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Canadian HIV/AIDS Policy & Law Newsletter

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NOTES

Update on Joint Network/CAS Project

The *Newsletter* first reported about the joint Canadian HIV/AIDS Legal Network and Canadian AIDS Society project on legal and ethical issues raised by HIV/AIDS in its January 1995 issue. Since then, funding for the project has been obtained from the AIDS Care and Treatment Unit, Health Canada.

This will enable the project to continue until June 1995. By that time, it will have assessed and prioritized key legal and ethical issues, researched and documented existing resources, sought partnership from other NGOs, institutions and professional associations, and produced a literature review and an annotated bibliography. This will serve as the groundwork for the production of a comprehensive set of resource documents addressing critical legal and ethical issues raised by HIV/AIDS in Canada.

If you are interested in this project or would like to receive further information, please contact the Project Coordinator, Ralf Jürgens. Phone: (450) 451-5457 Fax: (450) 451-5134.

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No Compulsory HIV-Antibody Testing of Persons Accused or Convicted of Sexual Assault

Federal Minister of Justice Allan Rock recently declared that persons accused or convicted of sexual assault would not be forced to undergo compulsory HIV-antibody testing.

Background

The issue of whether individuals accused or convicted of sexual assault should have to undergo compulsory HIV-antibody testing is highly controversial and has been the subject of a significant amount of media attention, community discussion and political debate in Canada and elsewhere. Few subjects are as emotionally troubling as AIDS and rape. Given the fear surrounding HIV/AIDS, calls to test certain groups of people perceived to be at increased risk of contracting (and transmitting) HIV infection have been frequent. Among these groups are immigrants, prisoners, prostitutes, and sex offenders. Responding to pleas from survivors of sexual assault, some states in the United States have enacted laws permitting survivors to request that accused or convicted sex offenders be tested for HIV. Other states have statutes that permit a sex offender's HIV test results to be disclosed to survivors. Where they have been adopted, compulsory testing programs have proven problematic "because they often fail to provide for the defendant's interests, which can include such concerns as confidentiality, privacy, and presumption of innocence." However, some maintain that the "HIV test is proper on accused or convicted rapists" and that "[m]aybe the law [in Canada] needs to be changed" to allow for testing.

In Canada in 1987, the National Advisory Committee on AIDS (NAC-AIDS) discussed a proposal "that persons convicted of sexual assault likely to transmit HIV infection, be tested on a compulsory basis for the presence of HIV antibodies." The proposal was rejected. Instead, NAC-AIDS formulated and passed two resolutions recommending **voluntary** testing of persons accused or convicted of sexual assault:

"The National Advisory Committee on AIDS strongly recommends voluntary testing of persons **accused** of sexual assault likely to transmit HIV infection and that such results must be treated as confidential, except for their limited disclosure to the victim of the crime."

"The National Advisory Committee on AIDS strongly recommends voluntary testing of persons **convicted** of sexual assault likely to transmit HIV infection and that such results must be treated as confidential, except for their limited disclosure to the victim of the crime [emphasis added]."

In 1993, the issue received renewed interest because of two cases that were widely reported in the media. In the first case, Margot Blackburn was sexually assaulted by a man who was out of prison on a day pass. As part of the preliminary inquiry, the Crown prosecutor asked the judge to order an HIV-antibody test because the woman feared she might have been infected with HIV. In deciding on this, Roberge J held that: (1) the prosecutor did not have the power to request testing of the accused; and (2) even if the law allowed for the prosecutor to make such a request on behalf of the victim, he would have had to reject it because the law does not authorize compulsory testing of sex offenders. Ms Blackburn later started a national campaign and presented Justice Minister Rock with a 50,000-signature petition calling on him to amend the law to allow judges to force persons accused or convicted of sexual assault to submit to a test for HIV antibodies.

The accused was later convicted of sexual assault causing bodily harm and sentenced to 12 years' imprisonment. The trial judge refused a second request that the accused be tested for HIV antibodies, but it appears that the accused agreed to be tested nevertheless. Ms Blackburn has undergone several HIV-antibody tests herself, testing HIV-negative.

In a second case, a man died from AIDS-related diseases 11 weeks after he was convicted of sexually assaulting a five-year-old boy. Montréal coroner Claude Paquin, who performed the autopsy on the deceased, issued a report recommending compulsory HIV-antibody tests of convicted sex offenders, for two reasons: [translation] "in order to take appropriate measures so that the disease does not spread in detention centres. Moreover, this approach would allow victims of sexual assault to know if they could have contracted the disease."

The Interdepartmental Committee's Report

A Working Group of the Interdepartmental Committee on Human Rights and AIDS was formed to study the issue of HIV-antibody testing of persons accused or convicted of sexual assault, and to "determine what measures were appropriate to deal with HIV in the context of sexual assault." In its report of 19 April 1994, the Working Group examines the status of HIV/AIDS testing and treatment and the concerns of the survivor of sexual assault; considers the arguments against compulsory HIV-antibody testing of persons accused of sexual assault; examines whether the use of the criminal law power to mandate HIV-antibody testing is warranted; and discusses possible strategies for ensuring that survivors of sexual assault are provided with assistance in addressing their concerns about HIV.

The report concludes that "imposing compulsory HIV antibody testing on persons accused of sexual assault is not the most effective way of dealing with the sexual assault survivor's concerns," will ultimately not help her, and is "misguided" for five reasons:(1) it does not provide timely or reliable information about the risks of contracting HIV infection; (2) it is a misdirected and unrealistic approach

to addressing a sexual assault survivor's needs; (3) it perpetuates the dangerous misperception that information about an assailant's HIV status is critical to the sexual assault survivor's health; (4) it does not facilitate a sexual assault survivor's psychological recovery; (5) it sets a dangerous precedent for extending mandatory testing to others, particularly pregnant women and sex workers.

According to the Report, a survivor of sexual assault, rather than knowledge of her assailant's HIV status, "needs reliable information about whether **she** is HIV infected, and support and assistance in coping with uncertainty during the window period, and in living with a positive test result if it occurs. [emphasis added] Therefore, the Working Group concluded that the focus should not be on HIV-antibody testing of persons accused or convicted of sexual assault, but on finding other, more practical and sensitive ways of addressing the needs of survivors of sexual assault: "In trying to use the criminal law to control the spread of HIV/AIDS we have to be careful not to send the wrong message to society, and divide the community between those with HIV/AIDS and those without. The focus instead should be on providing the appropriate counselling and assistance to those who may have been exposed to the disease, and ensuring that persons who commit violent sexual crimes are brought to justice for the offences defined in the *Criminal Code*."

The Working Group recommended that Health Canada, the Department of Justice and Status of Women, consider "the feasibility of developing, in consultation with involved non governmental organizations, a best practices model of the kinds of counselling, short and long term care, treatment and other services that should be made available to sexual assault survivors." According to the Working Group, the following options should be explored: (1) access to anonymous HIV-antibody testing and counselling for all sexual assault survivors, provided by trained staff of sexual assault crisis centres or similar facilities; (2) examination of the feasibility of making polymerase chain reaction (PCR) testing available to survivors of sexual assault to permit them to find out within a few days after the assault whether they themselves are HIV-infected, and development of an implementation plan for this proposal (the PCR test detects the presence of HIV itself within a few days of infection, as opposed to HIV antibodies, which take weeks or months to develop; it is, however, expensive and difficult to administer); (3) access to prophylactic AZT and other antiviral medications for sexual assault survivors, accompanied by counselling about their uncertain utility; (4) ensuring sensitivity to multiculturalism and societal diversity in the delivery of counselling, testing and support services; (5) assistance in the HIV/AIDS-related training of staff at sexual assault crisis centres and other professionals who have contact with survivors of sexual assault.

