed and supported in their decision-making, they will do what is best for themselves and their babies without coercion.

**Toward a Canadian Model for Reducing Perinatal Transmission**

Canadian public health services are much less engaged in the issue of perinatal HIV transmission than their US counterparts. Seroprevalence studies suggest a much lower rate of HIV infection among Canadian women: only 140-150 of the 400,000 yearly live births in Canada are to HIV-positive women.[5] HIV testing programs are a provincial and territorial responsibility, and "the relevant authorities will have to analyze the most cost-effective approaches for offering testing to pregnant women."[6] Further, "[p]rovinces, medical associations and physicians must ensure that pre- and post-test counselling is available, that testing is only done with informed consent and confidentiality, and that testing follows the established Counselling Guidelines for HIV Serologic Testing, 1993 edition, produced by the Canadian Medical Association."[7] On 29 June 1994, BC became the first province to "strongly recommend" that all pregnant women be tested for HIV as a routine component of prenatal care. According to a press release of 29 June 1994, physicians in BC are being advised to counsel all pregnant women about the advisability of being tested for HIV at the beginning of each pregnancy. The press release continues by saying that it is "not safe to assume that a woman who was HIV-negative in her previous pregnancy will remain so for subsequent pregnancies." It emphasizes that testing must be accompanied by adequate counselling and informed consent.[8] Other provinces have released or are planning to release similar policies.

**Comment**

A pregnant woman's decision to test for HIV and the decisions she makes subsequent to a positive test result are the result of a delicate balance of individual risks and benefits. In Canada, there appears to be general support for the model of routine HIV counselling for pregnant women and accessible, voluntary pre-natal HIV testing, but challenges remain in ensuring that counselling is always non-coercive, non-intrusive and respectful of a woman's rights. It must be specific to each woman's situation, acknowledging that some women will need more or different information and counselling than others. HIV research and practice must continue to strive for the tools that make individual risk assessment accurate and risk reduction possible within the context of women's varied abilities and convictions.

Further, this must not be accomplished as an alternative to or at the expense of:

programs that emphasize primary HIV prevention for women within a broad health-promotion context;

the availability of HIV testing to all women;

advances in the care and treatment of HIV-positive women and infants; and

research, including research about the determinants of perinatal HIV transmission and preventative interventions.

The counselling, testing and medical interventions described in this article are directed at reducing perinatal HIV transmission; they do not primarily aim at improving the health of pregnant women. Interventions directed at improving the health of all women are also necessary: they will benefit women, and through the better health of women, perinatal transmission will also be reduced. Unfortunately, in times of health-care cutbacks, approaches that produce quickly demonstrated, targeted and relatively inexpensive results are often favoured at the expense of strategies that would produce long-term benefits.

- *Darien Taylor and Julie Levene*

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[1] For a discussion of ACTG 076, refer to Centers for Disease Prevention and Control. Recommendations of the US Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency Virus. Pediatric AIDS and HIV Infection: Fetus to Adolescent 1994; 5(6): 387-398.

[2] Neenyah Ostrom. Study of AZT in Children Dismantled Early. New York Native; 27 February 1995: 13.

[3] B Weiser et al. Quantification of HIV type 1 during pregnancy: relationship of viral load titer to mother to child transmission and stability of viral load. Proceedings of the National Academy of Sciences USA August 1994; 91: 8037-8041.

[4] RD Semba et al. Maternal Vitamin A deficiency and mother-to-child transmission of HIV-1. The Lancet 25 June 1994; 343: 1593-1597.

[5] Health Canada. Reduction of HIV Transmission from Mother to Infant. Canada Communicable Disease Report 30 June 1994; 20(12): 97-100.

[6] Ibid.

[7] Ibid.

[8] B.C. First Province to Advise HIV Test for Pregnant Women. Victoria: Office of the Provincial Health Officer, 29 June 1994.

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## Criminal Justice

### Joint Project on Criminalization of HIV Transmission

**Many of the individuals and groups consulted during Phase I of the Project on Legal and Ethical Issues Raised by HIV/AIDS, jointly undertaken by the Canadian AIDS Society and the Canadian HIV/AIDS Legal Network, expressed concern about proposals to amend the Criminal Code to create an HIV-specific offence.**

In particular, they were concerned about the message it would convey

> that all persons living with HIV/AIDS are potential criminals;
>
> that the uninfected are potential innocent victims; and
>
> that one need not protect oneself because the law is there to protect.

They further raised the question of whether public health laws would not be better suited than the criminal law to deal with individuals who, knowing they are infected, engage in behaviours likely to transmit HIV without using precautions and without previously informing their partners about their HIV status. Some pointed to the need for educating the court system about HIV and how it is or is not transmitted.

Thanks to co-funding obtained from Justice Canada, the Project started working on the issue of criminalization of HIV transmission in November 1995. A discussion paper is being prepared and will be available in March 1996. It will address the various questions raised by the issue and propose a variety of means of resolving the issue.

For more information, contact Ralf Jürgens, Project Coordinator

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# Criminalization of HIV Transmission: A Literature Review

**Whether or not the criminal law should be used to deal with the behaviour of persons living with HIV/AIDS who put others at risk of contracting HIV is one of the most hotly debated topics and has received much attention in the media and from policy and lawmakers.**

This is reflected in the legal literature, which includes numerous articles on the issue.[1] Most were written in the US, but there is a fairly large and growing body of Canadian literature. Articles from the US are particularly useful in this area because many states have enacted criminal statutes that deal specifically with HIV transmission or endangerment, whereas Canada is just now considering an amendment to the *Criminal Code* to make it a crime to "knowingly communicate" HIV.[2] The experiences in the US with some of the statutes enacted there can be valuable for Canada, and the conclusions reached in the articles reviewing them should be taken into account in deciding whether such an offence should be enacted here, and, if so, what it should look like.

Most articles follow the same pattern. They first review the traditional criminal law offences that have been used in some HIV-related cases, and then discuss whether an HIV-specific penal statute should be enacted and what the most appropriate form of criminal proscription would be were the criminal law to intervene.[3]

## Traditional Criminal Laws or HIV-Specific Offences?

Most articles argue that traditional criminal laws are ill-suited to the context:

> After reviewing Canadian case law and *Criminal Code* offences, Holland concludes that existing offences "are not adequate, have to be stretched and often send out the wrong message."[4]
>
> Hermann argues that traditional criminal laws are ineffective and inappropriate in dealing with conduct likely to transmit HIV.[5]
>
> Dalton points out that HIV-specific statutes, unlike traditional penal laws, do not require proof of either "harm," "causation," or "state of mind": it is sufficient that the accused

have engaged in the forbidden behaviour. She argues that such statutes have several advantages over traditional laws because, for example, they provide much clearer warning of what constitutes a crime.[6]

After reviewing a case in which a prisoner was convicted of two counts of assault with a deadly or dangerous weapon for biting two US federal correctional officers, Stauter suggests that, rather than relying on traditional offences, HIV/AIDS-specific offences should be created to deal with behaviour that is truly likely to put others at risk of contracting HIV.[7]

Sullivan and Field refer to the risk of inconsistent and unfair judgments that the use of traditional criminal law offences carries with it, and argue that this risk could be reduced and the educative value of criminal law be enhanced by creating an HIV/AIDS-specific law.[8]

Some authors propose "model criminal statutes." Under one such statute, proposed by Closen and Deutschman,[9] persons would commit a criminal offence if, knowing that they are HIV-infected, they engage in sexual intercourse or other activities that could potentially transmit HIV, without previously informing their partner about their positive HIV status.[10]

**Should the Criminal Law Intervene at All?**

There is disagreement about whether the criminal law should intervene at all. Some stress the importance of using it, arguing that the threat posed by HIV is such as to require "all reasonable measures of containment to be seriously examined, including the use of the criminal law."[11] Holland argues that there are compelling reasons why criminalization may be appropriate in "some cases." According to her, anyone who knowingly engages in high-risk conduct and does not inform the other participant deserves condemnation, and the strongest way to express that condemnation is through the criminal law. She continues by saying that "[t]he consequences of infection are so severe that there is a pressing need for such condemnation which will have a salutary denunciatory effect." Holland argues that if the criminal law is not used, there will be public outrage at high-profile cases "where individuals have recklessly infected others." Such outrage, she continues, would "be aimed indiscriminately at all individuals who are HIV infected. We need an outlet for expression of outrage at such wilful or reckless behaviour." Holland concludes by saying that "[p]rotection of society is a well-recognized aim of sentencing" and that "[i]ndividuals who are convicted and incarcerated will be effectively quarantined for a period of time."[12]

**Limits of Criminal Law**

While they argue that, in principle, the criminal law should be used to deal with persons who engage in "irresponsible behaviours," many authors also point to the limits of criminal law. For example, Hermann believes that in a "case where individuals knowing they are infected choose to engage in behavior [that

will] likely lead to the infection of others," criminal prosecution for the purpose of punishment and deterrence is justified.[13] However, he admits that the use of the criminal sanction to punish and deter conduct likely to result in transmission of HIV raises serious doubts about the purposes of the criminal law and its efficacy in dealing with problems such as HIV transmission. Shekter sees only a limited role for the criminal law. After reviewing Canadian case law, he concludes that "in very limited circumstances, where the conduct of an individual is manifestly wanton and reckless, there appears to be a persuasive argument for the creation of a new and properly crafted offence." However, at the same time he warns against creating a provision that would deal only with HIV/AIDS, thereby singling out HIV/AIDS from other serious communicable diseases.[14] The Council of Europe stresses that its "principal concern was prevention through education and adequate information rather than the possibility of imposing penalties whenever they might appear necessary."[15]

**Arguments Against Criminalization**

Many authors oppose the use of the criminal law, and the American Civil Liberties Union even went so far as to publish a position statement containing the "best arguments against criminalization."[16] Gostin and Curran, in one of the earliest articles on the subject, express reservations about the use of the criminal law in the private realm and, generally, place little reliance upon the criminal law as a mechanism for impeding the spread of HIV. They conclude that compulsory legal interventions will not provide a fair and effective means of preventing the spread of HIV.[17] Jackson also believes that the criminal justice system is "an inappropriate mechanism through which to combat the AIDS crisis." He argues that individual prosecutors "scattered throughout the country, untrained in the medical intricacies of HIV, should not be employing coercive measures ... particularly when the public health system has largely ruled out such measures."[18] Dalton concludes that "the case for criminalizing risky behaviour is highly dubious." According to her, "a wise nation would consider whether in so doing [prosecuting individuals who, for many reasons, put others at risk of contracting HIV] we advance the public health."[19] Sullivan and Field also argue against criminalization, pointing to the many disadvantages of using the criminal law as a tool to contain the spread of HIV. In their view, criminalization would encourage people to avoid testing, threaten the privacy of sexual relationships and encounters, and raise a risk of official harassment and abuse: "In short, it would be a mistake to enact ... criminal measures ... to deal with the problem of transmission of AIDS."[20] Holland, however, argues that individuals will not be deterred from testing just because of the possibility that at some future stage they may face criminal liability.[21]

Many Canadian organizations and institutions, including the National Advisory Committee on AIDS, [22] the Royal Society of Canada,[23] the Canadian Bar Association-Ontario,[24] and the AIDS Committee of Toronto, have argued against the use of the criminal law.[25] For example, the Canadian Bar Association-Ontario says that it is not persuaded that the use of the criminal law is an appropriate way to deal with HIV/AIDS, and that there exists adequate protection against the "irresponsible person" under provincial public health legislation. The view that using the criminal law would be inappropriate is shared by:

the AIDS Committee of Toronto, which developed the first policy of any community-

based organization in Canada on the use of criminal sanctions as a response to the transmission or threatened transmission of HIV;

the National Advisory Committee on AIDS, which recommends that in the "very small number of cases where involuntary measures are reasonably and demonstrably essential, the use of carefully controlled involuntary public health measures is generally to be preferred over criminal sanction"; and

the Royal Society of Canada, which holds that it would not be reasonable to criminalize sexual intercourse solely on the basis of HIV seropositivity, and that existing criminal laws or provincial public health legislation should be used to deal, on an individual basis, with those "[i]ntransigent people who have abandoned any sense of social responsibility" and put others at risk of contracting HIV.

