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[Canadian HIV/AIDS Policy & Law Newsletter](#)

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Canadian HIV/AIDS Policy & Law Newsletter

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Human Rights, Women, and HIV

After being virtually absent from the HIV epidemic in the 1980s, women living with HIV now number close to 7 million. In 1995 alone, one million women became infected with HIV, and close to half of all newly infected adults in the world today are women. By the year 2000, over 13 million women will have been infected and 4 million of them will have died.

Colouring both the choices and consequences of HIV for women, are issues of human rights, discrimination and stigmatization. In this paper, I will focus specifically on HIV and vulnerability in women, the importance of education for girls and young women, the unequal burden of care, and the potential impact of HIV on the status of women in developing countries.

HIV and Vulnerability in Women

Women are vulnerable to HIV because of sexual subordination, economic subordination, and biological vulnerability.

Sexual Subordination

Societal forces and gender-based power inequalities create the sexual subordination that puts women at risk. Socialized concepts of masculinity and femininity as well as gender and power relations limit the capacity of young women to negotiate the boundaries of sexual encounters so as to ensure both their safety and their satisfaction (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1992). This is true to a greater or lesser extent in all societies. But in developing countries, poverty further interacts with gender imbalances to prevent women from protecting themselves from HIV.

The lack of economic and educational opportunities for women in developing countries can lead them to resort to entering into sexual relationships for economic reasons. In this context, extra-marital sexual encounters almost always involve the transfer of material resources, such as cash, clothing, or gifts from a man to his female partner. These gifts have to be seen as a contribution to a woman's survival. The

term "commercial sex" should be reserved to describe a straightforward transaction of money for sex (Vos, 1994). For many women, sex work is an occupation born of necessity - cold, stark economic necessity - and directly related to a woman's survival. But these survival strategies have turned into death strategies (Schoepf, Engundu, Mkeru, Ntsomo, & Schoepf, 1991) as women engaged in prostitution provide sexual services in social contexts which are ripe for transmission of HIV, have limited education and hence choice, are frequently exposed to STD and receive wholly inadequate STD care, provide vaginal intercourse to large numbers of clients, and are seldom able to use condoms (Wilson, 1993).

We need to deconstruct the category of prostitution, and better understand the contexts of sexual servicing where few jobs are available to women and where women have limited access to the cash economy (Seidel, 1993). There may not only be different types of work in this context - all survival strategies for women - but often there is no distinction between marriage and other relations which imply sexual-economic exchange, only a continuum of forms of sexual service. Delegates from 14 African states at the first Society of Women and AIDS in Africa meeting held in 1989, unanimously agreed that "forces ranging from early childhood training to state laws governing marriage, divorce and property rights prepare women to defer to male partners, not to instruct or oppose them...especially in the context of marriage" (Mahmoud et al, 1989).

Coerced sex can include rape and other sexual abuse, in and outside the family, as well as forced sex work. Any non-consensual penetrative sex carries an increased risk of transmission of HIV and other STDs, due to the absence of lubrication and because men who rape are not likely to use condoms. The problems associated with rape and other forms of violence against women are often intensified in war situations, in which occupying or invading armies systematically rape women as part of a strategy to intimidate the local population.

Economic Subordination

In virtually every society, women face discrimination in employment and social status, which results in economic vulnerability to HIV. This includes occupational segregation of women into low-paying clerical and service jobs, unequal pay and fewer promotions compared to men, fewer workplace benefits and concentration of women in the informal sector. For example, in agricultural sector development, women lack access to technical assistance, training and credit, with funds and technical training typically going to men involved in cash crop farming rather than to women who are more likely to be engaged in subsistence farming (World Health Organisation, 1994).

Households headed by women - estimates indicate that women are the sole earners in one-fourth to one-third of all the world's households (CEG, 1989) - are more likely to be financially poor than those in which there is a working resident male (Heise & Elias, 1995). Women's economic dependence on male partners in order to avoid poverty for themselves and for their children makes it difficult for women to negotiate safer sex practices to protect themselves from infection. Some national laws reinforce this economic dependence by limiting property ownership and inheritance to men. Some laws limit women's

ability to enter into independent contracts or to obtain credit under their own names. These laws impede women's ability to control income and property, and reinforce their economic dependence on male relatives, with the result that it may be difficult for them to refuse sexual practices that may put them at risk for STDs and HIV. Laws regarding marriage, divorce, and child custody can impede women's ability to leave relationships in which they or their children are physically or sexually abused or exposed to the risk of HIV infection. Worldwide, many women rely on prostitution, or commercial sex work, for economic survival. The proportion of women who engage in commercial sex work is often directly related to the economy and the level of unemployment. In many parts of the world prostitution is illegal and underground, which means that prostitutes often work without adequate control over their own working conditions, the conditions of the sex work transaction.

Migration as a result of economic necessity, war, famine, or political oppression increases the risk of HIV transmission to women by disrupting the normal mechanisms controlling male sexuality and by constraining women to engage in sexual barter for survival. Sexual bartering to obtain entry or residence permits, in exchange for transport, or to obtain or hold onto jobs has been reported in many situations, and is particularly likely when women are isolated from their own community structures and when they do not speak or read the local language. Cross-border trafficking of young girls in Southeast Asia is a rather flagrant example of the interaction between migration and violation of the rights of girls and women.

In an environment of reduced opportunities, young school girls may be particularly vulnerable to the personal validation, gifts, and payment of school fees that may be provided by sexually experienced older men, or so-called sugar daddies, who seek extra-marital relationships at low risk of HIV. As well, school girls and students may be required to provide sexual services to teachers in order to avoid having their marks suffer (Vos, 1992).

Biological Vulnerability

HIV is essentially a sexually transmitted disease and women are biologically more vulnerable than men to HIV infection and other STDs. Studies in many countries show that male-to-female transmission of HIV appears to be 2 to 4 times more efficient than female-to-male transmission (WHO/UNDP, 1994). This is thought to be due to the larger mucosal surface area exposed to the virus in women and the greater viral inoculum present in semen as compared with vaginal secretions. Young girls are particularly vulnerable as a result of the lack of maturation of the cervix and due to their relatively low vaginal mucous production which presents less of a barrier to HIV. Women are also biologically vulnerable to HIV infection because they are more likely to have untreated STDs, in part due to lack of access to adequately equipped and culturally appropriate medical services and in part due to the fact that women do not recognize low grade infections, particularly when they are the result of their partners' behaviour and not their own. Finally, with respect to biological vulnerability, women are disproportionately the recipients of blood transfusions and other blood products for complications at childbirth or preventable conditions such as anaemia.

Solutions

Increasingly it is being argued that short-term solutions to women's vulnerability to HIV infection and other sexually transmitted diseases lie in the development of clandestine, woman-controlled methods of HIV prevention that do not require male complicity or agreement; and that long-term solutions lie in the empowerment of women to achieve economic autonomy. It is also evident that reducing the impact of the HIV epidemic for women and girls in developing countries will also involve strategies that focus on educational opportunities, on careful review of women's changing role as caregivers, and vigilant analysis of the impact the HIV epidemic is having on the status of women.

Education for Young Girls

Around the world, girls face discrimination in both educational institutions and in the family. Girls may be encouraged to take different subjects than boys, they often have decreased access to financial and other family resources, and it is common for girls to be withdrawn from school to assume domestic responsibility. When family finances are tight the schooling of boys takes precedence over the schooling of girls in most societies.

The lack of educational opportunities for young girls and the tendency for girls to be withdrawn from school to assume domestic responsibilities can and does act to encourage early partnership formation and early sexual activity. Staying in school appears to have a retardant effect on the onset of sexual activity in young women, helping girls move beyond the heightened biological vulnerability of adolescence and increasing the chances that healthy sexual choices will be made. In developing countries, better educated women marry later and start their families later (World Bank, 1993, p. 42).

Furthermore, as DeCosas & Pedneault (1992) have argued, improving the access of girls and women to formal education not only helps to equalize the age of partnership formation which can reduce the risk of HIV but it also increases women's competitiveness in urban economies which could positively affect the unequal gender-mix seen in many cities. The uneven gender ratio created by the movement of a mainly male labour force to urban environments has combined with a lack of economic resources other than the commercial sex trade for unmarried women to create conditions for rapid spread of HIV in cities.

A strong correlation has been reported between female to male school enrollment ratios at the secondary school level and HIV prevalence in the general adult population (Over and Piot, 1992). These results suggest that significant decreases in seroprevalence would be achieved if the urban sex ratio and the secondary school sex ratio moved toward parity.

To increase the chance that girls will receive schooling we must address the link between poverty, education, cultural constraints, and gender factors. The World Development Report "Investing in Health" (World Bank, 1993, p. 49) argues that lowering the barriers to schooling for girls can be done through scholarships, by offering free textbooks or fee exemptions, with safeguards to prevent diversions to males, and by siting schools close to people's homes so that parents are less worried about

their daughters' safety. Education increases the chance that women will make good use of health services, increases their access to income, and enables them to make healthier choices. Investing in women through improved education is the key to both reduced HIV transmission and to higher productivity and growth for developing country economies in the long term.

Burden of Care

The HIV epidemic is imposing an unequal burden of care on women by increasing the care burden overall and by stimulating changes in the models of care. As one woman stated: if there is ever any talk of anyone replacing another and doing the work, it is always the woman, never the man. Or as Margaret Mshana of the KIWAKKUKI Women's group in Tanzania (personal communication, July 1994) said: "Women are everything to everybody." And it is often female children who are required to spend less time in school and more time at home performing tasks normally carried out by adults when someone in the family has advanced HIV disease.

Meeting the medical needs of those affected by HIV alone is a great challenge in sub-Saharan Africa due to rapidly growing demands and severe resource constraints. In order to reduce costs, countries have moved rapidly toward providing hospital-based or community-based home care services for patients with HIV disease. But this effort to relieve pressure on acute care hospital beds can easily become a means of dumping patients back into an unprepared home setting. A colleague of mine, when visiting a homecare program in an unnamed country, discovered that the volunteers, who had received special training, were highly motivated to participate in the program because of their experience with a person living with AIDS in their own family. However, these volunteers were visiting families, not even able to provide soap to bathe the dying patient, let alone offer food or medicine.

For women who are the traditional nurturers and caregivers both in the home and in the community, having a sick person in the home without adequate support services may mean major changes in activities which could influence the health of other family members. For example, caring for someone in the home may mean one has less time available to tend crops. As a result decisions may be made to switch to less labour-intensive crops which are not as nutritious or income-generating. Or livestock may be sold to compensate for loss of income, and remaining animals could have lower levels of care with resultant sickness and loss.

Distance from potable water sources may become an additional strain for women coping with the demands of caring for someone in the home, increasing the chances of skin diseases related to water scarcity. But if the sick family member has chronic diarrhea as many AIDS patients do, the situation may become intolerable for most families who do not have convenient toilet facilities or running water. Finally, women who are employed outside the home may jeopardize their continued employment or their small businesses by missing too many work days caring for their sick loved one.

To address the unequal burden of care for people with HIV-related disease including AIDS, we must encourage men and women in all societies to share in the caregiving role. Both women and men should

benefit from support interventions aimed at providing training in basic health-care procedures. Community-based institutions that can provide professional alternatives to home care and provide respite care for primary caregivers should be supported. Families should be encouraged to keep their daughters in school and should be discouraged from relying on their adolescent girls for caregiving responsibilities.

Status of Women

What is the impact of HIV on the status of women in developing countries? It is broadly recognized that the pandemic has catastrophic cost consequences since it mainly affects people in the economically productive adult years. The heavy macroeconomic impact of AIDS comes partly from the high cost of treatment which diverts resources from productive investments, and partly from direct effects on productivity due to illness and the loss of skilled adults. These macroeconomic effects are superimposed on a deepening crisis associated both with the effects of structural adjustment policies and with employment structures inherited from colonial times which have contributed to the weakening of the extended family and to the feminisation of poverty (Seidel, 1993). With declining real income, women have had to compensate by working longer hours, competing with men in a labour market which severely undervalues women's work. Women currently account for half of the world's population and two-thirds of the hours worked. They receive one tenth of the world's income and have one hundredth of the world's property registered in their name (CEG, 1989). The potential of the HIV epidemic to worsen gender imbalance is high.

On the microeconomic level, the death of an adult can tip vulnerable households into poverty. Studies are now showing that the effects of losing an adult in a household persist into the next generation as children, and particularly female children, are withdrawn from school because school fees cannot be paid and because their help is needed at home. And if the household has lost an adult female member to AIDS in the previous year, school attendance of young people aged 15 to 20 years is reduced by half (World Bank, 1993, p. 20).

In Thailand today, one in 50 adults is infected. In Sub-Saharan Africa, 1 in 40 adults is infected and in certain cities of Africa, the prevalence of infection is as high as 1 in 3 (World Bank, 1993, p. 99). In some of these high prevalence communities, AIDS is already starting to reverse long-term declines in child mortality and increases in life expectancy. In Sub-Saharan Africa, life expectancy at birth had reached 50 years by the early 1980s (World Bank, 1993, p. 23). Without the AIDS epidemic and under standard assumptions, the gap in life expectancies between women and men would have gradually increased, with women living longer than men. But this trend has been reversed by the AIDS epidemic with women now predicted to have a shorter life expectancy than men after the year 2000. By the year 2020, life expectancy for males at birth will be 17 years below projected life expectancy had there been no AIDS epidemic in sub-Saharan Africa. And for women, the loss in life expectancy is even greater: 21 years (Armstrong & Bos, 1992).

As the HIV/AIDS epidemic intensifies, we are seeing increased stigmatization of women, and a change

in women's social and political position. Women are frequently identified as the reservoirs of infection or as vectors of transmission to their male partners and to their offspring. In fact many countries appear more prepared to invest in programs to prevent mother-to-child transmission than in programs to prevent transmission to women in the first place. This perspective is harmful in that it fails to focus on men's equal responsibility to prevent HIV, it prevents programs from developing services that meet the needs of women, and it underlies research and intervention strategies that have been designed more to protect men from women than to enable women to protect themselves.

In many countries, the law does not allow women to inherit land. This means that women lack collateral for financial services; combined with low levels of education, this constitutes a clear gender-based constraint to economic activity. Inheritance laws also mean that widows are vulnerable to making sexual decisions influenced by economics: it may mean accepting the levirate or traditional marriage to a brother-in-law, a social safety net with a distinct risk of encouraging HIV transmission; or becoming involved in some form of prostitution to support themselves and their children. Attempts thus far to change the legal status of women in the face of the HIV epidemic have met with social resistance even when the actual laws themselves are changed.

Conclusion

In order to address economic and biological vulnerability of women, educational inequities, increasing health burdens being placed on women, and impediments of the current status of women, a multi-pronged strategy will be required. At all levels of the strategy, women, both infected and affected, must be involved if this is to be effective. Solutions are not simple but the seeds of those solutions are found in the conventional wisdom of communities themselves. They are also found in systems-level analysis which should inform the creation of gender-sensitive HIV and development policies (Reid, 1992). We must engage decision makers at local, national and international levels to address these imbalances and these issues if we are to mitigate the devastating psychosocial and economic impact of HIV on women in developing countries. Strategies should be aimed at enhancing the responses of families and communities to the HIV epidemic in such a way that they enhance women's status. Only by doing so will women's vulnerability to HIV transmission be reduced and the possibility that women will play full roles in society enhanced.

Strategic interventions to promote gender equity deserve a central focus in national AIDS plans. Governments can help eliminate the financial inducements to multiple partnerships by revising laws and labour codes to guarantee women the right to own and inherit property, to earn salaries on a par with men, and to have equal access to credit and training. They can improve women's ability to protect themselves by expanding female education, educating women about their rights, fighting the cultural beliefs that denigrate women and value boy children over girls, and helping women to organize on their own behalf (Heise & Elias, 1995). Until women become part of the dialogue that establishes policy and distributes resources, women's issues will remain vastly underattended. And until women share power more equally with men - in both the public and the private sphere - they will remain at heightened risk both for HIV and for the discriminatory practices and stigmatization associated with AIDS.

- Catherine Hankins

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REFERENCES

Armstrong J, Bos, E (1992). The Demographic, Economic, and Social Impact of AIDS. In J Mann et al (eds). AIDS in the World (pp. 195-226). Cambridge, MA: Harvard University Press.

Berer M, Ray S (1993). Women and HIV/AIDS - An International Resource Book. London, England: Pandora.

CEG (Commonwealth Expert Group). (1989). Engendering Adjustment for the 1990s (Report of a Commonwealth Expert Group on Women and Structural Adjustment). London, England: Commonwealth Secretariat, London.

DeCosas, J, Pedneault V (1992). Women and AIDS in Africa: Demographic Implications for Health Promotion. Health Policy and Planning, 7(3), 227-233.

Heise LL, Elias C (1995). Transforming AIDS Prevention to Meet Women's Needs: A Focus on Developing Countries. Social Sciences and Medicine, 40(7), 931-943.

Holland J et al (1992). Risk, Power and the Possibility of Pleasure: Young Women and Safer Sex. AIDS Care, 4(3), 273-283.

Mahmoud FA et al (1989). Women and AIDS in Africa: Issues Old and New. Paper presented at the 1989 Annual Meeting of the African Studies Association, Atlanta, GA.

Over M, Piot P. (1992). HIV Infection and Sexually Transmitted Disease. The World Bank Health Sectors Priorities Review. In DT Jamison, WH Mosley (eds). Disease Control Priorities in Developing Countries. New York, NY: Oxford University Press for the World Bank.

Reid E (1992). Gender, Knowledge, and Responsibility. In J Mann et al (eds). AIDS in the World (pp.

657-667). Cambridge, MA: Harvard University Press.

Schoepf BG et al (1991). Gender, Power and Risk of AIDS in Zaïre. In Gender and Health in Africa (pp. 187-204). Trenton, NJ: Africa World Press, IUC.

Seidel G (1993). The Competing Discourses of HIV/AIDS in SubSaharan Africa: Discourses of Rights and Empowerment vs Discourses of Control and Exclusion. *Social Sciences and Medicine*, 36(3), 175-194.

Vos T (1994). Attitudes to Sex and Sexual Behaviour in Rural Matabeleland, Zimbabwe. *AIDS Care*, 6 (2), 193-203.

Wilson D (1993). Preventing Transmission of HIV in Heterosexual Prostitution. In L Sherr (ed). *AIDS and the Heterosexual Population* (pp. 67-81). Chur, Switzerland: Harwood Academic Publishers.

World Bank. (1993). *World Development Report 1993*. New York, NY: Oxford University Press.

World Health Organisation and the United Nations Development Programme in Consultation with the United Nations Division for the Advancement of Women. (1994). *Women and AIDS: Agenda for Action*.

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Needle Exchange in Prisons: An Overview

Evaluation of an AIDS prevention program including needle distribution for female prisoners in Switzerland has demonstrated clear positive results:

the health status of prisoners improved;

no new cases of infection with HIV or hepatitis occurred;

an important decrease in needle sharing was observed;

there was no increase in drug consumption; and

needles were not used as weapons.[1]

The Pilot Project

The evaluation report concludes:

The results of the pilot-project undertaken at Hindelbank Institution do not provide any argument against the continuation of the distribution of sterile syringes. The fears expressed at the beginning - that drug use would increase, that needles would be used as weapons or accidentally cause injuries, etc - were unjustified,[2]

According to the report,

[t]he proven feasibility of the distribution of needles and syringes and the very wide acceptance of the project by inmates and staff ... allow us to draw the conclusion that the distribution of sterile needles and syringes should be continued after the end of the pilot project.

Following this evaluation, the Prison authorities have decided to continue the project.

A Tale of Pragmatism

Hindelbank is not the first institution to distribute sterile injection equipment to inmates, but it is the first to scientifically evaluate such a program. It was in another Swiss prison, Oberschöngrün prison for men, that sterile needles first became available to inmates in 1993:

Dr Franz Probst, a part-time medical officer, working at Oberschöngrün prison in the Swiss canton of Solothurn was faced with the ethical dilemma of as many as 15 of 70 inmates regularly injecting drugs, with no adequate preventive measures. Unlike most of his fellow prison doctors, all of whom feel obliged to compromise their ethical and public health principles daily, Probst began distributing sterile injection material without informing the prison director. When this courageous but apparently foolhardy gesture was discovered, the director, instead of firing Probst on the spot, listened to his arguments about prevention of HIV and hepatitis, as well as injection-site abscesses, and sought approval from the Cantonal authorities to sanction the distribution of needles and syringes. Thus, the world's first distribution of injection material inside prison began as an act of medical disobedience.[3]

Three years later, distribution is ongoing, has never resulted in any negative consequences, and is supported by everyone in the institution. According to the prison director, initial scepticism by front-line staff has been replaced by their full support:

Staff have realized that distribution of sterile injection equipment is in their own interest. They feel safer now than before the distribution started. Three years ago, they were always afraid of sticking themselves with a hidden needle during cell searches. Now, inmates are allowed to keep needles, but only in a glass in their medical cabinet over their sink. No staff has suffered needle-stick injuries since 1993.[4]

Programs in Other Countries

As a result of the positive experiences in Swiss prisons, more and more prison systems around the world are announcing that they will also make sterile injection equipment available: At the interdisciplinary symposium on harm reduction strategies in prisons, which took place in Berne, Switzerland, from 28 February to 3 March 1996, representatives of several German prison systems, as well as the Spanish system, presented their programs or talked about their intention to start one soon.[5] In Australia, a recent study also showed that needle and syringe exchange is feasible in prisons.[6]

The Situation in Canada

Providing sterile needles to inmates has been widely recommended as a health measure necessary to reduce the spread of HIV in Canadian prisons. In its *Final Report*, the Expert Committee on AIDS and Prisons (ECAP), concluded that making sterile injection equipment available in prisons "will be inevitable," particularly because of serious doubts that have arisen concerning the efficacy of bleach to destroy HIV.[7] ECAP was concerned that the scarcity of drug-injection equipment in prisons almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment. They pointed out that access to sterile equipment is the only policy that makes it possible for inmates not to share their equipment. However, the Correctional Service of Canada (CSC), in its official response to ECAP's Report, refused to even pilot needle exchange programs in prisons,[8] a decision for which it has been severely criticized. An editorial in the *Vancouver Sun* of 2 April 1994 called the "prison system guilty of AIDS complacency," and added that

[i]f any lesson should be learned from the continuing outcry over the Red Cross[']s sluggish response to the threat of AIDS transmission through the blood supply, it's that such attitudes [as expressed in CSC's response to the report] can be lethal.[9]

HIV/AIDS in Prisons: A Discussion Paper

In November 1995, only eighteen months after the release of ECAP's *Final Report*, a new Discussion Paper on HIV/AIDS in prisons was released. Written as part of the Project on Legal and Ethical Issues Raised by HIV/AIDS, jointly undertaken by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society, the paper reviews several new developments that occurred in Canadian and other prison systems since the release of ECAP's *Final Report*, and concludes:

[N]ot enough is being done to prevent the spread of HIV and other infectious diseases, in particular hepatitis C, in prisons. This poses a danger for inmates, but also for staff and the public, and raises the question of the legal responsibility of prison systems for transmission of HIV in prison.