Conclusion

Justice Minister Allan Rock accepted the conclusions reached in the Working Group's Report, saying that he was persuaded that nothing could be gained from introducing compulsory testing of perpetrators of sexual assault. By doing so, he resisted the temptation of enacting legislation that would probably have received widespread public approval, and suggested that the government was taking a strong stand in protecting survivors of sexual assault, while in reality doing little if anything to help them, and diverting attention from the real, underlying problems. He did not follow the example provided by those legislatures which, anxious to take steps in response to public outcry, have "scrambled to piece together

legislation to pacify the masses," providing for the compulsory testing of persons accused of sexual assault.

Although, unquestionably, governments need to be concerned with the safety and needs of the survivor of a sexual assault and of the public in general with respect to HIV transmission, the question is whether measures such as laws allowing for compulsory testing of persons accused or convicted of sexual assault "actually combat the AIDS crisis in general and protect the rape victim's interests in particular, or whether the measures serve only to heighten existing fears and violate the rights of certain members of society."

As demonstrated in the Working Group's report, compulsory testing and disclosure of the test result to the survivor of a sexual assault provide little if any benefit to her. While many have wrongly characterized the choice whether or not to require HIV-antibody testing of persons accused or convicted of sexual assault as being either pro-woman or pro-criminal, and have failed to address underlying issues, the Working Group examined the issue in its full complexity and developed a set of recommendations that, if implemented, would much better address the needs of survivors of sexual assault.

- *Ralf Jürgens*

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HIV/AIDS and the Military in Canada

It appears that the situation of people with HIV/AIDS in the Canadian military has not improved, despite a recent ruling by the Federal Court in the case of *Simon Thwaites* v *Canadian Armed Forces*.

In October 1989, Mr Thwaites filed a complaint with the Canadian Human Rights Commission against the Canadian Armed Forces (CAF). This complaint alleged that he had been discriminated against on the basis of disability.

Mr Thwaites had served with the CAF for approximately nine and a half years from June 1980 to 23 October 1989, when he was medically discharged from the CAF for being HIV-positive. At the time of his discharge, Mr Thwaites operated large weapons and electronic surveillance equipment on a variety of warships.

In 1986, Mr Thwaites discovered that he was HIV-positive. From May 1986 until November 1987 the progression of his disease was uneventful, yet in the fall of 1986 he was removed from his final qualifying course to become a full Master Corporal and at the same time his security clearance was downgraded. It was only as a result of a tribunal hearing in 1992 that he discovered that this removal was a result of his sexual orientation and not his HIV-positive status.

In late October and during November of 1987, he began developing symptoms of HIV, including night sweats and a reduced T-cell count. In March 1988, military doctors conducted a "paper" medical assessment, at which time his medical category was downgraded. As a result, in November 1988 the CAF decided to release Mr Thwaites, effective 23 October 1989.

In June 1993, after a lengthy inquiry, a human rights tribunal upheld Mr Thwaites's complaint. It found that the CAF had an obligation to properly assess the risks involved in retaining Mr Thwaites, including the risks of his going to sea, far from hospital facilities. The military was also required to consider various options other than outright release. These included, for example, using medical assistants on ships in conjunction with military doctors to assist Mr Thwaites, as well as transferring him to another

military occupation.

The Tribunal held that the military had discriminated against Mr Thwaites as a result of his disability. It held that the military failed in its legal duty to accommodate Mr Thwaites's disability and to individually assess his capabilities in the context of the risk that he potentially posed to himself and others. It also held that the increased risk posed by retaining a disabled person in the Forces had to be more than a minimal risk before the Forces could justify outright dismissal.

As part of its award, the Tribunal ordered the military to pay back wages as well as some future amounts that would have been owing to Mr Thwaites had he been retained in the CAF. The Tribunal awarded the maximum amount possible for hurt feelings + $5,000 + and its total compensation totalled more than $160,000. It also awarded his legal and actuarial expenses.

The military appealed this decision. It also applied to the Federal Court for an interim order allowing it to withhold payment to Mr Thwaites pending the outcome of the appeal. In September 1993, the Federal Court refused to grant the interim order, saying that Mr Thwaites "should be allowed to live his remaining days in dignity." In March 1994, the Federal Court dismissed the military's appeal in its entirety.

It is interesting to note, as did the Tribunal, that the military's approach to HIV/AIDS has become significantly more rigid since 1985, when its first policy was introduced. Initially, military medical authorities favoured a flexible approach geared toward the needs of an individual member after his or her abilities had been assessed. In 1988, however, the military opted for a more category-driven approach, which automatically labelled people living with HIV/AIDS as being medically unfit for service.

The latter approach was softened somewhat in 1991 to provide for automatic medical discharge only if a person was symptomatic or asymptomatic and had a T-cell count below 500. It should be noted, however, that this leads to the discharge of most asymptomatic individuals, despite their good health.

Commenting on this new directive, the Tribunal stated that "the CAF cannot escape its responsibility for dealing with such members as individuals." They said that it "is inappropriate to specify an across the board medical category for infected persons." Despite these findings, the military has not taken steps to return to its previous policy of individual assessment, and still relies on the category-driven approach described above.

In the future, despite the strong decision in *Thwaites*, it will be very difficult for people living with HIV/AIDS, as well as other individuals with disabilities, to challenge the military's decision to release or not hire them. This is because of two recent cases from the Federal Court of Appeal: *Husband* v *CAF* (involving an applicant/recruit with visual-acuity problems) and *Robinson* v *CAF* (involving a member with epilepsy). These two cases, both decided subsequent to *Thwaites*, state that the military can release or refuse to hire a member if retaining that member poses any greater risk than retaining an able-bodied

member, *regardless* of how small that increase in risk may be. As the dissenting judge in *Husband* noted, this effectively insulates the CAF from having to comply with its human rights obligations when it comes to people with disabilities.

Unfortunately, in December 1994 the Supreme Court of Canada refused an application for leave to appeal these cases, effectively gutting the rights of all people with disabilities in the military.

It remains to be seen what effect these decisions will have outside the military setting. The acceptance of a small increase in risk could have serious consequences for disabled people in non-military employment. If this had been the standard at the time of *Thwaites*, the decision of the Tribunal would likely have been different.

Despite this, however, it appears that the *Thwaites* decision may be an extremely important precedent for those who continue to work while living with HIV/AIDS. The extent to which the disease and its effects are described in the decision, coupled with the Tribunal's detailed analysis of the law, leads us to hope that the decision will stay the course of time.

- *Richard Ellis and Peter Engelmann*

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PRISONERS AND HIV/AIDS

Switzerland: Prison Needle Exchanges Declared Judicially Admissible

In a report tabled in July 1992, the Swiss Federal Department of Justice concluded that the provision of sterile syringes and the making available of disinfectants in prisons was judicially admissible and compatible with responsible health policy.

