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ONTARIO ADVISORY COMMITTEE ON HIV/AIDS
REDUCING HIV TRANSMISSION BY PEOPLE WHO ARE UNWILLING OR UNABLE TO USE APPROPRIATE PRECAUTIONS

INTRODUCTION

The Ontario Advisory Committee on HIV/AIDS established a working group to address the issue of reducing HIV transmission by people who are unwilling or unable to use appropriate precautions. Members of the working group included: Maggie Atkinson (Voices of Positive Women), Glen Brown (AIDS Action Now!), Clarence Crossman (AIDS Committee of London), Mary Fanning (Wellesley Hospital), David McKeown (City of Toronto Department of Public Health), John Plater (Hemophilia Ontario), Douglas Pudden (Middlesex-London Health Unit), Michael Sobota (AIDS Committee of Thunder Bay), Lori Stoltz (Goodman and Carr), Robert Trow (Hassle Free Clinic).

The previous AIDS advisory committee had developed a consultation paper on this issue which had been distributed to organizations across the province for comment. No recommendations had been made as a result of the consultation.

The working group used the previous consultation paper as a starting point for discussion. Information was gathered from Australia and Illinois about how these jurisdictions have handled the problem as well as up-to date information from Ontario and Canada. In addition, presentations were heard from Dr. Ian Gemmill, Associate Medical Officer, Ottawa-Carleton Regional Health Unit and Mr. Tony Di Pede, President, Toronto PWA Foundation.

The purpose of the working group was to re-examine the issues related to reducing HIV transmission and to make recommendations to the Ontario Advisory Committee on HIV/AIDS. The issue is broad and deals with overall reduction of transmission of HIV as well as the issue of people who are unwilling or unable to use appropriate precautions.

BACKGROUND

HIV/AIDS in Ontario and HIV Testing: Between November 1, 1985, when Ontario's HIV antibody testing program began, and June 30, 1993, the Ontario Ministry of Health Laboratory Services Branch identified 13,272 cases of HIV infection. Between 1982 and June 30, 1993, a total of 3,593 AIDS cases were reported. Of those, 2,822 had died. The majority of cases of AIDS are included in the total number of cases of HIV infection.

HIV testing in Ontario is voluntary. Therefore, the incidence of HIV infection in the population is not known, nor is it known whether the incidence is increasing or decreasing. The HIV laboratory, however, has been able to identify a number of people who have seroconverted since their first HIV test. This gives an indication that people are not consistently practising safer sex or that there are other factors affecting safer sex that are not addressed by prevention education or pre- and post-test HIV counselling.

There are three ways that people can be tested for HIV - nominal, non-nominal, anonymous.

Nominal testing means that the results are linked to the person being tested by both the patient's name and the physician's name. Non-nominal testing means that the results can be linked to the person being tested by a code known only to the patient and the physician. Anonymous testing means that the results can be linked to the person being tested by a code known only to the patient. Neither the physician ordering the test nor anyone else knows the identity of the person being tested. Nominal and anonymous HIV reporting of positive tests are legal in Ontario. A process is underway to legalize non-nominal HIV reporting.

The regulation changes that were made to legalize anonymous HIV testing include a section on pre-test counselling as a requirement of the anonymous HIV testing program. Counselling guidelines were developed for the anonymous HIV testing program. Training/information sessions were held for all counsellors doing anonymous HIV testing. In some areas, counsellors who are not doing anonymous testing but are doing routine HIV testing attended the sessions and are using guidelines. Pre- and post test counselling along with the informed consent of the individual being tested are expectations in nominal and non-nominal HIV testing, but are not legally required.

A great deal of information is collected in the anonymous HIV testing program including information from the laboratory requisition forms, client satisfaction questionnaires and counsellors checklists. Thus, it is possible to obtain information about risk behaviours of people who are using the program which may be more widely applicable.

The anonymous HIV testing program, however, raises issues about the ability to conduct partner notification and to track people who are HIV-positive. In the first year of anonymous HIV testing, 312 people (4 per cent) indicated that they had been notified by an HIV-positive partner as an indication that some partner notification is occurring, but it is not known how much is occurring in routine HIV testing. However, when people with HIV enter the health care system, it is recommended that physicians repeat the HIV test and that they ensure that appropriate counselling has occurred. This second test may serve as an additional check on partner notification and/or counselling.

recommended by whom?