Clearly, prison systems have a moral, but also a legal responsibility to do whatever they can to prevent the spread of infectious diseases among inmates and to staff and the public, and to care for inmates living with HIV and other infections. Canadian prison systems are failing to meet this responsibility, because they are clearly not doing all they could: measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment and methadone maintenance available to injection drug users, are not being undertaken in Canadian prisons, although other prison systems have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrations, politicians and the public.[10]

Responses to the Working Paper

Since November 1995, more than 500 copies of the *Discussion Paper* have been distributed in Canada

and internationally to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and/or drug use in prisons an opportunity to provide input into the Final Report. Over 70 responses have been received from prisoners, staff, physicians, lawyers, ministries of health and of corrections, and national and international organizations. The vast majority of respondents supported the conclusions and recommendations in the *Discussion Paper*. As stated by Mr Demers, Assistant Deputy Minister, Ministry of Attorney General of British Columbia, respondents generally agreed that

more is needed to be done in both federal and provincial correctional systems to minimize the very real public and individual health consequences resulting from disease transmission during high risk behaviours.

"There is no time to waste. It would be unethical not to immediately implement a fully integrated response to HIV/AIDS in Canadian prisons," wrote Anne Malo in her former capacity as National Coordinator of CSC's AIDS Programs. Dr Christiane Richard, a member of the Expert Committee on AIDS and Prisons and of the Health Care Advisory Committee of CSC, said: "I can't but agree with the conclusions, namely to implement in prisons, as soon as possible, a needle and syringe exchange program, as well as methadone maintenance." The Inmate Committee of William Head Institution in British Columbia emphasized that "the problems of disease transmission inside of our prisons, is an issue which should concern society in general because it will ultimately affect the community as a whole, and not enough is being done to prevent exposure to HIV and other infections." The committee continued by saying:

[B]y the look of some of the homemade syringes around here lately, we're in for a tough year. It certainly does seem ridiculous for Corrections Canada to supply condoms and not syringes. It is our opinion that many more people are in danger of contracting HIV/AIDS through intravenous drug use than through sexual practices. ... We view the present policy concerning hypodermic syringes as a blatant disregard for human life, and responsibility should fall squarely on their shoulders.

Not all respondents, however, were supportive of making sterile injection equipment available to inmates. According to Lynn Ray, National President of the Union of Solicitor General Employees, "[p]eace officers cannot condone, or be seen to condone, what amounts to an illegal activity. ... Does the CSC expect Correctional Officers to hand over a clean needle to an inmate knowing that an hour later they may have to extract him from his cell by force due to an overdose?" Ms Ray continues by emphasizing the importance of "a coherent, practical and manageable approach to controlling the influx of drugs into institutions. ... The flow of drugs into institutions can, and must, be curtailed. I am perfectly aware that it will be expensive, but the safety and health of staff are at stake."

Final Report on HIV/AIDS in Prisons Released

In July 1996, *HIV/AIDS in Prisons: Final Report* will be released. The report integrates all comments received from respondents to the *Discussion Paper* and proposes solutions that will enable CSC and

provincial prison systems to increase their prevention efforts and fulfil their legal and ethical obligations toward inmates, staff, and the public. It will be widely distributed and the federal and provincial prison systems will be asked to respond to it.

After reviewing relevant developments in prisons in Canada and internationally, the report stresses the following points:

The importance of a long-term, coordinated, strategic approach to HIV/AIDS and drug use in prisons. Thus far, CSC has taken a piecemeal approach, without undertaking any strategic planning involving all sectors of the organizations whose decisions impact on HIV/AIDS programming, and with no accountability for decisions taken. There is "a clear lack of coordination, commitment, inspiration, and vision."

The importance of coordination and collaboration between the federal and various provincial prison systems;

The importance of involving staff in the development of all initiatives taken to reduce the spread of HIV. In Switzerland, staff support availability of sterile injection equipment because they participated in the design of the programs, their security concerns were taken into account, and they realize that such programs are in their own interest;

The importance, for prison systems, of adopting a more pragmatic approach to drug use. The idea of a drug-free prison is no more realistic than the idea of a drug-free society. Because of HIV/AIDS, prisons cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy. Reduction of drug use is an important goal, but reduction of the spread of HIV and other infections is more important: "the spread of HIV is a greater danger to individual and public health than injection drug use itself." [11] Nevertheless, in 1995-96, CSC spent

\$1,200,000 for its urinalysis program;

\$1,000,000 for the other components of its Drug Strategy; but only

\$175,000 for its entire AIDS Program.

In addition, CSC spent \$5,656,324 (in 1994-95) for substance abuse offender treatment programs in the institutions and the community. [12]

The importance of understanding that making bleach, sterile needles, and methadone programs available to inmates does not mean condoning drug use, and is not in conflict with the role of a peace officer. Police officers in Canada and many other countries are supportive of needle exchange programs because they

have understood that they cannot eradicate drug use and that, as part of their role to protect the public, they have to contribute to reducing the spread of HIV.

The importance of acting without further delays to protect prisoners, staff, and the public. The recommendations made in the *Discussion Paper*, by ECAP, the Prisoners with HIV/AIDS Support Action Network,[13] the World Health Organization,[14] and many other national and international organizations need to be implemented to prevent the further spread of HIV among prisoners and to staff and the public.

The importance of educating the Canadian public and decision makers about the importance of implementing harm reduction measures in prisons. This is a public health issue requiring a pragmatic response - we owe it to the prisoners, and we owe it to the community, to protect prisoners from infection in prison.

Conclusion

"A disobedient Swiss prison doctor and a courageous experiment in a women's penitentiary have shown that effective HIV prevention based on harm reduction is feasible in prisons," and Swiss health authorities "have shown their colleagues elsewhere that it is possible to advocate public health measures in an environment where the language of discipline, security, and punishment predominate." [15] If prison systems in Canada and worldwide will fail to follow the Swiss example, they will be held morally and legally responsible for the harm resulting from their refusal to provide adequate preventive means.

- *Ralf Jürgens* For information about how to obtain a copy of the *Final Report*, contact Ralf Jürgens, Project Coordinator, at (450) 451-5457; fax: (450) 451-5134; email: ralfj@aidslaw.ca

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[1] J Nelles, A Fuhrer. Drug and HIV Prevention at the Hindelbank Penitentiary. Abridged Report of the Evaluation Results. Berne: Swiss Federal Office of Public Health, 1995.

[2] Ibid at 18.

- [3] J Nelles, T Harding. Preventing HIV Transmission in Prison: A Tale of Medical Disobedience and Swiss Pragmatism. *The Lancet* 1995; 346: 1507.
- [4] Personal communication with P Fäh, Warden of Oberschöngrün, on 1 March 1996.
- [5] See, Needle Exchange Programs Now Also in German Prisons. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(2): 18.
- [6] Australia: Needle Exchange in Prisons. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(3): 15.
- [7] Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Minister of Supply and Services Canada, 1994 at 68.
- [8] News Release. Correctional Service of Canada Announces Response to Final Recommendations Submitted by the Expert Committee on AIDS and Prisons. Ottawa: CSC, 24 March 1994.
- [9] Editorial. Prison System Guilty of AIDS Complacency. *Vancouver Sun*, 2 April 1994 at A18.
- [10] R Jürgens. *HIV/AIDS in Prisons: A Discussion Paper*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1995 at p 3 of the summary.
- [11] 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.
- [12] Personal communication with M Carpentier, CSC, dated 7 May 1996.
- [13] PASAN: *HIV/AIDS in Prison Systems: A Comprehensive Strategy*. A Brief from the Prisoners with HIV/AIDS Support Action Network (PASAN) to the Minister of Correctional Services and the Minister of Health. Toronto: The Network, June 1992.
- [14] WHO. *Statement from the Consultation on Prevention and Control of AIDS in Prisons, Global Programme on AIDS*. Geneva: WHO, 1987; and *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva: WHO, 1993.
- [15] Nelles & Harding, *supra*, note 3.

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US Appeal Courts Rule in Favour of Assisted Suicide

Less than a year ago, a federal district judge declared that Oregon Measure 16, legalizing physician-assisted suicide, violated the Equal Protection Clause of the US constitution.[1] In contrast, in March and April 1996, two US appeals courts ruled that Washington and New York statutes penalizing assistance in suicide are unconstitutional.

On 6 March 1996, the Ninth Circuit Court held, in *Compassion in Dying v State of Washington*,[2] that the Washington statute violated the Due Process Clause of the Fourteenth Amendment, to the extent that it "prohibits physicians from prescribing life- ending medication for use by terminally ill, competent adults who wish to hasten their own deaths."

One month later, the Second Circuit Court came to the same conclusion, but on different legal grounds. It ruled that the New York statutes criminalizing assisted suicide lacked a rational basis and therefore violated the Equal Protection Clause "to the extent that [they] prohibit persons in the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs." [3]

Although these decisions only deal with assisted suicide by terminally ill, competent adults, they have created general uncertainty about the legality of prohibitions of assisted suicide in many states. It has become more likely that the US Supreme Court will be willing to deal with the issue of assisted suicide.

Ninth Circuit Court: Liberty Interest in Assisted Suicide

The case was introduced by four physicians, three terminally ill patients who died before the case was decided, and *Compassion in Dying*, a nonprofit organization that supports assisted suicide. They argued that the prohibition of assisted suicide violated the right of terminally ill, competent patients who wish to hasten their death to obtain help from physicians. This right, they claimed, is an essential part of the constitutionally-protected liberty interest of the Due Process Clause of the Fourteenth Amendment. Moreover, they argued, the prohibition violated the Equal Protection Clause of the constitution insofar

as it prohibited a certain category of terminally ill patients to obtain aid in dying, while allowing it to others.

The First Instance Decision

At first instance, a district court followed both arguments and ruled that the Washington statute placed an undue burden on the constitutionally-guaranteed right to commit physician-assisted suicide and that it violated the Equal Protection Clause.[4] Rothstein J declared the law invalid insofar as it applied to cases of assisted suicide of terminally ill, competent adults.

The Appeal Decision

On appeal, a majority of a three-judge panel of the Ninth Circuit court reversed the ruling,[5] holding that there was no constitutionally-guaranteed right to physician-assisted suicide. Because of the importance of the case, the Ninth Circuit Court decided to rehear it en banc (in a "rehearing en banc," 15 judges of the court are invited to participate in the decision).

The En Banc Decision

In its judgment, the en banc Court ruled that there is a constitutionally protected "liberty interest in controlling the time and manner of one's death," or "in short, a constitutionally recognized right to die." In support of its argument it invoked, among other cases, the Supreme Court's decision in *Cruzan v Director, Missouri Department of Health*[6] (*Cruzan* involved the question whether family could request that treatment be withdrawn from an incompetent patient. In the case, the Supreme Court ruled that a state could impose strict standards of proof for determining whether the incompetent patients themselves would have wanted such withdrawal. According to many observers, the Court avoided recognizing a constitutional right to die[7]).

Acknowledging that countervailing state interests could justify a limitation of the liberty interest, the Court analyzed six state interests in prohibiting assisted suicide:

preserving life;

preventing suicide;

avoiding the involvement of third parties and precluding the use of arbitrary, unfair or undue influence;

protecting family members and loved ones;

protecting the integrity of the medical profession; and

avoiding adverse consequences caused by declaring certain statutory provisions unconstitutional.

However, the Court concluded that the state's interests are not compelling enough to outweigh the individuals' liberty interest. In particular, it saw no significant difference between the right to refuse or withdraw treatment - a right that is widely recognized - and assisted suicide. According to the Court, the fact that withdrawal of treatment is permitted indicates that the interests of the state will not seriously be affected by allowing assisted suicide.

Having found that the statute violates the Due Process Clause of the Fourteenth Amendment, the court saw no reason to discuss the Equal Protection Clause.

Risks in Permitting Assisted Suicide

Reinhardt J, speaking for the majority, recognized as a very serious concern "the fear that infirm, elderly persons will come under undue pressure to end their lives from callous, financially burdened, or self-interested relatives," or that terminally ill patients themselves may want to hasten their death "out of concern for the economic welfare of their loved ones." However, he continued by saying that, while both concerns require strict safeguards, it is not clear why competent adults should not be allowed to take economic considerations of surviving family members into consideration.

In his dissent, Beezer J stressed that in the American healthcare context, not only the elderly and the infirm, but also poor people and members of minority-groups, are at greater risk for being pressured into suicide. He concluded by saying that asking for the creation of a constitutional right to physician-assisted suicide - in a nation of "inadequate and unequal access to medical care" - is a "case of misplaced priorities."

In replying to this argument, the majority admits that "the country's refusal to provide universal health care ... demonstrates a serious flaw in our national values," but says that it is up to Congress, not the courts, to do something about it. And the majority, perhaps naively, is confident that Congress will take necessary action.

Comment

The reference to the different roles of Congress and the judiciary, and to the need of restraint for the latter - resulting in a refusal to address some of the dangers of legalizing assisted suicide in the US context - seems inconsistent. Indeed, it is in sharp contrast with the ease with which the Court rejects the legislative interests in prohibiting assisted suicide (eg, by brushing aside the distinction - made by an overwhelming majority of states - between assisting a terminally ill patient in committing suicide and ending medical treatment). The Court even goes so far as to suggest that the consumption of a lethal dose of medication should not be considered suicide, thus finding that legislators err in qualifying physicians' prescription of lethal doses of drugs as a form of assisted suicide.

Some other statements of the Court are also troubling: eg, it claims that "[t]erminally ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends;" it further claims that the risk of undue influence and abuse is greatly avoided by the fact that "physicians, who have a strong bias in favor of preserving life," are involved in the decision-making (Dr Kevorkian's practices and the fact that physicians in the Netherlands have assisted psychiatric patients in committing suicide clearly contradict such a statement).

Another En Banc Decision?

The case may continue. According to some sources, Ninth Circuit judges are pushing for another rehearing of the case, in an encore en banc procedure. Only 11 of the 30 judges of the Ninth Circuit participated in the en banc decision. The remaining 19 could request that the case be reheard for a third time. They could do so if consideration by a full court is necessary to maintain uniformity of the decision, or if the question is of exceptional importance. Surely, most people, opponents and proponents of assisted suicide alike, would agree that the latter applies to this case.

Second Circuit Decision

In July 1994, three physicians and three people in the final stages of their illness (two were suffering from AIDS) filed a complaint in front of a New York district court, claiming that the New York statutes prohibiting assisted suicide were in violation of the Constitution. The District Court rejected their claim,

stating that the issue of assisted suicide did not involve any fundamental liberty interest;

ruling that the State had a rational basis for distinguishing assisted suicide and withdrawal of treatment; and

ruling that it had legitimate interests in preserving life and protecting the vulnerable.

On appeal, the Second Circuit Court, in a decision rendered by an ordinary three-judge panel, held partially unconstitutional the New York statutes criminalizing assisted suicide. However, in contrast to the Ninth Circuit Court, the Court did not hold that these statutes violate the Due Process Clause of the Constitution, ruling instead that "[c]learly, no 'right' to assisted suicide ever has been recognized in any state in the United States." In the words of Miner J, "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of their illness, seek the right to hasten their death."

However, the Court held that the New York Statute violates the Equal Protection Clause of the Constitution insofar as it prohibits physicians to prescribe drugs, "to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness."

The Court argued that:

the prohibition of assisted suicide does not treat equally all terminally ill, competent people who wish to hasten their death;

while a law that treats people unequally is not necessarily unconstitutional, there has to be some rational relation between the unequal treatment and a legitimate state interest: this rational justification is lacking in the New York statutes (as the Ninth Circuit Court, the Court sees no rational distinction between withdrawing treatment and prescribing lethal drugs to patients); and

the risk of abuse is not greater than in cases of assisted suicide.

Remarkably, it seemed "clear" to the court "that most physicians would agree on the definition of 'terminally ill,' at least for the purpose of the relief that plaintiffs seek" (the bioethics literature, and the Dutch Chabot case, involving a patient who was considered to be 'terminally ill' because of her depression, would seem to clearly contradict the Court).

Calabresi J, concurring in the result, refused to make a final judgment about the validity of statutes prohibiting assisted suicide under either the Due Process or Equal Protection clauses. While he was willing to recognize that New York did not sufficiently justify its statutory prohibition of assisted suicide in the case of terminally ill, competent individuals, he left open the question of whether, "if the state of New York were to enact new laws prohibiting assisted suicide ..., such laws would stand or fall."

- *Trudo Lemmens*

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[1] See T Lemmens. Oregon's Measure 16 Declared Unconstitutional. Canadian HIV/AIDS Policy & Law Newsletter 1995; 2(1): 9.

[2] 1996 WL 94848 (9th Cir Washington), decision en banc.

[3] Quill v Vacco, Second Circuit, no 95-7028.

[4] *Compassion in Dying v Washington*, 850 Fed Supp 1454 (W D Wash 1994)

[5] *Compassion in Dying v Washington* 49 F 3d 586 (9th Cir 1995).

[6] 497 US 261 (1990).

[7] See references in T Lemmens. *Towards the Right to Be Killed? Treatment Refusal, Assisted Suicide and Euthanasia in the United States and Canada*. *British Medical Bulletin* 1996; 52(13.1-13):2.

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Canadian HIV/AIDS Policy & Law Newsletter

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TESTING & CONFIDENTIALITY

Project Begins Work on Testing and Confidentiality Issues

In Phase 1 of the Joint Network/CAS Project on Legal and Ethical Issues Raised by HIV/AIDS, testing and confidentiality issues were identified as one of the eight "top priority" legal and ethical issues raised by HIV/AIDS.

Many of the individuals and groups consulted expressed the view that, although many documents were produced about testing and confidentiality issues in Canada in the late 1980s and early 1990s, the issues remain unresolved or need to be re-examined. In particular, people expressed concern about:

testing for HIV without informed consent of the person being tested, which allegedly is taking place more and more frequently;

the lack of adequate counselling for people, whether they test positive or negative;

limited access to anonymous testing and, especially for women, to testing in general; and

calls for mandatory or compulsory testing of certain groups of the population, such as sex offenders, prisoners, health-care workers, immigrants, and pregnant women.

Recently, there has been increasing concern about the imminent availability of home testing for HIV, which raises public policy questions unique to HIV, as well as broader issues regarding the extent to which government regulatory bodies should protect the public from technically accurate devices that may have an adverse psychological impact.[1]

With regard to confidentiality, persons and individuals consulted often felt that the importance of maintaining confidentiality was not understood and expressed a need for guidance about situations in

which persons maintain that they "need to know" another person's HIV status. People were concerned about discrimination resulting from the disclosure of a person's HIV status. Examples of this included people being afraid to apply for benefits for fear that their HIV status would become widely known, particularly in smaller communities; or reluctance to lodge complaints with human rights commissions, because "people do not want to say to the world that they are HIV-infected."

From June 1996 to March 1997, the Project will:

produce a discussion paper on testing and confidentiality issues;

solicit comments on the discussion paper from a broad range of individuals and organizations;

organize a one-day workshop on the issues;

publish a final report on the issues, providing a comprehensive analysis of the issues and proposing solutions that would allow Canada to better address the existing problems and challenges.

A Literature Review: Testing[2]

Few legal and ethical issues raised by HIV/AIDS have been dealt with in so much depth as the issues raised by testing for antibodies to HIV. Many articles and reports deal with issues such as:

the possible objectives of testing;

proposals to test the entire population or specific populations for antibodies to HIV; and

disclosure of test results.[3]

Varied Opinion

Opinion about HIV antibody testing is widely varied:

There are those who recommend screening for all: their arguments are irrational and are not based on scientific fact. Others show interest in screening targeted groups: the problem then lies in the choice of the groups and in the motives of that choice, which are subjective as well as objective. Last, we found those who recommend voluntary screening: they defend both human rights and scientific inquiry.[4]

While hardly anyone recommends that the entire population should be mandatorily tested for antibodies

to HIV, some recommend that particular groups be subjected to mandatory or compulsory testing. For example, Werdel argues that testing should be required among prisoners, arrested prostitutes and drug users, and those who attend sexually transmitted disease and drug abuse clinics. In his view, "[t]hese groups are not only at a high risk of infection, but they also pose a serious risk to the health of the community," and "are likely to transmit the disease to innocent, healthy members of society." [5] However, most authors oppose mandatory or compulsory testing, whether of the entire population or of specific groups, "because it is unlikely to lead to changes in behaviour necessary to impede the spread of AIDS, and because of the potential for invasion of privacy and discrimination." [6] According to Persky, forced testing might locate a minuscule proportion of the "endangered population," but this would likely be offset by a larger proportion of the endangered population being "scared off" by the prospect and consequences of mandatory measures. [7] In the words of the American Civil Liberties Union, "civil liberties defects aside, mandatory testing seems destined to be counterproductive, irrationally wasteful of public funds, or both."

WHO's Position

According to a Statement from the Consultation on Testing and Counselling for HIV Infection published by the World Health Organization, "[m]andatory testing and other testing without informed consent has no place in an AIDS prevention and control program." The Statement contains the following reasons "why testing programs that do not require and secure an individual's informed consent can be damaging to efforts to prevent HIV transmission and are therefore not in the interest of public health":

because of stigmatization and discrimination directed at HIV-infected people, individuals who believe they might be infected tend to go "underground" to escape mandatory testing;

testing without informed consent damages the credibility of health services and may discourage those needing services from obtaining them;

mandatory testing can create a false sense of security, especially among people who are outside its scope and who use it as an excuse for not following more effective measures for protecting themselves and others from infection;

mandatory testing programs are expensive and divert resources from effective prevention measures. [8]

Field also concludes that funds would be put to better use in education and universal precautions to prevent the further spread of HIV, than in mandatory testing programs. She points out that proposals for mandatory testing generally are political rather than health policy proposals, and that they are often motivated by anti-gay or anti-drug user feelings and are rarely animated by legitimate public health objectives. [9]

Support for Voluntary Testing

While these authors oppose mandatory or compulsory testing, they support widely available, voluntary testing programs, coupled with adequate counselling and the assurance of anonymity or, if that is not possible, strict protection of confidentiality.

Testing: The "Canadian Approach"

In Canada there is consensus that testing should always be voluntary (except in cases of donations of blood, blood products, organs and tissue)[10] and carried out only after the patient has given informed consent,[11] and that it should only be done "when counselling and education before and following testing are available and offered, and when confidentiality of results or anonymity of testing can be guaranteed." [12] The National Advisory Committee on AIDS established a "general principle governing HIV antibody testing in Canada," according to which, in order "to facilitate HIV antibody testing, to avoid potential harms and harms while seeking the greatest benefits from HIV antibody testing, and to minimize the likelihood of coercion, voluntary testing should be the preferred approach for HIV antibody testing in Canada." [13] According to the Committee, compulsory HIV antibody testing is only justified "if its benefits outweigh its potential harms and is the least restrictive, least invasive, likely to be effective, reasonably available approach." An analysis of the benefits and harms of compulsory testing to the individual being tested, to the community and to society in general led the Committee to conclude that at "this time, in Canada, compulsory HIV antibody testing is unwarranted." [14] The Committee also made specific recommendations on testing of certain population groups (prostitutes, health-care personnel, prisoners, immigrants, etc) or in certain situations (when applying for insurance, seeking health care or employment, or are being evaluated for adoption). In all cases, it came to the conclusion that compulsory or mandatory testing is unwarranted.

