
**Reducing HIV
Transmission by
People With HIV Who
Are Unwilling or Unable
to Take Appropriate
Precautions**

Ontario Advisory Committee on HIV/AIDS

September 1997

Table of Contents

INTRODUCTION	3
Background.....	3
Defining the Issue and Scope of the Issue	3
Values and Principles.....	6
CURRENT APPROACHES AND ANALYSIS	7
PREVENTION EDUCATION, COUNSELLING AND SUPPORT	7
General Community Education	7
HIV Test Counselling.....	9
Counselling and Support for People With HIV/AIDS	11
HEALTH PROTECTION AND PROMOTION ACT (HPPA) (See Appendix 1)	12
General Information	12
Testing and Reporting (Sections 25 - 29).....	12
Notifying Partners	13
Reporting Unsafe Behaviour	14
How Risk Behaviour Comes to the Attention of Public Health.....	14
Section 22 Orders	15
Breaches of Section 22 Orders (Sections 100 - 102).....	19
Designation of AIDS as a “Virulent” Disease.....	19
Confidentiality of Information	21
Analysis of Section 22 Orders to Date	22
CRIMINAL CODE.....	22
PUBLIC HEALTH LAW vs. CRIMINAL LAW.....	25
Confidentiality.....	25
Procedural Protections.....	26
Which Approach is More Appropriate?	27
CIVIL PROCEEDINGS.....	28
OTHER ISSUES	28
Information Sharing and Confidentiality - Public Health, Community Organizations and Other Professionals	28
Disclosure.....	29
When to Disclose.....	30
Consent.....	31
Safe/Unsafe Behaviours and Interventions	32
CONCLUSIONS	33
NON-COERCIVE INTERVENTIONS	33
Prevention Education	33
Pre- and Post-Test Counselling	34
Support/Counselling.....	34
Provincial Community-Based Framework.....	35
Psychotherapeutic/Psychiatric Interventions.....	35

TOWARD COERCIVE INTERVENTIONS	35
Principles of Interventions.....	36
Informal Guideline for Public Health.....	36
Assessing People Who May Be Unwilling or Unable.....	36
Process of Public Health.....	37
Determining Unwillingness or Inability.....	39
COERCIVE INTERVENTIONS	40
Criminal Process.....	40
Mental Health Act (MHA)	40
Health Protection and Promotion Act (HPPA).....	41
RECOMMENDATIONS.....	45
Values and Principles.....	45
Implementation Principles	45
NON-LEGISLATIVE CHANGES.....	46
LEGISLATIVE RECOMMENDATIONS	47
LEGAL CLARIFICATIONS REQUIRED.....	49
Recommended Activity/Responsibility.....	51
APPENDICES.....	53
APPENDIX 1 - Select Sections of the Health Protection and Promotion Act.....	53
APPENDIX 2 - Anonymous HIV Testing Regulations.....	62
APPENDIX 3 - Mandatory Core Programs and Services Guidelines - April 1989:	
Sexually Transmitted Diseases.....	65
APPENDIX 4 - Other Jurisdictions	67
APPENDIX 5 – References.....	68
Books	69
Newspaper Articles	69
Magazines/Journals	70
Legal Documents.....	71
Unpublished Articles.....	71
APPENDIX 6 - Invitees to December 1995 Consultation on Reducing HIV Transmission.....	72

INTRODUCTION

BACKGROUND

The Ontario Advisory Committee on HIV/AIDS established a working group to address the issue of reducing HIV transmission by people with HIV who are unwilling or unable to use appropriate precautions in 1992. Members of the working group include: Maggie Atkinson (Voices of Positive Women), Clarence Crossman (AIDS Committee of London), Mary Fanning (formerly from the Wellesley Hospital), David McKeown (City of Toronto Department of Public Health), John Plater (Hemophilia Ontario), Douglas Pudden (formerly from the Middlesex-London Health Unit), Michael Sobota (AIDS Committee of Thunder Bay), Lori Stoltz (Goodman and Carr) and Robert Trow (Hassle Free Clinic).

In June 1990, the Ontario AIDS Advisory Committee (OAAC) distributed a consultation paper on reducing HIV transmission by people with HIV who are unwilling or unable to take appropriate precautions to organizations across the province for comment. In the fall of 1990, a new government was elected and the process of making recommendations was interrupted. The current working group used this paper and the responses to it as a starting point for discussion. Information was gathered from other jurisdictions (see Appendix 4) about how they handle the issue and Ontario information was updated.

Dr. Ian Gemmill (Ottawa-Carleton Regional Health Unit), Mr. Brad Larson (Toronto PWA Foundation), Mr. Greg Lafontaine (criminal law practitioner, formerly with Fuerst and Gold), Professor Barry Brown (University of Toronto), Ms. Christine Leonard (Black Coalition for AIDS Prevention) and Dr. Richard Schabas (Chief Medical Officer of Health, Ministry of Health) gave presentations about the issues to the working group. Ms. Joan Anderson (AIDS Committee of Toronto) and Ms. Christine Henderson (legal branch, Ministry of Health) provided ongoing input into the paper.

In December 1995, OACHA held a consultation with about 100 people from the perspectives of people living with HIV, community-based AIDS groups, public health, outpatient clinics, other health professions and the legal profession (see Appendix 6). The purpose of the consultation was to obtain feedback on the paper and to discuss the contentious areas of: disclosure/consent, determination of levels of risk, assessment of people who may be unwilling or unable, use of section 22 orders, and uses of the *Health Protection and Promotion Act* versus the *Criminal Code*. In addition, feedback was obtained from the PHA Caucus of the Ontario AIDS Network and the Ontario AIDS Network. Comments from these consultations have been incorporated into the final version of the paper. There were also a number of comments received that should be considered in the implementation phase. These comments will be passed on to the appropriate working groups for consideration.

DEFINING THE ISSUE AND SCOPE OF THE ISSUE¹

For the purposes of this paper, the term unwilling or unable is used to describe the small proportion of people with HIV who know they are HIV positive, but do not take precautions. In some cases, the lack of willingness or ability is due to a lack of information or misinformation. In other cases, people may be consistently unwilling as a result of personal and/or environmental factors, or consistently unable due to psychological, environmental and/or developmental reasons. The working group agrees that the two categories are distinct and that it can be difficult to determine whether a person is unwilling or unable. However, there are circumstances in which interventions can be beneficial in effecting behaviour change.

The working group acknowledges that the people who are consistently unwilling or unable are not reflective of all people with HIV and, in fact, represent a very small number of people with HIV. Furthermore, the working group believes that change is possible and worth pursuing without resorting to coercive measures for most people. Discussion about the minority has an impact on the majority and this discussion occurs within the context of the existing stigmatization of people with HIV who are sometimes perceived as a threat to individuals and to society. The working group recognizes that people with HIV/AIDS are very concerned about the impact the results of this discussion may have on their own lives. There are a number of situations in which coercive interventions are not appropriate and have not been used such as a gay male couple where both know the HIV status of the other or a heterosexual couple where a decision is made by both to attempt to have children. The working group has attempted throughout the paper to balance individual and societal rights and responsibilities and to recommend solutions that do not harm broader education and support efforts.

