National Library of Canada
Acquisitions and Bibliographic Services Branch
395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale du Canada
Direction des acquisitions et des services bibliographiques
395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

Canada

HIV: Public Health, Criminal Law and the Process of Policy Development

David Patterson

Faculty of Law, McGill University

Submitted January 1995

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements of the degree of Master of Laws

Supervisor: Prof. S. Toope

ISBN 0-612-05503-5

Canada

Abstract

This paper examines briefly the changing conceptions of HIV disease in the Canadian context. Historical reference is made to the increase in state involvement in the field of public health, and to the shift from an emphasis on environmental and behavioural factors to infectious agents as the causes of disease. The role of the state in the prevention of HIV disease is then discussed, with reference to human rights and changing perceptions of the role of the law. The paper then considers a specific issue: the criminal law and the sexual transmission of the virus. The Canadian legislation and case law is compared with the Australian response. It is suggested that the early focus on HIV legal policy in Australia led to a general agreement that the criminal law had a very limited contribution to make in this regard. The paper concludes with comments on the process of legal policy development, rather than specific recommendations for law reform.

Résumé:

VIH: Santé publique, droit pénal et processus d'élaboration de politiques

Cet exposé examine brièvement les changements dans la façon de concevoir la maladie du VIH dans un contexte canadien. Il fait des références historiques à l'accroissement de l'intervention de l'État dans le domaine de la santé publique, et au passage d'une emphase, d'abord sur des facteurs environnementaux et comportementaux, et ensuite sur des agents infectieux, en tant que cause de la maladie. Il discute ensuite du rôle de l'État dans la prévention de la maladie du VIH en s'appuyant sur des références aux droits de la personne et au changement de perceptions face au rôle du droit. Le travail aborde ensuite une problématique spécifique, soit le droit pénal et la transmission sexuelle du virus. Il compare la législation et la jurisprudence canadiennes aux solutions australiennes. Il suggère que l'Australie, en juridicisant tôt le débat entourant le VIH, a donné lieu à un consensus selon lequel la contribution du droit pénal à cet égard, serait limitée. L'exposé conclut par des commentaires sur le processus d'élaboration de politiques plutôt que par des propositions spécifiques de réforme du droit.

Acknowledgments

I wish to thank the following people for their conversations and advice in the research and writing of this thesis:

Bill Coleman, Nobby Gilmore, Ralf Jürgens, Stephanie Kane, Patrick Healy, and Margo Somerville.

I would also like to thank my supervisor Stephen Toope for his enthusiasm, patience and attention to detail.

Contents

1 Changing conceptions of HIV disease

1.1 Overview

This thesis will first explore the changing conceptions and representations of HIV disease. Conceptions of public health, the role of the state, and the role of the law will then be discussed. The ways in which HIV disease is similar to, and different from, other diseases that have been the object of legal attention and regulation will be also examined.

Different approaches to the regulation of behaviour which might transmit HIV infection are discussed. Underlying these different approaches are different models of disease prevention and public health promotion: the so-called 'traditional' model, which emphasizes identification and isolation of the infected; and an alternative 'inclusive' model, which emphasizes the confidence and cooperation of the infected and those most at risk of infection.

The application of these models as they underscore responses in Canada and Australia will then be explored in relation to a specific issue: the sexual transmission of HIV infection. These two countries have been chosen for the following reasons: an early similar epidemiological pattern of HIV infection; similar federal constitutional structures, but with differing allocations of powers between the federal and state or provincial governments; and differing legal responses, in both the criminal and public health

spheres, to the HIV epidemic.

Australia was also chosen for personal reasons, as I had worked in the non-government AIDS movement there for about seven years before coming to Canada. I therefore draw on my personal experience as a volunteer with the Legal Working Group of the AIDS Council of New South Wales, as honourary secretary of the Northern Territory AIDS Council, and two years' experience as a legal researcher with the Australian Federation of AIDS Organisations.

Reference will also be made to the developments, experiences and policies in other countries, particularly the United States. U.S. developments are of particular interest for several reasons, in spite of the sometimes very specific socio-cultural and political factors which have influenced U.S. HIV/AIDS policies and responses. First, HIV disease is believed to be more widespread in the U.S. than in any other Western country, and we are hence in the position of being able to learn from the successes and failures of U.S. policies and programmes. Second, the U.S. itself often influences, both directly and directly, HIV policy formation and programme development in many other countries.

In conclusion, the process of, and proposals for, law reform will be discussed. The need for leadership at the federal level on such reforms will be emphasized.

1.2 Introduction

The growing realization that science will not quickly provide a cure for or vaccine against HIV disease has led to a renewed focus on HIV prevention, and the very difficult issues of rights, duties and world-views that effective prevention strategies entail.

At the 1993 IXth International AIDS Conference in Berlin the failing hopes of an early cure or vaccine, which had limped yearly from international conference to conference, were finally put to rest. Further, AZT, the major drug which was widely believed to offer those who could gain access to it some hope of delaying the onset of the disease, was shown in a major study to be of more limited value than previously hoped.[1] It was becoming increasingly clear to an ever-widening audience that without a cure or vaccine, and with a virus of low ease of transmission, yet high chronicity and length of infectious period, that those working to contain HIV disease were in for the 'long haul.'[2]

Post-Berlin there was, however, evidence that new interest was being shown in prevention efforts. The *New York Times*, in an editorial following the conference,

---

1 Roberts J., "Criticisms of Concorde Dominate AIDS Conference" (1993) 306 BMJ 1631. AZT (azidothymidine), also known as Zidovudine, is thought to inhibit the replication of HIV in infected cells.

2 The 'long haul' nature of the HIV epidemic has been contrasted with other infectious diseases of high ease of transmission and shorter period of infectiousness. See Joseph S., *Dragon Within the Gates: The Once and Future AIDS Epidemic* (New York: Carroll & Graf, 1992) at 88.

observed:

> The international AIDS conference in Berlin last week left a depressing message: no scientific breakthrough is apt to wipe this scourge from the earth any time soon. Indeed, existing medical weapons against AIDS are less successful than once believed. There is little choice now but to shift the emphasis to prevention programs...
>
> Some 14 million people around the world are now infected with the AIDS virus, and that number will soar above 30 million by the year 2000, the World Health Organization predicts. In the United States, AIDS is now the leading cause of death among young men 25 to 44 years of age in 5 states and 64 cities...
>
> The only immediate hope for containing the epidemic is a heavier emphasis on prevention programs. That means patient, persistent, unglamorous work yielding small gains in areas that are often controversial: better sex education, promotion of condoms, needle exchange programs for drug addicts, safer blood supplies abroad and better treatment of venereal diseases that foster the spread of AIDS.
>
> Dr. Michael Merson, head of the AIDS program of the World Health Organization, suggests that $1.5 billion to $2.9 billion a year spent on prevention programs in developing countries could cut in half the number of new infections between now and the end of the century. Such a campaign would not only be humane, it would save money in the long run. Against a formidable disease like AIDS, prevention is almost certainly to be cheaper than cure.[3]

This observation so late in the day is no doubt galling to U.S. HIV educators who have for years worked to change the patterns of sexual behaviour and injecting drug use of those most at risk. It also reflects a perspective which ignores the fact that for many people, particularly those in less developed countries, the prohibitive cost of a cure or vaccine (let alone drugs that might ameliorate the effects HIV disease) will mean that prevention will in the medium term, and possibly the long term, be the only option for

---

[3] "The Unyielding AIDS Epidemic" *The New York Times* (17 June 1993) A24. The message was repeated at the Xth International AIDS Conference in Yokohama, Japan - there will be no early magic bullets.

survival.[4]

Why has it taken so long for a recognition of the importance of HIV prevention? A belief (linked to racism and homophobia) that only certain communities or sub-populations were are risk of infection certainly played a role. It has also been suggested that the early promise of a cure or vaccine for HIV disease hampered efforts to limit the spread of the disease by diverting attention, and hence funding, away from prevention strategies.[5] Possible reasons for the focus on biomedical technology to cure the infected or at least provide a vaccine for those at risk include both the promise of immense financial rewards for the discoverers of the 'magic bullet,' and inherent difficulties in addressing frankly the primary modes of transmission of the virus: sexual intercourse and injecting drug use.

---

[4] Many less developed countries face particular problems with prevention programs that emphasize condom use. Latex condoms are relatively expensive, have a limited shelf life, are particularly susceptible to heat, and may only be used once and with specifically water-based lubrication. The lack of recognition of the specific needs of these countries is significant. Nonetheless, recent developments in condom technology may soon provide an alternative in the plastic condom, which may be re-used, and with a variety of lubricants.

[5] Cook & Colby surveyed the U.S. network television coverage of the epidemic to 1987 and noted the factors that influenced the coverage, noting the need for news of breakthroughs rather than of failures. They claim the media may itself have been misled by politicians and scientists: 'The most notable example of the media's being misled was [Health and Human Services Secretary Margaret] Heckler's prediction that, with the isolation of the virus, a vaccine was only a few years away. ...Meanwhile, scientists downplayed dead ends and stressed advances - findings that the news media would cover and that would boost the scientists' credibility and their careers.' Cook T., & Colby D., "The Media-Mediated Epidemic: The Politics of AIDS on the Nightly Network News" in Fee E. & Fox D., eds., *AIDS: The Making of a Chronic Disease* (Berkeley: University of California Press, 1992) 84 at 103. See also Plummer D., "The Medical Establishment" in Timewell E., Minichiello V. & Plummer D., eds., *AIDS in Australia* (Sydney: Prentice Hall, 1992) 73 at 80.

In any case, it may be that renewed interest will now be taken in policies and programs which seek to prevent the spread of HIV. As the circumstances in which the vast majority of new infections occur involve 'consensual' behaviour, strategies to limit the spread of the virus must incorporate one or more of the following:

(a) Changing the behaviour of the uninfected so that their risk of infection is reduced or eliminated.

(b) Changing the behaviour of the infected so that the risk of their infecting others is reduced or eliminated.

(c) Removing the infected from contact with the uninfected in circumstances which would allow new infections to occur.

The last strategy clearly involves civil liberties and due process concerns. Legal issues also arise in the former two strategies, particularly regarding sexual practices and injecting drug use. In the past the law has also been readily, and uncritically, enlisted as an instrument of public health policy to control a range of diseases, and today HIV is no exception. Given the scepticism with which previous public health campaigns to control the spread of diseases are now viewed, we should be equally sceptical of current policies and proposals, especially where coercion is threatened and the curtailment of human rights is proposed.

The role of the law in HIV containment is controversial, yet for the most part the various legal positions were established relatively early in the history of the epidemic. Once a test

for HIV antibodies became available in 1985 opinion quickly divided, for example, over such issues as compulsory testing, compulsory contact tracing and isolation of the infected. Although 'public health' powers to test for HIV antibodies and to quarantine the infected were available in many jurisdictions, this option has not been generally pursued against other than a few individuals who were perceived to require some form of restraint. Even in these cases it is suggested that the primary reason for their detention was the need to be seen to be taking some definite action once the issue had received widespread media attention, rather than any real conviction that such detention would impact significantly on the spread of HIV infection.

This restraint in the exercise of 'public health' powers has not been mirrored in the domain of the criminal law. Some Canadian judges have been willing, in the name of deterrence, to incarcerate for substantial periods people accused of putting others at risk of HIV infection, even where no such infections resulted. There thus appears to be a contradiction in our HIV prevention policies. On the one hand public health officials caution against overzealous application of public health laws, while on the other there has not been a similarly coordinated and proportionate response from the criminal justice system. The Canadian and Australian experience in this regard will be explored more fully below.

Certainly more relevant to HIV prevention have been education programmes regarding safe sex and safe injecting drug use. In this context, legal questions have arisen regarding

censorship and the use of public funds to 'promote' illegal or 'immoral' activities.[6] It is beyond the scope of this paper to consider comprehensively the legal issues arising around the issue of education. These examples are given at this point merely to demonstrate the intimate connection between the law, public policy and all aspects of HIV prevention.

1.3 Terminology

Language is of its nature political, and the choice of terminology here will reflect a particular position in relation to the subject matter. I have tried to use neutral (non-judgmental) terms in relation to injecting drug use, commercial sex work, and sexual practices, preferences and orientations. Hence the phrase 'injecting drug user' (IDU) is used in preference to the pejorative and inaccurate 'intravenous drug abuser.'[7] Nonetheless 'homosexual' is used in place of the more accurate, but unwieldy, phrase 'men who have sex with men' which is used in some literature and which better reflects the diversity of male sexual behaviour. The word 'gay' denotes an identifiable community or political movement (the 'gay movement'), or men who identify with that community or

---

6 For example, the *Law Reform (Decriminalisation of Sodomy) Act 1989* (WA) s.23 provides: 'It is contrary to public policy to encourage or promote homosexual behaviour and the encouragement or promotion of homosexual behaviour shall not be capable of being a public purpose.'

7 The term 'intravenous' is underinclusive as there are other drug injection practices, such as the non-intravenous injection of steroids and of amphetamines, which also carry the risk of HIV infection if clean injection equipment is not used.

movement.[8] It is not synonymous with 'homosexual' or 'men who have sex with men'.

The term 'HIV disease' is used in preference to 'AIDS' because it is now believed that most people with even asymptomatic HIV infection are, in fact, ill. AIDS is now increasingly seen as the end stage of the continuing depletion of the immune system which is believed to result from infection with HIV. Nonetheless, it is appropriate to speak of an 'AIDS epidemic' when referring to the scope of the disease caused by this immune deficiency. In this sense there are two 'epidemics' - the visible AIDS epidemic and the 'invisible' HIV epidemic. Examples of legal issues arising from the latter include testing, contact tracing, HIV reportability, and managing the non-compliant HIV positive individual.[9]

In addition to those *infected* with HIV, it may be said that all of us are *affected* by this illness, in the sense that none of us will see the elimination of the disease in our lifetimes, and all of us will witness and be part of the consequent international, regional, societal, and personal devastation that the virus is wreaking throughout the globe. The phrase

---

8 See Watney S., "The Possibilities of Permutation: Pleasure, Proliferation, and the Politics of Gay Identity in the Age of AIDS" in Miller J., ed., *Fluid Exchanges: Artists and Critics in the AIDS Crisis* (Toronto: University of Toronto Press, 1992) 329 at 332.

9 These four issues were identified for discussion at a Satellite Conference on "HIV/AIDS and Public Health Policy Issues" at the 7th Annual British Columbia AIDS Conference on 23 October 1993 in Vancouver, British Columbia. The Conference followed a series of national and regional workshops for public health professionals in 1991-92. This process is reported in *HIV & AIDS: A Public Health Perspective* (Ottawa: Canadian Public Health Association, 1993).

'those most affected by the disease' is sometime used to refer to the communities or sub-populations which bore, and continue to bear, the brunt of HIV infection or the tide of fear and prejudice that accompanied it. These 'communities' or sub-populations include homosexual and bisexual men, injecting drug users, haemophiliacs, sex workers and some ethnic minorities.

1.4 Conceptions of HIV disease

Writing in 1987, and drawing on another's insight into another epidemic, Douglas Crimp offered the following challenging statement in relation to the social construction of 'AIDS:'

> "I assert, to begin with, that 'disease' does not exist. It is therefore illusionary to think that one can 'develop beliefs' about it to 'respond' to it. What does exist is not disease but practices." Thus began François Delaporte's investigation into the 1832 cholera epidemic in Paris. It is a statement we may find difficult to swallow, as we witness the ravages of AIDS in the bodies of our friends, our lovers, ourselves. But it is nevertheless crucial to our understanding of AIDS, because it shatters the myth so central to liberal views of the epidemic: that there are, on the one hand, the scientific facts about AIDS and, on the other hand, ignorance or misrepresentation of those facts standing in the way of a rational response. I will therefore follow Delaporte's assertion: AIDS does not exist apart from the practices that conceptualize it, represent it, and respond to it. We know AIDS only in and through those practices. This assertion does not contest the existence of viruses, antibodies, infections, or transmission routes. Least of all does it contest the reality of illness, suffering, and death. What it *does* contest is the notion that there is an underlying reality of AIDS, upon which are constructed the representations, or the culture, or the politics of AIDS. If we recognize that AIDS exists only in and through these constructions, then hopefully we can also recognize the imperative to know them, analyze them, and wrest control of

them.[10]

The first part of this paper discusses some of these constructions. Is our experience of HIV disease best characterized as an epidemic (or pandemic)? Or, in Canada and Australia at least, and in many other Western countries, as the anticipated spread of HIV into the 'white', 'heterosexual', 'middle classes' has not for the most part eventuated, will HIV disease be popularly reconceived as an endemic condition of the poor and otherwise alienated? What will be the consequences for legal policy?

Then again, how appropriate is our conception of HIV as an 'infectious', or 'contagious', or 'communicable' disease, when the modes of infection (excluding vertical transmission and through infected blood products, organ transplant or artificial insemination etc) generally require a conscious (if not 'consensual') act of unprotected sexual intercourse or unsafe needle use.[11] In this sense, is HIV disease more similar to smoking-related cancer, or obesity-related heart disease? If this is the case, will the same arguments for imposing a disproportionate financial burden on those who apparently 'wilfully' damage their own health appear in relation to the costs of treating HIV disease? Further, the law has been

---

10 Crimp D., ed., "AIDS: Cultural Analysis/Cultural Activism" (1987) 43 *October* 3; reprinted (Cambridge, Mass.: MIT Press, 1988).

11 Proponents of this 'lifestyle' model of infection do not generally emphasize the complicating psycho-social factors which determine behaviour in particular circumstances. The 'choice' to have unprotected sexual intercourse may be seriously constrained for young women of colour. Similarly, the 'choice' to share injection equipment will be determined in part by the legality of the activities and the simple availability of alternative, sterile equipment.

used in the name of public health to enforce the wearing of seat-belts and the age above which, and the circumstances in which, people can drink alcohol and smoke tobacco. Will we see specific criminal or regulatory laws tailored to curb the sexual transmission of HIV?

The characterization of HIV disease as a 'voluntary' condition would be regarded by most people working in the field of public health as a gross simplification. However, the shift in the perception from HIV disease as a pandemic which threatens everyone, to a disease of lifestyle, is accompanied by the notion that HIV disease, like smoking-related cancer, is here to stay, and that we can at best reduce, but not eliminate, HIV transmission. There are clear parallels with the failure of the criminalization of alcohol sale under Prohibition, contrasted with the contemporary harm reduction approach to alcohol-related sociopathology and health problems.[12]

Globally, not everyone affected by HIV disease is even aware of it as a discrete cause of illness and death. For millions of people affected by HIV in communities where even a minimum of modern health education or care has never been widely available, death due to HIV-related malnutrition or pneumonia would be indistinguishable from such a loss resulting from a gamut of similar illnesses affecting that community. In this sense only those who have named the disease can perceive it. Joseph notes that only the most

---

[12] The inappropriateness of the criminal law has also been recognized, for example, regarding teenage tobacco smokers or teenage pregnancy.

modern technology has enabled us to identify the virus believed to cause the disease, and to develop relatively cheap and accurate tests to detect this virus. In this sense, 'it could have been worse' if HIV had appeared even twenty years earlier.[13] These varying conceptions are explored in greater depth below.

Since 1981, when the end-stage of HIV disease was first identified as a discrete condition, first as 'GRID' ('gay related immuno-deficiency'), then as 'AIDS' (acquired immune deficiency syndrome'), perceptions and conceptions of the disease have undergone significant, identifiable shifts. The early, and in some quarters continuing, characterization of the disease as punishment by God or Nature for sin or lifestyle will not be discussed further here. There are nonetheless different ways in which HIV disease has been and is being be viewed in the context of particular communities or sub-populations. These different views determine greatly the public health and legal responses to the disease. The following discussion examines further these differing conceptions of HIV disease and the ensuing responses to them. The first two conceptions provide a macroperspective on the disease, irrespective of its mechanism of transmission. The third challenges comparisons with previous epidemics, offering another perspective to the traditional view of HIV as an infectious disease.

---

[13] Joseph, *supra* note 2 at 11.

1.4.1 Epidemic Model

HIV disease was first identified in the United States as an illness of homosexual men, and was also quickly characterised as an illness of injecting drug users, Haitian immigrants and haemophiliacs. Thus the initial, comforting identification of the illness with 'the other', the foreigner (Africans and Haitians), the morally defined 'deviant' (homosexuals, injecting drug users and prostitutes) and the 'already damaged' (people with haemophilia).'[14]

In 1987, the World Health Organization (WHO) identified three distinct epidemiological patterns of HIV transmission in different countries: the "Western" pattern (Pattern I) in which AIDS appeared primarily in homosexual and bisexual men; the "Third World" pattern (Pattern II) in which HIV was overwhelmingly transmitted through heterosexual sex and from infected women to their infants; and an intermediate pattern (Pattern III).[15]

However the characterization of pattern of transmission by country represented a gross oversimplification. As Mann et al noted in 1992, 'In one large metropolitan area in the United States, Dade county, Florida (in which Miami is located), at least five distinct

---

[14] See Aroni R., "Looking at the Media" in Timewell et al, eds., *supra* note 5, 125 at 139.

[15] Mann J., Tarantola D. & Netter T., *AIDS in the World* (Cambridge, Massachusetts: Harvard University Press, 1992) at 15-17.

subepidemics of HIV/AIDS are now under way"[16] Thus the subepidemic amongst the subpopulation of homosexual men has a separate dynamic from the subepidemic amongst injecting drug users, and so on. The authors note that the WHO approach thus has limited usefulness now, but at the time emphasized AIDS as a global phenomenon and hence a global problem. They propose a new global geography of HIV/AIDS based on epidemiological factors, operational/programmatic factors and societal factors.[17]

Even if the conception of the disease as an epidemic remains, the fact that it is increasingly perceived as confined to certain communities and sub-populations will affect responses to it. Writing of the U.S. situation in 1992 Joseph noted:

> The most immediate consequence of the epidemic's probable future track is that public attitudes will very likely shift back again to the alienated us/them perceptions of the early 1980s. As middle-class society, especially outside the big cities, begins to view the HIVirus *[sic]* as posing little personal threat of infection, society may react with both (1) increasing discrimination against homosexuals and minorities seen as vulnerable to AIDS, and (2) increasing political reluctance to support public funding for research, treatment, and other needed services.[18]

In this sense the perception of those at risk is coming full circle. In Australia, Canada and many other Western countries where the incidence of HIV infection continues to occur

---

16 *Ibid.* at 3.

17 *Ibid.* at 24. This 'holistic' global geography of HIV/AIDS represents in itself the tension between those who want to conceptualize and organize AIDS as a 'health issue' and those who see AIDS more broadly as a 'development' issue. See O'Malley J., "The Representation of AIDS in Third World Development Discourse" in Miller, ed., *supra* note 8, 169 at 171.

18 Joseph, *supra* note 2 at 37.

primarily as a result of sex between men, Altman noted in 1992 that

> ...the gay movement has had to argue simultaneously both that AIDS is and is not a gay disease: the former to prevent inaccurate and misleading assumptions, the latter to maintain access to resources and attention.'[19]

Watney has noted that in all of the Western countries where over 80% of the reported incidence of (new) HIV infection is attributable to sex between males, government funding of programmes to educate this group has never exceeded more than 5% of the total HIV/AIDS education budget.[20]

1.4.2 Endemic model

The view of HIV disease as a plague is being challenged by another, possibly even more frightening, conception of HIV disease as an endemic, chronic illness. In 1992 Fee & Fox noted:

> In the early 1980s most accounts presented AIDS as a radical break from the historical trends of the twentieth century, at least in the industrialized nations: a sudden, unexpected, and disastrous return to a vanished world of epidemic diseases. ...Debates about how to respond to the epidemic reinforced the belief that AIDS was discontinuous with the recent past. Oversimply, these were arguments between alarmists on the one hand and advocates of equanimity on the

---

[19] Altman D., "The Most Political of Diseases" in Timewell et al, eds., *supra* note 5, 55 at 68.

[20] Watney S., "Imagine Hope: Gay Men and the Epidemic" (Address to Concordia University, Montreal, 24 September 1993)[unpublished].

other.[21]

In an observation which should serve as warning to those who urge us to heed 'the lessons of history' Fee & Fox note the importance of considering the particular perspectives of those who wrote the lessons of history that we are urged to consider:

> ...[B]ecause the history of visitations of plagues was the only history that appeared relevant to the new epidemic, most people ignored the alternative historical models that were available. For example, most of those who used historical analogies avoided the most pertinent aspects of the histories of veneral *[sic]* disease and tuberculosis, emphasizing issues of surveillance and personal control policy and ignoring the problems of housing, long-term care, public education, and the financing of palliative care for people suffering from chronic infections. Tuberculosis and venereal disease had been for many years, both endemic and intractable. For individuals, they were chronic, debilitating conditions; lifetime burdens. For the people who provided and paid for health services, these diseases were characterized by a few acute episodes and long periods when patients required no care or only supportive care. For public health officials, venereal disease and tuberculosis raised difficult problems about surveillance, public education, and the long-term control of noncompliant patients. ...It may well be horrifying to realize that AIDS is fitting our patterns of dealing with chronic disease, since it puts the problem into a long-term perspective. But if we assume that the rate of HIV infection will continue for the 1990s much as it did for the 1980s; if we assume that, as with cancer, most treatments will prolong life rather than cure the disease; if we assume that scientific research will continue to expand our knowledge rather than soon provide a means of prevention or cure; and if we assume that we will continue to respond to AIDS through the provision of specialized hospital units, long-term care, and other institutional services, we must also conclude that we are dealing not with a brief, time-limited epidemic but with a long, slow process more analogous to cancer than to cholera.[22]

Fox notes that in the U.S., the re-conceptualisation of HIV disease as a chronic, endemic

---

21 Fee & Fox, eds., *supra* note 5 at 3.

22 *Ibid.* at 4-5.

disease of first-world minorities and third-world states, rather than an epidemic which threatens the white, the heterosexual, the powerful, has implications for four areas of policy: surveillance, prevention, research and financing.[23] Fox suggests that surveillance measures are consequently becoming more aggressive, and less responsive to the concerns of civil libertarians and advocates for minority groups. This has clear implications for the kind of coercive measures that might be proposed, and imposed.

The *New York Times* provides a contemporary example, calling for the notification of persons testing seropositive in certain sentinel testing programmes.[24] All new-born babies are tested for HIV in New York State. This testing is done anonymously and without the consent of the parents. A positive HIV antibody test in the baby indicates that the mother is infected, but neither the parents nor their doctors are informed for ethical reasons (as no consent was obtained prior to testing), and the results are not linked to specific babies. In an editorial that would appear to reflect the trend Fox is anticipating, the *New York Times* observed:

> Each year in New York State some 200 or more newborn babies infected with the AIDS virus leave the hospital without anyone lifting a finger to identify them or care for them. The babies receive no special treatment for their infections until, months or years later, they develop the first symptoms of their fatal affliction.

---

23 Fox D., "The Politics of HIV Infection: 1989-1990 as Years of Change" in Fee & Fox, eds., *supra* note 5, 125 at 134.

24 Sentinel HIV testing is the anonymous testing without consent of body fluids, usually blood taken for other purposes. Sentinel testing programmes are regarded as important for epidemiological purposes, and it is a fundamental precept of such programmes that the results are de-linked, i.e. unable to be traced back to the individual 'donors.'

> How could this happen in a supposedly enlightened community? The answer is not callousness or carelessness. The neglected babies are simply the price knowingly paid for what is perceived as the greater good - protecting the privacy of the mothers and thus enhancing the likelihood that mothers will voluntarily cooperate with the health system, not only in fighting AIDS but in improving overall family health. No doubt privacy is vital for many AIDS campaigns. But in applying it to newborns, the experts are following their theology over a cliff, dashing the prospects for babies who desperately need help...[25]

It is likely that most of the women who are identified in this way would be injecting drug users, their partners or women of colour. A change in the law to require them to be given the test results would effectively be compulsory HIV testing, as few would be able to seek hospitalization outside of New York State to avoid the requirement.[26] While using the image of the defenceless new-born baby, the *New York Times* is actually calling for the compulsory testing of a particular sub-population, a public health strategy that was rejected early in the epidemic as an unacceptable intrusion on civil liberties, as well as counter-productive in terms of limiting the spread of HIV.

Finally, it is worth noting that for people with HIV infection, HIV disease can only be a chronic, rather than acute, illness if the drugs necessary to control opportunistic

---

25 "AIDS Babies Pay the Price" *New York Times* (13 August 1993) A26. The editorial notes the introduction of a bill in the State Assembly which would require that test results on newborns be given to the parents.

26 'Compulsory' and 'mandatory' HIV testing have been usefully distinguished. Compulsory testing is used here to mean testing imposed without choice, often by law. Mandatory testing (and a negative result) may be required as a prerequisite for a particular position or service. See Flanagan W., "AIDS-Related Risks in the Health Care Setting: HIV Testing of Health Care Workers and Patients" (1993) 18 Queen's L.J. 71 at 76.

infections such as *pneumocystis carinii* pneumonia are available. In the absence of appropriate, and often expensive, drugs for prophylactic or acute treatment, early mortality will result. Hence the conception of HIV disease as a chronic disease is only appropriate where those infected have access to either universal health care or some other form of health insurance.

1.4.3 Behavioral model

Pickett and Hanlon, the authors of a standard text on public health, reiterate several commonly acknowledged reasons why the HIV epidemic, as it has been measured through the incidence of AIDS, has several characteristics that make it unlike other plagues in history:

* those infected are primarily young adults, and remain permanently infectious throughout their lives, even when they appear well;
* the disease is heavily biased towards stigmatized groups in society, confounding the discussion of interventions;
* the 'epidemic' may be better characterized as a series of discrete epidemics, each with its own characteristics; and
* the probabilistic nature of the risk, compared with other diseases such as addictions, lung cancer and obesity where the risk of developing the disease increases with cumulative exposure.[27]

---

[27] Pickett G. & Hanlon J., *Public Health: Administration and Practice*, 9th ed. (St Louis: Times Mirror/Mosby College Publishing, 1990) at 285-6.

This perspective emphasizes that HIV infection for the most part results from 'behavioral patterns', which necessarily involve individual decision-making.

