
Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Contents
(Volume 2 Number 3)

Drug Policy

Discrimination

Blood and Blood Products

Civil Liability

Criminal Justice

Prisoners and HIV/AIDS

Travel and Immigration

HIV/AIDS and Children

Euthanasia

Care, Support and Treatment

International News

Position Announcement

Top of this page

Return to Home Page

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

AIDS and Overdose Deaths in British Columbia

In January 1995, the Government of British Columbia released the Chief Coroner's Report[1] investigating an increase in the number of intravenous illicit-drug overdose deaths over a six-year period. In 1993 there were 356 deaths, an increase of 800 percent since 1988.

Overdose death due to use of illicit drugs was the leading cause of death among British Columbians between 30 and 44 years of age in 1993. Within this age group, illicit-drug overdose death surpassed death from AIDS in men and death from breast cancer in women. Men were four times more likely to die from illicit-drug overdose than women. Nearly two-thirds of the illicit-drug deaths occurred in metropolitan Vancouver, although four other communities throughout the province with high mortality rates were also identified. Most deaths involved heroin and cocaine, either alone, together or in combination with other drugs. In almost one-half of the deaths, high levels of alcohol were also detected. Methadone was associated with only two percent of the deaths.

HIV Seroconversion Rate Increased

Since the release of the Chief Coroner's Report, provincial health-care epidemiologists have concluded that the HIV-positive seroconversion rate within the sub-population of intravenous drug users is now at least equal to the seroconversion rate in gay men. Although HIV infection frequently results from injecting with contaminated needles and syringes, the sexual partners of HIV-infected intravenous drug users are also at risk.[2] Therefore, unless urgent public health interventions are initiated, HIV has the potential to quickly spread into the general population.

Recommendations

The Chief Coroner's Report includes a total of 63 recommendations directed at several government ministries, municipal governments, and the College of Physicians and Surgeons. Overall, the Report calls for increased coordination of existing services for users of illicit intravenous drugs as well as research into various treatment models, including methadone maintenance, harm reduction and abstinence. The Report also calls for the examination of existing legislation governing controls over illicit and licit substances for the purpose of amending inappropriate legislation. Included is the recommendation that the Attorney General of British Columbia begin to investigate the feasibility of decriminalizing certain illicit drugs as a means of reducing risks associated with illicit drug use and diverting funds from enforcement to prevention and treatment programs.

Needle Exchange and Methadone

In response to the Report, the provincial government has already taken steps to enhance access to both needle exchange and methadone maintenance programs. The provincial plan is to have needle exchange services available in all regions of the province through a combination of funded needle exchanges, existing public health units and private pharmacies. There are currently 14 needle exchange programs throughout the province whose contracts are managed by the provincial government. Clean needles and syringes are bulk-purchased by the government at a cost of $0.55 million annually and are provided free of charge to needle exchange clients along with condoms and lubricant. In addition to the needle exchanges, all public health units throughout the province have access to the bulk supply of needles, syringes, condoms and lubricant, and many units have begun to distribute these supplies to clients. With respect to private pharmacies, the *Pharmacy Act* has been amended to allow pharmacists who wish to sell needles and syringes to customers to openly display and advertise these supplies. In June 1995, funding was provided to the provincial College of Physicians and Surgeons, the organization responsible for training and supervising methadone prescribers, to enhance recruitment and training of new methadone prescribers and to improve the geographical distribution of prescribers. There are currently 215 physicians in British Columbia prescribing methadone to about 1650 patients. The College of Physicians and Surgeons would like to increase the number of methadone prescribers over the next two years to 300 physicians. Similarly, the provincial government, in cooperation with the College of Pharmacists, is recruiting new pharmacies throughout the province to dispense methadone.

Response to Recommendations

In addition to the above, the provincial government has formed an Interministry Working Group to develop a detailed coordinated response to the Report's recommendations. The Working Group is comprised of representatives from each ministry receiving recommendations from the Chief Coroner and from other ministries to which certain recommendations are relevant. The purpose of this coordinated response process is to review the recommendations and develop responses that enhance prevention and treatment services to intravenous drug users in order to reduce risk and mortality associated with intravenous drug use. The Working Group is aware that similar epidemics of injection-drug overdose deaths have occurred in other countries, for example, Germany,[3] and that specific interventions[4] have resulted in significant reductions in mortality and morbidity. To this end, the Working Group has focused on the development of policies and strategies that promote the following:

> inclusion of harm reduction philosophy in the development of policy and services for injection drug users;

increased access to social services and housing;

increased access to addiction and health-care treatment services.

Because there is an expectation that these enhancements would require significant new dollars, options for raising additional funding will need to be explored. The 1994/1995 budget for addiction treatment services in British Columbia was $51.14 million, less than one percent of the total Ministry of Health budget. The total number of admissions into provincial addiction treatment services in 1993/1994 was 38,781. At current funding levels, addiction treatment services are operating at capacity. Any initiatives that facilitate the movement of users of illicit intravenous drugs into the present system of care will most certainly place a strain on existing services unless the number of treatment services is increased.

Reducing Drug Law Enforcement Expenditures

The Chief Coroner would like to see drug law enforcement expenditures, especially those targeting users, reduced, and funding diverted to prevention and treatment. Enforcement expenditures currently outnumber prevention and treatment expenditures by a ratio of three to one. This funding ratio is not restricted to the province of British Columbia. In 1992, US federal drug-control expenditures were 69 percent for law enforcement, 17 percent for treatment and 14 percent for prevention.[5] Even when federal and state expenditures are combined, the law enforcement/treatment-prevention ratio remains constant. This funding formula persists in spite of a lack of evidence that enforcement measures are effective in controlling the supply and consumption of illicit drugs. In fact, studies suggest that drug treatment is the most cost-effective means of reducing consumption.[6] Other studies have also suggested that current illicit-drug legislation creates unintentional harm for both users and non-users by strengthening the connection between drugs and crime.[7] Therefore, an examination of current illicit-drug legislation is required in order to develop policies and legislation that encourages the most effective and humane use of public funds without compromising public safety. Such a strategy requires extensive public education and consultation, serious provincial/federal dialogue, and international debate among illicit-drug-producing and drug-consuming nations. However, because of the potential for overwhelming health-care costs related to the treatment of new cases of HIV/AIDS, governments must begin to develop strategies beyond those that attempt to control illicit-drug supply and consumption. The World Health Organization[8] estimates the retail value of the international illicit drug trade to be US$500 billion annually, second only to the international arms trade and exceeding international trade in oil. A multinational enterprise of such magnitude is unlikely to be stopped through prohibitionist policies and legislation.

The coordinated response is scheduled for review by Cabinet in early 1996. At that time, the provincial Cabinet will review the options presented by the Interministry Working Group and decide on a course of action.

- *Dr JF Anderson*

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] Office of the Chief Coroner. Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia. Victoria, BC: Ministry of Attorney General, 1994.

[2] T Myers et al. A Comparison of the Determinants of Safe Injecting and Condom Use among Injecting Drug Users. Addiction 1995; 90: 217-226.

[3] B Fischer. Drugs, Communities and "Harm Reduction" in Germany - the New Relevance of "Public Health" Principles in Local Responses. Journal of Public Health Policy 1995; 16(4).

[4] W Heckman. Personal communication. 37th International Congress on Alcohol and Drug Dependence, San Diego, 20-25 August 1995.

[5] P Murphy. Keeping Score: the Frailties of the Federal Drug Budget. A Rand Institution Issue Paper, 1995.

[6] The Rand Institution. Projecting Future Cocaine Use and Evaluating Control Strategies. Issue Paper, 1995.

[7] RJ MacCoun et al. A Content Analysis of the Drug Legalization Debate. Journal of Drug Issues 1993; 23(4): 615-629, and CE Faupel. Shooting Dope: Career Patterns of Hard-Core Heroin Users. Gainesville: University of Florida Press, 1991, at 148-168.

[8] United Nations Research Institute for Social Development. Illicit Drugs: Social Impacts and Policy Responses. Geneva: The Institute, 1994.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Drug Laws and HIV/AIDS

What is the impact of existing drug laws on efforts to prevent HIV infection and to care for HIV-positive drug users?

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, were concerned that:

> drug users, rather than being offered easy access to treatment for both their drug use and HIV/AIDS, are being "driven underground";
>
> existing laws and policies make it difficult to reach and educate them;
>
> drug use is treated as a criminal activity rather than a health issue.

Many pointed out the existing inconsistencies between laws and policies regulating licit drugs, whose use is sanctioned and often even encouraged, and laws and policies regulating the use of illicit drugs. Other concerns included:

> limited access to methadone;
>
> limited availability of drug treatment;
>
> mandatory HIV-testing for people seeking access to certain drug-treatment programs;
>
> counselling of abortion for drug users, whether HIV-positive or not, which was said to be common;
>
> limited availability of needle-exchange programs, often only in major centres, and there

> only in downtown areas; and
>
> non-inclusion of drug users in clinical trials.

Calls for Changes to Drug Laws[1]

Already in the early 1970s, the LeDain Commission recommended radical changes to Canadian drug laws,[2] including decriminalization of the possession of marijuana. A minority even called for decriminalizing the possession of all drugs, and for making "hard" drugs available to dependent users.[3] These conclusions were reached at a time when HIV/AIDS was unknown. They have remained controversial: for some, they did not go far enough and should have included a clear recommendation to decriminalize the possession of all drugs; for others, they went too far. Both supporters of decriminalization of drug use and supporters of the "War on Drugs" have continued to write numerous articles and reports laying out the main arguments in favour of their respective positions. Their positions seem irreconcilable, and both defend them with religious ardour. For example:

> Mitchell, who takes a position in favour of sweeping changes to existing drug laws, argues that drug-control legislation is founded on myth and prejudice rather than on principles of justice and scientific validity.[4] He calls for major changes in the law, in order to reduce drug-related social costs and to promote a more civil, drug-tolerant society;[5]
>
> Hadaway et al argue that "the harm to society and to individuals resulting from our drug control policies is ... greater than the benefits which drug policy legislators would have us believe are achievable. Through these policies, we are ... sacrificing our societal and individual rights, rather than supporting a rational effort toward lessening the abuse of drugs."[6]
>
> Erickson takes a more cautious position: although she admits that the "high costs and dubious benefits" of prohibitionist policies are well-documented, she argues that it would not be useful to abandon present legal controls "simply from frustration or a sense of defeat." In her view, positive alternatives must be provided.[7]

The Impact of HIV/AIDS

In recent years, partly as a consequence of the HIV/AIDS epidemic, many have abandoned the narrow debate in favour of or against decriminalization, and have begun focusing on the harms deriving from drug use in an effort to develop pragmatic ways in which to reduce them. There can be no question that concern about HIV/AIDS, especially about the connection between the sharing of contaminated syringes and the spread of HIV, is having a significant impact on the course of drug-prevention policy.[8] The government-funded establishment of needle-exchange programs is probably the most notable example of the major changes that are underway. According to O'Brien, such programs represent an explicit recognition of the social reality of drug use, the impracticality and futility of efforts designed to eradicate the problem, and the public health necessity of adopting measures to contain the rapidly increasing rate of HIV infection among injection drug users.[9] Many governments, including Canada's, are officially embracing the so-called "harm-reduction approach" to drug use. Under this approach, the first priority is to reduce the negative consequences of drug use rather than its prevalence. Harm reduction "establishes a hierarchy of goals, with the more immediate and realistic ones to be achieved as first steps toward risk-free use or, if appropriate, abstinence."[10] While some people fail to make a distinction between harm-reduction approaches and approaches advocating decriminalization, the difference is clear: a harm-reduction approach may or may not include the goal of decriminalization of drug use, but even if it does, this will only be one of many components of a strategy to reduce the harms from drug use, not its primary goal.

In practice, as pointed out by many, existing as well as proposed new drug laws and policies often render efforts to reduce the harms from drug use and, in particular, the spread of HIV/AIDS, more difficult to undertake. Riley and Oscapella reviewed Bill C7 (now Bill C-8), introduced in February 1994 to reform existing Canadian drug legislation, in a previous issue of the Newsletter, arguing that it promises to exacerbate the irrationality of current laws, add to the confusion, and increase the severity of existing penalties in a number of cases: "If the Bill is passed, the result will be continued misdirection of resources, continued emphasis on criminalization of drug users, and the unnecessary infection with HIV, and death, of many Canadians."[11] The authors provide a long list of reasons why "Canadian drug laws are contributing to the deaths of thousands of people through the preventable spread of HIV and other infections such as hepatitis and TB."

These laws have:

> created a culture of marginalized people, driving them away from traditional social support networks;
>
> fostered a reluctance to educate about safe drug-use practices, for fear of condoning or encouraging the use of illegal drugs;
>
> fostered public attitudes that are "vehemently anti-drug user," creating a climate "in which it is difficult to persuade Canadians to care about what happens to their fellow citizens who use drugs"; and
>
> focused too much attention on punishing Canadians who use drugs, "thereby downplaying critically important issues such as why people use drugs and what can be done to help stop unsafe drug-use practices."

The authors suggest that this should be a time to re-evaluate Canada's drug laws and to draft new ones based on public health and harm-reduction principles. According to them, Canada should move toward treating drugs as a health, rather than criminal, issue.

Drugs as a Health Issue

This view is shared by many authors. For example, Gostin argues that governments should pursue a policy on drug use that explicitly prefers therapeutic and public health goals to law enforcement goals "when these two are in conflict."[12] In his view, such a preference for therapeutic goals is needed because of the seriousness of the HIV epidemic and because the sweep of criminal prohibitions and government regulation often renders public health measures ineffective. He concludes: "Drug use and the needle-borne spread of infection are primarily public health problems. Seriously drug-dependent people are neither uncaring about the effects of drug use and HIV on themselves or their partners, nor unable to change their behaviors if given the education, means, and services to do so." Power et al urge that all legislation affecting drug policy take account of the consequences for preventative strategies concerning HIV, to avoid such legislation hampering HIV/AIDS prevention activities.[13] As stated by Oscapella, there are even more reasons today than 21 years ago (at the time of the LeDain Commission) for dealing with drugs as a health, not criminal, issue. The main reason for this is the advent of HIV/AIDS: a revived LeDain Commission "would have to question the sanity of laws and policies that invite further spread of this lethal disease for the sake of preserving some distorted notion of public morality."[14]

Drugs and Human Rights

A further aspect that should guide drug legislation and policy is mentioned by Kirby: drug laws and policies must be not only pragmatic, but also respectful of the human rights of persons using drugs. According to Kirby, the human rights of drug- dependent persons and of recreational drug users is a subject that has been ignored until now by most serious lawyers and virtually all judges:

> "We have all become caught up in the drug control prohibitionist model. ... The advent of the AIDS pandemic requires a completely fresh consideration of this strategy both at a global and at a national level. The matter must be addressed both in pragmatic and human rights terms. Putting it quite bluntly, it is an uncivilised act to punish people, with long periods of imprisonment, who are addicted to particular drugs. The problem is, and should be treated as, one of public health concern, not one of law and order. ... Drug use ... is here to stay. A sensible legal strategy will be targeted at harm minimisation. Not the elusive chimera of total legal prohibition. HIV/AIDS will eventually teach us this."[15]

McCarthy[16] and Silvis et al[17] also emphasize that the human rights of persons using drugs have been ignored. McCarthy points out that, for a variety of reasons, attempting to reduce discrimination against injection drug users is more difficult than attempting to reduce discrimination experienced by persons living with HIV/AIDS or by gay men. In her view, it has become apparent that society generally justifies discriminating against drug users "because the principle of fairness does not apply." Injection drug use is seen as a mere lifestyle choice, something that can be stopped, amended or changed, and people take the attitude that "[i]f they [drug users] don't like the way they're treated they can stop." McCarthy points out that experiences of discrimination are so common among injection drug users that most of them do not realize they are being discriminated against. For them, it has become "normal" to be treated badly and vilified, and fear of poor treatment is a major barrier to accessing needed services. For McCarthy, it was a "shock" to discover just how widespread discrimination against injection drug users is. She concludes:

> "I find it a sad comment on society when a group that is often most in need of services is denied access or actively discouraged from accessing these services. Even more disturbing is that this treatment of injectors seems so acceptable to society."[18]

Recommendations

Recognizing that "the spread of HIV is a greater danger to individual and public health than injection drug use itself," in 1990 the Working Group on HIV Infection and Injection Drug Use of the Canadian National Advisory Committee on AIDS (NAC-AIDS) issued a set of recommendations, many of which have still not been implemented. The Working Group pointed out that "major improvement in professional and public attitudes to injection drug use and injection drug users is necessary since policies and actions which fail to respect the human rights and dignity of injection drug users may promote the hidden use of drugs and impair the effectiveness of measures to combat the spread of HIV."[19]

In 1994, at the Second National Workshop on HIV, Alcohol, and Other Drug Use, participants agreed to adopt and promote the Working Group's recommendations as the foundation for a comprehensive action plan on HIV and drug use. They further debated a number of recommendations going beyond those contained in the NAC-AIDS document, focusing on the human rights of drug users and/or challenging some aspect of the way in which drug use is addressed through the criminal justice system in Canada. These include the following recommendations:

> de facto decriminalization of personal possession and use of cannabis, coupled with control of narcocriminality elements; changes to drug paraphernalia laws so that needles can be sold to shooting galleries;
>
> development of alternatives to imprisonment for people involved in drug crimes or drug-related crimes - drug offenders should generally be referred to community help and treatment services rather than be sent through the courts;
>
> acknowledgment by governments in Canada of the multiple harms caused by responding to drug issues through the criminal law, including: increased risk of HIV among injection drug users in the general population and in prisons; unwarranted criminalization of drug users;
>
> harm done to the fundamental human rights of all Canadians;
>
> stopping of proposed legislation, such as Bill C-7 (now Bill C-8), aimed at strengthening

> and perpetuating the use of the criminal law. Instead, governments should focus on social policy and health measures to reduce drug-related harms at the individual and societal level.