Anonymous Testing

No consensus has been reached on the issue of anonymous testing. For the Federal/Provincial/Territorial Working Group on Confidentiality in Relation to HIV Seropositivity,[15] anonymous testing is "less optimal" than nominal testing. In general, however, it is recommended that anonymous testing be accessible to those seeking testing. For example, in Nova Scotia, the provincial government expressed its agreement with testing and reporting procedures that will encourage "the largest number of individuals to be tested as soon as possible." [16] The Ontario Law Reform Commission also recommended that people should be provided with the opportunity to test non-nominally or to remain anonymous.[17] According to the AIDS Committee of Ottawa, anonymous testing "is the only acceptable and legal way of designing a testing scheme." [18]

Testing: The Future

As stated by Bayer, future policy determinations on screening will depend on the evolving technology of testing and on the "relative balance of moral and political values and the institutional and professional forces through which those values may find expression." [19]

Confidentiality: A Literature Review

A country doctor received a notice from the Red Cross Transfusion Service, recommending that his patients who were transfused with a blood product between 1980 and 1985 be tested for HIV; the risk of infection for any individual was low but finding those infected was important. When Tom came for his annual check-up, his doctor ordered an HIV test for antibodies to HIV, but Tom was not informed as the doctor did not wish to worry him. Tom had been given a blood transfusion in 1983 after a car accident. Two weeks later, on a Friday afternoon, the doctor was amazed to receive the news that Tom was infected with HIV. He called Tom on the telephone and spoke to his wife Mary, since Tom was still working in the fields. "Mary," he said, "you are going to have trouble believing this, but Tom has AIDS." Tom in fact did not have AIDS, he was infected with HIV. A shocked Mary turned to her friend Susan who was in the kitchen at the time and said, "Oh my God Susan, Tom's got AIDS." She continued her conversation with the doctor who suggested that both Tom and Mary should come and see him on Monday, when they could discuss what it all meant.

There were many tears in that family that night and when Mary went to shop at the supermarket in town on the Saturday morning, an embarrassed store manager asked her if she would shop elsewhere. The news that Tom had AIDS was all over town. Tom did not have adequate life insurance. He would lose his property, lose his friends, and lose his respected position in his small community.[20]

AIDS is not just another infectious disease. This case well "illustrates why it is so important that informed consent be obtained before HIV testing, why results should never be given to patients over the phone, how cruel communities can be if they are ignorant and uncaring, and how we must continue to strive to make sure that the medical profession is adequately educated about this disease." [21] Examples of the possible negative consequences of disclosing HIV/AIDS-related personal information are also provided in the report of the Information and Privacy Commissioner of Ontario.[22] According to the Commissioner, "[t]esting procedures must be clearly designed to reassure all sectors of society, especially those engaging in high risk activities, that being tested or providing HIV/AIDS-related personal information will not lead to disclosure of such information beyond those who absolutely need that information, such as one's physician."

Better Protecting Confidentiality

Because confidentiality of HIV-related information is so important, and because legislation is in itself an inadequate means of improving protection of HIV/AIDS-related personal information, Glenn et al have argued that:

there is a need to improve the effectiveness of existing means of protection of confidentiality, and to develop new methods of analysis and protection;

there is a need for widespread development of soft law (written procedures, policies, guidelines, protocols), at the level of individual communities and institutions, to enhance the protection of the privacy of persons living with HIV/AIDS; and

collection of HIV/AIDS-related information should occur only if its benefits outweigh its risks to personal privacy.[23]

Because of the possible negative consequences of disclosure of someone's positive HIV status for that person, the report of the Privacy Commissioner of Canada urges "caution in the collection of AIDS-related personal information, caution in its use and caution in its disclosure." However, the report points out that the situation calling for this extreme caution may change: "Disclosure of AIDS-related personal information may one day not threaten the physical and psychological well-being of those affected by the disclosure ... nor drastically alter the conditions of their membership in Canadian society. But for now, the strong possibility exists that public, and even government, opinion and actions could harm those individuals whose personal information is disclosed - without providing any measurable benefit to society." [24]

The Importance of Confidentiality

Confidentiality may be particularly important with respect to HIV/AIDS, but is generally important in medicine. According to Bayer,[25] there are two reasons for this:

the ethical reason is that respecting confidentiality is a way of respecting the dignity of the patient;

the pragmatic reason is that, if physicians and other professionals are to elicit information from patients and clients, they must be able to guarantee that what is revealed will be confidential: "In the absence of such a pledge, there can be no assurance of candor, and in the absence of candor, the capacity to engage in effective clinical work would be impaired."

Exceptions

While acknowledging the importance of respecting confidentiality, most agree that there are situations in which a breach of confidentiality would seem to be ethically warranted: confidentiality, while highly valued, "is not a sacrosanct principle." [26] Spencer argues that despite the historic importance of safeguarding medical confidentiality, secrecy "must be compromised as necessary to protect life." [27] However, most authors agree that information about HIV status should be disclosed only where there is a "reasonable basis for believing that the conduct of an HIV-infected person constitutes an unacceptable risk to the health of others," [28] for example in the case of an HIV-positive individual who refuses to warn an unsuspecting sexual partner. [29] Gillett suggests that doctors should be open with their patients

and that "the doctor is bound to share his moral dilemma with the patient and inform him of his intention to breach confidentiality." [30]

Difficult Questions

However, while most agree that there are situations in which breaching confidentiality would be justified, such breaches raise difficult questions:

What will occur if it becomes generally known that clinicians breach confidentiality to protect third parties? Will patients cease to speak with candor about their behaviour? ... Will the public health suffer as a consequence? [31]

According to Bayer, we face an extraordinary irony: the ethics of the clinical relationship, which usually favour strict confidentiality, appear to dictate a breach of confidentiality, while the ethics of public health, which are usually less concerned with confidentiality, may dictate a stricter adherence to it. In the same vein, Gillon concludes by saying:

Although in highly exceptional cases there may be justifications for overriding confidentiality, the requirement of medical confidentiality is a very strong, though not absolute, obligation. Patients, their contacts, doctors and their staff, and the common good are most likely to be best served if that tradition continues to be honoured. [32]

Kain is concerned that persons living with HIV/AIDS would not speak freely about either their antibody status or sexual activities after being informed that such disclosure could result in a breach of confidentiality and the resulting increased opportunity for discrimination. He concludes by saying that the question of whether to breach confidentiality seems to overshadow a more crucial question:

If a client is not telling his or her sexual partner about his or her seropositivity, why not? Prevention of the spread of AIDS lies not in police-like reporting practices but rather in the working through of deep-rooted issues of rejection, abandonment, loneliness, homophobia, and infidelity. Clients come to counsellors for help with troubling issues, not to be turned over to health officials. [33]

This leads to another important issue pointed out by Dickens. Although acknowledging the importance of protecting confidentiality, Dickens recognizes that protecting people from discrimination may be more important. In his view, legislative planning is better devoted not simply to enacting further confidentiality provisions but also to minimizing discrimination against persons living with HIV/AIDS. [34] Similarly, Spencer suggests that legislatures devote their attention to the social discrimination against AIDS that hampers voluntary HIV testing programs and control of HIV. [35]

Partner Notification Programs

There seems to be consensus that partner notification programs have a role in efforts to reduce the spread of HIV, although only a limited one. According to the World Health Organization, such programs should be considered, but only within the context of a comprehensive HIV/AIDS prevention and control program. It is recognized that partner notification raises serious medical, logistical, social, legal and ethical issues, and has the potential to produce individual and social harm and to detract from other HIV/AIDS prevention and control activities. Therefore, according to the [Canadian] National Advisory Committee on AIDS, the major prevention and control effort must be education aimed at personal risk reduction through behavioral change to reduce transmission, rather than partner notification programs. However, the Committee acknowledges that "individuals who may have no reason to suspect that they may have been exposed to HIV should have the opportunity to know that they may have been exposed." [36]

Patterson proposes a series of recommendations, including encouraging voluntary contact tracing and referring "worst" cases to a case-management panel rather than to leave responsibility for any decision to breach confidentiality with individual health-care providers. [37] The Ontario Law Reform Commission's report also contains a list of recommendations. According to the report:

patients should be encouraged to notify partners voluntarily, or to cooperate with their personal physician's attempt to do so, within a "physician-centred" program of partner notification;

physicians should be able to directly notify identifiable, unsuspecting partners of HIV-infected patients who are at risk, under clearly defined guidelines governing the disclosure of HIV-related information; and

physicians who notify partners should be protected against the potential for liability resulting from responsibilities relating to partner notification. [38]

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[1] See, eg, BM Branson, HD Gayle. Home Testing for HIV - It's Coming. Are You Ready? International AIDS Society Newsletter no 4, March 1996; R Bayer et al. Testing for HIV Infection at Home. New England Journal of Medicine 1995; 332: 1296-99; KA Phillips et al. Potential Use of Home Testing. Ibid, at 1308-10.

[2] 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 HIV/AIDS Legal Network and Canadian AIDS Society, 1995.

[3] See, eg, MA Field. Testing for AIDS: Uses and Abuses. In Gostin LO, Curran W (eds). The Harvard AIDS Legislation Project. American Journal of Law & Medicine 1990; XVI(1-2): 34-106; National Advisory Committee on AIDS. Human Immunodeficiency Virus Antibody Testing in Canada. Recommendations of the National Advisory Committee on AIDS. Canada Diseases Weekly Report 1989; 15(8): 37-43; Ontario Law Reform Commission. Report on Testing for AIDS. Toronto: The Commission, 1992.

[4] P Enel et al. Ethical Confusion: Detection of HIV Seropositives. AIDS & Public Policy Journal 1992; 7(1): 42-49.

[5] AA Werdel. Mandatory AIDS Testing: The Legal, Ethical and Practical Issues. Notre Dame Journal of Law, Ethics & Public Policy 1990; 5: 155-255.

[6] L Gostin, WJ Curran. AIDS Screening, Confidentiality, and the Duty to Warn. American Journal of Public Health 1987; 77(3) (reprinted in AIDS Reference Guide July 1988, No 512).

[7] S Persky. The Practical Case Against Mandatory Testing. In: Russell J (ed). Liberties. Vancouver: New Star Books, 1989, at 176-185.

[8] World Health Organization. Statement from the Consultation on Testing and Counselling for HIV Infection. Geneva: WHO Global Programme on AIDS, 1992 (WHO/GPA/INF/93.2).

[9] Supra, note 1.

- [10] Parliamentary Ad Hoc Committee on AIDS. *Confronting a Crisis: The Report of the Parliamentary Ad Hoc Committee on AIDS*. Ottawa: The Committee, 1990.
- [11] Canadian Medical Association. *Counselling Guidelines for Human Immunodeficiency Virus Serologic Testing*. Ottawa: The Association, 1993.
- [12] National Advisory Committee on AIDS, *supra*, note 1.
- [13] MA Somerville, N Gilmore. *Human Immunodeficiency Virus Antibody Testing in Canada. A Report Submitted to and Approved by the National Advisory Committee on AIDS*. Montréal: McGill Centre for Medicine, Ethics and Law, 1988.
- [14] *Ibid* at 23.
- [15] Federal/Provincial/Territorial Working Group on Confidentiality in Relation to HIV Seropositivity. *Report*. Ottawa: The Working Group, 1988.
- [16] Government of Nova Scotia. *Nova Scotia AIDS Strategy*. December 1993.
- [17] *Supra*, note 25.
- [18] AIDS Committee of Ottawa. *Submission to the Ontario Law Reform Commission Project on HIV/AIDS Testing*. Ottawa: The Committee, no date.
- [19] R Bayer. *Ethical and Social Policy Issues Raised by HIV Screening: The Epidemic Evolves and so Do the Challenges*. *AIDS* 1989; 3: 119-124.
- [20] JM Dwyer. *Legislating AIDS Away: The Limited Role of Legal Persuasion in Minimizing the Spread of Human Immunodeficiency Virus*. *Journal of Contemporary Health Law and Policy* 1993; 9: 167-176 at 171-172.
- [21] *Ibid*.
- [22] Information and Privacy Commissioner/Ontario. *HIV/AIDS: A Need for Privacy*. The Commissioner, 1990.
- [23] HP Glenn et al. *HIV Infection, AIDS and Privacy*. Working Paper. Montréal: McGill Centre for Medicine, Ethics and Law, 1990.
- [24] The Privacy Commissioner of Canada. *AIDS and the Privacy Act*. Ottawa: Minister of Supply and

Services Canada, 1989.

[25] R Bayer. Confidentiality and Its Limits. In: H Fuenzalida- Puelma et al (eds), Ethics and Law in the Study of AIDS. Pan American Health Organization Scientific Publication No. 530.

[26] RL North, KH Rothenberg. The Duty to Warn "Dilemma": A Framework for Resolution. AIDS & Public Policy Journal 1989; 4(3): 133-141.

[27] ETH Spencer. The Sexually Active, HIVInfected Patient: Confidentiality Versus the Duty to Protect. Psychiatric Annals 1988; 18(10): 571-576.

[28] Federal/Provincial/Territorial Working Group, supra, note 15.

[29] See, eg, Bayer, supra, note 25; B Freedman. Violating Confidentiality to Warn of a Risk of HIV Infection: Ethical Work in Progress. Theoretical Medicine 1991; 12: 309-323; M Gillespie. AIDS: Detection and Control. University of Toronto Faculty of Law Review 1989; 47(2): 354-382.

[30] G Gillett. AIDS and Confidentiality: The Doctor's Dilemma. In: Almond B (ed). AIDS - A Moral Issue. The Ethical, Legal and Social Aspects. MacMillan, 1990, at 56-67.

[31] Bayer, supra, note 25.

[32] R Gillon. AIDS and Medical Confidentiality. British Medical Journal 1987; 294: 1675-1677.

[33] CD Kain. To Breach or Not To Breach: Is that the Question? A Response to Gray and Harding. Journal of Counselling and Development 1988; 66: 224-225.

[34] BM Dickens. Legal Limits of AIDS Confidentiality. Journal of the American Medical Association 1988; 259(23): 3449-3451.

[35] Supra, note 27.

[36] National Advisory Committee on AIDS, supra, note 1.

[37]

[38] Supra, note 1.

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US - Hospital Sued Over Clandestine HIV Test

The American Civil Liberties Union filed a suit in federal court on 10 April 1996 charging that a suburban Chicago hospital tested a 33-year-old man for HIV without his consent.[1]

The suit alleges that the hospital and one of its physicians violated state and federal law by testing the man for HIV without informing him or asking for his consent. The man, who had been admitted for minor surgery, discovered that he had been tested when he found charges for the test on his hospital bill.

The suit charges that the hospital subjected the man to emotional distress, anxiety, embarrassment, and humiliation, as well as potential discrimination.

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[1] Reported in CDC AIDS Daily Summary of 11 April 1996, with reference to United Press International of 10 April 1996.

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CANADIAN NEWS

Renewal of AIDS Strategy Needed

Canada faces a crisis in AIDS funding at the federal level. Already, funding for new AIDS research initiatives in basic, clinical and Behavioural science has been cut off. The existence of other programs - such as funding for community-based AIDS organizations, the HIV/AIDS Treatment Information Network, the Clinical HIV Trials Network, and the National AIDS Clearinghouse - is threatened.

The crisis is due to the failure on the part of the federal government to make any commitments with respect to AIDS funding beyond March 1998, the end of Phase II of the National AIDS Strategy; and the expectation that - whatever federal funding is eventually made available - funding will be reduced, perhaps to levels significantly lower than the current ones.

The Strategy

Phase II of the National AIDS Strategy is a five-year plan involving expenditures of about \$40.7 million each year. The funds are specially earmarked for AIDS; they are not part of the core Health Canada budget. The annual budget breaks down as follows (these are average figures; the precise amounts vary each year):

Support to Non-Governmental Organizations: \$ 9.8 million

Prevention and Education: \$ 6.2 million

Research and Epidemiological Monitoring: \$17.8 million

Care, Treatment and Support: \$ 5.4 million

Coordination and Collaboration: \$ 1.5 million

Included in these figures are:

\$5.5 million for NHRDP;

\$7.5 million for the AIDS Community Action Program, which provides funding for local community-based organizations;

\$3.0 million for the Canadian HIV Trials Network, which provides support for conducting clinical trials in Canada;

\$2.0 million for the HIV/AIDS Treatment Information Network, operated by the Community AIDS Treatment Information Exchange; and

\$800,000 for the National AIDS Clearinghouse, operated by the Canadian Public Health Association.

Any significant reduction in the annual federal AIDS budget would result in severe cuts to these programs. Depending on the size of the reduction, some programs may have to be abolished. For community-based organizations in provinces where governments are providing little or no AIDS funding and support, the loss of federal funding could threaten their survival.

So far, the federal government has not made any formal statements about whether, and to what extent, it will provide funding for AIDS when Phase II of the Strategy expires. However, many fear that the Strategy will not be formally renewed. Indeed, it seems that the government would like to eliminate all national strategies, arguing that they don't work well, that renewing them every time they expire is work intensive, and that it would be better to roll them into ongoing programs within Health Canada. Another unstated reason is that these strategies cost money and that the government is looking for more and more ways to reduce expenditures. Former Minister of Health, Diane Marleau, is on the record saying that, while there may not be another phase of the Strategy, the federal government will continue to spend money on AIDS - however, in all likelihood, at levels lower than the current ones.

If the Strategy is not renewed, funding for AIDS would have to come out of the regular Health Canada budget, at a time when the ministry is facing very serious cuts to its budget.

Effects

The effects of government reluctance to make any commitments with respect to AIDS funding beyond March 1998 are already being felt: although Phase II of the Strategy does not end for another twenty months, the National Health Research and Development Program (NHRDP) is no longer accepting any new applications for AIDS-related research projects. Traditionally, NHRDP funds long-term research

projects that can span over several fiscal years. Because of the uncertainty surrounding AIDS funding beyond March 1998, NHDRP decided it cannot fund any new projects, causing big problems for researchers in a field evolving as rapidly as AIDS research. Furthermore, the ongoing effort to attract young researchers and researchers from other fields to work in AIDS are in jeopardy because of the NHRDP decision.

Increasing Demands

The uncertainty over continued dedicated funding for AIDS comes at a time when the demands of the AIDS epidemic are increasing:

the number of new AIDS diagnoses continues to grow each year;

every year, large numbers of people test HIV-positive;

studies reveal that women, injection drug users, prisoners and young people - especially gay youth - are particularly vulnerable; and

organizations offering services to persons living with and/or affected by HIV/AIDS are experiencing a rapid increase in people seeking care and support services.

To make matters worse, provincial governments are cutting back on social services, due in no small part to the reductions in federal transfer payments. As a result, more and more people are approaching community-based organizations for financial assistance, placing even greater demands on them.

Conclusion

Clearly, the federal government needs to (at least) maintain funding at current levels. If it doesn't, Canada's efforts to prevent further spread of HIV and to offer care, support and treatment to those living with HIV/AIDS will be severely affected. The result will be increased numbers of persons living with HIV/AIDS, increased suffering, and increased costs for persons infected and affected and, ultimately, for Canadian society as a whole.

- *David Garmaise*

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What is the impact of not having a National AIDS Strategy?

The National AIDS Strategy has received a significant amount of criticism, because it is missing many of the essential elements of a national strategy: a vision, a sense of direction, clear goals and measurable objectives. However, this does not mean that it cannot be strengthened. Canada needs, and can produce, an efficient AIDS strategy, a strategy that all stakeholders can endorse and support, and that provides real leadership.

Not renewing the Strategy would have significant negative consequences:

A decision not to renew the National AIDS Strategy would be seen as a lessening of the commitment of the federal government to confront AIDS. At a time when the demands of the epidemic are growing, this would be a wrong message to send out.

The Strategy comes with a significant budget, and many valuable federal programs owe their existence to it. Some of these programs provide funds directly to local community-based organizations. If the loss of the Strategy results in, or is accompanied by, a significant reduction in the AIDS budget, this would have very serious repercussions on Canada's fight against the epidemic.

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Discussion Paper on Criminal Law and HIV/AIDS

In April 1996, the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society released a Discussion Paper on Criminal Law and HIV/AIDS[1] as part of Phase II of their Joint Project on Legal and Ethical Issues Raised by HIV/AIDS. The Paper reviews the current state of Canadian law in this area, considers the experience in other jurisdictions, explores in detail the application of existing criminal offences and HIV-specific statutes, and questions whether criminalizing HIV transmission and/or exposure is desirable or justified in Canada.

Background

Many of those consulted during Phase I of the Project expressed concern about proposals to amend the Criminal Code to create an HIV-specific offence. With co-funding obtained from Justice Canada, the Project started working on the issue of criminalization of HIV transmission in November 1995.

The Discussion Paper considers the following questions:

How has the criminalization of HIV been addressed to date by judges, prosecutors, legislators, governmental and non-governmental organizations, academics, activists, service-providers, and the media?

What behaviours have attracted this attention?

Is the use of the criminal law appropriate, effective, and acceptable as a response? Are other mechanisms, such as those available under public health legislation, preferable?

If the criminal law is to be used, what are the appropriate circumstances for its use? In what form should it be applied? Are existing provisions of the Criminal Code appropriate and adequate, or should a new offence specific to HIV be enacted?

If the Criminal Code were to be amended, what form should this new offence take?

HIV Transmission and Canadian Criminal Law to Date

There have been at least 14 cases to date in Canada in which existing Criminal code provisions have been applied in an attempt to criminalize transmission of HIV or acting in such a way as to expose another to the risk of infection. Most cases have involved sexual activity; there are no reported prosecutions for sharing contaminated injection equipment. In one recent case, criminal prosecution arose for biting.[2] Charges have been laid for "criminal negligence causing bodily harm", "common nuisance", assault, "administering a noxious thing", and attempted murder. Terms of imprisonment ranging from one to more than eleven years have been imposed.

A private member's bill introduced in Parliament in October 1995 would have gone so far as to punish, with up to 7 years' imprisonment, any person who "knows or should reasonably know" of their HIV+ status and who "wilfully or recklessly" engages in sexual intercourse or any physical contact that may transmit the body fluid of one person to another's bloodstream.[3]

Policy Recommendations and Commentary

Numerous organizations and institutions have argued against the use of the criminal law. There is consensus that HIV transmission and risky behaviour are matters of public health first and foremost, and that the criminal law's role is limited at best. The legal academic literature reflects this conclusion, although commentators differ in their conclusions as to whether the criminal law should be used at all, and in what manner and circumstances.

Similarly, those interviewed for the Discussion Paper disagreed as to what activity might warrant criminal prosecution, and [...] whether criminalization, if pursued at all, should take the form of an amendment to the Criminal Code or the evolving application of existing offences. Nevertheless, there was overwhelming agreement that [...] there is a need to educate prosecutors and the judiciary about HIV/AIDS issues. Furthermore, all those interviewed agreed that criminal prosecutions should be a measure of last resort and should not be undertaken lightly. Most agreed that [...] measures under public health law should be employed first; however, procedural safeguards within public health schemes should be improved; several recommended guidelines for public health officials.

Arguments for Criminalization

The Paper reviews the standard rationales offered for the application of the criminal law.