> ...[T]he AIDS epidemic... is far better understood from the perspective of a behavioral model than an infectious disease model. It is also clear that, at least for the moment, a thorough understanding of such a behavioral paradigm offers the best basis for a strategy to control the epidemic... This becomes particularly clear if one looks at the disease on a global basis, examining both the demographic and the social patterns of who became involved as it emerged indifferent countries.... What is evident from all the data that have been gathered around the world is that AIDS is, under ordinary circumstances, a poorly transmitted disease of low infectivity. What is vital for its evolutionary success are what might be called "augmenting behavioral scenarios"... [U]nderstanding in detail these behavioral processes will be vital in determining whether we can control this epidemic.'[28]

Although the focus of this paper is on sexual transmission, the above analysis is equally applicable to the transmission of HIV through shared injection equipment. The danger of the behavioral model is that it invites simplistic solutions and 'victim blaming'. With its focus on intimate personal decisions about sexual and drug taking practices, it is easy to ignore the wider social context in which these practices take place. Yet it is at this level of individual behaviour that the criminal law and much public health law operates. Human behaviour in such circumstances is very complex. For example, what is a court to make of a defence that the accused indeed knew he was HIV positive, but was in a state of 'denial'? What level of *mens rea* should be required and how can a court be satisfied that it has been proved?

---

28 Bourne P., "The Behavioral Aspects of AIDS: An International Perspective" in Temoshok L. & Baum A., eds., *Psychosocial Perspectives on AIDS: Etiology, Prevention, and Treatment* (Hillsdale, New Jersey: Lawrence Erlbaum Associates, 1990) 167 at 167-171.

1.5 The need for an interdisciplinary approach

Because the challenges of HIV disease cross so many disciplines, much has been written about HIV prevention from a variety of perspectives. Many of these issues are highly complex, and demand an interdisciplinary approach, yet it is not uncommon to find people with no background in criminology or penology making simplistic and unrealistic assumptions, for example, about the deterrent value of incarceration. Similarly, courts have imposed heavy prison sentences for behaviour which in reality posed no threat of HIV infection.[29]

Fee & Fox note the range of different disciplines now writing their own 'truths' about HIV disease and warn:

> Although contemporary historians may disagree about what stance to take on particular theoretical issues, most would, we believe, urge their colleagues in other disciplines to pay more attention to three issues.... The first issue is social construction: the claim that historical reality does not exist as a truth waiting to be discovered, but, rather, is created by people. ... For contemporary history, social constructionism means an emphasis on the complex processes by which disease is negotiated, the ways in which our concepts of pathology are defined and redefined, and the ways in which these conceptions of disease in turn govern our

---

[29] A complicating factor in some jurisdictions is that a charge of attempt can be sustained if the court is satisfied that the accused *believed* the harm would result, even if it was virtually impossible to transmit the virus in the manner alleged. Convictions for attempted murder in cases of spitting or biting nonetheless send the (erroneous) message that HIV transmission is realistically possible in this way.

changing social and medical responses to illness.[30]

In this chapter, the social construction of HIV disease has been noted through the different writings of various commentators, each party to their own particular perspective.

> A second issue for historians is skepticism about the ideas of progress. Skeptical historians worry about pseudo-causal statements that substitute metaphors for data-driven analysis of why events occurred and in what direction history (reified) is tending. Pseudo-causal statements are often driven by organic metaphors ("evolve," "develop," "unfold," "mature"). Skeptics also try to look behind polite synonyms for social or medical progress ("advance" is the most common of these synonyms) and to examine instead who did what to, for, or with whom, with what documentable results.[31]

This warning is apt in the consideration of the metaphors used to describe public health actions taken in relation to HIV disease. For example, if the dominant metaphor is one of warfare, it is easier to justify the kinds of infringements of human rights (e.g. internment) that occur in times of war.

The brief accounts of the 'history' of public health that preface calls for 'traditional public health measures' in response to HIV disease are possibly the most blatant examples of the uncritical adoption of received truths in relation to the recent control of epidemic diseases. The following chapter will examine in greater detail the traditional model of public health and various accounts of its accomplishments.

---

30 Fee & Fox, eds., *supra* note 5 at 9.

31 *Ibid.*

> A third theoretical issue is wariness about presentism; that is, distorting the past by seeing it only (or even mainly) from the point of view of our own time... The desire for "lessons from history," while generally welcome, must be treated with caution and laced with an awareness of the problems of extrapolating from one historical context to another... Among people who write about contemporary events, historians are almost alone in asking what has been left out.[32]

Watney, who trained as an art historian, is very clear about what has been left out of many mainstream accounts of the response to HIV disease over the last 12 years. He identifies the extraordinary response of the international (Anglophone) gay community as the most significant omission. He also notes the downplaying of the early successes of community-initiated prevention campaigns and the general failure of state educators to liaise with their community-based colleagues in developing prevention campaigns.

Given the multiplicity of mini-epidemics in many regions and the singular successes of peer-based education, which entail programs tailored to the particular communities at risk, it is unlikely that any one prevention program or strategy will have the desired impact. For example, in areas of low seroprevalence, an active voluntary contact tracing program may be a productive option. In communities with high seroprevalence, it is not.

It is also clear that proposed approaches to HIV disease carry with them the accumulated baggage of both the past experiences with infectious diseases and the general loathing of

---

[32] *Ibid.* at 9-10.

the state by the sub-populations most affected by them.[33]

Watney notes that policy approaches to HIV, in common with all other such issues, are never value-free:

> From very early on in the epidemic, Aids *[sic]* has been mobilised to a prior agenda of issues concerning the kind of society we wish to inhabit. These include most of the shibboleths of contemporary "familial" politics, including anti-abortion and anti-gay positions. It is therefore impossible to isolate the representation of Aids, or campaigns on behalf of people with Aids, from this contingent set of values and debates. Aids is effectively being used throughout the West to "justify" calls for increasing legislation and regulation of those who are considered to be socially unacceptable.[34]

Nor is it only in the West that there have been calls, for example, for the compulsory testing of perceived 'high risk groups' such as homosexuals and commercial sex workers, and the incarceration of the HIV infected. The following chapters will explore further the past, present and future nexus between HIV, the law, and 'public health.'

---

33 'The sensitivity of the black community to possible racial implications in the AIDS debate were heightened by deep suspicions of the government's concerns for minority health problems... The scars left by the Tuskegee experiment - in which United States Public Health Service physicians allowed black men with chronic syphilis to go without penicillin treatment for decades as part of a controlled study of the effects of such treatment and long after the medical benefits of penicillin in treating syphilis were clearly established - run deep in black consciousness.' Joseph, *supra* note 2 at 126.

34 Watney S., *Policing Desire: Pornography, AIDS and the Media* (Minneapolis: University of Minnesota Press, 1987) at 3.

2 Public health and the state

2.1 Introduction

In the name of 'public health', states reserve extraordinary legal powers to test, treat and detain individuals infected, or suspected of infection, with certain diseases.[1] Even the criminal and penal laws do not grant such extensive powers to agents of the state. Further, these powers have been regarded as legitimate exceptions to otherwise inviolable principles of human rights. The *International Covenant on Civil and Political Rights* acknowledges, for example, that the right of liberty of movement is subject, *inter alia*, to legal restrictions necessary to protect public health.[2]

This chapter discusses the early and contemporary development of public health policies, as understood by writers on the subject.[3] Specifically, early definitions of 'public health' are

---

1 E.g *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7, s.22 provides that under certain circumstances a medical officer of health may require a person to take or refrain from taking any action in respect of a communicable disease.

2 *International Covenant on Civil and Political Rights*, 16 December 1966, U.N.T.S. vol. 999, p.171, art. 12(3). See the Syracuse principles on the limitation and derogation provisions in the Covenant, Annex to U.N. Doc. E/CN.4/1985/4, September 28, 1984.

3 Writers on public health in a range of countries are cited; U.K. and U.S.A.: White, K.L. *Healing the Schism: Epidemiology, Medicine and the Public's Health* (New York: Springer-Verlag, 1991), Fee E. & Acheson R., eds., *A History of Education in Public Health* (Oxford: Oxford University Press, 1991); nineteenth century Germany: Kroeger G., *The Concept of Social Medicine as Presented by Physicians and Other Writers in Germany, 1779-1932* (Chicago: Julius Rosenwald Fund, 1937).

examined. The importance of epidemiology as the basic tool of public health policy is noted. Then follows a discussion of the 'paradigmatic shift' in perspective which followed the articulation of the 'germ theory' of disease. The consequent 'schism' between public health and clinical medicine is then noted. This schism is important because the ascendancy of the clinical medical model, with its focus on the individual patient, is also reflected in the focus on the individual offender in the criminal justice system.

Some factors affecting public health policy are discussed. Three models of intervention are noted. Finally, recent developments are examined, including a broader definition of 'health' and the development of the new 'healthy public policy.'

The theme of this chapter is the responsibility of the state for the health of the public. Consequent upon this is the recognition of the multi-sectoral nature of effective public health policies and programs. At this stage no distinction is made between legal regulation within the particular domains of the public health or the criminal law. This distinction is explored in later chapters.

2.2 Early conceptions of public health

Any discussion of public health begs a definition of 'health' itself. In early times, it appears that health meant simply the absence of disease. The suggestion that the state should be generally

concerned with the welfare of its citizens was at one time a novel notion. Other than in the case of epidemics which threatened the wealthier classes, it was not at all evident that the privileged should be concerned with the ill health of the poor, which was variously ascribed to laziness, and poor breeding etc. Early reformers appealed to religious principles, nationalism, commercial interest, fear of infectious diseases, and philanthropy to stir the wealthy into action.

An account of the early public health movement by K.L. White is considered in detail here because the tensions he identifies appear particularly relevant to aspects of HIV public health policy today.[4] One example is the tension between the narrow focus of medical science on HIV, and a broader study of the behavioral and environmental factors that lead to infection.

Although lacking the scientific basis of policies today, actions to promote and protect the health of the public date back many centuries. White notes that Abbé Claude Fleury (1640-1723), a lawyer, ecclesiastical historian and a founder of the social hygiene movement

> ...argued with considerable specificity for the expansion of government's role in human affairs. ...[including] the need for adequate provision of food, clothing, housing, and buildings, and the importance of an aesthetically pleasing appearance to the environment.[5]

The following definitions of 'public health', both modest and expansive, have been proposed:

> [Public health is] ...[t]he application of scientific and medical knowledge to the

---

[4] White, *ibid.* Other accounts of the public health movement do not deny these tensions, but rather emphasize other aspects, such as developments in methodology, and successes and failures in relation to particular diseases.

[5] *Ibid.* at 39.

protection and improvement of the health of the group.[6]

The mission of public health is 'fulfilling society's interests in assuring conditions in which people can be healthy.'[7]

...[P]ublic health seeks to ensure the conditions in which people can achieve physical, mental and social well-being.[8]

Public health is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.[9]

The last definition reflects an equally expansive view of the role of the physician at the time. A prominent nineteenth century physician and social reformer, Rudolf Virchow, wrote in 1848: "The physicians are the natural attorneys of the poor and social problems belong in their jurisdiction."[10] Kroeger discusses Virchow's view of 'public health' as presented in Virchow's

---

6 Brockington F. *World Health*, 2d ed. (Boston: Little & Brown, 1968) at 131 in White, *ibid* at 1.

7 Institute of Medicine, *The Future of Public Health* (Washington, DC: National Academy Press, 1988) at 6 in White, *ibid* at 5.

8 Mann J., Address (First International Conference on Health and Human Rights, Harvard School of Public Health, 22 September 1994) [unpublished].

9 Winslow, Charles-Edward A. (circa 1920) cited in Fee E. & Porter D., "Public Health, Preventive Medicine and Professionalization: Britain and the United States in the Nineteenth Century" in Fee and Acheson, *supra* note 3 at 32-33 [footnotes omitted].

10 Virchow R., (1848) 1 *Medizinische Reform* cited in Kroeger, *supra* note 3 at 10.

short-lived journal, *Medizinische Reform:*

> In a series of articles entitled "Public Health" (Die Oeffentliche Gesundheitspflege), Virchow discussed the relations of medicine to social problems. He regarded it as one of the functions of public health to inquire into the living conditions of the various social groups. But, he concluded, because such an inquiry was a duty of public health, it should also be its privilege to have a deciding voice in the determination of methods intended to remedy conditions...
>
> Health should be the natural property of every individual. Virchow declared that the protection of this property was a logical consequence of the principles of democracy. He believed it to be the duty of society to guarantee the right of the individual not only to an existence under conditions which make for health. But he did not wish to make the state responsible for everything. He distinguished between health and disease of one individual and that of groups. Conditions pertaining to one person and controllable by him were to remain within his jurisdiction, while society, i.e., the state, was to assume the responsibility for those conditions which arise when people live together in groups.[11]

Broad in scope, the early conceptions of public health and the role of the state all embraced a wide range of social and environmental factors. White notes:

> Most definitions also include the notion of organized collective action for removing or altering factors affecting all citizens within some geopolitical jurisdiction. These factors usually are outside the capacity of the individual citizen to control or eliminate; they affect all those exposed without regard to individual differences and preferences. To address the problem effectively requires collective action for the "public good" or to further the "community's interest," in contrast to individual action required to achieve a "private good" or pursue a "personal interest," for example, in altering dietary habits or seeking personal medical care. The notions of sanctions, penalties, and restrictions on individual freedom in the interests of societal benefits permeates discussions, standards, regulations, and legislation.
>
> At a more abstract level, the prevailing reference body is usually a general population. Specifically designated subsets or groups, however, such as children, the homeless, migrants, or rural peasants, frequently are the focus of attention in contrast to an individual patient or citizen. The central idea is of organized, collective, and public action to remove or control those precursors of disease or impediments to well-being

---

[11] Kroeger, *supra* note 3 at 11 [footnotes omitted].

affecting all citizens or substantial subgroups.[12]

It is noteworthy that public health programmes are regarded as being undertaken for the benefit of society, not the individual. Thus, it would appear, it is the benefit to society rather than the individual that would justify a campaign to improve dietary habits and hence avoid obesity and coronary disease. In economic terms, particularly in those states with state-funded health care services, there are clear benefits in reduced demands on health care systems and extended periods of productive, tax-paying life.

However, once these economic arguments are admitted, the boundary between the public and private good is no longer clear. It may be argued that all individual ill health is in some sense a burden on the state. For example, one incident of HIV infection may cost the state hundreds of thousands of dollars in terms of medical and related expenses, loss of investment in education and training, and loss of production and taxes. Thus it could be reasoned on economic grounds alone that every aspect of the health of the individual is the legitimate interest of the state and hence within the domain of public health. The definition of 'health' becomes crucial: the broader the conception of 'health', the broader the legitimate interest of the state in the affairs of the individual.

White refers above to 'all citizens or substantial subgroups.' Strategies as disparate as ensuring a clean public water supply and the disclosure of an individual's HIV status to his or her sexual

---

[12] White, *supra* note 3 at 1.

partners have been identified as within the domain of public health. Yet the disclosure of a person's HIV status to his or her sexual partner could not ordinarily be said to be of benefit to a 'substantial subgroup' of the population.[13] Is the public health served by disclosure in every case?

Clearly, there must be limits on the intervention of the state in the name of public health. We should ensure that the public health mantle is not used to justify actions which do not in fact fall within the legitimate domain of public health. Otherwise we run the risk of diluting hard-won principles of human rights, or of discrediting other, legitimate, public health actions.

2.3 Role of epidemiology

The views of social reformers such Virchow in Germany, and somewhat later Winslow in the United States, would appear to have heralded an age of medical activism. Physicians, applying the public health perspective and perceiving that the eradication of most illnesses lay in improving the living conditions of the poor, would used their positions of privilege to effect the necessary social reforms.

---

[13] It may be argued that the long latency of HIV disease and its devastating impact on those infected distinguishes HIV from other agents of low infectivity. The subject of contact tracing and compulsory partner notification in the context of HIV infection has raised issues of confidentiality on the one hand, and a possible duty to third parties on the other. It is interesting to note that partner notification in these circumstances again focusses on the welfare of individuals, rather than the broader harm if the relationship of confidentiality between doctor and patient is ruptured.

However such medical activism on a broad scale did not eventuate. As medical education became increasingly regulated, the 'public health perspective' waned. Discussing contemporary medical education, White identifies as a major problem 'the failure by most physicians, in concert with many other health professionals, to understand or appreciate the population perspective.' White ascribes part of this failure a lack of adequate epidemiological training:

> ...the mother science of public health is epidemiology, i.e., the systematic, objective study of the natural history of disease within populations and the factors that determine its spread. ...Epidemiology is the 'glue' that holds public health's many professions together...[14]

Without such training it is difficult for medical practitioners to fully perceive the population-wide implications of the illnesses in the individuals they treat. Consider the crucial contribution of epidemiology to the identification and containment of HIV disease. Without the 'population perspective' provided, in this case, the by Centers for Disease Control in Atlanta, Georgia, the early isolated instances in 1981 of young men developing *pneumocystis carinni* pneumonia across the United States would have remained far longer only a medical curiosity and a personal tragedy. Through case analyses, and without any microbiological evidence, it was postulated that the causative agent (if it existed) might be sexually transmitted.[15] Epidemiologists also linked the first cases of AIDS in haemophiliacs and concluded that the

---

[14] Committee of Inquiry in to the Future Development of the Public Health Function, *Public Health in England*, (London: Her Majesty's Stationery Office, 1988) at 57 in White, *supra* note 3 at 15.

[15] See *Morbidity and Mortality: Weekly Report*, 5 June 1981, Communicable Diseases Center, Washington. The complex role of epidemiology can be further appreciated when it is recalled that HIV disease continued to be referred to as 'GRID' (gay-related immune deficiency) even after the first cases of HIV disease in women were reported.

disease could be transmitted through blood products. These advances, and the preventative measures proposed as a consequence, well pre-dated the discovery of HIV, the etiological agent believed to cause the disease.

The identification of causes of diseases is only one function of epidemiology. A broader function is the analysis of health needs of the population and of the provision, organization and evaluation of health services.[16] With HIV infection, as with other diseases, if the first goal of public health is the reduction of the net number of new infections, it is important that necessarily limited prevention efforts be targeted at the populations most at risk to ensure maximum effectiveness. [17]

If needed, such analyses can be used to provide economic arguments for specific interventions. The economic costs of disease and consequent benefits of prevention did not escape the early writers. White notes what might be considered eighteenth century cost-benefit analyses for medical intervention in specific diseases. Daniel Bernoulli (1700-1782), physician and mathematician, developed a formula for the estimation of the years of life added by vaccination against smallpox, and compared "the benefits and risks of a medical intervention for a specific

---

[16] See Committee of Inquiry in to the Future Development of the Public Health Function, *Public Health in England*, (London: Her Majesty's Stationery Office, 1988) at 57 in White, *supra* note 3 at 15.

[17] Note the observations by Watney, *supra* chapter 1 note 20 and accompanying text.

disease at both the individual and the population levels..." [18] Over a century later, Max von Pettenkoffer

> ...pointed out the monetary value of the time and the lives lost on account of illness. In this evaluation he included both loss of income and cost of medical care. He estimated the total number of sick people at a given time on a basis of sample studies and thus arrived at an estimate of the total problem of disease in a given community. By calculating the average duration of each case of illness, he attempted to shoe the total cost of sickness in a community.[19]

Such arguments may be made for greater intervention in relation to HIV disease. Measures to reduce the spread of HIV disease will be particularly cost effective as the disease largely affects younger men and women at what might otherwise be the most productive period of their lives.

A further example of early epidemiology was the 'proof' that treatment of illness by bloodletting was not only useless but often harmful.[20] Some 150 years later essentially the same reasoning was used to call into question over-optimistic assumptions about the efficacy of AZT in treating HIV disease.[21]

Hence a public health perspective, based on sound epidemiology, is essential to disease containment and eradication. Yet it appears that a development in medical science in the last

---

18 White, *supra* note 3 at 52.

19 Kroeger, *supra* note 3 at 20.

20 White, *supra* note 3 at 55.

21 See *supra* chapter 1 note 1 and accompanying text.

century 'derailed' this perspective, a blow from which public health, as a discipline, is only now recovering.

2.4 Paradigm shift

A paradigmatic shift occurred with Pasteur's articulation of a 'germ' theory of disease in 18??. While not denying the value of Pasteur's work in the control and in some cases elimination of diseases that killed millions, White observes:

> What Pasteur and his colleagues did was to demonstrate and then reify the link from the disease to the microbe while virtually excluding all other predisposing, proximate, precipitating, and perpetuating links or causes as they now began to be referred to in medical circles. ...For the ecological, even "holistic" paradigm that had guided the medicine and health enterprises heretofore, there was substituted a massive search and destroy mission directed at *the* causal agent associated with each disease. ...A monoetiological concept of causality ensued and was, of course, strongly supported by the expanding identification of even more microorganisms. ...The notion that there might be other approaches to health and healing came to be regarded as charlatanism; bacteriological orthodoxy became the dominating paradigm.[22]

White notes that these views were not unchallenged, and attributes to William Osler (1849-1919) the aphorism: "It is as important to know what kind of man has the disease, as it is to know what kind of disease has the man!"[23] Reportedly infuriated by the monoetiologists, Max von Pettenkoffer (1818-1901) sought to demonstrate that the presence of an infectious agent is not the same as the occurrence of disease:

> Pettenkoffer held that for a patient to become ill with cholera four conditions were

---

22 White, *supra* note 3 at 77-79.

23 *Ibid.* at 74.

essential: (1) a specific microorganism; (2) certain local conditions; (3) certain seasonal conditions; and (4) certain individual conditions.[24]

White reports that at the age of 74 von Pettenkoffer swallowed a vial of cholera vibrio, and survived, to make his point.

White notes:

> Until the latter part of the nineteenth century, most leaders of academic medicine and many members of the medical establishment had a broad view of their missions. These missions included both the care of individual patients and concern for unacceptable environmental and social conditions that endangered the public's health. During the previous three centuries, methods for investigating health problems in populations, when not originating with the work of mathematicians and statisticians, were developed by physicians, almost always clinicians. They evolved concepts and skills now subsumed under the rubric of *epidemiology* -"the study of that which is upon the people."
>
> With the advent of the "germ theory" of disease, medical academicians increasingly pursued the task of describing microorganisms while largely neglecting studies of the host and environment. Investigation in the bacteriology laboratory gradually dominated epidemiological studies in populations. When undertaken, population-based investigations focussed, quite reasonably, on the diseases of greatest prevalence and virulence at the time, infectious diseases. Epidemiology became virtually synonymous with bacteriology and bacteriology synonymous with biomedical science. Such was the specificity of the diseases associated with the growing number of microorganisms described that every "disease" was considered to have a single "cause," and that the cause was thought to be a microorganism.[25]

White suggests that the consequent failure to pay sufficient attention to the environmental and social factors in disease has offset many of the benefits of the advances in biomedical sciences.

---

24 *Ibid.* at 80.

25 *Ibid.* at 2.

He describes the development of a schism between those interested in these environmental and social factors, and those interested in biomedical science. In particular, he notes that "the narrowed mission of the medical school resulted in gradual abrogation of the social contract between the medical establishment - especially its academic component - and the public from which it derives its status."[26]

Fee and Acheson also note the 'schism' between public health and medicine and observe:

> The continuing struggle over the relationship of public health to medicine explains why so many terms have been used in the field, either to define public health or to indicate the specific contribution of the medical profession. Chadwick, the English pioneer, used the expression 'public health' and called the Parliamentary Act of 1848, of which he was the chief architect, the Public Health Act. 'Public health' clearly referred to the health of the public in broad terms and had no necessary connection to medical practice.... In contrast with the terms: public health; sanitary reform; sanitary engineering; sanitary science; and hygiene, others were specifically coined to stress the medical contribution to public health: state medicine; public health medicine; preventive medicine; social medicine; community medicine; and even clinical epidemiology...[27]

Fee and Porter note the practical consequences in public health policy of the new epidemiology:

> A new epidemiology developed, based on the new bacteriology, and like it, firmly orientated to the control of specific diseases. ... For example, Herbert Winslow Hill, director of the division of epidemiology of the Minnesota Board of Health "likened the epidemiologist to a hunter trying to find a sheep-killing wolf. The old fashioned amateur hunter covered the mountains with his assistants, and told them to follow all wolf trails until they found the one that led to the slaughtered sheep..."

---

[26] *Ibid.* at 3. Herein may lie the origins of the mistrust of the medical profession by marginalized groups such as sex workers, homosexuals and injecting drug users.

[27] Fee & Acheson, *supra* note 3 at 8 [footnotes omitted].

> The new epidemiologist, Hill argued, started with the 'slaughtered sheep' - the sick patient. From there, he traced back the single trail to the source of disease. All other unrelated environmental trails - decaying milk, flies in the market place, outdoor privies - were irrelevant.
>
> Hill explained that modern scientific methods were more efficient in the control of disease than old-fashioned approaches of social reform. To control tuberculosis, for example, it was not necessary to improve the living conditions of the 100 million people in the United States, only to prevent the 200 000 active tuberculosis cases from infecting others. He contrasted the expense and difficulty of trying to secure good food, decent housing, and safe working conditions for the entire population with 'the expense of supervision of two hundred thousand people *merely to the extent of confining their infective discharges*... Need any more be said to indicate the superiority of the new principles, as practical business propositions, over the old?'[28]

Consider these two approaches in the context of HIV disease. Under the former approach, HIV prevention would require the identification and control of the various factors which make people vulnerable to infection. The latter approach, as provided above by Hill, would require the identification and isolation of those infected, or at least those likely to spread the infection. It is suggested that exactly these two radically differing and antagonistic approaches to HIV prevention in fact characterize most HIV prevention programmes.

A particular corollary of Hill's approach is that public education regarding the modes of

---

[28] Fee E. & Porter D., "Public Health, Preventive Medicine and Professionalization: Britain and the United States in the Nineteenth Century" in Fee & Acheson, *supra* note 3, citing Hill, Herbert Winslow, *The New Public Health* (New York: MacMillan, 1916) at 19-20, at 35. However, although the narrow bacteriological view was dominant, the authors note there were several competing models for public health research and practice extant at the same time. Public health was characterized by a diversity of views and approaches. Compare, for example, Hill's narrow focus with the expansive gaze of Charles-Edward A. Winslow, a public health spokesman who would become head of Yale University's department of public health.

transmission is not the first priority of an HIV prevention campaign. Yet much of the early, and in some quarters continuing, fears of casual transmission and consequent discrimination against those thought to be infected stems from the failure to understand the precise, and highly limited, modes of HIV transmission.

Similarly, it can now perhaps be better understood why so much effort and funding has to date be focussed on the cause and cure of HIV disease, rather than preventing its spread. The latter course, in common with such investigations into, for example, work-related accidents and illness, would open up for reexamination a range of social relationships and realities.[29] These relationships and realities are difficult to discuss at the best of times. In the context of HIV infection, they are even less likely to be adequately addressed because they are outside the paradigm.

2.5 Other factors influencing public health policy

There is a complex relationship between science and epidemiology on the one hand and public health policies on the other. Early accounts of HIV disease in some African countries were denounced by their governments for fear that they would affect the tourist trade.[30] The placing

---

[29] As examples: the extent of commercial sex work and the clientele, male to male sex, injecting drug use, the sexuality and injecting drug practices of children, the sexual and general health of minorities, the failures of the criminal justice and penal systems, and of course White's favourite: the failures of tertiary medical education.

[30] See Caldwell J.C., Orubuloye I.O. & Caldwell P., "Underreaction to AIDS in Sub-Saharan Africa" *Soc. Sci. Med.* Vol.34 No.11, 1169-1182, 1992 at 1170.

of commercial interests above the public health is not without precedent. Beneson notes that although the etiological agent which causes cholera was postulated and identified in the mid-nineteenth century, it was not until 1892, some 39 years later, that the British authorities publicly accepted this theory:

> The British authorities insisted at the International Sanitary Conferences of 1874, 1881 and 1885 that cholera was not transmissible from man to man. This was the official British policy; it was clearly motivated because British commerce with her important colony would be seriously interfered with if the epidemiologic observation made by scientists from other European countries that the homeland of cholera was in India was generally accepted.[31]

A similar reluctance to embrace appropriate policies due to their negative financial impacts has been identified in the HIV-tainted blood product scandals now unfolding in various countries.[32]

In another example of the way in which economic interests can heavily influence health policy, Beneson notes how the fear of private legal action can hinder policy development. In particular, he notes that concerns by drug producers for legal liability led to the failure in the U.S. to distribute adequate supplies of a vaccine for a lethal influenza virus in 1976. These fears appear well-grounded, as following the commencement of the administration of the vaccine, more than 4,000 claims (many reputedly spurious) for over $3 billion were filed with the U.S.

---

31 Beneson A. "Infectious Diseases" in Levine S. & Lilienfeld A., eds., *Epidemiology and Health Policy* (New York: Tavistock, 1987) 207 at 210.

32 In Canada this issue is the subject of a Commission of Inquiry headed by Mr Justice Krever. A report is anticipated in 1995.

government. Yet health authorities had serious concerns that the virus could have been as virulent as the 'swine flu' virus which resulted in a world-wide pandemic of influenza in 1918-1919, killing an estimated 20 million people; 500,000 in the U.S. alone. Beneson notes the litigation over pertussis (whooping cough) vaccine has "caused vaccine producers to cease production because of the increasingly high cost of insurance... [while] the price of the vaccine has increased ten-fold."[33]

The above examples demonstrate that whatever perspective is adopted by public health policy makers, it does not necessarily follow that rational policies will be adopted. Levine and Lilienfeld offer a variety of reasons why rational policies grounded in sound epidemiology may be rejected by the legislature or other decision makers, or suddenly gain favour:

> Particular economic, political or ideological factors may stifle any policy reforms or, when circumstances are propitious, give birth to new specific regulations, laws or policies without any impetus from new epidemiological data. Changes in health policy, in turn, may determine the attention of epidemiologists. For their part, policy-makers may seek to justify their new policies by making use of established or "rediscovered" epidemiological findings. They may also support funding for studies that are likely to generate data that are relevant for the new health policies.[34]

It will be recalled that one characterization of HIV disease in certain populations is as an endemic chronic illness, similar in fact to 'lifestyle' induced coronary heart disease (CHD).