**Conclusion**

The criminal law has only a minor role to play in preventing the spread of HIV. As stated by Johnston, "education will prove the best way to reach HIV carriers, and the soft touch is likely to be more effective than the big stick."[26] Criminalizing HIV endangerment "will do little to stop the spread of the virus," and, "[w]orse, it gives the appearance of decisive action while distracting from the solutions that work."[27]

- *Ralf Jürgens*

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[1] This text is a shorter version of a literature review undertaken as part of the Joint CAS/Network Project. 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 & Canadian HIV/AIDS Legal Network, 1995.

[2] R Jürgens. Justice Minister Considers Introducing HIV/AIDS-Specific Criminal Offence. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(3): 6.

[3] See, eg, MA Field & KM Sullivan. AIDS and the Criminal Law. Law, Medicine & Health Care 1987; 15(1-2): 46-60.

[4] WH Holland. HIV/AIDS and the Criminal Law. Criminal Law Quarterly 1994; 36(3): 279-316. See also 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.

[5] DHJ Hermann. Criminalizing Conduct Related to HIV Transmission. Saint Louis University Public Law Review 1990; 9: 351-378.

[6] HL Dalton. Criminal Law. In: S Burris et al (eds). AIDS Law Today. A New Guide for the Public. New Haven: Yale University Press, 1993, at 242-262.

[7] RL Stauter. United States v. Moore: AIDS and the Criminal Law. The Witch Hunt Begins. Akron Law Review 1989; 22(4): 503-524.

[8] Supra, note 3.

[9] ML Closen, JS Deutschman. A Proposal to Repeal the Illinois HIV Transmission Statute. Illinois Bar Journal December 1990 at 592-600.

[10] See also ML Closen et al. Criminalization of HIV Transmission in the USA. Abstract PO-D27-4188, presented at the IXth International Conference on AIDS, Berlin, 6-11 June 1993; Field & Sullivan, supra, note 3; TW Tierney. Criminalizing the Sexual Transmission of HIV: An International Analysis. Hastings International & Comparative Law Review 1992; 15: 475.

[11] Note. Sexual Etiquette, Public Interest and the Criminal Law. Northern Ireland Legal Quarterly 1991; 42(4): 309-331.

[12] Supra, note 4.

[13] Supra, note 5.

[14] Supra, note 4.

[15] Council of Europe. European Committee on Crime Problems. Select Committee of Experts on Criminological and Prison Aspects of the Control of Transmissible Disease, including AIDS and Related Health Problems in Prison (including the problems of treating prisoners who are drug addicts or AIDS victims). Summary Report of the meeting held in Strasbourg, 29-31 May 1989. Council of Europe. Doc. PC-R-SI (89) 2.

[16] American Civil Liberties Union Foundation, AIDS and Civil Liberties Project. Criminalizing Transmission of the Virus. New York, NY: The Foundation, no date.

[17] L Gostin & WJ Curran. The Limits of Compulsion in Controlling AIDS. Hastings Center Report 1986 (December): 24-29 at 28-29.

[18] H Jackson. The Criminalization of HIV. In: ND Hunter & WB Rubenstein (eds). AIDS Agenda. Emerging Issues in Civil Rights. New York, NY: The New Press, 1992, at 239-270.

[19] Supra, note 6.

[20] Supra, note 3.

[21] Supra, note 4.

[22] HIV and Human Rights in Canada. Ottawa: The Committee, 1992, at 15.

[23] AIDS - A Perspective for Canadians. Ottawa: The Society, 1988, at 354-355.

[24] Report of the AIDS Committee. Toronto: The Association, 1986, at 60-61.

[25] ACT Preparing Policy on Criminalization of HIV Transmission. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(3): 7-8.

[26] C Johnston. AIDS and the Law: Do Courts Have a Place in the Bedrooms of the Nation? Canadian Medical Association Journal 1992; 146(11): 2065-2070.

[27] D Patterson. Should Canada Criminalize HIV Endangerment? Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(2): 1,14-15.

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# Criminal Law and HIV/AIDS: A Review of Cases (Part II)

**The following is the second part of a review of cases in which Canadian courts have used existing Criminal Code provisions to deal with HIV transmission or endangerment thereof.**

In vol 2, no 1 of the *Newsletter*,[1] we reviewed six cases involving charges of "common nuisance" (s 180 of the Code) or "criminal negligence" (s 219 of the Code). Five more cases are reviewed in this issue.

## A. Aggravated Assault

Section 268 of the Code provides that a person commits an aggravated assault when he or she wounds, maims, disfigures or endangers the life of a complainant. The term "assault" is defined in s 265 of the Code: a person commits an assault when, without the consent of another person, he or she applies force intentionally to the other person, directly or indirectly. For the purposes of s 265, no consent is obtained where the complainant submits or does not resist by reason of the application of force to the complainant or to another person. Consent is also vitiated by fraud or by threats or fear of the application of force to the complainant or to another person.

### *1. R v Lee[2]*

The accused was a 21-year-old bisexual man who had a sexual relationship with an HIV-positive gay man, ED. ED introduced the accused to the complainant, a 34-year-old woman who knew that ED was gay and an intravenous drug user, and that he had shared needles with the accused in the past. On the night of the alleged offence, the three met in a Toronto gay bar and had many drinks. The accused and the complainant eventually left together to go to the complainant's residence, where they engaged in unprotected sexual intercourse. When the complainant informed ED about this, ED told her that the accused was HIV-positive. When confronted by ED and the complainant, the accused himself confirmed that he was HIV-positive.

However, after his arrest the accused told the police that he had tested negative in the past, and only suspected that he might have seroconverted since. When tested, he did in fact test positive. The complainant herself tested negative on a number of occasions after the incident.

The accused was charged with aggravated assault for having engaged in consensual sexual intercourse with the complainant. The Crown argued that the complainant's consent was vitiated and nullified by fraud because the accused had failed to inform her that he was HIV-positive.

The accused was acquitted. The Court held that, although the accused might have suspected that he was HIV-positive, there was no evidence before the Court that he knew for a fact that he was HIVpositive at the time of the alleged offence.

After a review of the jurisprudence on the issue of consent obtained by fraud, the Court concluded that the consent of the complainant to the act of sexual intercourse was valid: only fraud as to the "nature and quality of the act" or as to the identity of the person who performs the act would have vitiated the consent.

***2. R v Ssenyonga***

This is probably the best-known criminal case in the area of HIV/AIDS.

**Public Health Measures**

In February 1990, a Medical Officer of Health in Ontario issued an order against Ssenyonga not to engage in certain unprotected sexual activities. Ssenyonga was HIV-positive and known to engage in unprotected sexual activities with various female partners. Notwithstanding the order, Ssenyonga continued to engage in unprotected sexual activities.

On 16 April 1991, the Chief Medical Officer of Health of Ontario sought a judicial order to prevent Ssenyonga from engaging in certain unprotected sexual activities. The order was granted by Montgomery J of the Ontario Court of Justice.[3]

**The Charges**

Ssenyonga was eventually charged with a number of criminal offences, including aggravated sexual assault, criminal negligence, administering noxious bodily fluids, and nuisance endangering the life of another, for allegedly having had unprotected sexual intercourse with a number of women while knowing that he was infected with HIV, which resulted in transmission of HIV to three women.

**Bail**

The accused was released on bail. An application by the Crown to put him back in prison was rejected

on 9 August 1991.[4] Jenkins J was of the opinion that:

> Ssenyonga was unlikely to flee;
>
> did not pose a threat to the safety of the general public (no evidence had been introduced to indicate that he had violated the second restraining order of 16 April 1991); and
>
> the Crown was unlikely to succeed in some or all of the charges against him.

**Closed Courtroom**

On 29 November 1991, the Ontario Court of Justice rejected the Crown's application that the complainants be allowed to testify in a closed courtroom, without members of the public being present.[5] The Court considered that the identity of the complainants would be sufficiently protected by orders:

> banning publication or broadcast of the evidence presented at trial; and
>
> directing that their identity, or any information that could disclose their identities, not be published or broadcast in any way.

**Preliminary Enquiry**

At a preliminary enquiry on 28 May 1992, Livingstone J of the Ontario Court of Justice ruled that the Crown had presented sufficient evidence upon which a reasonable jury could convict the accused on the counts of:

> criminal negligence causing bodily harm; and
>
> aggravated sexual assault.

The Court, however, dismissed the charges of[6]:

> common nuisance. The Court held that the accused did not endanger the life, safety or health "of the public." Livingstone J distinguished the case from Thornton, in which the accused had knowingly donated contaminated blood to a Red Cross clinic, thereby endangering the public.[7] Ssenyonga had had sexual relationships with individuals who were members of the public but did not represent the community as a whole.
>
> administrating a "noxious thing." Counsel for the accused admitted that the semen of the HIV-positive accused could be considered a "noxious thing." However, this offence requires that the "noxious thing" be administered with the intention of endangering life or

causing bodily harm. Livingstone J concluded that there was insufficient evidence that the accused could have foreseen the certainty, or the substantial certainty, of infecting the complainants with HIV by having unprotected sex with them.

**The Aggravated Assault Charges**

On 30 April 1993, the aggravated sexual assault charges were also dismissed.[8] It was established by the Crown that Ssenyonga knew that he was HIV-positive and that the complainants, had they themselves known, would not have consented to sexual intercourse with him. The Crown argued that:

> unprotected sexual intercourse with a person who knows and fails to disclose that he is infected with HIV is so inherently dangerous that it exceeds the scope of the complainants' consent. Nevertheless, McDermid J ruled that the purpose of the offence of aggravated sexual assault was to control the non-consensual direct or indirect application of force by one person on another. In this case, all three complainants had consented to the application of force inherent in sexual intercourse. Unwilling to import the common law notion of informed consent into the criminal law, McDermid J rejected the Crown's argument.
>
> the complainants' consent was vitiated by fraud. However, following R v Lee, McDermid J found that the consent was not vitiated by fraud.
>
> the consent of the complainants was vitiated on grounds of public policy. Reasonable persons, the Crown argued, would not consent to unprotected sexual intercourse with partners known to be HIV-positive. McDermid J rejected this argument, saying that, if the accused could not be held criminally liable under any other section of the Code - which remained to be seen, because he had yet to rule on the charges of criminal negligence - this was a matter for Parliament to address through legislation. He reiterated that the purpose of section 265 is to control the non-consensual direct or indirect application of force by one person on another, and not to control the transmission of HIV and the spread of AIDS. In his words, "the law of assault is too blunt an instrument to be used to excise AIDS from the body politic."

**Criminal Negligence**

Before the Court could deliver its verdict on the charges of criminal negligence causing bodily harm, the accused died. The Court refused to rule posthumously.

**Compensation**

On 8 February 1994, it was announced that the Criminal Injuries Compensation Board of Ontario had awarded $15,000 to each complainant, on the basis that criminal negligence had been established (it was

possible for the Board to find Ssenyonga criminally negligent because its findings were based on a balance of probabilities rather than on the criminal standard of "beyond reasonable doubt").[9] However, the two-member panel emphasized that "what has been found criminal is not the transmission of HIV per se," but Mr Ssenyonga's "wanton and reckless disregard" for the women's lives by lying about his health and repeatedly engaging in unprotected sex despite knowing he had tested positive for HIV. The Board declined the maximum amount of $25,000, saying that the women were partly at fault for not being more vigilant in protecting their own health. It was the view of the Board that each person must accept some responsibility for the consequences of unprotected sexual intercourse.

On appeal, the Ontario Divisional Court overturned the decision, holding that the Board had "erred in law in demanding an unreasonably high standard of behaviour" from the women. They were each awarded the $25,000 maximum.[10]

**B. Attempted Murder**

Section 239 of the Code provides that everyone who attempts by any means to commit murder is guilty of an indictable offence and liable to imprisonment for life.