Retribution

If the goal is to impose retribution on those who engage in HIV-transmitting/exposing behaviour, this can only ever justify a very limited application of the criminal law - namely, to the most egregious and

morally culpable cases, such as those in which an accused, aware of his/her serostatus, deliberately and maliciously seeks to infect another. But the bulk of HIV-transmitting instances are accidental, not deliberate.

Denunciation

The denunciatory function of the criminal law is also invoked as an argument in favour of criminalization. Here too, there is not much point in condemning accidental harms. But the Paper also suggests there may be little benefit to be gained in adding the denunciation inherent in a criminal conviction to the moral outrage already expressed against HIV-positive persons who engage in activity that infects others.

Incapacitation

The Paper rejects the argument that incarcerating an HIV-positive individual convicted of exposing others to infection will serve to incapacitate him or her from doing further harm. Rather than preventing an accused from engaging in further activity that may transmit HIV, incarceration places that person in a milieu where it is more, not less, likely that transmission will occur.

Rehabilitation

There is little support for the proposition that criminal prosecutions and penalties serve any significant rehabilitative function, and there is widespread agreement that counselling and support are far more effective means of rehabilitating a person who has engaged in risky activities.

Deterrence

The most common argument for criminalization is that it will serve to deter people from conduct that transmits, or risks transmitting, HIV. Yet most commentators acknowledge that the criminal law is unlikely to have any significant deterrent impact. The deterrence argument for criminalization may rest on inaccurate premises about the reasons for which people engage in activity that transmits, or exposes others to, HIV - activities that occur in a social context informed by highly complex relationships, levels of knowledge and power, expectations, and assumptions.

The Paper concludes that, on balance, the usual rationales for criminalization offer only a weak case for criminally prosecuting HIV+ individuals who engage in risk activities.

Charter Scrutiny

In addition, the Paper notes that criminalization may warrant Charter scrutiny. Criminalizing risk activities by HIV-positive people raises the question of whether the "principles of fundamental justice" permit such an infringement of the rights to liberty and security of the person of an HIV-positive

individual (s 7). Furthermore, it may be an unconstitutional violation of equality rights to criminalize certain conduct by people living with HIV/AIDS if that conduct is otherwise legal on the part of those who are HIV-negative.

Arguments Against Criminalization

According to the Paper, there are also several policy considerations that militate strongly against criminalizing HIV transmission/exposure. First, prosecutors may have difficulty proving that an accused's acts were the cause of another's infection with HIV. It may also be difficult in many cases to prove that the accused "knowingly" risked or caused another's infection.

Second, the Paper echoes the widespread criticism that criminalization will seriously undermine and impede public health initiatives. If knowledge of one's HIV-positive status may result in criminal liability for engaging in unsafe sex or needle-sharing, then criminalization will discourage testing, a key component of an effective HIV/AIDS response strategy. In addition, much support for criminalization may be rooted in misinformation and fear about HIV/AIDS; introducing criminal prosecution as a means of further denouncing the handful of individuals who may intentionally engage in risky behaviour may contribute to the stigmatization of all people with HIV/AIDS. This would, in turn, undermine broader public health efforts in the areas of education and counselling; stigmatization "drives underground" those individuals and communities most in need of health and social services. Finally, criminalization may create a false sense of security among HIV-negative people and encourage a lack of responsibility on their part.

Third, the Paper notes the possibility of selective prosecution, expressing concern that the burden of criminalization would fall disproportionately upon already marginalized communities.

Finally, criminalization would entail significant intrusions into the privacy of HIV-positive people suspected of engaging in risk activities, and their sexual or injecting partners. The Paper urges that any coercive legislative response must be guided by the principle of "most effective, least intrusive."

Public Health Law: An Alternative?

Public health legislation, while varying across jurisdictions, generally contains *quasi-criminal* provisions authorizing the use of the state's coercive power to prevent the spread of disease, including orders restraining a person with a transmissible disease from conduct that may infect others, and powers to detain a person who contravenes such an order. The Paper cautions that these applications of public health law raise some of the same concerns as full-scale criminalization: at a minimum, public health law requires additional guidelines for the exercise of officials' coercive powers and improved procedural safeguards for those whose liberty, privacy and equality may be infringed by such interventions.

The Paper concludes that public health law can achieve some of the same goals which are advanced as justifying criminalization, with fewer detrimental side effects on general health protection and

promotion efforts and individual rights. Criminal law is certainly better suited to punish and denounce, while public health powers are preferable for achieving rehabilitation and incapacitation. The Paper asks: "Can we afford to let a retributive interest dominate public policy, especially in the context of an epidemic whose spread has already been exacerbated by misguided moralizing and scapegoating?"

The Paper also questions whether adding the threat of criminal prosecution to a public health order already enforceable by a court will contribute significantly to modifying behaviour. Furthermore, the Paper notes that part of the skepticism regarding public health provisions, and the consequent urge to criminalize, may be that, when effective, public health measures are not particularly visible. It is only those cases in which public health measures fail, and criminal charges are brought, that receive widespread media attention and public discussion. Ironically, the successful use of public health powers may contribute to a general perception of their inefficacy.

Traditional Criminal Law Offences

Common Nuisance

The Paper argues that the use of the "common nuisance" offence to prosecute for risky sexual activity is inappropriate. Discrete sexual acts or instances of sharing needles with specific individuals do not endanger the health of "the public," as was recognized in *Ssenyonga*.^[4] Also of concern was the willingness of the court in *Thornton*^[5] to impose criminal liability for the negligent breach of a common law duty, seemingly drawn largely from the civil law of tort, to refrain from conduct which could cause harm to other persons. The Criminal Code specifically eliminates all common law criminal offences; only those offences defined in the Code are criminal acts in Canada.

Negligence

Concerns about imposing criminal liability on the basis of simple negligence are fundamental to the use of criminal negligence charges as well. The offence itself requires that an accused have shown "wanton or reckless disregard for the lives or safety of others,"^[6] but it is unclear exactly what degree of mental culpability is required.

Assault

In the case of assault charges, several arguments have been advanced that the consent of the accused's partners in such cases is inoperative, rendering the sexual activity an "assault" within the meaning of the Criminal Code. It has been argued that the failure to disclose one's HIV-positive status is "fraud" as to "nature and quality" of an act such as sexual intercourse, which vitiates a partner's consent to that activity. In two cases, courts have rejected the argument that there was no valid consent as a result of the accused's failure to disclose his HIV-positive status;^[7] a third case is scheduled to proceed to the BC Court of Appeal in June 1996. Prosecutors have also argued that unprotected sex with an HIV-positive person exceeds the scope of their partner's implied consent, and finally, that any consent given is invalid

on public policy grounds. However, the Paper concludes that the law of assault is an inappropriate response to the non-disclosure of HIV-positive status, and is ill-designed to address matters as complex as transmission of a virus via consensual sex or needle-sharing.

Attempted Murder

The Paper approves of the acquittals in the two cases in which attempted murder charges have been laid: a conviction requires proof that the accused acted with the intent of causing death. Most such cases, in Canada and elsewhere, have arisen where the accused is in conflict with police or prison officers, or during suicide attempts; it is highly questionable whether, in situations of extreme stress, an HIV-positive person has a desire to kill because they have acted irresponsibly. Those who truly intend to kill would be unlikely to choose such an indirect means as biting or spraying blood; murder prosecutions significantly overestimate the risk of infection from such an incident.

Should a New Offence be Created?

The Paper concludes that the criminalization of HIV transmission is unwise and unwarranted. However, there is considerable disagreement on this point; many of those who advocate the use of criminal law in some form argue that this should be done by amending the Criminal Code to add a specific offence prohibiting certain risk activities. Opinion seems to favour an approach that does not single out HIV/AIDS specifically. The Paper notes that in 1985, Parliament repealed the section of the Criminal Code making transmission of venereal disease an offence, recognizing that the issue was one of public health, not criminal law.

The Paper discusses how such an offence should be drafted were this route adopted. If deterrence is the most legitimate of the arguments for criminalization (and the Paper doubts the strength of this argument), it follows that, if the criminal law is to be used at all, the focus should be on prohibiting activity that risks transmitting the virus, rather than imposing sanctions only where actual infection results.

Furthermore, any offence that extends to activity that carries no substantial likelihood of transmission is unjustifiably broad; any provision should clearly exclude from criminal liability any lower-risk activity, and certainly prosecutions for conduct such as biting or spitting are unsupportable. One approach would be to specify, as a required element of the offence, that liability attaches to the accused's conduct only where s/he "reasonably" expected that conduct to injure another by transmitting HIV.

According to the Paper, *purposefully* infecting or exposing another to infection with HIV is conduct that may appropriately be criminalized. Most commentators have also accepted that any intent to infect or expose another should be criminalized - this includes not only a purpose to do so but also the knowledge that one's conduct is "reasonably certain" to bring about such a result. The Paper stresses that to criminalize intention would have a detrimental impact on HIV testing, as actual knowledge of one's HIV-positive status could expose someone to criminal liability. The importance of HIV testing outweighs any

small benefit to be gained by prosecuting the minority of HIV-positive individuals who act with the intent of infecting or exposing others.

The Paper strongly recommends against criminalizing behaviour that is merely reckless or negligent; in applying such low thresholds for criminal liability, the criminal justice system is too amenable to be influenced by misinformation and bias, opening the door to systemic discrimination against injection drug users, sex trade workers, and sexual minorities.

Finally, the Paper identifies a number of legal defences that should be available to the accused charged under any new HIV-specific offence. There is considerable, albeit not unanimous, agreement that taking precautions to prevent transmission should be sufficient to avoid criminal conviction on a charge of HIV transmission/exposure, and the Paper supports such a view.

Similarly, the Paper argues that a sex or injection partner's consent to "unsafe" sex or needle-sharing should also preclude criminal liability. If such consent is given after disclosure of HIV-positive status, prosecution would constitute an unjustifiable denial of that partner's liberty to take risks. It is those cases where there is consent without any disclosure of one party's HIV-infection that present a more difficult challenge. The Paper recommends that, on balance, criminalization in such circumstances is inadvisable: criminal prosecution of the HIV-positive accused seemingly ignores the fact that at least two parties must participate for transmission to occur, thereby undermining the more important public health message that everyone bears responsibility for taking precautions in every encounter. The Paper stresses that the criminal law is ill-suited to recognize the division of responsibility - albeit not always an equal one - between those who voluntarily engage in intimate and largely private activity that carries the risk of HIV infection.

The Paper further recommends that criminal liability should be precluded where an accused mistakenly believes that their sex/injecting partner is already aware of the presence of HIV and is therefore consenting. Similarly, a lack of knowledge as to modes of HIV transmission should be grounds for avoiding criminal liability.

Conclusions

The Paper concludes that the criminal law, in the form of either existing offences or a new offence is ill-suited to deal with the AIDS epidemic. Coercive interventions, while they may create the dangerous illusion of action, are neither desirable nor likely to be effective as a societal response to unsafe sex or injection practices. Furthermore, they divert attention and resources from important and more useful efforts such as education, testing, counselling, eliminating poverty, and substance abuse treatment programs. Any criminal or quasi-criminal measures implemented should be drawn narrowly and tailored to be as unintrusive as possible; criminalization can only be justified in very limited circumstances if at all.

- Richard Elliott

For more information or for a copy of the paper, contact Ralf Jürgens, Project Coordinator, at (514) 9878773; fax: (514) 9873422; email: aidslaw@web.apc.org

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[1] R Elliott. Criminal Law and HIV/AIDS. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996.

[2] CITATION FOR CASE NEEDED. The case will be summarized in vol 3, no 1 of the Newsletter (October 1996).

[3] For more details, see R Jürgens. HIVSpecific Criminal Offence Proposed. Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(2): 1, 26-27.

[4](1992), 73 CCC (3d) 216 (Livingstone Prov Div J).

[5]R v Thornton [1993] 2 SCR 445.

[6]Criminal Code, RSC 1985, c. C46 [as amended], s. 219.

[7]R v Lee (1991), 3 OR (3d) 726 (Gen Div); R v Ssenyonga (1993), 81 CCC (3d) 257 (Ont Ct Gen Div).

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US - Oregon Appeals Court Upholds Conviction For Attempted Murder by HIV Transmission

In State of Oregon v Hinkhouse[1] the defendant argued that his conviction on 10 counts of attempted murder and assault - based on his having engaged in unprotected sex without revealing his HIV-positive status - must be set aside because the evidence is insufficient to establish that he intended to cause death or serious physical injury to the victims.

After testing positive, Timothy Hinkhouse was advised about how HIV is transmitted by his probation officer, Bill Carroll, who instructed him to use condoms. On more than one occasion Carroll told Hinkhouse that if he transmitted the virus to another person "he would be killing someone" and that "that is murder." At one point, after having been taken into custody for a parole violation where he was overheard bragging about his sexual prowess, he was asked as a condition of his release to sign a probation agreement not to engage in unsupervised contact with women without Carroll's permission.

Throughout this time Hinkhouse engaged in numerous sexual relationships, refusing to wear condoms even when asked, and claiming that he was HIV negative when the matter came up. In one instance Hinkhouse had repeated unprotected intercourse with a 15-year-old girl. In another, after using condoms for three or four weeks, he penetrated the woman involved without a condom after promising to use one. The intercourse in this case sometimes involved vaginal bleeding as well as attempted anal penetration against the women's wishes. Hinkhouse eventually entered a romantic relationship with a woman he intended to marry. He informed her of his HIV status and always wore condoms during intercourse with her.

Despite testimony from the defendant's psychologist that he did not give much credence to the defendant's threats to go out and spread HIV, the lower court sided with the state's expert who believed that Hinkhouse's statements, coupled with his behaviour of systematically recruiting and exploiting multiple partners, demonstrated intentional, deliberate conduct.

The Court of Appeals of Oregon agreed, adding that Hinkhouse's sharply changed behaviour -

discussing his HIV status and using condoms when engaging in intercourse with the woman he intended to marry - underscored, by contrast, the element of intent requisite to a conviction of attempted murder and showed a conscious objective of causing serious physical injury to the other women he was involved with.

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[1] 1996 WL 99406 (Or App, 6 March 1996). Reported in Lesbian/Gay Law Notes April 1996, at 55.

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Australia - HIV/AIDS Sentencing Kit

The HIV/AIDS Legal Centre in New South Wales has produced a new edition of its HIV/AIDS Sentencing Kit, presenting arguments why people with HIV/AIDS facing the prospect of imprisonment should receive non-custodial sentences.[1]

Features of the kit include:

information about why imprisonment may be more burdensome for people living with HIV/AIDS, citing medical evidence relevant to sentencing decisions;

an examination of HIV/AIDS as a mitigating factor to reduce sentences, and as an aggravating factor for offences involving the risk of HIV transmission; and

an examination of cannabis offences for people with HIV/AIDS using cannabis for therapeutic purposes.

Copies of the kit can be obtained from the HIV/AIDS Legal Centre, PO Box 350, Darlinghurst NSW 2010, Australia.

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[1] Reported in the [Australian] HIV/AIDS Legal Link 1996; 7(1): 31.

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US - Written Consent from Sexual Partners

A person living with HIV/AIDS who pleaded guilty to an auto theft charge was ordered as a condition of probation to obtain written informed consent from anyone with whom he has sex.[1]

According to an article in the Houston Chronicle of 9 March 1996, a Texas District Judge sentenced Thomas Paul McDevitt to five years probation, with a condition on McDevitt to refrain from having sex with any partner who does not sign the following statement: "Thomas Paul McDevitt has advised me that he-she has been diagnosed as positive for the HIV virus [sic] in his-her body and may be symptomatic for the disease of acquired immune deficiency syndrome."

The article did not explain why the judge used the term "he-she" in the consent form he devised for McDevitt's use.

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[1] Reported in Lesbian/Gay Law Notes April 1996, at 56.

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PUBLIC HEALTH

Public Health and "The Unwilling and Unable": Part II

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 Québec paper is summarized here. An analysis of the Ontario paper was published in the January 1996 issue of the *Newsletter*.^[1]

The Québec Working Group

In October 1995, a working group consisting of two public health professionals and two representatives of the Canadian HIV/AIDS Legal Network produced a draft working paper titled *Réduction de la transmission du VIH par les personnes qui ne peuvent pas ou ne veulent pas prendre les précautions nécessaires* (Reduction of HIV Transmission by Persons Who Cannot or Do Not Want to Take Necessary Precautions).^[2]

Guiding Principles

From the outset, the working group acknowledges that HIV-positive persons have the right to a sexual life, and that those who are "unwilling or unable" represent only a small minority of people with HIV. It stresses that the purpose of any intervention should not be to punish, but to encourage changes in behaviour, and that in any intervention, individual rights must be weighed against the individual's civic responsibilities and the collective welfare. Like the Ontario working group, the Québec group agrees that HIV-positive persons have no obligation to disclose their HIV status if they take precautions to prevent transmission of the virus.

"Unwilling" vs "Unable"

The working group emphasizes that individuals engage in risky activity for different reasons, including, eg, domestic violence, or lack of food, shelter, or clean injecting equipment; to be effective, interventions must take these reasons into account. Addressing the underlying issues that cause a person to act irresponsibly may enable that person to modify his/her behaviour.

Persons who are "unwilling" or refuse to take precautions are different from persons who are "unable." A distinction must be drawn between:

those who are aware of the danger of HIV transmission but persist in placing partners at risk; and

those who engage in risky activity but are unaware that their behaviour carries risks for others, or cannot modify their behaviour because of coercion, mental health problems, or physical or emotional stress.

When Is Intervention Warranted and Justified?

Given the impairment of the rights to liberty and security of the person, and the right to privacy, the working group cautions that there must be a serious basis for intervention. The individual in question must:

be aware of his/her HIV-positive status;

have received counselling;

understand the modes of transmission; and yet

continue to engage in activities placing others at risk, without disclosing his/her status.

A public health intervention may be justified where:

a real risk of HIV transmission exists;

it may be effective in preventing transmission;

the economic, legal, and practical costs do not outweigh the public health benefits; and

it achieves the objective of reducing HIV transmission while infringing as little as possible on individual rights and freedoms.

The Paper stresses that, whenever coercive measures are taken, they must be in accord with a legal norm

and the rules of natural justice. A person subject to such measures should be given notice, the opportunity to be represented by counsel, and a right of appeal.

Different Scenarios

One of the members of the working group met with a variety of people working in HIV/AIDS, including health clinic social workers, a hospital psychiatrist working with injection drug users (IDUs), public health professionals, a bioethicist, and workers at CACTUS, Montréal's needle exchange program, and Séro-Zéro, the primary AIDS information and prevention organization in Montréal's gay community, to elicit their responses to the issue of persons "unwilling or unable" to take necessary precautions.

There was widespread agreement that "unwilling or unable" individuals are rare, and that non-coercive measures are more likely to be effective. Most were of the view that there should be no resort to criminal prosecutions or coercive public health interventions without first attempting other, less intrusive methods.

However, one psychiatrist questioned why public health officials make no effort to notify sexual partners in the case of a positive HIV-antibody test when they do for other STDs. He was of the opinion that HIV is treated with a degree of "political correctness" not afforded to other STDs.

Those working with homeless and/or IDU populations pointed out that:

for these populations, concern about HIV transmission may be secondary to immediate needs for shelter, food, medical care, drugs, etc;

most homeless people and IDUs are aware of the risks of unprotected sex or needle-sharing; and

coercive measures have little deterrent effect on those who perceive prison as simply an alternative to street life.

Rather than for coercive interventions directed against a few, they called for additional needle-exchange locations and methadone programs, saying that this would be much more effective in reducing the spread of HIV.

Those working with gay men emphasized the success of HIV-prevention interventions among gay men and stressed that increasing prevention efforts would do more to reduce HIV transmission than criminal or coercive public health approaches. Among other things, they suggested that public health officials force bathhouse owners to provide condoms and lubricant - currently only 5 of the 13 bathhouses in Montréal fully participate in Séro-Zéro's prevention campaigns. They added that open discussion is needed within gay communities about sexually active HIV-positive men, and that, in order to be effective, messages about seropositive men's responsibilities to their sexual partners should come from

HIV-positive gay men themselves.

Public Health v Criminal Law

According to the Paper, and in agreement with most of the literature on the subject, public health is better suited to respond to "unwilling or unable" persons than criminal law, which carries numerous drawbacks, such as a high standard of proof, its public nature, and its questionable deterrent effect on those who may already see themselves as condemned to death. Furthermore, imprisonment is unlikely to achieve rehabilitation, given the lack of counselling, and the frequency of unsafe sex and needle-sharing in prisons. Finally, requiring reporting of risky behaviour to police would seriously damage the expectation of doctor/patient confidentiality and may do more overall harm than good to the public health.

Privacy and Access to Information

Whenever a case of an "unwilling or unable" person is brought to the attention of public health authorities, the person's privacy may be maintained at the preliminary stages of public health's involvement. However, if more elaborate or coercive measures become necessary, an exchange of information among various intervenors and professionals could be required, raising the issue of whether the law allows for disclosure and sharing of such information.

According to the Paper, any disclosure of confidential information without an individual's consent must be reasonable and proportionate to the objective, and must be justifiable by the standards of a free and democratic society. It concludes that the Canadian and Québec *Charters* permit breaches of confidentiality in extreme cases, given that partners also enjoy rights to life, bodily integrity and security of their person. There have been judicial decisions to this effect.[3]

Some have suggested that article 2 of the Québec *Charter*, which imposes a duty on all persons to come to the assistance of those whose lives are in danger, gives rise to a duty to disclose a person's HIV-positive status to their partners. So far, article 2 has generally been interpreted as applying only to immediate physical assistance. However, in the Committee view, in extreme cases (ie, where someone engages in multiple sexual relations and displays a complete disregard for the health of others or even declares their intention to transmit HIV), and only in such cases, the duty to come to the assistance of others may require disclosure of a person's HIV status to partners. This duty does not attach solely to physicians, but to anyone who becomes aware of such conduct.

No consensus exists, however, with respect to less extreme cases, such as when a person takes precautions with all but his/her partner. The Committee notes that the conflict between individual and collective rights has not yet been settled in Québec law; the rationale set down in the leading California case of *Tarasoff*[4]

(in that case, a psychologist's patient threatened to kill his wife; when the patient carried this threat out,

the doctor was held civilly liable for his failure to warn the victim) may not necessarily be applied within the civil law context of Québec.

Several other Québec statutes regarding privacy issues or health and social services contain provisions addressing the disclosure of personal information in restricted circumstances; in order for disclosure to be justified, it is commonly required that there be some urgent threat to the life, health or safety of "the person concerned." It is unclear whether this phrase refers exclusively to the person whose privacy is being infringed, or whether it includes others such as partners.

Proposed Intervention Strategy

The working group proposes a detailed intervention strategy, involving public health officials and community-based organisations, for dealing with unwilling or unable HIV-positive individuals. The basic approach is preventive, not punitive.