As reported in the first issue of the *Canadian HIV/AIDS Policy & Law Newsletter*, a pilot project to provide sterile syringes was implemented in May 1994 in a Swiss prison for women. The project followed a study and consultation phase dealing with the complex range of legal and policy issues raised by the provision of such syringes in a prison environment. As part of the process, the Swiss Federal Public Health Department requested that the Department of Justice examine the judicial admissibility of such a measure.

In its opinion, the Department of Justice held that [TRANSLATION] "drug use in prison establishments is a reality." According to the Department, it could be stopped only through very strict measures that would not be compatible with a liberal enforcement of sentences. The Department acknowledges that [TRANSLATION] "drugs are rather easily introduced into prisons, but not syringes, which are a rare commodity, and this means that they are often exchanged between prisoners dependent on drugs."

The report analyses the meaning and scope of the right of prisoners to adequate medical assistance in prisons, and favours a broad interpretation that includes prevention:

"[TRANSLATION] Such medical assistance should not be available only when a disease has already spread ... but it is necessary to attempt to prevent the transmission of this disease through adequate preventive measures.... The provision of sterile syringes is ... one, if not the most important, strategy for preventing the transmission of HIV/AIDS to IV drug users. As in civilian life, it is clear that AIDS prevention for those serving sentences is not entirely dealt with simply through the provision of sterile injection equipment, but that it ... must also include measures involving therapy, withdrawal and substitutes. Nevertheless, the provision of sterile syringes is the most urgent measure."

Because abstinence in prisons is not achievable, prison establishments must, according to the report's authors, adapt their internal health policy. They conclude that, if prison establishments wish to fulfil their duty to provide medical assistance, the provision of syringes and disinfectants is recommended and that the establishments will have to comply.

The report also examines the issue of the punishability of those who provide sterile syringes, including the punishability of prison staff responsible for providing syringes and the punishability of drug-using prisoners, and compatibility with criminal law. The authors note that the criminal liability of staff comes into play only in cases of complications due to negligent handling in the provision of syringes and that, furthermore, the availability of syringes in a prison establishment does not in any way affect the punishability of drug use. The report concludes that, because drug use remains a punishable act, [TRANSLATION] "if one wishes the provision of syringes to be a success ... it must be done anonymously."

Finally, the authors deal with the delicate question of predicting whether such measures could put prison staff in danger: [TRANSLATION] "The argument has been put forward that the syringes provided ... could be used as weapons by prisoners against staff and that for this reason the provision of syringes must necessarily be rejected. This argument, although far from insignificant, is nevertheless an insufficient reason to prohibit the provision of syringes. Even now, syringes are circulating in prison establishments; staff have already had to deal with this danger for some time. Moreover, this is a problem with which staff are already confronted, in the sense that prisoners have many opportunities to obtain weapons or to make them themselves."

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Australia: Update on Prison Condom Case

As reported in the first issue of the *Newsletter*, 52 prisoners in New South Wales (NSW) are taking the government to court over their inability to access condoms in prisons.1 In a judgment handed down on 19 October 1994, Justice Dunford held that the prisoners would have to modify their case if they were to have any chance of success. The prisoners were expected to appeal the decision.2

Justice Dunford was unwilling to allow a challenge to the "policy decision" not to provide condoms in prisons, arguing that judicial review of an issue involving "political considerations" would lead to "political power [passing] from the parliament and the electorate to the courts." However, he continued by saying that "different considerations would apply if the prisoners claimed a breach of the duty owed to them as individuals";3 although a policy decision in itself may not be reviewable by the Court, its effect + a breach of duty of care owed to the prisoners + is.

If a duty of care were established, an injunction to restrain the tort of negligence might, although novel, be available. However, the Court pointed out that there might be problems with proving a duty of care in this case: it could be held that the prisoners were contributorily negligent or that they voluntarily assumed the risk of being harmed. Nevertheless, even if they were held to have been negligent, the negligence of the government would remain. Further, any consideration of the voluntary assumption of risk "must surely be tempered by questioning how much of a prisoner's actions are relevantly voluntary."4

The prisoners also sought a writ of habeas corpus (a written order requiring the investigation of the legitimacy of a person's detention). The Court held that this remedy was not available, but the prisoners were expected to appeal this point. If the appeal were successful, the order of the Court would presumably be to modify the conditions of imprisonment.

Responding to Justice Dunford's judgment, the Attorney General of NSW said that the government would consider distributing condoms in prisons even if the prisoners' case did not achieve that result. In fact, there can be no question that this issue would be more appropriate for swift legislation than for court action. As has been stated by many experts, including the NSW HIV/AIDS Legal Working Party, "[t]here is no question of balance in relation to the provision of condoms in prisons + the case for their

availability is overwhelming and the failure to make them available is absolutely contradictory to proper public policy."5

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ENDNOTES

1 See R Jürgens. Australia: Prisoners Sue for the Right to Condoms. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1, no 1 (October 1994) at 5.

2 Adapted from G Bloom. Prisoners Sue for Condoms - Court Battle Continues. [Australian] *HIV/AIDS Legal Link*, vol 5, no 3 (September 1994) at 11-12.

3 *Prisoners A to XX inclusive v New South Wales*, Supreme Court of NSW, Dunford J, 5 October 1994.

4 Supra, note 2 at 11.

5 The NSW Ministerial Review HIV/AIDS Legal Working Party. *The Courage of our Convictions - HIV/AIDS: The National Strategy and the Laws of NSW*. Sydney, 1993 at 121.

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Australia: Compulsory Testing Regime Ended in NSW

The NSW Department of Corrective Services recently announced the end of the compulsory testing regime introduced four years earlier, which provided for the testing of all inmates after reception and before release from prison.1

This regime had been widely criticized by a number of experts, who questioned what it sought to achieve and why the accepted arguments in favour of voluntary testing outside prisons did not apply equally in prisons. In the final analysis, it was probably the regime's high costs and few benefits that led to its being scrapped.

In Canada, testing of prisoners has always been voluntary. At present, the Correctional Service of Canada is undertaking a pilot study of anonymous testing, following, at least in part, a recommendation of the Expert Committee on AIDS in Prisons.2 However, there have been many calls for compulsory testing of prisoners or, at least, of certain categories of prisoners, and it will be important to resist any attempt to change the current system of voluntary testing.

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ENDNOTES

1 Reported in the [Australian] *HIV/AIDS Legal Link*, vol 5, no 3 (September 1994) at 12-13.

2 Correctional Service of Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: The Service, 1994.

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Australia: Claim by Prison Officer Settled

A prison officer, who allegedly contracted HIV after being stabbed by an inmate with a blood-filled syringe, settled his negligence action against the State of NSW for an undisclosed amount.1

The alleged attack occurred in 1990. Five weeks after feeling a sharp pain in his left buttock and turning to see a syringe held by a prisoner sticking in him, the officer was diagnosed with HIV. The prisoner has since died.

The officer's lawyer argued that the Department of Corrective Services had been negligent in not segregating the inmate, despite knowing before the incident that he was HIV-positive, had previously assaulted a prison officer, and had been found with a syringe in his cell on a previous occasion. Further, it was claimed that the Department had also been negligent because it had not provided officers with any warning during their training of the possibility of attacks from HIV-infected prisoners.

Apart from this Australian case, there has been no reported case of job-related HIV infection among correctional officers anywhere in the world.