***1. R v Lessieur[11]***

The accused was incarcerated at Donnacona Maximum Security Institution where, in March 1992, he assaulted penitentiary staff who were trying to restrain him in his cell. The inmate, who knew he was HIV-positive, smeared his blood on cuts on one of the guards' arms, saying that he was HIV-positive and would contaminate and kill him, and bit one of the guards on the wrist.

He was charged with four counts of assaulting a peace officer and uttering threats to cause death or serious bodily harm, and one count each of assault causing bodily harm and attempted murder in relation to biting the officer. On 17 February 1993, a jury returned a guilty verdict on all charges, except that of attempted murder.

In sentencing the accused, the Court stated that it had to take a firm stand to prevent the recurrence of such events, in prisons and outside, and that the public and penitentiary staff had to be protected from the spread of HIV. The accused was sentenced to four years in prison.

***2. R v Tremblay[12]***

An HIV-positive man who smeared his blood on a teenage girl's cuts and told her she was going to die was acquitted of attempted murder and death-threat charges. Recent tests have shown that the girl is HIV-negative. No medical evidence proving that HIV could be transmitted by the man's actions was presented to the judge, who ruled that there was not "adequate judicial knowledge" about whether smearing of blood could lead to transmission of HIV, and therefore acquitted the man of the attempted-murder charge. Interestingly, the Crown did not lay charges against the man for having had unprotected

sex with the girl, knowing that he was HIV-positive and not having informed her about his serostatus.

## C. Anal Intercourse

Section 159 of the *Criminal Code* provides that every person who engages in an act of anal intercourse is guilty of an indictable offence and is liable to imprisonment for a term not exceeding ten years. This section does not apply to any act engaged in, in private, between a husband and wife, or any two persons, each of whom is eighteen years of age or more, both of whom consent to the act.

Section 159 was recently found unconstitutional by both the Federal Court and the Ontario Court of Appeal.[13]

### *1. R v Langlois[14]*

In July 1990, a 17-year-old male met Langlois in a gay bar in Québec City. The two engaged in a consensual sexual activities that night. In the following days, the 17-year-old repeatedly asked Langlois whether he was HIV-positive. Langlois never answered in the affirmative, although he had known since 1988 that he was HIV-positive.

The 17-year-old later tested positive for antibodies to HIV, and reported Langlois to the police. On 29 October 1990, after charges had been laid, Langlois surrendered and pleaded guilty to having engaged in anal intercourse with a minor. Langlois was never charged with any other criminal offences, and his lawyer emphasized that he was charged solely for having had anal intercourse, not for transmitting HIV. Because Langlois had cooperated fully following his arrest and had expressed remorse, the lawyer recommended a suspension of sentence.

However, Lanctot J of the Court of Québec convicted Langlois to four-and-a-half years of imprisonment. He noted that anal intercourse between consenting adults has been decriminalized and that s 159 now focuses primarily on youth protection. He went on to say that Langlois' conduct was particularly offensive because he took advantage of a minor who was relatively inexperienced sexually.

Lanctot J noted that although transmission of the HIV virus is not in itself criminalized, the sentence had to reflect the need to protect public health against the reckless transmission of HIV. He considered that Langlois' conduct was aggravated by the fact that he did not disclose his HIV status and did not take any precautions to protect the minor.

In closing, Lanctot J noted that a long sentence could mean life imprisonment for the accused. He emphasized that this was not his goal, but merely a consequence of the need to impose a sentence long enough to reflect the gravity of the act committed.

- *Bruno Guillot-Hurtubise*

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[1] B Guillot-Hurtubise. Criminal Law and HIV/AIDS. Canadian HIV/AIDS Policy & Law Newsletter 1995; 2(1): 1, 15-16.

[2] (1991), 3 OR (3d) 726 (Gen Div).

[3] Ontario Chief Medical Officer of Health v Ssenyonga [1991] OJ No 544 (Ont Ct of Justice-Gen Div).

[4] R v Ssenyonga [1991] OJ No 1460 (Ont Ct of Justice-Gen Div).

[5] R v Ssenyonga [1991] OJ No 2581 (Ont Ct Justice-Prov Div).

[6] R v Ssenyonga (1992), 73 CCC (3d) 216 (Ont Ct-Prov Div).

[7] R v Thornton (1991), 3 CR (4th) 381; 1 OR (3d) 480 (CA).

[8] R v Ssenyonga (1993), 81 CCC (3d) 257 (Ont Ct-Gen Div).

[9] Ontario (Attorney General) v Ontario (Criminal Injuries Compensation Board) [1995] OJ No 278 (QL).

[10] For more details, see S Wilson. HIV-Positive Women Receive Higher Compensation Award. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(3): 1, 15.

[11] Québec Superior Court, District of Québec, file no 200-01-008541, unreported, 1993.

[12] Court of Québec, Montréal, 20 February 1995, file no 500-01-017674-935, unreported (Cadieux J).

[13] See D Patterson. Anal Sex Law Ruled Discriminatory. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(4): 3-4.

[14] Court of Québec, Québec, 25 January 1991, file no 200-01-010507-907, JE 91-954.

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## HIV-Positive Rapist Sentenced to 12 Years

**On 15 September 1995, the Ontario Court of Justice (Provincial Division) sentenced an HIV-positive man who had committed an aggravated sexual assault to 12 years in prison.**

The charge alleged that on 1 October 1994, the man sexually assaulted the victim, and that in the commission of that sexual assault he endangered her life. The accused admitted that in the course of raping and forcing fellatio upon the victim, he beat her about the head and face and caused her serious bodily harm. Further, he admitted that because "he is, and was to his knowledge at the time of the offence, a carrier of the AIDS virus," he endangered the life of the victim both by ejaculating into her mouth and onto an open facial wound caused by him, and by ejaculating inside her vagina during the act of forced sexual intercourse.

The accused had a lengthy criminal record and was last sentenced to nine months in 1993 for sexual assault, forcible confinement, robbery and possession of a narcotic, and in 1994 to eight months for trafficking in a narcotic.

There was no disagreement that the case called for a lengthy penitentiary term. This was reflected in a joint submission by the Crown and the counsel for the defendant that seven years' imprisonment would be a fit sentence. In Fairgrieve J's view, however, the recommended sentence, substantial though it was, remained "unjustifiably lenient." According to him, an unusual combination of aggravating factors was present in the case, and the recommended sentence would have failed to adequately reflect them: "While I think that seven years could be justified if the case invloved [sic] simply the acts of rape and forced oral sex committed by an offender with a criminal record like the accused's, it seems to me that both the vicious beating resulting in serious bodily harm and the wanton and reckless disregard for the life of the complainant shown by subjecting her to unprotected sex while knowing himself to be infected with HIV, place this offence in an altogether more serious category." Fairgrieve J emphasized that the accused's failure to use a condom when requested to do so by his victim demonstrated complete indifference to the safety of the woman involved, and concluded that "[i]t is difficult to envisage a more dangerous threat than an unrestrained, unrehabilitated HIV-positive rapist."

In determining the appropriate sentence, the Court expressed that it did not think "that it [the accused's state of health] is relevant to this sentencing in the sense that his personal tragedy warrants leniency." Adopting the reasoning of Marshall JA in Mercer,[1] the Court held that any residual feelings of sorrow toward the accused because of his HIV status must cede to the imperative of public protection. It concluded: "I think that the court must proceed on the assumption that the National Parole Board will exercise appropriate compassion when any danger to the public caused by Mr. Winn's [the accused's] release has been sufficiently minimized."

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[1] (1993), 84 CCC (3d) 41, 110 Nfld & PEIR 41 (CA); for a summary of the case, see Canadian HIV/AIDS Policy & Law Newsletter 1995; 2(1): 16.

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# Japan: Hemophiliacs Offered Compensation in Blood Product Scandal

Reprinted from Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(2).


The Japanese government and five major pharmaceutical companies have offered over Aus$1 billion (approximately Can$1 billion) in compensation to hemophiliacs who contracted HIV through imported blood-clotting agents.

The Sydney Morning Herald reported on 6 October 1995 that if the settlement, negotiated by courts in Tokyo and Osaka, is accepted, it will be one of the largest liability payouts in history.

A total of 1003 people in Japan are known to have contracted HIV through infected blood products. Of these, 530 have developed AIDS and 357 have died. Several hundred more are believed to be HIV-positive, but have not been told by their physicians. According to the Herald, Japanese physicians often refuse to tell people who have fatal illnesses.

Most of those covered in the compensation offer have refused to go public about being HIV-positive for fear of prejudice. People with HIV/AIDS in Japan are routinely dismissed from their jobs and ostracized, and more than 80 percent of hospitals allegedly refuse to treat persons living with HIV/AIDS.

The settlement offered, approximately Can$600,000 for each person, is less than half the amount sought by approximately 220 people covered by two class actions that started about six years ago. Under the offer, the government would pay 40 percent and the drug companies would pay the balance.

In the mid-1980s, the Japanese government refused to acknowledge that the blood-clotting agents factors 8 and 9 could transmit HIV, despite the introduction of blood screening in western countries. Drug companies took advantage of the situation to sell blood products carrying HIV on the Japanese market at half price, after they were banned in other countries. Lawyers allege that the head of the government's advisory committee, who allowed the lucrative trade to continue, was bribed by the drug companies with laboratory equipment worth hundreds of thousands of dollars.

Reported in the [Australian] National AIDS Bulletin 1995; 9(6): 4.

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## CANADIAN NEWS

### HIV & AIDS Legal Clinic Ontario Opened

**On 1 December 1995, the HIV & AIDS Legal Clinic Ontario (HALCO) opened in Toronto.[1] Funding for the Clinic is made available through the Ontario Ministry of the Attorney General and the AIDS Bureau, Ontario Ministry of Health**.

**Legal Services**

HALCO's mission is to find viable solutions to meet the legal needs of everyone in the communities affected by HIV/AIDS. The Clinic will provide legal services in areas such as human rights, employment, insurance, wills and estates, and health care. Whenever it is unable to provide direct representation, it will refer clients to the appropriate legal, community or government service.

**Education**

Persons living with HIV/AIDS often have a need to know the rights they have in various situations, such as in employment, health care, housing, dealing with insurance companies, banks, social welfare agencies, and families. HALCO will provide information to individuals concerning their specific situation, but will also act as a resource to community organizations serving persons living with HIV/AIDS, government agencies, other legal professionals, employers and the general public.

**Law Reform**

The Clinic will assist in advocating all law reform initiatives that are identified as being "necessary to protect and enhance the rights of persons living with HIV and AIDS."

**Statement of Principles**

The Clinic's Board of Directors adopted the following statement of principles on 19 June 1995:

It is agreed that:

1. People living with HIV and AIDS are confronted with unique legal problems of enormous proportions and complexity;

2. Those best equipped to make choices regarding HIV and AIDS issues and problems are those individuals who are HIV-positive themselves;

3. People living with HIV and AIDS must have control over their own lives;

4. The HIV and AIDS affected communities are very diverse and the priorities of those communities are by no means uniform;

5. It is necessary to create and foster a climate of understanding and mutual respect for the dignity and worth of people living with HIV and AIDS; and,

6. The confidentiality, bodily security, autonomy and privacy of people living with AIDS and HIV must be respected. This includes but is not limited to:

(a) the right of individuals to exercise control over their own medical treatment;

(b) the right of individuals to make decisions concerning their own socio-economic position;

(c) the right of all persons living with HIV or AIDS to be fully informed of all processes and procedures in which their interests are in any way involved; and

(d) the right of all persons living with HIV or AIDS to consent, or withhold their consent, in all matters affecting them.

**For more information, or to become a member of HALCO, contact the Clinic at 399 Church Street, 4th Floor, Toronto, Ontario M5B 2J6. Tel: (416) 340-7790 ext 401; fax: (416) 340-7248.**

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[1] The following text is a slightly edited and revised version of: Press Release - HIV & AIDS Legal Clinic Ontario. Securing the Rights of Persons with HIV and AIDS through Legal Services, Education and Law Reform. Toronto: The Clinic, 13 December 1995.