Media Attention: The issue of reducing HIV transmission by people who are unwilling or unable to use appropriate precautions has been highlighted in the media over the past year as a result of certain court cases. In particular, there has been a case in London, Ontario in which a man (Charles Ssenyonga) was charged with criminal negligence causing bodily harm and aggravated sexual assault. The aggravated sexual assault charges were disallowed on the grounds that each of the three complainants freely and voluntarily engaged in sexual intercourse with the accused without the use of a condom. The accused pleaded not guilty to the charges of criminal negligence causing bodily harm. The judge in this case will not be providing a ruling on the negligence charges as the accused died in August 1993.

There have also been cases in other provinces that are relevant to this issue. In Alberta (August 1989), a person with HIV who was alleged to have transmitted HIV to two women through unprotected sexual activity and who had not disclosed his status pleaded guilty to a charge of

being a common nuisance. He was found guilty and was sentenced to one year imprisonment and three years probation with the condition that he seek medical treatment and psychiatric counselling. A similar case occurred in Nova Scotia (September 1989), but the person with HIV pleaded guilty to a charge of criminal negligence causing bodily harm and was sentenced to three years imprisonment. In both these cases, HIV transmission occurred in the context of presumably ongoing relationships.

More recently there was a case in Newfoundland (August 1993) where a person with HIV allegedly infected two women with HIV after he had tested positive and had received counselling. The man did not disclose his HIV status to his partners and did not use condoms (or practise any other safer sex methods) to prevent transmission. He was found guilty on two charges of criminal negligence causing bodily harm and was sentenced to 11 years in jail.

Coverage of these cases in the media give the impression that all people with HIV are irresponsible (not just those who are accused) which contributes to a charged atmosphere in the treatment of people with HIV. There are sensational aspects to these kinds of stories and the media will continue to report on similar cases.

ISSUES AND DISCUSSION

1. Spectrum of Response

The first contact with an individual who is HIV positive is very important to set the stage for future behaviour. There are a number of people who do the counselling including physicians, nurses, and counsellors with a variety of backgrounds in the anonymous testing program. The regulation change that was made to allow for anonymous HIV testing included the requirement that pre-test counselling must occur. In the routine testing program (nominal and non-nominal HIV testing), there is no legislated requirement for counselling, but it is expected that counselling and informed consent will occur prior to testing. The only training for pre- and post-test counselling has occurred through the anonymous HIV testing program. Professional organizations such as the Canadian Medical Association have issued guidelines for their members, but these are not legally binding.

The "second" contact occurs when concerns have been made known to public health. It is possible to obtain written consent by the person with HIV for public health to consult with relevant community people (e.g., Toronto model) in the instances in which consultation would enhance the public health intervention. If there is no agreement signed and the activities continue, public health would continue to be involved. If an agreement is signed and the activities continue, consultation with relevant community people must continue to occur. It is important that the messages about prevention and transmission and risk activities be reiterated during the "second" contact. Resources available for use during the "second" contact include the pre- and post-test guidelines developed for the anonymous HIV testing program or those issued by the Canadian

Medical Association.

Part of the challenge at this point is an assessment of the person's willingness and/or ability to use precautions to prevent the transmission of HIV to others. There may be underlying causes such as a genuine lack of knowledge or psychiatric disorder that are influencing the person's inability or unwillingness to use precautions. There may be more appropriate steps to be taken other than a Section 22 order. Follow-up counselling at this point will probably be much more intense and it may be useful to have someone other than the original counsellor provide the counselling and assessment at this point (e.g., medical officer of health, appropriate community person, physician, psychiatrist). The counselling that is given during the "second" contact should be consistent.

2. Counselling

i) Pre- and Post-Test Counselling: A number of guidelines have been published for pre- and post-test counselling. The Canadian Medical Association recently updated its counselling guidelines for physicians and the Ontario Ministry of Health has published guidelines for use in the anonymous HIV testing program. The anonymous HIV testing guidelines have also been used by many people who are doing routine HIV testing.

There are a number of principles or education strategies that should be incorporated into test counselling which can increase the likelihood of clients understanding the information that they have been given and increase the likelihood of clients being able to act on the information. These strategies include discussion and interaction with the counsellor which may take place over a number of sessions. The information must be given in clear, explicit, detailed and accessible ways and be relevant to the client's experience including sexual experience and behaviours and cultural background. In addition, the counsellor must be prepared to deal directly and candidly with related and sometimes controversial issues. The client must feel that the counselling experience is a safe place to reflect on and express feelings and attitudes about being HIV positive, the sense of loss involved in changing attitudes, knowledge and behaviours as a result of being HIV positive and topics of concern for the client. The counselling session can be used as an opportunity to teach skills to deal with the sense of loss and changing circumstances, to openly and effectively communicate and to anticipate and prepare for changes in order to maintain control. Peer experience can be used to reinforce the skills and to heighten the person's sense of belonging (as opposed to isolation). The counselling experience should increase the quality and depth of life and its enjoyment as well as offering a range of choices which will result in a sense of personal empowerment.