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ENDNOTES

1 Reported in the [Australian] *HIV/AIDS Legal Link*, vol 5, no 3 (September 1994) at 16-17.

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TESTING AND REPORTING

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

As reported in the last issue of the *Newsletter*, between 1984 and 1985 the Canadian Red Cross Society ("Red Cross"), at its Toronto Centre, "collected and stored samples of blood from donors who were not told that samples of their blood would be stored or tested for HIV antibodies." Ontario's Chief Medical Officer has requested that the Red Cross report these results to public health authorities, including information that would identify the donors of the samples.

In its action, CAS is attempting to prevent such disclosure, arguing that only donors who specifically requested their results should be informed that the HIV test performed without their consent was positive. In its view, Ontario's decision is not compatible with the principles of informed consent and privacy protected by ss 7 and 8 of the *Canadian Charter of Rights and Freedoms*.

Carruthers J of the Ontario Court (General Division) ruled, however, that CAS could not rely on the *Charter* to make its argument because in his view the Red Cross was not "government" within the meaning of s 32 of the *Charter* [see below]. CAS's appeal contests this aspect of Carruthers J's decision and raises other issues in the light of new information.

Update on Blood Donors Notification Case

Canadian AIDS Society* v *Her Majesty the Queen in Right of Ontario, Dr Richard Schabas and the Canadian Red Cross Society

The Canadian AIDS Society (CAS) appealed the decision of Carruthers J dismissing CAS's application for an injunction prohibiting the Red Cross from releasing the names of HIV-positive donors whose blood was stored at the Toronto Centre of the Red Cross between 1984 and 1985, prior to the introduction of HIV-antibody testing.1

As part of the appeal, CAS submitted affidavit evidence supporting the argument that the Red Cross can be considered as "government" for purposes of applying the *Canadian Charter of Rights and Freedoms*. According to s 32 of the *Charter*, the *Charter* is applicable only to the Parliament and government of Canada and the legislature and government of each province. In order to be able to claim that the Red Cross violated the donors' privacy interest, protected under the *Charter*, CAS had to convince the Court that the Red Cross is "government" within the meaning of s 32.

Only a week before the appeal hearing, the Red Cross revealed that although the initial testing of these donor samples was done at various Red Cross blood centres, the confirmatory testing was done at the federal Laboratory Centre for Disease Control (LCDC) in Ottawa.

In light of this new information, the Court of Appeal referred the matter back to the Ontario Court (General Division) for a rehearing of the original application for an injunction prohibiting the Red Cross from releasing the names of HIV-positive donors. It was CAS's submission, upon receiving the information, that the laboratory at the LCDC is not subject to Ontario laws governing the reportability of diseases because it is a federal laboratory. The position of the Ontario government is that the initial test results must be reported to Ontario public health authorities because they indicate the presence of a reportable condition, namely AIDS.

The new hearing will begin on 5 June 1995. The issues to be argued include:

- !whether the federal laboratory at the LCDC is subject to Ontario laws on the reportability of diseases;
- whether, for the purposes of the application of Ontario laws on the reportability of diseases, an initial positive HIV-antibody test (the ELISA test) is presumptive of the presence of a reportable condition, namely AIDS; and
- whether the Red Cross is "government" for the purposes of application of the *Charter*.

- *Patricia A LeFebour*

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ENDNOTE

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

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Alberta Considering Mandatory Testing of Health-Care Workers

Alberta premier Ralph Klein announced on 7 February that he had formed a panel to consider introducing mandatory testing of health-care workers. This followed the announcement that a family practitioner practising at the Fort Saskatchewan General Hospital had tested HIV-positive.

Concern in Alberta was heightened by confusion resulting from the first announcement by provincial health officials that the doctor stopped practising in December 1994. However, it later became clear that the physician stopped performing surgery on 10 January 1995, the day on which he voluntarily informed the hospital authorities that he was HIV-positive. The hospital authorities were not aware of the date on which the doctor tested positive.

Letters recommending HIV-antibody tests have been sent to 170 patients treated by the doctor since July 1994. A hotline has also been set up to answer questions from people worried about having been treated by the doctor.

The Canadian AIDS Society (CAS), in a press release of 8 February 1995, reiterated its opposition, based on general principles of occupational health and the current understanding of HIV transmission, to mandatory testing of health-care workers who perform invasive procedures. It recalled that "the possibility of transmitting HIV from a health care worker to a patient during an invasive procedure is extremely remote." Further, CAS argued that "mandatory HIV testing of health care workers is unnecessary and extremely costly. Such funds would be better spent on targeted prevention campaigns and on promoting the use of proper infection control procedures in hospitals and other medical associations."

- *Sarah Wilson*

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IMMIGRATION

HIV-Positive Refugee Admitted to Canada

The Immigration and Refugee Board (IRB) has granted refugee status to a Polish man persecuted because of his sexual orientation and HIV-positive status.1 The ruling followed a Federal Court Trial Division judgment that overturned a Montréal board decision denying him status.

Under the Geneva Convention, refugees must demonstrate that they fear persecution because of their "race, religion, nationality, or membership in a particular social group." In this case, the man had been subject to arbitrary arrest and beatings on account of his sexual orientation. A letter from his doctor also described how AIDS clinics in Poland have been raided by police and patients' names passed on to their landlords and employers.

The Montreal board had denied his claim.2 In its opinion, since "heterosexuality is the very foundation of society, ensuring its continuity," homosexuals are an "asocial" rather than a "social group" and are therefore not protected under the Convention. Since then, homosexuals have been accepted in Canada as a "social group" within the meaning of the Convention.

The final decision to grant refugee status was criticized by Reform MP Grant Hill, who claimed that Canada will now become a magnet for people with serious medical conditions. Immigration minister Sergio Marchi responded by pointing out that each claim for refugee status is considered individually. Other Reform MPs revived a call for mandatory testing of all candidates for permanent residence in Canada, and denial of status to all candidates testing HIV-positive, including refugees. A motion introduced by Reform MP Art Hanger, proposing the HIV testing of all applicants for residence in Canada, was defeated in the House of Commons in September 1994.3

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ENDNOTES

1 [1994] DSSR No 92 (QL).

2 X(JK)(Re) [1992] CRDD No 348 (QL).

3 See House of Comons Debates, Official Report (Hansard), vol 133, no 96, 23 September 1994.

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BLOOD AND BLOOD SAFETY

Inquiry into the Blood System in Canada: The Krever Commission

The hearing into Canada's blood system began in Toronto on 14 February 1994. Heading the inquiry is Justice Horace Krever of the Ontario Court of Appeal. The "institutional parties" to the hearing include the Canadian Red Cross Society, the provincial and federal governments, and the manufacturers of coagulation products. The community-based groups represented at the hearings include the Canadian AIDS Society (CAS), the Canadian Haemophilia Society, and a variety of other groups representing haemophiliacs, transfusion recipients and people with hepatitis C. Unlike the French inquiry, these hearings will not lead to criminal prosecutions.

CAS has taken a great interest in this inquiry. One of the important issues for CAS is the social underpinnings of the spread of HIV. Good examples of this are the influence of homophobia and of racism on the spread of HIV infection in Canada through the blood supply. The indifference with which AIDS was treated in the early 1980s was justified by the institutional parties by the identity of the first groups affected by AIDS and their marginalized place in society. The hearings have also reflected a degree of racism in the way the Haitian community was dealt with in the early 1980s.