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# PROSTITUTION

## Prostitution and HIV/AIDS

**Legal, moral and social censure of prostitutes has increased dramatically since the advent of HIV/AIDS. As has been the case throughout history, sex-trade workers are seen as the "vectors of disease."**

Female prostitutes in particular are perceived as the bridge between an HIV-infected "underworld" and the "general population" (to be read as heterosexual white males). According to policy-makers and the media, the protection of public health justifies draconian legal measures and moral intolerance.[1] Few if any of these measures reduce a prostitute's own risk of contracting HIV.[2] Research has indicated that punitive measures to control the sex trade - such as increased criminal penalties, mandatory testing, and electronic monitoring - will further erode prostitutes' ability to negotiate safe sex and further alienate them from public health initiatives. As a result, HIV risks will be increased rather than reduced.[3] Nevertheless, governments continue to pursue these policies.

In order to develop policies that enhance rather than damage public health, policy-makers must understand what factors put populations at risk and how legal initiatives can affect the spread of HIV in stigmatized communities.

### Seroprevalence Rates and Transmission Risks

Early studies suggest that Canadian female prostitutes are no more likely to be infected with HIV or other sexually transmitted diseases than other women, unless they are also intravenous drug users.[4] Studies also show that in their sexual relations, sex-trade workers use condoms more consistently than other populations similar in age, race, and sex.[5] Further, with respect to female hookers, the fact that the transmission of HIV from female to male is so difficult would suggest that the sex trade is unlikely to be a source of the spread of HIV/AIDS. Early studies of men who use female prostitutes confirm this; they did not reveal a single case in which a client was infected by a prostitute.[6] It is far more likely,

particularly in the current legal context, which excludes sex-trade workers from the protection of the law, that prostitutes are at risk from their clients.

Because only few studies have been done, it is difficult to estimate the seroprevalence rate for male hookers. Rates as high as 50 percent and as low as 11 percent have been reported by US researchers.[7] It has been suggested that male hustlers in the US are at high risk of becoming infected by their clients due to several factors - their willingness to have sex without a condom for extra money (many hustlers are also drug users who need the extra money to buy drugs), the fact that receptive anal intercourse is a common service, and the young age of many hustlers. Fortunately, the extent to which the US experience can be applied to Canada is questionable. Toronto hustlers report that the most common sexual activity they engage in is oral sex. The second most common is anal intercourse, with the hustler giving rather than getting.[8] Finally, of all the arrests for prostitution in Canada in 1992, only three percent were of youths under 18.[9]

**Legal and Policy Initiatives**

**Imprisonment**

Imprisonment is one of the major responses to prostitution. A high percentage of women prisoners are incarcerated either for prostitution offences or for drug-related offences.

**Mandatory Testing and Detention**

Since the advent of HIV/AIDS, many US states have passed legislation requiring mandatory HIV testing of hookers convicted of, or in some cases charged with, prostitution.[10] Under a California law requiring mandatory testing, if a prostitute tests positive, subsequent prostitution convictions carry three-year sentences, whether the prostitute practised safe sex or not.[11] The law has spawned appalling forms of state oppression of HIV-positive prostitutes: for example, two women prostitutes who tested positive for HIV were released from custody only on condition that they agree to be "electronically monitored."[12] In another US state, Florida, an HIV-positive prostitute was charged with manslaughter despite the fact that all her customers tested seronegative and she had used condoms consistently.[13] Such draconian measures deter hustlers from seeking HIV testing or drug treatment.

Although Canada does not have legislation requiring mandatory testing, a BC prostitute was convicted of solicitation and then sentenced to monthly mandatory AIDS and STD testing. He appealed the sentence, arguing that it violated his right to be free from unreasonable search and seizure (s 8 of the *Canadian Charter of Rights and Freedoms*). On appeal, the BC Court of Appeal held that, although monthly examinations were excessive, one examination was reasonable and would promote "good conduct."[14] Further, quarantine powers under provincial public health acts have been used to detain prostitutes. In Victoria, BC, local public health authorities issued an order to confine an HIV-positive woman prostitute to Victoria Royal Jubilee Hospital, indefinitely, because she was suspected of having unprotected sex with male customers.[15]

## Prostitution Law Reform

Canadian policy-makers want to make prostitution laws tougher. In 1992, a Working Group on Prostitution was established by the Federal/Provincial/Territorial Deputy Ministers Responsible for Justice. The Working Group released "Dealing with Prostitution in Canada - A Consultation Paper" in March 1995. The paper discusses a number of options that have been proposed by various parties to deal with prostitution in Canada. It is mainly concerned with two issues: "youths in prostitution and street prostitution."[16] The majority of the options discussed involve changes to sections 212 and 213 of the *Criminal Code* (s 212 contains various offences known collectively as "procuring" or "living on the avails," which are not aimed at prostitutes but are designed to "prevent persons from being forced into a life of prostitution"; under s 213, it is an offence on the part of the customer, as well as the prostitute, to communicate in public for the purpose of engaging in prostitution). These options include:

> increased and/or mandatory jail sentences for pimps and customers of youths;
>
> making section 213 a dual procedure or hybrid offence to allow for the fingerprinting and photographing of prostitutes and customers charged under s 213;
>
> electronic surveillance and interception of communications between prostitutes, pimps and customers;
>
> mandatory and/or increased sentences for customers;
>
> allowing provinces/territories and/or municipalities to license and operate prostitution establishments or formal zones of tolerance for street prostitution.

The paper also contains a list of "social intervention options." For youth, options are explored to:

> divert young offenders to child welfare services; and
>
> develop informational and educational materials to warn youth about the dangers of prostitution.

Another option discusses the development of outreach services, with health, training, and rehabilitation programs located in bus terminals, restaurants, and storefronts, and the creation of safehouses with counselling programs.

On 6 November 1995, The Globe and Mail reported that Justice Minister Rock was planning "tougher penalties - not legalization of the sex trade - to tackle problems associated with street prostitution."[17]

## The Impact of Prostitution Laws on the Spread of HIV

How do prostitution laws affect the spread of HIV among prostitutes? The criminalization of sex for money means that hookers who are subject to abuse from their customers are less able to report their abusers. It also makes it difficult for them to insist on condom use with their customers, and thus increases their chances of becoming infected. In conversations I had with a number of women who were raped by their customers, without condoms, they said that because their work is illegal they are not willing to prosecute these men. Instead, they maintain a "bad date" list and disseminate it to other hookers. In contrast, it has been found that decriminalization of prostitution enables those in the sex trade to practise safe sex, and will ultimately result in lower infection rates.[18]

The intention behind increasing penalties in prostitution laws may be to discourage participation in the sex trade and thereby reduce health risks. In reality, however, few prostitutes are discouraged by tougher laws. Instead, such laws make them even more vulnerable. For example, increased penalties will result in an increased seriousness of a prostitute's criminal record, and this will reduce the employment opportunities for those who choose to leave the sex-trade industry.

Evidentiary issues also affect prostitutes' ability to protect themselves from contracting HIV from their customers. For example, possession of condoms is sometimes used as evidence of prostitution. As a result, prostitutes are less likely to carry condoms.

Because many drug users engage in prostitution to support their habits, drug laws can also affect HIV risk for this community. Bill C-7, the proposed new federal drug legislation, recently passed third reading in the House of Commons, and is now before the Senate for final consideration. If passed, it would criminalize possession of "containers" for drugs, and this would include hypodermic syringes. The new law would discourage users from carrying their own needles, with the result that they would share needles, exposing themselves to HIV, hepatitis, and other bloodborne diseases.

**Municipal By-Laws**

The Federal/Provincial/Territorial Working Group also proposes giving more power to municipalities to regulate prostitution through nuisance by-laws. There can be little doubt that many municipalities would consider enacting by-laws with the purpose of entirely outlawing prostitution in their jurisdiction.

Both Metro Toronto and the City of Mississauga have recently passed by-laws purporting to address public health issues - specifically citing HIV/AIDS - and that restrict touching between exotic dancers and customers.[19] Lap dancers merely relocated to municipalities that did not have similar restrictions.

The effect of nuisance by-laws directed toward street soliciting would be to drive sex workers into badly lit, deserted, non-residential areas. Sex workers would face even greater risk from violent customers. Further disempowering prostitutes would not encourage healthy working conditions or prevent the spread of HIV.

**Alternatives**

What are the alternatives to our current regime and the proposed changes of the Federal/Provincial/ Territorial Working Group? Calls for legalization and monitoring of the sex trade are being increasingly heard. However, for many reasons legalization is vehemently opposed by most prostitute groups.

The only rational solution is to decriminalize prostitution and provide prostitutes with the same rights and protections with respect to their working conditions as people in other occupations have.

Policy-makers must consult with prostitutes to develop a policy that will truly prevent and reduce the spread of HIV.

- *Karen Bastow*

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[1] D Brock. Scapegoating Prostitutes in the AIDS Epidemic. Broadside; 10(4): 6.

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

[3] Policy Paper on the Forced Testing and Quarantining of Prostitutes. Prostitutes Safe Sex Project (Maggies). Toronto: The Project, 1993; English Collective of Prostitutes. Prostitute Women and AIDS: Resisting the Virus of Repression. San Francisco, CA: PROstitutes Collective, 1988 (US edition). See also 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.

[4] D Brock. Prostitutes Are Scapegoats in the AIDS Panic. Resources for Feminist Research 1989; 18 (2): 13-16; N Padian. Prostitute Women and AIDS: Epidemiology. AIDS 1988; 2: 413-419; W Darrow. Prostitution, Intravenous Drug Use and HIV-1 in the United States. In M Plant, supra, note 1.

[5] P Alexander. Prostitutes and AIDS: Women as Alleged Vectors. National Now Times, February/ March 1991, at 12.

[6] P Alexander. Response to AIDS: Scapegoating of Prostitutes. San Francisco, CA: National Task Force on Prostitution, 1988; Brock, supra, note 4.

[7] D Waldorf & S Murphy. Call Men and Hustlers in California. In: M Plant, supra, note 1; W Darrow, ibid.

[8] Author's conversations with street hustlers in Toronto's boystown, 1995.

[9] Dealing With Prostitution in Canada: A Consultation Paper. The Federal/Provincial/Territorial Working Group on Prostitution. March 1995, at 1.

[10] P Alexander, supra, note 5 at 12.

[11] Awful New Prostitution Laws. COYOTE (Call off your old tired ethics) Howls, January 1989, at 1-2.

[12] Stiletto 1991; 1(3): 6.

[13] Prostitution and HIV Infection. In: Women, AIDS & Activism. New York: The Act Up/NY Women & AIDS Book Group, 1990, at 180.

[14] R v Cornier, unreported, 1991 CA 12803 BCCA.

[15] J Miller. AIDS Project News. Kinesis, June 1990 (Vancouver) at 5.

[16] The following summary is a shortened version of R Achilles. The Regulation of Prostitution. Unpublished background paper written for the Department of Public Health of the City of Toronto (updated 14 April 1995), on file with editor.

[17] Tougher Sex Trade Penalties Planned - Rock to Propose Changes in Code. The Globe and Mail, 6 November 1995, at A4.

[18] R Perkins. AIDS Preventative Practices among Prostitutes in New South Wales. [Australian] National AIDS Bulletin September 1991, at 28; see also CA Campbell. Women and AIDS. Social Sciences in Medicine 30(4) at 411.

[19] Metro Toronto by-law #20-85 was passed on 16 August 1995, although it is currently unenforceable pending a case before the Ontario Court of Appeal (R v Patrick Mara and Allan East, court file #C18057). City of Mississauga by-law #572-9 was passed on 14 September 1995.

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# Travel and Immigration

## Release of Report on Canada's Travel and Immigration Policies for Persons Living with HIV/AIDS

**The Report, written by the Canadian AIDS Society (CAS), in preparation for the XIth International Conference on AIDS, which will be held in Vancouver from 7 to 12 July 1996, was released on 25 September 1995. It provides information on Canada's policy on the admission of persons living with HIV/AIDS who wish to visit Canada or immigrate to Canada.**

The Report deals only with policies affecting persons living with HIV/AIDS; it does not cover policies affecting sex trade workers, injection drug users, or persons with a criminal record. It notes that there are no specific restrictions on gays and lesbians visiting Canada or immigrating to Canada: they must meet the same general admission criteria as other persons.

