Questions & Answers

Many Canadian provinces have passed legislation that authorizes testing someone for HIV without his or her consent. This document provides information about occupational exposure to HIV, and the legal and human rights concerns raised by forced HIV testing.

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

Forced HIV Testing

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Introduction

In the early years of the AIDS epidemic, fear, misinformation and prejudice resulted in calls for forced HIV testing. However, it has been established widely that HIV testing should only be done in accordance with three principles (sometimes called "the three Cs"), namely:

- *counselling* about HIV before and after the test;
- *consent* to be tested for HIV (consent in an informed and truly voluntary way); and
- *confidentiality* of having been tested and of test results.[1]

These principles are consistent with basic human rights, as protected in both international and Canadian law, including the *Canadian Charter of Rights and Freedoms*.[2]

However, in recent years in Canada, these principles have been called into question, with renewed calls for laws that authorize forced HIV testing and disclosure of test results; fear, misinformation and prejudice often still play a part.

In particular, some associations of police, firefighters and paramedics have raised concerns about situations where a person fears that he or she may have been infected with a communicable disease as a result of having been exposed to body fluids from another person (the "source person"). The associations have been lobbying for legislation that would permit the exposed person to get a legal order forcing a source person to be tested for HIV and for other communicable diseases, such as hepatitis B and C viruses (HBV and HCV).

Why is there a demand for forced testing?

The rationale behind forced-testing laws is that an exposed person should know whether a source person is infected with a communicable disease. Knowing this information could help the exposed person decide whether to start or continue treatment with antiviral drugs to reduce the chance of infection (known as "post-exposure prophylaxis," or "PEP"), deal with post-exposure anxiety and stress, and avoid the inconvenience of taking possibly unnecessary precautions to prevent further transmission to others, such as sexual partners.

But such demands are often driven by inadequate or incorrect information, and an exaggerated sense of both the risks associated with exposure to body fluids and of the potential benefits of forced testing to the exposed person. Testing of the source person, whether forced or voluntary, cannot always provide the information the exposed person might want.

And, as discussed below, forced testing violates important human rights. There are better ways to protect and support people at risk of occupational exposures, while also respecting the human rights of source persons.

Occupational exposure to body fluids: What are the health risks?

When is there a risk of HIV infection from an occupational exposure?

There is no risk of infection if body fluid containing HIV comes into contact with clothing. This is why health-care providers, emergency workers, and police use routine precautions (such as latex gloves, protective eyewear, or protective clothing) in circumstances that could involve exposure to body fluids.

There is only a risk of HIV infection if a body fluid capable of transmitting HIV comes into contact with[3]

- tissue under the skin, such as through a needle stick or a cut;
- mucous membranes, such as through a splash to the eyes, nose, or mouth;
- broken skin, such as when the skin is chapped, scraped, or afflicted with dermatitis.

Even in these cases, the risk of HIV infection is still very low.

Can all body fluids transmit HIV?

No. *Only some body fluids and tissues are capable of transmitting HIV.* They include:[4]

- blood, serum, plasma, and all biologic fluids visibly contaminated with blood;
- laboratory specimens, samples, or cultures containing concentrated HIV;
- organ and tissue transplants;
- uterine/vaginal secretions and semen;
- pleural, amniotic, pericardial, peritoneal, synovial, and cerebrospinal fluids; and
- saliva, though only if it is visibly contaminated with blood.

Unless they are visibly contaminated by blood, saliva, feces, nasal secretions, sputum, tears, urine, and vomit do not transmit HIV. And, even if there is some blood present in a body fluid, this does not necessarily mean there has been a "significant exposure."

What is the risk of HIV infection from an occupational exposure?

The risk of infection is very low.[5]

- *99.7% of under-the-skin exposures do not lead to infection*
  Direct, under-the-skin exposure to blood containing HIV is called "percutaneous exposure"; it happens through incidents such as a needle stick or a cut. Such exposure carries the highest risk of HIV infection — but even then, the British Columbia Centre for Excellence in HIV/AIDS and the United States Centers for Disease Control and Prevention have estimated that the risk of infection from a single exposure of this sort is only approximately 0.3% (1 in 300).
- *99.9% of mucous-membrane exposures do not lead to infection*
  Exposure of mucous membranes — a splash to eyes, nose or mouth, for example — to blood containing HIV is called "mucotaneous exposure." Such exposure carries a lower risk of infection, estimated at just under 0.1% (1 in 1000).
- The risk of infection from an exposure of intact skin to blood containing HIV is estimated to be even lower than 0.1% (less than 1 in 1000).