Although test counselling may only consist of two sessions (pre- and post-test), it is very important to begin laying the foundation for any additional counselling that may occur (both for formal counselling and more informal in support groups) and for continuation of preventive behaviour.

ii) Physician Counselling: Physicians in private practice and in hospitals (as opposed to those attached to anonymous HIV test sites or STD clinics) are providing the bulk of the HIV test requests in Ontario. There is a core group of physicians who have been actively involved in treating people with HIV, are well-versed in the issues related to pre- and post-test counselling and are providing high quality test counselling. However, many of the tests are being done by physicians who do not have any experience with HIV, may not have the time or expertise to do pre- and post-test HIV counselling and/or do not feel comfortable talking to their patients about possible risk activities (e.g., risk information is missing on laboratory requisitions for 40 per cent of the males with HIV and 47 per cent of the females with HIV.) There are also anecdotal reports from people who have tested positive that they have not received any counselling at all.

this may just indicate lack of facts in reporting

iii) Role of Counselling/Psychotherapy: Counselling can play a very essential role for people with HIV and can assist in reducing HIV transmission. Pre- and post-test counselling should be the minimum that a person with HIV receives, although some people with HIV may chose or require longer term counselling to deal with the variety of issues related to HIV. All intervention strategies, besides their specific purpose, can be used to develop trust and support and genuine concern about the person being counselled is one of the most essential factors in making counselling successful.

It is possible that some counselling interventions have little or no impact on a person's willingness or ability to take appropriate precautions to prevent the transmission of HIV - or in the worst case scenario may contribute to or reinforce a person's unwillingness or inability - because the most effective counselling strategies were not used. One of the most obvious examples of a potentially ineffective intervention style would be one that is directive and imperative. A person leaving counselling that involved an authority figure telling them what they should not do may feel that their concerns and emotions were not acknowledged and that the counsellor's primary concern was for other people and not for that particular person.

Counselling that deals as effectively as possible with all the dimensions of a person's potential unwillingness or inability is very complex. It is important, however, to systematize this counselling as far as possible in order to make it achievable. Counselling about reducing HIV transmission should be seen as an extension of other prevention/education activities (e.g., consistent messages). Counselling interventions that are the most effective will be those that empower any person to consistently protect themselves and others from HIV infection. These interventions, however, may be the most difficult to achieve.

Three components of a person's response to living with HIV need to be assessed and dealt with: (1) knowledge, (2) attitudes and emotions and (3) behaviour.

(1) Information given to people with HIV must be clear, explicit and accessible. Assessment of a person's knowledge and confirmation of their successful learning of new

information is essential. It is also essential that reinforcement and/or correction of existing knowledge occur. Counsellors should not make assumptions about a client's knowledge of HIV transmission and prevention. Intensive interaction is necessary to achieve that assessment and confirmation. A helping professional may be shocked and angry to hear a person with HIV say that they were not informed of important information after the helping professional perceived that he/she was careful to convey particular information. A counsellor needs to regularly check to see what a client has heard and understood. Linguistic, cultural, or disability barriers call for special preparation and communication and the skills and resources have already been developed should be used in these instances.

(2) Unacknowledged, unexpressed emotions and attitudes are among the most significant barriers to any person acting to protect themselves or others. A safe setting needs to be created in which a person can express and reflect on their feelings and attitudes. In some instances, the simple but profound process of being heard is sufficient to remove barriers that could have contributed to risky actions. In other instances, counselling would need to involve more complex dealing with attitudes and emotions in order to remove them as barriers. Again, there are already developed strategies that can be applied. Part of the role of a counsellor would be to assess what interventions might be needed that are beyond their own capacity and determine how a referral or team approach could occur.

Depending on the emotional and psychological needs of the person being counselled, complex psychotherapeutic or psychiatric interventions may be necessary. These are the challenges that may be least amenable to a counselling intervention. If a person is mentally ill and deluded or irrational, if they have a severe personality disorder, and particularly if they are sociopathic or psychopathic, counselling may not be at all effective. There are other psychiatric or psychological interventions beyond counselling that may be of use in these instances but making the assessment of which people will not benefit from counselling is extremely difficult.