---

[33] Beneson, *supra* note 31 at 221. The fear of legal action will no doubt have a similar impact if and when a vaccine for HIV disease is developed, unless legislative or other protection is provided for those who would otherwise be the targets of such legal suits.

[34] Levine & Lilienfeld, eds., *supra* note 31 at 2.

Syme and Guralnik note that since the late 1950s, elevated serum cholesterol, hypertension and smoking have been recognized as major risk factors for CHD. However, they note that the same "facts" are often seen quite differently by people with different perspectives, experiences and priorities. They identify three differences in approach to policy formation: (a) differences in interpretation of evidence; (b) differences in emphasis on certain specific interventions compared to others; and (c) differences in whether interventions should be at the individual or community level.[35]

Their observations in relation to CHD prevention are relevant to HIV prevention. In particular, they note that lack of conclusive evidence often delays the implementation of otherwise sound policies.[36] An additional factor is the difficulty, within the scientific paradigm, of offering 100% guarantees. Brandt notes

> Despite significant evidence that HIV (human immunodeficiency virus) is not casually transmitted, medical and public health experts have been unable to provide categorical reassurances that the public would like. But without such guarantees, public fear has remained high. In part, this reflects a misunderstanding of the nature of science and its inherent uncertainty. While physicians and public health officials have experience tolerating such uncertainty, the public requires better education in order to effectively evaluate risks.[37]

---

35 Syme S. & Guralnik J., "Epidemiology and Health Policy: Coronary Heart Disease" in Levine & Lilienfeld, eds., *supra* note 31 at 99.

36 *Ibid.* at 101.

37 Brandt A. M., "AIDS in Historical Perspective: Fours Lessons from the History of Sexually Transmitted Diseases" 1988 78(4) Amer. J. Pub. Hlth. 367, at 368. For example, HIV has been found in the saliva of infected individuals. Despite the fact that there has been no recorded case of HIV infection from such saliva, scientists are reluctant to say this is an impossibility. Non-scientists may misinterpret this reluctance as a lack of confidence in

Levine and Lilienfeld also note that equal emphasis cannot be given to all possible policy interventions:

> In a disease such as CHD in which multiple risk factors have been demonstrated, decisions must be made as to how to distribute resources among them. While policy may not explicitly define which risk factors are the most important, resources allocations certainly reflect the risk factors that policy-makers feel should be pursued most intensively. Ideally, these policy-makers should take into account research findings concerning both the relative impact of each risk factor on the disease and our ability actually to alter those factors.[38]

The authors observe that physicians may chose to prescribe drugs to reduce hypertension, rather than address factors such as stress, physical activity and obesity, noting that such "psychosocial and behavioral risk factors may involve the need for major social changes - an area in which many physicians feel their intervention is inappropriate."[39]

The most significant lesson learnt from applying CHD reduction policy to HIV prevention may be the recognition of the fundamental inadequacy of the 'medical model' to cope with the scope of the problem. Levine and Lilienfeld note that the policies of identifying *individuals* at higher

---

assurances that no real risk exists. See also Burris S., "Fear Itself: AIDS, Herpes and Public Health Decisions" (1985) 3 Yale L.& P.R. 479 at 500.

[38] Levine & Lilienfeld, eds., *supra* note 31 at 101-102.

[39] *Ibid.* at 102-103. In the context of HIV infection, difficulties include for example, the acknowledgement of teenage sexual (and homosexual) and activity and drug use, and the power relationships which make it difficult for women to insist on condom use with their male partners, even where otherwise appropriate. Contrast this view of the physician's role with that of Virchow, *supra* note 10.

risk for disease and subsequently treating them by modifying the risk factors 'cannot alone have an important impact on the distribution of disease in the community as long as they are based on this one-to-one medical model' for two reasons: (a) the scope of the problem; and (b) the difficulties in achieving and maintaining appropriate behaviour change.[40] The authors note the sheer impossibility of providing sufficient physician-patient contact estimated to be necessary to effect a change in those currently at risk of CHD in the U.S.A., let alone those becoming at risk every year. In addition, they note that programmes designed to effect *individual behaviour change* in relation to smoking reduction and changes in diet have had little success:

> One of the major problems in these cessation programmes is that we have viewed these behaviours almost exclusively as problems of the individual. Thus, virtually all smoking cessation programs have been directed at the individual smoker. It is true that cigarette smoking is an individual behaviour: individuals begin to smoke, they become regular smokers, and they quit smoking. However, this behaviour occurs in a social and cultural context. Smoking behaviour is neither random nor idiosyncratic but exhibits patterned consistencies by age, race, sex, occupation, education, and marital status. By focusing on the individual's motivations and perceptions, we neglect some of the most important influences on this behaviour... (such as) the cultural associations between smoking and relaxation, adulthood, sexual attractiveness, and emancipation; the socio-economic structure of tobacco production, processing, distribution, and legislation; explicit advertising on the part of the tobacco industry based on cultural values that favor smoking; subtle but effective advertising by such influential persons such as film stars and TV personalities; and the influence of parents, siblings, peers, and significant persons.
>
> ...These circumstances provide a climate that encourages smoking and that makes it acceptable, easy, and convenient. Virtually all smoking cessation programs ignore these issues and focus instead on the individual, his beliefs, his habits, his perceptions and desires. It is perhaps not surprising that success rates in these programs are as low as

---

[40] *Ibid.* at 104-105. The authors cite Winkelstein, W. & Marmot, M. (1981) Primary prevention of Ischemic Heart Disease: Evaluation of Community Interventions. *Annual Review of Public Health* 2:253-276.

they are.[1]

The authors thus emphasize cultural and socio-economic factors as major determinants in behaviour, and note the relative success of an alternative "public health model" of health education and community organization, which impacts on very large numbers of people in a community at a fraction of the cost of one-to-one programs. However they note that this model "still focuses on the individual as the prime target of educational and treatment programs."[2]

The authors provide a third alternative, an "ecological model":

> In this model, structural changes are introduced into the community that, indirectly, result in behaviour change and risk reduction. In this approach, no direct effort is made to change individual behaviour or health status.[3]

As further examples, they note the designation of non-smoking areas in public spaces, and that it may be cheaper to build safer cars and highways than to educate drivers, one at a time, in safer driving techniques.

> One of the criticisms of the ecological model is that it preempts individual freedom and choice by limiting options and by allowing the few to dictate to the many. In fact, the ecologic approach can be seen in precisely the opposite way - as increasing freedom of choice and options... The structural pressures now in place often favor unhealthful interests; the introduction of healthful structural changes can be seen as redressing the

---

1 *Ibid.* at 107.

2 *Ibid.* at 108.

3 *Ibid.* at 108-109.

balance and thereby providing true freedom of choice.[4]

It may be that HIV prevention policies providing an eclectic approach, drawing on all three models, will be most effective. Nonetheless, there appear to be sound lessons to be learnt from the experience of public health policies in, for example, the fields of smoking and coronary heart disease.

2.6 Recent developments

In the last two decades in Canada there has been a movement away from the microbiological causes of disease as the principal focus of public health strategies. In 1974 the Lalonde Report announced:

> The Government of Canada now intends to give to human biology, the environment, and lifestyle as much attention as it has to the financing of the health care organization so that all four avenues to improved health are pursued with equal vigour."[5]

In 1986 the World Health Organization adopted an expansive definition of 'health' as '...the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and, on the other hand, to change or cope with the environment.'[6] Also in 1986, the

---

4 *Ibid.* HIV prevention policies that seek to improve the economic status of women are examples of this ecological approach.

5 *A New Perspective on the Health of Canadians* (Ottawa: Ministry of National Health and Welfare, 1974) [hereinafter *Lalonde Report*] cited in White, *supra* note 3 at 145.

6 *Health Promotion: Concepts and Principles, In Action, A Policy Framework* (Geneva: World Health Organisation, 1986) cited in Pederson A. et al, *Coordinating Healthy Public Policy:*

Canadian government released *Achieving Health for All: A Framework for Health Promotion.*[7] Following the Lalonde Report, this report reflected the WHO definition and proposed a new vision of health as more than just the absence of disease, including 'quality of life' issues: 'Health is thus envisaged as a resource which gives people the ability to manage and even to change their surroundings.'[8] The report identifies three national challenges: (i) Reducing inequities in the health of low - versus high - income groups in Canada; (ii) Increasing the prevention effort; and (iii) Enhancing people's capacity to cope.

This new vision of health is not without its detractors. Criticisms include charges of 'empire building' by health bureaucrats, utopianism, 'healthism', and, ominously, 'the medicalization of problems which have not hitherto been within the physician's domain of activity.'[9]

Achieving Health For All states bluntly that '[p]revention involves identifying the factors which cause a condition and then reducing or eliminating them'[10] and acknowledges the shortcomings

---

An Analytical Literature Review and Bibliography (Ottawa: Health and Welfare Canada, 1989) at 3.

7 *Achieving Health For All: A Framework for Health Promotion* (Ottawa: Health and Welfare Canada, 1986) [hereinafter *Achieving Health for All*].

8 *Ibid.* at 3.

9 Pederson et al, *supra* note 46 at 3 [references omitted].

10 *Supra* note 47 at 4.

of previous health promotion strategies, observing that:

> Unfortunately, the causal relationships between behaviour and health are not nearly as clear-cut as they are between "germs" and disease. Today's illnesses and injuries and the disabilities to which they give rise are the result of numerous factors. This means that prevention is a far more complex undertaking than we may at one time have imagined.[11]

> ...It has become increasingly evident that to be effective, education campaigns should not take place in isolation; they had to be combined with a variety of other activities. Health promotion became a multifaceted exercise which included education, training, research, legislation, policy coordination and community development.[12]

The report thus recognizes that broad areas of public policy impact on health, and hence calls for 'healthy public policy' rather than merely a revised public health policy. Public health policy of earlier this century has been characterized as being

> ...primarily concerned with the health care system, dominated by a high technology approach to medicine, sectoral and analytic, present-orientated, and accepting of the quo.[13]

Healthy public policy, on the other hand,

> ...focuses on the determinants of health, ...[is] dominated by a low technology approach, "holistic", "future-oriented" and questioning of the status quo... multisectoral... and founded upon public participation in formulation and implementation.[14]

---

[11] *Ibid.* at 5.

[12] *Ibid.* at 6.

[13] *Ibid.* at 5.

[14] *Ibid.* The need for a multi-sectoral approach to the new definition of health was noted by the World Health Assembly in 1986, and expanded in a comprehensive review by the World Health Organization the same year: *Intersectoral Action for Health* (Geneva: World Health Organization, 1986).

The new healthy public policy has thus established firm roots, and provides new challenges. One such challenge will be the move from articulation of the new goals to their implementation - necessarily requiring the coordination of all sectors now deemed to be indispensable to achieving these goals. Ultimately, this may require a revolution of Copernican dimensions: the centre of the new 'ecological' universe would be the doctrine of health of all, rather than, perhaps, unconstrained economic growth.[15]

Looking back at the impact of bacteriology on public health, it may be seen that what today is characterized as a paradigm shift, must have been experienced, for those struggling to maintain the population perspective, to be the collapse of a vision. As Fee and Porter note:

> The historiography of medicine and science has rightly warned against assuming that what looks, with hindsight, to have been a revolution in knowledge, was perceived as such at the time.[16]

Similarly, it may be that the collapse of the narrow public health perspective of this century and the articulation of the new healthy public policy is also a paradigmatic shift of similar scale.

---

[15] See Pederson et al, *supra* note 46 at 15.

[16] Fee and Porter in Fee and Acheson, *supra* note 3 at 32-33 [footnote omitted].

3 HIV, law & public health

3.1 HIV and state responsibility

As noted in chapter 2, the public health movement of the last 150 years has become closely linked with the responsibility of the state for some measure of the protection and promotion of the health of the public. Where public health efforts impact on individual freedom, the justification for the intrusion of the state into the personal sphere may be found in liberal democratic theories of the state, whereby individual liberty may be curtailed for the greater common good.[1] In any event, the responsibility of the state for some measure of public health protection and promotion appears uncontroversial.[2]

It may be further argued that in some areas, state responsibility may be unique, as the private sector is unwilling and unable to assume such responsibilities. Such responsibility flows from the fact that the state is uniquely positioned both to monitor the public health and to take certain actions to protect and promote it. Although non-governmental organizations clearly have a role to play in public health protection and promotion, their

---

1 See e.g. Mill J.S., *On Liberty* (Indianapolis: Hacket, 1978) (edited by E. Rapaport) c.IV. In this essay, first published in 1859, Mill is adamant that the law should only intervene to prevent the violation of 'constituted rights.'

2 For examples of varied state responses see Kirp D.L. & Bayer R., eds., *AIDS in the Industrialized Democracies* (Montreal: McGill-Queen's University Press, 1992); Foyer J. & Khaïat L., eds, *Droit et Sida: Comparaison internationale* (Paris: CNRS, 1994).

efforts are generally restricted to the provision of campaigns and services, and the advising and lobbying of governments regarding legislative reform which, of its nature, remains the sole province of the state.[3] As in many other areas of health promotion, state policies and practices may have the effect of impeding HIV prevention.[4]

The responsibility of the state with respect to public health protection and promotion, and specifically with respect to HIV, has been expressed in terms of economic theory. According to this analysis, functions such as HIV prevention cannot be wholly delegated to the private sector as can, for example, medical treatment for HIV disease.

> Government intervention in addressing the problems of AIDS is most compelling, on economic grounds, in the area of prevention. This is because AIDS prevention addresses the needs of the society as a whole as well as those of individuals. The private market cannot, according to theory, operate effectively in the area of prevention because there are social benefits to preventing further transmission of AIDS cases, and these exceed private benefits. The fact that AIDS is a communicable disease means that there are externalities to private actions that call for government intervention. Therefore it is in the interest of a society that preventive actions for AIDS be initiated by government.[5]

---

[3] The influence of non-governmental organizations in this regard may nonetheless be significant. For example, consider the international impact of the Rockerfeller Foundation in the promotion of public health as a discipline; see White K., *Healing the Schism: Epidemiology, Medicine & the Public's Health* (New York: Springer-Verlag, 1991).

[4] Public health laws requiring compulsory nominal notification of HIV positive test results to health authorities may deter people from being tested. Criminal laws regulating homosexuality, commercial sex work, and injecting drug use are believed to drive those most at risk away from HIV information, counselling and testing if appropriate. In the Australian context see generally Patterson D., "The Law" in Timewell E., Minichiello V. & Plummer D., eds., *AIDS in Australia* (Sydney: Prentice Hall, 1992) 366.

[5] Lewis A. et al., *AIDS in Developing Countries: Cost Issues and Policy Tradeoffs* (Washington, D.C.: The Urban Institute Press, 1989) at 10-11.

To be most effective, public health promotion messages should reach everyone in the subpopulation or community at which they are targeted, and cannot be limited to those 'consumers' willing to pay for them. Hence, public health promotion is generally an unattractive economic prospect for the private sector. In the short term at least, the private sector, and in particular the pharmaceutical industry, would appear to have a greater interest in the care and treatment of HIV disease rather than in prevention.

> The private market cannot be relied upon to produce the socially optimal quantity of many preventive activities, such as education campaigns, because once the good is produced no one can be prevented from consuming it (called the free rider problem) and there is no way for private producers to reap the full economic return (called normal profit) necessary to finance its production. In such cases, according to economic theory, it is economically efficient for the government to determine the level and nature of the investment that should be made. In the case of AIDS public health information, economic theory has an additional rationale for government intervention. Since AIDS is harmful to individuals and the existence, transmission, and outcome of the disease are not commonly known, it is also economically rational for government to subsidize consumption [of preventive information] to promote its use.[6]

This may appear a relatively uncontroversial point in a climate of generous government services in which HIV disease is considered a communicable illness and the proper focus of government spending. However it may be envisaged that in harder economic times in which HIV disease is characterized as a disease of 'lifestyle', the role of government in

---

[6] *Ibid.* Clearly governments can contract out for specific campaigns, and health maintenance organizations (HMOs) are by nature interested in promoting the health of their members. However the primary responsibility for promoting and maintaining the public health remains with the government. A similar analysis can be applied to environmental issues.

HIV prevention, particularly in funding prevention campaigns, may well be questioned.

This chapter considers the general role of the law in public health promotion, and specifically with respect to HIV disease. The extent to which the criminal law may contribute to HIV prevention in specific circumstances is considered in the next chapter.

3.2 Constitutional and jurisdictional issues

In Canada the possible scope of federal action on health is very broad, particularly due to the implied federal spending power, which allows the federal Parliament to implement policies and fund programs in areas which would otherwise be the principal or sole responsibility of the provinces.[7] The Canadian government has also used the criminal law power 'to support prohibitory enactments aimed at protecting public health, such as the *Food and Drugs Act*, the *Narcotics Control Act*, and the *Proprietary or Patent Medicine Act*'.[8] The concurrent or exclusive jurisdiction of the federal Parliament may be relevant

---

7 The broad nature of the spending power of the power of the federal Parliament to make conditional grants to the provinces in fields of provincial jurisdiction was recently affirmed by a unanimous Supreme Court in *Re Canada Assistance Plan* [1991] 1 S.C.R. 525. Hogg P.W., *Constitutional Law of Canada*, 3d ed. (Toronto: Carswell, 1992) at 149ff. See generally Rayside D.M. & Lindquist E.A., "Canada: Community Activism, Federalism and the New Politics of Disease" in Kirp & Bayer, *supra* note 1, 49 at 53ff.

8 *A New Perspective on the Health of Canadians* (Ottawa: Ministry of National Health and Welfare, 1974) at 44.

in some circumstances.[9]

Nonetheless, the primary responsibility for health services lies with the provinces and territories. Yet although there are quasi-criminal provisions in the public health legislation in each province,[10] the jurisdiction of the provinces does not extend, for example, to regulating commercial sex work, even to the extent of 'protecting users of the streets from the activities of prostitutes and their customers.'[11]

---

9 In Canada, '...health is an "amorphous topic" which is distributed to the federal Parliament or the provincial Legislatures depending on the purpose and effect of the particular health measure in issue... The federal Parliament's peace, order and good government power probably also authorizes legislation regarding health, where a problem has attained a national dimension (air or water pollution perhaps) or where an emergency exists (an "epidemic of pestilence" has been suggested).' Hogg, *supra* note 7 at 476 (footnotes omitted). The following constitutional responsibilities and heads of power in which there is a measure of federal responsibility in health matters have been identified: quarantine and the establishment and maintenance of marine hospitals; Indians, and lands reserved for Indians; Yukon and Northwest Territories; criminal law; immigration; international matters; statistics; militia, military and naval services, and defence; the establishment, maintenance and management of penitentiaries; peace, order and good government; incidental and residual power; and the spending power. See generally *A New Perspective on the Health of Canadians, ibid.* c. 7, at 43ff. See also Gilbert C.D., *Australian and Canadian Federalism 1867-1984: A Study in Judicial Techniques* (Carlton: Melbourne University Press, 1986); Ducharme T., "Preparing for a Legal Epidemic: An AIDS Primer for Lawyers and Policy Makers" (1988) 26(3) Alta. L.R. 471 at 477ff.

10 For example, the British Columbia *Health Act, R.S.B.C. 1979, c. 161* provides that any "householder" (defined as the occupant in charge of the premises) or physician who knows or suspects that someone in the household has a contagious or infectious disease must give notice of this fact within 24 hours to the medical health officer or the local board of health (ss.85 & 88). Failure to give notice is punishable by a fine or imprisonment or both (s.112).

11 Hogg, *supra* note 7 at 494. Hogg notes that the Supreme Court in *Westendorp* v. *The Queen* [1983] 1 S.C.R. 43 struck down a municipal by-law that prohibited a person from remaining on the street for the purpose of prostitution, and from approaching another person for the purpose of prostitution. He concludes (at 495) that '...where the provincial offence cannot be

The Constitution of Australia similarly envisages that primary responsibility for health lies with the states.[12] Two differences from the Canadian situation are worth noting. The first is that criminal law is a state responsibility, which may allow for greater legislative co-ordination of the criminal and public health responses at the state level. In particular, the Australian states are not hampered in the implementation of quasi-criminal legislation by a possible lack of jurisdiction. As a consequence it has been easier for states to pass such legislation, and several have done so.[13]

The second factor which distinguishes the Australian and the Canadian constitutions is the existence of the 'external affairs power.' The Australian Parliament has jurisdiction over matters within Australia the subject of international covenants and treaties and,

---

safely anchored in property and civil rights or some other head of provincial power, then it will be invalid.' This is relevant to HIV prevention because the prohibition of commercial sex work is sometimes mentioned in this regard.

12 *Commonwealth of Australia Constitution Act* (U.K.), 63 & 64 Vict., c.12 [hereinafter *Australian Constitution*]. There is no general 'health' power allocated to the federal Parliament, although the following matters appearing in section 51 may serve as an appropriate head of power in some circumstances: naval and military defence; quarantine; insurance; marriage; the provision of benefits and medical and dental services; immigration; external affairs; and matters referred by the States.

13 For example, in New South Wales people with HIV infection are required to inform their sexual partners of that fact prior to sexual intercourse, or face a $5,000 fine (*Public Health Act 1991* (NSW) s.13(1)). A subsequent provision penalizes owners or occupiers of buildings who knowingly permit others to have sexual intercourse for the purposes of prostitution, and, in so doing, commit the above offence (s.13(2)). Although these provisions appear in the *Public Health Act* 1991, they could have been enacted in the *Crimes Act* 1900 (NSW) without risk of being *ultra vires.*

arguably, also of 'international concern'.[14] Such matters would include the containment of pandemics such as HIV disease.[15] International law has also been used by the federal government to override state criminal law.[16] It thus appears that both levels of government in Australia have in practice greater flexibility to legislate with respect to HIV than their Canadian counterparts: the states having criminal jurisdiction and the

---

14 *Australian Constitution* s.51(xxix). For the use of this head of power in relation to human rights, see generally Bailey P., *Human Rights: Australia in an International Context* (Sydney: Butterworths, 1990).

15 See generally Sieghart P., *AIDS & Human Rights: A UK Perspective* (London: British Medical Association Foundation for AIDS, 1989). Both Australia and Canada are parties to the *International Covenant on Economic, Social and Cultural Rights* , 16 December 1966, U.N.T.S. vol. 993, p.3.
Article 12 provides in part:

> 1. The States Parties to the Present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
> ...
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases...

16 Section 109 of the *Australian Constitution* provides that when a law of a State is inconsistent with a (valid) federal law, the latter prevails, and the former is, to the extent of the inconsistency, invalid. On 25 December 1992, Australia's ratification of the *Optional Protocol to the International Covenant on Civil and Political Rights,* 16 December 1966, U.N.T.S. vol.999, p.171, [hereinafter *International Covenant on Civil and Political Rights*] came into effect. The same day, a male homosexual from the state of Tasmania submitted a communication to the Human Rights Committee complaining that the criminal law in that State prohibiting all sexual relations between males breached his rights guaranteed under the Covenant. The Human Rights Committee ruled in his favour. The federal government thus gained the constitutional authority to override the Tasmanian law which puts Australia in breach of its international obligations; *Commonwealth* v. *Tasmania* (1983) 158 C.L.R. 1. See Alexander M., "Tasmanian Gay Activist Wins in the UN" (1994) 5(2) *HIV/AIDS Legal Link* 1. In late 1994 the federal government introduced a bill to this effect, the *Human Rights (Sexual Conduct) Bill* 1994.

federal Parliament enjoying a broad interpretation of the 'external affairs' power.[17] It is not assumed that this greater flexibility has in fact contributed to a more effective response to the epidemic.[18]

Both the Canadian and Australian federal governments have played a co-ordinating role in HIV-related law and policy.[19] Yet while in Canada the primary provincial responsibility for HIV-related health law and policy has remained largely unquestioned,

---

17 Gilbert notes that while the Canadian federal model seemingly emphasizes central dominance more than the Australian model, '(p)aradoxically, commentators are virtually unanimous in saying that, in fact, Canadian federalism is far more decentralized than its Australian equivalent. ...Thanks to judicial efforts, the practice of Australian federalism is very much oriented towards Canberra, while the practice of Canadian federalism emphasizes real power and autonomy at provincial level.' Gilbert, *supra* note 9 at 2-3.

18 It appears some Australian States have passed hasty and inappropriate laws, while the federal Parliament has not, generally, exercised its legislative options in this area. An exception is the *Disability Discrimination Act 1992* (Cth). Section 4(1) of the Act defines 'disability' to include the presence in the body of organisms causing, or capable of causing, disease or illness. The definition includes a disability that presently exists, may exist in the future or is imputed to a person. The Act covers both the public and private sectors in states and territories. See Godwin J. et al, *Australian HIV/AIDS Legal Guide,* 2d ed. (Sydney: Federation Press, 1993) at 91ff. The Act was supposedly introduced pursuant to Australia's obligations under the *International Covenant on Civil and Political Rights* and the *Discrimination (Employment and Occupation) Convention 1958,* 25 June 1958, U.N.T.S. vol.362, p.31.

19 For the Canadian federal government role, see e.g.: *HIV and AIDS: Canada's Blueprint* (Ottawa: Ministry of Supply and Services, 1990); *Building an Effective Partnership: The Federal Government's Commitment to Fighting AIDS* (Ottawa: Health and Welfare Canada, 1991); *National AIDS Strategy: Building on Progress* (Ottawa: Health and Welfare Canada, 1993). See also Rayside D. & Lindquist E.A., "Canada: Community Activism, Federalism, and the New Politics of Disease" in Kirp D. & Bayer R., eds., *AIDS in the Industrialized Democracies* (Montreal: McGill-Queen's University Press, 1992) 49. For the Australian federal government role see *infra* note 21.

there have been repeated calls in Australia for federal legislation in the face of perceived state inaction.[20] It may be that this readiness to call on the federal government to legislate with respect to HIV/AIDS is due, at least in part, to the perception of federal legislative competence in this area, as well as to the confidence of the community sector in federal HIV/AIDS policies engendered by extensive, and on-going, community consultation.[21]

3.3 Early legislative responses to HIV disease

A common early legislative response to the HIV epidemic was to identify AIDS as a communicable or sexually transmissible disease, and to append AIDS, and later HIV infection, to the schedules of such diseases in the relevant public health legislation. As Watchirs notes:

---

20 E.g. Hodge D., Smith A. & Patterson D., "HIV Status, Sexuality and Discrimination in Australia: Whose Turn to (En)act?" (1990) 4(6) *National AIDS Bulletin* 48. The authors noted the lack of uniformity in state equal opportunity laws and called on the federal Parliament to enact legislation to protect people with real or imputed HIV infection from discrimination. See *supra* note 18.

21 See, for example, *AIDS: A Time to Care, a Time to Act - Policy Discussion Paper* (Canberra: Australian Government Publishing Service, 1988); *Report of the Working Panel on Discrimination and Other Legal Issues* (Canberra: Department of Community Services and Health, 1989); *National HIV/AIDS Strategy - A Policy Discussion Paper* (Canberra, Australian Government Publishing Service, 1989). See also *The Final Report of the Legal Working Party of the Intergovernmental Committee on AIDS* (Canberra: Department of Health, Housing and Community Services, 1992) [hereinafter *LWP Final Report*]. This report followed the distribution of nine discussion papers on different aspects of HIV/AIDS law and policy, resulting in over 300 submissions from 111 organizations and individuals (*LWP Final Report* at 1-2). See also Ballard J., "Australia: Participation and Innovation in a Federal System" in Kirp & Bayer, eds., *supra* note 19 at 134.

> Between 1983-1985 Australian States reacted relatively quickly to the AIDS epidemic, often in a reflex statutory fashion by adding AIDS and related conditions to existing public health measures. This has had the unfortunate consequence in most legislation of making it compulsory to supply health authorities with the names and addresses of people who have tested HIV-positive. The obvious consequence is a deterrent to testing, especially where the means of transmission (e.g. homosexual acts, sharing of needles, prostitution) are illegal in the particular jurisdiction. The need for this information has not been justified and would naturally engender fear in persons at risk to its use - contact tracing, surveillance, quarantine, and other coercive measures. All notification requirements are subject to monetary penalties for non-compliance from $500 to $1000.[22]

A similar legislative response has been documented in Canadian provinces. Hamblin et al note:

> Many of the provinces have passed amendments to existing Public Health Acts which add "AIDS" or "HIV infection" to the list of "communicable" or "notifiable" diseases under the Act, which commonly include such other diseases as tuberculosis, cholera and salmonella infection. As a result, HIV/AIDS has been made subject to a number of public health provisions dealing with disease notification, quarantine, isolation etc., many of which were drafted with very different, and more readily transmissible, forms of disease in mind. The problems that have been caused by this approach are manifold. Provisions requiring the

---

[22] Watchirs H., *AIDS - A Public Law Perspective* (L.L.M. Thesis, Australian National University, 1990) at 44. Some states subsequently amended their reporting requirements to require only non-nominal, codified reporting of positive HIV antibody test results. See Watchirs H. et al, *Legislative Approaches to Public Health Control of HIV Infection* (Canberra: Department of Community Services and Health, 1991) (Intergovernmental Committee on AIDS discussion paper). As HIV infection is not transmitted by casual contact, it was inappropriate to include it in the same category of diseases such as tuberculosis or cholera. For example, in the state of Western Australia, AIDS was declared to be an 'infectious disease' and a 'dangerous infectious disease' for the purposes of the *Health Act* 1911. Section 264 of the Act provides, in part, that it is an offence for a person with an infectious disease to enter a public vehicle without notifying the owner, conductor or driver that he (or she) is so infected. See generally Godwin et al, *supra* note 18, c.1. A completely different reason for the states to encourage medical practitioners to notify AIDS cases is that the states receive federal funding for health services provided based on their declared AIDS case load.