Can the risk vary with the circumstances of the exposure?

Yes. The figures above apply to exposures to blood that is known to contain HIV. *If the HIV status of the source person is unknown, statistically the chance of infection from any exposure to blood is even lower than the figures above.* (And the risk of infection from an exposure to body fluids other than HIV-infected blood is lower still.)

In addition, *if the HIV-positive source person is taking antiretroviral drugs (ARVs), the chance of infection is lowered further*, because the drugs reduce the amount of virus (i.e. viral load) in their blood. In some cases, ARVs may reduce the viral load to clinically undetectable levels. This does not mean the virus has been eliminated or that the person has been cured — there is no cure for HIV infection. But it does mean that the risk of infection from a source person taking ARVs is considerably reduced because there is less virus in his or her blood.

How many cases have there been of HIV infection following occupational exposure?

There have been only two probable cases, and one definite case, of occupational transmission of HIV in Canada since the beginning of the AIDS epidemic more than 25 years ago. These cases involved significant exposures to fluids containing high concentrations of HIV.[6]

Support for forced-testing laws has come primarily from some associations of emergency workers such as police officers, firefighters and paramedics. But there have been no documented cases in Canada of occupational transmission of HIV among these emergency workers, or among people who have volunteered their help in an emergency. Evidence from a study of police in the U.S. puts the risk into perspective. Though one in three exposures reported by police was "significant," these exposures were rarely percutaneous or mucotaneous exposures to blood (most exposures were to broken skin) and *none of the exposures resulted in HIV infection*.[7]

Health-care workers are the workers at greatest risk of occupational exposures to HIV and other blood-borne communicable diseases. The Canadian Needle Stick Surveillance Network documented over 2600 reported exposures of health-care workers (primarily nurses, medical doctors and laboratory technicians) to blood-borne diseases (HIV, HBV, and HCV) between April 2000 and March 2002. *Not a single case of HIV infection as a result of exposure was documented.*[8] The Canadian Medical Association, the Canadian Nurses Association, the Canadian Association of Nurses in AIDS Care, the Canadian Public Health Association, and the Canadian Union of Public Employees (whose members include people in health-care or health-related occupations) do not support forced HIV testing.[9]

What about occupational exposure to hepatitis B and C?

Hepatitis B and C viruses (HBV and HCV) are often also mentioned as concerns and are usually included in forced-testing laws. But as with HIV, forced testing for these viruses is unjustified.

For HBV, a preventive vaccine is available and has been demonstrated to be highly effective in preventing HBV infection; those vaccinated are at virtually no risk of infection.[10] All health-care and emergency workers should receive this vaccine. If the exposed person has not been vaccinated before the exposure, vaccination after the exposure is recommended. In addition to helping prevent HBV infection, vaccination benefits the

exposed person in the event of future exposures. Preventive vaccination against HBV is a much better approach for all concerned than forcibly testing a source person after an exposure.

For HCV, there is no preventive vaccine. However, even though the risk of HCV transmission is higher than for HIV, medical experts have determined that HCV "is not transmitted efficiently through occupational exposures to blood."[11] The risk of infection from a single under-the-skin exposure to HCV-infected blood — the highest degree of occupational exposure — is estimated at just 1.8 percent. The risk of infection following exposure of mucous membranes to blood containing HCV is not known exactly but is believed to be very small, and the risk associated with other body fluids is expected to be low.[12] There is no post-exposure prophylaxis for exposure to HCV, so forcibly testing the source person will not be of use in making decisions about PEP. If infected, treatment with antiviral drugs is recommended.

HIV tests: How can they help the exposed person?

Why might the exposed person want information from the source person?

Information about the infectious status, risk factors, and medical history of the source person can help relieve uncertainty as to whether there was in fact an exposure to an infectious agent, and can contribute in a limited way to decisions about treatment and precautions for the exposed person.[13]

How many source persons agree to be tested after a worker has been exposed to their body fluids?