(3) Behaviour is susceptible to change by means of practical, learnable skills. A number of skills that foster a sense of personal control and empowerment have been identified and taught in relation to HIV prevention and can be used by people with HIV. It is important that the person with HIV/AIDS be able to reflect on the circumstances which may make it more likely for them to be involved in risk activity, try out responses to these situations and learn to anticipate and then avoid, change or exit potentially risky situations.

Counselling or psychotherapy can be very helpful in many situations to facilitate behaviour change. However, counselling may not produce long term behaviour change and other supports such as peers, reinforcement through mass media, etc. will be needed to help the person sustain the change. In addition, there are people for whom counselling will have no effect on their behaviour, particularly if the counselling intervention is seen to be involuntary (e.g., the person being counselled does not wish to be there) or

Not one word about the patient's health or support needs !!!

coercive.

iv) Peer Counselling: Peer counselling is a well-accepted approach to prevention education and to providing support for those who are infected with HIV. There is a role for peer counselling in the area of reducing HIV transmission through encouraging those who know they are infected to prevent the spread of HIV to others and to help people with HIV maintain preventive behaviour.

Discussion: The importance of the "first" contact with a person who is HIV positive should not be underestimated. In general HIV/AIDS education, it is an accepted premise that people need to hear the messages more than once and if an erroneous message is given, it can take as many as ten times to correct the information. In the pre-test counselling situation, the person being tested more often than not has a particular reason to be tested (e.g., has participated in a high risk activity) and may be more amenable to listening to information about risk and prevention.

High quality pre- and post-test counselling is an essential part of reducing HIV transmission. There are no guarantees that counselling will provide all the solutions particularly in the instances where a person is apparently unwilling or unable, but these sessions provide an opportunity to provide clear information about HIV transmission and prevention. It is also important in the instances where a person is apparently unwilling or unable, to initiate a process that will help form an assessment of the person, the situation, the variables that will promote behaviour, and the likelihood of counselling being effective.

3. **Ontario Public Health Responses:** Ontario public health has been involved in a number of responses to HIV issues including prevention education, testing through the STD clinics, follow up with people with HIV, partner notification and counselling, and intervention when problems arise.

+ surveillance, coercion + intimidation

i) Designation of AIDS: Under the Health Protection and Promotion Act (HPPA), AIDS is considered a reportable and a communicable disease and HIV is considered the agent of AIDS. AIDS has not been designated as a virulent disease.

Discussion: There has been a great deal of discussion about the designation of AIDS under the HPPA. The issue of possible designation of AIDS as a virulent disease under the HPPA has been hotly debated. Arguments against redesignation include a fear of the use and misuse of quarantine which is available under the virulent designation and the message about HIV/AIDS and people with HIV/AIDS implied by the use of the word "virulent" which does not describe the reality of transmission of HIV. In addition, there has been a supposition that people with HIV who are unable or unwilling to use appropriate precautions to reduce HIV transmission are adequately dealt with by criminal law.

and rejected

Effect on public health messages of personal responsibility.

Lack of resources

Driving people away from public health

On the other hand, there have been questions about the efficacy of the designation of AIDS as a communicable disease and the public health measures that can be used against someone who does not seem to be willing or able (for whatever reason) to protect partners from HIV. The case of Charles Ssenyonga, the London man, who continued to infect his partners in spite of counselling and an order to behave in a manner that would not infect others (e.g. no penetrative sex) has been used as an example to promote redesignation.

ii) Testing and Reporting: When a person tests positive for HIV, physicians are required by law to report to the local public health department. In addition, a wide variety of other people - laboratory operators, superintendents of institutions and schools - are required to report to the medical officer of health in the event that they are aware that a person has or may have a communicable disease (or is or may be infected with the agent of a communicable disease). HIV tests that are done anonymously are exempt from reporting requirements. In practice, when the Central Public Health Laboratory has a positive test result, a copy of the laboratory requisition is sent to the physician who ordered the test and a copy is sent to the medical officer of health in the health unit area where the physician is practising. Medical officers of health (or their designates) follow up with the physicians to ensure that complete epidemiological information is obtained, that counselling has occurred and that partners have been notified. In addition, if physicians need assistance with either the counselling or partner notification process, public health can help.