According to the Paper, any policy dealing with the "unwilling or unable" must be sufficiently flexible to permit tailored interventions for individuals from different groups with specific needs. It should display the following characteristics:

it should be behaviour-based, as opposed to based on an individual's membership in a given group;

it should be based on a policy of inclusion and respect, as it must be accepted and endorsed by affected communities in order to succeed;

recourse to coercive measures should only be taken after voluntary measures have failed;

the more coercive proposed measure are, the more safeguards for the individual's rights should be included;

coercive measures should be limited in time;

interventions must infringe individual rights and freedoms as little as possible;

Recommendations

In the area of prevention and education, the Committee has recommended that:

pre- and post-test counselling be standardized;

laboratory requisition forms specifically refer to pre-test counselling;

education/prevention campaigns, designed by HIV-affected communities, specifically target seropositive people;

condoms and lubricant be more accessible in bathhouses;

more needle exchange locations providing clean needles and condoms be established; and

long-term support and counselling programs become more accessible, with a focus on assisting HIV-positive people adopt and maintain safe sexual and needle-sharing practices.

The Committee has proposed the following approach to interventions:

A front-line intervenor would have the discretion to work directly with an unable or unwilling individual, with the option of seeking assistance from public health officials without having to breach confidentiality, or to request a coordinated management of the case.

A "case management coordinator" would assist front-line intervenors in determining whether further intervention is required, and, with notice to the individual in question, possibly refer the case to a committee.

A multidisciplinary "case management committee," including representatives from public health, social and health services, and HIV-affected communities, would review cases, ensuring that non-coercive measures have been attempted. It would carry out psychosocial and medical evaluation of persons who may be "unwilling or unable," using a holistic approach, seeking to identify and solve problems that may impede individuals' adoption of safer behaviour.

A protocol for preserving confidentiality, to be followed by front-line intervenors and the case management coordinator and committee, would be developed. If, after 6 months, the individual has permanently made the required changes in behaviour, the committee would destroy identifying information in its possession.

The public health department would lobby for statutory amendments permitting the exchange of confidential information where such disclosure is necessary to protect the life, health or safety of a third party.

If required, the committee may proceed to notify partners, or require counselling and/or support measures, such as peer groups or buddy support. Consent to such measures should be sought; to motivate behaviour change, the unwilling or unable individual may be asked to sign a written contract.

If all voluntary interventions have failed, and the committee is certain that an individual remains "unwilling or unable," the committee may recommend to public health officials that more coercive measures be adopted. Such measures must pass scrutiny under the Québec and Canadian Charters (including the s 1 requirements established in *Oakes*.)[5]

Coercive measures may include: orders by public health officials, court injunctions to refrain from risky activity, and, as a last resort, criminal prosecution (with continued monitoring and follow-up by the case management committee).

Conclusions

After the Working Paper was drafted, an enlarged working group was established to review the Working Paper and develop the final version of a public health policy on the "unwilling and unable." The final version is expected to be released in July 1996, and public consultations will follow.

So far, the recommendations in the Québec Working Paper are largely similar to those made in Ontario. The most significant difference is the Québec proposal to establish a case management committee to coordinate interventions. Both in Ontario and Québec, the importance of developing a sense of community ownership vis-a-vis any intervention policy, and a preference for preventive, non-coercive measures - with intrusive measures such as criminal prosecution seen as a last resort - have been stressed.

- *Richard Elliott*

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[1] R Elliott. Public Health and "The Unwilling and Unable." Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(3): 1, 29-30.

[2] D Thompson, A Adrien, G Lambert, R Jürgens. Montréal: Régie régionale de la santé et des services

sociaux de Montréal-centre. Direction de la santé publique, 1995.

[3] See, for example, Charbonneau c Poupart, [1990] R.J.Q. 1143.

[4] In Tarasoff v Regents of the University of California, 131 Cal Rptr 14, 17 Cal 3d 358 (US 1976).

[5] R v Oakes (1986), 24 CCC (3d) 321 (SCC).

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DRUG POLICY AND HIV/AIDS

Harm Reduction Around the World

Harm reduction is an approach to dealing with drug use and drug related issues that has attracted considerable attention in recent years and has become a subject of growing discussion and debate within the addictions community and, increasingly, by the media and the general public. One primary catalyst for the surge of interest in harm reduction in the last decade has been the emergence of AIDS and the spread of HIV among injection drug users through sharing of injection equipment.

Many countries now take the public health-based perspective that the dangers of the spread of AIDS among drug users - and from drug users into the general population - pose a greater threat to health than the dangers of drug use itself. Another important catalyst for the increased attention to harm reduction has been the growing dissatisfaction with established approaches to curtail drug use, in particular the "war on drugs" approach promulgated by the United States and, to a lesser degree, by Canada. Critiques of this approach have highlighted the excessive human and economic costs associated with its attempt to achieve an idealized social policy goal of zero tolerance: no availability of, illicit drugs, and complete abstinence from drug use.

Harm Reduction: What Is It?

Harm reduction approaches focus on reducing the negative consequences of drug use to the individual, the community and society as a whole - consequences such as ill health, as well as social, economic and a multitude of other problems - rather than on the elimination of drug use itself. The philosophy of harm reduction is not new, but has in fact been used for centuries in many countries in numerous guises prior to the drug prohibition movement of this century. The recent origins of harm reduction as we now know it are to be found in the 1980s in Merseyside, England and in Amsterdam, The Netherlands. Over the past few years, a number of other countries, including Australia, Germany, Switzerland and, to a limited extent, Canada, have introduced harm reduction programs and/or policies either at the local or national level.

Examples of Harm Reduction Programs and Policies

Syringe Exchange and Availability

For many, needle and syringe exchange programs are the epitome of the harm reduction approach. They were first established in a few European countries in the mid-1980s and, by the end of the decade, were operating in numerous cities around the world. In Canada there are now more than 200 syringe exchanges, with more being established every month. In a number of provinces, pharmacists are becoming actively involved in syringe exchange programs.

The rationale behind syringe exchanges is that many people who are currently injecting are unable or unwilling to stop, and that intervention strategies must at least help reduce their risk of contracting HIV infection and of transmitting it to others. Provision of sterile needles and syringes reduces the risk of spreading HIV, but is also a way of establishing contact with drug users through outreach services. There is now clear evidence that attendance at syringe exchanges and increased syringe availability is associated with a decrease in risk (eg, decreased sharing) and harms (eg, lower levels of HIV infection).

Some exchange programs provide outreach services in the form of mobile vans or street workers to deliver services to drug scenes or to users' homes. Automated syringe exchange machines are now being used in many European and Australian cities. These vending machines release a clean syringe when a used one is deposited, are fairly inexpensive, and accessible on a twenty-hour basis. However, their installation decreases the important personal contact between drug users and health-care workers.

In jurisdictions where laws prohibit making syringes available, such as in many states in the US, bleach kits (containing bleach and instructions for cleaning equipment) can be distributed. While bleach is not totally effective in destroying HIV and does not kill hepatitis, bleach kits do help to reduce the likelihood of infection being spread through sharing dirty equipment.

An important new development is the operation of needle exchange programs in an increasing number of prisons.[1]

Education and Outreach Programs

Educational materials about drugs that have a harm reduction focus are readily available in a number of countries including the United Kingdom, The Netherlands and Australia, but remain extremely controversial and often unavailable in most other countries. While not promoting drug use, such materials tell users how to reduce the risks associated with using drugs, eg by teaching safer injecting practices. In some countries, such as the UK, these techniques are also taught by nurses at clinics.

In many countries, outreach workers are used to make contact with drug injectors and prostitutes at risk of becoming infected with HIV. They distribute educational material, syringes, condoms and bleach kits and help users contact other services.

Prescribing of Drugs

In a tradition dating back to the 19th century, physicians in the United Kingdom prescribe drugs to users. In many regions, Drug Dependency Clinics or Community Drug Teams offer flexible prescribing regimes ranging from short-term detoxification to long-term maintenance. The majority of clients receive oral methadone, but some receive injectable methadone, others injectable heroin, and a small number receive amphetamines, cocaine or other drugs. These drugs are dispensed through local pharmacists.

In the Mersey Region, users can also be prescribed smokable drugs in the form of reefers. Drug users who are able to give up injecting often find that they are not able to switch immediately to oral prescriptions which don't provide the "rush" that an injected drug does. Smokable drugs do provide a rush, although less powerful. In the Mersey Region, where prescribing and other harm reduction programs are well established, anecdotal evidence suggests that drug-related health problems and acquisitive crime have decreased as a result of these services. In particular, the level of HIV infection among drug injectors in the region is very low.

Switzerland is currently carrying out a national experiment with prescribing of heroin and other drugs to users, to determine whether this will reduce users' criminal activity and their risk of contracting and spreading HIV and other infections. The Swiss studied the British prescribing programs before setting out on the largest and most scientific study of heroin maintenance ever attempted. The program started in January of 1994, with sites in eight cities. In each city, the program offers accommodation, employment assistance, treatment for disease and psychological problems, clean syringes and counselling. Users are in regular contact with health workers and links to drug-free treatment. Some programs started off by giving some users heroin and others morphine or injectable methadone. It was soon found, however, that most users preferred heroin, which is provided up to three times a day for a small daily fee. Two programs allow clients to take a few heroin reefers home each night. The preliminary reports on the program suggest that heroin maintenance is efficacious (there were insufficient data to draw conclusions about cocaine). The programs have not resulted in a black market of diverted heroin and the health of the addicts in the programs has clearly improved. The authorities have concluded from these preliminary data that heroin causes very few, if any, problems when it is used in a controlled manner and is administered in hygienic conditions. Based on these findings, the Swiss government expanded the program to more than 1,000 users in 1995 (approximately 800 slots for heroin, 100 each for morphine and injectable methadone). As part of the program, eight inmates in one prison in Switzerland are being maintained on heroin, so far with very good results.

Holland, several German cities, and the Australian Capital Territory are also preparing to institute heroin maintenance programs.

In Canada, as a result of the recommendations contained in the BC Chief Coroner's report,[2] various agencies are working with community groups to determine the feasibility of prescribing programs as one

part of their strategy to deal with drug-related harms.

Methadone Programs

North America is not usually thought of in connection with harm reduction, but it was the US and Canada who were home to a very significant harm-reduction strategy: methadone maintenance programs began in British Columbia in 1959. Many of the US and Canadian programs have been criticized, however, for their failure to provide the flexibility and range of services necessary for a successful methadone program.

In the Netherlands, methadone programs are used in three different ways:

to contact heroin users;

stabilize them; and

to detoxify and treat them.

By providing methadone without too many impediments ("low-threshold programs"), contact can be made with large sections of the heroin using population. For example, there is a "methadone bus" program where buses are used to distribute methadone throughout the drug-using community (no take-home dosages are provided). However, the Dutch programs have some disadvantages: like the US programs, they do not maintain all clients on levels of methadone that are high enough to prevent use of heroin; and do not provide anything other than oral methadone.

In Australia, measures introduced to combat the spread of AIDS included the marked expansion of methadone programs. The criteria for admission to these programs were made less stringent, and many more spaces were allowed for maintenance of clients with little motivation to change drug-using behaviour. These changes have been supported by a change in national and state drug policy: the highest priority has been given to the containment of HIV, rather than to the reduction of drug use.

In the United Kingdom, Europe and Australia, methadone is available from clinics as well as general practitioners that provide health care and counselling. In a number of European cities, more than 25 percent of all general practitioners prescribe methadone. Users pick up their prescription from pharmacies. Amsterdam, Barcelona, Frankfurt and other cities distribute methadone through methadone buses or mobile clinics.

In all countries, one of the key factors underlying the success of methadone as a harm reduction measure is that it brings the user back into the community rather than treating them like an outsider or a criminal. This not only allows for rehabilitation of the user but it also means that the drugs and crime cycle can be broken. There have been numerous studies on the effectiveness of methadone programs, the vast majority showing that they reduce morbidity and mortality, reduce the users' involvement in crime, curb

the spread of HIV and help users to gain control of their lives.

In Canada, opiate substitute programs are very limited, both in terms of size and in terms of the options available to users, although the experience of other countries shows that methadone programs work best if they are numerous, accessible, flexible and liberal.

In prisons, methadone programs are most often not available, creating problems and health risks for prisoners who were on methadone outside. A recent court case in British Columbia may mean that methadone will become available to some prisoners in that province.[3] Because currently many drug users end up spending time in prisons, it will be important to ensure wider availability of methadone in prisons, and to explore the advantages of offering methadone treatment as an alternative to imprisonment.

Tolerance Areas

One innovative harm reduction approach adopted in several European cities involves toleration by authorities of facilities known as "injection rooms," "health rooms," or "contact centres." These are facilities where drug users can get together and obtain clean injection equipment, condoms, advice, and medical attention. The majority of these places allow users to remain anonymous; some include space where drug users, including injectors, can take drugs in a comparatively safe environment. This is regarded as preferable over the injection of drugs in public places of consumption - shooting galleries - that are usually unhygienic and controlled by drug dealers.

In Switzerland, the first drug rooms were established by private organizations in Bern and Basel in the late 1980s. By the end of 1993 there were 8 such facilities, most often operated by city officials. Several other cities in the German-speaking parts of Switzerland opened drug rooms in 1994. An evaluation of three of these facilities after their first year of operation showed that they had been effective in reducing the transmission of HIV and the risk of drug overdose. Drug rooms are also provided by programs in Germany and in the United Kingdom.

Open drug scenes emerged in many European cities during the late 1980s. These were often in central areas near train stations, commercial areas and parks. In The Netherlands, an open drug scene called Platform Zero is located at the Rotterdam train station where it is supervised by police. Services available include syringe exchange and a mobile methadone unit. Rotterdam has also informally adopted a policy known as the "apartment dealer" arrangement. Following this policy, police and prosecutors refrain from arresting and prosecuting dealers living in apartments, provided they do not cause problems for their neighbours. This approach and Platform Zero are part of a "safe neighbourhood" plan in which residents and police work together to keep neighbourhoods clean, safe and free of "nuisances." Not all tolerance zones have been successful. The first Swiss attempt at an open drug scene, "Needle Park" in Zurich, grew unmanageable and was closed in 1992. A second attempt also became uncontrollable, and was closed in March of 1995.

In Germany, open drug scenes emerged in Frankfurt during the 1970s and settled in two adjacent parks in the 1980s when police officials decided that their earlier attempts to suppress them had failed. Local authorities established three crisis centres next to the drug scenes, provided a mobile ambulance to provide needle exchange services and medical help, offered first aid courses to users, and provided a separate bus for prostitutes. The police maintained their policy of apprehending dealers, but initiated a new policy of tolerating an open scene within a clearly defined area of one of the parks. These activities were carried out along with efforts to draw users away from the drug scene by providing accommodation and treatment centres outside the city centre. These efforts proved successful, and in 1992 the park drug scene was shut down. The policy has led to a significant reduction in the number of homeless drug users, drug-related crimes, and drug-related deaths in the city.

Toleration and regulation of open drug scenes and apartment dealers are forms of informal control similar to those used to regulate illegal prostitution. These controls are also compatible with the philosophy of community policing. In addition, local residents are chiefly concerned about the safety and peacefulness of their neighbourhoods, not with drug use itself. Public health and social service workers find that it is easier to provide services when drug scenes are readily accessible and relatively static.

Law Enforcement Policies

Merseyside Police in the northwest of England have developed a cooperative harm-reduction strategy (known as Responsible Demand Enforcement), together with the Regional Health Authority. The police are represented on Health Authority drug advisory committees and employ Health Authority officers on police training courses involving the drugs/HIV issue. They have also supported the Health Authority by agreeing not to conduct surveillance on them, referring arrested drug offenders to services, not prosecuting for possession of syringes which are to be exchanged, and publicly supporting syringe exchange.

One of the most important features of the Merseyside Police strategy has been its emphasis on using resources to deal with drug traffickers while operating a cautioning policy toward drug users. Cautioning, which has now been adopted to some extent by all Police Authorities in Great Britain, has been recommended by the Attorney General of the UK as an appropriate option for some classes of offense such as drug possession. It involves taking an offender to a police station, confiscating the drug, recording the incident, and formally warning the offender that any further unlawful possession of drugs will result in prosecution in court. The offender must also meet certain conditions, such as not having a previous drug conviction and not having an extensive criminal record. The offender is also given information about treatment services in the area, including syringe exchanges. The first time offenders are cautioned - they are not given a criminal record; on the second and third occasions they are sent to court where they are fined for possession of small quantities or sentenced for possession of large amounts. If an addict becomes registered through getting in touch with service agencies then he or she is legally entitled to carry drugs for personal use. The overall effect of this policy is to steer users away from crime and possible imprisonment. In recent years the approach has been extended to ecstasy, amphetamine and cocaine as well as heroin.

In The Netherlands, police have long been supportive of harm reduction programs, including de facto decriminalization of marijuana and tolerance zones; enforcement efforts are concentrated on large-scale traffickers and on ensuring a safe and peaceful environment. In Amsterdam, police stations will provide clean syringes on an exchange basis. In Hamburg, Germany, a recent policy shift to harm reduction has been reflected in co-operation between police, health officials and drug-user groups working together to help drug users access social services.

In Canada, the approach toward drug users has primarily been one of criminalization, although diversion to treatment is now being employed more regularly. The recent shift toward community policing in a number of cities may allow for the application of significant harm reduction measures at the enforcement level in the near future.

Conclusion

There are now numerous examples of harm reduction programs and policies in countries around the world. Many of these approaches have already been found to be cost-effective and acceptable to users and non-users alike. If countries are to reduce the tremendous fiscal and human harms that are being wrought by bad drug policy and inadequate drug programs, they must adopt comprehensive harm reduction strategies that include the programs described in this article. They need to do much more than most countries are doing now: one or two syringe exchanges in a city are simply not enough. Failure to introduce harm reduction measures is an offence to the citizens for which governments must be held accountable.

- *Diane Riley*

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[1] For more details, see R Jürgens. Needle Exchange in Prisons Works: An Overview. Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(4).

[2] See J Anderson. AIDS and Overdose Deaths in British Columbia. Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(3): 1, 25-26.

[3] See C McLeod. Is There a Right to Methadone Treatment in Prison?. Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(4).

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Canadian HIV/AIDS Policy & Law Newsletter

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Canadian Bar Association Joins Protest Against Bill C-8

In a letter of 27 March 1996 to Senator Sharon Carstairs, Chair of the Committee on Legal and Constitutional Affairs of the Senate, the Canadian Bar Association (CBA), heavily criticized Bill C-8.

With permission of the CBA, we reprint the letter, written by Mr Conroy, Chair of the CBA's Committee on Imprisonment and Release, in slightly edited form:

Dear Senator Carstairs:

As the Chair of the Canadian Bar Association's Committee on Imprisonment and Release of the National Criminal Justice Section, I am pleased to have the opportunity to discuss Bill C-8, the *Controlled Drugs and Substances Act*, with the Senate Committee on Legal and Constitutional Affairs. The Canadian Bar Association is a national association representing over 34,000 jurists, including lawyers, notaries, law teachers, students and judges across Canada. The Association's primary objectives include improvement in the law and in the administration of justice.

In the spring of 1994, the Canadian Bar Association's National Criminal Justice Section appeared before a Committee of the House of Commons with a submission on what was then Bill C-7, the *Controlled Drugs and Substances Act*. In that submission, we expressed unequivocal opposition to the passage of the Bill. [...]

In this letter, we would like to again emphasize the concerns we have with what is now Bill C-8. We remain convinced that, as currently worded, this legislation would move Canada's drug policy further in a direction that causes more harm than it remedies. While elements of the Bill have been amended, these amendments do not address the Section's overriding concerns with the approach taken.

In 1987, the government of the time announced that a harm reduction approach would subsequently guide Canadian drug policy. This approach seeks primarily to reduce the negative consequences

associated with drug use, as opposed to reducing the prevalence of drug use. The National Criminal Justice Section supports a harm reduction approach to drug control. Bill C-8 is inconsistent with such an approach, and would be a regressive move for Canadian drug policy. It continues to deal with drug users through criminalization and incarceration. As the Section believes this model has clearly proven itself to be ineffective and counterproductive, and is one that Canada can no longer afford, we believe this Bill should not be enacted.

Policy Underlying Bill C-8

In our earlier submission, we emphasized that the harm caused by an activity should determine if, and when, the use of the criminal law is appropriate. For drug use that causes no evident harm to others, except possibly the user, and no significant harm to society as a whole, we believe that criminalization is inappropriate.

The current approach of prohibition, criminalization, and incarceration has been attempted for many decades without achieving the desired results of decreased drug use, reduced drug-related crime, or improved public health. In fact, the opposite results have too often been achieved.[1] Aside from the inherent injustice of incarcerating people who have not harmed others, the criminalization and incarceration of drug users is expensive, adding stress to an overburdened justice system and taking away from resources available to address more serious crimes. The National Criminal Justice Section believes that if Canadians were aware of the consequences of the investigation, prosecution, and punishment of drug users and traffickers, and particularly the costs of incarceration per year per prisoner (it costs about \$44,000 per year to keep a person in a federal penitentiary; \$39,000 in a provincial facility)[2] most would agree that the use of the criminal law must be reserved for people who genuinely cause harm to others or to society.

Those convicted of possessing drugs represent only about 2-3 percent of drug users,[3] resulting in the fairly arbitrary prosecution of a few for conduct engaged in by many. Possession accounts for about half of all drug-related convictions, and about one third of those convicted of possessing drugs are sentenced to custody.

In our view, drug use is primarily a health and social policy issue. There is a genuine hypocrisy in deciding that the use of certain relatively harmless drugs, like marijuana, deserves criminal sanction, while others, which we know cause numerous deaths and related illnesses each year, like alcohol and tobacco, are treated as health risks and not criminalized. We ask for a cogent explanation for this discrepancy in approach. We also question the jurisdiction of the federal government under the peace, order, and good government clause, or the criminal law power, to legislate on a health issue which does not pose a significant threat to society.[4] By treating other prohibited substances as we now deal with tobacco, tax dollars would be shifted from organized crime to the government, money would be saved on enforcement and incarceration, drug production and distribution could be safely regulated, the spread of infectious diseases could be minimized and treatment alternatives could be offered.

The harm reduction approach to drugs has been successfully adopted by many countries.[5] Some of the benefits achieved are a reduced rate of HIV infection, decreased drug-related crime, and corresponding improved public safety. In contrast, the United States' "War on Drugs" has filled American prisons with drug users at great societal cost, while not diminishing the prevalence of drug use in American society. We are convinced that it is not in the interests of Canadians to take a similar approach to that of our neighbours to the south.

One justification offered for Bill C-8 is that it will bring Canada in line with its international obligations. We urge the Canadian government to withdraw from international agreements which require a misguided approach to drug control with a proven record of failure, and to take instead a leadership role, looking to the creative strategies tried with success in several European countries. It is not necessary to continue a prohibitionist approach in order to comply with international obligations. Rather, we support international Conventions that allow for drug policy in the direction of treatment, harm reduction, prevention and care (eg, the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) states that "[p]arties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment ... measures for the treatment, education, aftercare, rehabilitation or social re-integration of the offender" (s 4(d)).

As far back as the 1970s, a number of prominent organizations and government bodies recommended minimizing or eliminating the penalties for possessing marijuana. The LeDain Commission's Cannabis Report,[6] tabled in Parliament on 17 May 1972, recommended the repeal of offences for simple possession, and the non-profit transfer and cultivation of small amounts of cannabis for personal use. Shortly thereafter, then Health Minister John Munro announced that the government had taken action to prevent certain people charged with possessing cannabis from having criminal records, and to remove the records of those already convicted.[7] However, in spite of the intention expressed, even an absolute or conditional discharge continued to result in a criminal record under the *Criminal Records Act*.