Most source persons agree to be tested and permit relevant information to be provided to the exposed worker, when they are approached in a sensitive manner and the reason for the testing request is explained.[14] A survey of selected hospitals across the country found that the number of times that patients refused to be tested was very small, ranging from 0.2 to 0.5 percent.[15] One of the few studies of occupational exposure among police found that 94 percent of source persons agreed to be tested for HIV.[16]

If the source person tests HIV-negative, does this mean there has been no risk of infection?

Not necessarily.

If the test results of the source person are negative *and* the source person does not have a history that includes risks for HIV infection, the exposed worker may be reasonably certain that there was no risk of infection.

If the test results of the source person are negative *but* the source person has a history that includes risks for HIV infection, the exposed worker cannot be certain that the source person is HIV-negative. The source person may have been in the "window period." (HIV infection begins with a window period in which the virus is present in the body, but cannot be detected with confidence by current technology.)

What if the source person tests HIV-positive?

As noted, the vast majority of occupational exposures to HIV-infected blood do not result in HIV infection. The only way an exposed person can know if he or she has been infected is to be tested.

If there has been a significant exposure, the exposed person should be tested for HIV immediately, then six weeks after the exposure, three months after the exposure, and six months after the exposure. In virtually all cases, when a person has been infected with HIV, there is a definite diagnosis by six months. Usually, there is a definite diagnosis much sooner, within several weeks.

Why is there a delay in getting a definite diagnosis?

Because of the window period, it can take several weeks for antibodies to the virus to appear in blood at levels that can be detected with confidence by current tests that are usually used. There are tests that can detect HIV earlier than the standard screening tests, but these cannot provide a definite diagnosis. Also, these tests are more expensive and are not always available everywhere in Canada.

What about treatment to prevent infection after an occupational exposure?

Evidence suggests that beginning post-exposure prophylaxis with antiretroviral drugs (ARVs) very soon after exposure could reduce the risk of HIV infection by as much as 80 percent. It is currently recommended that the exposed person take the drugs for four weeks. The drugs can have side effects, such as nausea, malaise, fatigue, headache, vomiting and diarrhoea. These symptoms can often be managed with medications or by modifying the type or dose of ARVs used.[17]

Should an exposed worker wait to get the test results from the source person before beginning post-exposure treatment?

No. If the circumstances are sufficient to warrant post-exposure treatment, the exposed person should begin treatment with as soon as possible, preferably within one or two hours, and within 72 hours at the latest.[18]

If it later turns out that the source person tests HIV-negative and has no risk factors, the exposed person could decide to stop taking the drugs.

Forced HIV-testing laws and human rights

Which laws in Canada deal with forced HIV testing?

In 2001, proposed amendments to the federal *Criminal Code* to permit forced HIV testing were rejected by Parliament. However, as of this writing, five provinces — Ontario, Alberta, Nova Scotia, Saskatchewan, and Manitoba — had passed forced-testing laws.

How do these laws work?

The laws in each province are similar. They define the situations in which it may be possible for someone who has been exposed to another person's bodily substances to apply for an order forcing that person to be tested for one or more communicable diseases. Usually, this includes situations where someone is exposed to bodily substances in the course of doing certain kinds of work (e.g., duties as a firefighter, paramedic or police officer) or in coming to someone's aid in an emergency (e.g., as a good Samaritan). Some provinces' laws also allow applications for forced-testing orders in cases where someone has been a victim of crime (e.g., sexual assault) and has been exposed to bodily substances.

In addition, the laws also set out:

- which diseases are covered by the law;
- the procedure for applying for a testing order;
- the factors that must be considered in deciding whether to issue a testing order;
- the procedures for carrying out the testing order, including the use of force by police officers, if necessary, to detain and restrain the source person in order to take a sample of a bodily substance such as blood;
- whether or not it is possible to appeal a decision about granting a testing order;
- some restrictions on the use of bodily samples and the disclosure of test results; and
- penalties for disobeying a testing order or other parts of the law.

For a more detailed description of each province's legislation, read *Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV* (2007), available on-line at www.aidslaw.ca/testing.

Doesn't forced HIV testing violate human rights?

Yes. *Forced testing violates a person's right to security of the person* (i.e., to bodily and psychological integrity) by extracting blood or another bodily substance without consent. *Forced testing also violates a person's right to privacy*, by testing that blood or bodily substance and revealing the results to others without consent.