> isolation of an infected person until such time as the person "is no longer infectious" have been made applicable to HIV/AIDS in some provinces, as have other provisions prohibiting infected people from travelling on public transport or requiring warning signs to be erected outside the homes of infected people. The application of these provisions in the context of HIV/AIDS is clearly inappropriate and ineffective, but regrettably the addition of HIV infection and AIDS to public health legislation, as it stands, means that these provisions could be applied in the context of HIV infections *[sic]* and AIDS.[23]

Unfortunately, this ready resort to public health legislation had the effect of 'reviving' legislation which itself had its origins in the public health policies of the last century and had not, in most cases, been reviewed nor revised for decades. As noted by Hamblin and Watchirs, it was inappropriate to schedule HIV with other communicable diseases. Further, the legislation itself was in need of review - the wide-ranging and draconian powers granted to public health authorities being inconsistent with contemporary expectations of proportionality and due process.[24]

---

23 Hamblin J. et al, *Responding to HIV/AIDS in Canada* (Toronto: Carswell, 1990) at 1-2, 1-3; see also Friedman R., "The Application of Canadian Public Health Law to AIDS" (1988) 9 Health L.Can. 49. See generally Cassell J,. "Making Canada Safe for Sex: Government and the Problem of Sexually Transmitted Diseases in the Twentieth Century" in Naylor C., ed., *Canadian Health Care and the State: A Century of Evolution* (Montreal: McGill-Queen's U.P., 1992) 141.

24 Bayer contrasts the evolution of the criminal and public health law in the United States and notes '(w)hile the law and jurisprudence of privacy evolved around sexuality, intimacy, and procreation, that centering on epidemic control remained largely frozen in time, the product of an earlier pattern of disease, a limited therapeutic capacity on the part of medicine, and a permissive standard of review by the courts when confronted by challenges to the exercise of the state's "police powers" - the constitutional basis for the government interventions when threats to the public health were posed.' Bayer R., *Private Acts, Social Consequences: AIDS and the Politics of Public Health* (New York: The Free Press, 1989) at 8.

Indeed, the past contribution of coercive and punitive laws to the containment of infectious diseases has since been questioned. Writing in the context of the quarantine of U.S. commercial sex workers suspected of spreading disease during World War I, and of the more recent compulsory premarital screening for syphilis, Brandt notes:

> Compulsory measures often generate critics because such policies may infringe basic civil liberties. From an ethical and legal viewpoint, the first question that must be asked about any potential policy intervention is: Is it likely to work? Only if there is clear evidence to suggest the program would be effective does it make sense to evaluate the civil liberties implications...
>
> In this respect, it is worth noting that compulsory measures may actually be counterproductive. First, they require substantial resources that could be more effectively allocated. Second, they have often had the effect of driving the very individuals that the program hopes to reach farther away from public health institutions. Ineffective draconian measures would serve only to augment the AIDS crisis. Nevertheless, despite the fact that such programs offer no benefits, they may have substantial political and cultural appeal...[25]

The assumption that the compulsory immunization, screening and treatment campaigns were largely responsible for the decline in other infectious diseases such as whooping cough and tuberculosis has also been called into doubt. Rather, it has been suggested that the decline was principally due to the improvement in socio-economic conditions. Ashton and Seymour note the 'McKwown Hypothesis', that

> ...[w]ith the exception of the vaccination against smallpox, which was associated with less than 2 percent of the decline in the death rate from 1848 to 1871, it is unlikely that immunization or therapy had a significant effect on mortality from infectious diseases before the twentieth century. In particular, most of the reduction in mortality from tuberculosis, bronchitis, pneumonia and influenza, whooping cough and food and water-borne diseases had already occurred before

---

[25] Brandt A. M., "AIDS in Historical Perspective: Four Lessons from the History of Sexually Transmitted Diseases" 1988 78(4) Amer. J. Pub. Hlth. 367 at 370.

> effective immunization or treatment was available. Between 1900 and 1935 some specific measures contributed to reductions in death rates from infection. These included antitoxin in diphtheria, surgery in appendicitis, peritonitis, ear infections, salvarsan in syphilis, intravenous therapy in diarrhoeal disease, passive immunization against tetanus and improved obstetric care. However, the total contribution of medical and surgical interventions to reductions of mortality has been small compared with the impact of environmental, 'public health', political, economic and social measures.'[26]

Where medical intervention has been effective, it should be distinguished from the enshrouding bureaucratic apparatus. The early legislative responses to HIV were consistent with the prevailing bureaucratic model of the control of another sexually transmitted disease, syphilis. Plummer notes that in the late nineteenth century:

> [I]mportant but rudimentary developments in the understanding of infectious diseases led to a worldwide movement to enshrine preventive initiatives in legislation. The resulting medical and bureaucratic control of public health was absolute... [Yet i]t was an advance in biotechnology (the introduction of penicillin), rather than the harsh legislative measures, that ultimately brought syphilis under better (but far from perfect) control in the "developed" world.[27]

Legislation in regard to sexually transmitted diseases was based on a strategy of identification, compulsory reporting and treatment. Medical practitioners were required to report the names and addresses of patients diagnosed with certain diseases to public

---

26 Ashton J. & Seymour H., *The New Public Health* (Buckingham, U.K.: Open University Press, 1988) at 5-6.

27 Plummer D., "The Medical Establishment" in Timewell, *supra* note 4 at 83. Compare this view with Joseph's advocation of 'the time proven public health tools of of mandatory confidential reporting of infection, and the tracing of contacts of those who have been reported as infected.' Joseph S., *Dragon Within the Gates: The Once and Future AIDS Epidemic* (New York: Carroll & Graf, 1992) at 82.

health officials. Contact tracing would then allow others with the disease to be identified, and so on. If the system failed, it was due either to patient (or doctor) non-compliance, or lack of public health staff to follow up and treat the contacts so identified. The solution in this 'positivist' framework was therefore more coercive powers and more staff to 'police' the legislation.

The effectiveness of this model of identification, compulsory reporting and treatment has been challenged by a growing scepticism about the effectiveness of coercive and punitive laws. Legal theorists have challenged the foundations of legal positivism, and offered more complex models to understand the effect of law on behaviour.[28] Consequently, it has been questioned whether the greater allocation of resources to the enforcement of laws would, in fact, lead to a reduction in undesired behaviour, and hence the spread of disease.[29]

Hartog characterizes the positivist call for greater enforcement in terms of 'gap analysis':

---

[28] See e.g. Hartog H., "Pigs and Positivism" (1985) Wiscon. L.R. 899. See also Fuller L.F., "The Law's Precarious Hold on Life" (1969) 3 Georgia L.R. 530-545.

[29] A good example in the U.S. context is the proposal by the Commissioner of Health for New York City 1986-1990, Stephen Joseph, to have police close 'shooting galleries' in which unsafe injection practices were commonplace. Noting the campaign against gay bathhouses and other sex-on-premises venues, Joseph observed "If only we could have also found a way to successfully move with police action to shut down drug shooting galleries, I would have felt that we were taking a full range of responsible public health enforcement actions. But the Police Department told me repeatedly that this was impractical, that the galleries could just move from one abandoned building or apartment to another." Joseph, *supra* note 27 at 107.

> Gap analysis rests on the presumed existence of a norm which in one way or another could have been enforced...[however]... The idea of a gap only makes sense where there is some shared consciousness (some accepted structure of legitimation, a hegemonic order) that the law was the law, and therefore "ought" to be obeyed (since in gap analysis, law is a sphere of "oughts").[30]

Because the populations and communities most affected by coercive laws often inhabit competing normative spheres, no amount of enforcement will render these laws more effective. In fact, quite the opposite result might be the case. As Falk Moore notes:

> The law (in the sense of state enforceable law) is only one of a number of factors that affect the decisions people make, the actions they take and the relationships they have. Consequently important aspects of the connection between law and social change emerge only if law is inspected in the context of ordinary social life. There general processes of competition - inducement, coercion, and collaboration - are effective regulators of action. The operative 'rules of the game' include some laws and some other quite effective norms and practices.[31]

The questions raised by this 'problematization' of law should be addressed before further laws are enacted, or old laws revived, in relation to HIV disease. In particular, the real effects of such laws should be evaluated. For example, Hamblin notes that proscriptive legislation such as that which imposes criminal sanctions on the sale of condoms in Ireland, or which provides for compulsory reporting of HIV seropositivity,

> ...far from encouraging conduct that will reduce the spread of HIV, may actively impede prevention efforts by alienating those people who are most at risk of HIV

---

30 Hartog, *supra* note 28 at 924-925 [footnotes omitted]. Hartog characterizes the law as "... an arena of conflict within which alternative social visions contended, bargained and survived." *Ibid.* at 934-935.

31 Falk Moore S., *Law as Process An Anthropological Approach* (London: Routledge & K. Paul, 1978) at 78. In her description of land reform in Tanzania, Falk Moore notes that the government imposed reforms had the opposite effect to that intended (at 68ff).

and making it less likely that they will cooperate in prevention measures.[32]

3.4 HIV, the law and human rights

Hamblin distinguishes three roles of the law in HIV policy: a proscriptive role, a protective role, and an instrumental role:

> The distinction between the proscriptive and the protective roles of the law is important because it assists in determining whether active legal intervention is an appropriate policy response. While proscriptive and coercive laws may be counterproductive if they discourage the voluntary participation by people at risk of HIV in measures to reduce HIV transmission, protective laws may help enlist the support and cooperation of these people in prevention strategies.[33]

The demands of public health are often presented as in conflict with such principles. As noted above, the demands of public health are an exception to human rights principles set out in international covenants, and it is common to characterize the struggle against HIV disease in terms of a conflict between the 'general population' on the one hand, and the rights of the HIV-infected (and those most at risk of infection) on the other:

> The ethos of public health and that of civil liberties are radically distinct. At the most fundamental level, the ethos of public health takes the well-being of the community as its highest good and in the face of uncertainty - especially where the risks are high - would, to the extent deemed necessary, limit freedom or place restrictions on the realm of privacy in order to prevent morbidity from taking its toll. The burden of proof against proceeding from this perspective rests upon

---

[32] Hamblin J., AIDS 1991, **5** (suppl 2):S239-243 at S240.

[33] *Ibid.* at S241. See also Gostin L. & Ziegler A., "A Review of AIDS-Related Legislative and Regulatory Policy in the United States" (1987) 15(1-2) Law, Med. & Hlth Care 5 at 5.

> those who assert that the harms to liberty would, from a social point of view, outweigh the health benefits to be obtained from a proposed course of action...
>
> From the point of view of civil liberties, the situation is quite the reverse. No civil libertarian denies the importance of protecting others from injury... But since from (this point of view) the freedom of the individual is the highest good of a liberal society, measures designed to restrict personal freedom must be justified by a strong showing that no other path exists to protect the public health...[34]

An alternative argument, however, presents the protection of human rights as a fundamental plank of HIV prevention policies. According to this view, it is only by assuring the rights of the HIV-infected and those groups perceived as most at risk of infection that HIV prevention policies can in the long term be successful:

> The heated, intense dialogue between public health and human rights has been one of the most important and unanticipated outcomes of the first decade of the AIDS pandemic. Discrimination has been identified as both counterproductive for public health program effectiveness and as a major underlying cause of ill health worldwide. It is reasonable to speak of a "revolution" in thinking about health through its inextricable connection with human rights. Yet, the temptation to return to so-called traditional public health approaches is also strong and will intensify as the number of people with AIDS and the economic impact of the pandemic increases during the 1990s. As a result, some people speak of the need to end the special treatment accorded to HIV prevention (translation: special treatment = strong emphasis on human rights as a key component of public health strategies). Rather, as the challenges of AIDS and other major public health problems of the future involve behaviour - individual and collective - the value of incorporating human rights norms within public health practice will increase...[35]

In 1989 the link between public health and human rights was expressed thus:

> There is a strong and clear public health rationale for this emphasis on protecting

---

34 Bayer, *supra* note 24 at 15.

35 Mann J., Tarantola D.J.M. & Netter T.W., eds., *AIDS in the World* (Cambridge, Harvard University Press, 1992) at 537.

> the human rights and dignity of HIV-infected persons, including people with AIDS. HIV spreads almost entirely through identifiable behaviour and specific actions (sexual intercourse and intravenous drug use) which are generally - though not always - subject to individual control. In most instances, HIV transmission involves the behaviour of two persons; a change in behaviour of either the HIV-infected or the uninfected person will be sufficient to prevent HIV transmission. However, it must be remembered that HIV is transmitted mainly through behaviour which is private, secret, often hidden and, in some societies, illegal.
>
> Therefore, if HIV infection, or suspicion of HIV infection, leads to stigmatization and discrimination (e.g. loss of education or employment), persons already HIV infected, and those who are concerned they may be infected, will actively avoid detection and contact with health and social services will be lost. Those needing information, education, counselling or other support services would be "driven underground". The person who fears he or she may be infected would be reluctant to seek assistance out of fear of being reported - with severe personal consequences. The net result would be to jeopardize seriously educational outreach and thereby exacerbate the difficulty of preventing HIV infection....
>
> It is not a question of the "rights of the many" or the "rights of the few"; the protection of the uninfected majority depends on and is inextricably bound with the protection of the rights and dignity of the infected person.[36]

The narrow 'traditional public health approach' referred to above and the perceived conflict between human rights and public health have been stated by Joseph, who resists any re-conceptualisation of the HIV disease:

> Protecting the uninfected is the first duty. AIDS constitutes a public health emergency which carries with it extraordinary civil liberties issues. It does not constitute a civil liberties emergency which carries with it extraordinary public health issues.[37]

---

[36] United Nations, *Report of an International Consultation on AIDS and Human Rights* (New York, 1991) at 3-4 (UN Doc. HR/PUB/90/2). The meeting was held in July 1989 and organized by the Centre for Human Rights and the WHO Global Programme on AIDS.

[37] Joseph, *supra* note 27 at 53-54.

On the other hand, theorists such as Mann deconstruct 'public health' and 'human rights', and find a commonality between them. Yet there are dangers in such deconstruction and reconstruction. In our efforts to ensure the inclusion of the infected and affected in our prevention strategies, do we risk ignoring the rights of the uninfected to remain so?[38] Further, as HIV will not be the last microbe to assault us, are we too hasty in our rejection of coercive and punitive laws in all circumstances?[39]

3.5 Alternative roles for the law in HIV public policy

In linking social and economic vulnerability and vulnerability to HIV infection, Hamblin identifies a additional role for the law, which operates on a broader and more far-reaching level. Noting World Health Organization reports of patterns of infection concentrated in the developing world and amongst women, she observes:

> These patterns suggest that one of the most significant risk factors for HIV infection during the 1990s relates not to sexual or drug-use activities as such but rather to socioeconomic dependency. Because HIV infection is preventable,

---

38 In *Pitman* v. *The Canadian Red Cross Society* [1994] O.J. No.463 a man infected by tainted blood administered during cardiac surgery was never informed of his HIV status as his doctor judged that his heart condition precluded him from receiving bad news. His wife was subsequently infected through sexual intercourse. Guillot-Hurtubise B., "First Canadian Ruling in a Tainted-Blood Case" (1994) 1(1) Can. HIV/AIDS L.&. Pol. Nwsltr 8-9.

39 See e.g. *Tuberculosis: An Old Disease Poses New Challenges to Public Health Policy and the Law* (Washington: Buraff Publications, 1993) (Special Report).

> people who have access to information and appropriate measures and have the means to implement these measures will be able to protect themselves against infection. At this point in the epidemic, therefore, the people who remain most vulnerable are those who are denied the means of protecting themselves against the risks of HIV because of economic need or powerlessness to control the basis upon which their sexual relationships take place...
>
> One must be careful about making grandiose claims as to the extent to which the law can be used to bring about social and economic change. By the same token, however, the potential of the law to complement and reinforce other policy initiatives in this regard should not be overlooked, because legal interventions can address some of the social and economic factors that render particular groups of individuals susceptible to HIV infection.[40]

This conception reflects the view of the new 'healthy public policy' noted in chapter 2. In 1994 Mann expressed this new conception of the link between health and human rights thus:

> [T]he failure to realize human rights and respect human dignity has now been recognized as a major cause - actually, as the root cause - of vulnerability to a global epidemic.[41]

It thus follows that the extent to which the law may secure and promote human rights will be one measure of its usefulness in HIV prevention.[42]

---

40 Hamblin, *supra* note 32 at S242.

41 Mann J., Address (First International Conference on Health and Human Rights, Harvard School of Public Health, 22 September 1994) [unpublished].

42 For a sobering analysis of the limitations of 'rights discourse' in effecting social change see Minow M., "Interpreting Rights: An Essay for Robert Cover" (1987) 96(8) Yale L.J. 1860, below chapter 5 n.3.

3.6 Some further considerations

In further considering the role of law in HIV public policy, it is suggested that the following distinctions are useful:

3.6.1 Legislative purpose

The distinction can be made between the single purpose of public health legislation, and the sometimes multiple justifications for criminal legislation, only one aspect of which is the protection of the public from future harm. As noted above, in Canada the particular division of powers between the provinces and the federal Parliament has emphasized the distinction between public health and criminal law, whereas there are aspects of the criminal law which also serve a public health function. Conversely, there are aspects of the criminal justice system which serve no public health function, but exist for other reasons. This distinction is explored further in chapter 4.

3.6.2 Differing functions of public health

The distinction can be made between those functions of public health which relate to populations (such as seroprevalence surveys, research activities, and promoting and ensuring the provision of care and treatment) and those functions such as contact tracing

and compulsory treatment which relate to individuals.[43] Gilmore proposes that

> Separating these two public health functions provides a potential way to avoid some of the ethical quandries *[sic]* and potential interference with human rights raised by public health efforts. Restricting public health functions to those that are population-based efforts and interventions would make interventions at the individual level an exception to this presumption.[44]

By thus 'deconstructing' public health, it may be that the seemingly contradictory, and sometimes counter-productive, role and function of the law in HIV public policy can be better understood.

3.6.3 Risk and public health

The distinction can be made between the information and advice provided to, and the level of risk taken by, an individual in (for example) sexual practices on the one hand, and the minimum sufficient behaviour change necessary to reduce the society-wide incidence of (new) HIV infections to an 'acceptable' level.[45] Each individual must evaluate the level of personal risk in, for example, sexual intercourse that he or she

---

43 Gilmore N., "Public Health, Ethics and HIV/AIDS" (Paper presented at a Global Expert Meeting on AIDS: Questions of Rights and Humanity, Den Haag, The Netherlands, 21-24 May 1991.)

44 *Ibid.*

45 The concept of an 'acceptable' number of new infections may appear shocking, yet is accepted in other areas of risk - for example, car accidents, crime and preventable disease. As Osborne notes 'AIDS is here to stay. It is like the day after Hiroshima - the world has changed and will never be the same.' Osborne J. "AIDS: Politics and Science" 318 [1988] New Engl. J. Med. 444 at 445.

regards as acceptable. The incidence of condom breakage and resulting infection is so low (and can be further reduced) that an acceptable public health strategy to contain HIV infection need not require the disclosure of the HIV status of an infected person to his or her sexual partner (as proposed by many commentators and required in some jurisdictions). Yet, as Somerville notes, 'Western populations in the late twentieth century are very intolerant of identified risks.'[46] If such disclosure is to be legally required, it should not be falsely justified as a public health measure, but should be grounded in other, perhaps equally justifiable, policy considerations.

---

46 Somerville M.A., "Law as an 'Art Form' - Reflecting AIDS: A Challenge to the Province and Function of Law" in Miller J., ed., *Fluid Exchanges: Artists and Critics in the AIDS Crisis* (Toronto: University of Toronto Press, 1992) 287 at 294.

4 The criminalization of the sexual transmission of HIV

4.1 Criminal justice policy and public health policy

What is the relationship between criminal justice policy and public health policy? In particular, to what extent, if any, can the supposed deterrent effects of the criminal law change behaviour and reduce the sexual transmission of HIV? This chapter addresses the possible contribution of the criminal law to public health measures to prevent the sexual transmission of HIV infection.

Public health policy and criminal justice policy can be represented as intersecting sets within the universal set of public policy (Figure 1). The intersection of these two sets represents the aspects of criminal justice policy (as expressed in legislation and sentencing practices) that directly affect public health. These aspects supposedly deter those who would put themselves or others at risk. Hence criminal justice policy has implications for public health, and the public health is a consideration in criminal justice policy.[1]

---

[1] For example, in sentencing an accused for donating blood knowing it to be infected with HIV, courts have referred to the need to protect the public health by deterring such actions. See e.g. *R.* v. *Thornton* (1991) 1 O.R. (3d) 480, 42 O.A.C. 206, 3 C.R. (4th) 381 (C.A.), aff'd [1993] 2 S.C.R. 445, 21 C.R. (4th) 215, 13 O.R. (3d) 744 (S.C.C.) [hereinafter *Thornton*]. See also (Australia) "Blood donor with HIV sentenced to prison" (1993) 4(4) *HIV/AIDS Legal Link 24* (accused sentenced to 16 months' imprisonment for donating HIV-infected blood, knowing that he was HIV positive, contrary to *Health Act 1958* (Vic) s.136).

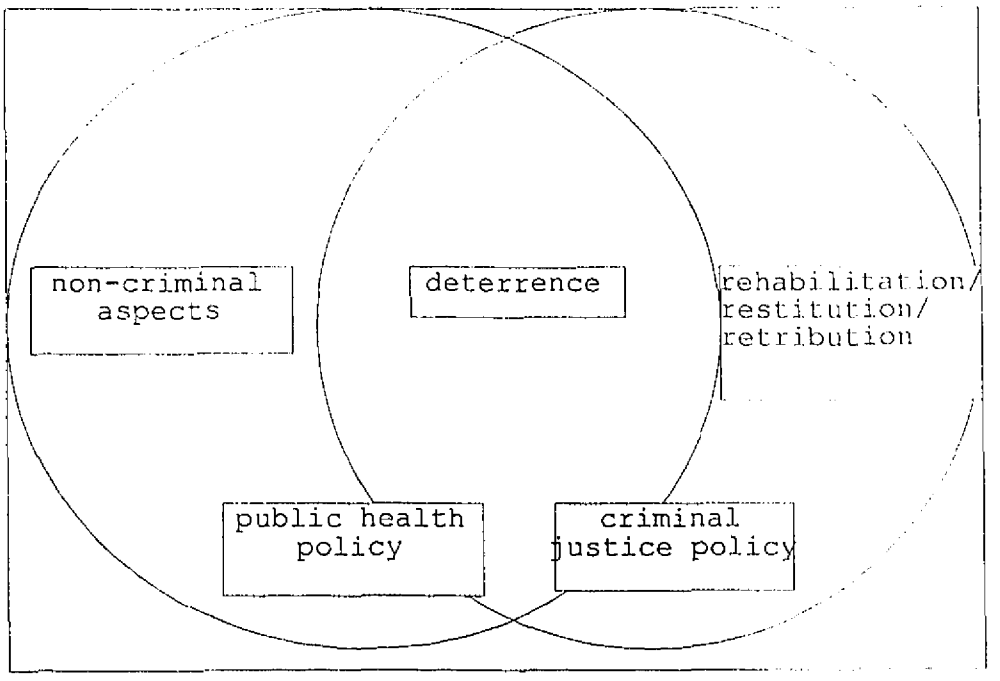

Figure 1 The interaction of public health and criminal justice policy

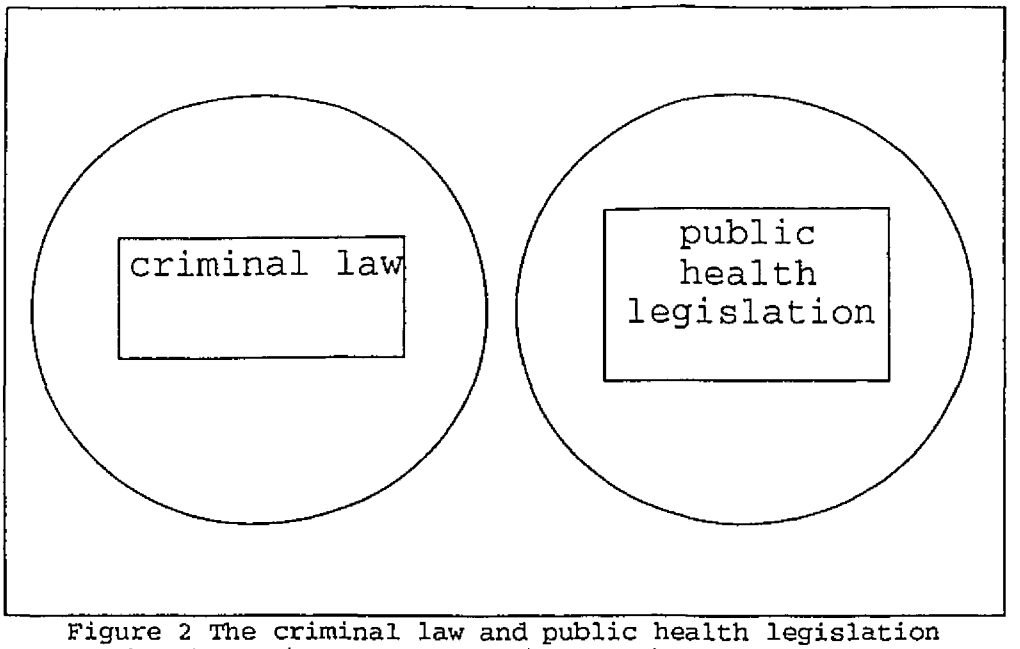

Figure 2 The criminal law and public health legislation regarding infectious and communicable diseases are generally distinct legislative domains

There are also areas of public health policy which are not relevant to the criminal justice system; for example, the funding of anonymous HIV testing clinics. Similarly there are aspects of the criminal justice system which have nothing directly to do with the health of the wider community; for example, the retributive aspects of punishment, the rehabilitation of the offender (beyond the mere deterrence from committing further harm), or orders for restitution.[2]

However, conceptually and legislatively in both Canada and Australia, the criminal law and public health legislation regarding infectious and communicable diseases are distinct domains (Figure 2).[3] In Canada this distinction is also reflected to some extent in the constitutional division of powers.[4] Hence areas of HIV policy that might best be considered within the one policy framework are addressed either by different Australian

---

2 In Canada, however, retribution as a principle of sentencing has been generally rejected. Ruby C., *Sentencing* 4th ed. (Toronto: Butterworths, 1994) at 11-16.

3 'Criminal law' is used here to denote both those enactments of a criminal character and, in those Australian jurisdictions which have retained them (the Australian Capital Territory, New South Wales, South Australia and Victoria), common law offenses such as 'keeping a disorderly house or bawdy house'; see Godwin J. et al, *Australian HIV/AIDS Legal Guide*, 2d ed. (Sydney: Federation Press, 1993) at 246, n.15. The federal parliament has also enacted criminal laws regulating food and drugs, however a discussion of these aspects of public health is beyond the scope of this paper.

4 See chapter 3, above, section 3.2.

state government departments (typically justice and health), and additionally in Canada, by different levels of government - provincial and federal. In Canada the situation is further confounded as the federal criminal law is generally administered by the provinces.[5]

The impact of this asymmetry (Figures 1 & 2) in both Canada and Australia is explored below in relation to the application of the criminal law to the sexual transmission of HIV infection. As every new case of HIV infection by its nature involves the transmission of the virus from one person to another, the application of the criminal law in this context has profound implications for HIV prevention policy.

4.2 Preliminary considerations

Before considering the policies, legislation and case law in this area, it is useful to set out some preliminary considerations specific to HIV. The following factors, overlooked by many commentators, underlie a comprehensive discussion of the criminal law and the sexual transmission of HIV:

---

5 *Constitution Act, 1867,* (U.K.), 30 & 31 Vict.,c.3, s.92(14) [hereinafter *Canadian Constitution*]. See generally Hogg P.W. *Constitutional Law of Canada,* 3d ed. (Toronto: Carswell, 1992) c.18-19.

4.2.1 Conceptions of risk

HIV infection is not spread by 'casual contact' and not all sexual practices are equally risky. There is general agreement that unprotected penetrative anal or vaginal sex (with or without ejaculation) with an HIV positive person poses a substantial risk for an (HIV negative) receptive partner, and that practices such as mutual masturbation pose minimal risk.[6] In any case, advice to 'avoid all sex with an infected person' is impractical[7] and

---

[6] 'Penetrative' here refers to penetration with a penis only. (Compare sexual assault statutes where penetration includes e.g. fingers and objects.) Ducharme notes

> '[o]ne study which estimated the risk from penile-vaginal intercourse with a known seropositive individual without using a condom to be 1/500 for one sexual encounter and 2/3 after 500 sexual encounters. Use of a condom would reduce the risk to 1/5000 for one sexual encounter and 1/11 after 500 sexual encounters.'

Ducharme T., "Preparing for a Legal Epidemic: An AIDS Primer for Lawyers and Policy Makers" (1988) 26(3) Alta. L.R. 471 at 507.

The author makes no acknowledgement of the greater risk faced by the receptive (female) partner. There figures have been disputed. See Fischl M.A. "Preventing Transmission of AIDS During Sexual Intercourse" in De Vita V.T., Hellman S. & Rosenberg S.A., *AIDS: Etiology, Diagnosis, Treatment, and Prevention,* 2d ed. (Philadelphia: J.B. Lippencott, 1988) 369. The author cites a study of 'monogamous heterosexual couples in which one partner was infected with HIV' and notes '[a]mong [20] couples who used condoms appropriately, there was a decrease in the incidence of HIV infection. However, three initially seronegative spouses did subsequently develop infection with HIV despite the regular use of condoms, suggesting a 13% failure rate of condoms in the prevention of HIV. This figure does not differ greatly from the condom failure rate for pregnancy.' There was no discussion of the number of acts of intercourse or the period over which the study was conducted, however the author cites another study which provided a mean 'breakage ratio' of 1:300 to 1:500 over a six month period (at 372).

[7] Given the 'window period' of the currently available tests, a negative HIV-antibody test result is no guarantee alone that a person does not, in fact, carry the virus.

unrealistic.[8] Risk is part of the human condition, and inherent in every human activity.[9] Yet legislators, prosecutors, judges, juries and commentators may overemphasize the degree of risk of HIV transmission in drafting or interpreting legislation, or in particular cases (e.g. involving spitting or biting).[10] The tendency to err on the side of safety may be great, especially if the costs of such inaccurate assessments are not immediately

---

8 Many people who learn that they are HIV-positive will be in on-going relationships. To advise them to cease all sexual activity is unduly harsh, and unnecessary from a public health point of view.