Bill S-19, sponsored by the Trudeau government, was passed by the Senate on 18 June 1975. Twenty years ago, that Bill would have made simple possession of cannabis punishable by summary conviction only. The Senate also amended the Bill to provide that any person receiving an absolute or conditional discharge for a first offense of simple possession would be deemed to have been granted a pardon under the *Criminal Records Act*. [8] However, the Bill later died on the House of Commons Order Paper. In 1978, the Canadian Bar Association considered the proper approach to dealing with marijuana, adopting a resolution supporting the decriminalization of the possession and cultivation of marijuana for an individual's own use, as well as the non-profit transfer of small amounts of the drug between adults. In 1974, the Association passed a resolution stating that the controlled medical distribution of heroin to addicts should be allowed as an alternative to existing options, and a system of heroin maintenance be undertaken to divert addicts from the criminal justice system. Since the time of those recommendations, a significant body of research has been accumulated to support decriminalization, showing again and again that marijuana is relatively harmless.[9] A harm-reduction approach to drugs would put the focus on health, and by repealing drug prohibition, would remove the current significant profit incentive from trafficking in drugs. However, in spite of the evidence, myths exaggerating the "dangers" of marijuana have too often been accepted as fact. We continue to incarcerate users of the drug for conduct that, on

the evidence, causes significant harm to no one, including the drug user. Even for drugs which may be more debilitating to the user, such as heroin, we believe that using a medical model is preferable to subjecting addicts to the weight of the criminal law. A medical model can also address the spread of disease through intravenous drug use, which is exacerbated by marginalizing drug users.

Amendments to Bill C-8

The National Criminal Justice Section was critical of the original version of Bill C-8 for the manner in which it increased the fines and penalties available for certain offences. While the Bill now before the Senate Committee has been amended in response to some criticisms made of the earlier version, it continues to provide for the criminalization of drug users, with the potential for incarceration. Our position is that the approach taken in Bill C-8 moves Canada's policy on drugs further in the wrong direction. This fundamental concern has not been assuaged by the present amendments.

Section 4(4) of Bill C-8 has been amended so that the maximum penalty on indictment for possessing a Schedule II drug (cannabis) is reduced from the seven year maximum under the previous version to five years less a day. While we generally support lower sentences, this reduction appears to represent an attempt to deprive an accused of the right guaranteed under s 11 of the Charter to a jury trial if the potential period of incarceration is five years or more. In other sections, the Bill provides for harsher penalties for marijuana than it does for Schedule III and IV drugs, which include amphetamines, LSD and barbiturates. For example, on indictment, s 4(6) provides for a maximum of less than three years for possession of a Schedule III drug (for example, amphetamines, LSD, mescaline), compared to the five years less a day maximum for possessing cannabis.

As suggested by past governments, this government has expressed an intention that the amended Bill C-8 will remove the possibility of a traceable criminal record for those convicted of possessing small amounts of cannabis. However, a summary conviction for an offence under a federal statute or regulation still gives a person a criminal record. A person has been convicted of a crime and has a criminal record even if convicted of possessing only a small amount of cannabis. While the information may not appear on the CPIC network at a border crossing, there is an ongoing exchange of information concerning drugs between Canadian and American customs authorities. Further, if asked by a judge whether an accused had a record, it is doubtful that the defence could simply reply that the accused had no "traceable" record. Therefore, to suggest that Bill C-8 would not impose a criminal record on those convicted of possessing cannabis is misleading. If the underlying assumption is that the Bill would allow a person to lie without being found out, this does not encourage respect for the law.

We appreciate the statement of the goals of sentencing which has been added to Bill C-8, especially in its recognition of the importance of treatment and rehabilitation. However, we believe that the emphasis given to "respect for the law," as the fundamental purpose of any sentencing provision under this Part, is optimistic. The arbitrary and harsh nature of the approach taken toward relatively harmless substances does not encourage respect for the law. In addition, it is our experience that judges are not imposing the kind of penalties suggested under Bill C-8 for possession of small quantities of marijuana, for example.

When legislation differs so dramatically from public opinion and judicial decision-making, we believe it brings the law into disrepute, rather than enhance respect for it.

Conclusion

The National Criminal Justice Section urges the government to take this opportunity to define a distinctly Canadian drug policy, rather than to follow the mistakes of American drug policy. We urge the Canadian government to show leadership based on current evidence and research, and to eliminate prohibition and its associated problems.

Amendments to the existing law to decriminalize the possession or cultivation of small amounts of drugs intended for an individual's own use, or the non-profit transfer of small amounts between adults, would be an excellent beginning. Heroin users could be treated in heroin maintenance programs according to a medical model. With those amendments, and a plan for realigning Canada's drug policy to address the health and social policy issues underlying the use of drugs and restricting the use of the criminal law to those activities that actually cause harm, we believe that Canada would have a more humane and progressive drug policy focused on harm reduction. This legislation should not precede a thorough review of these issues. It is our view that the passage of Bill C-8 would represent another step in the wrong direction for Canada's drug policy.

- *John Conroy*

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[1] The Committee on Drugs and the Law. *A Wiser Course: Ending Drug Prohibition*. The Record of the Association of the Bar of the City of New York 1994; 49(5): 523 at 524.

[2] Government Spending on Adult Correctional Services. *Juristat* 1996; 16(3): 1.

[3] See CBA's earlier submission: *Bill C7, Controlled Drugs and Substances Act*. Ottawa: CBA, 1994 at 45.

[4] *Ibid* at 7.

[5] Ibid at 17.

[6] Report of the Commission of Inquiry into the NonMedical Use of Drugs. Cannabis Report. Ottawa: Information Canada, 1972 at 302-303.

[7] CM Bryan. Cannabis in Canada A Decade of Indecision. Federal Legal Publications 1980 at 173.

[8] Ibid at 176.

[9] See, eg, L Zimmer, JP Morgan. Exposing Marijuana Myths: A Review of the Scientific Evidence (unpublished paper prepared for the Lindesmith Center, New York, October 1995).

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Swiss Expert Commission Recommends Decriminalization of Drug Use

An Expert Commission, charged with the revision of the Swiss drug laws, released its report in February 1996.[1]

According to the report, 30,000 people in Switzerland are dependent on so-called "hard drugs," and their health and social conditions have worsened over the last years. The report stresses that the legal measures employed against drug users have failed to a large extent, and urges that two goals should drive future drug policy:

the prevention of dependence and its consequences; and

the improvement of the social and health conditions of drug users.

In the view of the Commission, the goal of a drug-free society is unattainable. Therefore, it recommends that

prevention and treatment efforts, rather than law enforcement, be increased;

harm reduction be considered as the primary goal of drug policy; and

drug use be decriminalized.

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[1] Bericht der Expertenkommission für die Revision des Betäubungsmittelgesetzes vom 3. Oktober 1951 an die Vorsteherin des Eidgenössischen Departements des Innern. Berne: Bundesamt für Gesundheitswesen, 1996.

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Foundation for Drug Policy Releases Newsletter

In April 1996, the Canadian Foundation for Drug Policy released the first issue of its newsletter *Drug Policy News*.

The newsletter will:

contain current information about Canadian drug policy issues;

explain likely changes to drug laws and policies at the federal level;

discuss initiatives taken by government departments, agencies and private sector organizations on drug policy issues; and

explore what is happening in other countries.

According to the introductory article, the editors hope that the newsletter "will keep Canadians informed about drug policy issues so that they can work constructively towards reducing the harms associated with drugs to users and to society as a whole." They say:

We would not be writing this newsletter if Canada's current drug laws and policies were even modestly successful in reducing the harms associated with drugs. Our "bias" - one informed by years of experience in drug policy - is that our present laws and policies largely do not reduce the harms associated with drugs. Based on criminal prohibition, these laws and policies have created far more problems than they have solved, much as the prohibition of alcohol scarred North America earlier this century. More of the same types of laws and policies, more of what has not worked, is not the answer. The answer - or at least the hope of an answer - lies instead in an open and honest debate about how best to deal with drugs in our society.

For more information, contact the Canadian Foundation for Drug Policy, 70 MacDonald Street, Ottawa, ON K2P 1H6. Tel: (613) 236-1027; e-mail: eoscapel@fox.nstn.ca; web site: <http://fox.nstn.ca/~eoscapel/cfdp/cdfp.html>

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Drugs and Discrimination: Do They Mix?

In the fall of 1995, the New South Wales Anti-Discrimination Board released *Drugs and Discrimination: Do They Mix?*, a paper discussing whether people who use legal or illegal drugs should be protected by anti-discrimination laws.[1]

In Australia, as in Canada, the definitions of "disability," "impairment" or "handicap" in anti-discrimination legislation do not specifically mention drug use of any kind. There is disagreement in the medical profession as to whether drug addiction is a disease. According to the paper, this gives rise to a number of issues:

is drug use of any kind covered by the definitions of "disability," "impairment" or "handicap" in anti-discrimination legislation?

is there a need for drug use of any kind to be protected by anti-discrimination laws either explicitly as part of the definition of disability or as a separate ground?

would protection of drug users by anti-discrimination laws be consistent with other government policy on drug use?

if drug users should be covered,

who should be included?

in what areas of public life should they be protected? and

what exceptions should apply?

The purpose of the paper is to promote discussion on these issues so that the Board can:

give further consideration to whether or not complaints from drug users should be accepted and, if so, in what circumstances; and

decide whether to recommend amendments to anti-discrimination legislation to address the issue of discrimination against drug users.

For more information or to obtain a copy of the paper, write to the Anti-Discrimination Board, Level 4, 181 Lawson St, Redfern NSW 2016, Australia.

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[1] Drugs and Discrimination: Do They Mix? Anti-Discrimination Board of New South Wales. Redfern: The Board, 1995.

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PRISONER AND HIV/AIDS

Is There a Right to Methadone Maintenance Treatment in Prison?

In April 1996, an HIV-positive woman (the "Petitioner") was sentenced to 21 days imprisonment at the Burnaby Correctional Centre for Women ("BCCW") in British Columbia. At the time of her sentence, she was on a methadone maintenance program supervised by her primary care physician. In accordance with a long-standing BC Corrections Branch policy, the BCCW refused to provide her with methadone. As a result of this refusal, she petitioned the British Columbia Supreme Court for relief in the nature of *habeas corpus*.

The petition to the Court argued that, under the circumstances the Petitioner found herself in, her detention was illegal. It raised several constitutional arguments based on the *Canadian Charter of Rights and Freedoms*.

In March 1996, the Petitioner tested positive for HIV antibodies. She had been admitted to the hospital suffering from endocarditis. At that time, her T Cell count was 100, and her physician considered her HIV-disease to be relatively advanced. Since the Petitioner has a history of injection-drug use, her physician started her on a methadone maintenance program as part of a treatment protocol based on a harm reduction model.

Harm Reduction

In addition to the typical opportunistic infections that affect people living with HIV/AIDS, HIV-positive injection-drug users tend to suffer pyogenic bacterial infections, such as pneumonia, endocarditis, and sepsis, more frequently than 1) those who do not use injection-drugs and 2) HIV-negative injection-drug users.[1]

In any event, for the HIV-positive person, using injection-drugs increases the risk of potentially life-threatening medical complications relating to HIV-disease. In addition, when an HIV-positive person

engages in unsafe injection habits such as needle-sharing, others are also at risk of becoming infected with HIV themselves. The harm reduction model recognizes and addresses the increased risk of medical complication faced by the HIV-positive person who continues to use injection-drugs, as well as the risk of unsafe injecting practices leading to the further spread of HIV-infection. The harm reduction model also recognizes that severely addicted persons will not be able to immediately practice complete abstinence and that it would not be medically wise for severely addicted HIV-positive persons to do so. It seeks to reduce the HIV-positive person's use of injection-drugs by treating them with methadone.

BC Corrections Branch Methadone Policy

As a result of the sentence imposed on the Petitioner, she was imprisoned at the BCCW. It is the policy of BC Corrections Branch, which administers the BCCW, not to provide prisoners with methadone, even when it is prescribed to them by their primary care physician. In accordance with this policy, when the Petitioner arrived at BCCW, she was refused methadone maintenance treatment.

Withdrawal from Methadone and the HIV-Positive Person

Withdrawal from methadone has significant physiological effects on a patient. In particular, the patient may experience nausea, vomiting, diarrhea, muscle aches, cramps, sweating, chills, goose bumps, joint pains, insomnia, and agitation. For the HIV-positive patient, the extreme physical and psychological stress caused by withdrawal from methadone has a detrimental effect on the patient's T Cell count and already compromised immune system, making the patient even more susceptible to disease and infection.

When the Petitioner was incarcerated at the BCCW and was refused her daily dosage of methadone, she started experiencing symptoms of methadone withdrawal. Her primary care physician formed the opinion that the BCCW's refusal to provide the Petitioner with methadone was medically contraindicated and that it posed a significant threat to her life and physical integrity.

The Legal Arguments

A *habeas corpus* application is an allegation by a prisoner that his or her detention is unlawful. In a *habeas corpus* application, the applicant seeks his or her release from imprisonment on the basis of its illegality. In this case, the Petitioner argued that, under the circumstances outlined above, her detention was unconstitutional and, therefore, illegal. Her petition challenged the constitutionality of her detention on several grounds. The petition argued that to refuse her methadone and force her to go through withdrawal was a cruel and unusual punishment, contrary to s 12 of the *Charter*, and a violation of her right to security of the person, contrary to s 7 of the *Charter*. It also argued that she was being discriminated against on the basis of her status as an HIV-positive person, and her status as a methadone-addicted person.

The Supreme Court of Canada has said that a punishment will be contrary to s 12 of the *Charter* if it is

"so excessive as to outrage standards of decency" or if the effect of that punishment is "grossly disproportionate to what would have been appropriate." [2] The Court also indicated that some types of punishment and treatment would always be considered cruel and unusual. These included the infliction of corporal punishment, lobotomisation, and castration. It is submitted that the refusal to provide an HIV-positive person with medical treatment deemed necessary by his or her primary care physician is such a punishment.

In support of this argument, an Ontario court has decided that not providing an HIV-positive prisoner with adequate medical care constitutes cruel and unusual punishment. [3] HIV-positive patients, particularly those on methadone maintenance programs, have significant health care needs that need to be addressed in a rigorous and consistent fashion, or their health will be severely jeopardized, and they will suffer accordingly.

The Supreme Court of Canada has said that "state interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitute a breach of security of the person." [4] It is submitted that since, in the opinion of her physician, the BCCW's refusal to provide the Petitioner with methadone constituted a serious interference with her bodily integrity and exposed her to increased risk of life-threatening medical complications given her HIV-positive status, it was a violation of her right to security of the person.

Section 15 of the *Charter* guarantees equality before and under the law; in other words, it prohibits discrimination by the government. The Supreme Court of Canada has said that discrimination is a distinction "based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed on others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society." [5] It is submitted that the Petitioner was discriminated against on the basis of her HIV-positive status and her status as a methadone-addicted person, both of which can be viewed as physical disabilities, a prohibited ground of discrimination under s 15.

Generally, BC Corrections Branch provides prisoners with appropriate medical treatment for illness and injury. Because of her dual status as an HIV-positive and an methadone-addicted person, methadone maintenance was the appropriate medical treatment for the Petitioner. Therefore, the policy not to provide her with methadone is a distinction based on her physical condition, because if she had any other condition, she would have been provided with the appropriate medical care.

The BCCW's Response

In response to the petition, the BCCW filed affidavit material challenging the Petitioner's physician's opinion that methadone withdrawal is contraindicated for HIV-positive methadone-addicted patients and that the Petitioner's physical integrity was endangered by her withdrawal. The affidavit material filed by the BCCW characterized the harm reduction model as relating only to social harm (ie the risk of HIV transmission through needle sharing), and not to an increased risk of medical complications relating to

HIV-infection arising from injection-drug use. Despite the position taken by the BCCW, they arranged for a staff doctor to examine the Petitioner, and he prescribed methadone for her. After this, she withdrew her petition seeking habeas corpus.

In affidavit material filed in this case, the Director of Health Services for the BC Corrections Branch indicated that the BC Corrections policy would be changed to recognize the validity of the harm reduction model for prisoners and to allow for methadone treatment of prisoners in certain circumstances.

- *Clay McLeod*

The author would like to thank Dr Stanley de Vlaming for his assistance

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[1] PG O'Connor et al. Medical Care for InjectionDrug Users with Human Immunodeficiency Virus Infection. The New England Journal of Medicine 1994; 331(7):450.

[2] Smith v The Queen (1987), 34 CCC(3d) 97 (SCC) at 139.

[3] R v Downey (1989), 42 CRR 286 (Ont Dist Ct).

[4] Morgentaler et al v The Queen (1988), 37 CCC(3d) 449 (SCC) at 465.

[5] Andrews v Law Society of British Columbia (1989), 56 DLR(4th) 1 (SCC) at 18.

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Disclosure of Prisoners' HIV Status

On 1 May 1996, the Prisoners' HIV/AIDS Support Action Network (PASAN) along with nine supporting organizations officially notified Solicitor General Herb Gray of their opposition to changes in parole supervision in the downtown Toronto region - changes which require parole officers to question people on parole about their HIV status.

Since February 1996, both PASAN and the HIV/AIDS Legal Clinic Ontario (HALCO) had been receiving calls from people whose parole officers had been demanding to know their HIV status, saying that they would then be notifying their sexual partners if they admitted to being HIV positive.

After a joint investigation, PASAN and HALCO discovered that these demands about HIV status were the result of an internal Correctional Services Canada (CSC) legal opinion. Dated 30 January 1996, the opinion was prepared "to provide direction to [CSC] psychologists in the area of disclosure of confidential medical information." The legal advice to CSC stated that,

In the light of recent case law ... where a psychologist knows or has reasonable grounds to believe that an offender who is HIV positive is engaging in unprotected sex, and has not disclosed or is refusing to disclose this information to his partner(s), she has a duty to inform any partner(s) or potential partner(s) of the offender's medical status.

The opinion stated that it

completely disagree[s] ... that psychologists must respect the medical confidentiality of the offender and not disclose the offenders medical status to the offender's partner(s) who may be at risk [sic]. The medical information about an offender belongs to the CSC. CSC is the client, not the offender and as such it must determine the appropriate use to which the information should be put.

After obtaining copies of the legal opinion, PASAN and HALCO were further able to learn that the

opinion had been distributed to Area Supervisors of parole offices around Ontario, apparently leaving individual supervisors to set their own local policies based upon their interpretation of the document. In the downtown Toronto region, this resulted in parole officers being instructed to ask parolees about their HIV status and, if necessary, engage in partner notification.

PASAN and HALCO were obviously concerned about the effects of this directive for people on parole, especially those who are HIV positive. Furthermore, they feared that CSC would try to apply this opinion more broadly to include people under other types of supervision - those in prisons, in halfway houses, or on parole or mandatory release in other parts of the province or country. Indeed, because this document has obvious ramifications for people living with HIV/AIDS regardless of their legal status, PASAN and HALCO decided it was important to notify and involve other organizations working with prisoners, ex-prisoners, and people living with HIV/AIDS to take action against this policy.

On 1 May 1996, they and eight other organizations sent a joint submission to the Solicitor General demanding 1) that this practice be stopped immediately and 2) that the legal opinion be totally disregarded before other branches of CSC attempted to apply it to other people under CSC supervision. The other organizations adding their voices to these demands were the AIDS Committee of Toronto, the Canadian AIDS Society, the Canadian HIV/AIDS Legal Network, the Katarokwi Native Friendship Centre (Kingston), the Kingston AIDS Project, Ontario AIDS Network, the Peterborough AIDS Resource Network, and Voices of Positive Women. Other organizations consulted in this action included AIDS Action Now!, Aboriginal Legal Services (Toronto), Community AIDS Treatment Information Exchange, the Elizabeth Fry Society of Canada, and the John Howard Society of Canada.

Common critiques raised by this ad hoc coalition included the fact that this legal opinion, and subsequent actions of CSC, are contrary to a number of laws, including rules on doctor-patient confidentiality as set out by the *Regulated Health Professions Act* and the *Health Protection and Promotion Act*, various statutes in privacy legislation and in common law, as well as section 15 of the *Canadian Charter of Rights and Freedoms*. Also emphasized was the fact that forced disclosure policies only result in isolating people living with HIV/AIDS, falsely and unfairly placing the onus on them to reduce the risk of HIV transmission, and indeed discourages all people from getting tested for HIV. It also sends out the dangerous health promotion message that the government, in this case CSC, can protect people from HIV infection, rather than focusing on the responsibility of all individuals to protect themselves.

At the time of this writing, PASAN has received no official response from the Solicitor General.

- Rick Lines

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Any persons on parole who have been asked their HIV status by their parole officer as part of this new directive are encouraged to call either PASAN (416-920-9567) or the HIV/AIDS Legal Clinic Ontario (416-340-7790).

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US - Over \$1 Million Damages to Prisoner Living with AIDS for Abuse in Prison

In a verdict announced 1 March 1996, a federal jury in Kentucky awarded US \$1,180,000 damages to a man for mistreatment he endured during an overnight stay in the Jefferson County Correctional Facility.[1]

The plaintiff was arrested for public drunkenness and taken to the county jail. He told the police officer that he had AIDS, which the officer apparently told the jail staff. Sosa claims he was ridiculed and taunted, kicked, placed in a cell without a toilet for three hours during which, suffering from diarrhea and severe cramps, he soiled himself and repeatedly cried out for help. The jury levied both compensatory and punitive damages against the county and the individual jail guards.

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[1] Sosa v Jefferson County, No C-95-229 (W D Ky). Reported in Lesbian/Gay Law Notes April 1996, at 56. See also AIDS Policy & Law 22 March 1996; 11(5): 1.

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Australia - Condoms in Prisons in New South Wales

The New South Wales (NSW) government has decided to make condoms available in three prisons on a trial basis. The move is in keeping with a pre-election promise.

Prisoners in the three prisons will be given access to condoms via non-cash vending machines, which will be installed and serviced by outside contractors, so that prison staff will have nothing to do with the distribution or disposal of condoms.

According to the NSW Minister for Corrective Services,

For more than a decade health experts across Australia have been lobbying for the introduction of condoms into prisons as a precaution to prevent the transmission of HIV and Hepatitis B. It is a fact of life that some homosexual activity occurs in jails. As well as ensuring that inmates are protected from disease we are also ensuring that the prison system does not become the source of infection for the rest of the community when the inmates return to their family and friends.[1]

While condoms are only now being made available to prisoners, the NSW prison system's policy with regard to drug use has been much more enlightened: for many years already, bleach distribution and methadone maintenance programs have been undertaken and evaluated.[2] Recently, a NSW study found that needle and syringe exchange would also be feasible in Australian prisons.[3]

The Situation in Canada

In Canada, condoms have been available in the federal prison system since 1992, and are available also in many, but not all, provincial prison systems. Where they have been made available, this has not created any problems and, after initial resistance, has generally been well accepted by prisoners, prison staff, and the public.[4] Nevertheless, problems remain: in some provincial prison systems, condoms are not available at all. In others, they are available only on request, through prison medical services.