The following is a slightly edited version of the Report.

**Canada's Travel Policy**

Canada's Immigration Act does not mention HIV/AIDS or any other disease or illness specifically. Section 19(1)(a) of the Act says that visitors to Canada must meet two criteria before being allowed to enter the country:

> they must not represent a danger to public health and safety; and
>
> their admission must not place excessive demand on Canada's health and social service systems.

Prior to 1991, the government considered that persons living with HIV/AIDS represented a danger to public health. It was government policy that they should not be allowed to visit Canada. An exception

was made for the Vth International Conference on AIDS in Montréal in 1989; persons living with HIV/AIDS were allowed to enter the country to attend the conference.

CAS subsequently urged the federal government to remove all travel restrictions on persons living with HIV/AIDS. In response, in April 1991 the government announced that it no longer considered AIDS and HIV to be a danger to public health. The Minister of Health said that "visitors with AIDS or HIV infection will be treated in exactly the same manner as any other visitor to Canada."

However, even after this announcement there were a few instances of persons living with HIV/AIDS being denied entry to Canada. CAS continued to lobby for changes until on 3 August 1994 Minister of Immigration Sergio Marchi wrote to the Society outlining the government's policy. According to Minister Marchi:

> a diagnosis of HIV/AIDS is not in itself a barrier to visiting Canada;
>
> persons living with HIV/AIDS do not generally represent a danger to the public under s 19 of the *Immigration Act*;
>
> the issue is therefore whether visitors living with HIV/AIDS would place excessive demand on the Canadian health-care system;
>
> it is not normally expected that visitors with HIV would place any demand on the health-care system;
>
> therefore, for the vast majority of short-term visits by persons living with HIV/AIDS, the excessive demand criterion would likely not be invoked;
>
> the excessive demand criterion will only be invoked if there is reason to believe a person would need medical treatment while in Canada, although even in this case a person may still be able to enter the country if he or she had made arrangements for treatment and payment;
>
> the carrying of HIV/AIDS medication is not a ground for refusing admission; and
>
> the government will provide immigration officers with thorough information on the travel policy and implement a training program on HIV/AIDS for immigration officers.

Implementation of the training program has begun and is expected to be completed before the XIth International Conference on AIDS.

**The Position of the Canadian AIDS Society**

According to CAS, "the policy as outlined by Mr Marchi is the best that we will be able to obtain. The government will not provide an absolute guarantee that every person living with HIV/AIDS will be allowed to visit Canada. It insists that all visitors, including persons living with HIV/AIDS, meet the two medically-related criteria in the *Immigration Act* and that each visitor be assessed against these criteria." In particular, the Minister's statement meets the three major objectives CAS had established for its advocacy on this issue:

> clarification of Canada's policy, including a clear statement that: (1) people will not be excluded on the basis of their HIV status; (2) the vast majority of persons living with HIV/AIDS will be able to visit Canada;
>
> a commitment to communicate the policy to immigration officials; and
>
> a commitment to undertake HIV/AIDS training for immigration officials.

**Canada's Immigration Policy**

Persons who wish to immigrate to Canada must meet the same criteria as visitors: they must not represent a danger to public health and safety, and their admission must not place excessive demand on Canada's health and social service systems.

Currently, it is the policy of the Canadian government that persons living with HIV/AIDS would place excessive demand on Canada's health and social service systems and that they are therefore not allowed to immigrate to Canada. However, the government does not routinely test potential immigrants for HIV.

In contrast to immigrants, persons who are found to be refugees do not have to meet any medical criteria. There has been at least one case where a self-declared person living with HIV/AIDS has been allowed into Canada as a refugee.[1]

Recently, government officials have been preparing guidelines to clarify the meaning of "excessive demand" because the term is not defined in the Immigration Act.[2] According to CAS, it is possible that some persons living with HIV/AIDS would be able to officially immigrate to Canada under a new definition of excessive demand, "but there is no certainty of this."

**CAS's Position**

CAS is "opposed to routine or mandatory HIV testing of immigrants" and believes that "a blanket exclusion of immigrants living with HIV is inappropriate and that each application for immigration should be assessed on its merits."

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[1] See S Wilson. HIV-Positive Refugee Admitted to Canada. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(3): 5.

[2] For more details, see S Wilson. Recent Developments in Immigration Law. Canadian HIV/AIDS Policy & Law Newsletter 1994; 1(1): 9-10.

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# Testing and Reporting

## New York Policy on HIV-Testing of Newborns

**Under the terms of a settlement agreement announced on 10 October 1995, the administration of New York Governor George Pataki has agreed to promulgate regulations and guidelines that will change procedures governing HIV-testing of newborn infants in the state.[1]**

Under the old procedures, all newborns in New York State were tested for HIV anonymously, the results being used only for epidemiological purposes. The Association to Benefit Children, a non-profit organization, brought suit on behalf of infant children in New York State, seeking a policy change to mandate disclosing test results to the mothers of newborns.

A New York statute, Public Health Law Article 27-F, requires informed consent for HIV-testing and that test results be treated with strict confidentiality. Legislation introduced and passed by the state Senate, but blocked in the Assembly, would accomplish what the Association sought in its lawsuit.

Under the terms of the settlement agreement, the following changes - which the parties assert will not require modification of Article 27-F - will be made to current procedures:

> All pregnant women who come into contact with health-care facilities for prenatal care will be counselled and encouraged to submit voluntarily to HIV-testing, the goal being to try to prevent transmission of HIV to their offspring in utero through AZT treatment during pregnancy.
>
> Upon giving birth, new mothers will be counselled about HIV testing for their newborns and offered a consent form. If they consent, a test will be performed and the results reported to them by their doctors.

The state also agrees to establish a mechanism for ensuring appropriate treatment in cases of positive

tests. The agreement is somewhat ambiguous concerning what happens if the mother declines to consent. However, it provides that a doctor "shall determine whether the presence of one or more risk factors constitutes an emergency that requires an HIV test to be performed on the infant." Thus, it appears that obtaining written consent from a mother may be an unnecessary formality if the doctor determines that the infant's mother may have been "at risk" for HIV.

In announcing the settlement, both the Governor's office and the Association emphasized that their agreement did not commit the state to mandatory testing of newborns without the mother's consent. However, the provision on "emergency" testing could be interpreted as establishing de facto mandatory testing for infants born in hospitals that serve ethnic minority populations for the most part.

Assembly member Mayersohn, sponsor of the newborn testing bill blocked in the Assembly, announced her dissatisfaction with the settlement and indicated she would reintroduce her bill during the next legislative session.

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[1] Baby Girl Doe v Pataki, No 10661-95 (NY Sup Ct, NY Co). Reported in Lesbian Gay/Law Notes November 1995, at 155-156.

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# Women and HIV/AIDS

## The Global Situation

**The following fact sheet was prepared by, and is being reprinted with the permission of, the Interagency Coalition on AIDS and Development, Ottawa.**

### The Women Infected

By the year 2000, it is estimated that 15 million women will have been infected with HIV globally. Four million women will have died of AIDS. The global tally of people infected with HIV will be between 30 and 40 million people.

Nearly 3000 women are infected each day. In 1995, the number of women infected with HIV is estimated between 7 and 8 million worldwide.

The World Health Organization (WHO) estimates that there are currently 115,000 HIV-infected women in North America, 500,000 in Latin America and the Caribbean, more than 5.5 million in Africa and about 1.8 million in Asia and the Pacific.

Women are also becoming infected at a significantly younger age than men. On average, women become infected 5 to 10 years earlier than men. Seventy percent of all new infections in women are among 15 to 24 year-olds.

### Why are women more vulnerable to HIV infection?

Women are biologically more vulnerable than men to HIV infection. Studies have found that male to female transmission appears to be 2 to 4 times more efficient than female to male transmission, in part because semen contains a far higher concentration of HIV than vaginal fluid. Young girls are particularly vulnerable. Their immature cervixes and low vaginal mucus production presents less of a

barrier to HIV.

The economic, social and physical power imbalance between men and women contributes to the lack of safety in sexual relationships and the difficulty for many women in negotiating safer sex. To do so may have serious repercussions, ranging from stigma to fear of violence or abandonment.

The power differential between men and women is compounded by age differences. Women typically marry or have sex with older men, who have been sexually active longer and are more likely to have become infected. Men are also beginning to seek younger sexual partners believing that these girls are less likely to be infected with HIV.

Women are vulnerable to coerced sex, including rape and other sexual abuse - within and outside the family - and forced sex work. Any non-consensual or coerced penetrative sex can carry an increased risk of HIV transmission, particularly as men are not likely to use condoms in these situations.

Subordination in education, employment, social and legal status makes women more vulnerable to HIV. Women who have limited access to financial resources are more likely to become economically dependent on men, relegated to the subsistence sector or forced into commercial sex work.

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# PRISONERS AND HIV/AIDS

## Discussion Paper on HIV/AIDS in Prisons Released

**In November 1995, eighteen months after the release of the Final Report of the Expert Committee on AIDS and Prisons (ECAP),[1] a new Discussion Paper on HIV/AIDS in prisons was released. The Paper points out that many of ECAP's recommendations - including some recommendations the Correctional Service of Canada (CSC) agreed with in its response to ECAP's Report - have not been implemented, putting prisoners, staff, and members of the public at risk of their lives.**

### Background

Issues raised by HIV/AIDS in prisons have been extensively studied in Canada, in particular by ECAP and the Prisoners with HIV/AIDS Support Action Network (PASAN). Nevertheless, individuals and organizations consulted during Phase I of the Project on Legal and Ethical Issues Raised by HIV/AIDS, undertaken jointly by the Canadian AIDS Society (CAS) and the Canadian HIV/AIDS Legal Network (Network), indicated that issues raised by HIV/AIDS in prisons remain a priority in Canada. In particular, they expressed concern about CSC's reluctance to implement some of ECAP's major recommendations, such as the recommendation to undertake a pilot study of needle distribution in at least one prison.

They suggested that the joint CAS/Network Project should examine whether governments and prison systems have a legal obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV, even if they "voluntarily" engage in illegal or forbidden behaviours (drug use and sexual activity), and address the issue of potential liability for not providing condoms, bleach, and sterile needles, with the resulting transmission of HIV in prisons.

### Activities Undertaken So Far

After co-funding was obtained from the Correctional Service of Canada, work on this component of the Project began in August 1995. So far, the Project has

organized a plenary and a small group session at the First National Workshop on HIV/AIDS in Prisons, in Kingston;

produced the proceedings of the Kingston Workshop in the October 1995 issue of the Newsletter;

undertaken extensive research on legal and ethical issues raised by HIV/AIDS in prisons; and

produced *HIV/AIDS in Prisons: A Discussion Paper.[2]*

The Paper and its appendixes:

review relevant new developments in the area of HIV/AIDS in prisons, nationally and internationally;

examine whether there is a legal and/or ethical obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV, even if they "voluntarily" engage in illegal or forbidden behaviours (drug use and sexual activity); and

address the issue of the potential liability for not providing condoms, bleach, and sterile needles, with the resulting transmission of HIV in prisons.

**The Goal of the Project**

The Discussion Paper has been sent to over 200 individuals and organizations active in HIV/AIDS and prison issues, to solicit their comments and input. In March 1996, a final report will be published and the federal and provincial prison systems will be asked to respond to it.

The goal of the Project is to assist CSC and provincial prison systems in their efforts to reduce HIV transmission in prisons and to staff and the public. The Discussion Paper and final document will help them respond to some of the challenges arising from developments that have occurred since the release of ECAP's *Final Report.*

**New Developments**

Among the new developments reviewed in the Discussion Paper are:

a 40 percent increase in the number of known cases of HIV/AIDS in federal correctional institutions over a period of 18 months;

an increase in the number of prisoners living with symptomatic HIV infection or AIDS in prisons, requiring more extensive and costly medical care;

increasing evidence of high-risk behaviours in prisons;

increasing evidence that, as a result of such behaviours, HIV is being transmitted in prisons;

the rapid spread of hepatitis C in prisons, as evidenced by three recent studies that revealed hepatitis C seroprevalence rates of between 28 and 40 percent;

legal action undertaken by prisoners in two Australian states against their prison systems for failing to provide measures to prevent the spread of HIV;

reports on HIV/AIDS in prisons issued in other countries, reinforcing the consensus that more needs to be done to prevent the spread of HIV in prisons, and care for prisoners living with HIV/AIDS; and

a pilot project for needle distribution in prisons in Switzerland, demonstrating that sterile needles can be distributed in prisons safely and with the support of inmates, staff, prison administrations, politicians, and the public.