9 As one commentator has observed in relation to the risk of HIV transmission in another context:

> Much ordinary conduct entails at least a minuscule risk of causing serious bodily harm to another. Converting all such conduct into potential criminal liability for recklessness would cast a pall on spontaneity and make normal human frailty a matter of penal concern.

Schultz G., "AIDS and the Criminal Law in the United States" (Paper presented to the Polish Section of the International Association for Penal Law, Warsaw, 23 May 1991) [unpublished] at 14. The author notes that, for example, prosecution of a person in a biting incident for aggravated assault due to the remote possibility of HIV infection would tend to collapse the distinction between the degrees of assault and allow too much room for prosecutorial abuse. See *Model Penal Code & Commentaries* (Philadelphia: American Law Institute, 1985) [hereinafter *Model Penal Code*] §2.12 ("De Minimis Infractions") noted in Sullivan K.M. & Field M.A., "AIDS and the Coercive Power of the State" (1988) 23(1) Harvard Civ. Rts - Civ. Lib. L.R. 139 at 160.

10 In April 1993 a Quebec judge sentenced an HIV-positive man, Mario McKenzie, to three years imprisonment for allegedly attempting to infect another person with his own blood by cutting his finger and smearing the blood on his victim during a fight. Medical evidence rated the risk of HIV infection in this fashion if the victim had had an open wound at 0.3%. "Trois ans de prison pour tentative de meutre par transmission du sida" *La Presse [Montreal]* (1 April 1993) A15; *R.* v. *McKenzie* (30 March 1993), Trois-Rivières 400-01-000573-931 / 400-01-000574-939 (C.Q), Morand J. [unreported]

resisted, else they will form the basis of unrealistic policies and unworkable laws.[12]

---

[11] In *A.* v.*R.* (15 May 1992, NSW Compensation Court, McGrath C.J.) the appellant, a first aid officer, claimed he had contracted HIV from the infected blood of a patient as a result of his (the officer's) habit of biting his nails. Godwin et al note:

> The decision can be criticised on many grounds but the result is significant not so much for employers who may have renewed concerns about workplace safety, but for employees who may see workers compensation as an easy means of receiving compensation for HIV infection.

Godwin et al, *supra* note 3 at 421. See Buchanan D., "Workers Compensation for HIV/AIDS" (1992) 3(3) Nat. HIV/AIDS Leg. Link. Newsltr. 11, reprinted in (1992) 1(3) Aus. Hlth. L. Bull. 301. The costs of such a 'generous' finding in a workers' compensation application might be: inaccurate perceptions as to the ease with which HIV is transmitted in the occupational setting; increased discrimination against HIV positive employees; increased insurance premiums; unnecessary delays in treating the injured, especially those thought to be at risk of HIV due to exaggerated fears of transmission; and encouraged fraud.

[12] For example, in a proposal to *reform* an unsatisfactory HIV transmission statute in Illinois, authors Closen and Deutschman define 'sexual intercourse' as 'the actual penetration or insertion of the male sex organ into the mouth, vagina, or anus of another person, or the actual penetration or insertion of the tongue of one person into the vagina or anus of another person, regardless of whether precautions such as, but not limited to, condoms or spermicides, are employed.' Closen M.L. & Deutschman J.S., "A Proposal to Repeal the Illinois HIV Transmission Statute" (1990) Ill. Bar J. 592 at 596. Under this proposal, 'sexual intercourse' without the knowledge and consent of the (uninfected) partner would be generally punishable by a sentence of three to seven years in prison.

The proscription of fellatio where the 'receptive' partner is HIV positive is overcautious as saliva is not implicated in HIV transmission. Similarly the blanket inclusion of cunnilingus and oral-anal contact in this definition is overcautious. The risk of HIV transmission in cunnilingus is negligible where the 'insertive' partner is infected, as again saliva is not implicated in HIV transmission. Nor would oral-anal contact appear to pose more than a theoretical risk of HIV infection.

4.2.2 Issues of consent

Intricately linked with conceptions of risk are issues of consent. Two questions arise: can a person consent in law to the risk of HIV infection?; and, does the principle of informed consent require that the HIV status of an infected person be disclosed in every circumstance in which HIV transmission might occur?

As to the first question, the common law generally provides that consent is not a defence to serious bodily injury or death.[13] Yet it has been proposed that consent to sexual intercourse with an HIV positive person after complete disclosure ought to be a defence to any subsequent criminal (and civil) action arising from any resulting harm:

> Providing such a defense is not likely to increase the spread of the virus, because such disclosure in the context of sexual activity is likely to discourage rather than encourage dangerous conduct. Out of self interest, potential partners are likely to decline participation or to insist on safety precautions after they have been informed of the danger of infection.
>
> In addition, personal autonomy is important, especially in matters so intimate as sexual expression. Denying a defense of consent reduces personal autonomy by leaving a person who is infected with the AIDS virus, whether married or not, with the choice of sexual abstinence or potential criminal liability.[14]

---

13 *R.* v. *Jobidon* [1992] 2 S.C.R. 714, 66 C.C.C. (3d) 454 (S.C.C.) [hereinafter *Jobidon*] (Crown not required to proved absence of consent to assault where the accused *intended* to cause bodily harm); *R.* v. *Brown* [1992] 1 Q.B. 491, aff'd [1993] 2 All E.R. 75 (H.L.) (sado-masochistic activity cannot be consented to). The *Model Penal Code* provides consent is not a defense to serious bodily harm (§2.11(2)(b)(2)): see Field and Sullivan, *supra* note 9 at 49. *Jobidon* was distinguished in circumstances where there was no non-consensual application of force: *R.* v. *Ssenyonga* 21 C.R. (4th) 128 at 137 (Ont. Ct.(Gen.Div.)), McDermid J.

14 Schultz, *supra* note 9 at 29 [footnotes omitted]. Yet we do not always act rationally, and we should be wary of cloaking an abnegation of community responsibility in respect for

In some Australian jurisdictions in which the transmission of a prescribed disease is a public health offence, the consent of the partner at risk may be available as a defence.[15]

The second question arises because, although the principle of individual autonomy requires that each person be fully acquainted with the facts on which they are to base personal decisions for which they will bear the consequences, it is also clear that, given the disadvantages of disclosure for the seropositive person, good public policy would not require the disclosure of a person's seropositive status in circumstances in which a real risk of transmission is not present. However, it is not at all clear at what point and in relation to what *kind* of sexual encounters a person with HIV might be required to disclose this fact.

For example, if disclosure were to be required, should the law require that a person with HIV disclose his or her serostatus to prospective sexual partners if it is intended that a

---

individual autonomy. See West R., "Authority, Autonomy, and Choice: The Role of Consent in the Moral and Political Visions of Franz Kafka and Richard Posner" (1985) 99 Har. L.R. 384. For example in the context of safe sex advice given to women, Van Vliet observes: "It is believed that women's ability to deny sexual access to men is total and that their power to refuse consent is equal to or even greater than men's power to initiate sex. All of the social rules which constrain women's ability to freely consent are ignored." Van Vliet E., "Law, Medicine, HIV and Women: Constructions of Guilt and Innocence" (1993) 1 Hlth L.J. 191 at 199.

15 E.g. *Public Health Act 1991* (NSW) s.13(1); *Health Act 1937* (Qld) s.48(2) (Applies only where the partner is the 'spouse or de facto spouse'); *Health Act 1958* (Vic.) s.120.

condom be used (and hence the risk of transmission is greatly reduced)?[16] Should the relatively remote risk of transmission in such circumstances be the subject of the criminal law on public health grounds, given the factors which mitigate against the imposition of criminal liability? Such factors include the stigmatizing impact of such a measure, and the reinforced (and inaccurate) perception that the criminal law is an effective tool in HIV prevention.[17] Whatever the moral imperatives for disclosure in such circumstances, it is suggested that the imposition of a criminal legal obligation to do so will have a negligible impact on the spread of HIV.

---

16 See e.g. *Public Health Act 1991* (NSW) s.13(1)) (Disclosure of sexually transmissible medical condition required before sexual intercourse: penalty $5,000). Although this provision is found in a public health act and not a criminal statute and provides for a fine rather than imprisonment, it must be remembered that the failure, or inability, to pay such a fine could result in imprisonment in any case. Compare *Health Act 1958* (Vic) s.119(d) (principles to be applied when determining the application of the Act to the management and control of infectious disease):

> A person with an infectious disease must take necessary measures to ensure that others are not unknowingly placed at risk of becoming infected.

Public and Environmental Health Act 1987 (SA) s.37(1):

> A person infected with a controlled notifiable disease shall take all reasonable measures to prevent transmission of the disease to others. (Penalty: $10,000.00)

If disclosure is not to be required by law, should the use of a condom be a complete defence to a criminal or civil action in the unlikely event that HIV infection ensues? See *The Final Report of the Legal Working Party of the Intergovernmental Committee on AIDS* (Canberra: Department of Health, Housing and Community Services, 1992) [hereinafter *LWP Final Report*] at 21ff. For commentary see Bronitt S.H., "Criminal Liability for the Transmission of HIV/AIDS" (1992) 16 C.L.J. 85.

17 See "Statement by People Living With HIV/AIDS in Relation to Working Party Recommendation (9C)" in *The Courage of Our Convictions: HIV/AIDS: The National Strategy and the Laws of NSW* (Sydney: NSW Ministerial Review HIV/AIDS Legal Working Party, 1993) [hereinafter *The Courage of Our Convictions*].

4.2.3 Some considerations in the reform of the criminal law

It has been proposed that a criminal prohibition apply only when the following conditions hold:

> 1. There is a compelling social need to require compliance with a particular social norm... Though it is undoubtably necessary that in order for society to exist, some central moral order must be upheld, the criminal justice system is not the only nor even the most important basis of this order. ...
>
> 2. There is no feasible but less costly method of obtaining compliance. ...
>
> 3. There is some substantial basis for assuming that the imposition of the criminal sanction will produce greater benefit for society than by simply doing nothing. The imposition of punishment, it would appear, is superior to doing nothing when either there is strong reason to believe that the behaviour in question is capable of being deterred or when the norm is such that non-compliance is generally felt to be so serious that doing nothing would be unacceptable to the overwhelming majority of the population. This is not entirely rational but is an acknowledgement of the force of social contract theory.[18]

Considering these criteria in turn in relation to the sexual transmission of HIV infection, it can be readily agreed that there is a compelling social need to prevent such transmission. A common proposal is to criminalize certain sexual activity where one party is HIV positive, with possible defenses of the use of protective measures or the disclosure of the person's serostatus prior to intercourse.

The financial costs of implementing such a policy, publicizing it amongst the populations most likely to be influenced by it, and prosecuting and incarcerating offenders have not

---

[18] Ruby, *supra* note 2 at 21-22.

been estimated. Such costs include training criminal justice personnel; police, prosecution and courts costs; and costs of incarceration and parole supervision. However if the supposed deterrent effect of a particular criminal provision is offered in its justification, the financial and other costs of such a policy measure should be calculated and weighed against additional funding to other policy alternatives, such as safe sex education generally, the support and counselling of the HIV infected, and the addressing of the social determinants of vulnerability such as unemployment, poverty and powerlessness.

Regarding the effectiveness of deterrence, the behaviour in question is of the most intimate nature, in circumstances in which alcohol and drugs are common and which is intricate to a person's self-esteem. Further, the behaviour change required (e.g. the use of a condom) may be heavily stigmatized for many people. Again, this is not to condone or excuse the failure to use a condom in such circumstances, but rather to highlight the unlikelihood that the very remote threat of criminal prosecution, let alone conviction given the problems of proof involved, will influence this behaviour to any appreciable extent.

Procedure	Public Health System	Criminal Justice System
Purpose	Protection of Society by: *treatment/ punishment of offenders *the removal of the infected person (quarantine)	Protection of Society by: *specific deterrence (removal/ reform) *general deterrence
Process	administrative (civil burden of proof) fewer due process protections/ court orders/ review may be available	court hearing (criminal burden of proof) *but* the accused many be remanded in custody for trial
Personnel/ Institution	doctors/ nurses/ counsellors etc hospitals/ institutions have some familiarity with HIV/AIDS	police/ prosecutors/ correctional officers correctional institutions and personnel not (yet) geared to HIV/AIDS
Punishment	fine (imprisonment possible for non-payment)/ incarceration for (unlimited) period/ other order	fine/ imprisonment for specific period/ other order

Table 1. Comparison of the public health and the criminal justice systems in relation to HIV/AIDS

4.2.4 Some factors distinguishing criminal justice and public health

Public health legislation and the criminal law may be distinguished in a number of ways (Table 1).[19] Public health legislation is forward looking (aiming to treat, cure, protect or deter), whereas the criminal law has an additional retributive, punitive element. The penalty provided for breaches of public health legislation is usually a fine, and detention, where required, is typically in a hospital, quarantine station or similar institution.[20] The criminal law provides for the imposition of fines or imprisonment, usually in a correctional facility. Other orders available in the criminal justice system, such as orders for restitution, are not found in the public health setting. As noted above, public health legislation is always a creation of Parliament, whereas (in Australia) common law criminal offenses still exist in some jurisdictions.[21]

---

19 The siting of a provision within a legislative framework does not of itself determine that it will be treated as necessarily part of that framework. It is clear, for example, from the decisions of the Supreme Court of Canada that the mere placing of a provision within a particular provincial public health framework does not protect the provision from a jurisdictional challenge; see e.g. in relation to the control of prostitution *supra* c.3, note 11.

20 Note however that imprisonment may follow the non-payment of fines imposed under public health statutes, although in practice this is uncommon. Another avenue may be prosecution for contempt of court following breach of a court order to observe an order issued by a medical officer of health under public health legislation. This was the procedure followed in *R.* v. *Ssenyonga* [1991] O.J. No.544 (16 April 1991) (Ont. Ct.(Gen.Div.)), (Montgomery J.) (QL) [unreported] [hereinafter *Ssenyonga*]. The *Ssenyonga* case is discussed further, below, in section 4.4.2.

21 Godwin et al, *supra* note 3.

Further, a criminal justice approach to issues of HIV transmission entails a number of subsidiary considerations beyond the principle issues of health, deterrence and punishment. In particular, the criminal justice and public health systems are radically different in their processes, personnel, and punishments. For example, while the criminal law generally provides greater due process protection, an accused may be remanded custody in the most unsatisfactory conditions for lengthy periods awaiting trial.[22] Whatever the letter of the law, the knowledge, attitudes and beliefs of the personnel involved will determine greatly the situations in which, and the extent to which, legal solutions are sought to prevent the sexual transmission of HIV.[23]

---

22 In *R.* v. *Downey* (20 February 1989), [1989] O.J. No. 436 (Ont. Dist. Ct.) (QL). The Court noted that "the detention centres in Toronto have not yet come up with an adequate response to the problems of detaining people who have, unfortunately, become victims of this invidious virus." The Court held that the circumstances under which the accused had been detained amounted, on the balance of probabilities, to cruel and unusual treatment, contrary to the *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11, [hereinafter *Canadian Charter*] s.12.

Revised public health statutes have to some extent accommodated due process concerns: see e.g. *Public Health Act 1991* (NSW) s.24 provides that a public health order (compelling a person to undergo treatment, counselling or to be detained) must be confirmed by a Local Court; *Health Act 1958* (Vic.) (amended in 1988 and 1989) requires a stepped process leading to detention - such orders are reviewable by the Supreme Court. See part 4.5, below.

23 In some Australian states the decision to prosecute for criminal offenses is statutorily independent of government control as a safeguard against abuse of the criminal justice process. In particular, a prosecution may be launched even against the wishes of the alleged victim, who may be subpoenaed to give evidence against his or her sexual partner. In Canada, the decision to prosecute rests ultimately with the Attorney General. See *Controlling Criminal Prosecutions: The Attorney General and the Crown Prosecutor* (Ottawa: Law Reform Commission of Canada, 1990) (Working Paper No. 62).

Hence in the absence of legislative reform, it may be that only relatively arbitrary and informal arrangements can be made between prosecutors and health departments regarding the handling of such cases. The creation and functioning of these informal arrangements may

The deterrent effects of the criminal law will also be a consideration in the decision to invoke it to protect the public health. It is useful therefore to distinguish the imposition of criminal penalties for retribution from their imposition for deterrence. Two schools of thought on the purpose of punishment have been identified: the moral and the utilitarian.[24] Moral considerations of 'justice' are outside the utilitarian view of punishment as a deterrent:

> There is no sense in talking about a "just deterrent" or a "just cure"; we demand of a deterrent not whether it is just, but whether it will deter... just when we cease to consider what the criminal deserves and consider only what will cure him or deter others, we have passively removed him from the sphere of justice altogether; instead of a person, a subject of rights, we now have a mere object, a patient, a "case".[25]

---

be hampered by the radically different views of the role of the law in limiting the spread of HIV held by the personnel of the respective departments.

On the other hand, an example of a constructive relationship is the protocol established between the relevant departments in the Australian state of Victoria. Godwin et al note that following the dropping of criminal charges against two allegedly HIV-positive sex workers in 1991,

> Victoria Police and Health Department Victoria promulgated a joint protocol where police suspect a sex worker to be infected with HIV. The protocol requires police to notify the Office of Forensic Medicine who will make an assessment and decide whether to notify the Health Department. If Health is notified, the Department will advise police of their proposed action. Any further concerns of police about the matter are to be dealt with at a meeting of senior police and Health Officials. The procedures for management of an HIV infected person are detailed in Health Department Victoria's *Guidelines for the Management in Victoria of HIV Infected People Who Are Likely to Infect Others* (April 1990).

(Godwin et al, *supra* note 3 at 55, n.90.)

24 Ruby, *supra* note 2 at 2.

25 Lewis C., *Res Judicatae VI* (1953), at 224 cited in Ruby, *ibid.* at 2-3.

The question from a utilitarian point of view then becomes: what kind of punishment, if any, will serve to protect the public from harm? Ruby identifies both general and individual aspects of deterrence, the former intended as a warning to like-minded individuals, the latter to dissuade the convicted person from repeating the offence.[26]

However, Ruby questions the effectiveness of general deterrence:

> The deterrent role of the criminal law is effective mainly with those who are already subject to the dominant socializing influences of the day. Deterrence does not threaten those whose lot in life is already miserable beyond the point of hope. It does not improve the morals of those whose value systems are closed to further modification, either psychologically or culturally; and where the prohibited conduct is the expression of sufficiently compulsive drives or motivations, deterrence is often not possible at all...
>
> In its extreme form, the advocates of deterrence suggest that fear of punishment is the only significant modifier of criminal behaviour. While we do not know the size of that marginal class that exists on the borderline of criminality and is kept in check only by the fear of punishment, it would appear that, at least for serious crime, the immediate effect of general deterrence on the largest part of the population is negligible. For the majority, the influence of upbringing, education and conscience will prevent serious crime.[27]

Ruby notes that the Canadian courts have embraced uncritically the notion of a positive correlation between the severity of a sentence and its deterrent value, although:

> [w]hat evidence there is, suggests that it is the certainty of conviction rather than the severity of the sentence which constitutes the deterrent factor in criminal

---

[26] Ruby, *ibid.* at 5,9.

[27] *Ibid.* at 5-6.

law.'[28]

> ...[w]ith regard to any particular penalty, the proper question is not whether the penalty deters, but whether that penalty is a more effective deterrent than any alternative sanctions. Who is being deterred and to what extent?'[29]

The question also arises whether it is necessary to impose a more severe sentence as a general deterrent where such a sentence is not required as a specific deterrent to the offender. For example, there are particular reasons why a Court may not wish to imprison a defendant with HIV infection or disease. In addition to concerns regarding adequate medical treatment, given the acknowledged sexual and injecting drug practices in prisons, there are also concerns for the health of other prisoners.[30]

---

28 Ruby, *ibid.* at 6. *Contra:* Hermann D.H., "Criminalizing Conduct Related to HIV Transmission" (1990) 9 Saint Louis U. P. L. R. 351: discusses the deterrent effect of criminal sanctions in the context of the *Model Penal Code* and notes that "the fact that reckless endangerment is a misdemeanour, may reduce its efficacy as a criminal sanction and thus not serve the purposes sought in using the criminal law to punish or deter the type of conduct which has been cited as justifying the use of the criminal law." (at 369)

29 Ruby, *ibid.* at 9. Ruby notes that in the absence of any rational means of evaluation, 'theories of sentencing 'are better characterized as '*moral* claims as to what justifies the act of punishment - claims as to why, morally, punishment *should* or *may* be used.' One should further ask not only if there is a more effective deterrent, but also if there are policy alternatives, such as education, which might be more effective than any deterrent approach.

30 See generally *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons* (Ottawa: Correctional Service Canada, 1994).

4.3 *Mens rea* and degrees of culpability.

In general, we are most comfortable with the imposition of criminal sanctions where the culpability of the offender is clearest. There is an inverse relationship between the degree of culpability and the incidence of the targeted behaviour in relation to the sexual transmission of HIV (Figure 3). It appears that the number of people with HIV who *purposefully* or *knowingly* infect their sexual partners is extremely small (if such a phenomenon exists at all) whereas there are possibly thousands of HIV-positive people in Canada and Australia who are unaware they are infected and thus may transmit the disease without any *mens rea,* and hence (strict liability aside) without any degree of criminal culpability. Between these two extremes lie those who have 'unsafe' sex suspecting that they may have been exposed to infection, or suspecting they may be infected but have not been tested, and so on. There is no evidence to suggest that the problem of the 'knowing', 'deliberate' or 'purposeful' spread of HIV is so widespread as to justify the attention devoted to it in the popular media and legal literature in the context of the hundreds of new infections occurring yearly in Australia and Canada.[31] Part of the problem is that the careful distinctions

---

[31] The *incidence* (as opposed to *prevalence* (cumulative incidence)) of HIV infection is very difficult to estimate, as a positive HIV antibody test result of itself gives no indication of when infection actually occurred. In those jurisdictions where HIV infection is reportable, the incidence of reported infections will be determined by a number of factors, including for example media coverage which may lead those infected years previously to seek a test. Other methods, such as (long-term and expensive) prospective studies of certain sub-populations, may provide a more accurate indication of the yearly incidence of HIV infection. See Mann J., Tarantola D. & Netter T., *AIDS in the World* (Cambridge: Harvard University Press, 1992) at 12-13 [hereinafter *AIDS in the World*].

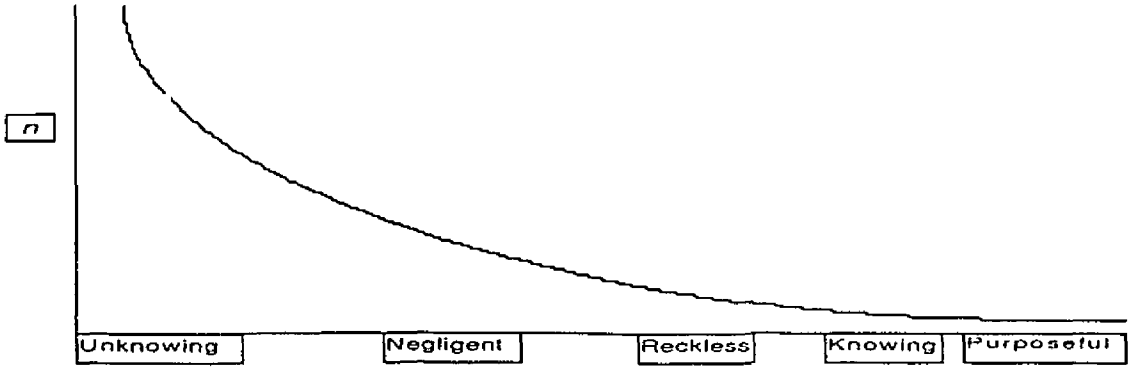

Figure 3. Degree of criminal culpability

n = incidence of sexual transmission of HIV infection

as to the varying degrees of *mens rea* made in the criminal law are lost when the 'deliberate' spread of HIV is discussed in the media.[32]

This may be contrasted with, for example, drug-related offenses. In most offenses relating to the possession and use of prohibited substances, the accused can be said to have knowingly and intentionally committed the acts the subject of the criminal charges. The prosecution rarely faces the problem of proving the necessary degree of *mens rea* to attain a criminal conviction once the facts are accepted by the Court.

Discounting popular beliefs regarding the purposeful spread of HIV, one psychologist, with the experience of over 400 HIV-positive clients, has noted:

---

[32] Aroni notes:

> The media frequently contribute to the creation of "folk devils". These can be individuals, members of groups or even illnesses. Their production by the media may involve processes such as exaggerating the incidence of a phenomenon, increasing the likelihood of its being noticed, raising concern about its supposed epidemic proportions and mobilising society against the perceived threat. This process of manufacturing folk devils is said to occur in periods of social or political crisis or upheaval. The responsibility for such crises is often attributed to groups whose marginal structural position makes them ideal scapegoats.

Aroni R., "Looking at the Media" in Timewell E., Minichiello V. & Plummer D., *AIDS in Australia* (Sydney: Prentice Hall, 1992) c.7, 125, at 129 [hereinafter *AIDS in Australia*]. See e.g. Mackie I.D., "Erecting Barriers to Slow the Spread of AIDS" *Globe & Mail* (31 August 1993) in which the author, Associate Professor of Medicine at the University of Western Ontario and Director of the HIV care program at St. Joseph's Health Centre in London, Ontario, advocates specific laws and a 'radical new approach' to those who 'deliberately spread HIV'; see also the front page banner headline: Madill J., "AIDS Fiend Strikes Again" *The [Halifax] Chronicle-Herald* (19 September 1988) 1. In the accompanying article on the same page, Health Minister Joel Matheson was quoted as saying, "My concern of course is that the public is being exposed to a very serious health hazard."

> The popular psyche evidently has a deep need to believe that some people with HIV set out by way of revenge to infect as many 'innocent' others as possible. In hundreds of clients seen over six years, however, I have come across only a handful of people who ever knowingly put anyone in danger, and none who disclosed a sexual act of revenge. They usually endangered others when alcohol or lust loosened their grip on their behaviour, and in all but two cases were deeply troubled by having done so. Far more common, indeed routine, are clients who withdraw themselves (usually 2-3 months after diagnosis) from all sexual contact in anticipatory guilt, and take many months to be persuaded to see themselves once more as sexual beings.[33]

It is suggested that the above consideration is but the first of a number of factors that should temper the speedy application of the criminal law to the sexual transmission of HIV infection. In the absence of evidence to the contrary, it appears that the number cases in which the criminal law might most easily and appropriately be invoked is extremely small, if any exist at all. Hence a general policy premised on the assumption that most, or even many, new HIV infections are the result of a conscious desire to spread the virus, and hence most amenable to the application of the criminal law, would be unsound.

However, given that the criminal law is being invoked in this context in both Canada and Australia, it is useful to consider in greater detail the kinds of provisions, if any, that might most usefully be applied. The discussion of the U.S. *Model Penal Code* below is

---

[33] Timewell E., "Counselling and Psychotherapy" in *AIDS in Australia*, *ibid.* 324 at 340. Nonetheless, the circumstances in which an HIV-positive person might 'knowingly put anyone in danger' require further examination, as intoxication and lust are not readily accepted as defenses to criminal prosecution. The '2-3 month period' following diagnosis noted here when a person may remain sexually active corresponds with a period of initial shock and denial during which the person may not accept that they are both HIV positive and infectious. See *R.* v. *Kreider* (1993), 140 A.R. 81 [hereinafter *Kreider*] (defence of such 'denial state' rejected.)

followed by a consideration of the specific criminal provisions and case law in both Canada and Australia.[34]

The *Model Penal Code* identifies four possible states of mind that might be required to accompany a crime (in descending order of culpability): purposeful, knowing, reckless, and negligent. Sullivan and Field note:

> Of these four possible states of mind, three involve the taking of risks, not the will to harm others. Only *purposeful* is defined as wanting the prohibited result. *Knowing* is defined as being consciously aware that the result is practically certain to occur, and proceeding anyway; *reckless* is defined as being consciously aware of a substantial and unjustifiable risk that it will occur, and proceeding anyway; *negligent* is defined as possessing knowledge that should cause a reasonable person to avoid such a risk, and proceeding anyway.[35]

There have been no Canadian or Australian cases in which it has been alleged that the accused engaged in unprotected sexual intercourse *purposely* to infect his or her partner.[36] The application of the criminal law in this context is relatively uncontroversial. This section will focus on the ethically more difficult, and in practice relatively more common,

---

34 See Sullivan & Field, *supra* note 9 at 160 n.67; see also Field M.A. & Sullivan K.M., "AIDS and the Criminal Law" (1987) 15 (1-2) L. Med. Hlth Care 46; Schultz G., "AIDS: Public Health and the Criminal Law" (1988) 7 St Louis U.P.L.R. 65 (comprehensive analysis of *Model Penal Code* provisions and HIV/AIDS).

35 Sullivan & Field, *ibid.* See *Model Penal Code* §2.02(2).

36 In one Australian case involving an attack on a correctional officer with a syringe containing HIV infected blood, the accused died of AIDS before the case came to trial. The officer later tested HIV positive; see Godwin et al, *supra* note 3 at 54, n.84.

situation of reckless or negligent risk.

The risks of HIV infection following unprotected penetrative sexual intercourse[37] are believed to vary greatly according to a number of factors, such as: the infectivity of the infected person (as determined by the amount of virus in their blood or semen); the presence of other sexually transmitted diseases[38]; whether the infected partner is insertive or receptive; and, for women and girls, their age.[39] In any case, it cannot be said that infection 'is practically certain to occur' and, therefore, unprotected penetrative sexual intercourse alone cannot meet standard of culpability ascribed to the *knowing* infliction of harm noted above.

The issue as to whether a person is 'consciously aware' that he or she is placing another at risk is problematic. In addition to the factors of 'alcohol or lust' noted above, some people, on being informed of a positive HIV antibody test result, initially refuse to believe they have contracted HIV and are hence infectious, and may continue, while in

---

37 This phrase is used to denote penile penetration of the vagina or anus without a condom, with or without ejaculation. It does not, for the purposes of this paper, include fellatio because the risks of transmission in such circumstances appear very low.

38 *AIDS in the World* at 178; Crofts N., "Patterns of Infection" in *AIDS in Australia, supra* note 32, 24 at 32ff.