In contrast to NSW, Canadian prison systems' response to drug use has been and continues to be slow. Bleach has been available in a few provincial systems, but is only now being introduced to the federal system and remains unavailable in other provincial systems. Methadone maintenance and needle and syringe distribution programs, although they have proven successful in other systems, have yet to be introduced to Canadian prisons.

- Ralf Jürgens

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[1] Reported in [Australian] HIV/AIDS Legal Link 1996; 7(1) at 4.

[2] See, eg, K Dolan et al. Bleach Easier to Obtain but Inmates Still at Risk of Infection in New South Wales Prisons. Technical Report. Sydney: National Drug and Alcohol Research Centre, 1996.

[3] S Rutter et al. Is Syringe Exchange Feasible in a Prison Setting? An Exploration of the Issues. Technical Report No 25. Sydney: National Drug and Alcohol Research Centre, 1995. Reported in Canadian HIV/AIDS Policy & Law Newsletter 1996; 2(3) at 15.

[4] See Appendix 5 (Results of the Staff Questionnaire) in: Correctional Service Canada. HIV/AIDS in Prisons: Background Materials. Ottawa: Minister of Supply and Services Canada, 1994.

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Australia - Failure to Inform Prisoner of Positive Diagnosis

A prisoner who had a compulsory HIV test but was not told the result until almost 16 months later is suing the state of New South Wales.[1]

The prisoner had an HIV test in February 1991. A nurse told him he would be notified only if the result was positive. However, it was not until the following year, after he had been transferred to another prison, that he discovered that he was in fact HIV- positive, and that this had been known to the prison health authorities since the previous February. The Supreme Court of New South Wales has granted him leave to sue the State.

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[1] Reported in [Australian] HIV/AIDS Legal Link 1996; 7(1): 5, with reference to Sydney Morning Herald of 16 December 1995.

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Australian Medical Association Calls for Needle Exchange Programs for Prisoners

In its February 1996 *Position Statement on Blood Borne and Sexually Transmitted Viral Infections*, the AMA states that "[e]ffective prevention among prison populations requires the establishment of preventative education programs, needle exchange programs for intravenous drug users and safe sex programs for those involved in high risk sexual behaviour."^[1]

In addition, the Statement endorses the right of prisoners with HIV or hepatitis infection to proper care.

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[1] Reported in [Australian] HIV/AIDS Legal Link 1996; 7(1) at 7.

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EUTHANASIA

Australia - Lenient Sentence in Euthanasia Case

In a recent Australian case, a "long-term survivor" of HIV who helped his lover with HIV to die was acquitted of manslaughter, receiving instead a three-year good behaviour bond for aiding and abetting an attempted suicide. The case provoked debate on euthanasia and on the need for law reform.[1]

The man, Mr Hoddy, was charged with manslaughter, and aiding and abetting suicide, after he contacted police and told them he had helped his lover commit suicide using prescription medication. He further told them that he and his lover, Mr Brooks, had previously discussed the possibility of helping Brooks - who had been hospitalized with HIV-related conditions a number of times and had previously attempted suicide - to die.

Hoddy said his lover had phoned him from a hotel room saying that he had "fucked up" in his attempt to kill himself, and had asked him to help him "do it properly." Hoddy, an enrolled nurse, then went to see Brooks at the hotel, where they talked about their lives and hugged and cried together before Hoddy crushed 15 codeine phosphate tablets for Brooks to take. When Hoddy left, his lover was still alive although slurring his speech and slumped on the bed.

A magistrate discharged Hoddy on the charge of manslaughter on the basis of toxicology evidence and Brooks' medical history. The latter showed that Brooks was habituated to morphine derivatives; therefore, the level of codeine phosphate found on post-mortem would not have necessarily been fatal to Brooks. The drugs found on post-mortem also included lethal levels of at least one other drug, plus a number of other drugs.

Accordingly, the magistrate found that it was not possible to say that the drug administered by Hoddy had caused Brooks' death. For this reason, the prosecution then changed the second charge to one of aiding and abetting attempted suicide (from aiding and abetting suicide). To this charge, Hoddy pleaded

guilty and was committed for sentence.

Sentence

On 28 November 1995, a Sydney District Court imposed a threeyear good behaviour bond on Hoddy. Solomon J took into account the "tragic circumstances" of the case and Hoddy's ill health, and added that Hoddy was not motivated by anything but his affection for Brooks, who had terminal AIDS and "was in great physical and psychological distress."

Reaction

The AIDS Council of NSW (ACON) welcomed the result, saying that the "judgment shows the judiciary is unwilling to jail people for assisting friends to die with dignity." ACON called upon politicians from all parties to enact voluntary euthanasia legislation, saying that "[f]amily, friends, doctors - and particularly people dying - should not have to go through the traumatic process Mr Hoddy and his dying friend had to endure."

Euthanasia Bill

ACON released a draft bill for voluntary euthanasia in September 1995 to promote public discussion of euthanasia.[2] Subsequently, a Liberal MP in NSW announced that he would introduce a bill into Parliament that would allow for euthanasia where there is a terminal illness, but not on the ground of an unacceptable quality of life.

Extent of Medically Assisted Suicide

In a paper delivered at the 1995 conference of the Australasian Society for HIV Medicine,[3] it was reported that, of the doctors surveyed,

56 percent (including 70 percent of HIV general practitioners) supported euthanasia law reform; and

18 percent had been involved in assisted suicides.

Doctors who had been involved in assisted suicides received a large number of requests (438 requests among 41 doctors). They did not always respond with assisting suicide; rather, commencement of palliative care was a common outcome. Nevertheless, large numbers of people with HIV were assisted to suicide by their doctors: in some practices, euthanasia or assisted suicide accounted for as many as one-third of all HIV- related deaths.

Disconcertingly, four people who were assisted with suicide were healthy; 30 healthy clients who also requested assistance were refused it.

Generally, the survey "highlighted not only the extent of assisted suicide in HIV cases but also that counselling or earlier palliative care is often the outcome for patients reporting problems to their practitioner."

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[1] The following text is a slightly edited version of D Buchanan. Bond for Man in Euthanasia Case. [Australian] HIV/AIDS Legal Link 1996; 7(1): 24-25.

[2] For more details, see [Australian] HIV/AIDS Legal Link 1995; 6(2).3. 16-19 Nov 1995, Coolum, Queensland.

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Dutch Study on Euthanasia in Gay Men with AIDS

A group of Dutch researchers studied the rate of euthanasia, physician-assisted suicide, and other medical decisions concerning the end of life among 131 gay men with AIDS.[1]

The researchers found that:

22 percent of the men died by euthanasia or physician- assisted suicide; and

in another 13 percent another medical decision concerning the end of life had been made.

Further analysis showed that:

the likelihood of euthanasia or physician-assisted suicide increased the longer patients survived after AIDS diagnosis; and

most of the patients would have died naturally within one month of the time euthanasia or physician-assisted suicide was induced.

The authors of the study suggest that the high rate of medical decisions concerning the end of life was due to the patients' high level of knowledge about AIDS. Furthermore, the higher rate of euthanasia in long-time survivors could be the result of additional suffering or the greater opportunity to discuss the option with friends and doctors. According to the researchers, euthanasia and other medical decisions concerning the end of life did little to shorten life.

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[1] P Bindels et al. Euthanasia and Physician-Assisted Suicide in Homosexual Men with AIDS. Lancet 1996; 347: 499. Reported by Michael Howe, hivinfo@itsa.ucsf.EDU

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HIV/AIDS IN THE MILITARY

HIV in Military Populations: Whose Problem Is It?

The escalating spread of HIV within military populations is appearing on the agendas of defence ministries and military hierarchies around the world. This is a welcome, if overdue, development. How these agendas are defining the problems they set out to address is of concern, however. The assumption that the presence of HIV in the military is a matter for the military alone appears to be rarely questioned.

In this regard, the recent decision by United States Congressional leaders to repeal legislation that would have forced the Defense Department to discharge military personnel who have tested positive for HIV is significant precisely because not only military, but also civil, arguments were used in its favour.[1] The nature of the virus, and the social and cultural meanings of HIV, are such that its presence in military populations creates a problem for us all.

There are many responses that military authorities can and are making to the HIV epidemic within their ranks. Examples of good work abound:

the Royal Thai Army's peer education model;

the US military's emphasis on counselling and support; and

the Belgian Armed Forces' policy on anti-discrimination and the rights of HIV-infected military personnel.

There are many others. Such responses often capitalize on the strengths of military culture, like discipline and teamwork, the command and control hierarchies and the institutional infrastructures of training, medical treatment and logistical management that many militaries have in place.

Drawing on the strengths and particularities of military culture provides a rationale for the operational characteristics of military HIV programs. However, it is important to differentiate this from the conceptual basis of such programs: many current responses to HIV in military populations are conceptualized as military-only responses to a military problem, often defined in terms of readiness capacity or unit morale. Such a focus blurs the reality that military and civilian communities, although distinct, are not separate or separable entities. This is a truism insofar as it refers to sexual contact and HIV transmission, within and between the two communities. Civil - military sexual contact extends beyond military spouses and partners, along a continuum that includes "rest and recreation" sex economies as well as rape and sexual torture as modes of terror and subjugation during conflict. The presence of HIV in military populations inevitably affects civilian populations as well.

Sex and Sexuality in Military Life

A greater understanding of the factors that shape the continuum of sexual contact between military and civilian populations may help to illuminate this problem and to reconceptualize the nature of the response. The questions that follow from recognition of this continuum have been neglected and are worthy of exploration; they concern the place and purpose of sex in military life. Such questions are difficult, not least because sexuality remains enveloped in taboos in many parts of the world. Within military settings sexuality is often proscribed by regulation; homosexual acts remain illegal in most armed forces, and military personnel may still face punishment along with their treatment if they report a sexually transmitted infection.

But while military institutions attempt to regulate their members' sexual behaviour, they continue to regard such behaviour in individual, rather than occupational, terms. HIV highlights this well: whereas bloodborne infection with HIV is regarded as an occupational risk for military personnel, sexual infection is deemed a matter of personal responsibility and indeed blame. Evidence for this is to be found in policies that apply different medical and welfare benefit entitlements to HIV- positive military personnel depending on how they became infected, with sexual transmission carrying a lower (or no) entitlement because it is not defined as an occupational risk (such a policy approach was reported by several military participants at a seminar on "AIDS Prevention in the Military Populations - Regional Seminar for South and Southeast Asia," Cha Am, Thailand 13-16 September 1995).

Further exploration of sexuality in military life may call this differentiation into question. The sexual attitudes and behaviour of military personnel are both reflective and constitutive of the values and power relationships of societies in general. Even the use of sex as a weapon of war, for example, in the Bosnian and Rwandan conflicts, cannot be understood in isolation from concepts of patriarchy and sexual oppression that characterize the civilian world. But there is historical and contemporary evidence to suggest that sexuality in military culture is not merely a mirror image of its civilian counterpart, but rather a refraction.

Sex and Occupational Risk

This refraction can be seen in the well-documented historical association between military forces and the spread of sexually-transmitted infections, as well as in the boost given to sex work economies in surrounding communities by the presence of armed forces (eg, it is acknowledged that the Vietnam war played a significant role in the growth of sex industries in Southeast Asia). Evidence points to the occupational utility of sex in military life, be it as an organized, and sometimes officially sanctioned, release from occupational stress, as an expression of occupational norms of masculinity and power, or as a mode of terror and subjugation. The burden of such a statement is not a blaming of the military, but rather an illumination of the refraction which sexuality in the military context may undergo. Pressing and strategic questions then arise: to what extent can military personnel's vulnerability to sexual infection with HIV be understood to be occupationally determined and what are the implications of such an understanding?

Such questions are rarely asked in discussions of HIV and the military. Occupational risks of HIV infection in the military remain narrowly defined in terms of blood-to-blood transmission, for example, during combat or post-combat surgery. Broadening the enquiry into occupational risk to include a discussion of the ways in which military personnel's sexual behaviour is in part shaped by their occupational culture opens up an imaginative space; in this space, different military sexualities may be envisaged and considered. Given that military sexualities are refractions of societal norms and practices, consideration of the occupational aspects of sexual infection with HIV becomes a civil - military endeavour ³/₄ in the same way that the imaginative space for envisaging safer military sexualities becomes a civil - military space in which society's constructions of sexual norms and practices may be challenged and changed.

Civil - Military Partnerships

But are there any prospects of such a civil - military partnership, especially given the innate conservatism of military institutions in many societies? The involvement of some militaries, for example, in Senegal and Vietnam, in programs of civil development offers a model of partnership. This work has often related to infrastructural projects, but the same concept of civil - military partnership could be applied to addressing the structural determinants of the spread and impact of HIV. There are precedents: eg, from the human rights field in Ecuador, where military authorities are working together with a human rights non-governmental organization (NGO) to explore the principles and practice of human rights in the context of Ecuadorean society (this human rights education project for the military is implemented by a Quito-based NGO, ALDHU, with a grant from the United Nations Development Program). In the same way, there is a need for civil - military partnerships to explore questions of sexuality alluded to earlier, for these questions lie at the heart of social change in response to the HIV epidemic.

Civil - military partnerships to bring about social change in response to HIV are also threatened by the epidemic. The presence of HIV creates tension between civilian and military communities. Sexual relations result in HIV transmissions and risk becoming a matter of blame. Fear of HIV heightens the tendency within military hierarchies to regard their institution as separate - and indeed separable - from the rest of society and from those whom it perceives it must protect itself against from the threat of

infection.

HIV Testing

HIV testing is seen as a powerful policy instrument by those who believe that HIV can and should be kept out of the military; and yet the debate on HIV-testing policy is also a site at which civil - military partnerships for social change may be constructed.

There are well-rehearsed ethical, public health and economic arguments against pre-employment HIV testing programs. These arguments continue to sustain an unusual consensus among international and national agencies working in response to the epidemic. This consensus is important because it reflects a common commitment to challenging the stigmatization and discrimination that still accompany the epidemic. As such, this policy position on HIV testing may be seen as a part of a movement for social change using regulations and guidelines on testing to promote an ethic of inclusion and respect for human rights.

As the outcome of a continuing debate, this consensus remains both fragile and in flux. Pre-employment HIV screening is common in civilian life, even in countries in which it is officially proscribed by government policy. The contribution that military institutions may make to either strengthening or undermining the consensus is clear, given the significance of militaries as major employers and symbols of national identity and state authority. The fact that some militaries have invested in HIV screening programs for their recruits, disallowing entry for those who test positive, is of great concern. Indeed, the United Nations Department of Peacekeeping Operations has lent its considerable moral authority to such action by recommending that all nations supplying personnel for peacekeeping missions should test such personnel for HIV antibodies and not deploy those who test positive - although it makes clear that any decision on this matter remains a national one.

The most striking aspect of military interest in pre-employment HIV testing is the lack of debate, at either the national or international level, about the grounds for, and the implications of, such policy decisions. In common with other employers, military authorities who have instigated pre-employment testing justify their decision:

on economic grounds, as a protection of costly investments in training; and

as a limitation on the medical and other costs that would be incurred by HIV-positive military personnel.

Protection of the blood supply in emergency or conflict situations and preservation of military readiness are also advanced as uniquely military arguments for screening out those who are HIV positive from military service.

It is true that military and civilian communities differ in significant respects. However, the extent to

which such differences warrant a different HIV-related policy approach on HIV testing is debatable. Such a debate should be informed by further research on key questions, for example, regarding the extent to which the presence of HIV-positive military personnel threatens the military's readiness or its blood supply. This debate, and the research which may stimulate it, is not the responsibility of the military alone: civilians and military personnel form interdependent communities; recognizing this interdependence, and engaging in informed civil - military policy debates, are necessary pre-conditions for coherent and consistent national policy decisions on critical issues like HIV testing.

Metaphors of War

The lack of debate may reflect a traditional view that military policy-making is the preserve of the military and designated civilian authorities. It may also be stifled by confining the definition of the problem to the virus itself, rather than referring to the conditions that enable HIV to spread. In this regard, the combat metaphors of military HIV awareness campaigns, applauded for their relevance to the target audience, may not serve us well, implying as they do that HIV is an enemy to be repulsed. HIV testing then becomes a "weapon" with which to keep the enemy at bay, distracting attention from a discussion of the contexts and behaviours that continue to drive the epidemic in military populations.

Such a discussion is further hampered by the confusion that surrounds some policy decisions on HIV testing. In Thailand, linked HIV tests are conducted on conscripts at the pre-employment stage on the grounds that this:

protects the army from the presence of HIV-positive individuals; and

generates valuable surveillance information which help the Thai authorities to track the course of the epidemic in the population as a whole.

For reasons that are unclear, such pre-employment testing is only applied to conscripts below the rank of officer. As a result, significant numbers of young men, who as non-officer conscripts tend to be from lower socio-economic backgrounds, lose their immediate employment prospects (and perhaps longer-term prospects as well), and learn of and have to live with their serostatus in a society in which HIV remains highly stigmatized.

Military policy on HIV testing has implications for civilian society. In South Africa,[2] the Defence Force has instituted a policy of pre-employment HIV testing; because this contradicts the Government's policy against such testing, it undermines the credibility of the Government's decision and weakens efforts to build a national consensus. If a major employer like the South African Defence Force takes such a policy decision, it is not surprising that other major employers feel justified in initiating or maintaining their own pre-employment testing programs.

Such decisions suggest an unwillingness to acknowledge the interdependence of civil and military policy making on such issues as HIV testing. Without such an acknowledgement, the prospects for civil -

military partnerships for social change on issues as fundamental as sexuality do not appear good. But as Maxine Greene stresses in "The Dialectic of Freedom," social change begins with an act of imagination and a recognition that reality is not given but chosen. Patriarchal values are deeply embedded in most if not all societies and refracted by military culture; but is it possible to imagine different sexualities within which we all may live more safely in a world of HIV? In this act of imagination is created the space between what is and what could be. Civil and military institutions, groups and individuals are beginning to occupy this space, for example, at international fora and conferences, and beginning to debate shared understandings of and responses to the epidemic. There is a need to stimulate similar debates at national and local levels. In these spaces for questioning what is, rather than prescribing what should be, civil - military partnerships for social change may be constructed through dialogue and hope.

- Alan Greig

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This paper is based on a presentation given to a satellite seminar on Civil - Military cooperation at the Third International Conference on AIDS in Asia and the Pacific, 17-21 September, Chiang Mai, Thailand.

[1] Reported in the New York Times, Thursday, 25 April 1996.

[2] Reported by R Goodman. South Africa: Mandatory Military Testing. Civil-Military Alliance Newsletter 1995; 1(3).

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INTERNET NEWS

HIV/AIDS Law and Policy on the Web

Among sites that do little more than promote organizations or maintain a logo presence within the information highway's magma, it is not easy to locate web pages that actually offer a consistent body of information. Highlighted here is a selection of worthy places to visit that provide access to texts on issues of AIDS law and policy.

Canadian HIV/AIDS Legal Network

Our new web site offers numerous excerpts from recent issues of the *HIV/AIDS Policy and Law Newsletter* and a quantity of information produced by the Joint Project on Legal and Ethical Issues Raised by HIV/AIDS under the following titles: Prisons, Criminal Law, Gay and Lesbian Legal Issues, Testing and Confidentiality, Drug Laws and Policies, Discrimination, Prostitution Laws and Policies, Access to Care and Treatment. As well there are various press releases (including those published for each HIV/AIDS Policy & Law Seminar), other texts published by the Network, an advocacy alert for the Renewal of the National AIDS Strategy, and a list of selected links. An efficient way to keep in touch while you wait for the next issue of the *Newsletter*!

<http://www.odyssee.net/~jujube>

HIV/AIDS Ethics and Policy Update: Journal of the American Medical Association

Although this site is rather new and its online corpus is not large at the time of writing, its quality promises great things for the future. Selected opinions are listed, along with the American Medical Association's general and HIV/AIDS-related Principles of Medical Ethics. The compendium of online information is organized under headings which include HIV Testing and Confidentiality, Reporting, Privacy and the "Right to Know", Discrimination and Disability Law, Insurance, HIV-Infected Health

Care Workers, and Drug Use. Most of these interesting texts, if not all, are by Lawrence O. Gostin.

<http://www.amaassn.org/special/hiv/ethics/ethihome.htm>

Australian Federation of AIDS Organizations

This site is an exposé of the Australian community's response to AIDS. It includes excerpts from the *HIV/AIDS Legal Link*, the *National AIDS Bulletin* and the *HIV/AIDS Herald*. Also worthy of mention: Injecting Drug User Policy, Sex Worker Policy, Legal Policy, People Living With HIV/AIDS Policy are online as well as a discussion paper on the policy development process; HIV Testing An updated policy response from AFAO; Policy on the ACT Heroin Trial; Drug Law Reform and Harm Reduction a discussion paper by Tim Moore and Dave Burrows; Statement of Principles; Sex Worker Policy Folder; Condom Breakage and Slippage Policy and Guidelines; information on Applying for Permanent Residence in Australia. Go to the two small underlined menu items, publications and policy, at the top of the home page: that's where a lot of the stuff is found.

<http://www.pinkboard.com.au/~afao>

CDC National Prevention Information Network

Highlights of this site include: New Report to the President, Youth & HIV/AIDS: An American Agenda; the 1995 yearend HIV/AIDS Surveillance Report; AIDS Clinical Trials Information Service; HIV/AIDS Treatment Information Service; and Free Online Publications Ordering.

<http://www.cdcnpin.org>

However, an abundance of other materials is more easily found on the Gopher site: among others, the *Weekly Mortality and Morbidity Reports* and the *AIDS Daily Summaries*, are chronologically gathered at: <gopher://cdcnac.aspensys.com:72>

The Dutch Approach to AIDS

The Dutch policy on AIDSrelated issues, which has been characterized for quite some time by a pragmatic approach, is well documented here in a text that covers most issues, from drugs to prostitution to gays and lesbians and much much more.

<http://www.xs4all.nl/~mlap/count/nl/adam2.html>

Center for AIDS Prevention Studies (CAPS), University of California, San Francisco

The highlight of this site is the series of fact sheets on very specific preventionrelated issues: women's

prevention needs, AfroAmericans, Latinos, gays and lesbians, sextrade workers, inmates, street people, men who have sex with men, and of course safe sex, syringe exchange and education. All these pages contain many endnotes and bibliographic references. Good presentation and readability.

<http://www.epibiostat.ucsf.edu/capsweb>

Canadian Foundation for Drug Policy

This site criticizes, and offers realistic solutions to, the current Canadian drug laws and policies. The text of the proposed Bill C8 (formerly C7) is online, as well as regular and detailed updates on its ongoing legislative process and numerous submissions made to the Senate Committee by various Canadian organizations. Demystification of drug use, as well as texts about the harm reduction approach to drugs hold a place of honour on this site. The links to drugrelated sites are quite impressive and more relevant than what you get from mainstream browsers (Yahoo & Cie.).