Support for these recommendations was not unanimous. However, delegates agreed that reducing the harms from drug use must be the primary concern of Canadian drug laws and policies, and that this requires rethinking current laws and policies, respecting the human rights of drug users, and seeing drug use as a health, rather than criminal, issue.

- *Ralf Jürgens*

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] The following is a revised version of a literature review undertaken as part of the Project on Legal and Ethical Issues Raised by HIV/AIDS. See R Jürgens. Legal and Ethical Issues Raised by HIV/AIDS: Literature Review and Annotated Bibliography. Montréal: Canadian AIDS Society and Canadian HIV/AIDS Legal Network, 1995.

[2] For a review of Canadian drug legislation, see RM Solomon & SJ Usprich. Canada's Drug Laws. Journal of Drug Issues 1991; 21(1): 17-40.

[3] E Oscapella. Le Dain Revisited - 21 Years Later. The Lawyers' Weekly 1995; 14(35): 5.

[4] CN Mitchell. A Justice-Based Argument for the Uniform Regulation of Psychoactive Drugs. McGill Law Journal 1986; 31: 212-263.

[5] CN Mitchell. Introduction: A Canadian Perspective on Drug Issues. Journal of Drug Issues 1991; 21 (1): 9-16.

[6] P Hadaway et al. Canadian Drug Policies: Irrational, Futile and Unjust. Journal of Drug Issues 1991; 21(2): 183-197.

[7] PG Erickson. A Public Health Approach to Demand Reduction. The Journal of Drug Issues 1990; 20 (4): 563-575.

[8] R Power et al. Drug Prevention and HIV Policy. AIDS 1990; 4(Suppl 1): S263-S267.

[9] M O'Brien. Needle Exchange Programs: Ethical and Policy Issues. AIDS & Public Policy Journal 1989; 4(2): 75-82.

[10] D Riley. The Harm Reduction Model. Pragmatic Approaches to Drug Use from the Area Between Intolerance and Neglect. Ottawa: Canadian Centre on Substance Abuse, 1993.

[11] D Riley, E Oscapella. Bill C-7: Implications for HIV/AIDS Prevention. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(2): 1, 11-13. For an update, see infra, D Riley, E Oscapella. Bill C-7: An Update.

[12] L Gostin. The Interconnected Epidemics of Drug Dependency and AIDS. Harvard Civil Rights-Civil Liberties Law Review 1991; 26: 113-184; see also Gostin. Drug Dependency and HIV. In: S Burris et al (eds). AIDS Law Today. A New Guide for the Public. New Haven: Yale University Press, 1993, at 150-186.

[13] Supra, note 8.

[14] Supra, note 3.

[15] Kirby M. Sex, Drugs and the Family. [Australian] National AIDS Bulletin February 1994; 7(12): 20-22 at 21.

[16] G McCarthy. Drug Use & Discrimination. [Australian] National AIDS Bulletin; August 1994: 32-33.

[17] J Silvis et al (eds). Drug Use and Human Rights in Europe. Utrecht and Montréal: Willem Pompe Institute for Criminal Law & Criminology and McGill Centre for Medicine, Ethics and Law, 1992.

[18] G McCarthy. Drug Use & Discrimination. [Australian] National AIDS Bulletin August 1994: 32-33.

[19] NAC-AIDS Working Group on HIV Infection and Injection Drug Use. Principles and Recommendations on HIV Infection and Injection Drug Use. In: Second National Workshop on HIV, Alcohol, and Other Drug Use: Proceedings, Edmonton, Alberta, February 6-9, 1994. Ottawa: Canadian Centre on Substance Abuse, 1994.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Public Health and "The Unwilling and Unable"

Several provinces have witnessed efforts to develop responses to individuals with HIV who are "unwilling or unable" to take appropriate precautions to prevent transmission. British Columbia has issued guidelines; Newfoundland and Manitoba have been examining the issue. Both Ontario and Québec have produced detailed working papers that analyze the issue and possible approaches. The Ontario paper is summarized here. An analysis of the Québec paper will follow in the next issue.

The Ontario Working Group

In September 1995, a working group of the Ontario Advisory Committee on HIV/AIDS produced *Reducing HIV Transmission by People Who Are Unwilling or Unable to Take Appropriate Precautions*, "intended for public health officials, community-based AIDS organizations, people with HIV/AIDS and other people responding to people with HIV who are unwilling or unable."

The working group expressly acknowledges "that people who are truly unwilling or unable are not reflective of all people with HIV and, in fact, represent a very small number of people with HIV or AIDS. Discussion about the minority has an impact on the majority and this discussion occurs within the context of the existing stigmatization of people with HIV who are sometimes perceived as a threat to individuals and to society."

The paper outlines and analyzes current approaches to reducing transmission by those who are unwilling or unable, under the following headings: education, counselling and support; public health legislation; criminal prosecutions; and civil proceedings. The working group also offers both legislative and non-legislative recommendations.

Education

While studies indicate that education efforts have increased awareness of HIV/AIDS and how to prevent transmission, "the working group acknowledges ... that it is unlikely that general education will have a substantial impact on people with HIV who are unwilling or unable."

Test Counselling

The paper points out that, because pre-test counselling is required by Ontario law in anonymous testing programs, guidelines and counsellor training for such programs are well-developed, leading to consistent and high-quality counselling. But no such requirements exist for nominal and non-nominal testing, carried out primarily by private physicians and hospitals, and accounting for most HIV testing in Ontario. Many physicians have little experience with HIV; they "may not have the time or expertise to do the counselling and/or may not feel comfortable talking to their patients about risk activities." Furthermore, "it is suspected that most physicians who request HIV testing for their patients do not do pre-test counselling... ."

Longer-Term Support: The working group recognizes that "support programs in community-based AIDS organizations can greatly contribute to ongoing individual prevention efforts and reinforce the person's abilities and willingness to protect others." Based on evidence from studies such as the 1993 *Men's Survey*,[1] it concludes that "broadening the range of available choices and building self-esteem are key strategies in counselling and support programs for people with HIV/AIDS."

Public Health Legislation

The Ontario *Health Protection and Promotion Act*[2] (HPPA) contains provisions regarding the designation of diseases, HIV testing, reporting requirements, contact tracing, and intervention:

Disease Designations

AIDS is currently designated as reportable and communicable. Because the powers of a Medical Officer of Health (MOH) depend in part upon a disease's designation, there have been calls to designate AIDS as a "virulent" disease. However, others have pointed out that HIV is not "virulent," and are concerned about the message such a designation would send out about the disease and persons living with HIV/AIDS. They argue that public health powers available under the current designation are adequate for dealing with the majority of people with HIV.

Reporting

Physicians are obliged to report positive HIV test results and diagnoses of AIDS. In addition, s 34 of the HPPA requires physicians to report any patient with a communicable disease who refuses treatment. There is no express requirement that physicians treating an HIV-positive patient provide any report other than the original diagnosis, and the provision of the HPPA has rarely been used. However, the Committee's position is that refusal to act on counselling advice directed at reducing HIV transmission would meet the statutory criteria and constitute grounds for reporting a person whom a physician believes is placing others at risk.

Partner Notification

It is the responsibility of public health officials to ensure that contact tracing occurs in nominal and non-nominal testing, although actual notification of partners is generally left to the physician and the HIV-positive individual.

Disclosure, Risk Activities and Intervention

There is no express statutory requirement that people with HIV disclose their status to others. The working group agreed that "people with HIV who know their status have a responsibility either to disclose their status to their partner or to ensure that high-risk behaviour does not occur," and that "if there is no possibility of HIV transmission in a given situation, the person with HIV is under no obligation to disclose HIV status." However, it could not reach consensus about whether disclosure prior to engaging in low-risk sexual or needle-sharing activities is required.

Intervention by Public Health Officials

Under s 22 of the HPPA, the MOH may issue a written order against any person with a communicable disease, requiring that person to take, or refrain from taking, any action the MOH deems necessary to prevent or inhibit the spread of the disease. The MOH may only make such an order if he or she is of the opinion, based on "reasonable and probable grounds," that a communicable disease exists, that it poses a risk to the health of people in the area, and that the order is necessary to decrease or eliminate the risk. The HPPA expressly states that the MOH need not offer a hearing to any person against whom an order is being given.

The use of s 22 orders varies greatly across Ontario. By the end of 1993, 45 orders had been written under s 22 against people with HIV/AIDS: 37 in Ottawa-Carleton, 5 in Toronto, and the rest in other parts of the province. Orders have generally been restricted to requiring modifications to sexual and/or drug-using behaviour. Section 22 also permits orders that a person with a communicable disease be isolated, but such orders "have generally been seen by public health as unreasonable in the control of HIV."

The working group found that in cases where sexual transmission has been the concern, some orders stipulated "no insertive sex" rather than prohibit penetration only when done without a condom. It recommended that in all cases "the least intrusive orders should be written."

Failure to obey an MOH order is a provincial offence punishable by fines up to $5000. Alternatively, the MOH may apply to the court for a restraining order, without notice to the person who is the subject of the order. Finally, in the case of any contravention of the HPPA, the Minister of Health may apply to the court for an order prohibiting any such activity; in this event, notice to the person affected is required, and that person has the right to a hearing, representation by counsel, and an appeal. To date, no such application has been made in relation to a person with HIV.

Criminal Code Provisions

As noted in previous issues of the Newsletter,[3] there is currently no HIV- or STD-specific criminal legislation in Canada applying to those who knowingly transmit, or attempt to transmit, HIV. In 1985, Parliament repealed the section of the *Criminal Code* that made it an offence for a person who is aware that he or she has a communicable venereal disease to transmit that disease to another, on the grounds that transmission of disease is a matter of public health rather than a criminal act. However, there have been a handful of cases in which HIV-positive individuals have been criminally prosecuted under existing Code offences for allegedly infecting others or exposing them to the risk of infection.

According to the working group, there are several advantages in using public health rather than the criminal law to deal with situations in which HIV-positive persons are unwilling or unable to take appropriate precautions:

> a complaint-driven criminal process cannot be used as a preventive measure;
>
> few cases will satisfy the requirement of proof beyond a reasonable doubt required in criminal law, due to evidentiary difficulties in proving actual infection of a complainant by an accused;
>
> confidentiality is better protected by written public health orders than criminal proceedings in open court; and
>
> the potential consequences of criminal prosecution are more intrusive than a s 22 order.

However, criminal proceedings offer better procedural safeguards than the HPPA: "before making a decision that results in a deprivation of liberty, the MOH is not required to prove that the person with HIV has infected others, just that he or she is posing a risk to others on 'reasonable and probable grounds.'"

Civil Proceedings

To date, there have been no civil lawsuits in Ontario against an HIV-positive person for transmission of the virus through sex or needle-sharing. In *Bell-Ginsberg v Ginsberg*,[4] a wife accused her husband of possibly exposing her to infection because he failed to disclose his bisexuality. Although there was no evidence that he was HIV-positive, the judge allowed the action to proceed.

Recommendations

The Committee concludes that increased community and physician efforts could reduce the number of people identified to public health officials as unwilling or unable; that short-term improvements are feasible without major legislative changes; and that, in the longer term, legislative changes should be considered to make the system more responsive and relevant to HIV/AIDS.

It emphasizes that non-coercive methods should be used first, and that there should be no expectation that coercive interventions will always follow: "The working group agrees that the first recourse should be through the public health system rather than the criminal justice system or other health legislation" such as the *Mental Health Act*.

Among the Committee's recommendations are:

Education, Counselling and Support:

to develop standardized pre- and post-test counselling guidelines and training/ information sessions for physicians and counsellors; and

to develop a framework to assist community-based organizations in dealing with a client who may be unwilling or unable.

Public Health Measures

to issue provincial guidelines under the HPPA, and establish a process for the exercise of public health authority in the least invasive, least restrictive and most reasonably available way. Such guidelines should include: (a) a list of indicators for assessing a person's willingness or ability to take appropriate precautions; (b) interventions to be used prior to issuing a s 22 order; (c) a requirement that the MOH interview a person prior to issuing an order; and (d) a process to be used after issuing a s 22 order, including provision for appeals.

Criminal Interventions

to issue directives to Crown prosecutors, including a strong recommendation to consult with public health officials before laying criminal charges.

Legislative Recommendations

The Committee also presented a number of legislative recommendations:

AIDS should remain a reportable, communicable disease under the HPPA, and should not be designated as virulent. Consideration should be given to creating a new designation to address life-long infectious diseases such as HIV;

pre- and post-test counselling should be required in all HIV testing; and

non-nominal reporting of HIV should be legalized.

Finally, the Committee recommended a number of legal clarifications with respect to, among other things, the sharing of information between public health officials and the Attorney General prior to criminal charges being laid.

Conclusion

The working group agreed that "the expectations on people who are unwilling or unable should be the same as the expectations on all people with HIV but that, in some cases, it may be necessary to use more intrusive interventions that may involve prohibitions not generally given to people with HIV." It repeatedly stressed, however, that "interventions that are the least intrusive, least restrictive and are readily available are believed to be the most effective."

The working group held a consultation on the paper in December 1995, and is currently reviewing its recommendations in light of those discussions.

- *Richard Elliott*

Top of this page

Return to Table of Contents

Return to Home Page

Translation of this article was made possible by a financial contribution from the AIDS Bureau, Ontario Ministry of Health.

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[1] T Myers et al. The Canadian Survey of Gay and Bisexual Men and HIV Infection: Men's Survey. Ottawa: Canadian AIDS Society, 1993.

[2] RSO 1990, c H-7.

[3] D Patterson. Should Canada Criminalize HIV Endangerment? 1995; 1(2): 1; R Jürgens. Justice Minister Considers Introducing HIV/AIDS-Specific Criminal Offence. 1995; 1(3): 6; B Guillot-Hurtubise. Criminal Law and HIV/AIDS. 1995; 2(1): 1 and 1996; 2(2): 5.

[4] (1993), 14 OR (3d) 217 (Gen Div).

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

DRUG POLICY

Access to Sterile Needles for Young People under the Age of 14

Several programs for preventing the transmission of HIV and hepatitis B among IDUs have been set up across Québec. Almost 290 centres where needles are made available are officially listed.

Many are financed by the department of health and social services through the Québec centre for AIDS coordination (CQCS). These projects involve the distribution of sterile needles or the exchange of dirty needles for clean ones by centres such as CACTUS-Montréal and Point de Repères in Québec City, by community organizations or the health service network, such as CLSCs (local community service centres), hospital centres, even pharmacies and private clinics. Distribution of sterile needles is generally carried out anonymously.

Some of those in charge of or involved in these prevention projects are sometimes faced with requests for needles from young people under 18, even under 14. In these cases, intervention consists in counselling these young people so as to learn why they are using needles and to try to dissuade them from injecting, and then seeing to it that they are directed to the specific resources that are so necessary.