Court cases have highlighted the issue of reducing HIV transmission by people who are unwilling or unable. Media coverage can give the impression that all people with HIV are "irresponsible" not just those who are charged or convicted. This contributes to an incriminating atmosphere in the treatment of people with HIV. There are sensational aspects to these stories and the media will continue to report on similar cases. It may be difficult for people, including health care workers, lawyers, judges and medical officers of health (MOHs) to view the issue dispassionately and make reasoned decisions affecting people who are unwilling or unable.

There are indications from the voluntary HIV testing program in Ontario that not all people with HIV are consistently practising safer sex or drug use or that there are other factors affecting safer sex or drug use that are not being addressed by current prevention education or HIV counselling². When people with HIV are identified to public health for intervention, there have been concerns raised about their ability or willingness to protect others. It is to be expected that there will always be some people who cannot or will not use appropriate precautions. The underlying reasons for the behaviour may vary. The interventions that are used for those who are unwilling or unable will depend on what is necessary to effect the desired goal of reducing HIV transmission. The working group agrees that people with HIV have the right to a safe sexual life and that the goal of interventions is to change behaviour not to

¹ OACHA decided to leave the definitions below as they are. Each case will have to be evaluated on its own merits. It is not possible and perhaps not wise to detail all the permutations and combinations that may occur in any particular case.

² HIV Laboratory statistics, Central Public Health Laboratory

punish. The working group agrees that the expectations on people who are unwilling or unable should be the same as the expectations on all people with HIV but that, in some cases, it may be necessary to use intrusive interventions that may involve prohibitions not generally given to people with HIV.

The working group re-examined issues related to reducing HIV transmission by people who are unwilling or unable in order to make recommendations to the Ontario Advisory Committee on HIV/AIDS. The issue of reducing HIV transmission is broad and the working group attempted to focus only on the issue of people who know they are HIV-positive and are unwilling or unable to take appropriate precautions. It did not focus on occupational issues such as health care workers with HIV nor on reproductive issues such as pregnancy. Although pregnancy may be a sign of unsafe behaviour and may warrant follow-up, the working group agrees that women with HIV have the right to make informed choices about reproduction.

This paper will:

- outline the approaches being used to address the issue
- analyse the approaches
- outline a spectrum of recommended interventions that can be used to address the issue more effectively.

Approaches such as counselling and general education are available to many people with HIV/AIDS. Interventions that are the least intrusive, least restrictive and are readily available are believed to be the most effective based on the individual circumstances of the situation. The interventions presented at the end of the paper refer specifically to people who are unwilling or unable **and should not be construed as applying to all persons with HIV**. In addition, many of the approaches outlined in the paper are specific to HIV and may not be appropriate for use in other diseases.

This paper, influenced by the broad range of interests of the working group members, is intended for public health officials, community-based AIDS organizations, people with HIV/AIDS and other people responding to people with HIV who are unwilling or unable.

VALUES AND PRINCIPLES

The working group believes that reduction of HIV transmission is achievable and worth striving toward. The working group affirms the basic civil and human rights of people living with HIV and all Ontario citizens. We maintain the following values and principles³:

- People with HIV are entitled to a quality of life that includes sexual intimacy.
- Where informed consent for risk of HIV infection exists, interventions are not necessary.
- All people with HIV should not be judged in light of those people who persistently expose others to HIV infection, especially in the climate of stigmatization.

³ There has been a great deal of discussion that there is not enough emphasis on protecting the rights of uninfected individuals. OACHA believes that the protection of uninfected individuals is implicit in the process and, as only people with HIV will be part of the section 22 process, it is important to ensure that the process protects their rights.

- Interventions to reduce activities that put people who are not HIV-infected at risk of infection should strive to be the least intrusive, least restrictive, most readily available and most likely to be effective based on the individual circumstances of the situation.
- The intent of measures must be to reduce risk, not to punish.
- While there are several organizations and individuals with explicit mandates, roles or responsibilities to reduce HIV transmission within society, people cannot realistically expect authorities to ensure complete protection from HIV infection. People must take responsibility for their own risk behaviour.

2

CURRENT APPROACHES AND ANALYSIS

This section will outline approaches that are currently being used in HIV prevention education, counselling and support, public health, criminal law and civil law areas and give some analysis of these approaches.

Interventions require an understanding of what activities entail risk of HIV infection. The Canadian AIDS Society Safer Sex Guidelines are widely accepted and thoroughly researched documentation of degrees of risk for HIV infection through sexual activities⁴. The working group adopts these guidelines as a basis for determining degrees of risk in sexual activity⁵. Harm reduction is a policy and approach to reducing health risks associated with drug use. The working group adopts the harm reduction model as a basis for determining the degree of risk posed by needle use. The working group did not come to agreement on the manner in which the guidelines should be interpreted and applied for the purposes of interventions.

PREVENTION EDUCATION, COUNSELLING AND SUPPORT

General Community Education

There are a number of prevention education activities across the province. These include local programs (e.g., pamphlets, presentations) of community-based AIDS organizations, public health and schools as well as provincial efforts (e.g., Ministry of Health's multi-media program). Some of the

⁴ Canadian AIDS Society, *Safer Sex Guidelines: Healthy Sexuality and HIV, A Resource Guide for Educators and Counsellors*, March 1994

⁵ “The first priority of harm reduction is to decrease the *negative consequences* of drug use. By contrast, drug policy in North America has traditionally focused on reducing the *prevalence* of drug use. Harm reduction establishes a hierarchy of goals, with the more immediate and realistic ones to be achieved as first steps toward risk-free use or, if appropriate, abstinence.” D. Riley, *The Harm Reduction Model: Pragmatic Approaches to Drug Use from the Area between Intolerance and Neglect*, Canadian Centre on Substance Abuse, p1.

programs are targeted at specific vulnerable groups such as gay men, bisexual men, women, drug users, street youth, culturally and linguistically diverse communities, aboriginal people and people with disabilities. Other programs are more general (e.g., workplace). Some provide health promotion activities specifically for people with HIV.⁶

Various knowledge, attitude and behaviour and tracking studies of mass media campaigns indicate that these efforts have influenced awareness of HIV transmission and methods of prevention and have affected the development of a supportive environment. Education efforts can reinforce messages about preventive behaviour and decision making for people who are not infected and for those who know they are infected. It is an accepted premise that people need to hear messages more than once, and to reverse erroneous messages, they may need to hear the right message as many as ten times to correct it. General education also has a role to play in creating supportive environments that help people make behaviour change.

General community information messages about prevention should emphasize risk reduction and harm reduction in which it is understood that the messages are being heard by people with a variety of HIV statuses (positive, negative, unknown). The risk reduction model attempts to impart the needed information and skills that allow people to reduce and/or eliminate their risk of HIV infection rather than to merely eliminate all risk. The risk reduction approach to safer sex seeks to reduce and/or eliminate the frequency of activities which pose the *highest risk* of HIV transmission. When all high risk activities have been eliminated (i.e., through the use of latex condoms during vaginal/anal intercourse), the risk of HIV transmission is dramatically reduced. People may also decide to practice only those activities which entail low or no risk⁷. Safer sex advice acknowledges the options that can be exercised by people who feel comfortable with some risk, as well as validates those who want greater assurances. There are “no-risk” options for engaging in sex and some will choose them. For many people, however, some level of risk is acceptable or unavoidable and therefore, a broad range of risk reduction choices is available in safer sex education⁸.