39 Reid E & Bailey M., *Young Women: Silence, Susceptibility and the HIV Epidemic* (New York: HIV and Development Programme, United Nations Development Programme, 1992) (Issues Paper #12).

this state of 'denial', to place others at risk through unprotected penetrative sexual intercourse.[40]

Regarding recklessness, the fact that HIV infection is a debilitating and life-threatening condition is relevant to whether there is a 'substantial and unjustifiable risk' of HIV infection in unprotected penetrative sexual intercourse with an infected person. It is suggested that given the catastrophic personal implications of HIV infection, such a risk, though small, would be 'substantial and unjustifiable'.[41]

Discussing the applicability of the criminal law to recklessness and negligence, Sullivan and Field note:

> To be sure, the Model Penal Code, like the laws of most states, requires for most crimes a culpability level of recklessness or higher. Since negligence can be the product of carelessness, inadvertence or ignorance, it is generally considered an insufficiently culpable state of mind to support criminal sanctions, with the stigma and severe deprivation of liberty that they impose. When the Code does accept

---

[40] See *Kreider, supra* note 33: (evidence of such a 'denial state' not accepted as a defence or in mitigation of sentence). Adequate pre- and post-test counselling would thus appear to be crucial in this regard. See e.g. *Health Act 1958* (Vic.) s.127(1), which provides that medical practitioners are prohibited from carrying out or authorizing the carrying out of a test for HIV on a person who requests it unless the person has been given information about the medical and social consequences of being tested and of the possible results of the test. If the test result is positive the person must be advised about the medical and social consequences of being infected with the virus and guidelines on ways to prevent the transmission of the virus to others (s.127(2)).

[41] In other circumstances in which there is a small but real risk of HIV transmission, there may be policy considerations which would weigh against disclosure, for example in the health care setting; see Flanagan W., "AIDS-Related Risks in the Health Care Setting: HIV Testing of Health Care Workers and Patients" (1993) 18 Queen's L.J. 71.

> negligence as sufficient, it invariably reduces the severity of the offense. And as to *both* recklessness and negligence, the Code requires more that mere carelessness; it requires a "gross deviation" from ordinary standards of care... Lesser deviation from such standards may create civil but not criminal liability.[42]

The Law Reform Commission of Canada agrees that 'gross negligence' should be the subject of the criminal law where a 'substantial risk' of death or serious injury results.[43] The Commission noted the general consensus that negligence attracting criminal liability must be greater than that attracting merely civil liability - 'rather a matter of public concern calling for stigma and punishment through criminal law.'[44]

It is suggested that a 'reasonable person' who was HIV-positive would seek to avoid the risk of infecting his or her partner (by e.g. using a condom for penetrative sexual intercourse). Hence the failure to take such care, given the possible consequences, would meet at least the first level of culpability, gross negligence, as noted above.[45]

---

42 *Ibid.* See *Model Penal Code*, *supra* note 9, §§2.02(2)(c)-(d).

43 *Omissions, Negligence and Endangering* (Ottawa: Law Reform Commission of Canada, 1985) (Working Paper No. 46) c.3.

44 *Ibid.* at 29. However, it would appear that the decision of the Supreme Court of Canada in *Thornton*, *supra* note 1, approved the attachment of criminal liability to acts which would have previously attracted only civil liability.

45 For a discussion of culpability following the failure of such precautions, see *LWP Final Report*, *supra* note 16 at 21ff.

Finally, it is worth noting that the *Model Penal Code* provides that consent is a defence to assault, but only where the injury was a reasonably foreseeable outcome of the conduct. It has been suggested that this formulation would require informed consent to sexual intercourse.[46]

If, as suggested, the deterrent effect of the criminal law is remote, it must be assumed that the deterrent effect of the civil action in Australia and Canada is for all practical purposes nonexistent. While the civil law has provided some compensation in cases of actual infection, its application in cases of risk where no infection results is more problematic.[47] As the focus of this paper is on HIV prevention, it is *all* behaviour which puts others at substantial and unjustifiable risk, not only those occasions on which HIV infection actually occurs, which is of interest. The remainder of this chapter considers the policies, law and jurisprudence in Australia and Canada in relation to the sexual transmission of HIV infection, or the placing of others at risk of such infection.

---

46 Tierney T.W., "Criminalizing the Sexual Transmission of HIV: An International Analysis" (1992) 15 Hastings Int'l & Comp. L.Rev. 475 at 498.

47 Unlike in the United States, civil actions for compensation following the sexual transmission of disease are very rare in Canada and Australia and there have been no successful actions for the sexual transmission of HIV. See generally O'Dair R., "Liability in Tort for the Transmission of A.I.D.S.: Some Lessons from Afar and the Prospects for the Future" (1990) 43 Current. L. Prob. 219; Schwartz J., "Liability for the Transmission of AIDS and Herpes" (1987) An. Surv. Amer. L. 523; Taitz J., "Legal Liability for Transmitting AIDS" (1989) 57(4) Medico-L.J. 216; Darby J.P., "Tort Liability for the Transmission of the AIDS Virus: Damages for Fear of AIDS and Prospective AIDS" (1988) 45 Wash. & Lee L.R. 185; Schoenstein R.C., "Standards of Conduct, Multiple Defendants, and Full Recovery of Damages in Tort Liability for the Transmission of Human Immunodeficiency Virus" (1989) 18 Hofstra L.R. 37.

4.4 Canadian policies, legislation and case law

4.4.1 National policies

The Canadian national HIV/AIDS policy document makes no mention of criminal law and the sexual transmission of HIV.[48]

The National Advisory Committee on AIDS (NAC-AIDS) has recommended:

> In the very small number of cases where involuntary measures are reasonably and demonstrably essential, the use of carefully controlled involuntary public health measures is generally to be preferred over criminal sanction. For example, in these rare circumstances, if it is possible that involuntary institutionalization, coupled with appropriate counselling, may result in the desired behaviour modification, this option is preferable to the criminal law...
>
> In the unusual event that a person with HIV infection knowingly and recklessly, or by reason of serious mental instability or illness, continues to present a demonstrable risk of infection to a third party, and all reasonable efforts to encourage risk-reducing behaviour have failed, it may be appropriate for a health care professional to report the name of his individual to the public health authorities, in order to permit the consideration of additional public health measures to reduce the risk of infection.[49]

The Canadian Public Health Association (CPHA) has noted:

> When a person who is HIV positive is unwilling or unable to change his or her behaviour, public health is challenged to determine the most appropriate intervention. These situations, while extreme and small in number, are both

---

48 *HIV and AIDS: Canada's Blueprint* (Ottawa: Ministry of Supply and Services, 1990).

49 *HIV and Human Rights in Canada* (Ottawa: National Advisory Committee on AIDS, 1992) at 15.

> difficult and challenging... Public health officials must endeavour to keep interventions in difficult cases within public health law unless a criminal act, such as a sexual assault, is involved.'[50]

The authors of this report made no reference to the criminal convictions in Canada of people with HIV infection for the infection others, or putting others at risk, in circumstances that did *not* involve 'sexual assault.'

Keeping such matters within the domain of public health law may be the preferred option for NAC-AIDS, the CPHA and other bodies, but it does not reflect the views of Canadian prosecutors and judges. The lack of national coherence in this regard is amply illustrated by the relevant cases and decisions of Canadian courts. On the one hand, the advocates of the 'public health' approach appear to view the criminal law as a last resort, if appropriate at all. Further, although there is no specific offence of 'reckless endangerment' in the absence of resulting bodily harm in Canada, convictions have nonetheless been obtained in such circumstances following guilty pleas to arguably inappropriate charges, and the comments of the Court at the time of sentencing make it clear that some members of the judiciary believe that the criminal law has an important role to play in this regard.

There appears to have been little attempt to coordinate the criminal justice system and public health efforts. Rather than seeking to rationalize the decision to prosecute in circumstances in which HIV-positive people are contributing to the risk of HIV transmission by developing policies in conjunction with provincial prosecutors, it appears

---

50 *HIV & AIDS: A Public Health Perspective* (Ottawa: Canadian Public Health Association, 1993) at 20, 21.

that public health officials and others working with people with HIV have simply relied on the general unlikelihood that such circumstances will come to the attention of the police. Counsellors handling such 'difficult cases' clearly do not inform prosecutors at the first disclose of such behaviour. In fact, there appears little evidence that there is any constructive relationship between provincial public health workers and their counterparts in the criminal justice system. Hence when such matters have come to the attention of the police, the reaction of prosecutors and the courts has been generally untempered by the considerations of 'healthy public policy'.[51]

4.4.2 Canadian criminal legislation and case law

As noted above, Canadian courts have on several occasions considered cases where people with HIV have infected others, or put others at risk of infection (see Table 2).[52] In some cases, the law was deemed appropriate to support a conviction. In *Thornton* the accused was convicted of committing a 'common nuisance' by donating blood, knowing

---

51 E.g. regarding *Thornton* Ducharme, *supra* note 6 at 492 notes (footnote omitted):

> Perhaps the most disturbing aspect of this case was the way it was handled by the police. Shortly after Mr Thornton was charged, Supt. J. McCombie, head of the Ottawa Police Department's criminal investigation branch, held a news conference during which he released a photograph of Mr Thornton and alleged he was continuing to spread HIV through continued sexual activity. The story and photograph were widely reported in the Canadian print media.

52 See generally Hamblin J. et al, *Responding to HIV/AIDS in Canada* (Toronto: Carswell, 1990) [hereinafter *Responding to HIV/AIDS*]; Shekter R.H., "The Criminalization of AIDS in Canada" (Paper presented to the Canadian Bar Association of Ontario, November 1992) [unpublished].

at the time that he was HIV-positive.[53]

Section 180(1) of the Canadian *Criminal Code* provides:

> 180. (1) Every one who commits a common nuisance and thereby
> (a) endangers the lives, safety or health of the public, or
> (b) causes physical injury to any person,
> is guilty of an indictable offence and liable to imprisonment for a term not exceeding two years.
> (2) For the purposes of this section, every one commits a common nuisance who does an unlawful act or fails to discharge a legal duty and therefore
> (a) endangers the lives, safety, health, property or comfort of the public; or
> (b) obstructs the public in the exercise or enjoyment of any right that is common to all the subjects of Her Majesty in Canada.[54]

The Court of Appeal held that a "legal duty" includes a duty arising at common law, specifically the duty to refrain from conduct which, it is reasonably foreseeable, could cause serious harm to other persons.[55] It appears that the broad interpretation of 'legal duty' given by the Court of Appeal and affirmed by the Supreme Court has thus 'criminalized' the 'mere civil negligence' that the Law Reform Commission of Canada considered should remain outside the criminal law.[56]

---

53 *Supra* note 1. The accused was charged under s.176(a) (now s. 180) of the *Criminal Code Act*, R.S.C. 1985, c.C-46 [hereinafter *Criminal Code*].

54 *Ibid.*

55 (1991) 1 O.R. (3d) 480, at 484, Galligan J.

56 *Omissions, Negligence and Endangering, supra* note 43 at 28ff. For example, under the interpretation given to s.180 of the *Criminal Code* in *Thornton*, it appears a person leaving a bicycle lying across a footpath could now be prosecuted for 'common nuisance' and face up to two years' imprisonment.

Table 2 Canadian cases relating to the sexual transmission of HIV infection

Case/ Jurisdiction	**Facts/ Allegations**	**Charges (Criminal Code)/ Plea**	**Trial Court**	**Appeal Court**
Summer Alberta	Unprotected sexual intercourse without informing 5 female partners he was HIV+ (no transmission)	'common nuisance, (s.180)/ guilty	10 August 1989 (1989), A.R. 191 convicted/ 1 year prison/ 3 years probation	13 September 1989 (1989), 73 C.R. (3d) 32, 69 Alta. L.R. (2d) 303, 99 A.R. 29. appeal rejected
Kreider Alberta	Unprotected sexual intercourse without informing female partner he was HIV+ (no transmission)	'common nuisance, (s.180)/ guilty	25 May 1993 (1993), 140 A.R. 81, [1993] A.W.L.D. 560 convicted/ 1 year prison	
Lee Ontario	Unprotected sexual intercourse without informing female partner he might be HIV+ (no transmission)	'aggravated assault' (s.268,s.265) not guilty	17 April 1991 3 O.R. (3d) 726 acquitted no evidence of fraud as to the nature and quality of the act	

Ssenyonga Ontario	Unprotected sexual intercourse without informing partners he was HIV+ (3 women infected)	1. 'aggraveated sexual assault' (s.273); 2. 'administering a noxious thing' (s.245); 3. 'common nuisance' (s.180); 4. 'criminal neg. causing bodily harm' (s.221) not guilty	28 May 1992 Livingstone J. (Prov. Div.) preliminary hearing: 1. committed to trial 2. discharged 3. discharged 4. committed to trial 30 April 1993 McDermid J. (Gen. Div.) (1993) 21 C.R. (4th) 128, 81 C.C.C. (3d) 257 1. acquitted (Crown appealed) 4. (unfinished)	Appeal heard on directed verdict of acquittal on charges of aggravated sexual assault. Accused died before judgment handed down.
Wentzell Nova Scotia	Unprotected sexual intercourse without informing partners he was HIV+ (1 woman (pregnant) infected)	'criminal neg. causing bodily harm' (s.221) guilty	8 December 1989 C.R. No. 10888 Halifax County Ct. convicted/ 3 years prison	
Mercer Newfoundland (considered in *R.* v. *Young* Nfld. S.c. Trial Div. 15 July 1994 S.J. 2625/92)	Unprotected sexual intercourse without informing partners he was HIV+ (2 women infected)	1. 'criminal neg. causing bodily harm' (s.221) 2. 'breach of recognizance' guilty	Date? convicted/ 30 months prison (Crown appeal against sentence)	12 August 1993 (1993), 84 C.C.C. 41 1. raised to 11 years. 2. upheld Leave to appeal to S.C.C. refused.

Thornton Ontario	Donated blood knowing he was HIV+ (no transmission)	'common nuisance' (s.176) [now s.180] not guilty	convicted 15 months prison	Court of Appeal 42 O.A.C. 206 upheld Suppreme Court of Canada 21 C.R. (4th) 215 upheld
Langlois Quebec	Anal sex with 17 1/2 year old male (minor infected)	'anal intercourse with a minor' (s.159) guilty	25 January 1991 J.E. 91-954 (Que. Ct.) convicted/ 4.5 years prison (infection of minor an aggravating factor)	

Section 180 has been used in two cases in which an HIV-positive person has put another person at risk of infection through unprotected sexual intercourse, although no infection resulted.[57] In both cases the accused men pleaded guilty to the charge of common nuisance. If they had pleaded not guilty, it is may be that the convictions would not have been upheld on appeal, given other precedents that one element of the charge is some risk

---

57 In *Kreider, supra* note 33, the accused pleaded guilty to a charge of committing a common nuisance under section 180 of the *Criminal Code*. The accused tested HIV positive in February 1991, and was, according to the judge's reasons for sentence, warned against having unprotected sex at that time. About six weeks after being diagnosed, the accused met the complainant, a woman he knew well but had not seen in many years. He subsequently had unprotected sex with her on three occasions, without telling her he was HIV positive. When he told the complainant he was HIV-positive they both sought medical advice, at which time the accused was described as being 'tearful and extremely remorseful over what he had done' (at 82). The woman subsequently tested negative and thereafter continued a (protected) sexual relationship with the accused. Evidence was given by a psychologist that the accused 'may well have being going through a period of temporary denial at the time of the offence', *ibid.* The judge expressed concern that to excuse or exonerate the accused on this ground 'would be tantamount to saying that people diagnosed with this disease are at liberty to have unprotected sex without informing their victim until they can come to terms with the terrible news', *ibid.* Mitigating factors were held to be: the fact there was only one 'victim'; the accused's admission of his serostatus to the victim; his extreme and genuine remorse; his psychological state at the time; his lack of any relevant criminal record; and his timely guilty plea. On the other hand, the judge noted that 'the potential risk to the victim of even one act of unprotected sex is so devastating that a clear and unequivocal message must be sent to others who might be tempted to put other innocent victims at risk' (at 85). Taking into account 12 days spent in pre-trial custody, the accused was sentenced to one year imprisonment.

In *R.* v. *Summer* (1989), 73 C.R. (3d) 32 (Alta. C.A.) [hereinafter *Summer*] the accused pleaded guilty to a charge 'that he did commit a common nuisance by engaging other people in unprotected sexual intercourse while knowing he was infected with the human immunodeficiency virus, thereby endangering the lives and health of the public contrary to Section 180 of the Criminal Code' and was sentenced to one year imprisonment and three years probation. His appeal against sentence was rejected.

to the public at large.[58]

Section 219 of the *Criminal Code* provides:

> 219. (1) Everyone is criminally negligent who
> (a) in doing anything, or
> (b) in omitting to do anything that it is his duty to do,
> shows wanton or reckless disregard for the lives or safety of the public.
> (2) For the purpose of this section, "duty" means a duty imposed by law.[59]

Although defining criminal negligence, s.219 provides no penalty in the absence of bodily harm. Police have resorted to charges of common nuisance, aggravated assault or aggravated sexual assault, and administering a noxious thing. If guilty pleas are entered (and accepted by the Court) the applicability of these provisions will be unchallenged.

---

58 There is case law for the proposition that a conviction under this section cannot be supported where the acts are directed against particular individuals: *R.* v. *Schula* (1956), 115 C.C.C. 382, 23 C.R. 403 (Alta. C.A.) [hereinafter *Schula*], aff'd *R.* v. *Ssenyonga*, [1992] O.J. No. 1154 (Ont. Ct.(Prov. Div.)). In *Thornton* Galligan J. noted that the early common law offence of common nuisance encompassed exposing others to the risk of infection by a contagious disease: 42 O.A.C. 206 at 211. However the cases referred to by the learned judge related to either small pox (*R.* v. *Vantandillo* (1815) 4 M. & S. 73, 16 R.R. 389; *R.* v. *Burnett* (1815) 4 M. & S. 272, 16 R.R. 468), or a zoonosis ('glanders') (*R.* v. *Henson* [1852] Dears C.C. 24). Communicable diseases such as smallpox are by definition easily transmitted and hence threaten the public at large. HIV infection may be distinguished from such diseases as it is not transmitted by casual contact and hence a person with HIV is arguably not a risk to the public at large.

59 See Barnhorst S., Barnhorst S., & Clarke K.L., *Criminal Law and the Canadian Criminal Code* (Toronto: McGraw-Hill Ryerson, 1992) 212-217 for a discussion of the required *mens rea* and whether a subjective or objective standard is to be applied. The Supreme Court has since held that an objective standard will suffice. See Healy P., "The Creighton Quartet: Enigma Variations in a Lower Key" (1993) 23 C.R. (4th) 265.

Regarding aggravated assault (s.268) or aggravated sexual assault (s.273), it has been argued that the failure of the accused to inform his partners of his seropositivity vitiated the consent to sexual intercourse. It is argued that the consent was thus obtained through fraud, providing the grounds for the charges.[60] This argument has been generally rejected by those courts called to consider it, following an English decision which distinguished fraud as to the nature of the act or the identity of the accused from fraud or misrepresentations regarding the accused's sexual health.[61]

---

60 Section 268(1) of the Criminal Code provides:

268. (1) Every one commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant.

This section relies on the definition of assault provided in section 265, which provides:

265. (1) A person commits an assault when

(a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly ...

(2) This section applies to all forms of assault, including sexual assault ...

(3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of ...

(c) fraud ...

61 *R.* v. *Clarence* (1888), 22 Q.B.D. 23, [1886-90] All E.R. 133. A husband who had infected his wife with gonorrhoea without previously informing her he had the disease. The conviction for sexual assault occasioning actual bodily harm was quashed on appeal, partly on the basis that the accused could not be convicted of assault where the act of sexual intercourse was consented to; aff'd *R.* v. *Lee* (1991), 3 O.R. (3D) 726 [hereinafter *Lee*], aff'd *Ssenyonga, supra* note 13, 21 C.R. (4th) 128, 81 C.C.C. (3d) 257 (Ont. Ct.(Gen.Div.)). In *Lee* the accused was charged with "aggravated assault" after engaging in unprotected penetrative sexual intercourse with the complainant. The Crown submitted that the accused had obtained the complainant's consent to sexual intercourse by fraud, because he had failed to tell her that he was HIV-positive (even though he was first tested after he was arrested). The Crown further argued that the accused should be found guilty of "aggravated assault" because he endangered the complainant's life. (She later tested negative.) The accused was acquitted of aggravated assault. After reviewing the authorities the Court held that the consent of the complainant to the act of sexual intercourse was valid. Only fraud as to the nature and quality of the act or as to the identity of the person who performs the act alleged to be an assault will vitiate the consent. There was no evidence of any fraud by the accused as to the nature and quality of the act of sexual intercourse itself. Consequently, the Court held that the accused

Where not guilty pleas were entered, charges of administering a noxious thing and common nuisance have also been held to be inapplicable in these circumstances.[62]

Several different approaches have been adopted by the police and prosecution in those cases in which the failure of the accused to take precautions during penetrative sexual intercourse or to inform his sexual partner of his seropositivity has resulted in HIV transmission.

Considering first a charge of criminal negligence causing bodily harm, prosecutions have been successful in two cases. In both instances the accused men were aware of their

---

had not obtained the complainant's consent to sexual intercourse by fraud. *Contra R.* v. *Bennett* (1866), 10 Cox. C.C., 176 Eng. Rep. 925.

62 In *Ssenyonga, supra* note 13, Livingstone J. at a preliminary hearing, [1992] O.J. No. 1154 (28 May 1992) (Ont. Ct.(Prov. Div.)) (QL) [unreported], discharged the counts of 'administering a noxious thing' under section 245 of the *Criminal Code* because there was no evidence of the required *mens rea* nor 'that the accused could have foreseen the certainty or substantial certainty of infecting the complainants with HIV by having unprotected sex with them.' Livingstone J. also discharged the counts of common nuisance under s.180 of the *Criminal Code*. The prosecution had argued that the 'legal duty' referred to was the legal duty to obey the public health order of 12 February 1990. Livingstone J. distinguished *Thornton, supra* note 1, observing:

> The facts in this case are significantly different. I have heard no evidence that Mr Ssenyonga offered himself to the general public. The evidence before me is of sexual relationships with specific individuals with whom the accused had apparently developed an attachment over time.
>
> Certainly the complainants are members of the public but I cannot accept that they, from a legal perspective, represent the community as a whole. The offence of common nuisance, is, in my view, not appropriate based on the evidence presented at this preliminary inquiry.

seropositivity, did not inform their sexual partners, had been counselled as to the necessity of condom use, and demonstrated a callous disregard for the safety of their sexual partners by having repeated unprotected penetrative sexual intercourse with them. In both cases the accused men pleaded guilty to the charges of criminal negligence causing bodily harm.

Section 221 of the Criminal Code provides:

> 221. Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

R. v. *Wentzell* was the first such case in Canada.[63] The Court noted that the accused not only knew, but had been counselled regarding his infection and the necessity of practising safer sex. The accused was sentenced to three years imprisonment.

In *R.* v. *Mercer*, the accused had infected two partners and was sentenced by the trial judge to 30 months imprisonment. On appeal by the Crown, his sentence was increased to eleven years and three months imprisonment.[64]

In *Mercer*, the Court considered the *mens rea* requirement of s.221 and noted (*obiter*

---

63 *R.* v. *Wentzell*, C.R. No. 10888 (Halifax County Court, Nova Scotia, 8 December 1989)[unreported].

64 *R.* v. *Mercer* (1993), 84 C.C.C. (3d) 41 (at 50).

dicta, as this was an appeal against sentence only) that 'even those who maintain that the objective test alone is an insufficient basis for a finding of guilt in a criminal negligence charge, but must be supplemented with a degree of guilty knowledge, acknowledge that a finding of deliberation is "the minimal intent requirement of awareness or advertence or wilful blindness to the prohibited risk"'.[65]

The Ssenyonga Case

The current incapacity of the public health and the criminal justice systems to handle such cases was revealing illustrated in the case of Charles Ssenyonga, who infected at least three women before he died. Ssenyonga was indeed a 'difficult case' and it appears neither the public health, nor the criminal justice system, was able to cope with him adequately. The public health response was delayed and ineffective; the criminal justice system responded equally ponderously and inappropriately.

Legal action commenced against Ssenyonga in February 1990, when a Medical Officer of Health issued an order under s.22(4)(h) of the Ontario *Health Protection and Promotion Act* prohibiting Ssenyonga from engaging in certain sexual activities.[66] The Chief

---

65 *Ibid.* at 53 per Marshall J.A. citing *R.* v. *Tutton* (1989), 69 C.R. (3d) 289, 314 per Wilson, J.

66 S.O. 1983 c.10 s.22, (now R.S.O. 1990 c.H.7 s.22). See Johnston C., "AIDS and the Law: Do Courts Have a Place in the Bedrooms of the Nation?" (1992) 146(11) Can. Med. Assoc. J. 2065. According to Johnston, Ssenyonga was ordered "to abstain from any sexual activities involving penetration. The ban [applied] even if a condom [was] used, and to sexual acts involving his fiancee" (at 2065).

Medical Officer of Health later sought an order restraining the contravention by the accused of that order under s.101(1).[67] In April 1991, the Ontario Court (General Division) issued such an order prohibiting the accused from breaching the order of February 1990, pending a hearing before Ontario's Health Protection Appeal Board.[68]

Ssenyonga allegedly continued unprotected penetrative sexual intercourse with a number of partners knowing that he was HIV positive, and was charged with aggravated sexual assault,[69] criminal negligence causing bodily harm,[70] administering noxious bodily fluids,[71] and nuisance endangering the life of another.[72] In June 1991 the accused was released by a Justice of the Peace on $5,000 bail on the grounds that it was unlikely that

---

67 The resort to a court order was probably made because in Ontario, HIV is classified as a 'communicable' rather than a 'virulent' disease. The Act only allows the incarceration and treatment of persons with the latter, hence application for the court order and the threat of imprisonment for contempt.

68 [1991] O.J. No.544 (QL) (Montgomery J.) [unreported].

69 *Criminal Code* s.273.

70 *Criminal Code* s.221.

71 *Criminal Code* s.245.

72 *Criminal Code* s.180.

the Crown would succeed in convicting him of any of the charges.[73]

In 28 May 1992 there was a preliminary hearing on the charges and the accused was ordered to stand trial on the counts of criminal negligence causing bodily harm and aggravated sexual assault. The other charges were dismissed.[74] On 30 April 1993 the accused was acquitted on the charges of aggravated sexual assault, on the ground that each of the complainants freely and voluntarily engaged in sexual intercourse with the accused without the use of a condom. The defence had submitted that, as the Crown had failed to negative consent, no assaults were committed. The Court rejected the submission that on public policy grounds the accused's failure to disclose his HIV status should vitiate the complainants' consent:

> What the Crown is asking this court to control is the transmission of HIV and the spread of AIDS rather than the application of force. In my opinion, the law of assault is too blunt an instrument to be used to excise AIDS from the body politic.[75]

---

73 In August 1991 an application to reverse the bail decision was dismissed for lack of evidence by Jenkins J. of the Ontario Court (General Division) [1991] O.J. No. 1460 (QL). The Crown argued that the accused should have been detained in custody on two grounds: first, that there was a serious risk that the accused would not appear for trial; and second, that he was a danger to the public "because he is likely to engage in sexual relations without advising his partners that he is a carrier of the AIDS virus and without taking precautions to avoid spreading the virus."

74 [1992] O.J. No. 1154. (Prov. Div.) (Livingstone J.) (QL) [unreported]. It is noteworthy that Livingstone J. rejected *Lee* and committed Ssenyonga for trial on the charge of aggravated sexual assault.

75 (1993) 21 C.R. (4th) 128 at 137. The Crown had argued that consent had not been given because unprotected sexual intercourse with a person who knows and fails to disclose that he is infected with HIV is so inherently dangerous that it exceeds the scope of the complainants'

The Crown appealed this decision, however the accused died before the verdict on the charges of criminal negligence causing bodily harm, or the decision on the appeal against the dismissal of the charges of aggravated assault, could be handed down.

In my view the courts were correct to reject as inappropriate the charges of aggravated assault in *Lee* and *Ssenyonga,* because to allow fraud to vitiate consent in such circumstances is to effectively import into the criminal law the civil law notion of 'informed consent', which is itself increasing in breadth, notably in the medico-legal sphere.[76]

---

implied consent. The Crown also argued that consent in the absence of disclosure of a relevant factor such as HIV infection could not be considered 'informed consent.' The Crown further argued that failing to disclose HIV infection in such circumstances constituted fraud that vitiated consent. The Court dismissed this argument, following *R.* v. *Petrozzi* (1987), 35 C.C.C. (3d) 528 and *R.* v. *Lee* (1991), 3 O.R. (3d) 726 and holding that 'fraud' for the purposes of the *Criminal Code* means fraud as to 'the nature and quality of the act' and should not be extended to all frauds causally connected with consent.

[76] See e.g. David M. & Scott R.S., *Lovers, Doctors & the Law* (New York: Harper & Row, 1988) for a proposed check-list of questions and disclosures before sexual intercourse to avoid civil liability.

HIV transmission as an aggravating factor

It is worth noting a Quebec case in which the sexual transmission of HIV, did not form the basis of a charge, but rather was considered an aggravating factor in sentencing.[77] On reading this case, as with the others above in which it appeared a genuine friendship existed between the accused and the person(s) he infected, one must ask why Langlois put the young man at such risk. Whatever one's conclusions it is hard to believe the remote threat of a criminal prosecution would have affected his decision not to use a condom at that time. If we are genuinely concerned with stoping the sexual transmission of HIV much more research will be required into the dynamics of such interactions.

It is not known why a charge of criminal negligence causing bodily harm was not laid, and it is interesting to consider the comment of the Quebec prosecutor that if the events had occurred somewhat later (i.e. after the complainant's eighteenth birthday) the matter would not have come to court. This is the only case of homosexual transmission of HIV to come before the Canadian courts and one must thus speculate as to whether a different standard is applied according to the sex or sexual orientation of the parties involved.