**The Moral and Legal Responsibility of Prison Systems**

The Paper concludes that, although the prevalence of HIV among Canadian prisoners is more than 10 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: "Provincial and federal prison systems have taken steps in the right direction, and there can be no question that the situation with regard to HIV/AIDS in prisons in Canada has improved over the years. However, 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, putting prisoners, staff, and members of the public at risk of their lives."

The Paper points out that, if federal and provincial prison systems want to fulfil their moral and legal obligations, they need to reconsider their response (or lack of response) to the recommendations made, and will have to adopt a more pragmatic approach to drug use in prisons. It emphasizes that the idea of a drug-free prison does not seem to be any more realistic than the idea of a drug-free society, and that stability may actually be better achieved by moving beyond this concept:[3] "Because of HIV/AIDS, prisons cannot afford to continue focusing on the reduction of drug use as the primary objective of drug

policy. While reduction of drug use is an important goal, reduction of the spread of HIV and other infections is more important: unless prison systems act aggressively to reduce the spread of HIV, there may be slightly reduced rates of drug use in prisons, but many more prisoners living with HIV/AIDS and/or hepatitis C and other infections."

According to the Paper, making available to inmates the means that are necessary to protect them from HIV transmission does not mean condoning drug use in prisons: rather, it is a pragmatic measure acknowledging that protection of prisoners' health needs to be the primary objective of drug policy in prisons. The Paper continues by saying that introducing harm-reduction measures is not incompatible with a goal to reduce drug use in prisons: "making sterile needles available to drug users has not led to an increase in drug use, but to a decrease in the number of injection drug users contracting HIV and other infections.[4] Similarly, making methadone available to some users does not mean giving up on the ultimate goal of getting people off drugs: rather, it is a realistic acknowledgment that for some users this requires time, and that they need an option that will allow them to break the drug-and-crime cycle, reduce their contact with the black market, link with needed services, and reduce the risk of their becoming infected with HIV."

The Paper concludes by saying that: "Clearly, prison systems also have a moral and legal responsibility to do whatever they can to prevent the spread of infectious diseases among inmates and to staff and the public, and to care for inmates living with HIV and other infections. Currently, they are failing to meet this responsibility, because they are not doing all they could: measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment and methadone maintenance available to injection drug users, are not being undertaken in Canadian prisons, although other prison systems have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrations, politicians and the public.

The Paper expresses the hope that governments and the prison systems in Canada will act without prisoners having to undertake legal action holding them responsible for the harm resulting from their refusal to provide adequate preventative means. It emphasizes that "prisoners, even though they live behind the walls of a prison, are still part of our communities and deserve the same level of care and protection that people outside prison get: they are sentenced to prison, not to be infected."

To obtain a copy of HIV/AIDS in Prisons: A Discussion Paper (ISBN 1-896735-00-2), or to receive more information about the Project, contact the undersigned at:

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*- Ralf Jürgens*

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[1] Correctional Service Canada. HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons. Ottawa: Minister of Supply and Services Canada, 1994. The report includes two other documents: HIV/AIDS in Prisons: Summary Report and Recommendations; and HIV/AIDS in Prisons: Background Materials.

[2] Montréal: Canadian AIDS Society & Canadian HIV/AIDS Legal Network, 1995.

[3] D Shewan et al. Drug Use and Scottish Prisons: Summary Report. Scottish Prison Service Occasional Paper no 5, 1994, at 24.

[4] See, eg, Centers for Disease Control and Prevention. The Public Health Impact of Needle Exchange Programs in the United States and Abroad. Summary, Conclusions and Recommendations. The Centers, September 1993, at iii-vii.

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## Needle Exchange Programs Now Also in German Prisons

**As reported in a previous issue of the Newsletter,[1] the Swiss pilot project to provide sterile needles to inmates - the first one of its kind - has been working well. Germany has now become the second country to allow for distribution of needles to prisoners.**

Pilot projects will be undertaken over a period of two years in two institutions in Lower Saxony: Vechta (a prison for women) and Lingen-Gross-Hesepe (a prison for men). A research project will study the effects of the pilots, which will be rigorously evaluated.

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[1] Update on Needle and Syringe Exchange in Swiss Prisons. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(4): 2-3.

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## Hepatitis B and C, Tuberculosis and AIDS: Risks and Challenges in Prisons

A training program on these issues for health services staff working in detention centres under Québec jurisdiction was held on 23 November 1995 in Montréal. The program was organized and coordinated by representatives of the departments of public security (correctional services directorate) and of health and social services (Québec centre on AIDS coordination).

The goal was to promote cooperation between prison health services teams with regard to strategies to be put into place in order to reduce risks and to treat prisoners with HIV infection, hepatitis B and C, and tuberculosis.

As Dr Catherine Hankins pointed out in the opening speech, "the rate of HIV infection in prisons is so high that incarceration itself becomes a risk factor for prisoners." According to Hankins, such an observation must lead us to reflect deeply on the choices to be made concerning prevention, with respect to prisoners, health and social services staff, and correctional authorities. Hankins reiterated that, with regard to the prison system, it is important to understand that risk behaviours connected with HIV infection - in particular, unprotected sexual relations and the use of non-sterile syringes for drug use - "underlie a shared responsibility between those who practise such behaviours and those who, although they know of the existence and the risks associated with such behaviours, do not provide means of prevention."

Many of those involved stressed the need to facilitate prisoner access to condoms, observing that current measures for distributing condoms, which are given only upon the express request of a prisoner, are worth "absolutely nothing." They also stressed the need to make sterile needles and syringes available to inmates who use injection drugs. The debate centred on the applicability of the idea of risk reduction in prisons from various points of view involving public health, legal, ethical, politico-administrative, and community issues.

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# New Studies on HIV/AIDS in Prisons

## Germany - New Evidence about the Transmission of HIV in Prisons

**More and more data from scientific studies are becoming available on how many prisoners become infected while in prison.[1]**

Results of the latest of these studies, undertaken in the prison for women in Vechta, Lower Saxony (Germany), showed that at least 20 women had definitely been infected while in prison.[2]

In the study, 1032 health records were examined to evaluate data on the prevalence of HIV, hepatitis A, B and C, and syphilis among female prisoners between 1992 and 1994. About one-third of the study population were injection drug users (IDUs), and 74 percent had been tested for the above-mentioned infectious diseases at least once. Prevalence of infectious diseases was as follows:

HIV: 4.9 percent among IDUs, 0.5 percent among non-IDUs;

hepatitis A: 65.6 percent among IDUs, 34.7 percent among non-IDUs;

hepatitis B: 78 percent among IDUs, 12.7 percent among non-IDUs;

hepatitis C: 74.8 percent among IDUs, 2.9 percent among non-IDUs;

syphilis: 4.5 percent among IDUs, 5.1 percent among non-IDUs.

Records of prisoners who underwent at least two tests for the same disease were examined to determine whether seroconversion had occurred during uninterrupted prison sentences. For 41 IDUs, seroconversion could be documented; of these, 20 (48.8 percent) had definitely been infected while in prison.

## New York - High-Risk Behaviour for HIV Transmission

Mahon conducted a focus-group study among 50 inmates in state prisons and city jails in New York, in which prisoners and former prisoners reported frequent and tragic instances of unprotected sex and often-desperate injection drug use with non-sterile injection equipment being used behind bars.[3] One woman summarized the prevalence and range of sexual activity described by participants in the study when she stated:

> "Male CO's are having sex with females. Female CO's are having sex with female inmates, and the male inmates are having sex with male inmates. Male inmates are having sex with female inmates. There's all kinds, it's a smorgasbord up there."[4]

With regard to injection drug use, participants stated that it was "very common" in prisons and jails and that drugs enter the system through a variety of routes, including correctional and medical staff, visitors, and personal mail. Drugs and drug paraphernalia were more scarce behind bars than on the street; this scarcity increased the level of desperation among active drug users, heightened the value of drugs and drug paraphernalia, and transformed them into a form of currency. Participants indicated that they could obtain an array of drugs, including heroine, cocaine and marijuana. They further indicated that syringes were relatively difficult to find in prison and therefore were almost always shared. Several participants indicated that they believed they became HIV-infected from sharing needles in prison.

Mahon concludes:

> "Of all populations at risk for HIV, prisoners are increasingly isolated and vilified in the mind of the public and politicians. Evidence of high-risk behavior behind bars could well be used to further such marginalization. Yet as data from this study indicates, prisoners are a bridge community, largely composed of IDUs, that flows in and out of inner-city communities. The public health challenge, then, is to actively oppose such marginalization and to explore how prisoners' unprotected high-risk behavior affects the epidemic in the community at large. Given the current course of the epidemic, the ability of the US to control AIDS may well rest in our capacity to honestly and humanely confront the epidemic behind bars. For with regard to HIV prevention, the question is not who is right or who is wrong, but instead, who is at risk."

## Indiana - HIV Risk in Rural Jails

Research undertaken by Kane and Dotson indicates that, although rural jail administrators and staff may have hoped that their facilities were free from the HIV/AIDS epidemic taking place in prisons and large urban jails, they may only be lagging behind and are not at all immune to increasing rates of HIV infection among their inmate populations.[5] The data show that rural jails in Indiana do house a population that is at risk of HIV. In particular, 23 percent of inmates have used needles to inject drugs at some point in their lives.

## Delaware - A Study of Sexual Contact among Male Inmates

Saum et al report that studies of sexual contact in prison have shown "inmate involvement to vary greatly."[6] In her own study of the nature and frequency of sexual contact between male inmates in a Delaware prison, respondents were questioned extensively about sexual activities they themselves engaged in, directly observed, and heard about "through the grapevine." Saum concluded that "although sexual contact is not widespread, it nevertheless occurs," and that most sexual activity is consensual.

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[1] See, eg, Alarming Evidence of HIV Transmission in Prisons. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(2): 2-3.

[2] Transmission of Infectious Diseases in Prison - Results of a Study in the Prison for Women in Vechta, Lower Saxony, Germany. Abstract on file with author.

[3] N Mahon. High Risk Behavior for HIV Transmission in New York State Prisons and City Jails. Forthcoming, manuscript on file with editor.

[4] Ibid, with reference to the transcript of the first focus group of female city inmates, December 1993, at 46.

[5] S Kane & J Dotson. HIV Risk in Rural Indiana Jails. As yet unpublished manuscript of October 1995 (on file with author).

[6] CA Saum et al. Sex in Prison: Exploring the Myths and Realities. Prison Journal, December 1995.

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## European Network of Services for Drug Users in Prison

The Network was formed with the purpose of disseminating information on prison drug use and treatment to professionals in the European Union. It is funded by the Commission of the European Union and is coordinated by the Cranstoun Projects Prisoners Resource Service (PRS). PRS is an independent agency that provides education, information, advice and counselling to prisoners who have problems with drugs, alcohol and/or HIV.

The Network is based in London, England. It publishes Connections, a newsletter containing information about drug policy and drug treatment in prisons around the world.

**For more information about the Network and its activities, contact Alex Stevens, European Network Coordinator, Prisoners Resource Service, PO Box 3689, London NW1 8QE, England. Tel: (011-44-171) 267-4446; fax: (011-44-171) 482-5334; e-mail: prs@easynet.co.uk**

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## A Scotsman's Tale

**Alan is a long-term prisoner in Perth Prison, Scotland. He has a long history of drug-related crime. He told his experience to *Connections*.**

The following paragraph is a short excerpt from his story:[1]

> "I am afraid that the Scottish Prison Service is not doing enough to stop the spread of HIV and Hepatitis B and C. The Service made a great deal of introducing [bleach] sterilising tablets in December 1993, but the sterilising process takes 40 minutes. Prisoners do not have time to go through this process. So what we have is "camps" of as many as 6-12 inmates, all in one cell, sharing the same works. Until the Service addresses the problem seriously and looks realistically at setting up needle exchanges, well I'm afraid that

Scottish prisons will continue to be a breeding ground for all blood borne viruses."