Harm reduction is both a philosophy and a set of strategies related to substance use. The underlying rationale for harm reduction is that the risk of HIV transmission and infection is a greater harm to a person’s health than drug use. The approaches are pragmatic, respectful, collaborative and non-judgemental. Harm reduction places the health of drug users as a priority and offers a variety of options for drug users to decrease the harm associated with drug use such as needle exchange programs, bleach bottle kits for cleaning drug equipment and methadone programs for heroin users. The approach allows the user to make informed decisions about what harms associated with drug use he or she is willing to address and how. A harm reduction approach also addresses larger societal issues that have an impact on drug use. Educating the community including social service providers and the police in order to combat the stigma associated with drug use and drug users is extremely important to harm reduction. Drug users often do not access medical and social services because of the stigma.

⁶ see also: AIDS-SIDA Consensus Forum on HIV/AIDS Prevention: The Voices of Experience, Future Directions for HIV/AIDS Prevention Education”, *Canada Strategic Report*, Health Canada, 1992

⁷ adapted from, *Sexual Safety: A Guide*, AIDS Committee of Ottawa, September 1994.

⁸ Canadian AIDS Society, *Safer Sex Guidelines: Health Sexuality and HIV, A Resource Guide for Educators and Counsellors*, March 1994.

They also may not access services where abstinence is the sole treatment method. Within the framework of harm reduction, drug or alcohol use does not hinder a person's access to necessary care and services. Employment and housing services are also essential components of a harm reduction approach⁹.

The working group agreed that risk reduction and harm reduction approaches are essential to prevent HIV transmission. There was agreement that on a population health basis, these strategies are appropriate and effective. There was not agreement on prevention advice that would be given to people who know they are HIV-positive. Some members believe that the goal for a person who knows their HIV status is elimination of risk to others rather than reduction of risk to others. Other members believe that it is important to apply the same strategies to everyone, both those who know they are infected and those who are not infected or do not know they are infected. The working group acknowledges that it is unlikely that general education alone will have a substantial impact on people with HIV who are unwilling or unable¹⁰.

HIV Test Counselling

Pre- and post-test counselling provides preventive education both for people who are uninfected and for people who are infected. It is one of the few opportunities for individual prevention counselling, and for reinforcing preventive behaviour that has already been learned. The person requesting the test will often have a particular reason for being tested, and may be more amenable to listening to information about risk and prevention than they would on other occasions. For people who test positive, test counselling also provides an opportunity to offer support and access to other resources. For people with HIV who are unwilling or unable, this may be the only prevention counselling they receive until they enter the health care system. The quality of counselling can have a major impact on subsequent risk behaviour, and insufficient information or inadequate explanations may lead to continued risk taking by people testing positive or negative.

The changes made to legalize anonymous HIV testing include a legislative requirement for pre-test counselling for the HIV test can be done (Appendix 2). With the introduction of anonymous testing in the Ontario, the Ministry of Health developed counselling guidelines¹¹ and protocols for setting up the program in each of the locations. The Ministry of Health also provided related information and training to ensure a consistently high standard in the delivery of pre- and post-test counselling as well as the program at the anonymous test sites¹².

⁹ Ontario Harm Reduction Coalition

¹⁰ Similar to the discussion about safe/unsafe behaviours, there remains a great deal of disagreement on the kind of prevention advice given to people with HIV (risk reduction vs. risk elimination). Open discussion in this area must continue.

¹¹ Ontario Ministry of Health, *HIV Antibody Testing, Guidelines for Pre- and Post-Test Counselling In Anonymous Testing*, June 1992.

¹² Ontario Ministry of Health, *HIV Antibody Testing, Procedures and Protocols for Anonymous Testing*, June 1992.

In all cases, it is expected that HIV testing will be conducted with the informed consent of the person being tested. At the request of the Ministry of Health, the College of Physicians and Surgeons of Ontario distributed a notice to all licensed physicians in Ontario advising of the introduction of anonymous testing. This notice also advised physicians that, as a matter of practice, they should advise patients considering HIV testing that they could be tested either nominally (in which case a positive test result would be reported by name to the local MOH) or anonymously (in which case a positive test result would not be reported by name to the local MOH)¹³. There is no statutory requirement for post-test counselling in the anonymous HIV testing program as the person may not return for his or her results and is not traceable. It is recommended in the anonymous testing program, however, that clients make an appointment at the time of pre-test counselling in order to receive their results and post-test counselling. Alternatively, special arrangements can be made at the time of pre-test counselling for clients who cannot return for the results.

A. Anonymous and STD Clinic Test Counselling

The Ministry of Health expects that each person who is tested for HIV in Ontario receives pre- and post-test counselling. In reality, this only occurs with any consistency in the anonymous testing program, in STD clinics and in some physician offices.

When anonymous HIV testing was legalized, *HPPA* regulations were changed to include a requirement that pre-test counselling be given. Written guidelines have been developed and training and/or information sessions are held for counsellors in this program. The guidelines and training sessions are also used by counsellors in STD clinics and other testing programs. As a result, the counselling that occurs tends to be fairly consistent and of high quality. It should be noted that in most cases, test counselling consists of only two sessions (one pre- and one post-test), thus counsellors are sometimes limited in the amount of support and reinforcement they can provide.

B. Physician Pre- and Post-Test Counselling

Physicians in private practice and in hospitals do most of the HIV testing in Ontario. The Canadian Medical Association (CMA) has issued guidelines for physicians, but the guidelines are fairly brief, and give no guidance on counselling techniques, nor on taking an accurate risk history. Furthermore, in the non-nominal and nominal testing programs offered by physicians, there is no actual requirement for pre or post-test counselling, with the result that most physicians probably provide very little pre-test counselling. Basic risk information is missing on almost half the HIV-positive laboratory requisitions submitted by physicians. There are consistent reports from patients that they received no counselling at all. A core group of primary care physicians who treat many people with HIV are well versed in the issues related to HIV testing, and do provide high quality test counselling. However, many physicians offering the test still do not have much experience with HIV, may not have the time or expertise to do the counselling and may not feel comfortable talking to their patients about personal risk activities.

C. Anonymous HIV Testing Guidelines¹⁴

All pre-test counselling should cover the format set out in the provincial Anonymous Testing

¹³ *College Notices*, Issue No.24 January 1992.

¹⁴ Ontario Ministry of Health, *HIV Antibody Testing, Guidelines for Pre- and Post-Test Counselling In Anonymous Testing*, February 1995.

Guidelines, as outlined below:

- discussing HIV transmission and prevention
- taking the patient's previous and current risk history
- discussing testing procedures
- preparing the client for a positive result
- informing partners.