<http://fox.nstn.ca/~eoscapel/cfdp/cfdp.html>

The Lindesmith Center

This Manhattanbased drug policy research institute keeps a generous site that focuses primarily on academic information and articles about drugs and drug policy. The site features an abundance of recent articles written by Ethan A. Nadelmann and his staff: Is Needle Sharing a Ritual?, A Heroin Epidemic in Macedonia, Switzerland's Heroin Experiment, Toward a Sane National Drug Policy, Should We Legalize Drugs? History Answers Yes, and many more. Web visitors can also subscribe to the Center's email list and receive information on media events and new articles. Some U.S. Government Documents are also available: Bureau of Justice Statistics (BJS), Drug Enforcement Administration (DEA), National Institute on Drug Abuse (NIDA), Office of National Drug Control Policy (ONDCP).

<http://www.soros.org.org~lindesmith/tlcmain.html>

Safe Works AIDS Project

Were it only for the colorful syringe graphics, it would be worth visiting this site! But there is a lot more to it: many texts on harm reduction and an impressive compilation of press clippings on syringe exchange. Quite a compelling and lively site.

<http://www1.minn.net/~mikempls/safe.html>

Canadian Centre on Substance Abuse

Even though the organization itself is being discreetly dismantled, its website is still beaming. Many

useful resource documents can be found in the "Statistics" section, about drugs, drug use, and drug-related crime. The "Search the CCSA's Database" option lets the visitor explore by keyword: texts will be suggested that cannot be found on the main index page which is not updated very often. Ironically, when you first enter the site you may read the text of the expired Canadian Drug Strategy that led to the foundation of this Centre, which unfortunately died away without much fanfare.

<http://www.ccsa.ca/cclat.htm>

Links, links and more links!!

Try the following.

Canadian Law Resources on the Internet

This list of resources on Canadian law and government features a list of links to Associations and Institutes, Civil Liberties and Human Rights, Courts and Tribunals, Federal Government, Law Journals, Law Reform Commissions, Lawyers and Law Firms, Legislation, Newsletters, Other WWW Source Listings, Provincial Governments, Publishers and Commercial Sites, Universities and Colleges, as well as Canadian sources classified by Province, and International links.

http://mindlink.net/drew_jackson/mdj.html

Other strong lists of links:

Osgoode Law School - <http://www.yorku.ca/faculty/osgoode/uc.htm>

Access to Justice Network - <http://www.acjnet.org.french/french.html>

Findlaw's Law Crawler - <http://www.findlaw.com/search/lawcrawler.html>

Virtual Medical Law Center - <http://wwwsci.lib.uci.edu/%7Emartindale/Legal.html>

If you know of sites that you would like to see mentioned in this review, please contact Jean Dussault at the Network's office or at jujube@odyssee.net

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AIDS AS A DEVELOPMENT ISSUE

HIV/AIDS is a borderless global pandemic, with no country beyond its reach. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that at the end of 1995, 20.1 million adults worldwide were living with HIV/AIDS, almost half of them women, and 90 percent living in poor countries in the developing world. The virus tends to spread along the pre-existing fault lines of society, fuelled by societal and structural factors such as poverty, discrimination, and the subordinate status of women.

Integral to an understanding of the global dimensions of HIV/AIDS is the fact that AIDS is both a symptom and increasingly a cause of underdevelopment. In high-prevalence countries with a long-standing epidemic, AIDS has begun to (1) wipe out achievements in child survival; (2) shorten life expectancy; and (3) threaten the very process of development.

The response to HIV/AIDS to-date, by multilateral agencies, governments and many NGOs alike, has been hindered by the perception that AIDS is only a health issue. In reality, AIDS is much more than a health or medical issue, and medical and health personnel alone cannot solve the many problems it poses. Experience has shown that, in order to be successful, efforts to prevent the spread of HIV and to deal with the many consequences of HIV/AIDS need to recognize and address the social, economic, political and cultural factors that construct personal and societal vulnerability to AIDS.

The Geographical Spread of AIDS

Overview

More than 15 years after the discovery of AIDS the pandemic shows no sign of relenting. As of late 1995, cumulative AIDS cases worldwide had risen to more than 6 million, and 20.1 million people were living with HIV. It is conservatively estimated that by the year 2000, 30-40 million men and women worldwide will have contracted HIV; some estimate that up to 110 million persons could be HIV-positive by then. Africa has the greatest number of cases of HIV/AIDS, but HIV is now spreading faster

in Asia than in any other part of the world. The impact of the pandemic on women is increasing dramatically, and heterosexual transmission accounts for the largest proportion of new HIV infections.

Sub-Saharan Africa

With more than 12.9 million HIV-infected adults, Sub-Saharan Africa is the region in the world hardest hit: the region has only 10 percent of the world population, but accounts for three out of every four HIV infections among adults, over 80 percent of infections among women worldwide and 90 percent of infections among infants. HIV probably started to spread in this region in the 1970s, and transmission has been overwhelmingly heterosexual. Sub-Saharan Africa is the only region in the world where more women are infected than men: 11 to 12 women for every 10 men.

South and Southeast Asia

HIV only began to spread in South and Southeast Asia in the mid-1980s or even later, but since then the progression of the pandemic in this region has been rapid: UNAIDS estimates that as of late 1995 over 4 million people were living with HIV/AIDS. India and Thailand account for the majority of infections, but HIV is rapidly spreading to other countries of the region, the predominant modes of transmission being unprotected heterosexual intercourse and needle-sharing. In some Asian countries, a large proportion of sex outside marriage is commercial sex. One study showed that Thai men had their first sexual experience with a commercial sex worker at an average age of about 18 years.

Latin America and the Caribbean

In Latin America and the Caribbean, over 1.7 million adults are living with HIV/AIDS. Rates of infection are rising particularly in Honduras, some other Central American countries, and the Caribbean. Since the mid-1980s, there has been increasing heterosexual transmission, principally among bisexual men and their female sex partners, and female sex workers and their clients. Heterosexual transmission is spurred by a high prevalence of STDs and other genital tract infections, and by social conditions that favour unprotected sex with many partners, frequently as part of a strategy of survival through sex work.

Linking AIDS to Underdevelopment

To understand AIDS as a symptom of underdevelopment, one must examine the context in which it spreads. This requires understanding the factors that construct personal and societal vulnerability to AIDS:

poverty;

the status of women; and

discrimination.

Poverty

With certain exceptions, the overriding reason for the rapid spread of HIV has been the high correlation between poverty and vulnerability to the virus, a correlation that has led to high rates of infection in the most economically deprived populations of cities as far apart as Harare, Bombay, Edinburgh, New York, and Rio de Janeiro. For many reasons, poverty makes people vulnerable to contracting HIV:

Poor communities have less access to health care. STDs are widespread in many developing countries because individuals cannot afford treatment, and health authorities cannot afford to provide the comprehensive network of clinics and medical staff that would ensure disease prevention and care.

Poor people tend to receive less education and are more likely to be illiterate, limiting their access to information about HIV/AIDS. Illiteracy may be compounded by lack of access to radio or television. Those with little or no education tend to start their sexual life without any knowledge of the means of preventing HIV/AIDS or other STDs, or pregnancy. Even where awareness of HIV/AIDS exists, people may not be able to afford condoms or there may not be the infrastructure to distribute them effectively.

Poverty forces more and more people to leave their families and migrate in search of work. The resulting disruption of social and family patterns has implications for the spread of HIV.

Poverty affects attitudes toward risk-taking. For people struggling to meet their immediate needs for food and shelter, avoiding a disease that might remain symptomless for months or years may be a low priority.

Experts agree that structural adjustment programs have exacerbated poverty in the developing world and aggravated the transmission, spread and control of HIV transmission. These programs are funded by loans from the International Monetary Fund and World Bank and contain conditions that require that recipient governments cut back on funding of basic social services. Consequently, spending on health and welfare of the populations of many Least Developed Countries has fallen dramatically during the 1980s and 1990s.

The Link Between STDs and AIDS

The World Health Organization estimates that, annually, at least one in ten sexually active people is infected with an STD, and in many developing countries, STDs are among the five most common health problems for which people seek treatment. Having an STD increases the risk of contracting HIV from a sexual partner by as much as nine times (Campbell, 1994). Generally, STDs have a major impact on people's health, especially for women and new-born babies.

Because STDs increase the efficacy of transmission of HIV, controlling these infections is an important part of efforts to contain the spread of AIDS. However, commentators have warned that an over-reliance on STD programs would be a mistake: Klouda (1995) has cautioned against placing too much hope on STD control as a way of reducing HIV transmission, saying that:

AIDS is a symptom of underdevelopment. It shows up where health services are weak, where women's position is weak, where employment opportunities are limited. Unless you deal with those conditions, you won't make a substantial difference in terms of HIV reduction.

In addition, as Sabatier (1995) has pointed out,

to influence sexual behaviours in vulnerable communities successfully, HIV/STD diagnosis and treatment programs need to be coupled with intensive community-led prevention and support activities.

Status of Women

According to conservative estimates, by the end of 1995 nine million women were living with HIV, 95 percent in Africa, Latin America, the Caribbean and Asia. In the Third World, almost as many women as men are HIV-positive, and in some regions women even outnumber men. By the year 2000, at least 14 million women worldwide will be HIV-positive.

In order to understand why women, and especially young girls, are becoming infected with HIV at increasingly high rates, consideration must be given to the status of women in society: AIDS, more than any other disease, has exposed the damaging consequences, for all of society, of women's powerlessness.

Women's subordinate status relative to men constructs their vulnerability to HIV:

The economic dependence of women on men is common throughout the developing world. Laws that restrict property ownership and inheritance to men, and in certain cases limit women's ability to enter into independent contracts or obtain credit under their own names, impede women's ability to control income and property, and reinforce their dependence on male relatives. Women's economic dependence on men is fuelled by the discrimination they face in education and employment: (1) In the area of education, girls are encouraged to take different subjects from those taken by boys and often have less access to financial and other family resources. Furthermore, girls are often withdrawn from school to assume domestic responsibilities. (2) In the employment sector, occupational segregation of women into low-paying clerical and service jobs, unequal pay, fewer promotions, fewer workplace benefits, and concentration of women in the

informal sector are factors that breed economic insecurity.

Laws regarding marriage, divorce, and child custody can impede women's ability to leave relationships in which they or their children are physically or sexually abused.

Dependence on men makes it difficult for women to refuse sexual practices that put them at risk of STDs and HIV infection.

Often women are forced into sex-work as a means of sustaining themselves and/or their families. In a study conducted in Zimbabwe, high-school girls acknowledged the "sugar daddy" phenomenon in their communities, and reported that having sex with these men was largely motivated by economic factors (Gupta).

Being married can be a factor of risk for women: in Latin America and Africa, the women most at risk of HIV are married women whose husbands have many sexual partners. Many countries which promote monogamy and mutual fidelity, and discourage multiple casual partners as a societal norm, tacitly condone male deviation from this norm. Often, women are unable to negotiate safe sexual relations because it is culturally not accepted for them to be sexually assertive or even to discuss sex.

Women's biology renders them more vulnerable to HIV infection: studies have found that male-to-female transmission of HIV is 2-4 times more efficient than female-to-male transmission. Young girls are particularly vulnerable because their immature cervixes and low vaginal mucus production presents less of a barrier to HIV.

Further reasons why women are becoming HIV-infected in the Third World in such great numbers are: the prevalence of rape; the silent epidemic of STDs among women; "cultural" practices such as ritual cleansing, the use of drying agents, and circumcision or infibulation; and women's greater exposure to unsafe blood through maternity-related blood transfusions.

Discrimination and Stigmatization

Discrimination and human rights violations increase people's vulnerability to becoming infected with HIV:

The societal marginalization of those with whom the disease was originally associated in many countries (eg commercial sex workers, gay and bisexual men, intravenous drug users, and racial/ethnic minorities) helps to explain the lack of political leadership or governmental efforts that characterized the early response to the pandemic. As a result, the virus has spread rapidly within vulnerable groups and communities.

Stigmatization and discrimination impede health-seeking behaviour and thus early diagnosis and treatment of HIV and AIDS: the silent nature of the pandemic is in part

related to the fear about living publicly with the virus. This fear is very real because of the prospect of job discrimination, loss of benefits, and ostracism, leading to increased psychological suffering for individuals and families.

For those living with HIV/AIDS, access to adequate support, care, and treatment remains a central issue: many have experienced discrimination in receiving care, or find it difficult if not impossible to access any of the available treatments.

Generally, many nations maintain a political and social structure that has allowed the suppression of human rights through deeply rooted sexism, racism, homophobia and heterosexism.

Denial and lack of leadership

In many countries throughout the world, there is still a tendency to deny that AIDS is a problem or that it even exists. In some countries, the promotion of condoms and safe-sex messages are seen as going against culture, religion and tradition. As recently as 1995, Catholic and Muslim leaders led a mass demonstration in the streets of Nairobi, Kenya, to protest against sex education in Kenya's primary schools. Church leaders watched as demonstrators burned sex education textbooks and condoms (Knight).

The Impact of AIDS on Development

AIDS is causing underdevelopment. It has a devastating impact on households and communities, the economy, women, children, causes community grief and is linked to the resurgence of tuberculosis throughout the world.

The Economic Costs of AIDS to Households and Communities

AIDS lowers household income and alters patterns of consumption, production, savings, and investment. Multiple HIV infections in a household are common, magnifying the disease's economic effects and exhausting the abilities of immediate and extended families to provide care for the dependent elderly and orphaned children.

In some severely affected countries in Asia and Africa nearly 75 percent of family income may be lost because of AIDS. The diversion of both cash and labour affects the ability and willingness to keep children in school, and threatens food security by exhausting families' ability to deal with drought and other adverse conditions.

Economic Impact at Macro and Sectoral Level

The AIDS epidemic, through its effects on savings and productivity, poses a threat to economic growth in many countries that are already in distress. World Bank simulations indicate a slowing of growth of

income per capita by an average 0.6 percentage points per year in the ten worst-affected countries in Sub-Saharan Africa.

AIDS increases the cost of doing business in terms of health care, death benefits, pensions, recruitment, training, and other costs. It results in decreased productivity and disruptions in production as workers are absent due to illness, or away from work to care for sick relatives. Costs rise as experienced workers with valuable training become ill and unable to work:

An economic analysis of five Kenyan companies found that AIDS is costing an average of US\$45 per employee annually, or about 3 percent of company profits (Roberts).

At a large hospital in Kinshasa, more than one percent per year of health personnel, become infected through sexual contact.

Among the largely male employees at a Kinshasa textile mill, managers had a higher infection rate than foremen, who in turn had a higher infection rate than workers.

Throughout the developing world, AIDS will have negative effects on the service and industrial sectors, including commercial and subsistence agriculture; mining; manufacturing; construction; transport and communications; services (banking, finance and tourism); trade; and government services (including security, health and education).

In some regions, AIDS is also a threat to Africa's food supply: approximately 85 percent of the population works in the agricultural sector and the primary participants in agricultural labour - young women - are among those with the highest infection rates. Labour lost through death and absenteeism could lead to a fall in food production and, with poor nutrition, people will become even more vulnerable to all types of infection.

Women

In the developing world, every day 3000 women become infected with HIV, and 500 die of AIDS or related illnesses. Most HIV-positive women are between 15 and 35 years old, and generally women become infected at a significantly younger age than men. The reproductive, productive, and community-related roles of women are made significantly onerous by the spread of AIDS:

Women are often stigmatized and blamed for "causing" HIV/AIDS and other STDs, identified as "reservoirs of infection" or "vectors of transmission." This is harmful in many ways: (1) it fails to focus on men's equal responsibility to prevent HIV/AIDS; (2) prevents the development of services that meet the needs of women; and (3) is the reason why some research and intervention strategies have been designed more to protect men from women than to enable women to protect themselves.

The severe stigma associated with HIV in women known or thought to be HIV-positive has caused their dismissal from jobs, eviction from their homes, abandonment by their husbands or partners, and denial of custody of their children.

In the absence of legal rights to property, inheritance and income, women are often left in a state of complete impoverishment when their husbands die of AIDS, particularly if they themselves are HIV positive.

Most societies rely on women to be voluntary caregivers for their families, as well as occupational caregivers for the community. In communities where AIDS is widespread older women may be expected to assume a major care-giving responsibility for orphaned children, and adolescent daughters may be kept out of school to care for younger children or other family members who are ill. The expectation that women will provide most of the care for people with HIV/AIDS results in high stress, especially if care must be provided in addition to other work, such as paid work outside of the home and family-centred work, such as subsistence farming.

Children

UNAIDS estimates that by the year 2000, there will be five million AIDS-orphaned children. The suffering of such children is acute; it ranges from the emotional trauma of watching one or both parents slowly die, to the double stigma of AIDS and orphanhood, to profound insecurity and deprivation. As communities lose more and more of their adult population to AIDS, increasingly the children left behind cannot be absorbed into traditional coping mechanisms. The results are harrowing: elderly individuals caring for up to twenty-five children; young children heading households themselves; children grouped into makeshift "orphanages" with few or no facilities; and children living on the streets.

Recent analysis cautions that the focus upon orphans has distracted the development community from the threats posed for all children in AIDS-affected societies. AIDS affects entire communities and societies:

"non-orphan" households' resources will be stretched while absorbing orphans;

many of the key players in the communities development - teachers, village health workers, agricultural extension workers - will be lost to AIDS; and

national health-care systems may have difficulties in maintaining child survival programs (Goldenberg).

Community Grief

The implications of the collective grief of individuals and communities as a result of the loss of family

members and friends are rarely discussed in AIDS literature. Given the scale and magnitude of the pandemic, grief has an inevitable impact on development. According to Campbell:

Community pain is one highly significant result of accumulating loss. The symptoms of such pain provide indicators of extreme 'ill health.' There are signs of resignation and lethargy which often speak of disempowerment, lack of capacity for decisiveness, a leaning to a search for survival rather than living with a high relational quality of life. The loss within communities is not just numerical and accumulating but it is a loss of quality of relationship, of community memory. It is a loss of the past and the future in the present. This characterizes the distinctiveness of HIV/AIDS. If the description of the quality of loss is not allowed, and if it does not happen, then neither is the quality of response that is needed defined, and it will not happen.

HIV/TB Co-Epidemic

WHO estimates that at least 5.6 million people, the overwhelming majority of them in the developing world, are infected with both HIV and TB. Unlike HIV/AIDS, TB is highly infectious and can be spread by coughing. It is also almost always curable providing there is access to treatments. Examples of the impact include:

In Africa, TB has become the prime cause of death in adults with HIV. Since the late 1980s, the annual number of TB cases with HIV co-infection has nearly tripled in Zambia and more than doubled in Malawi. A recent study in the Ivory Coast showed that 35 percent of adults with HIV died of TB.

Nearly half of Asia's population is infected with TB, and preliminary WHO reports suggest that in parts of Asia, up to 70 percent of AIDS patients are becoming sick with TB.

Conclusion

More than fifteen years into the AIDS pandemic, we have learned a lot about what works and what does not in confronting HIV/AIDS and its consequences. Organizations as diverse as UNAIDS, the World Bank and ICAD are advocating an approach to AIDS that acknowledges both the health and development dimensions of the pandemic. AIDS must be considered in relation to the other key aspects of human development and factored into social and economic planning. Integral to a humane, ethical and effective response to the pandemic are development NGOs, community-based organizations, and people living with HIV/AIDS: we must affirm that AIDS is a development issue, that community is central to an effective response and that international AIDS policies and expenditures reflect these basic tenets.

This text was prepared by the Interagency Coalition on AIDS and Development, Ottawa.

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REFERENCES

AIDS & Society Newsletter (January/February 1995). 'The Economic Impact of AIDS.' (Compiled by the editors of the AIDS & Society Newsletter)

AIDS & Society Newsletter (July/August 1993). 'International Security Issue? HIV/AIDS in the Global Military'. (Compiled by the editors)

Campbell, Ian (July 1994). Trends and Involvement of Development NGOs in HIV/AIDS Work. The Salvation Army International Headquarters, London, England.

Center for Strategic & International Studies (1994). Global HIV/AIDS: A Strategy for U.S. Leadership.

Dubé, Ginette and Smailes, Angela, eds. (1991). AIDS and Human Rights: Sharing the Challenge. Vancouver World AIDS Group with IDERA & the OXFAM Global Health Project.

Goldenberg, DA. All Children in Developing Countries Will be Affected by AIDS, Not Just Orphans. AIDS Analysis Africa May 1996 at 8.

Gupta, G Rao. Male-Female Inequalities Result in Submission to High-Risk Sex in Many Societies. AIDS Analysis Africa August 1995 at 8.

Interagency Coalition on AIDS and Development (February 1995). Morality vs. Mortality. HIV/AIDS, a crisis in international development: Can we afford to ignore it?

Interagency Coalition on AIDS and Development (December 1994). 'Canadian Foreign Policy and AIDS.' Presentation to IDRC on World AIDS Day.

Interagency Coalition on AIDS and Development (October 1994). Women and HIV/AIDS: Local Action for a Global Response - Workshop Report.

Interagency Coalition on AIDS and Development, (May 1994). Presentation to CARE Canada on AIDS & Development.

Interagency Coalition on AIDS and Development (March 1994) Children Orphaned and Isolated by AIDS: A Challenge for NGOs Programming for a Positive World - Workshop Report.

Interagency Coalition on AIDS and Development (1994). 'The AIDS Epidemic in Africa.' Presentation for the Partnership Africa Canada Workshop.

Interagency Coalition on AIDS and Development (1994). Backgrounder - Women and HIV/AIDS: The Global Picture.

Interagency Coalition on AIDS and Development. (October 1993) Women and HIV: An International Perspective: Presentation to the 7th Annual B.C. AIDS Conference.

Klouda, Tony. AIDS Analysis December 1995 at 1.

Knight, V Kurtin. Catholics and Muslims Unite to Oppose Contraception in Kenya. AIDS Analysis Africa April 1996 at 5.

National Council for International Health (January/February 1994). AIDSLINK #25. 'Broadening the Focus: AIDS and Development' by Eliot Putnam, Jr.

Panos, (1993). The Hidden Cost of AIDS: The Challenge of HIV to Development.

Panos, WorldAIDS Newsletter. (January 1995) "United Nations troops in the dock", by Sue Montgomery.

Panos AIDS Media Briefing No. 1 (Updated December 1994) AIDS: Towards 2000. (An update of AIDS: The Second Decade)

Roberts, Matthew. AIDSCAP, Coping With the Impact on Business: Positive Lessons From the African Experience. AIDS Analysis Africa June 1995.

Sabatier, Renée (Fall 1994). Canadian Public Health Association - Southern African AIDS Training Programme Newsletter 'Care and Prevention: An Essential Link.'

Sabatier, Renée. Reorienting Health and Social Services. AIDS/STD Health Promotion Exchange 1995; 4.

WHO (April 1994). TB: A Global Emergency. WHO Report on the TB Epidemic.

WHO, Global Programme on AIDS (April 1994). The HIV/AIDS Pandemic: 1994 Overview.

WHO/UNDP. Women and AIDS: Agenda for Action.

WHO/UNICEF (December 1994). Action for Children Affected by AIDS.

World Bank (1994). World Bank HIV/AIDS Activities: 1994.

Whiteside, Alan (1993) AIDS: Socio-economic Causes and Consequences. Occasional Paper No. 29. Economic Research Unit, University of Natal, Durban.

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