The right to security of the person is protected by international human rights law, criminal and civil law, and rules of professional ethics governing health-care providers. Forced-testing laws authorize the violation of this right. Forced testing constitutes assault under the *Criminal Code*, battery in civil law, and a breach of professional ethics. Forced-testing laws also violate constitutional rights. The Supreme Court of Canada has consistently interpreted the *Canadian Charter of Rights and Freedoms* to protect a person's body from violation by the state. (Section 7 guarantees the right to "security of the person".) According to the Court, "a violation of the sanctity of a person's body is much more serious than that of his office or even of his home."[19] In addition, when the government's laws or actions impose serious psychological distress, this too can amount to a violation of security of the person.

The right to privacy is protected by international human rights law, the *Canadian Charter of Rights and Freedoms* (sections 7 and 8), federal and provincial privacy statutes, civil law, and rules of professional ethics governing health-care providers. According to the Supreme Court of Canada, privacy lies at the heart of liberty in the modern state.[20] The constitutional protection of privacy under the Charter includes the right of a person to determine for himself or herself when, how, and to what extent to release personal information.[21] The Privacy Commissioner of Canada has stated that "compulsory blood testing, and compulsory disclosure of the results of blood testing, is a massive violation of privacy and the personal autonomy that flows from privacy."[22]

Does the law permit limits on these human rights?

Yes. Sometimes the government can pass laws or take other actions — such as using police to forcibly detain and restrain a person for a medical procedure such as taking a blood sample — that breach an individual's rights. However, the Supreme Court of Canada has ruled that any such measure that breaches a right protected by the Charter may only be constitutional if the government can show four things:[23]

- First, the government must have some legitimate, important objective in adopting laws or taking actions that limit a person's rights. The objective must address a concern so serious that it could warrant overriding rights such as privacy and bodily integrity, which are so highly valued in a free and democratic society that they are in our constitution.
- Second, limiting a person's rights must somehow help achieve that important objective. In other words, there must be a "rational connection" between the government's objective and the actions that limit the person's constitutional rights.
- Third, only a "minimal impairment" of the person's constitutional rights is allowed. In other words, the breach of the person's rights is not justified

if there is some other way, which violates the person's rights less, of achieving the important objective.

- Finally, there needs to be some "proportionality" — the greater the harm to the individual's constitutional rights, the more important the objective must be if the government is to justify violating his or her rights.

Does forced HIV testing meet these requirements?

No. According to the Privacy Commissioner of Canada, forced HIV testing after an occupational exposure does not meet these tests.[24]

Forced HIV testing is not necessary. As noted above, the risk of HIV transmission from an occupational exposure is very low. Furthermore, in most cases when the source person is known and available to be tested, he or she agrees to be tested.

Forced HIV testing is also of limited effectiveness. As already noted, if there is a risk of HIV infection based on the nature of the exposure, the exposed person should take preventive treatment within one or two hours. It could take days or weeks for the process of forced testing to be completed.

There are alternatives to forced testing. According to the Canadian Medical Association and the Canadian Nurses Association — professions which have the greatest rates of occupational exposure to body fluids — procedures to prevent exposures, voluntary HIV testing with appropriate counselling and consent, and procedures to respond quickly and effectively to exposures are the best way to deal with accidental exposures to body fluids.[25] In response to calls from unions representing health-care and other workers, some provinces have also taken the better, sensible step of mandating the use of safer equipment to reduce the number of workplace exposures, such as laws requiring the use of safety-engineered needles to reduce the number of needle-stick injuries.

Forced HIV testing is not proportional — the harms outweigh the limited benefits. Forcibly performing medical procedures on people without consent should not be done lightly. And forced HIV testing after an accident is a very significant invasion of privacy of the source person, whereas the risk of transmission of HIV from an occupational exposure to body fluids is very low.

What harm could come from HIV testing?

First, the very act of performing a medical procedure on someone without consent, and without the purpose of benefiting that person as a patient, sets a dangerous precedent.

Second, the process by which people would be forced to be tested does not necessarily protect confidentiality. It could involve court or tribunal hearings that are open to the public, and unless the court orders a ban on publishing identifying information, the source person's identity could be made public. Information and testimony about the source person, and about any possible risk factors (such as drug use or sexual practices) that might convince the court or tribunal to issue an HIV testing order, could become public. Even if a testing order is not issued, or if the results of the forced test are negative, people may assume that the person has an infectious disease, and he or she could still face discrimination based on perceived infection, or based on his or her drug use or sexuality.