Post-test counselling guidelines for people who test HIV-positive should include the following:

- helping the client to express reactions to the results
- reassuring the client about future health status
- reviewing the client's support system and support needs
- reviewing the client's understanding of transmission and prevention
- discussing how to inform partners
- making medical and support referrals.

For clients who test negative, the post-test counselling session should reinforce safer sex and drug-using behaviour and provide medical/support referrals as needed.

Counselling and Support for People With HIV/AIDS

Longer-term support and counselling services for people with HIV/AIDS are provided by a number of organizations, including community-based AIDS organizations, HIV and other hospital-based outpatient clinics, and public health offices. Each location offers a somewhat different type of counselling, depending on the role and background of the person providing the counselling (e.g., public health nursing, social work, psychology, lay counselling). Services offered range from providing HIV-related information to emotional support and lifestyle counselling.

In the context of the unwilling or unable, counselling can help reduce the person's sense of isolation and helplessness, in addition to teaching negotiating skills and risk prevention activities. Information and messages conveyed by individual counsellors should always be consistent with general education messages, and tailored to the specific needs of the person being counselled.

Some organizations also offer peer counselling, where the counsellor is also HIV-positive and may have a similar background. This is a well-accepted approach to prevention education and providing support for people with HIV. Peer counsellors may be particularly effective in helping people with HIV initiate and maintain preventive behaviour specific to their needs. The peer counsellor could be an employee or a volunteer, and would be trained by the organization to provide this kind of counselling.

Finally, some HIV-positive people have private counsellors or psychotherapists to whom they may turn for support.

There are no standards or guidelines to assist in providing HIV-related counselling beyond the general counselling guidelines of individual professions. As a result, no formal evaluation of the effectiveness of counselling/support programs has been done. Some specific projects, however, have been evaluated. One was a project that brought together gay men (infected and uninfected) to talk about safer sex

behaviour.¹⁵ The content of the groups was educational and the psychosocial aspects of prevention were not addressed. The evaluation of this project indicated that those who had the peer experience were more likely to have better attitudes toward safer sex and to practise it more consistently than those without the peer experience. There have been other projects that included the psychosocial aspects of prevention education and the results have been the same.

The *Men's Survey*¹⁶ used the theory of planned behaviour to demonstrate that men who feel most positive about their choices, got the most support from their peers and felt the most control over the situations in which they might find themselves at risk were more likely to protect themselves (96% of the time). Men who felt the least optimistic about their choices, got the least support from their peers and felt the least sense of control over the situations in which they might find themselves at risk were much less likely to protect themselves (12% of the time). The survey concluded that broadening the range of available choices and building self-esteem are key strategies in counselling and support programs for people with HIV/AIDS.

HEALTH PROTECTION AND PROMOTION ACT (HPPA)

(See Appendix 1)

General Information

The authority of the MOH to act to attempt to prevent or minimize the spread of disease depends upon the designation of the disease in question under the *HPPA*. There are three designations of diseases under the *HPPA* — “reportable”, “communicable” and “virulent”. AIDS is currently designated as both a reportable and a communicable disease. HIV, generally accepted by the medical and scientific communities as the causative agent of AIDS, is also considered the agent of AIDS for the purposes of the *HPPA*.

Testing and Reporting (Sections 25 - 29)

HIV testing in Ontario is voluntary except for blood, semen and organ donations. People can be tested for HIV nominally, non-nominally or anonymously. In nominal testing, the results are linked to the person being tested by both the patient's name and the physician's name. In non-nominal testing, the results can be linked to the person being tested by a code known only to the patient and the physician. In anonymous testing, 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. In Ontario, nominal and anonymous HIV reporting of positive test results are permitted by the *HPPA* and regulations. Non-nominal reporting is not permitted by the *HPPA* and regulations, but some MOHs in some circumstances do allow non-nominal reporting (i.e., if MOH is satisfied that counselling

¹⁵ Tudiver, F., Myers T., et. al., “The Talking Sex Project: Description of a Randomized Controlled Trial of Small Group AIDS Risk Reduction Intervention for 612 Gay and Bisexual Men” *Evaluation and the Health Professions* 15(4)26-42, 1992.

¹⁶ Myers, T., Godin, G., Calzavara, L., Lambert, J., Locker, D., *The Canadian Survey of Gay and Bisexual Men and HIV Infection: Men's Survey*. Ottawa: Canadian AIDS Society, 1993.

has occurred, epidemiological information is complete and partners are being notified, he or she may allow physician to report non-nominally).

Certain professionals (e.g., physicians) and institutions (e.g., hospitals, schools, children's aid societies) have reporting responsibilities to the MOH when they form the opinion that a patient/client under their care has or may have AIDS¹⁷ or is or may be infected with HIV¹⁸. Laboratories are required to report to the MOH positive laboratory findings in respect of reportable diseases¹⁹. When the Central Public Health Laboratory has conducted an HIV test, a copy of the laboratory requisition with the result is sent to the physician who ordered the test and, if the result is positive, also to the MOH of the health unit in which the physician is practising. The MOH (or designate) will initiate follow-up with physicians of patients with positive HIV test results to ensure that complete epidemiological information is obtained, that counselling about HIV transmission and prevention has been provided and that partners (sexual and needle-sharing) have been notified in accordance with Ontario's current partner notification guidelines (see below). MOHs use their discretion in determining whether to conduct direct follow-up counselling of people who test HIV positive, but will definitely do so at the request of the attending physician.

For anonymous HIV testing, physicians are exempt from reporting positive test results, but are required to provide complete epidemiological information before a specimen will be processed.

The ability of public health officials to administer the *HPPA* consistently and uniformly across the province depends on the extent with which physicians and others comply with reporting provisions and the extent to which follow-up information is directed to, or obtained by, public health.

Notifying Partners

Partner notification, or contact tracing, is one of the cornerstones of traditional public health efforts to reduce transmission of sexually transmitted diseases. Partner notification is based on the principle that "individuals who may have no reason to suspect they may have been exposed to HIV should have the opportunity to know that they may have been so exposed²⁰." It allows partners to make their own decisions about counselling, testing and participation in risk behaviour.

In October 1986, the Ministry of Health established guidelines for contact tracing by MOHs²¹. These guidelines have been replaced by the guidelines for mandatory core programs offered by public health units (see Appendix 3). Adherence by all MOHs to these guidelines is required by the Public Health Branch of the Ministry of Health as a mandatory health service in accordance with section 7(1) of the *HPPA*.

¹⁷ Section 25, *HPPA*.

¹⁸ Sections 26, 27, 28, *HPPA*.

¹⁹ Section 29, *HPPA*.

²⁰ National Advisory Committee on AIDS, Ottawa, 1987.

²¹ Ontario Ministry of Health, *Guidelines for Medical Officers of Health: Notification of HIV Seropositivity*, Public Health Branch, 1986.