Discussion: The ability of public health officials to enforce the HPPA consistently and uniformly across the province depends on the extent to which physicians and others comply with reporting provisions and the extent to which follow-up information is directed to public health. In some health unit areas, non-nominal reporting is the widely accepted practice. In other health unit areas, non-nominal reporting is rarely used. In addition, people test positive in the anonymous program are not reported. Without the names and addresses of those with HIV, public health officials are unable to take any action. As the reporting obligations imposed by the HPPA are unevenly enforced by public health officials in Ontario, there uneven enforcement of the HPPA against people with HIV and an uneven ability to take public health action.

iii) Orders by Medical Officers of Health (HPPA, Section 22): Under certain circumstances, medical officers of health are empowered to issue a written order against any person with a "communicable" disease, requiring that person to take, or to refrain from taking, any action the medical officer of health deems necessary to prevent or inhibit the spread of the disease. When making an order, the medical officer of health may rely on information required under the various reporting requirements of the HPPA. There is a reporting requirement in the HPPA that requires the attending physician of a person with a communicable disease who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to the physician to report to the medical officer of health the name and resident address of a person who is under care or treatment in

respect of a communicable disease (Section 34 (1)). However, this section is most often used when a person has a disease such as gonorrhoea where treatment is possible. With a disease such as HIV where a person is infectious for life, this section is rarely used. More often, information used to alert public health of a potential problem is directed to the medical officer of health from sources in the community.

Before issuing an order against a person with a communicable disease, the medical officer of health must have formed an opinion on "reasonable and probable grounds" that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in his/her health unit area; that the communicable disease poses a risk to the health of people in the health unit area; and that the requirements of the order are necessary to decrease or eliminate the risk (Section 22(2)).

To date, there have been 45 Section 22 orders written in Ontario (37 - Ottawa-Carleton, 5 - City of Toronto, 2 - Middlesex-London, 1 - Kingston, Frontenac, Lennox & Addington). Of the Ottawa cases, approximately 75 per cent include an order to attend counselling and about 50 per cent of the total are written to prohibit the transmission of HIV through sex or needles. In a few cases, Section 22 has been used to order people to reveal names of contacts. The Toronto cases all involved people who contracted another sexually transmitted disease following a positive HIV test. Middlesex-London cases have involved one man who infected a number of women (Charles Ssenyonga) and a woman with HIV who was repeatedly jailed for prostitution and used drugs. She is currently in a compulsory drug rehabilitation program in another community. The case in Kingston, Frontenac, Lennox & Addington involved a woman with HIV who had been admitted to hospital for AIDS-related problems who threatened hospital staff with bloody needles. In this case Section 22 and Section 101 (restraining order) orders were written simultaneously. The woman died while in hospital.

Discussion: These criteria limit the discretion of the medical officer of health, but do not ensure that the medical officer of health can prove that the person is posing a risk to the health of others. There is, therefore, some latitude for the prejudices and beliefs of the medical officer of health to influence his/her decision to issue an order. There is a provision in the HPPA which gives the Minister of Health the power to issue guidelines "for the provision of mandatory health programs and services" (HPPA, Section 7), but there have been no guidelines written addressing Section 22 orders against people with HIV or AIDS.

There are some procedural protections extended to the person to whom the medical officer of health has directed the order. The person may request a hearing by the Health Protection Appeal Board by written notification to the medical officer of health. The hearing takes place before a panel of people who have not been involved in any investigation or consideration leading up to the issuing of the order. The person may be represented by counsel and will have the opportunity to examine the evidence used to write the order. In addition, the person may appeal the decision of the Health Protection

Appeal Board. However, these protections come into effect once an order has been written.

Although an appeal of a Section 22 order can be made, the order remains in effect until the appeal has been decided. There are no guidelines about issuing Section 22 orders against people with HIV. Medical officers of health have generally been involved in sessions leading up to the writing of the order, but there is no guarantee that they will be involved (e.g., may take advice of another party and never interview the person directly). In addition, there is no official mechanism for the person to be heard, with counsel available, in advance of the issuance of the order.

The scope of the order that a medical officer of health may make is unlimited. He or she may order any person - not only the person with the communicable disease - to do anything or refrain from doing anything that the medical officer of health deems necessary to inhibit or prevent the spread of the disease. The HPPA does not require that the medical officer of health design the least intrusive order possible to achieve the desired effect.