Third, when the source person is forced to be tested and the results of the test are provided to the exposed person, the source person loses control over personal medical information. There is no effective way to prevent the exposed person from telling other people about the results of the blood test. It would be reasonable to assume that the exposed person would want to tell others, such as family and perhaps co-workers, about the results. Once the information is released, it is very difficult to control who may learn about the results.

Why is the right to privacy so important for people with HIV?

People with HIV often experience discrimination when their HIV status becomes public knowledge. A major HIV legal clinic in Canada gets several calls a month from people who have lost their jobs, been run out of their apartments, or are forced to move to a different city or town because their HIV status has become known. People with HIV in other parts of Canada report similar experiences.

A recent national survey by the Public Health Agency of Canada (PHAC) of Canadians' knowledge about HIV/AIDS and attitudes toward people living with HIV/AIDS shows that a worrisome level of ignorance, discomfort, stigma and prejudice remains.[26] Many Canadians think a person living with HIV should not be allowed to do certain kinds of jobs, even when there is no risk of transmission, or would be uncomfortable having an HIV-positive co-worker or shopping at a store owned by a person living with HIV. And according to the discrimination index used by PHAC for this survey, "20 per cent of Canadians do not believe in supporting the rights of people living with HIV/AIDS."[27]

What should be done to protect workers dealing with occupational exposures?

What can be done to protect workers from exposure to body fluids?

Employers must ensure that workers have the necessary equipment and training to protect themselves from exposure to body fluids in the first place. This includes:[28]

- engineering controls (e.g., needles with safety features, containers for

the disposal of sharp implements, Kevlar-lined gloves for police searches, etc.); and

- work-practice controls (e.g., immunization, routine precautions, techniques for disposing of needles, hands-free techniques in the operating room, techniques for police searches, etc.).

Some provinces, such as Manitoba, Saskatchewan and Nova Scotia, have legislated the use of safety-engineered needles in some workplaces to reduce the risk of occupational exposure to HIV and other blood-borne diseases. At least two dozen states in the U.S. have passed similar laws.[29]

Workers should receive regular and ongoing training and support in implementing these engineering and work-practice controls. It is also important that employers address other workplace factors that increase the risk of exposures, such as fatigue as a result of long shifts.

Is there room for improvement in the use of routine precautions?

Yes. The Canadian Needle Stick Surveillance Network found that, out of the 1436 exposures that were reported from 12 hospitals across Canada between April 2000 and March 2001, 45 percent of injuries to tissue under the skin may have been prevented by proper handling and disposal of used needles, and two thirds of splashes to the mucous membranes may have been prevented by the use of protective eyewear or face shields.[30]

Will routine precautions prevent every possible exposure to body fluids?

No. Unfortunately, even with the best available equipment and training, which can drastically reduce the frequency of occupational exposures, there will be times when exposures still occur. In addition, in some circumstances, such as when health-care providers are dealing with a violent patient or when police are arresting a suspect, it may be possible to use only some of the full range of routine precautions.

What can be done for workers after an exposure to body fluids?

Employers and health authorities must ensure that systems are in place and that personnel are trained to respond quickly to an exposure. This includes:

- an up-to-date protocol for responding to an exposure;
- well-informed and trained personnel designated to assess the exposure and liaise with medical specialists, public health officials, and other relevant service providers;
- quick access for the exposed worker to an infectious-disease specialist;
- expedited analysis for blood tests obtained voluntarily from the source person and the exposed worker;
- emotional support and counselling for the exposed worker and, if desired, their family or intimates;
- workplace education about infectious diseases (e.g., means of transmission, risks of transmission, etc.); and
- workplace programs to address stigma associated with occupational exposure and infectious diseases.

Is there room for improvement in post-exposure responses?

Yes. A study of British Columbia's post-exposure HIV treatment program found that 54 percent of people who received drugs to prevent transmission of HIV should not have received them if current guidelines had been followed.[31] This suggests that people are not receiving appropriate and expert information and counselling after exposures. As a result, they may suffer needless anxiety about the exposure, as well as needless side effects from the drugs.

Why are workplace education, and emotional support and counselling for the exposed worker, important?