However, if the attempt to dissuade is unsuccessful, there is sometimes no other choice but to give them needles. It is known that young people who inject for the first time do not generally have adequate equipment for doing so, and run a high risk of infecting themselves by borrowing used needles from older people.

Several organizations are asking to know whether they are respecting the law when they give needles to young people who may be less than 14 years old.

Although Québec's *Youth Protection Act* could lead one to believe that it is necessary to obtain the parents' consent or that it would be necessary to report these young people to the youth protection directorate, s 142 of the *Public Health Protection Act* permits this kind of action; professionals must, however, be able to justify the circumstances surrounding such action. Thus, a professional who gives needles to a young person under 14 could possibly be blamed for doing so under the *Youth Protection Act*, and those who refuse to do so could be blamed under the *Public Health Protection Act* because they would thereby contribute to the possibility of young people infecting themselves. Faced with this "grey zone," some CLSCs have, for example, unilaterally decided not to give needles to young people under 14, while others have decided to do so, but only when the young person has consulted a health professional (some CLSCs have receptionists hand out needles).

It is in this context that the CQCS has asked for an ethical analysis from Dr David Roy of the Clinical Research Institute of Montréal.

- *Richard Cloutier*

We reprint Dr Roy's response to Ms Laberge-Ferron, Director General of the CQCS:

Access to Sterile Needles for Young People under the Age of 14: An Ethical Analysis

Dear Ms Laberge-Ferron:

You have asked for an ethical analysis of issues raised by needle-exchange programmes for very young persons (less than 14 years old) [who are] IV drug users. I believe you understand that your need for a rapid response from me does not give me the time needed for a comprehensive and extensively documented study of this question. I shall try to identify the main considerations that support an ethically acceptable practical course of action.

First, it would be ethically unacceptable, indeed, it would be even irresponsible, to use the conflict (alluded to in your letter) between the law for the protection of youth and the law for the protection of public health as a reason for doing nothing to protect vulnerable young people against the transmission of HIV.

Second, in an ideal world, one would not give syringes to young people to help them to engage in IV drug use. One would rather rapidly institute a comprehensive programme of psychological, social, and familial rehabilitation to protect these young people against both drug addiction and the transmission of HIV. But... but... we do not live in an ideal world. We have to act, as we try to protect these young people, within constraints that simply do not allow us to achieve the ideal immediately and in a comprehensive fashion.

Third, one should state the obvious[,] should it be forgotten. If a young person is ready and open for comprehensive rehabilitation and can be persuaded to avoid IV drug use altogether, that is the goal that should be pursued. To such a young person, one would not distribute syringes.

Fourth, we are largely unequipped in resources and personnel immediately to initiate comprehensive rapidly effective programmes of psychological, familial, and social rehabilitation for those most difficult of youth who are: abandoned; lacking in a sense of self-worth and self-identity; lacking in family bonds; susceptible to manipulation by pimps and drug pushers; and who find their shelter, their only "home," in the company of those who are deeply into IV drug use. These very difficult young people may and do include some who are less than 14 years old.

Fifth, it is not the age of a young person, but that young person's danger of being inducted into IV drug use with needle sharing, and that young person's danger of becoming HIV-infected via needle sharing, that should govern the kinds of protective intervention that we do or do not adopt.

Sixth, in this context, we would be unwise absolutely to insist on a set of conditions (such as: you must submit to counseling; you must see a physician, etc.) before giving such a young person sterile, clean needles. To so insist simply increases the risk of losing contact with the young person altogether. It also increases the risk that the young person, faute de mieux, will share needles for IV drug use.

Seventh, we must never lose sight of the most immediate objective of our protective intervention with these highly vulnerable young people whose lives are maximally disorganized. The most immediate goal is to protect them against lethal HIV infection. That biological goal should be paramount and predominate. This goal may well require furnishing these young people, whatever their age may be, with sterile, clean needles. It would be wise to do this in a way, for example, via street workers, that would maximize the youths' chances for helpful stable contacts with persons who may eventually be able to help them to grow out of the mess they are in now. To insist immediately on rapid transformation of these young persons' lives is practically to invite them to disaster.

Eighth, one should give particular and careful consideration to young people who are in the web of IV drug use and who live in small towns or rural areas. The danger in preventing such youth from access to clean needles is potentially twofold: 1) they may be forced into needle-sharing and a heightened risk of HIV infection; 2) they may be induced to seek shelter in very large cities where the chances to maintain therapeutic contacts with them become very much more difficult than should be possible in a small town. It is also in large cities where young persons' risk of becoming HIV-infected may be greater, particularly if they become submerged in high-risk behaviour sub-cultures.

These eight considerations are based upon the ethical principle of first avoiding the greatest of evils when not all evils can be avoided at the same time. It is more important that we protect these vulnerable, socially disorganized youth from HIV infection and eventual death; more important that we have surviving youth for eventual rehabilitation - than that we immediately insist on ideal ways of living that these youth cannot now understand, adopt, or achieve. This is, in other words, the principle of harm reduction. This principle, in the context of youth whose lives are marked by psychological, familial, and social disorganization, justifies needle-exchange programmes for youth who are within or on the fringes of IV drug use.

It would be unwise and ethically dubious to cancel or block a needle-exchange programme when this is the immediately needed protective intervention to help imperiled young people from being drawn into needle-sharing and HIV infection.

It would also be utterly unwise and imprudent to think that the simple handing out of clean needles will solve the problem of HIV transmission among those who inject drugs. Injection drug use is part of a complex of problems. A simple technological fix - distribution of needles - that pays little attention to the wounded humanity of (these) young people is bound to fail in the mid- or long-term.

Lastly, we should take nothing for granted, including the efficacy of needle-exchange programmes in preventing HIV transmission. We need to evaluate these programmes carefully within our own society, with precise attention paid to the details of how the programme is organized.

- *David Roy*

Top of this page

Return to Table of Contents

Return to Home Page

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Bill C7: An Update

Diane Riley and Eugene Oscapella first reported about Bill C7, the Controlled Drugs and Substances Act, in vol 1, no 2 (January 1995) of the Newsletter. At the time, they concluded that if the Bill was passed, the result would be "continued misdirection of resources, continued emphasis on criminalization of drug users, and the unnecessary infection with HIV, and death, of many Canadians."

History of Bill C-7

The bill was first introduced in February 1994 by the Liberal government. It very closely resembled Bill C-85, introduced by the Conservative government in June 1992 and harshly criticized by the Liberals. Bill C85 died with the Conservative government, but the Liberals resurrected it within months of coming to power. Bill C7 is technically a "health" bill, introduced in the House of Commons by the Minister of Health. However, its punitive focus suggests that as a practical matter it is criminal law, normally a responsibility of the Minister of Justice.

Bill C7 consolidates much of the drug legislation now set out in the *Narcotic Control Act* and the *Food and Drugs Act*. It repeals the *Narcotic Control Act* and parts of the *Food and Drugs Act*. It creates a number of new drug offences and adds new powers of search and seizure. Numerous deputations to the parliamentary sub-committee in the spring of 1994, including the Canadian Foundation for Drug Policy, the Addiction Research Foundation of Ontario and the Canadian Bar Association, severely criticized the Bill for its "War on Drugs" approach and, in particular, for its very harsh stance with regard to cannabis possession. The bill was then revised. These revisions included a lessening of penalties for possession of cannabis for personal use, so that simple possession would become a summary offence. Nevertheless, such possession was to remain a criminal offence.

After considerable delay, Bill C-7 underwent third reading in the House of Commons in October 1995. On 30 October, while the country's attention was turned to the Québec referendum and the Bloc Québécois was absent from the House, Bill C-7 quietly passed its final reading and went to the Senate for approval.

The Senate Hearings

The Senate Standing Committee on Justice and Constitutional Affairs began hearings on the bill in December of 1995. Deputations were made by the Law Union of Ontario, the Addiction Research Foundation, and the Canadian Foundation for Drug Policy (CFDP). The CFDP were requested to submit to the Senate Committee an amended version of the bill, revised in line with criticisms expressed in their deputation, by 1 February 1996.

Proposed Amendments

The CFDP drafted a series of amendments. These did not address all of its many concerns with the bill, but they would help to resolve several of the most pressing problems arising from it. To address remaining issues, the CFDP proposed adding a section to the bill calling for the establishment of an independent committee to review Canada's drug laws and policies and to report to Parliament within one year. The call for an independent review is consistent with promises made in the House of Commons on 30 October 1995.

The goals of the CFDP in proposing amendments to C-7 are:

> to reduce the violence associated with the black market in drugs;
>
> to reduce the risk of acquiring HIV and other lethal bloodborne infections;
>
> to reduce the financial burden on society that arises from unnecessary drug-related expenditures;
>
> to stress the need to explore alternatives to current drug policies and laws, so that the harms of drug use to users and society alike will be kept to a minimum;
>
> to respect international human rights obligations; and
>
> to reduce the unnecessary and unproductive criminalization of large numbers of Canadians for the possession of substances.

The principal amendments proposed by the CFDP are:

> to include a declaration of principle about the goals and aims of drug laws and policies;
>
> to confirm that the provisions of the Criminal Code relating to impairment continue to apply to any impairment caused by any substance regulated by the bill;

> to remove the criminal prohibition for the possession by adults of small amounts of substance for personal use, the amounts of these substances to be determined by an expert advisory committee;
>
> to clarify the law to ensure that syringe exchange programs are not impeded by defining "controlled substance" to include containers used to deliver substances;
>
> to rationalize sentencing for offences involving possession of larger amounts of substances;
>
> to remove the criminal prohibition on the transfer among adults, for no consideration, of small amounts of substances;
>
> to continue to prohibit the trafficking of substances to minors, whether for consideration or not;
>
> to allow the cultivation of up to 10 plants of cannabis without a permit, or more with a permit issued under the regulations.

The Future of the Bill

On 2 February 1996, the government announced the prorogation of the current session of Parliament. Since Bill C-7 had not yet been enacted, it died at this time. However, on 1 March, the Hon Herb Gray, the Government House Leader and Solicitor General of Canada, announced the government's intention to reinstate the bill in the new session of Parliament, which began on 26 February. On 6 March, the new Minister of Health, the Hon David Dingwall, introduced a motion that in effect revived the bill, renaming it Bill C-8, and deemed it passed by the House of Commons. The House adopted the motion and the Bill was deemed passed. Apart from changing the bill's number from C-7 to C-8, Bill C-8 is identical to the bill originally passed by the House of Commons on 30 October 1995. The reinstated bill will return to the Senate, where the Standing Senate Committee on Legal and Constitutional Affairs will likely continue the hearings that were interrupted when the session ended on 2 February. The CFDP will continue to draft model drug legislation for Canada in order to be able to offer an alternative to either the present laws or what ever laws the government decides to resurrect.

- *Diane Riley and Eugene Oscapella*

This article has been edited and updated for the Newsletter. Reprints of the original can be obtained from Dr Diane Riley, Canadian Centre on Substance Abuse, 100 College Street, Room 207, Toronto, Ontario, Canada M5G 1L5.

Top of this page

Return to Table of Contents

Return to Home Page

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

DISCRIMINATION

Transgendered People, Discrimination, and HIV/AIDS

Sandra's Story

When I decided to clean up and walk away from 17 years of prostitution, addictions and bikers, I found nothing more frustrating than not being able to find any services specifically addressing the needs of transgendered people.

For the next four years I lived secretly among the heterosexual community with a fear of being discovered, rejected, and ostracized.

Like many of my sisters and brothers I have felt like a freak of nature, and had a sense of not belonging anywhere. When on the streets, I was accepted and validated, and was able to escape from the realities of being transgendered. I did not need to adjust to the real world and the expectations of others. In the straight world we were abandoned, forgotten, and occupied a social status reminiscent of that of the lepers of earlier times. In the real world there was no human rights protection, and no dignity for the transgendered.

When I cleaned up, I entered a world where many services treated me like a man, even though I had sex-reassignment surgery 16 years ago - a world where even the professionals had little understanding of transgendered people. I dealt with the guilt of letting the world dictate to me their view of who I was supposed to be.

So I hid in religion for those four years, going around the bars and preaching the gospel of our Lord Jesus Christ through the Salvation Army. I began a long road of facing buried emotions of anger, pain and resentment. Because I didn't fit the model of binary gender I was not supposed to exist, to think or to feel, yet I feared most the rejection of those for whom I did not exist, and became a people pleaser and lost myself.

One day an angel in disguise told me she had had a dream and saw me in a white uniform and talking to a lot of people. She asked me if I had ever thought of going back to school and pursuing a career. I felt frightened and thought it impossible - a self-defeating attitude that many of us assume so well. I applied to college and was accepted into the psychiatric nursing course at Douglas College in Vancouver.

During that period of time I gained self-confidence and realized that something needed to be done about the lack of support sensitive to the transgendered. I left the Salvation Army to follow up on my own roots, which are Native American - more specifically, Cree Métis. I discovered that I had a history and that I had traditions I now value dearly and practise to the best of my abilities. I also took the risk of teaching students all about transgender issues. This proved to be excruciating because it polarized the class room - I began to face the pressures of being "out." At times it felt lonely and depressing, but the voice inside me kept telling me that I was on the right track. By the end of my studies I had launched a gender-discrimination case against a fellow student and won the case. As a result, Douglas College now has a comprehensive sexual-harassment policy that is considered a model policy in Canada. This prepared me to fight for my rights in other areas, and to become an advocate and role model for other transgendered brothers and sisters.

The High Risk Project

After I graduated as a Registered Psychiatric Nurse I discovered the High Risk Project (HRP), a project dealing specifically with the street transgendered. HRP had been initiated by an ex-streetworker and an HIV-positive member of our community, as a support group serving a hot meal to transgendered street people one night a week. When I joined, I realized the importance of this service and the need to expand into being more than a support group. I began networking with service providers, and presented my cause as a holistic nursing care plan for transgendered street people. To my amazement I found a lot of support: community workers and nurses had long wondered how to reach the transgendered, and had recognized that the specific needs of the transgendered required a peer-driven model. I was given a space free of rent; knocked on doors and got free food; solicited for peer volunteers, and created the first Canadian drop-in centre for the transgendered addressing the health issues of our sisters and brothers.

By then the two original founders of HRP had left, and I continued the project with Deborah Brady. We incorporated as a non-profit charitable organization in January 1995 and initially ran the drop-in with money from our nursing jobs. When we began to lobby the government for money, we were able to educate the public through media exposure, professionals, laypersons, and government officials with whom we came into contact.

Now we have a drop-in centre with a shower, laundry and kitchen facilities, a lounge, support services, hot meals, and other services for transgendered street workers. We provide information on safe needle use, safer sex practises, free condoms, and bad tricks. About one hundred transgendered people use the centre regularly, people who would never make it to the offices of the more traditional AIDS-service organizations.

Discrimination

The High Risk Project applied for a grant from the Law Foundation of British Columbia and has prepared a report on the lack of basic human rights protection for transgendered people.[1] barbara findlay has made an application to the Charter Challenges program on behalf of Deborah Brady to do a test case to have "gender identity" added to the *Canadian Human Rights Act*.

Even though there are no official "gender identity" grounds in human rights legislation, we advise transgendered people to lodge human rights complaints if they are discriminated against. I have a complaint against the Vancouver City Police, who refused to help me in a domestic violence situation and laughed at me, saying I was a man. Another woman was turned down by an educational institution because "she would upset the students and staff because of how she looked," and was told to come back when she had finished her transition from male to female.

barbara findlay says we should file complaints on the basis of every possible ground - sex, physical and mental disability, sexual orientation - because we can drop a ground later but cannot add one easily.

- *Deborah Brady, Sandra Laframboise, Barbara Findlay*

Top of this page

Return to Table of Contents

Return to Home Page

"Transgendered" is an umbrella term that applies to transsexual people, transvestites, drag queens, and cross-dressers. Transsexuals are people who are born with a core gender identity that is not congruent with their external genitalia. Some transsexual people choose hormone treatment and/or sex reassignment surgery to bring their genitalia into line with their core gender identity. Cross-dressers are people who dress all the time as members of the opposite gender. Transvestites dress in clothes of the other gender usually in the context of erotic play. Drag queens are often performance artists. Transsexuals, cross-dressers, and transvestites may be gay or straight; drag queens are all gay men.

There is no explicit protection in any human rights legislation in Canada for transgendered people. There is only one reported human rights case in the country. That case was fought, and won, in Quebec - but on the basis that the transgendered woman had been discriminated against because of her "civil status," a protected ground that does not exist in any of the English-speaking jurisdictions.