Examples of the effect of homophobia include the following:

! In 1983, a memo from the National Office of the Red Cross to all Medical Directors (MDs) in each of the 17 blood transfusion centres in Canada instructed them to contact a representative of the local gay community to encourage gay men to refrain from donating blood. In some cases, the name of a contact was provided. Some Mds complied. For example, the MD in Saskatoon consulted the local telephone directory and found a listing under "gay." By contrast, in New Brunswick the MD did not contact any gay organizations. His evidence revealed that, given the same circumstances today, he would not act differently.

- In Manitoba, where the first AIDS case did not appear until 1985, the Gay Coalition of Manitoba produced a brochure about AIDS and the blood supply in 1983. The coalition approached the Red

Cross with a view to making the brochure available in blood donor clinics, but the Red Cross refused. The reason stated by the Manitoba MD in her evidence was that the brochure might have offended some blood donors. In reviewing the brochure, it became apparent that the only so-called offensive word was "gay."

- Most, if not all, of the provincial governments did not fund AIDS Service Organizations (ASOs) until the mid-1980s. The reasons for this vary, but have as their common thread that to fund an ASO was to fund a "gay rights, political" group.

There is little doubt, however, that some of the initiatives taken by gay organizations might have reduced HIV-transmission rates in Canada. For example, one of the first ASOs in Canada, AIDS Vancouver, developed a poster in 1983 that was distributed in Vancouver's bathhouses. The poster's message was blunt: if you are here, do not donate blood. It was also effective, as demonstrated by British Columbia's lowest rates of transfusion-related cases of HIV infection in Canada.

Finally, it is disturbing to note that evidence to the Commission suggests that the mistakes of the past may well be repeated in the future. The parties representing people infected with hepatitis C have suggested that the appearance of a new bloodborne infection may be treated in the same manner as HIV by the institutional parties.

- *Patricia A LeFebour and Douglas Elliott*

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Krever Commission Releases Interim Report

On 17 February 1995, Justice Horace Krever submitted his Interim Report on the safety of the blood system in Canada, containing 43 recommendations on actions that might be taken to address any current shortcomings.

The question addressed in the Report, though on an interim basis only, is the degree of safety of the blood, blood components, and blood products used therapeutically in Canada. In Justice Krever's words, "how safe can Canadians feel if it is necessary for them to receive a blood transfusion?" According to the Report, Canada's blood supply has never been safe in absolute terms, and can never be made absolutely safe. At the same time, the report states that Canada's blood supply is not less safe than that of other developed nations. However, the risks in using blood can be reduced further, and the 43 recommendations in the Report, if implemented, would produce that result. The recommendations, among many other things, emphasize the need for treating physicians to obtain the informed consent of the patient to the administration of blood and blood products, as well as the need to notify transfusion recipients about the potential risk of HIV infection.

The Report is available from the Canada Communications Group in Hull, Québec for $19.95 plus GST. Tel: (819) 956-4800. The catalogue number is CP 32-62/1-1995.

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CRIMINAL JUSTICE

Justice Minister Considers Introducing HIV/AIDS-Specific Criminal Offence

In January 1995, Federal Minister of Justice Allan Rock declared that he was considering an amendment to the *Criminal Code* to make it a crime to "knowingly communicate" HIV.1

The *Criminal Code* does not currently contain a provision specifically dealing with HIV transmission or endangerment thereof. For many years, the issue of whether such a provision should be enacted and, if so, what form it should take, has been widely debated and has received much media attention. This is the result of a few high-profile cases in which heterosexual men had unprotected sex with women, knowing that they themselves were HIV-infected and without informing the women about their HIV status. In three of these cases, this resulted in HIV being transmitted to the women. The best known case is that of Ssenyonga, whose story recently made the first page of a national news magazine.2 While the issue is certainly a very serious one, it is somewhat surprising that an amendment to the *Criminal Code* is now being considered. Experts, including the National Advisory Committee on AIDS,3 the Royal Society of Canada,4 and the Canadian Bar Association + Ontario,5 as well as community groups,6 have all studied the issue and recommended against the use of the criminal law in such situations. There are many reasons for this: existing public health laws may be better suited to deal with persons who, knowing that they are HIV-positive, continue to engage in unsafe sexual or drug-using behaviours; creating a criminal offence may send out the wrong message + that the law can protect people from contracting HIV infection, whereas everyone needs to protect themselves; the deterrent effect of such an offence is, at the very least, questionable; a criminal offence dealing with transmission of certain sexually transmitted diseases was repealed as recently as 1985 because it had never been used and because it was held that the criminal law was inappropriate for dealing with such private issues; finally, in countries in which such offences have been created, they have rarely been used and have often been harshly criticized.7

So far, Canada has resisted the easy temptation of enacting HIV-specific legislation "for the sake of legislation or ... for the sole purpose of suggesting that authorities are doing something."8 Such legislation, often enacted in reaction to a public demand for action, can be counterproductive because it diverts attention from the underlying problems. As has been stated by David Patterson: "Criminalizing HIV endangerment will do little to stop the virus. Worse, it gives the appearance of decisive action,

while distracting from the solutions that work. The whole thrust of our response to this issue should not be determined by a handful of hard cases."9

These and other issues are addressed in the policy on criminalization of HIV transmission that is being prepared by the AIDS Committee of Toronto. It is hoped that this document will stimulate much-needed debate on the difficult issues involved.

- *Ralf Jürgens*

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ENDNOTES

1 See S Bindman. Rock Pondering Stepping Into Debate Over Medical Records. *Law Times*, January 23-29 1995.

2 J Callwood. A Date with AIDS. *Saturday Night*, March 1995.

3 National Advisory Committee on AIDS. *HIV and Human Rights in Canada*. Ottawa: The Committee, 1992 at 15.

4 Royal Society of Canada. *AIDS - A Perspective for Canadians. Summary Report and Recommendations*. Ottawa: The Society, 1988 at 10.

5 Canadian Bar Association + Ontario. *Report of the AIDS Committee*. Toronto: The Association, 1986 at 60-61.

6 See infra, AIDS Committee of Toronto Preparing Policy on Criminalization of HIV Transmission.

7 See, eg, M Closen et al. Criminalization of HIV Transmission in the USA. Abstract PO-D27-4188, IXth International Conference on AIDS, Berlin, 6-11 June 1993.

8 Cited from Sev S Fluss. International AIDS Legislation. In: HF Puelma et al (eds). *Ethics and Law in the Study of AIDS*. Washington, DC: Pan American Health Organization Scientific Publication No 530.

9 D Patterson. Should Canada Criminalize HIV Endangerment? *Canadian HIV/AIDS Policy & Law Newsletter*,

vol 1 no 2 (January 1995) at 15.

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HIV-Positive Man Acquitted of Attempted Murder Charge for Smearing Blood on Victim

Montréal + An HIV-positive man who smeared his blood on a teenage girl's cuts and told her she was going to die was acquitted of attempted murder and death-threat charges on 20 February 1995 by Québec Court Judge Gilles Cadieux. Recent tests have shown that the girl is HIV-negative.

The HIV-positive man was found guilty on a lesser count of assault causing bodily harm, and sentenced to 53 days in prison.

The man had met a 16-year-old girl in the summer of 1993 and had a two-month sexual relationship with her. After they had sex without a condom in September 1993, the man told her that he was HIV-positive, and that she had just "joined the club."

The incident for which the man faced the attempted-murder and death-threat charges happened later that month. On 23 September, the man beat the girl and opened up cuts on her face. He then cut himself and smeared his blood into the girl's open wounds, telling her that she was going to "catch the virus, too."