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[1] A Scotman's Tale. Connections 1995; 1(2): 12.

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## Zambia Releases Prisoners with HIV

**Zambian prison authorities, worried about the spread of HIV in prisons, have started releasing inmates living with HIV/AIDS.[1]**

"We have realised that the disease is spreading fast in many prisons.... Prisons are not the place to keep such people," said a representative of the Zambia Prison Service, Mr Phiri.

Under Zambian law, prison authorities are allowed to release terminally ill prisoners. When prisoners are convicted, they undergo a medical examination before being admitted to prison. If they are found to have an incurable disease such as AIDS, the prison authorities are advised to discharge them.

To date, ten prisoners with AIDS have been released, and more releases are planned. Mr Phiri said it was not clear precisely how many inmates were living with HIV or AIDS, but he believed the number was "quite big." HIV is spread in prisons in Zambia through homosexual sex. Some AIDS-awareness campaigns are now under way.

The decision to release prisoners with HIV/AIDS has drawn sharp criticism from some sectors. Raymond Muchindu, deputy chairman of the Family Life Movement in Zambia, said that "they should not be released. Releasing them does not curb the disease, just transfers it from the prisons to the public."

The general public's reaction to the decision has been mixed, but many people have expressed their support. One person commented: "Since we are a Christian nation, we must exercise lenience and release those who are really ill. Besides, our prisons are almost uninhabitable. We should not allow ill people to remain there."

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[1] Reported in: Zambia Releases Prisoners with HIV. AIDS Analysis Africa 1995; 5(5): 1. Most of the following text is taken from this article.

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## Prisons: First National HIV/AIDS and Prisons Workshop

The last issue of the Newsletter devoted a great deal of space to the results of the First National HIV/AIDS and Prisons Workshop, held in Kingston from 18 to 20 August 1995 and organized by the Prisoners with HIV/AIDS Support Action Network (PASAN).

The following article, a summary of a paper presented on 20 August in Kingston, concludes our review of the themes dealt with at the Workshop.

## AIDS, Prisons and Parole

**This article describes the cases of two prisoners with AIDS in federal institutions and to whom parole was refused even during the terminal phase of their disease.**

The article maintains that there are problems with the health services offered to severely ill inmates, and suggests that parole on humanitarian grounds be regularly granted to inmates who have AIDS. According to the authors, "the prolonged detention of a prisoner with AIDS under current conditions" constitutes "cruel and unusual" treatment.

### The first case

PG died on 30 January 1995 in a federal correctional facility. He died of complications from AIDS, alone in his bath. In February 1994, Amaryllis House, a hospice for people living with AIDS, agreed to receive PG, but the NPB considered that PG's state of health was good enough to enable him to move about with sufficient ease and decided to delay review of the file until January 1995. A few days before his death, the NPB refused him parole. The Board's refusal was based on its lack of information, the Correctional Service not having submitted a complete and up-to-date file.

### The second case

In July 1994, RL, another inmate living with HIV/AIDS, weighed 78 kg and had a CD4 count of 289/mm3. By October the rate had fallen to 60, in March 1995 it was 20, and in July 1995, when he was finally granted parole, it was zero. By that time, his weight had dropped to 55 kg. Other facts in this case are:

> On 4 October 1994, the institutional physician submitted a report to the case management officer, indicating that RL's state of health was normal overall. However, a previous medical record had indicated candidosis in the throat (thrush) and a recent abdominal scan had revealed hepatosplenomegaly and a spleen more than 13 cm in diameter.
>
> On 2 November, in a memorandum to the case management officer, the institutional physician wrote that RL was in stable condition, with a CD4 count of 289 as of July, omitting the more recent rate of 60/mm3.
>
> In his expert opinion of 16 January 1995, requested for hearing by the National Parole Board (NPB), the institutional physician pointed out that RL "does not present systematic symptoms that would lead one to believe it was a stage of AIDS." However, the same physician had written less than a month earlier that RL had been suffering from an opportunistic PCP infection for a few weeks. Moreover, his weight had dropped to 64.5 kg.
>
> On 23 March 1995, a physician pointed out that RL was in a precarious state of health and that a diagnosis of advanced HIV disease had been made by the microbiologist at the Cité de la Santé in Laval. He neglected to say that this physician had pointed out that RL was in a terminal phase.
>
> In the report summarizing the development of the file dated 18 April, the NPB again refused parole on humanitarian grounds because RL "was not in a terminal phase."

**A conflict of interest?**

Several gaps in health services have been criticized by inmates who have AIDS, and also by the Expert Committee on AIDS and Prisons (ECAP).[1] Harding and Schaller attribute these gaps mainly to physicians' lack of independence and the adoption of policies that mainly serve the needs of the institutions.[2] Inmates living with HIV/AIDS are dependent on the institutional physician and the initiatives of prison medical health personnel. As Harding and Schaller observe, the contractual link between physician and correctional services distorts the normal doctor/patient relationship. In a prison environment, physicians have obligations to their employer, namely the prison establishment, and not only to their patients, the inmates.

**Parole on Humanitarian Grounds**

Inmates who have AIDS should be able to benefit from release on humanitarian grounds, as set out in

section 121 of the *Corrections and Conditional Release Act*, so that they may die in dignity, surrounded with specialized and constant physical and psychological care.

Section 121 stipulates that parole may be granted at any time to an offender:

> (a) who is terminally ill;
>
> (b) whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement;
>
> (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced

It could be held that under certain circumstances, such as when medical treatment available to a prisoner is not equivalent to that available outside, prisoners with AIDS should be released not only when they are in the terminal phase of their disease, according to paragraph (a), but also because their health can be compromised by imprisonment (paragraph (b)), or because imprisonment represents an excessive burden on them (paragraph (c)).

**Protection against Cruel and Unusual Treatment**

It could be maintained that, under certain circumstances (such as inappropriate or insufficient care, inadequate nutrition, conditions of detention that promote the onset of opportunistic infections, the absence of specialized psychological support, intense stress, etc), the prolonged detention of an inmate living with AIDS constitutes cruel and unusual treatment. Under s 12 of the Charter, "[e]veryone has the right not to be subjected to any cruel and unusual treatment or punishment."

In 1990, the issue was referred to a district court in Ontario; in R v Downey,[3] an inmate with AIDS appeared and pleaded s 12 of the *Charter*, invoking the lack of medical treatment, no access to special treatments, and the isolation of which he was a victim. The Court held that the fact that the accused was not receiving appropriate treatments, that he was isolated in a cell 24 hours a day, that he was the target of threats and that he did not have access to an appropriate diet, constituted cruel and unusual punishment. The order to keep him incarcerated was quashed and the inmate was granted a conditional release.

Clearly, the legal challenging of conditions of detention is not the ideal solution; the judicial process is too long, above all for a person living with AIDS. Moreover, case-by-case challenges are not the best means of changing a situation in the prison system that is urgent.

- *Jean-Claude Bernheim and Julie Montreuil*

**Comment**

The participants in the Kingston Workshop insisted that more needs to be done to ensure that inmates suffering from progressive life-threatening diseases be released earlier in the course of their disease. This corresponds with the World Health Organization's Guidelines on HIV Infection and AIDS in Prisons,[4] which contain the following provision:

51. If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom.

ECAP submitted a similar recommendation, adding that "imprisonment can be more detrimental to the health of a person with HIV or AIDS than to the health of prisoners whose immune systems are not compromised."[5]

However, as participants in the Workshop made clear, it is often a question of inmates dying in prison or being released just before they died. This corresponds to what ECAP was told and what PASAN had pointed out: "[C]ompassionate release is currently only considered for terminally ill prisoners whose sickness is so advanced that they are near death, and ... release at such a point means little else than a transfer from one form of institution to another - from the prison to a hospital."[6]

In response to a letter from MP Svend Robinson, the Commissioner of CSC acknowledged that only very few inmates with a life-treatening or disabling illness obtain parole:

> Between January 1, 1990 and December 31, 1994, approximately 66 inmates were diagnosed as having a life-threatening illness with a statistical prognosis of one year or less to live. Forty-three had a diagnosis of illness which disabled them to the extent that they were incapable of committing harm. Of these two groups (109 in total), 41 requested parole and 15 were granted it.

He added that some inmates who were offered parole refused it due to lack of community support available to them, and that, in one case, "an inmate was refused parole at the time of his request because he was still viewed as being too dangerous to be released."[7]

One inmate living with HIV in a federal prison told ECAP that his greatest fear was to have to die in prison, without his friends and family at his side. In order to allow inmates with AIDS and other progressive life-threatening disease to live without this fear, the NPB and CSC need to work together to ensure that such inmates "regularly be released earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety."[8]

- *Ralf Jürgens*

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[1] Correctional Service Canada. HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS in Prisons. Ottawa: Minister of Supply and Services Canada, 1994.

[2] TW Harding & G Schaller. HIV/AIDS Policy for Prisons or for Prisoners? In JM Mann et al (eds). AIDS in the World. Cambridge, MA: Harvard University Press, 1992, 761-769 at 762.

[3] [1990] CRR 286.

[4] WHO. WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: WHO, 1993.

[5] Supra, note 1 at 106.

[6] PASAN, as cited in ECAP's Final Report, supra, note 1 at 106.

[7] Letter dated 26 April 1995, on file with editor.

[8] Supra, note 1 at 107.

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# DRUG POLICY

## Harm Reduction Model Proposed

**The Redfern Legal Centre Drug Law Reform Project in Australia recently published a paper on a harm reduction model of controlled drug supply.[1]**

Whereas in Canada the House of Commons passed Bill C-7, the controversial Controlled Drugs and Substances Act, on 30 October 1995 (the bill is now being reviewed by the Standing Senate Committee on Legal and Constitutional Affairs), in New South Wales a recently released paper is intended to encourage discussion about the reform of laws related to drug use, possession, manufacture and supply.

The Drug Law Reform Project notes that the Legal Working Party of the Australian Intergovernmental Committee on AIDS called upon all jurisdictions to review their drug laws to assess whether such laws help to prevent HIV transmission among drug users. The Project believes that the current prohibitionist approach does not help HIV prevention, and obstructs effective prevention and support for people using illicit drugs and who live with HIV or AIDS. It proposes a model that would help to reduce the harms from drug use, and discusses the advantages and disadvantages of implementing a harm reduction model.

More than 1500 copies of the model have been distributed for comment, and the Redfern Legal Centre is seeking endorsement from a wide range of professional and community groups. After comments have been collated, a final version of the model will be produced.

**To obtain a copy of the Harm Reduction Model, contact Steve Bolt at Redfern Legal Centre, 73 Pitt St, Redfern 2016, Australia. Tel: (011-61-2) 698-7277; fax: (011-61-2) 310-3586)**

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[1] Reported in the [Australian] HIV/AIDS Legal Link 1995; 6(3): 20-21.

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## HUMAN RIGHTS

### APCASO: Linking Human Rights and HIV/AIDS at the Grass Roots

**In July 1995, the World Health Organization (WHO) estimated that 3.5 million adult HIV infections had occurred in Asia - a million more than just one year before.**

Human rights violations such as discrimination against people with HIV, mandatory testing and testing without consent, breaches of confidentiality, denial of funeral/burial rights/rites, improper medical research and unequal access to health care are of special concern to those most vulnerable to HIV/AIDS. They include women and children, injecting drug users, commercial sex workers, overseas contract workers, and prisoners.

The linking of HIV/AIDS to human rights and ethical and legal issues has recently been taken up in Southeast Asia by a network of non-governmental organizations (NGOs), community-based organizations (CBOs), human rights and HIV/AIDS service organizations called the Asia Pacific Council of AIDS Service Organizations (APCASO). It is the regional expression of the International Council of AIDS Service Organizations (ICASO) and shares its mission to promote the non-governmental community-based AIDS organizations' response to the global challenge of HIV and AIDS, with particular emphasis on strengthening the response in communities with few resources and within affected communities. Among its guiding principles is the strong belief that a recognition of the human rights of all persons is central to any intelligent public health strategy to combat the epidemic. The emphasis is to develop networks and to support grass-roots activities in each country, not a burdensome and costly regional bureaucratic structure.