Because our culture absolutely assumes that everyone is "either" male "or" female, there is literally nowhere that transgendered people fit. They are regularly hospitalized or imprisoned with people whose gender identity they do not share, kicked out of washrooms, even denied space at women-only events if they are transgendered women.

Because of the extreme transphobia of society, many transgendered people end up on the street as sex-trade workers or IV drug users. Estimates in Vancouver are that 70 to 80 percent of transgendered people on the streets are HIV-positive.

Human rights legislation requires that services accommodate the particular needs of people who do not "fit" the usual model. This means that AIDS service providers have an obligation to provide services appropriate to transgendered people and not to continue the discrimination against them.

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[1] b findlay et al. Finding Our Place: The Transgendered Law Reform Project. Vancouver: The High Risk Project (449 East Hastings Street, Vancouver BC V6A 1P5.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

US: Court Finds Dentist Guilty of Unlawful Discrimination

Joining a growing body of precedent in Canada[1] and in the US,[2] the US District Court in Maine ruled on 22 December 1995 that a dentist violated the *Americans With Disabilities Act* (ADA) and the Maine *Human Rights Act* by refusing to treat an HIV-positive patient in his office.[3]

The opinion by Judge Brody focused on two issues: whether an asymptomatic HIV-positive person has a disability under the ADA, and whether such a person would present a "direct threat of infection" to a dentist.

Brody noted that it is clear that HIV-infection is to be considered a "physical impairment" under the ADA, but that there was less unanimity about whether asymptomatic HIV-infection, as such, "substantially limits" one or more "major life activities" of the infected person [in order to qualify as a person with a disability under the ADA, a person needs to have an impairment that "substantially limits" one or more "major life activities"]. However, in the case of the female plaintiff, Sidney Abbott, Brody found credible her assertion that the impact of her HIV-status on her reproductive ability was sufficient to qualify her as a person with a disability under the statute. Noting the growing body of cases so holding, Brody produced a detailed discussion of the issue, concluding that the plaintiff was disabled "as a matter of law."

Turning to the more contentious issue of risk to the dentist, Brody found that the defendant had not submitted sufficient evidence to support his assertion that treating the plaintiff in his office would subject him to significant risk of infection. Abbott presented testimony by the CDC's Director of the Division of Oral Health, who asserted that "when implemented, the CDC recommendations [for risk reduction] reduce the already low risk of disease transmission in the dental environment, from either patient to dental health care worker, dental health care worker to patient, or patient to patient." Brody specifically rejected Bragdon's attempt to use cases in which courts ruled against HIV-infected health-care workers who had charged their institutional employers with violations of the ADA, finding that such cases did not support Bragdon's position.

Top of this page

Return to Table of Contents

Return to Home Page

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[1] See, eg, Hamel v Malaxos, 25 November 1993, no 730-32-000370 929, Small Claims Court, Joliette, unreported (summarized in the Canadian HIV/AIDS Policy & Law Newsletter 1994; 1(1): 1, 3-4); and Québec Human Rights Commission v Dr G, QHRT, Québec, no 200-53-000002-944, 11 April 1995, Michèle Rivet J (summarized in Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(4): 1, 14-15).

[2] D.B. v Bloom, 896 F Supp 166 (DNJ 1995), and US v Morvant, 898 F Supp 1157 (ED La 1995).

[3] Abbott v Bragdon, No 94-0273-B. Reported in Lesbian/Gay Law Notes January 1996, at 10.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

HIV/AIDS and Child Care

At the request of people involved in public health and child care, the Québec Human Rights Commission issued a notice concerning the exclusion of children with HIV from child care. The following is a summary of this text, entitled *The Right to Child Care for Children Living with HIV/AIDS*.[1]

Despite the information available, training on blood-transmissible diseases, and the recommendations and conclusions of a public health notice sent to day care centres in 1994,[2] it appears that "[e]ven though some children currently benefit from day care when those responsible for the day care centre are aware of their seropositivity, others have access only because their parents have decided to hide the fact following the more or less explicit refusals of some day care centres." As the person who signed the Commission's notice indicated, parents "are too often ... refused the right to day care if they reveal that their child is HIV-infected."[3]

Before studying this situation with regard to the *Charter of Human Rights and Freedoms* (the "Charter"), the Commission cites various notices connected with medical and public health issues in Québec and elsewhere. Its unanimous conclusion is that "HIV is not transmitted in the course of everyday activities in the home or at work. Specific notices concerning the situation in day care centres have come to the same conclusion."

The Commission then deals with two questions concerning the legislation applicable to the exclusion of seropositive children:

> the right to day care; and
>
> the right to respect for the confidentiality of personal information.

Public Health Notices

A notice issued by the public health directorate of the Montréal-Centre health and social services regional board states that "the only potential risk of HIV transmission in day care centres relates to blood, whereas saliva, urine, tears and perspiration do not involve risk."[4] The notice contains the following recommendations:[5]

> **It is not appropriate to exclude or to refuse registration to day care solely on the basis of HIV infection. Infected children ... have the same rights as all others....**
>
> **It would be desirable that day care staff involved be informed of the situation, both for the protection of the [seropositive] child and that of the others in the day care centre.**
>
> Finally, in a general way, the implementation of basic hygienic measures is a crucial element of protection ... because it reduces the already low risk of transmission of the virus. ... **Training programs for day care staff should be implemented.** [Emphasis in the original.]

These recommendations arose from work carried out by the provincial committee on infectious diseases in day care centres, which concluded that "given the low prevalence of the infection [HIV], the low risk of blood being exposed, and current knowledge ... the risk of HIV transmission in day care centres is almost nil."[6]

The principles of a day care policy proposed by the committee with regard to blood-transmissible diseases are similar to the recommendations of the public health directorate:[7]

> It is not appropriate to exclude or to refuse registration to day care solely by reason of HBV or HIV infection.
>
> Parents are encouraged to inform a resource person of their choice at the day care centre of their child's infection. However, there is no obligation to divulge this information.
>
> The implementation of universal precautions.
>
> Vaccination against hepatitis B.

Is the Exclusion of Seropositive Children Discriminatory?

The Commission cites, and explains that "[p]ursuant to section 10 of the *Charter of Human Rights and Freedoms*, it is a violation of the right to equality to make an exclusion based on a handicap, an exclusion that would have the effect of destroying or compromising the right to the recognition and the exercise, in full equality, of a human right or freedom. For the exclusion of seropositive children from child day care to be considered discriminatory, it must be demonstrated that such care is contemplated in section 12 of the Charter[8] and that the exclusion is based on a handicap.

According to the Commission, "it is clear that the fact of being a carrier of HIV constitutes a handicap.[9] This opinion has been confirmed by the courts."[10]"

As to whether day care is a service ordinarily offered to the public, s 2 of the *Act respecting child day care*[11] entitles children (the right is exercised by the persons having parental authority) to receive day care." The same section "also provides that a child may be refused without other reason. However, such a refusal may not be based on a ground of discrimination listed in s 10 of the Charter. ... A day care centre may not refuse access to its services unless there is a real and serious risk of transmission."

The Commission thus concludes "that in the presence of a risk of HIV transmission in day care centres that is almost nil, meaning an absence of real and serious risk of transmission, the exclusion of a seropositive child based solely on this reason would constitute discrimination based on the child's handicap."

Confidentiality of Information Concerning Seropositivity

"[T]here is no obligation [for parents] to reveal that a child attending a day care centre is HIV-infected. ... The Charter recognizes that every person has a right to respect for his private life (s 5) and to non-disclosure of confidential information (s 9)."

Where the parents choose to indicate the seropositivity of their child on the registration card, the day care centre must maintain the confidentiality of this information pursuant to s 22 of the *Act respecting child day care*: "The information referred to ... is confidential and no person may give or receive a written or verbal communication of it or otherwise have access to it ... except with the express authorization of the person having parental authority over the child concerned, or upon the order of a tribunal." Day care staff must also keep confidential the fact that a child takes medications generally associated with HIV.

Conclusion

According to the Commission, "[e]ven if judicial remedies exist, it is firstly through information that such crisis situations can be avoided or at least mitigated."

It states that the parents of children who attend day care establishments should be informed that a day care centre may not refuse its services to a child living with HIV: "It is up to the treating physician, together with public health authorities, to assess the presence of risk to the other children of a day care centre, based on the state of health or the behaviour of a child who has a blood-transmissible disease."

The recommendations of the public health directorate of the Montréal-Centre health and social services regional board[12] therefore remain highly appropriate, in particular those concerning:

> respect for the right of children infected with HBV or HIV to receive quality day care and to be admitted without discrimination;
>
> informing parents of the day care centre's policy and of the considerations that led to its being adopted;
>
> the understanding that policies and recommendations do not in themselves forecast possible situations of crisis or panic; and
>
> the advance provision of internal mechanisms, in particular the designation of a resource person capable of reassuring parents.

In order to help educators and parents to welcome into day care children living with HIV, and to promote the development of policies that serve the best interests of all children who use these services, the Canadian Child Care Federation (CCCF) has developed a bilingual HIV/AIDS training kit in partnership with Health Canada. The "HIV/AIDS and Child Care" kit[13] includes a fact book, a facilitator's guide, a poster on universal precautions, and a parent resource sheet. It provides facts on HIV/AIDS and child care and suggests specific strategies for dealing with the questions and emotions to which it can give rise. A product of consultations with many specialists, this material comes with references to other resources and suggests concrete ways of facing the situation in the child care environment and of curbing discrimination there.

- *Jean Dussault*

The training kit can be obtained by contacting the CCCF. Tel: (613) 729-5289; fax: (613) 729-3159.

Top of this page

Return to Table of Contents

Return to Home Page

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[1] D Carpentier. The Right to Health Care for Children Living with HIV/AIDS. Text adopted at the 329th meeting of the Québec Human Rights Commission. Resolution COM-392-6.1.2. The

Commission, 19 May 1995. Unattributed quotes in this article are taken from this text, and have been translated into English, as have other texts for which English versions are not available.

[2] D Lambert. Notice Concerning Child Day Care: Human Immunodeficiency Virus (HIV) or the AIDS Virus and Day Care. The Bureau: March 1994.

[3] See K Beaugé. Daycare Centres: Another Area of Concern. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(2): 5. The article discusses the case of "Baby J", who was expelled from Les Petits Lutins daycare centre in Montréal.

[4] Public Health Notice. The transmission of the human immunodeficiency virus (HIV) in the context of child day care. Public health directorate, Montréal-Centre health and social services regional board, February 1994, at 1.

[5] Ibid at 2-3.

[6] Public health notice on the control of blood-transmissible diseases in the context of child day care. Department of health and social services, public health directorate, in collaboration with the provincial committee on infectious diseases in day care centres. 1994, at 36.

[7] Ibid at 51.

[8] Charter of Human Rights and Freedoms, section 12: "No one may, through discrimination, refuse to make a judicial act concerning goods and services ordinarily offered to the public."

[9] Human Rights Commission. AIDS and Respect for Human Rights and Freedoms. The Commission: 1988.

[10] Human Rights Commission v Dr G.G., unreported, CQ (QHRT), 200-53-000002-944, 11 April 1995, Michèle Rivet J; Hamel v Malaxos, [1994] RJQ 173 (CQ). See also Jerome v DeMarco (1992), 16 CHRR D/402 (Ontario Board of Inquiry), which recognized that both the fact of having AIDS and of being seropositive constitute a handicap.

[11] RSQ c S-4.1.

[12] Supra, note 6 at 56-60.

[13] B Kaiser & JS Rasminsky. HIV/AIDS and Child Care. Ottawa: The Federation, 1995.

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Discrimination in the Military

US: HIV-Positive Servicemembers to Be Discharged

In the US, conservative Republicans in the House of Representatives succeeded in adding to the defense budget bill a requirement that all HIV-positive servicemembers be discharged.[1]

At the end of 1994, there were more than 1200 HIV-positive personnel in the US military. While new recruits who tested positive were denied entry, serving personnel were allowed to remain on duty as long as they were physically able, although they were put on limited assignment and could not be sent overseas.

In December 1995, President Clinton vetoed the bill requiring discharge of HIV-positive personnel, citing this provision among many with which he disagreed. However, in the ensuing negotiations over a revised bill, the Republicans stood firm on this provision, and the bill passed Congress again with the discharge requirement intact. Late in January 1996, the White House outraged AIDS activists by announcing that the President would reluctantly sign the bill because to veto it would further delay an overdue pay raise for military personnel. Republicans claimed the bill was necessary because HIV-positive servicemembers are not available for overseas assignment. The Pentagon disputed this, noting that it has a significant training investment in these members and plenty of work for them to do, but recommended signing the bill in order to get the pay raise and fund various other projects that have been on hold.

Editorial response in the US media was almost uniformly condemnatory of this provision, pointing out that there are thousands of military members with other illnesses and debilitating conditions who are allowed to remain in the service until they become too disabled to work. Illustrating the point, the Washington Post published an article on 1 February 1996 highlighting the plight of a widowed female staff sergeant who contracted HIV from her late husband, has been in the Army for ten years with an excellent record, has children to support, and will be mandatorily discharged under this provision.

At the time of writing, there were reports that a bipartisan group in the Senate was attempting to secure the introduction of a narrowly focused bill to repeal the discharge provision before anyone would have been dismissed.

Australia: Defence Force's Policy Held Discriminatory

In Australia, the Human Rights and Equal Opportunity Commission ruled in June 1995 that the Australian Defence Force's (ADF) HIV policy, which contained a requirement similar to that just introduced in the US, is in breach of antidiscrimination legislation.[2]

According to ADF policy, all recruits are tested for HIV on entry to the ADF, and any recruits who test positive are discharged. Existing defence personnel are tested from time to time in various circumstances prescribed by the policy. Personnel who test positive are discharged as soon as their health deteriorates; if they are in good health, their employability is assessed by a medical board on a case-by-case basis. As of 30 December 1994, the ADF had carried out 147,673 tests. Forty-six people had tested positive, 3 new entrants and 43 serving personnel. All but 11 had been discharged from service.

The Australian defence minister reacted with hostility to the Commission's decision, saying that overweight, under-height, hepatitis B- and C-positive people and others are banned from the ADF, and that HIV-positive people should also be excluded. In contrast, the president of the Australian Federation of AIDS Organizations welcomed the decision as an important victory for people with HIV and for all people with disabilities: "The Defence Force, like other employers, has to comply with the law. People with HIV are quite capable of serving their country, and should not be prevented from doing so."

Europe and Canada: Other Approaches

As reported in the Australian *HIV/AIDS Legal Link*, several European countries have progressive HIV policies for their military forces: in Germany, the Netherlands, and France, for example, HIV tests are not compulsory for new recruits, and HIV-positive status is not a reason for exclusion from the military forces. In France, however, soldiers wishing to serve abroad must be HIV-negative, and soldiers returning from Africa and French Guiana are subjected to compulsory HIV testing. The Canadian situation has been discussed in a previous issue of the *Newsletter*.[3]

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] Reported in Lesbian/Gay Law Notes February 1996, at 29.

[2] Human Rights and Equal Opportunity Commission, No H94/98, Decision dated 29 June 1995. See also M Alexander. Offensive Defence: Military HIV Policy under Scrutiny. Australian HIV/AIDS Legal Link 1995; 6(3): 7-8. Most of the following text is taken from his article and case summary.