No medical evidence proving that HIV could be transmitted in such a manner was presented to Cadieux J. The judge ruled that there was not "adequate judicial knowledge" about whether smearing of blood could lead to transmission of HIV, and acquitted the man of the attempted-murder charge.

Interestingly, the Crown did not lay charges against the man for having had unprotected sex with the girl while knowing that he was HIV-positive and without previously informing her about his serostatus (reported in *The [Montréal] Gazette*, 21 February 1995, at A3).

The case is somewhat similar to a case tried in 1993. In that case, the accused was incarcerated at Donnacona Maximum Security Institution when he assaulted penitentiary staff who were trying to restrain him in his cell. The inmate, who knew that he was HIV-positive, tried to bite staff. He then sprayed them with his blood, saying he would in this way contaminate and kill them. The inmate was

charged with a number of offences, including attempted murder. On 17 February 1993, a jury returned a guilty verdict on charges of assaulting a peace officer, uttering threats to cause death or serious bodily harm, and assault causing bodily harm. The inmate was sentenced to four years in prison. However, as in the above case, the inmate was found not guilty on the charge of attempted murder.

- *Ralf Jürgens*

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HIV-Positive Man Acquitted of Two Counts of Common Nuisance

Donald Napora was charged with two counts of common nuisance (section 180 of the *Criminal Code*) for engaging in consensual anal intercourse with two men without using a condom, knowing that he was HIV-positive. In a judgment issued on 27 February 1995, he was found not guilty by Veit J of the Court of Queen's Bench of Alberta, Judicial District of Edmonton.

The Court did not attach criminal consequences to Mr Napora's activity with one of the two men, and stayed one count on the indictment because of a prior arrangement made by the Crown prosecutor with the accused. With regard to the second count, the Court reached a non-guilty verdict.

With regard to the facts in this case, it was undisputed that Mr Napora had consensual anal intercourse, with ejaculation, without using a condom, with one partner, Mr May, between 1 February and 30 November 1990. It was also undisputed that Napora learned that he was HIV-positive on 14 April 1989. However, the evidence established that May could also have been HIV-positive at the time of his sexual contact with Napora, since he had engaged in unprotected anal intercourse with between 30 and 50 partners prior to his sexual contact with Napora.

Napora was charged with common nuisance, a charge that was traditionally used to punish people who inconvenienced the general public by activities such as blocking a road or a public street. Recently, however, this charge has been used in a number of cases involving persons living with HIV/AIDS who put others at risk of contracting HIV. According to s 180(2)(a) of the *Criminal Code*, "every one commits a common nuisance who does an unlawful act or fails to discharge a legal duty and thereby endangers the lives, safety, health, property or comfort of the public."

The Court held that Napora, once he became aware that he was HIV-positive, owed a "legal duty" to May to use "reasonable care" in their sexual contacts. However, the Court was not satisfied that Napora exposed the public to danger, harm or risk. Napora had argued that the act in question, sex with May, is a private act, and that May and any other of Napora's prospective sex partners "has an effective means of protecting himself by just saying no to sexual contact." The Court did not accept Napora's contention that the act in question was merely a private concern. In a decision on a non-suit application made halfway through the trial (this is an application by the defence to the judge for dismissal of the matter on

the grounds that, in law, the Crown has not put before the Court evidence on one of the key elements of the criminal charge), the Court concluded that the Crown had led some evidence of the "public effect of the transmission of HIV," noting that "an HIV infected person may feel, and look, perfectly well for between 8 to 11 years after infection. That person might, during a decade or more, engage in high risk sexual behaviours that could affect many partners. And a similar risk of spread of infection occurs with each of those partners. HIV is not a disease, like smallpox, that inevitably has observable symptoms. This constitutes some evidence of a public aspect to the transmission of HIV." However, in its reasons, the Court later says that the Crown has not proved that May was exposed to any danger, harm or risk as a result of his sexual contact with Napora: the evidence established that May could well have been already infected when he resumed his sexual activity with Napora in 1989.

Although consent was not a legal issue in the trial, the Court went on to say that "the informed consent of a person to have unprotected high risk sexual activity would not relieve the HIV infected person from criminal responsibility." The Court said that it would not "allow a person to expose others to the risk of contracting a fatal disease" for two reasons: (1) the fatal nature of the disease and the high medical costs of the disease, which "involve the public"; and (2) where discordant couples (one partner infected with HIV, the other not) continue to have unprotected high-risk sexual activities, the consent of the uninfected partner may arise "as much from fear, or anger, or despair, as from love or loyalty."

This case raises important issues. First, only the conduct that occurred after Napora learned that he was HIV-positive was taken into account in determining the issues in the trial. The Court itself acknowledges that criminalizing informed and consensual but unprotected high-risk sexual activity may have the negative effect of discouraging people from getting tested for HIV antibodies: "if a person knew that they might be charged criminally with having consensual, unprotected, high risk sex, they may decide not to get tested, or not to get tested under their real names. This reluctance might well have a negative effect on the work of those epidemiologists who are working towards the arrest of this virus in our communities." However, the Court continued by saying that it was Parliament and the Legislature, and not the courts, "that have to make these important decisions." Secondly, the Court's position that consent is irrelevant in such cases could lead to the criminalization of persons living with HIV/AIDS whose partners, for various reasons, knowingly engage in unsafe sexual activity with them. While such behaviour should be discouraged, the use of the criminal law will do little if anything to change this, and hardly seems appropriate for dealing with such situations.

The next issue of the *Newsletter* will provide a more detailed commentary on this decision.

- *Ralf Jürgens*

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CANADIAN NEWS

Ontario Advisory Committee on HIV/AIDS: Reducing HIV Transmission by People Who Are "Unwilling or Unable" to Take Appropriate Precautions

The Ontario Advisory Committee on HIV/AIDS, established by the Minister of Health in 1991 to provide advice on policy and planning issues, is currently addressing the problems posed by individuals who are unwilling or unable to use appropriate precautions to prevent transmission of HIV.

A working group has been established whose members include people living with HIV/AIDS, physicians, public health officials, representatives of community-based HIV/AIDS organizations, lawyers and staff of the Ministry. The group has collected information on the subject from other jurisdictions, prepared an overview of the current situation in Ontario, and is preparing a paper summarizing the results of its deliberations and developing a consultation process. Eventually, recommendations will be made to the Minister of Health on how best to respond to the issue.

The paper + written for public health officials, community-based HIV/AIDS organizations, people living with HIV/AIDS, and other people involved in the response to those who are "unwilling or unable" + is nearing completion. It will outline and analyze the approaches currently used in Ontario, and outline a spectrum of possible interventions ranging from supportive interventions to intrusive interventions involving prohibitions not generally given to people living with HIV/AIDS. The reasons underlying why some people may be unwilling or unable to take precautions vary, and interventions will depend on what is necessary to reduce HIV transmission.

- *Anne Bowlby*

[Editors' note: The *Newsletter* will summarize and comment on the working group's recommendations when they are released.]

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New Ontario Legislation Important for Persons Living with HIV/AIDS

3 April 1995 heralded the proclamation of a trilogy of Ontario health statutes, the *Consent to Treatment Act*, the *Advocacy Act* and the *Substitute Decisions Act*. This legislation had been in a draft stage since at least as early as 1988 and was given second reading by the Ontario government and Royal Assent in 1992. Proclamation of these statutes was delayed for fiscal reasons and because they represent a significant change in Ontario health law. This article describes the most notable reforms introduced by the trilogy from the perspective of persons in Ontario living with HIV/AIDS, their families, their health practitioners and their other care providers.