---

77 *R.* v. *Langlois* (25 January 1991), Quebec 200-01-010507-907, J.E. 91-954 (C.Q.). The accused was charged with anal intercourse with a minor, contrary to s.159(1) of the Criminal Code. The complainant was aged about seventeen and half years old at the time of the offence. In sentencing the accused the Court treated as an aggravating factor the fact that the accused had unprotected anal sex with the complainant knowing he (the accused) was HIV positive, and in fact infected the complainant with HIV. The accused was sentenced to four and a half years imprisonment.

Finally, reference has been made by several commentators to the 1985 amendment of the *Criminal Code* to repeal the provision specifically relating to the transmission of venereal disease.[78] It has been suggested that the provision was repealed, at least in part, because (at the time) "sexually transmitted disease was considered to be a public health matter rather than a matter for the criminal law", and that "the existence of a criminal offence inhibited the reporting desired for statistical and research purposes and required by provincial law."[79]

---

[78] Repealed by *Criminal Law Amendment Act*, S.C. 1985; c.19, s. 42. This provision provided, its most recent form prior to repeal:

> 253(1) Everyone who, having venereal disease in a communicable form, communicates it to another person is guilty of an offence punishable on summary conviction.
>
> (2) No person shall be convicted of an offence under this section where he proves that he had reasonable grounds to believe and did believe that he did not have venereal disease in a communicable form at the time of the offence is alleged to have been committed.
>
> (3) No person shall be convicted of an offence under this section upon the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused.
>
> (4) For the purposes of this section, 'venereal disease' means syphilis, gonorrhea or soft chancre.

[79] MacKinnon M. & Krever H., "Legal and Social Aspects of AIDS in Canada" in *AIDS: A Perspective for Canadians* (Ottawa: Royal Society of Canada, 1988) (Background Papers providing tentative recommendations only)[footnotes omitted] 347 at 354. It is probable that the actual amendment was drafted well prior to 1985, when it is even less likely that HIV/AIDS would have been a consideration.

4.5 Australian policies and legislation

HIV-related legal issues appear to have attracted the attention of policy makers earlier in Australia than in Canada. There appears to have been earlier and more extensive public and community involvement in policy formation at the federal and, in many cases, state level. There have also been conversely fewer criminal cases dealing with the sexual transmission of HIV infection.

In fact, there have been no convictions for the sexual transmission of HIV, and in cases where charges have been laid, they have usually been dropped for lack of evidence to sustain a conviction, because the accused has died, or following the intervention of public health authorities. Thus it can be said that in relation to the sexual transmission of HIV in Australia, the criminal law has played a minor role, with a strong emphasis on the public health alternatives in each state.

The major policy document to date has been the 1989 *National HIV/AIDS Strategy,*[80] which itself drew on extensive community consultation following the circulation of a policy discussion paper *AIDS: A Time to Care, A Time to Act.*[81] Prior to the *National*

---

80 *National HIV/AIDS Strategy - A Policy Discussion Paper* (Canberra, Australian Government Publishing Service, 1989) [hereinafter *National Strategy*].

81 *AIDS: A Time to Care, a Time to Act - Policy Discussion Paper* (Canberra: Australian Government Publishing Service, 1988).

Strategy another community consultation process resulted in the *Report of the Working Party on Discrimination and Other Legal Issues.*[82]

The *National Strategy* states:

> 5.7.6 ...HIV-infected persons thought to be knowingly running the risk of infecting others should not automatically be isolated, but instead should be educated and counselled on a personal basis, with community groups being involved in support, counselling and guidance.
>
> However, there should be capacity in public health legislation to deal with exceptional cases which require placing restrictions on an infected person's living circumstances and employment, and confinement as a last resort. These powers should be exercised only on the authority of a court order, using the following criteria:
>
> * the person has in the past wilfully or knowingly behaved in such a way as to expose others to the risk of infection;
> * the person is likely to continue such behaviour in the future;
> * the person has been counselled, but without success, in achieving appropriate and responsible behaviour change; and
> * the person presents a danger to others.
>
> 5.7.7 Hearings in such cases should be conducted in closed court with restriction orders given for a fixed period, and subject to rights of review and appeal.[83]

The Intergovernmental Committee on AIDS (IGCA) was established to monitor the implementation of the National Strategy at the state and territory level. The IGCA

---

82 *Report of the Working Panel on Discrimination and Other Legal Issues - HIV/AIDS* (Canberra, Department of Community Services and Health, 1989).

83 *National Strategy, supra* note 80 at 46.

convened the Legal Working Party, which itself released a series of nine comprehensive discussion papers. In particular the discussion paper addressing public health issues proposed:

> If exposure to HIV-infection offenses are provided for then full and partial defences should exist where the other party to the transaction in issue (i.e. sex or needle-sharing) consents and/or protective measures are taken, respectively.[84]

The *LWP Final Report* recommended:

> A public health offence should exist where a person knows that he or she is HIV-infected and significantly exposes or infects another person without his or her consent. Such and offence should provide for a full defence where protective measures are insisted upon in cases of significant exposure. A lesser penalty should apply in cases of actual infection where protective measures, as advised by health authorities from time to time, have been taken, but have not prevented transmission. Charges under these offenses should only be brought after approval by public health authorities rather than police, so that the risk of transmission can be scientifically evaluated, and cases can be individually assessed as to the appropriate form of intervention e.g. staged restrictions on living/working circumstances have not been complied with.[85]

In addition to these reviews at the federal level, some state governments also undertook to review their relevant laws and policies.[86] In October 1993 the federal government

---

84 Watchirs H. et al, *Legislative Approaches to Public Health Control of HIV Infection* (Canberra: Department of Community Services and Health, 1991) at 47.

85 *LWP Final Report, supra* note 16 at 21.

86 See e.g. *The Courage of Our Convictions, supra* note 17.

released a second national strategy on HIV/AIDS.[87]

It is clear that the criminal law is envisaged as having little, if any, role to play in relation to the sexual transmission of HIV in Australian federal HIV/AIDS policy. Criminal justice policy is, nonetheless, a matter of state and territory jurisdiction, and some states have amended their criminal laws to address the sexual transmission of HIV. However, even where reforms have been introduced which aim to facilitate the prosecution of people who transmit HIV sexually, no jurisdiction has introduced or amended the criminal law relating to endangerment in the absence of bodily harm. There is still no offence of reckless endangerment in five of the eight states and territories.[88] There have been very few cases of police interest or prosecution.[89]

In New South Wales, the impetus for law reform for HIV transmission was speeded by

---

87 *National HIV/AIDS Strategy 1993-94 to 1995-96* (Canberra: Commonwealth of Australia, 1993) [hereinafter *National HIV/AIDS Strategy 1993-1994 to 1995-1996*].

88 See *Criminal Code Act* 1983 (NT) s.154(1); *Criminal Law Consolidation Act* 1935 (SA) s.29; *Crimes Act* 1958 (Vic) s.22. See generally Godwin et al, *supra* note 3 at 55.

89 In 1993 it was reported that a Melbourne man had been charged with recklessly engaging in conduct likely to endanger life and recklessly causing serious injury. At committal the second charge was dismissed, and the accused was ordered to stand trial on the first charge. The proceedings lapsed when he died; see "Transmission Offenses" (1993) 4(2) *HIV/AIDS Legal Link* 3. In June 1994 it was reported that an HIV-positive Victorian man had been committed to stand trial on three counts of "reckless conduct endangering life" after it was alleged that he had unprotected sex with two women; Ward C., "HIV-positive man charged with "reckless conduct" after engaging in unprotected sex" (1994) 5(2) *HIV/AIDS Legal Link* 4.

the case of a prison warder who was stabbed with a blood-filled syringe.[90] Although intended to cover 'syringe attacks' in robberies and assaults, the section could apply to malicious infection through sexual intercourse. The standard of *mens rea* required is very high, however, and there have been no prosecutions under this section.

The other principle legislative reform in the criminal domain has been the abrogation of the common law year-and-a-day rule in some jurisdictions, in recognition that the death from AIDS may result more than a decade after the initial infection[91]

The principle focus of legislative reform and activity has been the revision of public health laws. As noted above, this has not been for jurisdictional reasons, but rather reflects the 'public health' emphasis of the *National Strategy*, in which the criminal law was generally characterized as an *impediment* to HIV prevention. In cases of endangerment, where a person with HIV is thought to have put others at risk, the general approach has been to avoid the criminal process. All jurisdictions have broad powers to detain and 'treat' people with scheduled diseases under public health acts, and reform in this field has focussed on the tempering, rather than the augmenting, of these powers. In

---

90 The *Crimes Act* was amended to provide that any person who maliciously by any means causes, or attempts to cause, another person to contract a grievous bodily disease, with the intent in such case of causing the other person to contract a grievous bodily disease, is liable to penal servitude for 25 years (*Crimes Act 1900* (NSW) s.36). See also Ward, *ibid.* (notes creation of similar legislation in Victoria.)

91 See Godwin et al, *supra* note 3 at 48. Needless to say, in many cases the accused would die before the complainant.

practice, formal orders are rarely made, partly, it is suggested for the following reasons:

(i) in deference to the delicate balance of trust established between public health authorities and affected communities;[92]

(ii) coercion is regarded by public health officials as the endpoint, rather than the starting point, of state intervention;[93]

(iii) recognition that compulsory measures, such as detention, are expensive and often effective only to the extent that the patient is removed from a situation in which he or she can do harm;[94]

(iv) adherence to the principle that each person is responsible for preventing themselves from becoming infected;[95]

---

92 The *National HIV/AIDS Strategy 1993-94 to 1995-96* notes that the relationship between government, affected communities and the medical, scientific and health care professions is at the core of Australia's approach to HIV/AIDS, *supra* note 87 at 2. The Australian Federation of AIDS Organisations and its members have consistently and vigorously opposed proposals to 'criminalize' HIV transmission.

93 Education and counselling are seen as legitimate tools of public health officials, whereas police and prosecutors have relatively little flexibility in the range of possible responses. See *Guidelines on the Management of People With HIV/AIDS Who Knowingly Place Others at Risk of Infection* (Sydney: NSW Health Department, 1990).

94 Again, whereas this is an acknowledged function ('specific deterrence') of the criminal law, the health care system is generally ill-prepared at this stage to incarcerate the infected in 'lock-hospitals': preference will be given to other, less drastic, solutions.

95 Each person must accept responsibility for preventing themselves becoming infected and for preventing further transmission of the virus. *National Strategy, supra* note 80; *National Strategy 1993-94 to 1995-96, supra* note 87 at 9.

(v) the sheer volume of work and a differing perception of responsibilities and accountability *vis-a-vis* the police and public prosecutors.[96]

It is suggested that where public health officials do act, it is in response to the undesirable alternative of police action. An example of such a (reluctant) government response to the 'irresponsible' sexual behaviour of a person with HIV was the 1989 case of 'Sharlene'. Sharlene was a NSW sex worker who appeared on television stating that she was HIV-positive and that she had unprotected intercourse with clients (who often paid more for the privilege). She was temporarily detained under s.32A of the *Public Health Act* in force at the time. After the media attention had died down she was quietly released. It was quite clear that short of detention or full-time supervision, there was little at that time that could be done to dissuade her from returning to the sex-trade.

In my view the stated Australian policy of generally avoiding criminal proceedings in such cases has proved a viable alternative to the so far haphazard development of Canadian law and policy in this area. There are indications that policy is not applied universally, however, as demonstrated by the charging of two men with reckless endangerment in Victoria in the last couple of years. The protocol developed between Victoria Police and Health Department Victoria was developed to apply to commercial sex workers, and it may therefore have not been thought appropriate in the two cases

---

96 The decision to prosecute in Australia is generally independent of government control, while public health officials are generally not able to act independently of government policy, which in all jurisdictions has in turn has been greatly influenced by the work of the Intergovernmental Committee on AIDS, and the *National Strategy, supra* note 80.

noted above. If this is the case it has the interesting implication is that an HIV-positive commercial sex worker who has sexual intercourse without protecting his or her client (and is presumably doubly morally condemned) is less appropriately the concern of the criminal law than a person who puts others at risk for other, non-pecuniary rewards. It may be argued that purchaser of sex also buys the risk of disease, or at least should be aware of such risks and insist on protective measures, whereas those sexual relationships of an (at least, less overtly) non-commercial kind are based on mutual trust which should be shored up by the threat of criminal prosecution. In my view however this apparent moral paradox only serves to emphasize the general inappropriateness of the criminal law to such circumstances.

5 HIV: policy and law reform

5.1 HIV disease and healthy public policy

HIV disease in Canada is posing an immense social burden. The costs in terms of medical care, lost investment in education and productive years of those infected, let alone the personal suffering of individuals, families and friends, are already high. From the cases that have come before the courts in Canada involving the sexual transmission of HIV infection, it appears that the state, through existing public health and criminal laws, is not responding adequately to the many challenges of the HIV epidemic. There has been a lack of direction and initiative at both the federal, and provincial and territorial levels regarding appropriate policy and legislative responses.

With no indication of a suitable vaccine or cure for years to come, there will be an increasing emphasis on other policies and programmes to prevent the spread of HIV infection. If, as predicted, the conception of the disease changes from that of an infectious epidemic to that of a endemic disease of lifestyle, experience with other such diseases will become increasingly relevant. For example, it has been suggested that major social changes are needed to adequately address the psychosocial and behavioral risk factors of coronary heart disease. Research in the United States has shown that individual counselling and mass education programmes targeted at individual behaviour are either not cost effective or have only a limited impact. An alternative 'ecological model'

proposes social change of a structural nature to address the underlying contributing factors, such as obesity and smoking. The designation of non-smoking areas in public buildings has been given as an example of such a structural change. Another would be an increase in the price of tobacco.

Similar structural changes have been suggested to address the underlying risk factors for HIV infection. Such risk factors are indeed complex and the solutions are non-intuitive. It has been suggested that there is an intimate connection between the general level of health (including freedom from HIV infection) enjoyed by certain communities and sub-populations, and the degree to which their human rights are respected. The epidemic will spread fastest, so it is argued, where there is a climate of intolerance (which inhibits an open discussion of sexuality and risk); where women are disempowered (and hence unable to insist on safe sexual practices); where poverty impacts on physical health (and specifically sexual health); and where sexual, drug-related or other gratification today seems more important than health in five or ten years time (for example, in times of war or major social dislocation). This link between human rights and HIV, and health more generally, has been heralded as 'a new understanding of health and society.'[1] There are clear antecedents, however, in the work of the nineteenth century social reformers who perceived that the eradication of most illnesses lay in improving the living conditions of the poor.

---

[1] Mann J., Address (First International Conference on Health and Human Rights, Harvard School of Public Health, 22 September 1994) [unpublished].

At the same time there has also been a paradigm shift from a narrow conception of 'public health' to an expansive conception of 'healthy public policy.' As has been noted, healthy public policy is more than health policy, it embraces all aspects of public policy that impact on health (as redefined). To be truly comprehensive, healthy public policy must involve all the relevant players and disciplines in its formation and implementation. Without the input of this multitude of voices, the charges of empire building and 'healthism' would be valid. The proposed scope of healthy public policy necessitates close attention to the process by which it is created and implemented. The recognition of the need for structural changes to address the HIV epidemic thus accords well with contemporary general views on health promotion.

5.2 The process of reform

It is a commonplace experience that policies requiring radical changes in human behaviour are ineffective in the long term if they are imposed without the consent of the parties most affected. Hence a prohibition on smoking, for example, in office buildings will be routinely flaunted if an exhaustive process of consultation and consensus building is not undertaken prior to the introduction of the new policy. The alternative of increased policing of these areas is expensive and, it is suggested, will also be ineffective in the longer term. The process of consultation and consensus building may, however, be very difficult. The following contemporary example is relevant to both Canada and Australia.

In both countries, the majority of new HIV infections still occurs in males and result from unprotected anal intercourse. A rights analysis is not intuitively applicable to many of the cases in which such infections occur, as many of the newly infected are educated, middle class and informed about HIV disease. In response, it has been argued that in such cases the 'decision' not to take measures to avoid infection is a reaction to a homophobic society in which gay culture, sensuality and relationships are generally either unrecognized or derided. The remedies proposed include the presentation of homosexuality as a socially valid orientation in school human development curricula, the prohibition of discrimination on the basis of sexual orientation in the public sphere, and the recognition of gay relationships for the purposes of spousal benefits.[2]

These remedies are thus couched in the legal language of rights: their recognition and enforcement, and the politico-legal process is the path to their 'recognition'. Minow notes that legal language translates but does not initiate conflict: the language of rights gives this conflict public expression and provides a method for public resolution.[3] She further

---

2 In November 1993 the Quebec Human Rights Commission held public hearings into violence and discrimination against gay men and lesbians. Many of the submissions made the connection between discrimination and the level of HIV infection among homosexual men in the province. See *De l'illégalité à l'égalité: Rapport de la consultation publique sur la violence envers les gaies et lesbiennes* (Montréal: Commission des droits de la personne du Québec, 1994). The issue of same-sex spousal benefits is currently before the Supreme Court: *Egan* v.*Canada* (1993), 153 N.R. 161 (C.A.), leave to appeal to S.C.C allowed (1993), 163 N.R. 239 (note); The federal government has promised, but is now wavering, on amendments to the *Human Rights Act*, R.S.C. 1985, c.H-6 to include sexual orientation.

3 Minow M., "Interpreting Rights: An Essay for Robert Cover" (1987) 96(8) Yale L.J. 1869 at 1871-1872.

notes:

> Although the language of rights, on its surface, speaks little of community or convention, those who exercise rights signal and strengthen their relation to a community. Those who are claiming rights implicity agree to abide by the community's response, and to accord similar regard to the claims of others.[4]

In this view the process of asserting rights is a form of community consensus building. In our democratic system, so the argument goes, the measure of success of such consensus building would be the according by Parliament and the recognition by the courts of gay sexuality and relationships on par with heterosexual sexuality and relationships.

Yet it is also clear that if and when such relationships are recognized there will be many people who will continue to be bitterly opposed to them on religious, moral and other grounds. Minow warns that recourse to rights discourse and the tools of the state (police, courts, judiciary) to enforce the recognition of rights is still experienced as violence by those who lose that battle:

> If... the violence inflicted by the judge threatens to destroy normative ties between the judge and those before the court, what, if anything, can be salvaged of the conception of community forged through interpretive conversation in the language of rights?[5]

In relation to HIV policy the conflict is not of course limited to gay rights. The litigants

---

4 *Ibid.* at 1874. See also Slattery B., "Rights, Communities and Tradition" (1991) 41 U.T. L. J. 447 at 451.

5 Minow, *ibid.* at 1905.

(or combatants) in this scenario might be parents who object to school-based sex education, employers who resent the expense of accommodating the intermittent periods of ill-health of employees with HIV disease, or inner-city home-owners who are horrified at the thought of a having a needle and syringe exchange bus visit their neighbourhood in the evenings. Given the seemingly irreconcilable differences between the parties and viewpoints in some such cases, what hope is there for the true consensus that is required for HIV prevention policies to work, and how can the assertion of rights possibly facilitate this process?

Minow suggests that the experience of litigation (and, I would add, any engagement in the broader political process) may help the parties to realize that there is another side to the story. She suggests that the risks imposed by legal violence can force litigants to reach new insights about what has meaning for them, or what matters most.[6] In some cases, Minow suggests litigation may foreclose rather than enable conversation. However the shadow of the law may nonetheless provide another bargaining space well away from the courtroom.[7] The importance lies in (nuanced) dialogue, Minow asserts, whether it be "to communicate disjunction, misunderstanding, even the right to avoid conversation."[8]

---

6 *Ibid.* at 1906.

7 See also Galanter M., "Justice in Many Room: Courts, Private Ordering, and Indigenous Law" (1981) 19 J. Legal Pluralism 1.

8 Minow, *supra* note 3 at 1913.

This dialogue is thus an essential part of the reform process. Because many proposals to limit the spread of HIV and reduce its impact are so controversial, so intricately tied to the vision of the society we would want for our children, the particular outcomes, whether they be reformed drug laws, condom-vending machines in schools or civil marriages for homosexuals, are less important than the fact of the process itself.

For this reason, I do not chose to offer any specific conclusions about necessary legal or policy reforms in this paper. By force of the above, I must admit that I might also adjust my views following the process of extensive community consultation that I am proposing. I have noted below however the possible parameters of such reform, and some considerations that might form the basis for the dialogue I would hope will take place.[9]

Recalling the dimensions of the new 'healthy public policy' and considering HIV disease, one would adopt policies that focus on the determinants of health, are dominated by a low technology approach, and are holistic, future-oriented, multisectoral, questioning of the status quo, and founded on public participation in formulation and implementation.

In practice this might mean:

---

[9] In early 1995 the Canadian AIDS Society in conjunction with the Canadian HIV/AIDS Legal Network commenced a review of the most urgent HIV-related legal and ethical issues in Canada, with a view to convening a series of national meetings to propose particular policy responses. It is interesting that (in contrast to the Australian experience) while this initiative would be funded by the federal government, it originated from, and remains within, the non-government sector.

(i) an examination of the social and physiological determinants of vulnerability to HIV infection particular to different communities within Canada;

(ii) the avoidance of complicated legislative strategies, such as legislation which prescribes the circumstances in which HIV-positive people can have sexual intercourse;

(iii) the development of a policy framework which links the public health and the criminal justice systems; and

(iv) the recognition of the importance of including voices from the range of relevant disciplines and the community sector, including people living with HIV.

Finally, there is a need for a new openness on HIV issues from Canadian governments, based on trust with the communities they represent. At the federal level, the current lack of trust is evidenced by the reluctance to release background papers on HIV-related law reform prepared in-house.[10] This material, properly adapted, could well serve to fuel community debate and ultimately achieve consensus on necessary reforms. Without unduly lauding the Australian government's response, reforms have in general followed extensive community consultation and debate. In particular, through the Legal Working Party of the Intergovernmental Committee on AIDS (IGCA) and the discussion papers on aspects of HIV/AIDS law and policy, virtually every sector of the community had a

---

[10] For example, much material prepared by Justice Canada is 'advice to the Minister' and hence treated as an exception to freedom of information legislation (personal communication, Ms Elissa Lieff, Justice Canada, 19 January 1995).

chance to be informed and to contribute to the final report which followed.[11]

5.3 Which laws and what kind of reform?

As noted by Hamblin in chapter 3 above, the law can be enlisted in HIV prevention policy in either a proscriptive, protective or an instrumental role. She envisages the first as being of relatively little assistance, emphasizing the contribution of the latter two roles in limiting the spread of HIV and reducing its impact on those most affected.

In Canada, the suggestion that the law has a useful proscriptive role in the public health domain has also been criticized by the Medical Officer of Health for Vancouver, Dr John Blatherwick. He has questioned the efficacy of compulsory public health orders in this context:

> It's ludicrous for public health officers to think that they could enforce a safe sex ban, and it's ludicrous for us to think we could prove that somebody was breaking a ban... This is such a hidden disease that unless we get the cooperation of the people who think they might be at risk, all of our work goes out the window.
>
> There's only one rule when it comes to AIDS transmission... Both people are responsible for safe sex. We are talking about sex between adults here, and if they can't figure out that safe sex means wearing a condom every time they go to bed, there is nothing I or anyone else can do to help them. The courts certainly have no

---

11 *The Final Report of the Legal Working Party of the Intergovernmental Committee on AIDS* (Canberra: Department of Health, Housing and Community Services, 1992). The Legal Working Party comprised representatives of health and attorney-general's (justice) departments of the federal, state and territory governments.

place in the bedrooms of the nation.[12]

Yet there have been calls for law reform to address the spread of the virus sexually,[13] and governments at the territorial, provincial and federal levels may soon feel obliged to respond. Whatever reforms are proposed, it is also clear that coercive and punitive laws alone, whether within the criminal or public health domains, will have little impact on the spread of HIV. To the extent that law reform is a substitute for, rather than a part of, the necessary societal reforms that must take place, such law reform could in fact be damaging rather than constructive.

Those who would amend the criminal law to prohibit, for example, sexual intercourse without disclosure of one's HIV status are in one sense trying to identify the 'sheep-killing wolf', rather than asking where the flock is wandering. There is a striking similarity between Herbert Winslow Hill's plans in 1916 to control the fraction of the U.S. population with tuberculosis 'merely to the extent of confining their infective discharges'[14]

---

12 Johnston C., "AIDS and the Law: Do Courts Have a Place in the Bedrooms of the Nation?" (1992) 146(11) Can. Med. Assoc. J. 2065 at 2068.

13 Holland W.H., "HIV/AIDS and the Criminal Law" (1994) 36(3) C.L.Q. 279 at 313; Shekter R.H., "The Criminalization of AIDS in Canada" (Paper presented to the Canadian Bar Association of Ontario, November 1992) [unpublished]. In the United States a Presidential Commission recommended that specific statutes be created requiring HIV-infected individuals who know their status to disclose this fact to their sexual partners and to use precautions: *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic* (Washington: United States Government Printing Office, 1988).

14 Fee E. & Porter D., "Public Health, Preventive Medicine and Professionalization: Britain and the United States in the Nineteenth Century" in Fee E. & Acheson R. eds., *A History of*

and proposals to police Canadians living with HIV in 1994 to the extent of confining their infectious body fluids. Hill noted 'the good business sense' of policing people with tuberculosis when contrasted with the expense of securing good food, decent housing and safe working conditions for the entire population. Such an analysis would be generally unacceptable today, and yet calls for punitive measures to stop the spread of the virus, in the absence of proposals to address other factors facilitating transmission, amount to little better than Hill's callous pragmatism.

Because many people with HIV do not know they are infected, it is clear that to stop the spread of the virus more must be done than targeting the minority believed to be knowingly putting others at risk. This will be increasingly the case as the epidemic seeps into the heterosexual population; the popular characterization of HIV disease as a 'gay' disease has meant that most people do not perceive themselves at risk.

The Australian approach has been generally to *avoid* HIV specific offenses in the public health and criminal law, although the practice has not been uniform. In October 1993 the federal government released its second national strategy on HIV/AIDS.[15] This policy document proposed four guiding principles, within the broad principle that the law should

---

Education in Public Health (Oxford: Oxford University Press; 1991) 15 at 35; *supra,* chapter 2 note 28.

15 *National HIV/AIDS Strategy 1993-94 to 1995-96* (Canberra: Commonwealth of Australia, 1993).

complement and assist education and other public health measures. These principles are:

1. Social justice principles and a supportive legislative environment are integral to Australia's success in responding to the HIV epidemic;
2. Law reform should take a rational, humane and responsive approach to the problems of the HIV epidemic;
3. Laws specially created to deal with HIV/AIDS alone require particular justification;
4. Reform measures should be as uniform as possible across the different jurisdictions.[16]

At present there appears some confusion in Canada as to the status of the criminal law regarding the sexual transmission of HIV.[17] In spite of the existing case law, debate has continued as if there is no applicable offence under the *Criminal Code* in circumstances in which HIV transmission occurs. Discussion has focussed on whether a new offence should be created, and whether it should be of a general nature or specific to HIV disease.[18]

---

16 *Ibid.* at 38.

17 For example, complainants in *Ssenyonga* were reportedly disappointed that the judge hearing the case decided not to hand down his decision after the accused's death. A Canadian Press report noted "Victims wanted a verdict delivered to send a message that knowingly spreading HIV, the virus believed to cause AIDS, is criminal." (Canadian Press, 16 January 1994, (QL)). Justice Minister Alan Rock has observed "We're considering whether in order to send the message and to remove all doubt we should have a specific section of the code. Obviously we don't add sections except when we're satisfied that they are really needed." "No AIDS tests of rape subjects: Rock - But Minister considers making it a crime to knowingly spread virus" *The [Montreal] Gazette* (9 January 1995) A6.

18 Shekter, *supra* note 13, calls for the creation of 'a new and properly crafted offence':

> It is difficult to argue against the proposition that one who, maliciously and intentionally, and with full knowledge of his/her seropositive status, attempts to transmit the virus through acts of either sexual intercourse or the sharing of contaminated drug paraphernalia merits criminal prosecution. The intentional infliction of physical injury or disease is something that must be accepted as being

MacKinnon & Krever have noted:

> There are several problems with the enactment of a specific offence of AIDS transmission, considering the purposes and the effects of such legislation. The extent to which criminality would act as a deterrent to irresponsible individuals may be doubtful, given that the infected individuals may assume they are facing a 'death sentence' already. Consideration should be given to the wisdom of incarcerating irresponsible infected persons in custodial institutions where sexual activity and needle-sharing seem to be inevitable. A criminal offence of AIDS transmission may also create policing or enforcing problems. If concerned physicians, psychiatrists or other counsellors were entitled or required to notify the police of irresponsible individuals, would all infected individuals be more reluctant to seek medical care or counselling?[19]

Assessing the benefits and costs of criminalizing 'AIDS' transmission, Field and Sullivan suggest that while criminalization of sexual transmission 'might well have a significant deterrent effect... [t]he issue is whether these gains would be great enough to outweigh the costs of criminalization.'[20] The authors conclude that

> ...the criminal law is not a desirable means of regulating sexual transmission of AIDS. The deterrent effect of such an approach would have would not be great enough to be worth its costs: first, the threat of massive government intrusion into sexual privacy and second, the predictable danger or selective prosecution and misuse of the criminal law to harass particularly unpopular groups, especially gay men.[21]

---

universally abhorrent.

19 MacKinnon M. & Krever H., "Legal and Social Aspects of AIDS in Canada" in *AIDS: A Perspective for Canadians* (Ottawa: Royal Society of Canada, 1988) (Background Papers providing tentative recommendations only)[footnotes omitted] 347 at 354.