There is no mechanism to review the continuing relevancy of a Section 22 order nor to revoke a Section 22 order written against a person with HIV. With other communicable diseases, there are generally clear endpoints for the enforcement of the order - the danger to the health and safety of people in the health unit area no longer exists. With HIV, the person cannot be rendered non-infectious and there could be a perceived possibility of a continuing danger due to the infectious nature of HIV.

In the event that the person with HIV is posing an immediate danger to the health and safety of the people in the health unit area, the process of writing a Section 22 can be done expeditiously which can be an advantage. However, the number of cases in which speed is required are probably few and the Section 22 order may not in fact be effective in these cases.

Relevance of Section 22 Orders: Whether Section 22 orders have any impact on reducing HIV transmission has been widely debated. There is some agreement that the involvement of public health officials in instances where a person is allegedly unwilling or unable to use appropriate precautions can be more useful than invoking more draconian measures outside the health care field (e.g., criminal charges), but there is minimal evidence that Section 22 orders are effective, being used effectively or should be used at all.

In the Ottawa-Carleton Regional Health Unit area, it is estimated that Section 22 orders are effective in about 50 per cent of the cases - the person seems to benefit following Section 22 intervention (e.g., changed behaviour, notified partners). In the other 50 per cent of the cases, the people may never come to the attention of the health department again (could presume intervention was effective) or they may move out of the health unit

area which means the Section 22 is no longer enforceable and be posing the same kind of risk in another health unit area.

Other health unit areas that have used Section 22 orders use them as a last resort - the person has been seen by a number of other organizations, has been repeatedly been named as a partner through partner notification, has been repeatedly counselled by public health about prevention and there is some evidence that the person is continuing to put others at risk.

As stated above, there are concerns about the lack of procedural protections afforded people against whom a Section 22 order has been issued and there continue to be questions about the fundamental effectiveness of the order.

Discussion of Alternatives to Section 22 Orders: There has been a great deal of discussion about Section 22 orders based on the assumption that the designation of AIDS under the HPPA will continue as it exists. There has also been some discussion about creating a new designation for AIDS and diseases such as hepatitis B which would be tailored to address concerns about the current process.

iv) Breaches of Section 22 Orders: When Section 22 orders are breached, the activity moves from a primarily public health sphere into the legal/court sphere. Under the HPPA, any person who fails to obey an order made under the HPPA is guilty of a provincial offence and upon conviction, may be liable to a fine of $5,000 or less for every day the offence continues. With HIV, fines are generally held to be ineffective sanctions. In some instances, a court order requiring the person to attend counselling sessions has been the sanction imposed following a breach of a Section 22 order.

Alternatively, if a person contravenes an order, the medical officer of health can apply without notice to the individual to a judge of the Ontario Court (General Division) for a restraining order (HPPA, Section 101). Although the person can appeal the restraining order, there is no requirement for a hearing to take place prior to the writing of the restraining order.

The Minister of Health may also take action in the case of any contravention of the HPPA (not just orders by medical officers of health). In this instance, however, the Minister is required to give notice and the person would have the right to a hearing and to be represented by counsel (as well as a right to appeal).

Discussion: There have been instances of breaches of Section 22 orders (e.g., following order, person with HIV is reported with a second sexually transmitted disease or is named as a contact). However, the medical officer of health must have evidence that the order has been breached and by the time this evidence comes to light, it is very possible that more people are infected with HIV. As the order is only in effect for the health unit area in which it is written, if the person with HIV moves, the order does not follow. In

addition, if the person breaches the order in another health unit area, it is very difficult to move quickly to contain the situation.

4. **Criminal Legislation:** There is no specific criminal legislation that applies to people who do not protect their partners from HIV transmission and/or do not disclose their HIV status to their partners. The charges that have been laid against people in this situation include sexual assault, being a common nuisance and criminal negligence with intent to cause bodily harm. Although there has been a great deal of discussion about including HIV in criminal legislation, there have not been any changes to the **Criminal Code**.

   Discussion: There have been suggestions that in cases where criminal charges are being laid, the Attorney General should contact local public health officials to attempt to ascertain if public health has been involved (e.g. has post-test counselling taken place, is public health involved with the case) and what recommendations might they have about proceeding with criminal charges. There are confidentiality provisions that restrict the flow of information between public health and the Attorney General, but there could be advantages in a co-operative approach.

   There has also been discussion about the procedural protections afforded people under the criminal system. Some people argue that they would prefer to risk their futures to the lack of knowledge about HIV in the criminal system than to be involved in the public health system where there are fewer procedural protections.