The *Advocacy Act*

The *Advocacy Act* (the *Act*) creates an Advocacy Commission (the Commission) to advocate for "vulnerable persons," which term is defined to mean persons with disabilities who are unable or are having difficulty ascertaining or exercising their rights. The 13-member Commission will employ advocates whose job it will be to advocate for vulnerable persons and work with the families and care providers of vulnerable persons. A majority of the members of the Advocacy Commission will be elderly persons and persons who have or have had disabilities.

An Advisory Committee, consisting of persons who are family members of vulnerable persons, will advise the Commission regarding the impact of the Commission's work on care givers and family members and on the Commission's policies and procedures generally.

The Commission will publish an annual report and, with certain exceptions, its meetings will be open to the public. One of the Commission's functions will be to make grants to community agencies working for systematic change in the law for vulnerable persons. The advocates employed by the Commission will have a right: (1) of entry to premises where an advocate has reasonable grounds to believe that vulnerable persons reside; (2) to meet with vulnerable persons in facilities and "controlled-access residences" such as private and public hospitals, nursing homes, hospices, psychiatric facilities and special-care homes; (3) in certain circumstances, to access vulnerable persons' medical and other records. Advocates' and the Commission's obligation to keep information about vulnerable persons confidential is set out in the *Act*, with stiff penalties for contravention of this statutory duty of

confidentiality.

The *Consent to Treatment Act*

The *Consent to Treatment Act* (the *Act*) enshrines in Ontario statute law the common law principle that there shall be no treatment administered by a health practitioner without the consent of the person to whom the treatment will be administered, or the consent of the person who has authority to give or refuse consent to the proposed treatment on behalf of the person to whom the treatment is proposed to be administered. Both the phrase "health practitioner" and the term "treatment" are broadly defined. Anyone in the health field in Ontario rendering virtually any kind of health-related service is bound by the provisions of this *Act*. The elements of valid consent are set out, and the notion of "informed consent" is formally recognized and defined. Capacity to consent to treatment is defined and the notions of temporary and partial incapacity are recognized.

The *Act* creates the Capacity and Consent Review Board (the Board). A person determined by a health practitioner to be incapable with respect to a treatment has the right to apply to the Board for a review of the finding of incapacity. After hearing the evidence and submissions of both the applicant and the health practitioner, the Board has the power to substitute its opinion regarding the applicant's capacity for that of the attending health practitioner. Except in limited circumstances, no treatment will be administered to the person pending the outcome of the person's application to the Board.

The *Act* stipulates the factors that a substitute decision-maker shall consider in consenting or refusing to consent to treatment on behalf of an incapable person. Treatment wishes expressed while the incapable person was capable have to be respected by the substitute decision-maker. If the substitute decision-maker is not aware of any treatment wishes expressed by the person when capable, the substitute is obliged to apply a "best interests" test that is described in detail in the *Act*. Living wills are implicitly recognized by the *Act*, which states that a person may, while capable, express wishes with respect to treatment. Even in medical emergencies, previously expressed treatment wishes, if known to the attending health practitioner, are binding.

The *Act* creates a hierarchy of substitute decision-makers to whom a health practitioner must turn for substitute consent if a person is found to be incapable with respect to a proposed treatment. The *Act* obliquely recognizes the existence of gay and lesbian relationships by introducing the term "partner" and by ranking partners on the same level as spouses for the purposes of giving or refusing to give substitute consent. The *Act* defines "partners" as "two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives." From the point of view of a gay man living with HIV/AIDS who has a "partner," this reform in the law of substitute consent is perhaps the single most important innovation in the law brought about by this trilogy of statutes. This is the first time in Ontario history that Ontario statute law, albeit obliquely, recognizes the validity and importance of gay and lesbian relationships.

The *Substitute Decisions Act*

The *Substitute Decisions Act* (the *Act*) sets out the manner in which a person may delegate decision-making authority regarding his or her property and/or personal care to another person. Delegation of property decision-making authority is made through a Power of Attorney for Property, and delegation of personal care decision-making authority is made through a Power of Attorney for Personal Care. There is no required form for these documents, except that the appointment of an attorney must be made in writing and witnessed by two people. Also, in order to be valid, the donor of the power of attorney must be capable of giving a power of attorney. The *Act* provides definitions of "capacity to give a power of attorney for personal care." These statutory definitions will assist health practitioners, who are often called upon to assess a patient's capacity to give a power of attorney.

The *Act* sets out the duties of an attorney acting under a power of attorney for property and an attorney acting under a power of attorney for personal care. An attorney for property care now has a statutory right to compensation. Subject to the terms and conditions in the actual Power of Attorney for Property, the *Act* sets out the types of expenditures that an attorney for property care is entitled to make on behalf of incapable persons.

The *Act* creates the office of the Public Guardian and Trustee. In certain circumstances the Public Guardian and Trustee will become the guardian of an incapable person's property and/or personal care. The *Act* creates an application to court for guardianship of an incapable person's property and/or personal care, but various mechanisms are set out in the *Act* to avoid the necessity of making a court application. One example of this is a procedure whereby the office of the Public Guardian and Trustee "validates" a power of attorney for personal care. Once the document is validated, the incapable person has only limited ability to oppose the actions taken by an attorney acting under the validated power of attorney for personal care.

At first glance, the trilogy of Ontario statutes proclaimed on 3 April 1995 is confusing. The trilogy introduces terms and entities hitherto unknown in Ontario health law, such as partners, Capacity and Consent Review Board, power of attorney for personal care, and guardianship. However, the substantive content of the trilogy marks an important advance for Ontarians with disabilities, their care providers and health practitioners.

- *Philip MacAdam*

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INTERNATIONAL NEWS

HIV/AIDS-Related Law Reform in Australia

For several years, Australia has been engaged in a painstaking process of consensus-building around HIV-related policy and law reform. This process has resulted in the publication and wide distribution of a number of documents and reports on HIV-related policy and law.

The first of these were the 1989 *Report of the Working Panel on Discrimination and Other Legal Issues + HIV/AIDS*1 and a major national policy document addressing legal issues, the *National HIV/AIDS Strategy*.2 Both documents were based on extensive community consultation.

Following the release of the *Strategy*, the Intergovernmental Committee on AIDS (IGCA) was convened to bring together representatives of federal, state and territorial departments of justice and health to monitor the implementation of the *Strategy* at the state and territory level. The IGCA prepared and released a series of nine comprehensive discussion papers on law and policy reform and invited comments from all quarters. The papers documented the HIV-related law and policy aspects of the following areas: public health; civil liability for HIV transmission; discrimination; homosexuality; sex workers and their clients; employment; injecting drug use; therapeutic goods (including condoms, HIV test kits and injection equipment); and the media, broadcasting, censorship, and privacy.

In 1992, the IGCA published its conclusions and recommendations based on the community response to these discussion papers.3 The challenge was then to implement these recommendations at the state level.