Ministry of Health guidelines provide that it is the MOHs responsibility to ensure that individuals who test HIV-positive receive proper counselling. As a matter of practice, this is achieved by the MOH contacting the person's physician to assess the adequacy of counselling already provided and to offer assistance if needed. Actual partner notification is often left to the physician and the person who has tested positive. The anonymous test counselling guidelines give physicians and counsellors guidance about discussing partner notification with people with HIV, including determining who will inform partners. Public health is available to assist with partner notification when requested.

MOHs cannot follow up in this way on the positive test results of people who have been tested anonymously to ensure that appropriate counselling has been provided or to offer assistance. It is for this reason that the introduction of anonymous testing was accompanied by a legislative amendment to regulations under the *HPPA* to require pre-test counselling. Evaluation of the counsellor checklist used in the anonymous testing program indicates that some voluntary partner notification is occurring²². In nominal and non-nominal HIV testing, it is not known how much partner notification is occurring as there is no systematic collection of partner notification information. Regardless of the mode of testing (nominal, non-nominal or anonymous), it is important to note that successful partner notification requires the co-operation of the person who has tested positive to either disclose information about known partners to public health or the physician or to tell partners directly.

Reporting Unsafe Behaviour

Section 34(1) of the *HPPA* requires that a physician report to the MOH with the name and residence address of a person with a communicable disease who is under the care and treatment of the physician and who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to the physician. There has been no judicial determination whether the term "care and treatment" in this section of the *HPPA* is broad enough to include physician counselling about risk reduction in the context of HIV including, for example, safer sex or needle use.

Some public health officials argue that section 34(1) of the *HPPA* is not appropriate for a disease such as HIV as a person is infectious for life and there is no treatment to cure infectiousness. They take the position that it applies only to diseases such as gonorrhoea for which "care and treatment", more narrowly defined, will effect a cure and render the patient non-infectious.

The working group is of the view that the term "care and treatment" is sufficiently broad to include physician counselling about risk reduction and harm reduction, with the result that refusal by a person with HIV to comply with the advice of a physician aimed at reducing HIV transmission may fall within the scope of section 34(1) and be considered as grounds for physician reporting under this section.

How Risk Behaviour Comes to the Attention of Public Health

Persons engaging in behaviours presenting a risk of HIV transmission may come to the attention of public health officials in a number of ways. These currently include:

²² Ontario Ministry of Health, *Anonymous HIV Testing Evaluation: January 1992 to June 1993*, November 1994.

- **Public Health Follow-Up:** Public health officials may receive information directly as a result of involvement in the follow-up of a person with HIV because their assistance has been requested by that person, by his or her physician or by some other person or institution or, alternatively, because of a report made under the provisions of the *HPPA*.
- **Reports of Secondary Infections:** Diagnosis with another sexually transmitted disease subsequent to diagnosis with HIV infection may be viewed as an example of unsafe sexual practice. This information may come to the attention of public health officials by virtue of the *HPPA*'s reporting provisions as they apply to STD's other than HIV — including, for example, gonorrhoea and syphilis.
- **Physician Reporting:** Unsafe behaviour may be reported to the MOH by physicians pursuant to section 34(1) of the *HPPA*.
- **Other:** Complaints about the risk behaviour of individuals are occasionally made directly to public health officials by past or current partners affected by the risk behaviour.

It is critical to recognize that not all persons who may be identified as engaging in behaviours presenting a risk of HIV transmission are or should be characterized as “unwilling” or “unable” as those terms are used in this paper. The objective of the working group is to make recommendations that:

- describe, as specifically as possible, the circumstances in which public health officials may become involved in individual cases in an attempt to minimize the risk of HIV transmission posed by risk behaviour; and
- establish a framework to guide decision-making of public health officials in this area in an effort to ensure procedural fairness to the person with HIV, to maximize the effectiveness of any intervention while pursuing the least intrusive intervention appropriate to reducing the risk, and to ensure consistency of approach between health units.

Section 22 Orders

MOHs are empowered by section 22 of the *HPPA* to issue a written order in certain, specified circumstances against a person who has or who is suspected of having a communicable disease.

The MOH is without any power to issue an order unless he or she has formed an opinion, upon “reasonable and probable grounds”:

- (a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the MOH; and
- (b) that the communicable disease presents a risk to the health of persons in the health unit served by the MOH; and
- (c) that the requirements of the order are necessary to decrease or eliminate the risk to health presented by the communicable disease²³.

²³ Section 22(2), *HPPA*.

There is no requirement that actual transmission of the communicable disease — in this case, HIV — take place before an order may be issued by the MOH. The underlying purpose of the *HPPA*, as set out in section 2 of the Act, is to prevent or minimize the risk of such transmission before it occurs.

- **Content:** The content of a section 22 order is governed by the nature and extent of the specific risk identified. There must be a relationship — a rational link — between the risk that has been identified and the steps the person to whom the order is issued is being required to take.

The *HPPA* does not expressly require that the MOH design the order with the aim of minimal intrusion to bring about the reduction of HIV transmission, but this is implicit in the requirement of necessity set out in section 22(2)(c). The working group is of the view that orders should be specific and impose the least intrusive, least restrictive measures necessary to effect appropriate behaviour change.

Section 22(1) extends a general power to the MOH to order any person — not only the person with the communicable disease — to do anything or refrain from doing anything that the MOH believes to be necessary to inhibit or prevent the spread of disease.

Section 22(4) provides a more specific list of those items that may be included in an order. It is clear that this list is not intended to be exhaustive of all possible terms that may be included in an order. However, the express provision in section 22(4)(g) that a person with a virulent disease may be ordered to place himself or herself under the care of a physician makes it clear that such an order cannot be made in respect of communicable diseases such as AIDS not designated as virulent. This is important in view of the fact that section 22 orders in the context of HIV/AIDS often require a person to receive counselling from a physician (i.e., MOH) or his or her designate. The working group is of the view that the ability of an MOH to order a person to receive counselling should be made express in the *HPPA*.

Section 22(4)(f) of the *HPPA* provides that an order may include a term requiring the person to whom it is directed to submit to an examination by a physician to determine whether he or she has a communicable disease. In the context of HIV/AIDS, this section might be interpreted as authorizing an MOH to issue an order requiring the person to submit to nominal HIV testing — in effect, an order for mandatory testing. The working group does not advocate mandatory HIV testing except in the instance of blood, semen or organ donation. Although an order of this nature may appear to be advocating widespread mandatory testing, some members of the working group were of the opinion that it could be used, but only as a last resort to confirm the HIV status of an individual when there are sufficient grounds to issue a behavioural section 22 order against a person where HIV is presumed but not known.