5. **Disclosure/Consent:** The issues of disclosure and consent are extremely complex. For most people with HIV/AIDS, disclosure to family, friends, co-workers can be a difficult and ongoing process. Disclosure with respect to past, current and future sexual or needle using partners is even more complex.

   The purpose of disclosure to partners is to ensure that they have the opportunity to make informed decisions about seeking counselling or testing (past or current partners) and about engaging in risk activities (future partners). There are two principles that underlie the legal doctrine of consent: the right of individuals to inviolability (to be protected from interference from others), and the right to self-determination (to control one's own body).

   In the context of medical care, the right of individuals to self-determination is well recognized and protected by law. The doctrine of informed consent has developed as the primary means of according patients a decisive role in medical decision-making. In other contexts, however, the courts have been much more reluctant to allow individuals to determine their own fates and have ruled that a person offering an activity, even if the activity is inherently dangerous (e.g., parachuting), is responsible for any injuries a willing participant suffers.

   In the criminal context, the question of consent is equally problematic. The general rule

in criminal law is that the "true" consent of the victim is always a defense to criminal responsibility. One clear and unambiguous exception to this is that a victim may not consent to death. In addition, "true" consent cannot be given if it has been induced on the basis of force or the fear of force, or was obtained by false and fraudulent misrepresentations as to the nature and quality of the act characterized as criminal.

The question of whether a person has consented in the instance of HIV transmission may be more a question of public policy rather than of law. Public health law is directed towards the protection of society against disease rather than directed towards individual behaviour change. One of the fundamental questions from a public health point of view is whether the person with HIV is posing a "risk to the health of persons in the health unit". If so, medical officers of health have a legal duty to act. However, the kind of intervention acceptable has been hotly debated. One side of the argument states that with all the education that is available, everyone should be using precautions and the onus of responsibility should not only be on the person with HIV. The other side argues that without knowledge, an uninfected person may have engaged in behaviours that he/she would not have engaged in if he/she had known that the partner was HIV-positive.

A compounding factor in the debate about disclosure/consent is that of a professional's or counsellor's obligation towards his/her client in providing advice about disclosure to partners. The counselling guidelines developed by the Canadian Medical Association does not directly discuss the issue of the physician's responsibility to their patient with respect to disclosure to future partners although there is a great deal of information for the person with positive results about the transmission of HIV, behaviour modification to prevent transmission/"reducing risk-producing behaviour" (never donate blood, semen, ova or organs, always practise "safer sex", never share uncleaned injection equipment and never share uncleaned personal hygiene items) and past/current partner notification as well as stressing the fact that HIV infection is lifelong and can be transmitted to others.[1] The counselling guidelines for the anonymous HIV testing program are somewhat more direct on providing advice to counsellors about the issue of disclosure. In the post-test counselling section for people with positive results, future sexual/drug use partners are included under the discussion of disclosure[2].

People providing pre- and post-test counselling seem to have an ethical duty to encourage their clients with HIV to disclose to past and current partners or to encourage their clients to facilitate the process of empowering people who may have no reason to suspect that they may have been exposed to HIV that they may have been exposed so that they

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[1] Canadian Medical Association, **Counselling Guidelines for Human Immunodeficiency Virus Serologic Testing**, Ottawa, 1993, page 11

[2] Ontario Ministry of Health, **Guidelines for Pre- and Post-test Counselling in Anonymous Testing**, Toronto, 1992, page 25.

can make their own choices about seeking counselling and being tested. However, encouragement of people with HIV to disclose to future partners which may also be an ethical responsibility of people doing pre- and post-test counselling is not as clear.

For some people with HIV, there is a very real danger of violence if they disclose their HIV status to their partners. It is very important that people who are counselling be able to work with their clients to recognize and balance the benefits and risks of disclosure and assist them in developing plans to deal with the issue of potentially infecting another person (e.g., the scenario of a woman who cannot disclose nor insist on condom use for fear of violence). Referral to counsellors who have experience with situations such as abusive relationships should be made if the test counsellor does not have the experience.

Discussion: The committee agreed that if the risk of HIV transmission is zero (there is absolutely no reasonable possibility of HIV being transmitted in the situation), the person with HIV is under no obligation to disclose his/her HIV status.

There was also consensus that disclosure is appropriate if unsafe sex is being suggested or practised (e.g., in a relationship in which safer sex has not been the norm). However, this must be balanced against the potential for physical violence in the relationship.