[3] R Ellis and P Engelmann. HIV/AIDS and the Military in Canada. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(3): 1, 14-15.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

BLOOD AND BLOOD PRODUCTSUpdate on the Krever CommissionThe last date of the scheduled hearings of the Commission of Inquiry on the Blood System in Canada (the "Krever Commission") was 21 December 1995. When the hearings broke at the end of that day, it was the expectation of many of the parties with standing before the Commissioner that the proceedings of the Commission would likely wind up by the end of February and that the Commissioner's final report would be released in September 1996.This expectation has been dramatically altered by the judicial review proceedings commenced in the Federal Court (Trial Division) on 19 January 1996 by a number of the institutional parties with standing before the Commissioner. At the heart of the applications for judicial review by the some 86 applicants are allegations that the Commissioner is without the jurisdiction to make findings of "misconduct" against them and that the proceedings of the Krever Commission failed to afford them procedural protections to which they were entitled. There is little doubt that the time now required to respond to these court proceedings will delay the preparation and delivery of both final submissions to the Commissioner by those parties with standing before him at the Inquiry and the Commissioner's final report. In addition, of course, the shape and content of the final report may be affected by the outcome of the court proceedings.All parties with standing before the Commissioner at the Inquiry appeared before Mr Justice Richard of the Federal Court (Trial Division) on 2 February 1996 to argue whether the so-called "consumer groups" accorded standing at the Inquiry should also have standing in the Federal Court proceedings. None of the applicants had named the consumer groups as respondents in their respective applications for judicial review, and all opposed the consumer groups' motion for standing to the Federal Court as either respondents or intervenors. Despite the applicants' opposition, the consumer groups were wholly successful in their efforts and were granted the status of intervenors with full rights of participation throughout the Federal Court proceedings, including the right to appeal the final decision of the Court (independent of the respondent Commissioner's intentions with respect to an appeal).At the end of the day, the following parties had been accorded intervenor status by Mr Justice Richard: the Canadian Hemophilia Society, the Canadian AIDS Society, the HIV-T Group (Blood Transfused), Janet Connors (Infected Spouses and Children), Canadian Hemophiliacs Infected with HIV, Committee for HIV-Affected and Transmitted, Association of Hemophilia Clinic Directors of Canada, Hepatitis C Survivors Society, Gignac Sutts Group, Guy-Henri Godin and Jean-Daniel Couture, the Hepatitis C Group, and the Toronto and Central Ontario Regional Hemophilia Society.In addition to granting intervenor status to these groups, Mr Justice Richard also established a timetable for the conduct of the Federal Court Proceedings prior to argument of the merits of the applications for judicial review. The hearing on the merits of the applications will begin on 22 May 1996 in Toronto. - Lori Stoltz

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Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

CIVIL LIABILITY

Supreme Court Orders New Trial in Artificial Insemination Case

Ms ter Neuzen participated in an artificial insemination (AI) program from 1981 until January 1985, and became infected by HIV as a result of the final AI procedure she underwent. In 1991, the British Columbia Supreme Court held the obstetrician and gynaecologist who had performed the AI procedures negligent, and awarded her damages totalling $883,800.[1] On appeal, the British Columbia Court of Appeal set aside the verdict and ordered a new trial.[2] On 19 October 1995, the Supreme Court of Canada confirmed that the BC Supreme Court's verdict could not stand and dismissed ter Neuzen's appeal against the Court of Appeal's decision.[3]

At the time of the AI procedures, the respondent obstetrician and gynaecologist, Dr Korn, had not warned ter Neuzen of the risk of HIV infection. Although Korn knew that HIV could be transmitted by heterosexual sex, he became aware only in July 1985 that HIV could be transmitted by AI:

> it was not before then that the first documented case of HIV transmission through AI was published in the lay media (it took even longer - until September 1985 - before it was published in a medical journal);
>
> none of the obstetric literature mentioned AI as a mode of transmission of HIV and no article summarized the disease risks of AI before 1986; and
>
> as of January 1985, there was no test available for the detection of HIV in semen or blood in Canada.

There was expert evidence at trial that the respondent's AI practice was in keeping with general practices across Canada. Specifically, his practice of recruitment and screening of donors and semen accorded with standard practice. However, the trial judge instructed the jury that it was open to find the respondent negligent on the basis that he failed to comply with the standard medical practice at that time; and alternatively, that they could find that the approved practice itself was negligent. The jury found the respondent negligent and awarded damages, but the Court of Appeal set aside the verdict and ordered a new trial on the issue of liability as well as damages. With respect to the negligence claim, the court distinguished between two aspects of the respondent's practice:

> the conduct of the AI procedure, which reflected the current state of knowledge as to the risk of transmission of HIV involved in the use of that procedure; and
>
> the screening and follow-up of donors.

The Court of Appeal concluded that it was impossible to determine whether the jury found the respondent negligent on the first or second aspects of his practice. It held that, on the evidence, it was not available to the jury to find that the respondent ought to have known of the risk of HIV by AI. However, the trial judge charged the jury in this manner, and it may have been the basis upon which the jury found negligence. Therefore, according to the Court of Appeal, the verdict could not stand. The Court further concluded that the damages award must be corrected to conform with the jurisprudence because the damages awarded exceeded the upper limit for non-pecuniary damages.

The Supreme Court confirmed that "[i]t was not possible for a jury acting judicially to have found that, in 1985, the respondent ought to have known of the risk of HIV by AI." However, Sopinka J, in writing the Court's unanimous decision, conceded that it would have been legally open to the jurors to conclude that the accepted standards for AI or screening donors were negligent: "While conformity with common practice will generally exonerate physicians of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be where the standard practice is fraught with obvious risks such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise." According to Sopinka J, there was no way of knowing which route the jurors chose to arrive at their decision, necessitating a retrial. If a retrial takes place, it would centre on whether the accepted standard for screening sperm donors and following-up on the AI procedure was itself deficient.

With respect to the $883,800 damages award, the Supreme Court held that, "[w]hile the appellant has suffered immensely as a result of this tragedy, and AIDS is a dreadful disease which will eventually take her life prematurely, with respect to non-pecuniary losses this case is no different from other tragedies." Therefore, according to the Court, the adjusted rough upper limit on non-pecuniary damages should apply (currently this limit is set at about $240,000) and the trial judge should have reassessed the jury's award.

For more detail, consult the original French version of this article written by Norman Halde.

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] Ter Neuzen v Korn, (1992) 3 WWR 469, 64 BCLR (2d) 125, (1991) BCJ No 3849, British Columbia Supreme Court, Hutchinson J, 23 December 1991.

[2] (1993), 81 BCLR (2d) 39, 103 DLR (4th) 473, [1993] 6 WWR 647, 29 BCAC 1, 48 WAC 1, 16 CCLT (2d) 65.

[3] File No 23773, 19 October 1995.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Canada - HIV-Specific Criminal Offence Opposed

As reported in the last issue of the Newsletter, 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, and died on 2 February 1996, when the government announced the prorogation of the session of Parliament. However, the bill may be reintroduced in the new session of Parliament, which began on 26 February.

We reprint, in slightly edited form, a brief on Bill C-354 prepared by Derek Scott from the East York Health Unit, for a recent meeting of the Ontario medical officers of health:

This bill, if adopted, would come close to criminalizing HIV-positive status. It would make criminal virtually all sexual activity by HIV-positive persons. A Criminal Code amendment was considered by Justice Minister Rock in January 1995, in order to respond to public concerns about wilful transmission of HIV. However, the government has so far not introduced any legislation in the area. The issue seems to be dormant at the highest levels of the justice system.

Case law is still accumulating on these issues. Attempted murder charges have usually been dropped, but reckless endangerment and assault causing bodily harm convictions have been returned and sentences handed out. There is concern among some members of the public that the law offers little protection from wilful transmission of HIV.

There is virtual unanimity in the HIV/AIDS community and amongst professional organizations that the proper way to stem the tide of the HIV pandemic is not through criminalization. There is ample theoretical reasoning, and some empirical evidence to suggest that criminal sanctions will likely deter those who may be HIV-positive from seeking appropriate testing and counselling regarding safe sex practices. Furthermore, it would lead to marginalization and stigmatization of those individuals living with HIV/AIDS, thus impacting negatively on the individual's health. The law would undermine the ongoing work of public health and AIDS-service organizations to create a culture of trust and focus on counselling and education as the main initiatives to control the pandemic. Most authorities believe that rare examples of extreme behaviour can be appropriately managed under existing provincial public health laws that, as they currently stand in Ontario, give broad scope for action. Criminalizing the sexual acts, though symbolic, may have questionable deterrent value or even give the false impression that the law is able to afford protection from HIV.

Consequently, the bill should be vigorously opposed by all public health practitioners and HIV/AIDS organizations. The CPHA [Canadian Public Health Association] is considering a resolution at its July 1996 meeting. Other groups, such as ACT [the AIDS Committee of Toronto] have published policy statements outlining their opposition to any legislation that would criminalize HIV status.

- *Derek Scott*

Top of this page

Return to Table of Contents

Return to Home Page

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

CRIMINAL JUSTICE

US - Court Rules on Sexual Assault by HIV-Positive Person

On 26 December 1995, the Minnesota Court of Appeals affirmed a trial judge's decision to sentence an HIV-positive defendant to 30 years in prison, which the Court described as a "greater-than-triple durational departure from the sentencing guidelines."[1]

The case involves a vicious sexual assault of the female victim, accompanied by death threats and violence that, under the guidelines, would have justified a sentence of 105 to 115 months.

The defendant, who was charged with a plethora of serious crimes arising out of the incident, pleaded guilty to one count of first-degree sexual assault. The state's guidelines authorize an upward departure where the victim is treated with particular cruelty.

The sentencing court found particular cruelty because Perkins was infected with HIV, threatened A.L. with death, choked her to the point of unconsciousness, suffocated her with a pillow, and threatened to kill her children. The Court said: "I cannot fathom on the face of this earth a more devastating offense to a victim than being sexually assaulted by a person with AIDS. The victim of this offense will not know for several months whether or not she contracted the HIV virus. If she does become HIV-positive, it's a death sentence. It is clear from the record that Perkins knew he had AIDS when he committed the offense." Commenting that such an extreme departure upward is justified "only in extremely rare cases where the aggravating circumstances are severe," the Court of Appeals found that this was such a case, asserting that "the fact that Perkins had AIDS is a severe factor that, coupled with the gratuitous acts of cruelty, warrant the greater-than-triple departure" [from sentencing guidelines].

A similar case was decided on 15 September 1995 by the Ontario Court of Justice (Provincial Division). In that case, an HIV-positive man who had committed an aggravated sexual assault was sentenced to 12 years in prison.[2]

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] Perkins v State, 1995 WL 756698. Reported in Gay/Lesbian Law Notes January 1995, at 11.

[2] R v Winn (1995), 25 OR (3d) 750 (Prov Div). For more details, see HIV-Positive Rapist Sentenced to 12 Years. Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(2): 8.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

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

In vol 2, nos 1 and 2 of the Newsletter, we reviewed 11 cases involving charges of "common nuisance," "criminal negligence," "aggravated assault," "attempted murder," and "anal intercourse." Two more cases involving charges of "aggravated assault" are reviewed in this issue.

R v Cuerrier[1]

In August 1992, the accused received news from a BC health unit that he had tested HIV-antibody positive, and was informed about the implications of this result, including the need to use condoms for sexual activity. He indicated he was aware of the ways in which HIV could be transmitted, but stated to the public health nurse that he could not disclose his status in the small community he was living in, and refused her offer to notify his sexual partners without revealing his name.

About three weeks after receiving his results, the accused began a relationship with KM, during which they frequently engaged in unprotected vaginal sex. At the beginning of this relationship, in response to KM's questions, the accused indicated he had had a number of recent sexual encounters with women who had themselves had many sexual partners. The complainant did not specifically ask about HIV, but the accused told her he had tested negative eight or nine months earlier; he did not tell her that he had tested positive within the past month.

In January 1993, the accused and the complainant KM both attended an STD clinic and were tested. The accused was asked if he had been tested previously; he responded that he had not. The complainant tested negative. The accused was informed that his test had returned positive and advised of the risk of transmission to KM and the importance of using condoms. The complainant KM was then called in and informed of the accused's test results. The accused again said he did not wish to use condoms.

The accused and the complainant KM continued their relationship for another 15 months, and continued to have occasional unprotected sex. The complainant testified that she loved the accused, and that by that point, she felt that it was likely she would soon test positive for HIV, given the unprotected sex they had already had.

In May 1994, the same public health nurse spoke by phone with the accused to reiterate that it would be "preferable" for him to disclose his status to sexual partners and to use condoms. According to the nurse, the accused stated he clearly understood the importance of practising safer sex, and "the legal implications of not complying and wilfully putting another individual at risk for HIV infection." This conversation was followed up with a hand-delivered letter in June 1994. At the same time, the nurse delivered an order from the Medical Health Officer that the accused inform his sexual partners of his HIV status, use condoms, and meet quarterly with the public health nurse to confirm compliance with the order.

The second complainant began a relationship with the accused in June 1994, but ended it soon thereafter once she discovered he was HIV-positive.

The accused was indicted in November 1994 and charged with two counts of aggravated assault. As of trial, both complainants had tested HIV-negative. At the end of the Crown's case, as in *Ssenyonga*,[2] the defence made a motion for a directed verdict of acquittal, on the ground that the Crown had not made out the offence of assault because the complainants had consented to the unprotected sex.

Drost J cited the decision of the Supreme Court of Canada in *Thornton*[3] in concluding that the accused's acts of engaging in unprotected sex "endangered the lives" of the complainants and therefore could constitute aggravated assault. However, he noted that the facts and arguments of this case were virtually identical to those in *Ssenyonga*, and adopted the reasoning of McDermid J in that case in directing an acquittal on both counts.

The Crown's appeal of the acquittal will be heard in June 1996 by the BC Court of Appeal. The appeal raises the important issue of whether an HIV-positive person who does not disclose his/her serostatus to prospective sexual partners may be liable to criminal prosecution. On the day set for the hearing of the appeal, 18 January 1996, the Court indicated that in light of the important policy issues raised by the case, interested groups (including the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society) may wish to apply for intervener status. Accordingly the appeal was adjourned to 18 and 19 June 1996.

R v Tan[4]

In 1995, the accused was charged with, among other offences, aggravated assault for allegedly injecting the complainant with HIV-infected blood on two separate occasions. She pleaded not guilty to the charges in March 1995, and was acquitted in May 1995.

- *Richard Elliott*

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] Court File No. CC941279, unreported decision of 5 January 1995, Supreme Court of British Columbia (Vancouver), Drost J.

[2] [1991] OJ No 544 (Gen Div) (QL) (application for restraining order under HPPA); [1991] OJ No 1460 (Gen Div) (QL) (bail review hearing); (1992), 73 CCC (3d) 216 (Ont Ct Prov Div) (preliminary inquiry dismissing common nuisance and noxious thing charges); (1993), 81 CCC (3d) 257 (Ont Ct Gen Div) (directed verdict dismissing assault charges); [1993] OJ No 3273 (Gen Div) (QL) (decision not to deliver judgment).

[3] [1989] OJ No 1814 (Dist Ct) (QL); aff'd (1991), 3 CR (4th) 381, 1 OR (3d) 480 (CA); aff'd [1993] 2 SCR 445, 82 CCC (3d) 530, 21 CR (4th) 215 (SCC).

[4] (23 May 1995), Alberta Court of Queen's Bench, Edmonton, unreported, Ritter J.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

PRISONERS AND HIV/AIDS

Outbreak of HIV in a Scottish Prison: Why Did It Happen?

In 1993, the first documented outbreak of HIV infection among incarcerated drug injectors was reported among male inmates in Glenochil prison in Scotland.[1] Following the outbreak, 12 HIV-positive inmates and 10 other drug injectors were each interviewed at length about their risk behaviours in prison.

Quantitative data about drug-use patterns and needle and syringe sharing were collected at the time of the outbreak. The aim of the in-depth interviews, which were conducted in private and tape-recorded, was to augment this information with a more detailed report of the nature and dynamics of risk-taking within the prison's drug-injecting culture. Such an account could perhaps provide a greater understanding of how the outbreak occurred and of how a similar incident could be avoided in the future.

The Outbreak

Full details of the outbreak have been published elsewhere.[2] Briefly, following the diagnosis of two apparently recent seroconversions to HIV infection among prisoners, a public health initiative was launched in which prisoners were offered confidential counselling and testing for HIV.

Of 227 prisoners who came forward for counselling, 33 (14.5 percent) declared that they had injected in Glenochil prison. Twenty-seven of these "Glenochil injectors" were tested and 12 were found to be HIV-positive. A further two Glenochil injectors had been diagnosed HIV-positive two months previously, giving a total of 14 HIV-positive drug injectors. Of the remaining 137 inmates who were tested for HIV but had not injected in Glenochil, none were found to be HIV-positive. There was also evidence to prove that at least eight of those infected definitely contracted the infection in the prison within the first half of 1993 and the others probably became infected at that time.

Injecting, Sharing and Cleaning

At the counselling session, prisoners were asked about their injecting and needle-sharing practices both inside and outside prison:

> Seven of the injectors had begun their injecting careers in Glenochil. For the rest, frequency of injecting was found to be lower in prison compared with outside. Outside, injecting tended to be on a daily basis, compared with an average of weekly or monthly while in Glenochil.
>
> However, although frequency of injecting was greatly reduced in prison, the opposite applied with regard to sharing injecting equipment; only two prisoners always injected with used equipment outside prison in the six months prior to sentence, as opposed to at least 20 who did so inside. All Glenochil injectors had shared there at least sometimes.
>
> Almost all claimed always to clean their equipment prior to use. However, the methods they used were mostly ineffective, the majority usually rinsing with hot or cold water. One of the prisoners who definitely contracted HIV in Glenochil claimed always to clean needles and syringes with bleach prior to injecting.