In New South Wales (NSW), Australia's most populous state, with the largest number of cases of HIV infection and AIDS, the Minister for Health convened a committee to review the relevant state law and advise on the necessary changes flowing from the IGCA report and any other changes supportive of the *Strategy*. In a 1993 report, *The Courage of Our Convictions*,4 each of the IGCA recommendations is examined by the state department(s) responsible for its implementation. Specifically, comments were sought, where relevant, from local government, police, workers' compensation, the anti-discrimination board, the superannuation office, etc. Where there were objections to the recommendations, they were

noted alongside the rationale for the recommendations in the report.

There can be no doubt that the process of HIV-related law and policy reform in Australia was not an easy one. Nor is it over. The IGCA recommendations regarding, for example, sex work and injecting drug use, were radical and directly challenged previous policies in these fields. Consider the recommendation that commercial sex work be decriminalized, and that sex workers be afforded employee benefits such as holiday and sick leave, superannuation (employer-contributed retirement savings plans) and compensation in case of accidental HIV infection.

Herein lies the strength of the process. The legal and policy response to the HIV epidemic in Australia has been relatively open, inclusive, proactive and non-directive. Open, because the Commonwealth [federal] government has published and distributed widely for comment the products of its research. Inclusive, because despite lacking primary jurisdiction in most relevant fields such as health, the Commonwealth government initiated a process (albeit expensive and time-consuming) of community consultation and consensus-building. Proactive, because debate on the role of the criminal law, for example, was initiated early in the process. This lessened the likelihood of recourse to inappropriate criminal charges. Finally, non-directive, because the primary role and responsibility of the states has been generally acknowledged, because the implementation of most of the IGCA recommendations is ultimately their responsibility.

Is there a lesson for Canada in the Australian experience?

For a copy of *The Courage of Our Convictions*, contact: Matt Field, AIDS/Infectious Diseases Branch, New South Wales Health Department, Locked Bag 961, North Sydney, NSW, 2059, Australia. (Fax: 61-2-391-9101).

- *David Patterson*

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ENDNOTES

1 Consultation Paper No 2. Canberra: Department of Community Services and Health, 1989.

2 Canberra: Australian Government Publishing Service, 1989 (revised 1993).

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

4 *The Courage of Our Convictions: HIV/AIDS: The National Strategy and the Laws of New South Wales,* New South Wales Ministerial Review HIV/AIDS Legal Working Party, November 1993.

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WOMEN AND HIV/AIDS

Title to Our Bodies: Women, AIDS and Human Rights

The following article is a personal reflection prompted by the two-day Interagency Coalition on AIDS and Development Workshop "Programming for a Positive World: Women, Development, and Cultural and Social Change,"1 which the author helped to organize. Many of the conference speakers criticized the lack of attention in policy-making to actual experience of sexuality. Instead, technical solutions are emphasized, thus divorcing the examination of HIV transmission from social reality. The social reality of sexual intercourse for many women is that they lack negotiating power and experience coercion.

At the heart of women, human rights and AIDS policies must be the women in the world who, through custom and law, are not entitled to sexual pleasure or protected sex. Women throughout the world who have HIV/AIDS have become infected in circumstances that are often outside their control. Although AIDS literature abounds in accounts of women being "vectors" of HIV transmission as prostitutes or mothers, the reality of the situation is quite different. If we look at the situation of women and HIV/AIDS globally, we find that 40 percent of the HIV-positive are women. New infections in sub-Saharan Africa are in a female-to-male ratio of 6:5. African women are also infected, on average, at an age 10 years younger than men. It has further been estimated that an average of 1500 monogamous women are infected every day by their husbands. Studies from Africa show that 60 to 80 percent of infected women have had only one sexual partner. Thus, for many women in the world it is their marital relationships that are the arena of greatest danger for contracting AIDS. Women's testimonies from all over the world show that they just cannot ask their male partners to wear a condom, even when they know that their partner may have many sexual partners. In many cultures, it is simply unthinkable for such a conversation to be initiated by a woman. The psychic trauma for women submitting to sex, knowing their husband may be infected, is very painful, and in the context of AIDS the consequences are deadly.

Coercive sexuality is not experienced only by women in their relationships with their husbands. When a sexual experience is not mutual there is more physical tearing of the vagina and less protective vaginal mucous produced. Incest, rape, sexual slavery, child prostitution, and female genital mutilation are all widespread, and examples of the ways in which women do not have control over their bodies, thus

rendering them vulnerable to AIDS. The existence of such human rights violations is backed up by customs and laws that give title to women's bodies to fathers, husbands and the state.

There has been a general failure in AIDS and human rights analysis to address issues of sexuality, including coercive sexuality. AIDS-prevention strategies that emphasize condom use, sticking to one partner, or practising non-penetrative sex do not present viable options for the many women who are denied the right to enjoy sex or refuse sex, or who are in social, economic and cultural contexts that undermine their ability to insist on safe sex. We must address the fact that it is the legal and customary privileging of male sexual pleasure over female sexual pleasure that has resulted in the numerous ways in which women do not have title to their bodies throughout the world. The absence of sexual reciprocality is a vivid illustration of how women do not control their bodies in their most intimate experiences. This understanding must inform our work on women, human rights and AIDS, and be accompanied by activism on such issues as the legal status of marital rape, the age of consent, the right to have/not have children, the ownership of children, child prostitution, sexual slavery, and female genital mutilation.

- *Aine Costigan*

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ENDNOTE

1 See S Wilson. Programming for a Positive World: Women, Development, and Cultural and Social Change. *Canadian HIV/AIDS Policy & Law Newsletter*, vol 1 no 2 (January 1995) at 8-9.

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PUBLICATIONS REVIEWED

The Netherlands + The Dutch National Committee on AIDS Control (NCAB) recently released a 90-page report called *AIDS and Detention: The Combat Against AIDS in Penitentiary Institutions in the Netherlands*. In the report, concern is expressed about the present state of HIV/AIDS policy in prisons in the Netherlands. The NCAB points out that many prisoners belong to societal groups + such as drug users, prostitutes, marginal youth, migrants + that are especially vulnerable to contracting HIV infection. Prisons are considered as an opportunity to reach these groups with education and prevention activities. According to the authors, AIDS policy in prisons should correspond with AIDS policy in the wider society, as well as with the *WHO Guidelines on HIV infection and AIDS in Prisons*.

The report, which is available only in Dutch, but is accompanied by a brief English summary, can be obtained from the National Committee on AIDS Control (NCAB), Polderweg 92, 1093 KP Amsterdam.

United Kingdom + A collection of articles on HIV/AIDS in prisons, written by experts from 10 countries, was published in September 1994. The book, *AIDS in Prison*, edited by Philip Thomas from Cardiff Law School and Martin Moerings from the University of Utrecht, contains articles about HIV/AIDS in prisons in Norway, Germany, Poland, England and Wales, the Netherlands, Belgium, Italy, Spain, Canada, and the US. In each article, the national laws and procedures relating to HIV/AIDS and prisons, and the extent of their application within the prison system, are reviewed. In addition, the book covers the issues of drug use and sexual activity by prisoners, early release, drug-free units, education, and the availability of condoms and bleach. Official discourse is compared and contrasted with the daily experience of prisoners, thereby identifying the reality gap that exists between institutional statements made for public consumption and the experiences of prisoners. The Canadian contribution was written by the undersigned.

For more information about the book, or to order a copy, contact Dartmouth Publishing Company, Gower House, Croft Road, Aldershot, Hants., United Kingdom GU11 3HR. Tel: (011-44-252) 331-551; fax: (011-44-252) 317-446.

- *Ralf Jürgens*

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