- **Direct Involvement with the MOH:** MOHs (or Associate MOHs) have generally been directly involved in the interview/counselling process leading up to the writing of section 22 orders, but it is unclear whether they have always been involved. The working group is of the view that, at the very least, the person writing the order (MOH or Associate MOH) should interview the person prior to the issuing of an order when the person has HIV and the order is specific to HIV.
- **Procedural Protections:** Concern has been expressed that there are few procedural protections in the *HPPA* for people against whom a section 22 order is written. The working group is of the view that the *HPPA* does, in fact, extend substantial procedural protections. These are:

- to be valid, the order must inform the person to whom it is directed that he or she is entitled to a hearing²⁴
 - the person may request a hearing by the Health Protection Appeal Board (HPAB) by written notice to the MOH within 15 days after the order is issued;
 - the Board is required to hold the hearing within 15 days of receiving notice²⁵;
 - although the order takes effect when issued, a person who seeks a hearing may seek a stay of the order from the HPAB to prevent the order from taking effect until the hearing has taken place and a determination has been made as to its validity²⁶;
 - the hearing takes place before a panel of people who have not been involved in any way in the investigation or consideration leading up to the issuing of the order²⁷;
 - the person is entitled to documentary disclosure before the hearing which consists of the right to examine any written or documentary evidence or any report whose contents will be relied upon at the hearing;
 - the person may be represented by counsel at the hearing²⁸;
 - the person has full opportunity to test the evidence of the MOH in support of the order by cross-examination and to introduce his or her own evidence to challenge the order;
 - the HPAB must scrutinize the evidence upon which the order was based and its terms to determine whether the order meets the requirements of the *HPPA*;
 - the HPAB has broad powers to confirm, alter or rescind the order; and
 - the person may appeal the decision of the HPAB to Divisional Court and that right of appeal is broad.
- **Outstanding Concerns about Procedural Protections:** Outstanding concerns about the level of procedural protections provided by the *HPPA* that have been raised for consideration by the working group include:
 - concern that the standard of proof under the *HPPA* (which requires a proof that “reasonable and probable grounds exist”) is lower than the ordinary criminal standard (which requires proof

²⁴ Section 44(1), *HPPA*.

²⁵ Section 44(5), *HPPA*.

²⁶ Section 44(3), *HPPA*.

²⁷ Section 45(3), *HPPA*.

²⁸ Section 45(2), *HPPA*.

- “beyond a reasonable doubt”) and the ordinary civil standard (which requires proof on the “balance of probabilities”): The working group is of the view that the standard of proof required by the *HPPA* is appropriate in view of the seriousness of the harm sought to be prevented — the unnecessary transmission of HIV from one person to another.
- concern that the MOH is not required to give the person an opportunity for a hearing before issuing the order²⁹. The working group discussed instituting a formal hearing before the issuing of a section 22 order, however, decided to recommend a pre-order interview in which the person would be encouraged to bring an advocate of his or her choice. A formal hearing was felt to move the activity into an adversarial arena and out of the preventive, problem-solving arena designed to avoid the issuing of a section 22 order.
 - concern that a section 22 order takes effect when served notwithstanding an appeal of the order to the HPAB unless a stay is sought and obtained: The working group discussed the possibility of the HPAB instituting automatic appeals of section 22 orders written for people with HIV unless the person declined to appeal. It was decided, however, that this would be taking power away from a person with HIV and that the inclusion of the names and telephone numbers of the local community-based AIDS organization and the HIV/AIDS Legal Clinic would provide the person with guidance about appeal.
 - the person may appeal the decision of the HPAB to Divisional Court and that right of appeal is broad, allowing the Divisional Court:
 - to exercise all of the powers of the Board to confirm, alter or rescind the order as the court considers proper; or
 - to refer the matter back to the Board for re-hearing in whole or in part, as the court considers proper³⁰.
 - **Review:** Section 22 orders are not time-limited and there is no mechanism prescribed by the *HPPA* to require a review of the continuing relevance or necessity of a section 22 order (other than provision for an appeal, if desired by the person to whom the order is issued). With most communicable diseases, there are generally clear endpoints for the duration of the order -, i.e., the risk of disease transmission no longer exists once the person is no longer infectious either as the result of treatment or the passage of time. In the case of HIV, a person cannot be rendered non-infectious. Rather, the endpoint of a section 22 order against a person with HIV would be the adoption of behaviours that minimize or eliminate the risk of disease transmission to others.
 - **Effectiveness of Section 22 Orders:** Whether the use of section 22 orders succeeds in reducing HIV transmission has been widely debated. There is some agreement that the involvement of public health officials in circumstances in which a person is allegedly unwilling or unable is preferable to recourse to measures outside the public health field such as laying criminal charges. However, there is little more than anecdotal evidence that section 22 orders are effective when used in this context. There is no tracking of orders and outcomes at the provincial level.

²⁹ Section 92, *HPPA*.

³⁰ Section 46(5), *HPPA*.

It is important to note that this anecdotal evidence does not take into account the possible impacts of such measures on the wider community and the extent, if any, to which persons have been discouraged from seeking HIV testing and related counselling out of fear of finding themselves subject to coercive public health action.

Most health units that have issued section 22 orders in the context of HIV emphasize that they have used them as a last resort. Typically, the person to whom the order is issued has been seen by a number of other organizations, has been repeatedly named as a partner through partner notification and/or has been repeatedly counselled by public health about prevention and there is some other evidence that the person is continuing to put others at risk.

- **Scope:** Section 22 orders are limited in their geographic reach. Section 22(5) provides that an MOH may only issue an order to a person with a tie to his or her health unit -, i.e., a person who resides or is present in the health unit. As a matter of law, an order issued in one health unit is enforceable across the province -, i.e., if a person moves to a different health unit or engages in risky behaviour in another health unit. There is no central registry of section 22 orders, so an MOH in one health unit would generally not be aware of the existence of an order issued by another MOH in a different health unit.

Breaches of Section 22 Orders (Sections 100 - 102)

Enforcement steps after a section 22 order is written move from the confidential public health sphere into the public sphere of the courts. 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 up to \$5000 for every day the offence continues.³¹ The working group is not convinced that fines are effective sanctions in reducing HIV transmission when an order is breached.

In addition, if a person contravenes an order, the MOH can apply to a judge of the Ontario Court (General Division) for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order that, in the opinion of the judge, will or will likely result in the continuation or repetition of the contravention.³²

Alternatively, an MOH may bring an application for a court order to prevent an anticipated breach of an order without any evidence that it has been breached in the past pursuant to section 102(1) of the *HPPA*. Although the *HPPA* allows such an application to be brought without notice to the person who is the subject of the order, in *Ssenyonga*, the Court required that he be notified before proceedings to deal with the application.

Designation of AIDS as a “Virulent” Disease

The possible designation of AIDS as a virulent disease under the *HPPA* has been hotly debated.

³¹ Section 100, *HPPA*.

³² Section 102(2), *HPPA*.