20 Field M.A. & Sullivan K.M., "AIDS and the Criminal Law" (1987) 15 (1-2) L. Med. Hlth Care 46 at 54.

21 *Ibid.* Regarding the inapplicability of the criminal law as a mechanism for impeding the spread of HIV infection because of arbitrary prosecutions, harassment of sexual minorities

Nonetheless, if an HIV-specific offence were to be considered, the role of 'safe sex' and disclosure prior to intercourse must be considered. Closen and Deutschman oppose the availability of a defence for the use of 'protective measures such as condoms and spermicides' because 'those measure cannot guarantee that HIV will not be transmitted.'[22] The authors state baldly:

> ...people who know that they suffer from HIV/AIDS should not donate blood or other body tissue, should not share intravenous drug syringes, and should not engage in sexual intercourse, because these activities risk HIV transmission to uninfected individuals.[23]

Field and Sullivan, proposing the creation of an 'AIDS specific offense' would require *both* precautions *and* disclosure:

> While it is appropriate for the law to encourage precautions, we believe it would not be appropriate for a law to make precautions alone negate the offense. Rather, the AIDS carrier should also be obligated to disclose his condition to his partner before intercourse.
>
> Such disclosure is highly desirable. An AIDS carrier has no right to defraud others

---

and practical problems of proof, see Gostin L. & Curran W.J. "The Limits of Compulsion in Controlling AIDS" 1986 Hastings Center R. 24 at 29; Kane S.C., "Criminal Law on the Heels of Epidemiology: The Arrest and Sentencing of HIV-Infected Street Prostitutes" (Paper presented to the Annual Meeting of the American Society of Criminology, Miami, 9-12 November 1994)[unpublished]. See generally Hermann D.H., "Criminalizing Conduct Related to HIV Transmission" (1990) 9 Saint Louis U. P. L. R. 351; Schultz G., "AIDS, Public Health and the Criminal Law" (1988) 7 Saint Louis U.P.L.R. 65.

22 Closen M.L. & Deutschman J.S., "A Proposal to Repeal the Illinois HIV Transmission Statute" (1990) Ill. Bar J. 592, at 599-600.

23 *Ibid.* at 593.

> into taking deadly sexual risks by being silent about his condition. His sexual partner deserves to know the facts before consenting to sexual contact. Even if the AIDS carrier believes he can shield his partner from risk by silently taking precautions, he should nonetheless disclose the truth and allow his partner to make the choice.[24]

The obligation to act remains with the person with HIV, however. Discounting the possibility of requiring *every* sexually active person to use condoms 'so long as AIDS remained uncured', the authors note 'it would be quite harsh as well as politically impossible to do so through the criminal law.'[25]

Holland would require disclosure but not precautions, arguing

> [t]here is danger that the law will become too intrusive if it should seek to intervene in the area of private sexual relations between fully consenting adults. Sexual interaction, unlike fisticuffs, does have social utility and we should hesitate before applying *Jobidon* to intimate relationships.[26]

Holland also proposes an HIV-specific offence of endangerment.[27] However it is suggested that if such reforms are to be considered, a general offence of endangerment would be preferable to avoid further stigmatization of HIV disease. The Law Reform

---

24 Field & Sullivan, *supra* note 20 at 53.

25 *Ibid.* [footnote omitted].

26 Holland, *supra* note 13 at 315-316.

27 Reckless behaviour in specific circumstances is addressed in the *Criminal Code* in the context of firearms (s.86) and motor vehicles (s.249(1)(a)).

Commission of Canada has recommended the introduction of a general crime of endangering for purposefully, recklessly or through negligence causing the risk of death or serious harm to another person.[28]

---

[28] *Recodifying Criminal Law* (Ottawa: Law Reform Commission of Canada, 1987) (Report No. 31) at 67. See also *Omissions, Negligence and Endangering* (Ottawa: Law Reform Commission of Canada, 1985) (Working Paper No.46).

6 Conclusion

In the foregoing analysis, I have endeavoured to show that the HIV epidemic has been constructed, interpreted and presented to the public and among public health and legal professionals in varying ways. None of these differing perceptions and presentations of HIV alone is adequate to enable us to understand and respond effectively to the epidemic. It appears that the best one can do is to construct a response from the multitude of relevant perspectives, a multi-disciplinary approach, which involves *a priori* a willingness to step outside one's own training and experience and to listen to, and try to understand, the perspectives and contributions of others with differing viewpoints.

This is not a cynical exercise in appeasement, but rather an acceptance of the constantly expanding frontiers of knowledge, and of the widely differing vantage points accorded by generation, class, culture, discipline, sex, sexual orientation, and HIV status.

Coming from a background in science and law, I am very aware of the inadequacy of this, my own foray into the realm of public health. More confusing still, I learnt that the very conception of 'health' was itself the site of struggle for definition and control. Yet I believe that my readings of the accounts of this struggle, and of the evolution of the public health movement, have contributed greatly to my understanding of this epidemic and the varying possible legal and other responses to it. In particular, recent writings in public health have described an 'ecological model' for understanding societal problems

which proposes structural changes to address them. Such changes would address the formal societal structures which determine to a large extent the nature and ambit of our social interactions. The law is one such formal structure, and hence has a major role to play in directing, or impeding, the required changes. This perspective has been very useful for one whose most recent training emphasized individual responsibility, and culpability.

Important too has been an examination of the interface between law and public health concerning other illnesses in earlier times. Alternative accounts of the (in)efficacy of draconian public health laws, and an anthropological analysis of the contribution of the formal legal system as just one of a number of normative forces on behaviour, should deter any hasty recourse to conventional legal authority. 'Business as usual' and 'more of the same' are inappropriate responses not only because HIV is unique, but also because such responses appear, on close examination, ineffective.

These insights appear to me particularly applicable to the criminal law. I confess that I have found the responses of some judges and legal commentators to the difficult issues raised by the sexual transmission of HIV infection ill-informed, moralizing, callous, even shocking. In addition, I find the assumption that harsh sentences in a particular case will deter risky sexual behaviour and hence promote public health both naive and dangerous.

Naive, because the efficacy of punishment in a particular case as a deterrent for the public

at large has long been questioned. Naive too, because it ignores the power of human sexuality and the complexity of human sexual behaviour. Dangerous, because the public is led to believe that the criminal justice system can somehow protect those who are uninfected from HIV infection and hence absolve them of the personal responsibility for avoiding HIV infection themselves.

These observations need not leave us powerless to act. Productive discussions on reforms can be initiated immediately in many areas. Yet as we come to better understand who is becoming newly infected and why, it is clear that nothing short of broad social reform will adequately address factors such as poverty, sexism, and homophobia which increase personal vulnerability to HIV infection. But have we not struggled against these social evils for decades, if not centuries? Surely such an analysis can only lead to despair?

It is possible that some societies may not 'survive' this epidemic in any recognizable form. Yet both Canada and Australia enjoy a relatively high standard of human rights, though there are communities in both countries whose experience falls significantly below the norm. This is to say that both nations appear to have the capacity to survive the epidemic. Initiating and continuing the dialogue, or 'multilogue', across disciplines such as law and public health (of which this thesis is hopefully an example) is an essential part of the process which will lead to effective and sustainable policy responses the HIV epidemic.

Bibliography

A New Perspective on the Health of Canadians (Ottawa: Ministry of National Health and Welfare, 1974)

Achieving Health For All: A Framework for Health Promotion (Ottawa: Health and Welfare Canada, 1986)

AIDS: A Time to Care, a Time to Act - Policy Discussion Paper (Canberra: Australian Government Publishing Service, 1988)

"AIDS Babies Pay the Price" *New York Times* (13 August 1993) A26

Alexander M., "Tasmanian Gay Activist Wins in the UN" (1994) 5(2) *HIV/AIDS Legal Link* 1

Altman D., "The Most Political of Diseases" in Timewell E., Minichiello V. & Plummer D., *AIDS in Australia* (Sydney: Prentice Hall, 1992) 55

Aroni R., "Looking at the Media" in Timewell E., Minichiello V. & Plummer D., *AIDS in Australia* (Sydney: Prentice Hall, 1992) 125

Ashton J. & Seymour H., *The New Public Health* (Buckingham, U.K.: Open University Press, 1988)

Bailey P., *Human Rights: Australia in an International Context* (Sydney: Butterworths, 1990)

Ballard J., "Australia: Participation and Innovation in a Federal System" in Kirp D.L. & Bayer R., eds., *AIDS in the Industrialized Democracies* (Montreal: McGill-Queen's University Press, 1992) 134

Barnhorst S., Barnhorst S., & Clarke K.L., *Criminal Law and the Canadian Criminal Code* (Toronto: McGraw-Hill Ryerson, 1992)

Bayer R., *Private Acts, Social Consequences: AIDS and the Politics of Public Health* (New York: The Free Press, 1989)

Beneson A., "Infectious Diseases" in Levine S. & Lilienfeld A., eds., *Epidemiology and Health Policy* (New York: Tavistock, 1987) 207

"Blood donor with HIV sentenced to prison" (1993) 4(4) *HIV/AIDS Legal Link* 24

Bourne P., "The Behavioral Aspects of AIDS: An International Perspective" in Temoshok L. & Baum A., eds., *Psychosocial Perspectives on AIDS: Etiology, Prevention, and Treatment* (Hillsdale, New Jersey: Lawrence Erlbaum Associates, 1990) 167

Brandt A. M., "AIDS in Historical Perspective: Four Lessons from the History of Sexually Transmitted Diseases" 1988 78(4) Amer. J. Pub. Hlth. 367

Brockington F., *World Health*, 2d ed. (Boston: Little & Brown, 1968) at 131 in White K., *Healing the Schism: Epidemiology, Medicine and the Public's Health* (New York: Springer-Verlag, 1991)

Bronitt S.H., "Criminal Liability for the Transmission of HIV/AIDS" (1992) 16 C.L.J. 85

Buchanan D., "Workers Compensation for HIV/AIDS" (1992) 3(3) *HIV/AIDS Legal Link* 11, reprinted in (1992) 1(3) Aus. Hlth. L. Bull. 301

Building an Effective Partnership: The Federal Government's Commitment to Fighting AIDS (Ottawa: Health and Welfare Canada, 1991)

Burris S., "Fear Itself: AIDS, Herpes and Public Health Decisions" (1985) 3 Yale L.& P.R. 479

Caldwell J.C., Orubuloye I.O. & Caldwell P., "Underreaction to AIDS in Sub-Saharan Africa" *Soc. Sci. Med.* Vol.34 No.11, 1169-1182, 1992

Cassell J,. "Making Canada Safe for Sex: Government and the Problem of Sexually Transmitted Diseases in the Twentieth Century" in Naylor C., ed. *Canadian Health Care and the State: A Century of Evolution* (Montreal: McGill-Queen's U.P., 1992) 141

Closen M.L. & Deutschman J.S., "A Proposal to Repeal the Illinois HIV Transmission Statute" (1990) Ill. Bar J. 592

Controlling Criminal Prosecutions: The Attorney General and the Crown Prosecutor (Ottawa: Law Reform Commission of Canada, 1990) (Working Paper No. 62)

Cook T., & Colby D., "The Mass-Mediated Epidemic: The Politics of AIDS on the Nightly Network News" in Fee E. & Fox D., eds., *AIDS: The Making of a Chronic Disease* (Berkeley: University of California Press, 1992) 84

Crimp D., ed., *AIDS: Cultural Analysis/Cultural Activism* (1987) *October*, reprinted (Cambridge, Mass.: MIT Press, 1988)

Crofts N., "Patterns of Infection" in Timewell E., Minichiello V. & Plummer D., *AIDS in Australia* (Sydney: Prentice Hall, 1992) 24

Darby J.P., "Tort Liability for the Transmission of the AIDS Virus: Damages for Fear of AIDS and Prospective AIDS" (1988) 45 Wash. & Lee L.R. 185

David M. & Scott R.S., *Lovers, Doctors & the Law* (New York: Harper & Row, 1988)

De l'illégalité à l'égalité: Rapport de la consultation publique sur la violence envers les gaies et lesbiennes (Montréal: Commission des droits de la personne du Québec, 1994)

Ducharme T., "Preparing for a Legal Epidemic: An AIDS Primer for Lawyers and Policy Makers" (1988) 26(3) Alta. L.R. 471

Falk Moore S., *Law as Process: An Anthropological Approach* (London: Routledge & K. Paul, 1978)

Fee E. & Fox D., eds., *AIDS: The Making of a Chronic Disease* (Berkeley: University of California Press, 1992)

Fee E. & Acheson R., *eds., A History of Education in Public Health* (Oxford: Oxford University Press, 1991)

Fee E. & Porter D., "Public Health, Preventive Medicine and Professionalization: Britain and the United States in the Nineteenth Century" in Fee E. & Acheson R., eds., *A History of Education in Public Health* (Oxford: Oxford University Press, 1991) 15

Field M.A. & Sullivan K.M., "AIDS and the Criminal Law" (1987) 15 (1-2) L. Med. Hlth Care 46

Fischl M.A. "Preventing Transmission of AIDS During Sexual Intercourse" in De Vita V.T., Hellman S. & Rosenberg S.A., *AIDS: Etiology, Diagnosis, Treatment, and Prevention*, 2d ed. (Philadelphia: J.B. Lippencott, 1988) 369

Flanagan W., "AIDS-Related Risks in the Health Care Setting: HIV Testing of Health Care Workers and Patients" (1993) 18 Queen's L.J. 71

Fox D., "The Politics of HIV Infection: 1989-1990 as Years of Change" in Fee E. & Fox D., eds., *AIDS: The Making of a Chronic Disease* (Berkeley: University of California Press, 1992) 125

Foyer J. & Khaïat L., eds, *Droit et Sida: Comparaison internationale* (Paris: CNRS, 1994)

Friedman R., "The Application of Canadian Public Health Law to AIDS" (1988) 9 Health L.Can. 49

Fuller L.F., "The Law's Precarious Hold on Life" (1969) 3 Georgia L.R. 530
àGalanter M., "Justice in Many Room: Courts, Private Ordering, and Indigenous Law" (1981) 19 J. Legal Pluralism 1

Gilbert C.D., *Australian and Canadian Federalism 1867-1984: A Study in Judicial Techniques* (Carlton: Melbourne University Press, 1986)

Gilmore N., "Public Health, Ethics and HIV/AIDS" (Paper presented at a Global Expert Meeting on AIDS: Questions of Rights and Humanity, Den Haag, The Netherlands, 21-24 May 1991.)

Godwin J. et al, *Australian HIV/AIDS Legal Guide*, 2d ed. (Sydney: Federation Press, 1993)

Gostin L & Curran W.J. "The Limits of Compulsion in Controlling AIDS" 1986 Hastings Center R. 24

Gostin L. & Ziegler A., *"A Review of AIDS-Related Legislative and Regulatory Policy in the United States" (1987) 15(1-2) Law, Med. & Hlth Care 5*

Guidelines on the Management of People With HIV/AIDS Who Knowingly Place Others at Risk of Infection (Sydney: NSW Health Department, 1990)

Guillot-Hurtubise B., "First Canadian Ruling in a Tainted-Blood Case" (1994) 1(1) Can. HIV/AIDS L.&. Pol. Nwsltr 8

Hamblin J., *AIDS* 1991, 5 (suppl 2):S239-243

Hamblin J. et al, *Responding to HIV/AIDS in Canada* (Toronto: Carswell, 1990)

Hartog H., "Pigs and Positivism" (1985) Wiscon. L.R. 899

Health Promotion: Concepts and Principles, In Action, A Policy Framework (Geneva: World Health Organisation, 1986)

Healy P., "The Creighton Quartet: Enigma Variations in a Lower Key" (1993) 23 C.R. (4th) 265

Hermann D.H., "Criminalizing Conduct Related to HIV Transmission" (1990) 9 Saint Louis U. P. L. R. 351

HIV & AIDS: A Public Health Perspective (Ottawa: Canadian Public Health Association, 1993)

HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons (Ottawa: Correctional Service Canada, 1994)

HIV and AIDS: Canada's Blueprint (Ottawa: Ministry of Supply and Services, 1990)

HIV and Human Rights in Canada (Ottawa: National Advisory Committee on AIDS, 1992)

Hodge D., Smith A. & Patterson D., "HIV Status, Sexuality and Discrimination in Australia: Whose Turn to (En)act?" (1990) 4(6) *National AIDS Bulletin* 48

Hogg P.W. *Constitutional Law of Canada*, 3d ed. (Toronto: Carswell, 1992)

Holland W.H., "HIV/AIDS and the Criminal Law" (1994) 36(3) C.L.Q. 279

Jackson M.H., "The Criminalization of HIV" in Hunter N.D. & Rubenstein W.B., eds., *AIDS Agenda: Emerging Issues in Civil Rights* (New York: New Press, 1992)

Johnston C., "AIDS and the Law: Do Courts Have a Place in the Bedrooms of the Nation" (1992) 146(11) Can. Med. Assoc. J. 2065

Joseph S., *Dragon Within the Gates: The Once and Future AIDS Epidemic* (New York: Carroll & Graf, 1992)

Kane S.C., "Criminal Law on the Heels of Epidemiology: The Arrest and Sentencing of HIV-Infected Street Prostitutes" (Paper presented to the Annual Meeting of the American Society of Criminology, Miami, 9-12 November 1994)[unpublished]

Kirp D.L. & Bayer R., eds., *AIDS in the Industrialized Democracies* (Montreal: McGill-Queen's University Press, 1992)

Kroeger G., *The Concept of Social Medicine as Presented by Physicians and Other Writers in Germany, 1779-1932* (Chicago: Julius Rosenwald Fund, 1937)

Lewis A. et al., *AIDS in Developing Countries: Cost Issues and Policy Tradeoffs* (Washington, D.C.: The Urban Institute Press, 1989)

Mackie I.D., "Erecting Barriers to Slow the Spread of AIDS" *Globe & Mail* (31 August 1993)

MacKinnon M. & Krever H., "Legal and Social Aspects of AIDS in Canada" in *AIDS: A Perspective for Canadians* (Ottawa: Royal Society of Canada, 1988) 347

Madill J., "AIDS Fiend Strikes Again" *The [Halifax] Chronicle-Herald* (19 September 1988) 1

Mann J., Address (First International Conference on Health and Human Rights, Harvard School of Public Health, 22 September 1994) [unpublished]

Mann J., Tarantola D. & Netter T., *AIDS in the World* (Cambridge, Mass.: Harvard University Press, 1992)

Mill J.S., *On Liberty* (Indianapolis: Hacket, 1978) (edited by E. Rapaport)

Minow M., "Interpreting Rights: An Essay for Robert Cover" (1987) 96(8) Yale L.J. 1860

Model Penal Code & Commentaries (Phildelphia: American Law Institute, 1985)

Morbidity and Mortality: Weekly Report, 5 June 1981, Communicable Diseases Center,

Washington

National AIDS Strategy: Building on Progress (Ottawa: Health and Welfare Canada, 1993)

National HIV/AIDS Strategy - A Policy Discussion Paper (Canberra, Australian Government Publishing Service, 1989)

National HIV/AIDS Strategy 1993-94 to 1995-96 (Canberra: Commonwealth of Australia, 1993)

"No AIDS tests of rape subjects: Rock - But Minister considers making it a crime to knowingly spread virus" *The [Montreal] Gazette* (9 January 1995) A6

O'Dair R., "Liability in Tort for the Transmission of A.I.D.S.: Some Lessons from Afar and the Prospects for the Future" (1990) 43 Current. L. Prob. 219

O'Malley J., "The Representation of AIDS in Third World Development Discourse" in Miller J., ed., *Fluid Exchanges: Artists and Critics in the AIDS Crisis* (Toronto: University of Toronto Press, 1992) 169

Omissions, Negligence and Endangering (Ottawa: Law Reform Commission of Canada, 1985) (Working Paper No. 46)

Osborne J. "AIDS: Politics and Science" 318 [1988] New Engl. J. Med. 444

Patterson D., "The Law" in Timewell E., Minichiello V. & Plummer D., eds., *AIDS in Australia* (Sydney: Prentice Hall, 1992) 366

Pederson A. et al, *Coordinating Healthy Public Policy: An Analytical Literature Review and Bibliography* (Ottawa: Health and Welfare Canada, 1989)

Pickett G. & Hanlon J., *Public Health: Administration and Practice*, 9th ed. (St Louis: Times Mirror/Mosby College Publishing, 1990)

Plummer D., "The Medical Establishment" in Timewell E., Minichiello V. & Plummer D., eds., *AIDS in Australia* (Sydney: Prentice Hall, 1992) 73

Rayside D. & Lindquist E.A., "Canada: Community Activism, Federalism, and the New Politics of Disease" in Kirp D. & Bayer R., eds., *AIDS in the Industrialized Democracies* (Montreal: McGill-Queen's University Press, 1992) 49

Recodifying Criminal Law (Ottawa: Law Reform Commission of Canada, 1987) (Report No. 31)
Report of the Working Panel on Discrimination and Other Legal Issues - HIV/AIDS (Canberra, Department of Community Services and Health, 1989)

Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic (Washington: United States Government Printing Office, 1988)

Roberts J., "Criticisms of Concorde Dominate AIDS Conference" (1993) 306 BMJ 1631

Ruby C., *Sentencing*, 4th ed. (Toronto: Butterworths, 1994)

Schoenstein R.C., "Standards of Conduct, Multiple Defendants, and Full Recovery of Damages in Tort Liability for the Transmission of Human Immunodeficiency Virus" (1989) 18 Hofstra L.R. 37

Schultz G., "AIDS and the Criminal Law in the United States" (Paper presented to the Polish Section of the International Association for Penal Law, Warsaw, 23 May 1991) [unpublished]

Schultz G., "AIDS, Public Health and the Criminal Law" (1988) 7 Saint Louis U.P.L.R. 65.

Schwartz J., "Liability for the Transmission of AIDS and Herpes" (1987) An. Surv. Amer. L. 523

Shekter R.H., "The Criminalization of AIDS in Canada" (Paper presented to the Canadian Bar Association of Ontario, November 1992) [unpublished]

Sieghart P., *AIDS & Human Rights: A UK Perspective* (London: British Medical Association Foundation for AIDS, 1989)
Slattery B., "Rights, Communities and Tradition" (1991) 41 U.T. L. J. 447

"Statement by People Living With HIV/AIDS in Relation to Working Party Recommendation (9C)" in *The Courage of Our Convictions: HIV/AIDS: The National Strategy and the Laws of NSW* (Sydney: NSW Ministerial Review HIV/AIDS Legal Working Party, 1993)

Somerville M.A., "Law as an 'Art Form' - Reflecting AIDS: A Challenge to the Province and Function of Law" in Miller J., ed, *Fluid Exchanges: Artists and Critics in the AIDS Crisis* (Toronto: University of Toronto Press, 1992) 287

Sullivan K.M. & Field M.A., "AIDS and the Coercive Power of the State" (1988) 23(1) Harvard Civ. Rts - Civ. Lib. L.R. 139

Syme S. & Guralnik J., "Epidemiology and Health Policy: Coronary Heart Disease" in Levine S. & Lilienfeld A., eds., *Epidemiology and Health Policy* (New York: Tavistock, 1987) 85

"Syracuse principles on the limitation and derogation provisions in the Covenant", Annex to U.N. Doc. E/CN.4/1985/4, September 28, 1984

Taitz J., "Legal Liability for Transmitting AIDS" (1989) 57(4) Medico-L.J. 216

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

The Future of Public Health (Washington, DC: National Academy Press, 1988) in White K., *Healing the Schism: Epidemiology, Medicine and the Public's Health* (New York: Springer-Verlag, 1991)

Tierney T.W., *"Criminalizing the Sexual Transmission of HIV: An International Analysis" (1992) 15 Hastings Int'l & Comp. L.Rev. 475*

"The Unyielding AIDS Epidemic" *The New York Times* (17 June 1993) A24

Timewell E., *"Counselling and Psychotherapy" in Timewell E., Minichiello V. & Plummer D., AIDS in Australia* (Sydney: Prentice Hall, 1992) 324

"Transmission Offences" (1993) 4(2) *HIV/AIDS Legal Link* 3

Tuberculosis: An Old Disease Poses New Challenges to Public Health Policy and the Law (Washington: Buraff Publications, 1993) (Special Report)

United Nations, *Report of an International Consultation on AIDS and Human Rights* (New York, 1991) (UN Doc. HR/PUB/90/2)

Van Vliet E., "Law, Medicine, HIV and Women: Constructions of Guilt and Innocence" (1993) 1 Hlth L.J. 191

"Victims wanted a verdict delivered to send a message that knowingly spreading HIV, the virus believed to cause AIDS, is criminal." (Canadian Press, 16 January 1994) (QL)

Ward C., "HIV-positive man charged with "reckless conduct" after engaging in unprotected sex" (1994) 5(2) *HIV/AIDS Legal Link* 4

Watchirs H., *AIDS - A Public Law Perspective* (LL.M. Thesis, Australian National University, 1990)

Watchirs H. et al, *Legislative Approaches to Public Health Control of HIV Infection* (Canberra: Department of Community Services and Health, 1991) (Intergovernmental Committee on AIDS discussion paper)

Watney S., *"Imagine Hope: Gay Men and the Epidemic"* (Address to Concordia University, Montreal, 24 September 1993)[unpublished]

Watney S., "The Possibilities of Permutation: Pleasure, Proliferation, and the Politics of Gay Identity in the Age of AIDS" in Miller J., ed., *Fluid Exchanges: Artists and Critics in the AIDS*

Crisis (Toronto: University of Toronto Press, 1992) 329

Watney S., *Policing Desire: Pornography, AIDS and the Media* (Minneapolis: University of Minnesota Press, 1987)

West R., "Authority, Autonomy, and Choice: The Role of Consent in the Moral and Political Visions of Franz Kafka and Richard Posner" (1985) 99 Har. L.R. 384

White K., *Healing the Schism: Epidemiology, Medicine and the Public's Health* (New York: Springer-Verlag, 1991)

Reid E. & Bailey M., *Young Women: Silence, Susceptibility and the HIV Epidemic* (New York: HIV and Development Programme, United Nations Development Programme, 1992)

International covenants

International Covenant on Civil and Political Rights, 16 December 1966, U.N.T.S. vol. 999, p.171, art. 12(3)

Optional Protocol to the International Covenant on Civil and Political Rights, 16 December 1966, U.N.T.S. vol.999, p.171

International Covenant on Economic, Social and Cultural Rights , 16 December 1966, U.N.T.S. vol. 993, p.3

Discrimination (Employment and Occupation) Convention 1958, 25 June 1958, U.N.T.S. vol.362, p.31

Canadian Statutes

Criminal Law Amendment Act, S.C. 1985; c.19

Criminal Code Act, R.S.C. 1985, c.C-46

Health Protection and Promotion Act, R.S.O. 1990 c.H.7

Health Act, R.S.B.C. 1979, c. 161

Human Rights Act, R.S.C. 1985, c.H-6

Canadian Cases

Egan v.*Canada* (1993), 153 N.R. 161 (C.A.), leave to appeal to S.C.C allowed (1993), 163 N.R. 239 (note)

Pitman v. *The Canadian Red Cross Society* [1994] O.J. No.463

Re Canada Assistance Plan [1991] 1 S.C.R. 525

R. v. *Downey* (20 February 1989), [1989] O.J. No. 436 (Ont. Dist. Ct.) (QL)

R. v. *Jobidon* [1992] 2 S.C.R. 714, 66 C.C.C. (3d) 454 (S.C.C.)

R. v. *Kreider* (1993), 140 A.R. 81

R. v. *Langlois* (25 January 1991), Quebec 200-01-010507-907, J.E. 91-954 (C.Q.)

R. v. *Lee* (1991), 3 O.R. (3D) 726

R. v. *McKenzie* (30 March 1993), Trois-Rivières 400-01-000573-931 / 400-01-000574-939 (C.Q), Morand J. [unreported]

R. v. *Mercer* (1993), 84 C.C.C. (3d) 41 (at 50)

R. v. *Petrozzi* (1987), 35 C.C.C. (3d) 528

R. v. *Schula* (1956), 115 C.C.C. 382, 23 C.R. 403 (Alta. C.A.)

R. v. Ssenyonga [1991] O.J. No.544 (16 April 1991) (Ont. Ct.(Gen.Div.)), (Montgomery J.) (QL) [unreported]; [1991] O.J. No. 1460 (Ont. Ct.(Gen.Div.)) (Jenkins J.) [unreported] (QL); [1992] O.J. No. 1154 (28 May 1992) (Ont. Ct. (Prov. Div.)) (QL) [unreported]; (1993) 21 C.R. (4th) 128 at 137 (Ont. Ct.(Gen.Div.)), McDermid J.

R. v. *Summer* (1989), 73 C.R. (3d) 32 (Alta. C.A.)

R. v. *Thornton* (1991) 1 O.R. (3d) 480, 42 O.A.C. 206, 3 C.R. (4th) 381 (C.A.), aff'd [1993] 2 S.C.R. 445, 21 C.R. (4th) 215, 13 O.R. (3d) 744 (S.C.C.)

R. v. *Tutton* (1989), 69 C.R. (3d) 289

R. v. *Wentzell,* C.R. No. 10888 (Halifax County Court, Nova Scotia, 8 December 1989)[unreported]

Westendorp v. *The Queen* [1983] 1 S.C.R. 43

Australian Statutes

Crimes Act 1958 (Vic)

Crimes Act 1900 (NSW)

Criminal Law Consolidation Act 1935 (SA)

Criminal Code Act 1983 (NT)

Disability Discrimination Act 1992 (Cth)

Health Act 1958 (Vic)

Health Act 1937 (Qld)

Health Act 1911 (Qld)

Human Rights (Sexual Conduct) Bill 1994 (Cth)

Law Reform (Decriminalisation of Sodomy) Act 1989 (W.A.) s.23

Public and Environmental Health Act 1987 (SA)

Public Health Act 1991 (NSW)

Australian cases

Commonwealth v. *Tasmania* (1983) 158 C.L.R. 1

A. v *R.* (15 May 1992, NSW Compensation Court, McGrath C.J.)

U.K. Statutes

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11

Commonwealth of Australia Constitution Act (U.K.), 63 & 64 Vict., c.12

Constitution Act, 1867 (U.K.), 30 & 31 Vict.,c.3

U.K. Cases

R. v. *Brown*, [1992] 1 Q.B. 491, aff'd [1993] 2 All E.R. 75 (H.L.)

R. v. *Burnett*, (1815) 4 M. & S. 272, 16 R.R. 468

R. v. *Clarence*, (1888) 22 Q.B.D. 23, [1886-90] All E.R. 133

R. v. *Henson*, [1852] Dears C.C. 24

R. v. *Vantandillo*, (1815) 4 M. & S. 73, 16 R.R. 389