In-Depth Interviews

Once this basic information about injecting, sharing and cleaning practices had been collected and analyzed, and in order to obtain as full as possible an account of risk-taking within the prison, in-depth interviews were undertaken with 22 inmates, including all but one of those diagnosed as HIV-positive. Two months after the counselling sessions, a private room was set aside within the prison, and prisoners were interviewed individually. Interviews lasted on average about one-and-a-half hours and were tape-recorded. The interviews were unstructured. They aimed at elucidating details of sharing networks, the availability and condition of injecting equipment and the procedures used to clean it.

From the interviews emerged a vivid description of random sharing with a limited number of needles and syringes, which were mostly blunt, broken, or fashioned out of a variety of materials. What follow are verbatim accounts from the prisoners themselves.

Descriptions of Sharing Networks and Needle and Syringe Availability

"You wouldn't believe it. It was like something out of the Bronx. The cells were packed with junkies waiting on a hit."

"There was only one set of syringes in the hall and there was estimated to be about fifteen or twenty users."

"I've seen, in my cell, seven or eight people waiting to use one set of tools at one time."

While most claimed always to clean used equipment, circumstances in prison mitigate against this being carried out effectively, even if sterilizing equipment is made available. Injecting in prison, as in the community, is an illicit activity. Within the prison setting, recreation time is limited, and few sets of needles and syringes are available. Because prisoners can be accosted at any moment by prison officers, injecting and cleaning is a hurried affair:

> "When you're cleaning it [injecting equipment] there are usually a few waiting for it. I've seen boys just jumping up and giving it a couple of flushes with cold water and then on to the next boy. A few times I've noticed a few wee clots of blood still down at the bottom of it."

Even if bleach is available, and was made available in Glenochil after the outbreak in the form of tablets, it may remain either unused or ineffectively used:

> "They wouldn't use bleach. If you are sitting in a cell and hurrying before lock up, you just give them a quick flush out, have your hit and on to the next one."

Effectiveness of Bleach as a Decontaminant

The effectiveness of bleach as a decontaminant for injecting equipment has been questioned on both biological and behavioral grounds.[3] Drug injectors have been shown to underestimate the time required for sterilizing purposes. The chance of effective decontamination is likely to be decreased even further when the equipment used is as follows:

"There was one time I was using this green spike and it was actually bending because it was so blunt. I had to get someone to force it in."

"My arms are in some mess, big bruises and big massive holes. The spikes were sharpened on wee bits of sandpaper."

"We were all cleaning them out but I reckon we were catching it off the needle with it being corroded on the inside and maybe blood was clinging to it. Or the plunger - we had to get a plastic bag and stretch it over and get a bit of thread and tie it round. But the plastic bag would split when it was stretched over and I reckon the virus was in that because I've seen - it wasn't exactly fungus, but it was getting that way."

Shooting galleries and random sharing have been shown to be high- risk factors in the transmission of HIV.[4] That there was a shooting gallery in Glenochil is undoubtedly the case.

Harm-Reduction Strategies

In many countries harm-reduction strategies such as needle and syringe exchanges and methadone maintenance have been implemented to reduce such risk behaviours. In most cases, prisons are excluded from these programs, although evidence of the success of these preventive efforts is growing,[5] and can be seen in Glasgow, the city of residence of 13 of the 14 HIV-infected inmates. Glasgow began a program of needle and syringe exchange schemes in 1987. This program has continued to grow and is now complemented by a methadone prescribing service. Evidence of a reduction in risk behaviours among the city's drug injectors has been reported and HIV prevalence among this group has remained low and stable at around one percent.[6]

In Scottish prisons, bleach tablets are now available and detoxification programs have been implemented in some establishments, including Glenochil. But the two principal and highly successful means of HIV prevention - needle and syringe exchange schemes and methadone maintenance - are not available. If HIV transmission is to be most effectively prevented, however, harm-reduction methods that are implemented in the community should also be implemented in prisons. The World Health Organization guidelines recommend this course of action, unless it jeopardizes prison security.[7]

Prison staff are understandably concerned about the possible security risks surrounding the wider availability of needles and syringes within the prison environment. Even with the apparent success of the pilot needle and syringe exchange schemes in Swiss prisons,[8] there will still be resistance to such a solution at both political and cultural levels in many other countries. Nevertheless, if another outbreak of the type reported from Glenochil is to be avoided, the same efforts that have gone into preventing HIV transmission among drug injectors outside prisons must be given to the prevention of spread inside. The illegality of drug taking and the lifestyle of crime that many injectors adopt to support their drug use means that drug injectors spend large parts of their life in prison. For some injectors, prison provides the opportunity to cease drug use, at least for the duration of their sentence. This in turn means that some come out of prison healthier than when they went in. On the other hand, for those who continue, prisons continue to be an extremely high- risk environment:

"Are we still sharing? It's still going on. It'll always go on because we've not got works, no spikes, not like outside."

- *Avril Taylor and David Goldberg*

Top of this page

Return to Table of Contents

Return to Home Page

---

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Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Australia: Needle Exchange in Prisons

A recent study by the Australian National Drug and Alcohol Research Centre (NDARC) found that needle and syringe exchange is feasible in Australian prisons.[1] As a result, the Australian Federation of AIDS Organizations (AFAO) is calling for pilot programs of needle and syringe exchange in prisons across Australia.[2]

Introduction of syringe exchange programs in Australian prisons had previously been recommended by the Community Policy on Prisons and Blood Borne Communicable Diseases.[3] Both the Australian Minister of Health, Dr Carmen Lawrence, and the then President of the Australian Medical Association, Dr Brendan Nelson, had also urged that "serious consideration be given" to introducing syringe exchanges in prisons.

The study was conducted to consider the issues raised by syringe exchange programs in prison and to assess their possible benefits, adverse consequences and the feasibility of implementing them. This was done by documenting - in facilitated discussion groups - issues raised by key stakeholders in the New South Wales (NSW) prison system.

The researchers asked groups comprising correctional officers, prison health-care staff, ex-inmates, community agencies and politicians to provide information on likely safety issues associated with an exchange program. The groups

> emphasized the necessity for effective, broad-range treatment and harm minimization programs in prisons for injection drug users;
>
> questioned the implementation and effectiveness of existing HIV prevention programs; and
>
> addressed the likely impact on the wider community.

Based on the discussions undertaken, the researchers concluded that syringe exchanges in prisons are feasible, but only under limitations. In particular, they pointed out that the cooperation of prison staff would have to be secured before implementation of a syringe exchange program could be considered. Among other things, they recommended that a working committee with representation from health-care and correctional officers discuss syringe exchanges in prisons to identify an option that does not represent any risk to staff and is acceptable to correctional officers.

The researchers found that the conditions needed before considering a syringe exchange pilot were:

> establishment of a specialist drug treatment wing;
>
> voluntary custodial and health staff;
>
> special training for custodial and health staff;
>
> policy of strict one-for-one distribution of needles and syringes;
>
> selection of distribution option by a joint committee of custodial and health staff and inmates from the following: (1) vending machine; (2) nursing staff; (3) outside agency; (4) injection room;
>
> the pilot should be assessed by measurements such as increase/decrease in risk of infections to staff or inmates or visitors from assault, from occupational or accidental injury.

The researchers further recommended that

> bleach be made available to all prisoners;
>
> all inmates be assessed and offered methadone maintenance treatment if suitable;
>
> peer educators be trained;
>
> a pilot syringe exchange program be rigorously evaluated; and
>
> for evaluation purposes, participants be tested for hepatitis B and C and HIV every six months.

AFAO welcomed the study's overall findings, but emphasized that it did not agree with all its findings, in particular those related to compulsory testing of prisoners. Acting National AFAO President Mike Kennedy used the release of the report to call for trials of syringe exchange programs in prisons across

Australia, and expressed support for the report's recommendations that condoms, methadone, and bleach should also be made available.

Top of this page

Return to Table of Contents

Return to Home Page

---

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Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

Spiritual Care: A Model for Inmates Living with HIV

The following is a condensed version of a presentation given by the Reverend Bell, a chaplain with the Correctional Service of Canada who visits men and women living with HIV in federal prisons, at the British Columbia HIV/AIDS Conference in November 1995.

This article continues our extensive coverage of issues raised by HIV/AIDS in prisons. To obtain a complete text of Reverend Bell's presentation, please write to the Editor for a copy.

For the past year-and-a-half, I have been working as chaplain in an HIV clinic and with HIV-positive inmates. In preparing for this presentation, I asked my clients to write about how they have experienced my work with them, and about what needed to be addressed and developed in a model of spiritual care with inmates living with HIV. Four significant areas emerged: support, meaning, hope, and faith.

Support

Inmates stressed that support, in a number of forms, was one of the most important provisions of a spiritual model. In this setting, support includes education, and it is crucial that the spiritual caregiver be knowledgeable about - and comfortable with - discussing HIV/AIDS.

In most of my sessions, the people I work with often want to know more about HIV/AIDS, hepatitis and tuberculosis. I help them to answer questions and better understand any information they have. My role as liaison between the other clinic staff and the patient allows me to gain access to more information: I have often returned to the clinic from a prison visit to share a patient's particulars with the doctors and social workers, and this has enabled us, as a team, to provide that person with better care. Further, because I work at the hospital, my relationship with the staff allows me to better help inmates adjust to being hospitalized.

Being a nonjudgmental listener is another kind of support. Several inmates said that the simple act of telling their story was a great relief. All the inmates who offered their insights said that they had few, if any, people to speak with in prison about AIDS: either it was not safe to talk or they felt that others would not understand. The stigma and ignorance surrounding AIDS is often even greater in prison than on the street - most inmates do not feel safe having their diagnosis known, and confidentiality is a major concern.

Finally, those who work in prison settings know that respect - highly valued by inmates - is a crucial form of support. My relationship with clients depends on both earning their respect and showing my respect for them.

Meaning

In the course of pastoral care, I help people to discover what has upmost meaning in their lives. Understanding how illness affects that meaning, and being able to express what this feels like, is the next step.

One inmate said that it was vital to be able to speak with someone unafraid of his feelings. He said that it was important that I helped him to examine where his feelings were coming from, to accept that it was all right to be feeling them, and to understand better what they meant.

Hope

Several inmates said that I help them to remain hopeful. I do this by always trying to explore where a client's hope lies: it may be in a negative result on an HIV test, in a cure, in having a good quality of life, in being pain-free, or in the hope for a life after this one.

Finding that place of hope can be crucial to spiritual care. One man I am working with has the understandable fear of dying while incarcerated - unfortunately, a strong possibility. Knowing that he puts great hope in the prospect of parole, I and the others in the clinic are able to ease his mind by helping him prepare for his parole hearing. We support his hope as best we can. We will also be there for him if parole is denied.

Faith

Even though I act as a spiritual caregiver, I am aware that few of the people I work with are religious. Not approaching inmates with a religious agenda is appreciated: clients tell me that, while they feel free to raise religious issues with me, they are confident that I am not imposing my views on them.

Facing death has a way of uncovering faith issues: the reality of mortality - especially heightened for people living with HIV in a prison setting - forces us to encounter what it is we believe. In the course of such struggle, I try to discern if a client has a faith, and if so, what it looks like. If their faith is helpful and gives them strength, then it is an asset and can be built on.

Conclusion

A model for spiritual care for inmates living with HIV and AIDS is one that helps tap the resources that these clients have within themselves. This can be accomplished when chaplains work with inmates to address the place of support, meaning, hope and faith in their lives.

- *Reverend D Bell*

Top of this page

Return to Table of Contents

Return to Home Page

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

TRAVEL AND IMMIGRATION

Australia: Allowing People with HIV Permanent Residence

Canada's immigration policy for persons living with HIV/AIDS was the subject of articles in previous issues of the Newsletter.[1] In this issue, we provide a summary of the situation in Australia, where until 1994 no persons living with HIV had been granted permanent residence. However, in 1994 pressure from community organizations led to the introduction of a new system for considering applications from persons living with HIV. Australia now has a system that allows persons living with HIV permanent residence, in certain circumstances.[2]

In 1989, the Australian government issued the first *National HIV/AIDS Strategy*, which contained the following statement:

> HIV testing will be required for applicants for permanent residence. This is not intended to have a significant impact on the spread of HIV infection, but HIV infection status, as with other medical conditions, is a factor to be considered when assessing applications on the ground that there are considerable potential costs to the Australian community. A positive result will not automatically exclude applicants from permanent residency; scope will be retained to approve applications where justified by compassionate or other circumstances.

However, between 1989 and 1993 no HIV-positive applicants were approved for residence, and a number of people were rejected solely on the basis of their HIV-positive status. It was only after a meeting of the Australian Federation of AIDS Organisations (AFAO) with the Australian Minister for Immigration and Ethnic Affairs that the policy guidelines on the assessment of HIV/AIDS were reviewed to ensure alignment with the government's policy as announced in 1989. Since early 1994, quite a number of persons living with HIV have been granted permanent residence.

HIV Testing

In contrast to Canada, in Australia all persons aged 15 years or over who apply for permanent residence, or for temporary residence of 12 months or more, are required to undergo an HIV test. Children under 15 are tested if they are adopted by an Australian resident and have a history of blood transfusions, or have clinical signs of illness. The HIV test is part of the medical examination undertaken by all applicants for permanent residence.

Health Requirements

As a matter of practice, a person who tests positive for antibodies to HIV will not meet the health requirements that apply to all classes of immigrants, except refugee applicants applying within Australia. However, the health requirements may be waived in certain circumstances. Waivers are limited in scope and are available only for those applying under the following classes:

> spouse, including de facto spouse, of Australian citizen or permanent resident;
>
> interdependency, which includes a gay or lesbian partner of an Australian citizen or permanent resident;
>
> child of Australian citizen or permanent resident; and
>
> refugee and humanitarian applications.

If an applicant in any of these classes does not meet the usual health requirements, the Department of Immigration and Ethnic Affairs (DIEA) has an obligation to consider the question of whether to waive the health requirements.

The main issue in the waiver process is whether the granting of a visa to a person living with HIV will likely result in undue cost to the community. In each case, the DIEA will obtain from the Department of Human Services and Health an estimate of the overall lifetime cost to public funds of treatment, care, social security, and housing. The figure currently used is in the region of Can$240,000, but may be less depending on the stage of disease progression.

In their decision-making process, DIEA officers are advised to take the following matters into account:

> the extent of social welfare, medical, hospital or other institutional care likely to be required in Australia;
>
> the educational and occupational needs of, and prospects for, the applicant in Australia;
>
> the availability of, and local demand for, the appropriate health, welfare, educational and employment services in the area of intended residence in Australia;

> the willingness and ability of a sponsor, other family member or other person or body to provide any special services and care at no public cost;
>
> the potential for deterioration in the applicant's state of health, taking into account not only the known medical factors but influences such as the strains of adjustment to a new environment, life-style, occupation, etc;
>
> the overall lifetime charge to Australian public funds.

The decision must weigh the estimated cost (a "negative factor") against the positive factors identified in the application. If the positive factors are stronger, the decision-maker may waive the health requirements and grant the visa.

Implementation of the Policy

According to AFAO, the policy appears to be working satisfactorily. The Federation is not aware of any applicant since early 1994 who has been refused permanent residence solely on the basis of having HIV. Applications have been approved in the following circumstances:

> husbands and wives of Australian citizens and permanent residents;
>
> gay partners of Australian citizens and permanent residents;
>
> children of Australian citizens and permanent residents; and
>
> refugees.

Applicants with HIV are considered in the same way as applicants with other disabilities, such as heart disease. However, there are still many people with HIV - otherwise qualified to migrate - who cannot possibly qualify for residence under the present law.

Further Progress

AFAO's preferred position is that HIV testing should be discontinued, and that HIV status should not be taken into account in determining applications for permanent or temporary residence. However, the Federation points out that further progress is difficult because it would require a substantial change to Australia's immigration system: it is difficult to justify an argument that different rules should apply to people with HIV/AIDS compared with those that apply to people with other disabilities and medical conditions.