There was agreement that non-infected people have a responsibility to discuss their HIV status (if known).

If asked directly about HIV status, there was some consensus (if the risk of transmission is greater than zero) that the person should answer truthfully. There should be more responsibility on the person with HIV in situations in which the risk is greater than zero since the person with HIV can change the outcome of the situation. There is agreement about which situations are zero risk and probably agreement about which situations are extremely high risk (e.g., unprotected anal intercourse), people with HIV should disclose their status in situations where the risk is greater than zero.

Much of the discussion about disclosure and consent is based on the assumption that if an uninfected person knows that his/her partner is infected with HIV, there will be less risk of transmission (e.g., will participate in activities that are very low risk for transmission and/or will provide consent to particular activities that they know could put them at risk). If this is true, then it would follow that if the risk of transmission in the particular situation is greater than zero, consent should be obtained. However, HIV transmission is very complicated and even if the risk is greater than zero, HIV may not be transmitted. The counselling guidelines for the anonymous HIV testing program discuss some of the factors that can increase or decrease the risk of HIV transmission: likelihood your partner is infected, frequency of intercourse, type of intercourse and

condom use[3]. There is a great deal of debate about safer sex and levels of risk. Given the debate, it may be that disclosure should occur in any situation greater than zero as the uninfected person should have the right to consent and assumptions about level of risk of any particular activity should not be made.

There has also been a great deal of discussion about whether general public education such as the Ministry of Health television spots or brochures is sufficient for people to have enough knowledge to protect themselves from HIV. The consensus seems to be that while general education of this sort does raise awareness and does support more individual efforts such as counselling, mass media in and of itself does not seem to be sufficient to ensure that people actually have enough information to protect themselves (e.g., a 30 second television spot will reinforce messages about protection, but is not long enough to give specific details). If general education interventions are not sufficient to induce everyone to protect themselves all the time, then it may not be reasonable to expect that the uninfected person should bear the responsibility of protection without the knowledge of the partner's HIV status.

RECOMMENDATIONS

1. Involvement of the criminal system is seen as the least attractive option and a last resort to deal with the issue of reducing HIV transmission by people who are unwilling or unable to take appropriate precautions since the criminal system does not facilitate the reduction of transmission. However, guidelines for Crown prosecutors should be written and made available across the province. In addition, the involvement of public health in the process (e.g., ensuring counselling has occurred, strategies other than criminal charges be examined) prior to continuing with the case.

2. Pre- and post-test counselling should be made legally mandatory in HIV testing (similar to the requirement in the anonymous HIV testing program). No test results should be given without post-test counselling. Standardized counselling guidelines should be developed and include encouragement for counsellors to be explicit in their discussion of sexual practices as well as identification of skills and attitudes that may pose barriers to practising safer sex.

3. Guidelines for writing Section 22 orders against people with HIV/AIDS must be developed so that there is consistency across the province and should be issued under Section 7 of the HPPA. The goal of a Section 22 order should be very clearly to reduce HIV transmission by a person who is unwilling or unable to use appropriate precautions using the least intrusive measures. The guidelines should be based on the following principles:

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[3] ibid, page 9

- Interventions should be such that other people are not discouraged from testing (e.g. if word on street is that those who test positive will be punished, less people will avail themselves of testing).

- Protect rights of people with HIV/AIDS and those who are not infected: There has to be a balance between protecting the rights of people with HIV and those who are not infected.

- Interventions should be the least invasive/restrictive as possible and aim to do more good than harm.

- Pro sexuality/sex positive: A range of choices should be discussed. Abstinence is an option for some people, but should not be forced on people.

- Self-identification: Everyone should be encouraged to take responsibility for themselves and be aware of placing themselves at risk.

The issuing of Section 22 orders should be based on the following process:

- Time limits must be set (e.g., review after one month including procedural protections at the review). Review must occur at least every 6 months to determine continuing relevancy of order.

- A thorough investigation must take place prior to the issuing of an order. Standardized counselling guidelines can be used at this point. Activities such as meeting with a trained public health nurse to determine if the original counselling has been adequate, interviews by the medical officer of health, assessment by a psychiatrist if necessary or referral to community-based organizations may be included in the process at this point.

- Section 22 orders may not be issued without the medical officer of health having interviewed the person directly. Although this may appear to be overly directive towards medical officers of health, it is essential.

5. The committee recommends that a judicial review be conducted to assess the HPPA with respect to the Charter of Rights.