At present, all diseases designated as “virulent” under the *HPPA* are also designated as communicable. The additional powers which flow from the further designation of a communicable disease as virulent are as follows:

- **Additional terms may be included in a section 22 order:** A section 22 order may include a term “requiring the person to whom the order is directed . . . to place himself or herself forthwith under the care and treatment of a physician³³.”
- **A court order may be sought for detention in a hospital:** If the person to whom a section 22 order has been issued has failed to comply with an order that:
 - (a) the person isolate himself or herself and remain in isolation from other persons;
 - (b) the person submit to an examination by a physician;
 - (c) the person place himself or herself under the care and treatment of a physician; or
 - (d) the person conduct himself or herself in such a manner as not to expose others to infection,

Then the MOH may apply to a judge of the Ontario Court (Provincial Division) for an order that the person:

- (a) be taken into custody and be admitted to and detained in a hospital named in the order;
 - (b) be examined by a physician to ascertain whether or not the person is infected with an agent of a virulent disease; and
 - (c) if found on examination to be infected with an agent of a virulent disease, be treated for the disease³⁴.
- **Problems of proof of non-compliance alleviated:** A person who has withdrawn from the care and treatment of a physician or failed to take or continue an action contrary to specific terms in a section 22 order is deemed to have failed to comply with the order.³⁵

Arguments for the designation of AIDS as a virulent disease question the efficacy of public health measures currently available under the communicable designation under the *HPPA*. In order to resolve this debate, it is important to decide whether all of the additional powers listed above are reasonably necessary to most effectively reduce HIV transmission in Ontario. It has been argued that a virulent designation would allow MOHs to move more quickly and effectively to halt HIV transmission. The Ssenyonga case has been used in support of this argument. It is worth noting, however, that in the Ssenyonga case the public health authorities succeeded in obtaining a restraining order using section 102(1) of the *HPPA* even without putting evidence before the court that Mr. Ssenyonga has breached the section 22 order issued by the MOH³⁶. Any delay in securing that court order, therefore, must be

³³ Section 22(4)(g), *HPPA*.

³⁴ Sections 35(1), (2), (3) and (7), *HPPA*.

³⁵ Section 36(1), *HPPA*.

³⁶ Ontario (Chief Medical Officer of Health) v. *Ssenyonga*, (1991) O.J. No.544 (Gen. Div.); unreported; 16 April 1991, p.3

attributed to factors other than a lack of enforcement power available to the MOH.³⁷

The powers described above are currently available in respect of communicable diseases not designated as virulent if the MOH has issued an isolation order.³⁸ This use of isolation orders to control HIV transmission has never been advocated or used in Ontario.

What is different for virulent disease designation is the ability to effect detention in a hospital in response to non-compliance by a person with an order to submit to an examination by a physician, to place himself or herself under the care of a physician or to conduct himself or herself in such a manner as not to expose another person to infection. As HIV is a life-long disease and hospitalization will not change infectiousness, the working group is of the view that the additional powers of the virulent designation are not necessary.

Concerns have also been raised about the messages about HIV/AIDS and people with HIV/AIDS implied by the use of the word “virulent”, which does not describe the reality of HIV transmission. A virulent disease in common language connotes not only a disease to be feared, but the people carrying the disease should also be feared. This runs directly counter to all the efforts over the past 15 years to promote compassion for people with HIV and that HIV cannot be transmitted through casual contact.

An additional suggestion has been that AIDS (and HIV as the agent of AIDS) be made not reportable, as was the case with herpes. Herpes was made unreportable due to the difficulty in determining if the infection was new or a flare-up of a pre-existing one. However, the working group does not believe that making AIDS unreportable would help reduce HIV transmission. It would also result in less information and epidemiological trends about HIV in Ontario, which are used in prevention and support programs. Without reporting under the *HPPA*, it would not be possible to develop effective strategies to assist people with HIV who are unwilling or unable without creating new law.

Confidentiality of Information

Section 39 of the *HPPA* establishes a clear requirement that information about people with reportable, communicable or virulent diseases must be held confidential. Exceptions to this requirement of confidentiality are specific.³⁹ In some circumstances, MOHs have found it helpful to involve people outside the health unit to address concerns about risk behaviour in identified cases — for example, to establish contact between the person with HIV and an appropriate community-based AIDS organization to facilitate peer counselling which is generally thought to be the most effective in achieving behavioural change, or to seek specialized expertise in order to educate and inform the MOH as to what options might be most likely to succeed in addressing a particular concern. Given that such interventions do result in the disclosure of HIV status and other confidential information about the health status of the person in question, the practice of public health officials in such cases has been to require the written consent of the person to whom the information relates before proceeding with the involvement of others in developing an intervention.

³⁷ The Ssenyonga case is not considered a standard by OACHA nor is there any expectation that it will be used as a precedent. The paper attempts to consider each case as unique and tries to lay out the individual facts of each case.

³⁸ Section 36(2), *HPPA*.

³⁹ Section 39(2), *HPPA*.

The *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)* provides access to and protection of personal information held by the municipal government. It could be used to release information to the public or people affected when it is in the public interest, and the information is of a grave environmental, health or safety hazard to the public. The person must be informed that this is going to happen if it is possible. Some have argued that there may be instances in which *MFIPPA* could be used if the person with HIV is posing a danger to others. The issue is extremely complex and questions about the interface of the *HPPA* and *MFIPPA* needs further discussion. These issues may be addressed in the new Ministry of Health initiative on confidentiality of health information. The working group believes that section 39 of the *HPPA* ought to prevail and the use of *MFIPPA* is not appropriate for use in these circumstances.

Analysis of Section 22 Orders to Date

By the end of 1993, 13,971 people had tested HIV positive in Ontario since 1985.⁴⁰ At the same time, there had been 45 section 22 orders written in Ontario in relation to people with HIV (37 in Ottawa-Carleton, five in the City of Toronto, two in Middlesex-London, one in Kingston, Frontenac, Lennox & Addington). Of the cases in Ottawa, about 50 per cent were written to prohibit the transmission of HIV through penetrative sex or needles and about 75 per cent included a requirement to attend counselling. In a few of these Ottawa cases, section 22 orders were used to order people to reveal the names of sexual or drug contacts. Many of the people who were identified to public health in these cases had pre-existing problems, either drug use or mental health problems, that influenced their ability to use appropriate precautions. Current numbers of people who have had section 22 orders issued since the end of 1993 are not available.

One of the Middlesex-London cases demonstrates how the section 22 process works. Mr. Ssenyonga was identified as the partner of women who subsequently tested HIV-positive and was continuing to put others at risk. A section 22 order was issued to Mr. Ssenyonga. Following the issuance of the section 22 order, an application for a restraining order was sought by the MOH in the absence of evidence that Mr. Ssenyonga had breached the section 22 order. The court granted an injunction, although the MOH was required by the court to inform Mr. Ssenyonga of the application even though this is not required under the *HPPA*. Mr. Ssenyonga appealed the injunction to the Court of Appeal for Ontario. He also appealed the section 22 order to the Health Protection Appeal Board. Hearings on both the *HPPA* cases were deferred until the completion of the criminal case. If Mr. Ssenyonga had been successful in the appeal of the section 22 order, the injunction would have ceased.

CRIMINAL CODE

Until 1985, the *Criminal Code* contained a prohibition which rendered it a criminal offence for a person who is aware that he or she has a communicable venereal disease to transmit the disease to another person. This prohibition was repealed in 1985 on the grounds that the transmission of disease was a matter of public health rather than a criminal act⁴¹. As a result, there is no HIV- or venereal disease-

⁴⁰ HIV Laboratory, Ministry of Health

⁴¹ At the time the decision was made to repeal the *Criminal Code*'s prohibition against the transmission of venereal disease, there had not been a prosecution under the section since 1922: Canada Parliament, The Standing Committee on Justice and Legal Affairs, *Minutes of the Proceedings and Evidence*, Issue 17, March 19, 1985, p.27.

specific criminal legislation that applies to people who knowingly transmit or attempt to transmit HIV. Although there has been a great deal of discussion about including HIV-specific offenses in criminal legislation, both for and against, there have not been any changes made to the *Criminal Code*.