The Canadian Police Association has stated that most employees are reluctant to talk about the effects of an exposure — anxiety about possible infection, side effects of post-exposure drugs, strain on intimate relations — on themselves and their immediate family.[32] The same may be true in other settings. Employers must create a workplace environment that is supportive of workers as they deal with the stresses associated with an exposure.

This difficulty can be compounded by misinformation and stigma. Surveys show that many people have inaccurate beliefs about HIV transmission and negative feelings towards people living with HIV.[33] In this environment, an exposed worker has to deal not only with anxiety about the risks associated with the exposure (which are very low), but also mistaken beliefs and negative feelings among co-workers, family, and friends (which, based on the results of surveys and the experience of people living with HIV, are relatively widespread).

Why are these types of efforts more important than forced HIV testing?

Forced HIV testing does not address factors in the work environment that increase the risk of exposure, increase the stress associated with an exposure, and result in inadequate or inappropriate responses to an exposure. Forced HIV testing does not address the need, demonstrated by numerous studies,[34] for improved education and practice for workers in using routine precautions and responding to exposures.

Forced HIV testing may also create a false sense of assurance that could increase the risk of transmission. For example, one of the circumstances in which police have been exposed is when they are jabbed by a syringe while

searching a suspect. The presence of a syringe suggests that the source person could have a history of risk factors (such as sharing needles to inject drugs) associated with infection with HCV and HIV. Even if the source person tests negative for these viruses, the presence of risk factors means that the test could have been taken during the "window period". The exposed worker should not assume that a negative test result in this instance is in fact a true result.

Additional information

For a more detailed description of the forced-testing laws in place in each province, see the publication *Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV* (Canadian HIV/AIDS Legal Network, 2007), available on-line at www.aidslaw.ca/testing.

For an overview of occupational exposure and blood testing, see: T. de Bruyn. *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Backgrounder*, published by the Canadian HIV/AIDS Legal Network in 2001. This *Backgrounder*, and a series of accompanying info sheets on compulsory HIV testing following occupational exposure, can be retrieved at the website of the Canadian HIV/AIDS Legal Network at www.aidslaw.ca/testing (under "Publications"). The info sheet on "Readings and Resources" provides references to further information on managing occupational exposure, HIV testing, the positions of professional associations on forced blood testing, and selected scientific literature.

For a complete review of the management of occupational exposures and the relevant scientific and medical literature, see: U.S. Centers for Disease Control and Prevention, "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis", *Morbidity and Mortality Weekly Report* 2005; 54(RR-9), on-line: www.cdc.gov/mmwr/PDF/rr/rr5409.pdf.

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[4] Health Canada, "Integrated Protocol," *supra* note 3 at p. 2.

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[9] E.g., see: Canadian Medical Association. *CMA Policy: HIV Infection in the Workplace (Update 2000)*, PD-0103, 9 December 2000, on-line: www.cma.ca > Policy/Advocacy > CMA PolicyBase; Canadian Nurses Association. *Position Statement on Blood-Borne Pathogens*, November 2000. A more recent CNA position statement, *Blood-borne Pathogens: Registered Nurses and their Ethical Obligations* (May 2006), makes no explicit reference to the issue of compulsory testing, but suggests implicitly that such measures are not necessary by declaring that adherence to infection control precautions "as ethically acceptable because it precludes the need to know the blood-borne pathogen status of clients or nurses and safeguards the rights of all individuals to privacy and confidentiality of information." For additional discussion, see the various associations' policies described in: T. de Bruyn. *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Backgrounder* (Canadian HIV/AIDS Legal Network, 2001), pp. 25–29, on-line via: www.aidslaw.ca/testing.

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[27] Ibid.

[28] Health Canada. "Preventing the transmission of bloodborne pathogens," *supra* note 6.

[29] For additional information and updates on the status of such legislation across the country, see the website of the "Safer Needles Now" campaign, led by the Services Employees International Union (SEIU) Canada in collaboration with various other labour unions in various provinces at www.saferneedlesnow.ca.

[30] M. Nguyen et al. "Update — Surveillance of healthcare workers exposed to blood/body fluids and bloodborne pathogens: 1 April 2000 to 31 March 2001," *Canada Communicable Disease Report* 2001; 27(24): 201–212 at 208–209, on-line: www.phac-aspc.gc.ca/publicat/ccdr-rmtc/01pdf/cdr2724.pdf.

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