The current *Australian Disability Discrimination Act* 1992 prohibits discrimination against people with disabilities in a wide range of areas, but contains a total exemption for immigration matters. This is a matter of considerable concern to the disability community generally. If this situation is to change, the AIDS community will need to join with other disability communities to argue for a fundamental rethinking of the way in which immigrants are selected and excluded.

Case Studies

Hans is a European national who is married to an Australian woman. He has had HIV for a number of years but is in good health. He works in a highly paid job, as does his wife. The couple want to live in Australia to be close to the wife's family.

Julio is an HIV-positive gay man from a developing country where there is a lot of discrimination against gays and people with HIV. He has been in a relationship with his Australian partner for eight years. He is in good health and has a good job.

Rose is a refugee from a developing country. She became infected with HIV in Australia after a sexual relationship with an Australian man, which subsequently broke up. She is not currently in a relationship, but is working full-time and studying part-time. There is evidence that there is a high level of prejudice against people with HIV in her home country.

All these applicants have been granted permanent residence.

Top of this page

Return to Table of Contents

Return to Home Page

---

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Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

HIV/AIDS and Children

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

AIDS-Affected Children

Children Living with HIV/AIDS

The World Health Organization estimates that, as of mid-1995, over 1.5 million children had been infected with HIV. By the year 2000, it is predicted that 5 to 10 million children will be infected.

Children Whose Parents Are Sick or Have Died

By the year 2000, it is estimated that 5 to 10 million children under the age of 10 will have lost their mother or both parents to AIDS. Ninety percent of these orphans will be in Africa, where the epidemic first struck. In parts of Africa, the number of households headed by children or grandparents is rising alarmingly.

Children at Increased Risk of HIV

These include: girls sought by men as sex partners on the belief that they are "safe"; street children who are vulnerable to sexual exploitation and who are often uneducated about risk behaviour; children who experience sexual abuse; and those who become sexually active at an early age.

Children in Communities Devastated by AIDS

Some communities have lost so many productive members that life for everyone has been disrupted. The extended family is not able to cope with the number of orphaned children who need care. Health workers, teachers, literacy instructors and farm workers have died, reducing the capacity of communities to produce food, to educate their young and to promote health care.

The Impact on Children

Poverty

When primary income earners and caregivers become ill, the family faces impoverishment. In rural areas the capacity of families to produce crops is reduced, and in urban and rural areas the capacity to generate income diminishes. Children may be forced to drop out of school to care for an ill family member or because the family cannot afford school fees. The family may have difficulty providing adequate shelter, nutrition and health care for the children.

Insecurity

The death of a parent is the most profound loss a child can experience. The child may fear that AIDS will take the other parent. Orphaned children may be rejected by the extended family because of the stigma associated with AIDS. The loss may be compounded if orphaned children are separated from their siblings. And psychological assistance is often seen as a luxury or indulgence.

Loss of Inheritance

If orphaned children are sent away from their villages to relatives or to institutions, they may lose their property. Even if these children remain in their villages, relatives may claim the property for themselves. Often there are no laws that grant women and children the right to inherit property, and where such laws do exist they can be ignored by the local people and authorities who follow customary laws.

Top of this page

Return to Table of Contents

Return to Home Page

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

AIDS in the World: The Impact On Infants, Children, and Youth

AIDS is having a big impact on the lives and education of infants, children, and youth in the countries most affected by the disease. This article reviews the impact AIDS is having and proposes solutions to some of the challenges posed by the disease.

The Impact of AIDS

The impact of the AIDS pandemic on individuals, families, and communities at the micro-level of society is immense. People fall ill, cannot work, and lose income. Their families spend money on care and treatment and lose further income in taking time to care for them. People die; specialized workers, skilled artisans and experienced government officials disappear, and replacements are difficult to find; businesses close and farms lie fallow; current earnings are lost and future earnings foregone; and time and money are spent on funerals and mourning. Traditional support systems are stretched and then broken, and families and communities lose their economic, social, and cultural viability.

Although the elite classes of society can be seriously affected, the greatest impact falls on the poor. Particularly among the poor, the pandemic represents a major threat to the health, well-being, and rights of infants, children, and youth. Part of this threat is direct - through risk of infection from mothers, transfusions and unsterile skin-piercing instruments, and coercive or consensual sexual activities. Part of the threat is indirect - through the impact of parental illness and death, abandonment and orphanhood, family poverty, and a deteriorating home environment that often results from the presence of HIV/AIDS.

Much of this impact of HIV/AIDS relates to the fact that children and their families have less access to the prerequisites for a healthy environment and good health: AIDS-affected governments, communities, and families have less time, energy, and money to focus on preventive health services such as the provision of safe water and sanitation, family planning, neo-natal care, the systematic monitoring of children's growth and development, the assurance of food security, and the maintenance of immunization coverage. Less attention may also be paid to the elimination or reduction of various dietary deficiencies, malnutrition, low birth weight, and diseases such as polio, measles, diarrhea, and acute respiratory infections.

In addition to the impact on health status, children find themselves in especially difficult circumstances because of AIDS-related problems. This includes increased family poverty, higher risk of abandonment and orphanhood, forced migration, disinheritance, psychological trauma, ostracism and discrimination, and physical and sexual abuse.

Impact on Education

The pandemic also has a large impact on children's education. Early-childhood development programs lack the resources to expand. As more and more extended families are formed and more and more traditional child-minders (older girls, grandparents) are required for more productive labour, the need for care of young infants grows. But in resource-poor environments, child care may not be able to be provided or, if available, afforded.

Formal education for children is also affected, leading ultimately to a reduction in demand for, supply, and quality of education, and thus to greater difficulty in increasing school enrolment, completion rates and overall learning achievement.

Demand for Education

As a result of HIV and AIDS, relatively fewer children will need education. Fewer children and their families will be able to afford education because of:

> the direct loss of family income due to AIDS, from the illness and death of productive members of the family and from the loss of income due to the cost of treatment, care, and funerals;
>
> the expansion of extended families, with many more children of school age needing money for school but living in a family led by less productive adults (grandparents) or teenage children; and
>
> the loss of the traditional economic safety net of extended family and community, a net stretched even further in many places because of migration, population pressure, infestation, drought, and war.

Fewer children will be able to complete their education because of:

> financial constraints;
>
> illness;

high absenteeism due to the need for children to work and to care for ill adults;

trauma related to the illness and death of family members;

the ostracism, discrimination, and stigmatization suffered by children in schools and classrooms, due to infection or to membership in a family with HIV infection and AIDS deaths; and

the lower motivation provided within an extended family by less educated guardian grandparents, and the smaller amount of attention paid to orphans by heads of households in such families.

As a result of HIV/AIDS, the educational disparities between boys and girls may increase. Girls are often taken out of school in order to care for unattended siblings or ill relatives, to substitute for the productive work of others in the family, or because of a lack of funds for school fees. Girls may marry earlier and drop out of school. This can occur because:

they are pushed out of (or seek to escape from) overcrowded extended families;

men seek younger, and presumably uninfected, wives; and

parents want to keep daughters out of what is perceived as the dangerous environment of the school, due to the presence both of the risk of infection in the school and of sex education in the curriculum.

The burgeoning population of orphans is a particular problem with regard to the demand for education. Orphans not only appear to die earlier and have higher mortality rates than other children but may also be overworked by their relatives or other guardians and may lack supervision, proper caretaking, and school or vocational activities. This, and the uprooting of people from family and community - either because of the often forced migration of widows and their children to other parts of the country or because of complete orphanhood - could lead to an increasing number of abandoned, exploited, and largely unschooled street children.

Supply of Education

The supply of education may be also affected, because of the death of teachers, the closing of schools, and a reduction in budgets for educational systems.

It is likely that a decrease in the number of pupils - either through lower initial enrolment or through higher drop-out or non-continuation rates - will lead to a decrease in the number of classes and schools. In addition, there may be a lack of teachers and other personnel to maintain previous levels of service. This is due to such factors as:

absenteeism from work resulting from illness, funerals, and caring for the ill;

the death of teachers; and

transfers out of, or refusals to be posted to, areas heavily affected by HIV/AIDS.

Another possible reason for smaller supply may be the lack of support and financing from heavily affected communities and governments, which have other competing demands for their resources. At the school and community levels, as extended families grow larger, less income is earned, more resources are needed to pay for expenses related to illness and death, and less money is contributed by the community to schools. At the level of the educational system, more money may have to be spent on the health-related costs of education ministry personnel (treatment and care, insurance, death benefits, etc), on costs for training and then paying for replacements of affected personnel (some of whom may still be on the payroll), and on implementing an effective AIDS education program.

At the same time, more money might be required for the various new clients and new roles the education system may be pushed to adopt - scholarships for orphans, training of teachers in guidance and counselling, new curricula in family-life education, new school-based programs in income generation. And ministries of education may be provided an ever-smaller piece of the national budget as the demand for resources increases from sectors more clearly associated with the pandemic, such as ministries of health.

Quality of Education

The quality of education is also changing, for many reasons:

the increased randomness of the education provided, especially in systems already affected by recession, debt, poverty, and natural or man-made disasters, because of the added absenteeism of both teachers and pupils due to the presence of HIV and AIDS;

a less-qualified teaching force, as trained, experienced teachers are replaced with those who are younger and less well-trained;

discrimination, ostracism, and isolation of infected or affected students and teachers. Teachers may face suspension of social and health benefits and/or dismissal from the system. Pupils may face formal suspension by the system or be pressured into leaving school "voluntarily"; and

the occurrence in some societies of sexual relations, voluntary or involuntary, in schools, among students and between teachers and students. Rape and the sexual abuse of female students by male students and teachers is not uncommon; sexual abuse is often submitted to in exchange for fees or various academic rewards.

Responses

There are several activities that should be undertaken to face the challenges presented by AIDS to the health, well-being, and education of infants, children, and youth. First, it will be necessary to recognize the challenges, seek out the quantitative and qualitative data that can help to clarify their nature and magnitude, and encourage agencies, government units, and NGOs to explore further how their activities are being affected - and will be further affected in the future - by HIV and AIDS.

The data collected should be used as further argument for greater investment in the social sectors, particularly in education. Evidence of the impact of the pandemic on the daily work of educational systems may help convince education ministries to "own" the AIDS problem and thus to put additional effort and resources into AIDS education and into more general health promotion.

Activities and services that might help in this regard include the following:

> AIDS education policies and programs within ministries of education, for teachers and other ministry personnel, and for students, before the beginning of sexual relations and drug-injection practices and before large numbers of children leave the school system. School programs should be developed in the context of integrated health education activities and the promotion of healthy schools;
>
> access by teachers, other ministry personnel, and older students to information and counselling with regard to techniques for preventing HIV transmission;
>
> special efforts to keep AIDS-affected children, especially girls, in school, through fee reductions, scholarships, and other kinds of support;
>
> a special focus on reaching those not in school and already in "especially difficult circumstances" (on the street, engaged in prostitution or child labour) - and thus particularly vulnerable to HIV infection - through a variety of innovative educational mechanisms, both formal and informal;
>
> special concern for AIDS-affected orphans, to ensure that their educational, psychological, and social needs are met. Experience has shown, however, that targeting only orphans - when many children are in difficult circumstances - may be counterproductive and add to problems of discrimination. Providing assistance to schools and communities heavily affected by AIDS may be more useful;
>
> expanded child-care programs that permit older siblings to continue in school rather than stay home to care for younger children;

flexible schedules for school, to permit children to attend when they are not working in the home and in productive labour;

the training of teachers and counsellors in issues related to the non-discriminatory treatment and psychological needs of AIDS-affected children;

regulatory and legal instruments - laws that make it possible for widows and orphans to inherit property, laws prohibiting early marriage, ministry regulations concerning non-discrimination against AIDS-affected children;

income generation schemes for both families and schools affected by AIDS, to make up for the income lost due to illness and death.

- *Sheldon Shaeffer*

Top of this page

Return to Table of Contents

Return to Home Page

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Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

EUTHANASIA

In volume 2(1) of the Newsletter, Lemmens offered arguments against the legalization of euthanasia and called for greater discussion.[1] He identified what he believes are flaws inherent in the pro-choice position and expressed concern for harm arising from legal mercy killing.

Given that some of Lemmens's arguments respond to Russel Ogden's empirical work on euthanasia and AIDS,[2] we invited Ogden to respond to Lemmens's arguments.

Euthanasia: A Reply

My research demonstrates that the prohibition on euthanasia forces some people to commit acts of euthanasia or assisted suicide in conditions akin to those of back-street abortions. Lemmens refers to these data and concludes that some proponents of euthanasia have adopted a social-policy position that he calls "the new realism": "[B]ecause euthanasia is actually practiced, it should be legalized so that control can be exercised on the manner in which people are put to death." He refutes the argument, drawing upon the ethical principle that the end does not justify the means.

The "New Realism"

Indeed, the "new realism" argument is a poor one, but is it really an argument that is commonly being advanced to justify legal euthanasia? What is the basis for such an argument? It would appear that the "new realism" position has its origins in the reaction to data from my study on euthanasia and AIDS in the British Columbia population of persons with HIV/AIDS. Moreover, the "new realism" argument ignores the conclusions offered in the study, which do not call for legalization of euthanasia, but instead recommend a form of euthanasia regulation. Obviously, coat-hanger euthanasia alone is an inadequate justification for a change in the law, but it does reflect a catastrophic social injustice. There are higher principles to consider, such as personal autonomy, equality and justice, and self-determination.

Pain and Pain Relief

Lemmens asks: "Is it true that the euthanasia prohibition is the cause of back street killings?" The empirically informed reply would be "yes," but I suspect what Lemmens is really trying to imply is that many PWAs fear a painful death. In my study, fear of pain was articulated by very few PWAs. Indeed, pain was apparently well-managed in virtually all of the 34 cases of euthanasia or assisted suicide that I documented. The self-awareness of many PWAs is such that they are fully cognizant of the imminence of death and what the disease holds in store for them. They do not want to have to go through all of that and seek to control the manner and timing of death. The capacity to plan one's death allows one to deal with death and organize the final phases of life.

There are several alternatives to euthanasia: for example, starvation, dehydration, or refusing treatment. Although Canadian common law permits these alternatives, they carry the same dangers as euthanasia (consent, intent, motive). How is it more ethical to allow someone to slowly starve to death than to allow them to control the precise manner of their death by a lethal drug dose?

Regarding pain relief, Lemmens notes that most pain can be adequately managed and for "the approximately five percent of patients who do not respond to traditional pain-relief treatment, total sedation can be practised." Although it is commonly argued that virtually all pain can be managed adequately, the Canadian Palliative Care Association claims that 16 percent of terminally ill patients "require medication to control all symptoms, meaning drugged to a degree which does not permit meaningful interaction with the family."[3] Twilight sedation, snowed existence, induced sleep, are gentle terms used by proponents of palliative care. Others have less kindly called it pharmaceutical oblivion. Whatever one's preferred term, total sedation is a practice that, although legal where there is patient consent, is a completely unregulated practice in Canada,[4] and represents a fine, if not indistinguishable, ethical line between palliation and voluntary euthanasia.

Dignity

Our world is one in which we appreciate, respect, and value many things differently. Dignity is one of these things. For Lemmens, dignity "refers essentially to the way others perceive us." Alternatively, many people equate dignity with self-respect and personal integrity. For them, dignity "means respecting the inherent values of our own lives."[5] For some, being dependent on others, or being completely sedated, may be undignified, even tortuous. It is true that infants begin life in a state of dependence, but they gain security and self-esteem by learning to be independent. With increased autonomy they reject diapers and handholding. It is overly simplistic to suggest that a loss of autonomy and dependence on others need not be considered degrading. There are some things that most people prefer to do on their own, in private. For example, it is undignifying to not be able to go to the toilet on one's own, when one wants. A recent large-scale study of people dying from all causes showed that the desire to avoid being dependent and to die with dignity rather than the fear of pain were principal reasons for wishing to die an earlier death.[6]

Who Decides?

To legalize or, as I prefer, to regulate euthanasia does not require that we redefine our social values such that we "allow" physicians to ask patients if they want euthanasia. Rather, we should be allowing patients to make their own choices. Physicians, for all their expertise, are hardly professionally suited to be making moral decisions for their patients.