One of APCASO's chief priorities is to support local efforts to raise and respond to the many human rights issues and concerns related to HIV/AIDS. In September 1994, members of APCASO from Australia, Indonesia, Malaysia, Pakistan, the Philippines, Sri Lanka and Thailand held a regional training session on issues related to HIV/AIDS. The workshop equipped participants with knowledge and skills required to effectively document and monitor HIV/AIDS-related human rights issues. A working committee was formed to maintain communications and provide updates.

From this workshop, participating organizations went on to develop their own action plans, a regional working team was established, and responsibilities allocated. National plans focused on four principle areas: refining tools for documentation and data gathering related to human rights; establishment of focal points for reporting; development of mandates and sets of principles; and popular educational endeavours linking human rights and HIV/AIDS.

In April 1995 a follow-up consultation was held in Langkawi, Malaysia, to review the status of the objectives set at the end of the initial workshop and to plan for future activities. Building upon members' efforts to monitor and document violations of human rights, the network shifted its focus to setting standards for upholding rights in the region. At the conclusion of the workshop, participants agreed to continue to carry out country-specific programs and activities related to human rights and HIV/AIDS.

The consultation also produced a regional plan of action that included the launching of the APCASO *Compact on Human Rights* (ACT-HR) at the Community Forum held this September in Chiang Mai, Thailand. The Compact on Human Rights is a covenant on human rights aspects of AIDS and is meant to meet the need of NGOs/CBOs within APCASO for a common framework and mandate in their efforts to seek the recognition of human rights as an integral part of an effective response to HIV/AIDS. It is seen as a framework that countries can refine and use to evaluate and develop effective responses to the epidemic.

The document's preamble expresses APCASO's aspiration toward the universal recognition and respect for the human rights of all persons living with HIV/AIDS (PLWHAs). A section on standards lists and clarifies the human rights of all PLWHAs. A copy of the Compact may be acquired through the APCASO Secretariat in the Philippines, or through the ICASO Central Secretariat in Ottawa at the addresses below.

In September, APCASO co-sponsored the Third International Conference on AIDS in Asia and the Pacific held in Chiang Mai, Thailand. Prior to the conference, APCASO also convened a community forum for NGO, CBO and PLWHA groups to discuss and address some of the priority issues in the region, including the needs of persons living with HIV/AIDS, human rights, gender and sexuality, and migrant workers.

APCASO's human rights initiatives are proceeding well: the Malaysian AIDS Council has adapted the APCASO Compact on Human Rights; Indonesia is having ongoing consultations with local groups to expand the number of members of the Indonesian HR working group (ACT-HR has also been translated into Indonesian); and the Philippines have managed to interest more NGOs active in HIV/AIDS to integrate human rights into their existing programs.

APCASO has produced a directory of NGOs/CBOs in South and Southeast Asia, the Pacific, Australia and New Zealand. The directory identifies 120 HIV/AIDS service organizations, a number of which are actively pursuing human rights issues. The list of APCASO regional contacts continues to grow as the

name spreads by word of mouth among local groups in the region.

You can read more about APCASO human rights developments in *ICASO Update*, published quarterly. Copies may be ordered by contacting Yolanta Cwik, editor, ICASO, Central Secretariat, 100 Sparks Street, Suite 400, Ottawa, Ontario, Canada K1P 5B7. Fax: (613) 563-4998; e-mail: icaso@web.apc.org; WWW site: http://www.web.apc.org/~icaso/webpage.html

To contact APCASO directly, write to Teresita Marie P Bagasao at APCASO - Asia/Pacific, Kabalikat Ng Pamilyang, Pilipino, 3rd Floor B & M Building, 116 Aguirre Street, Legaspi Village, 1229 Makati, M.M.PHILIPPINES. Tel: (63-2) 813-6476; fax: (63-2) 893-9535; e-mail: kablikat@mozcom.com.

- *David Shanks*

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## Family Law

### US Court Restores Child to HIV-Positive Foster Mother

**On 3 October 1995, the Nebraska Court of Appeals ruled that removing a three-and-a-half-year-old child from his foster parents, due to the foster mother having AIDS, was not in the child's best interest.[1]**

John had been placed with his foster parents at the age of three months. The foster placement was expected to lead to adoption by the foster parents when John became available for adoption. After learning that the foster mother was HIV-positive, the Nebraska state department of social services decided that it would be in the best interest of the child to place him with a different foster family. The department's reasoning was that, in his current placement, John would in all likelihood watch his foster mother die. The department thought it preferable that John be transferred to a "healthy" set of foster parents.

Medical experts offered conflicting testimony. Two witnesses testified that removing John from his foster parents created a risk of damage to John's personality greater than that of the "ordinary life event" of a parent's death. A psychiatric consultant for the department testified, however, that John's removal from his foster parents would do him no harm.

Observing that the future course of the mother's illness was speculative, and that death was in any event a natural, although painful, part of the life cycle, the court found it improper to attempt to save John from one possible tragedy, his mother's death, by visiting upon him another tragedy, the loss of both his mother and father. The court noted that the mother's parenting abilities were presently unimpaired, that there was no risk of John's contracting HIV from his mother, and that the family was strongly bonded. Discussing the mother's failure to disclose her HIV-positive status when the parents originally applied for John's foster placement, the court held that punishing the parents for the admitted deception should not be a factor in assessing John's best interests.

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[1] In Re John T; State v Carraher, 1995 WL 578022. Reported in Lesbian/Gay Law Notes November 1995, at 154-155.

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## Literature Reviewed

### AIDS, Health and Human Rights: An Explanatory Manual[1]

Three models have competed to be the all-encompassing, overarching conceptual framework for understanding and countering the HIV epidemic:

> the biomedical-behavioral model, which recognizes that HIV is a virus that affects the immune system - transmission is facilitated by biological factors such as virulence and coexisting sexually transmitted diseases, and by behavioral factors, the determining human element;
>
> the HIV and development model, in which the HIV epidemic is understood as having its root causes in conditions of economic and social disparity at the local and global levels. Its consequences can be measured in terms of individual suffering, microeconomic and social effects on family and community life, and a major impact on a country's human development; and
>
> the human rights model, which recognizes the public health rationale for respecting, protecting and promoting human rights and dignity in order to both reduce vulnerability to HIV and mobilize populations to achieve effective prevention and to alleviate the impact of HIV/AIDS.

*AIDS, Health and Human Rights* is an explanatory manual that explores the third model. It will rapidly become "must reading" for anyone seeking to create effective public health programs in the face of HIV. In effect a primer on the link between human rights, health and HIV, it has been written with public health professionals in mind, as well as those interested in the legal and ethical aspects of proposed and current responses to the epidemic. A result of the collaboration between the International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health, the manual aims to bridge gaps in understanding between

human rights activists and public health professionals.

In addition to providing information that is basic to both domains and helping to clarify the underlying tenets of public health and human rights discourse, the manual contains three major sections illustrating a public health-human rights dialogue on HIV/AIDS:

prevention and testing;

access and barriers to caring for people with HIV/AIDS; and

HIV testing, care, and confidentiality.

These are followed by case scenarios illustrating how "win-win" situations can be created through effective dialogue. A classical 2 X 2 table, familiar to epidemiologists and public health specialists everywhere, provides a framework for negotiations to achieve the best possible harmonization of public health goals and respect for human rights and dignity.

From zero, two axes are drawn. The PH axis represents public health quality; the HR axis represents human rights quality. Each sector or quadrant is marked with a separate letter, which represents a specific assessment as to whether or not the two goals, human rights quality and public health quality, have been realized with respect to a proposed policy or program. The criteria for ranking the policy or program along each axis are presented as a series of questions that aims to ensure that public health and human rights goals are optimally realized and conflicts negotiated rationally, in a climate of mutual understanding and respect. A policy or program that realizes the maximum number of points will make it possible to locate such a policy or program in the upper right quadrant, which reflects high quality public health and high quality human rights.

This may seem rather "cookbook" in its approach, but those of us who have been involved in the struggle to integrate what at first may seem like competing values may appreciate the clarity that a 2 X 2 table reflects.

Finally, a particularly useful aspect of the manual is an annex including all major human rights bills, covenants, and declarations, and an integrated list of human rights provisions in three international documents, presented by topic area.

The principles laid out in this manual would be useful in addressing human rights and public health issues surrounding any infectious disease. They are particularly important for addressing HIV/AIDS, the first major epidemic to occur in the modern era of human rights.

- *Catherine Hankins*

**Copies of AIDS, Health and Human Rights can be ordered from the International Federation of**

**Red Cross and Red Crescent Societies or the Harvard School of Public Health, 8 Story Street, Cambridge, MA 02138 USA.**

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[1] International Federation of Red Cross and Red Crescent Societies & François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, 1995.

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## News

### US - School Teacher Suspended for Showing "Philadelphia"

**A junior high school health teacher in Union County, South Carolina, has been suspended and placed on probation for showing the film "Philadelphia" as part of an AIDS education lesson, without obtaining prior approval from school administrators.**

The school superintendent said the action was taken after complaints from parents at a school board meeting that they had not been given the option of refusing consent for their children to view the film, which they characterized as "vulgar and favoring a homosexual lifestyle."[1]

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[1] Reported in Lesbian/Gay Law Notes November 1995, at 157.

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# Canadian HIV/AIDS Policy & Law Newsletter

## Volume 2 Number 2 - January 1996


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## UPCOMING EVENTS

### 11th World Congress on Medical Law

**The 11th World Congress on Medical Law will take place in Sun City, South Africa, from 28 July to 1 August 1996.**

The program of the Congress, which is organized by the World Association for Medical Law and co-sponsored by the World Health Organization and the Council for International Organizations of Medical Sciences, will include a section devoted to HIV/AIDS legal and ethical issues, and sections on medical confidentiality and patient privacy, the right to refuse treatment, death, dying and euthanasia, blood transfusions, drug use, and prisoners.

**For more information, please contact the Secretariat, c/o International Centre of Medicine & Law, PO Box 51, Buhrmannsdrif 2867, Northwest South Africa. Tel: (011-27-140) 842-470/1; fax: (011-27-140) 24894.**

### Symposium on Harm Reduction Strategies in Prisons

**An interdisciplinary symposium on harm reduction strategies in prisons will take place in Berne, Switzerland, from 28 February to 3 March 1996.**

As stated in the conference brochure, "[h]armful behaviour regarding drug use and sexual contacts are a well-known problem in almost any prison of the world, but harm reduction strategies differ quite extremely from country to country." In Switzerland, there are two projects providing inmates with sterile syringes. In one prison, even prescription of heroine has become possible.

At the symposium, results from these pilot projects will be presented and compared with international strategies. The objective of the symposium is to enable an interdisciplinary dialogue between practitioners and scientists "in order to work out scientific foundations for political decisions."

**For more information, please contact Dr J Nelles, "Symposium", Bolligenstrasse 111, 3072 Berne, Switzerland. Tel: (011-41-31) 930-9111; fax: (011-41-31) 930-9404.**

## Ist International Conference on Healthy Prisons

**The Ist International Conference on Healthy Prisons will take place in Liverpool, UK, from 24 to 27 March 1996.**

The Conference will be an exploration of the ways in which health can be achieved in prison, and will have four main themes:

> the potential of prisons to have a positive effect on the health and lifestyle of the prison population;
>
> the role of non-health professionals in promoting the health of the prison population;
>
> the prison as a community and a setting in which to promote health;
>
> prisons as a re-entry point into society.

**For more information, contact Andrew M Bennett, Conference Secretariat, HIT Cavern Walks, Mathew Street, Liverpool L2 6RE, UK. Tel: (011-44-151) 227-4423; fax: (011-44-151) 227-4023; email: ICHP@hit.l.demon.co.uk.**

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