Indeed, there are individuals who may feel pressured to die sooner rather than later. That is a tragedy that we will have to safeguard ourselves from as best we can. Those who try to influence people to end their lives should face the full force of the law. Moreover, concern for the vulnerable and easily influenced assumes harm for only one part of the population. What of the harm done to those who feel pressured to die "natural" or palliative deaths? "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."[7]

The Slippery Slope

Lemmens argues that, before "allowing individuals to request the assistance of others to kill themselves, we should consider the potential consequences." This is certainly true. However, the consequences of not allowing individuals to request the assistance of others to kill themselves also need to be considered. Nevertheless, they are often disregarded. For example, we know that the unregulated practice of illegal euthanasia also carries social harms. It forces people to commit suicide alone, often sooner than they would prefer. It forces people to collude in covert acts of euthanasia, often to the exclusion of loving relations and friends who might be supportive of the act. It forces "coat-hanger" euthanasia, often causing suffering far worse than the disease it was intended to defeat. It fosters disrespect for the law, because on those rare occasions where euthanasia or assisted suicide is prosecuted, ridiculous legal gymnastics are performed in an effort to reduce charges to offences more tolerable to the Canadian public.

Conclusion

It is fundamental that we reassure seriously ill people that they are not burdensome, that their lives are valued, and that we will make all efforts to relieve their suffering. Nevertheless, if we are to be truly compassionate, we must also respect the moral values and beliefs held by others. People should have the freedom to choose palliative care and pain relief, but they should also be free to choose other alternatives, including euthanasia.

It may be the case that Canadians are not ready to address legal euthanasia, but maintaining the status quo is also unacceptable because it offers no comfort to the public that people are dying properly, according to their definitions of what constitutes a good death. We must be aware that, "the first slippery slope is a slope upon which light cannot be shed."[8] At least with regulated euthanasia we would have an idea of who is doing it, why, how often, and under what conditions. Such data would contribute substantially to a debate that is based more on opposing ethical viewpoints than anything else.

- *Russel Ogden*

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] T Lemmens. Legalizing Euthanasia. Canadian HIV/AIDS Policy & Law Newsletter 1995; 2(1): 7-9.

[2] R Ogden. Euthanasia, Assisted Suicide & AIDS. New Westminster: Peroglyphics, 1994. See also R Ogden. The Uncloseting of AIDS-Related Euthanasia. Canadian HIV/AIDS Policy & Law Newsletter 1994; 1(1): 14-15.

[3] Canadian Palliative Care Association Submission to the Special Senate Committee on Euthanasia and Assisted Suicide. Ottawa: The Association, 1994.

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

[5] R Dworkin. Life's Dominion. New York: Knopf, 1993.

[6] C Seale & J Addington-Hall. Euthanasia: Why People Want to Die Earlier. Social Science & Medicine 1994; 39(5): 647.

[7] Ibid at 217.

[8] E Sutorious. Oral testimony before the Special Senate Committee on Euthanasia and Assisted Suicide, 1st Session, 35th Parliament, 1994, 21 at 42.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

CARE, SUPPORT AND TREATMENT

Care and Treatment of Terminal-Phase AIDS

How is care and treatment of people with terminal-phase AIDS handled? The following article examines various ways in which care and treatment is handled in Montréal and Paris, France.

The article summarizes some of the conclusions reached on the basis of research carried out for a Master's degree in Social Law jointly supervised by the University of Paris X and the University of Québec at Montréal.[1] The research strategy was based on documentary analysis and on interviews with many people involved in the issue. The concept of quality of life was one of the principal guidelines of this analysis because it made possible the reintroduction of a qualitative component to a debate on medical expenses that has used volume of care provided as the only rationalizing element of our health-care systems.

Although the average lifespan of people with AIDS has increased considerably with the introduction of new prophylactic methods and progress in medical expertise, the growing dependence caused by the slow and progressive deterioration of their state of health is the other side of the coin. On both sides of the Atlantic, the restructuring of the health-care distribution system is now on the agenda, evidencing a will to provide a minimum level of care and treatment.

Treatment in Hospital

Historically, hospitals were the first to be confronted with AIDS. The disruptions the disease has caused have pushed hospital administrations to innovate. New units have been created in France (the human immunodeficiency information and care centres) and in Québec (research, education and AIDS-care hospital units). These will in the years to come act as reference centres.

However, the very composition of this type of hospital service reveals a basic difference between Paris and Montréal. Québec's strategy depends on the various care providers complementing each other's skills and cooperating, whereas the French idea of a multidisciplinary approach is characterized more by an extension of medical care to other fields than by a truly multifaceted opening to all the everyday realities that people living with AIDS experience.

The research carried out also made it possible to highlight the difficulties of integrating a palliative approach into the care and treatment of people living with terminal-phase AIDS. Some hospital administrations still refuse to encourage the creation of units specializing in terminal-phase care. The few existing palliative-care units have only recently accepted people with AIDS, mainly because of a lack of information on the extent of the physical and psychological pain connected with the disease. Moreover, space is very limited: a service of this kind can only deal with an average of 15 patients at a time, regardless of the pathologies involved. In both Montréal and Paris, mobile teams are being created to offset the disadvantages of fixed units. This way of organizing care has certain advantages:

> the mobility of these teams makes it possible to reach more patients, the goal being to improve their quality of life and also to provide training more rapidly for the other care providers, thereby encouraging, for those most closely involved, changes in the practices that structure the care of patients with terminal-phase AIDS;
>
> moreover, this organizational flexibility appears to be altogether adapted to the rapid and sudden deteriorations in health that patients with terminal-phase AIDS experience.

However, it should also be noted that this model has its weaknesses: mobile teams only operate when they are called to do so. The same problem prevents some "AIDS teams" in Montréal from involving themselves in an advisory capacity with respect to several hospital services identified as being an exclusively medical preserve. Some care-provider teams consider that they manage crisis situations best and that they do not need the intervention of outside parties, especially at times when "there is nothing more to be done," with reference to the possibility of healing inherent in the curative health-care model.

The cost of palliative care was discussed in the thesis insofar as this kind of service forces hospitals to maintain very high numbers of medical staff. Only with great difficulty would this appear to meet the profitability criteria developed by most institutions in managing their operations. With a neo-liberal approach to the restructuring of health-care systems, public authorities are more inclined to favour the development of less onerous alternative models, such as home care or hospices.

Alternative Care and Treatment Models

Whereas Québec has developed an Anglo-Saxon type of functionalist approach based on a broad conception of care and treatment that involves the whole medico-social service sector as well as the affected person's social environment, France has chosen to make home care a direct extension of hospitalization, leaving the main burden of social care to charitable associations. In any event, whether it is called "a shift to ambulatory care" in Québec or "control of health-care costs" in France, the direction of reform is toward greater de-institutionalization and the development of out-patient care. AIDS treatment has not escaped this.

Hospices are also part of the out-patienting of affected people. However, in France this distribution model is in an experimental stage only. Gardanne, near Marseilles, is the pilot city, whereas Montréal already has about ten hospices. Nevertheless, approaches diverge mainly with respect to the development of beneficiary profiles. Some hospices, as in the French model, have targeted beneficiaries who are experiencing a radical loss of autonomy. Consequently, the average stay in a hospice is approximately three months, and 70 percent of residents die in the establishment without returning to hospital. Other hospices have chosen not to specifically target those who are experiencing a radical loss of autonomy, but rather to centre distribution services on a semi-autonomous population that does not require permanent care. The criteria for defining beneficiary profiles nevertheless remain very broad, and this leads to the admission of people in various stages of the disease, often including those experiencing other problems, in particular alcoholism and drug use. Those involved in the provision of care recognize the difficulty of operating this type of structure, where the desire to re-create a community way of life may harm the quality of life of residents.

The fact that lengths of stay vary is also one of the results of the absence of targeting in accordance with degree of pathology. Some affected people stay one month, whereas others stay for two-and-a-half years. During interviews, those involved in this kind of hospice said they were aware of the fact that each death that occurred over a long period of time forced the other patients to confront their own death a little more, but this is a reality they refuse to hide because they prefer to emphasize the fact that such institutions are "places for living."

With regard to the kind of care provided, the study underlined significant differences, mainly due to the composition of the teams within the institutions. Montréal counts on an efficient partnership between the public health network (physicians and nursing staff), hospice workers, volunteers, and other service-providing associations. Gardanne is operating more independently, given the quality of staff, who are for the most part medical professionals. A physician and nurses are always present, which makes it more analogous to a decentralized hospital structure, whereas Montréal hospices provide, through their workers, supervision and permanent care for those affected by AIDS.

An analysis of the organizational problems that home care and hospices bring up also made it possible to raise questions directly related to current reforms, in particular the role of community resources in the reconceptualization of the health-care system. Over time, and given the scope of the pandemic, a number of factors have coalesced and made possible the substantive development of an "informal" service network (based on volunteers, families, and community resources), thereby reintroducing into "classical" models of caring for and treating the sick more traditional ways in which people show solidarity with others. However, French and Québec public authorities have been much criticized for their tendency to make this network more instrumental in the provision of care as a means of restructuring government activities. The crisis of the Keynesian-type welfare state has forced most western societies to adjust government activities more closely to the general state of public finances.

Out-patienting appears today to be becoming one of the major planks of neo-liberal health policy, in that the pruning of hospital services is viewed as a way of revitalizing public health structures. However, carrying out this kind of change can only be achieved with the active involvement of the private business sector and the "informal" service network. In the study, a number of those involved expressed their concerns over the development of a "two-track" health system - a product of minimalist public policies - that would tend to reduce public obligations and to lean unduly on charitable efforts. All agree that if de-institutionalization does in fact proceed from a will to reinvest the sick with decision-making powers and to count on the quality of home care, it must never be the result of budget cuts. If neo-liberal policy-makers praise the saving virtues of de-institutionalization with regard to public finances, they should nevertheless not forget the implicit and unknown costs with which it burdens the "informal" service sector.

A fragmented health-care system inevitably leads to a process of excluding populations that are already marginalized in society. AIDS has made it possible to identify several dysfunctional elements, both micro- and macro-organizational. It now falls to the public authorities and the whole health-care sector to jointly implement a voluntary training and information policy on new methods of care and treatment, and to redefine action plans in order to encourage the creation of a real continuity in the distribution of care and services.

- *Bertrand Mongodin*

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] B Mongodin. Programmes et politiques de prise en charge des malades du sida en phase terminale: comparaison Paris-Montréal. Paris and Montréal: University of Paris X and University of Québec at Montréal, 1995.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

INTERNATIONAL NEWS

The Paris Summit on AIDS: One Year Later

The following brief was prepared by, and is being reprinted in a slightly revised version with the permission of, the International Council of AIDS Service Organizations (ICASO).

On 1 December 1994 the Government of France, along with the World Health Organization (WHO), held a summit in Paris, inviting 42 heads of state to renew their political commitment to the fight against AIDS by signing the Paris Summit Declaration. This document, which was signed by all 42 participants in the Summit, reaffirms the need for "political leaders to make the fight against HIV/AIDS a priority" by undertaking in their national policies to "make available necessary resources to better combat the pandemic, including adequate support for people infected with HIV/AIDS (PHAs), nongovernmental organizations (NGOs) and communitybased organizations (CBOs) working with vulnerable populations."

The official delegations included various representatives from ministries of foreign affairs and/or health. The Secretary General of the United Nations, Mr Boutros Boutros Ghali, other UN agency heads, and the French Prime Minister presided over the opening ceremonies. CBO/NGOs and PHAs were invited to attend the Summit as observers. Each country decided on the composition of its own delegation which included representatives from the community sector [Canada was represented by Prime Minister Jean Chrétien and then Health Minister Diane Marleau; the Canadian delegation also included Aine Costigan from the Interagency Coalition on AIDS and Development and René Raymond from the Canadian AIDS Society]. The Cellule des Personnes Atteintes par le VIH/SIDA (a Parisbased coalition comprised mainly of PHAs) and other groups such as ICASO had regular meetings with the WHO and the French Government, cosponsors of the meeting. Their aim was to have input and involvement from people living with HIV/AIDS and nongovernmental and community-based organizations.

The expression of a strong political will is all the more necessary at a time when the international community has launched, on 1 January 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS). It is hoped that this program, based on better coordination between United Nations agencies active in the area of HIV/AIDS (UNDP, UNESCO, UNFPA, UNICEF, WHO, World Bank) will enable intergovernmental, governmental and non-governmental institutions to more effectively respond to the pandemic.

However, more than one year after the Summit, the Declaration has not been signed by any country beyond the original 42 signatories. Furthermore, key countries are cutting their funding for development assistance. Massive cuts in HIV/AIDS budgets put community programs in jeopardy at a time when they are most required to respond to the pandemic.

ICASO, in collaboration with other organizations such as the Global Network of People Living with HIV/AIDS (GNP+) and the International Community of Women Living with HIV/AIDS (ICW), is committed to undertaking an evaluation of the Paris AIDS Summit: a study on how governments are addressing the issues raised in the Declaration. The results of this study will be presented at the XI International Conference on AIDS in Vancouver in July 1996. ICASO will also be urging the Secretary General of the United Nations to have other nations sign the Declaration.

Other AIDS organizations will be asked to lobby their respective heads of government not only to sign the document, but also to take the necessary steps toward strengthening national HIV/AIDS programs.

In commemoration of the oneyear anniversary, ICASO has produced a trilingual poster (English, French and Spanish) of the Declaration. The poster is being distributed to the community-based, nongovernmental AIDS movement and government organizations as a reminder of the commitments made.

For more information about the study, or about how to obtain a copy of the poster, contact the ICASO Central Secretariat, 400 - 100 Sparks Street, Ottawa, Canada K1P 5B7. Tel: (613) 2303580; fax: (613) 5634998; email: icaso@web.apc.org; web site: http://www.web.apc.org/~icaso/webpage.html

---

Top of this page

Return to Table of Contents

Return to Home Page

LIST OF PARTICIPANTS AT THE SUMMIT

Australia
Bahamas
Belgium
Brazil
Burundi
Cambodia
Cameroon
Canada
China
Denmark
Djibouti
Finland
France
Germany
India Indonesia
Italy
Ivory Coast
Japan
Mexico
Morocco
Mozambique
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Philippines
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Sweden
Switzerland
Thailand
Vietnam
Uganda
United Kingdom
United States
Zambia
Zimbabwe

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

US - New HIV Test about to Be Licensed

The Food & Drug Administration in the US is reportedly about to approve licensing of an HIV test that uses saliva and other oral fluids rather than blood, according to the *San Francisco Examiner* of 27 December 1995. If approved, the test would be distributed through clinics and health-care professionals, not through over-the-counter sales to the public, according to the news report.[1]

The Vatican - Roman Catholic Church Against Promotion of Safer Sex

The Roman Catholic Church's Pontifical Commission for the Family issued a 60-page booklet in December 1995 stating that Catholic parents have a duty to keep their children away from sex education programs that promote the use of condoms and "safer sex" techniques.

According to an Associated Press report published in newspapers during the third week of December 1995, the booklet also says that acceptable instruction about sex must deal with homosexuality as being "against natural law." "Parents must refuse the promotion of so-called `safe sex' or `safer sex,' a dangerous and immoral policy," said the Vatican.

Top of this page

Return to Table of Contents

Return to Home Page

---

[1] This and the following news are reprinted from Lesbian/Gay Law Notes 1996, at 13.

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)

Canadian HIV/AIDS Policy & Law Newsletter

Volume 2 Number 3 - April 1996

POSITION ANNOUNCEMENT

Brock University, Health Studies Program

The Health Studies Program is seeking applications for one full-time tenure track position at the rank of assistant professor. Applicants should have demonstrated an ability to teach and conduct research in at least one of the following primary areas: policy development and analysis, health planning and development, or program planning and evaluation; and at least one of the following secondary areas: health law; qualitative health research methods; or aging populations.

Qualified applicants must possess a Ph.D or equivalent, and a demonstrated area of research interest. The position, which is subject to budgetary approval, will begin July 1, 1996, and the salary will be commensurate with qualifications and experience. Closing date for applications is May 10, 1996. Applicants should submit a letter of application, statement of research interests, a curriculum vitae, and three confidential letters of reference to:

Dr William Montelpare,
Associate Professor and Director
Health Studies Program
Brock University
St Catherine, Ontario
L2S 3A1

In accordance with Canadian immigration requirements, this advertisement is directed to Canadian citizens and permanent residents. Qualified women and men are equally encouraged to apply.

Top of this page

Return to Table of Contents

Return to Home Page

Return to HOME PAGE
(Canadian HIV/AIDS Legal Network)

Retour à la PAGE D'ACCUEIL
(Réseau juridique canadien VIH/sida)