Although AIDS has been followed since 1982 and HIV testing has been available since 1985, there have only been a few cases across Canada in which people with HIV were prosecuted for allegedly infecting others. The following are examples:

An Ontario criminal case (1991) involved a man, Mr. Lee, who was charged with aggravated assault after engaging in consensual sexual intercourse. After the incident, Mr. Lee tested HIV-positive. There was no evidence that Mr. Lee knew before the incident that he was HIV-positive although there was evidence that he suspected that he might be. There was also no evidence that the complainant asked him about the possibility of being HIV-positive. Mr. Lee was acquitted.

The most widely reported Ontario case occurred in London. Mr. Ssenyonga was charged with three counts of criminal negligence causing bodily harm and three counts of aggravated sexual assault. The aggravated sexual assault charges were dismissed 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 Court was not willing to find that the consent to the sexual activity had been obtained by fraud, the alleged fraud being the non-disclosure of the fact of infection by the accused to the complainants. The criminal negligence causing bodily harm charges remained. The accused pleaded not guilty to all the charges. There will be no ruling on the criminal negligence causing bodily harm charges as the accused died in July 1993 after the conclusion of the trial before the judge delivered his ruling. In February 1994, the Criminal Injuries Compensation Board (Ontario) awarded the complainants the maximum award of \$25,000 but reduced it to \$15,000. The awards were reduced as the tribunal apportioned a degree of responsibility to the women for having intercourse without use of a condom. On appeal, Ontario's Divisional Court rejected the Board's decision and granted the women \$25,000 each in February 1995. The court said the Board demanded an unreasonably high standard of behaviour from the women and the women had no reason to disbelieve Mr. Ssenyonga's statements about his health.

There have been criminal 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 sentenced to one year imprisonment and three years probation with the condition that he seek medical treatment and psychiatric counselling (*Somner*).

A similar case occurred in Nova Scotia (September 1989) and the person with HIV pleaded guilty to a charge of criminal negligence causing bodily harm. He was sentenced to three years imprisonment (*Wenzell*). In both these cases, HIV transmission occurred in the context of ongoing relationships.

There was also the *Mercer* case in Newfoundland (August 1993). Mr. Mercer allegedly infected two women with HIV after he had been tested and had received counselling. He did not disclose his HIV status to his partners and did not practise any safer sex methods. Mr. Mercer pleaded guilty to criminal negligence causing bodily harm and was sentenced to 27 months. On appeal of the sentence, it was increased to 11 years. The Supreme Court of Canada refused to hear an appeal of the sentence.

In British Columbia (November 1994), a person was charged with two counts of aggravated assault (*Cuerrier*) after he continued to have unprotected sex with his partners in spite of counselling about

HIV transmission. Neither partner at the time of the trial had tested HIV-positive. Mr. Cuerrier pleaded not guilty and was acquitted on the grounds that the Crown had not made out the offence of assault because the complainants had consented to un protected sex. The judge concluded that the accused acts of engaging in unprotected sex “endangered the lives” of the complainants and therefore could constitute aggravated assault. However, he noted that the facts and the arguments were virtually identical to those in *Ssenyonga* and Mr. Cuerrier was acquitted on both counts. The Crown appealed the decision, but no judgement had been made by the end of August 1996.

It is important to note that in the three cases, *Somner*, *Wenzell* and *Mercer*, the defendants all pleaded guilty. Therefore, the issue of the applicability of the relevant provisions of the *Criminal Code* used to prosecute each accused person was never fully litigated and passed upon by a Court. None of the cases would, for that reason, amount to persuasive authority for the applicability of the relevant *Criminal Code* provision in similar situations.

Current offenses under the *Criminal Code* that seem to be appropriate in the case of a person who is apparently unwilling or unable to take appropriate precautions may be criminal negligence causing bodily harm or common nuisance (this was the charge used in Ottawa where a man with HIV attempted to donate his blood, *Thornton*). Assault charges do not really address the issue of HIV transmission, and fraud charges, because the person did not disclose HIV status would not be appropriate since consent to sexual intercourse is not invalidated by non-disclosure of an STD. Another charge could be administering a noxious substance, but it would be very difficult to prove intent of the person.

When criminal charges are being laid, the police appear on behalf of a private informant before a justice of the peace with “reasonable and probable grounds” that a crime occurred. The justice of the peace has to agree that the grounds exist. The justice of the peace may issue a summons to appear in Court or an arrest warrant. The person who is charged may not be granted bail on the grounds that he or she would not show up for the trial or that he or she poses a serious risk to the public. Conditions of bail could theoretically include an order that the accused not partake in any unprotected sex. The restrictiveness of the conditions of bail in the case of a person with HIV who is unwilling or unable where the charge is related to spreading HIV may depend on the knowledge level of the justice of the peace about HIV transmission. If a person is out on bail, it can take two to three years to get the case through the Courts. If the person is in jail, the process moves much faster.

The charging document sworn before the justice of the peace is called the “information”. The “information” is a public document, although the control of the wording initially is the responsibility of the police. The accused person would inevitably be identified though occasionally it is worded in such a way as to avoid identifying the complainant. Courts have the ability to protect the identity of an accused person from broadcast or publication, but this only takes place where the Court has ruled that it will protect the complainants identity in the first place. The *Criminal Code* has a provision which makes it fairly routine to protect the identity of complainants in sexual misconduct cases (e.g., sexual abuse of children). It is not likely that such an order would be issued in a case involving HIV transmission. The identity of the complainants, however, may be protected by the Court.

The majority of the activity in the criminal sphere has been a result of sexual partners coming forward to lay charges for the infection. The majority of charges that have been laid are criminal negligence causing bodily harm. Although there have not been many criminal cases, it is believed that some of the factors that will influence whether a case proceeds include: the ability to prove that the accused person was the person who infected the complainant, which involves a review of the complainants sexual history and other risk factors, and the willingness of the complainant to submit to a lengthy, stressful

process that may not be successful in obtaining a criminal conviction. Depending on the charge laid, the judge or jury must be convinced on the basis of admissible evidence beyond a reasonable doubt that the accused knowingly or by criminal negligence infected the partner.

The criminal process is initiated through evidence suggesting that an offense has been committed and, unlike public health law, cannot be used as a preventive measure (e.g., cannot charge a person in case he or she was thinking of committing a crime) with the exception of prevention of conspiracy. After the process is initiated, the case takes on a momentum of its own. The complainant may wish to drop the charges, but the Crown prosecutor may choose to continue. Appeal of a sentence cannot be made until after a sentence has been imposed. An appellant may ask for bail, however, pending an appeal.

In addition to rehabilitation of the offender, sentencing in the criminal justice system is designed primarily to protect the public and to provide a deterrent to the individual offender and to other like-minded individuals. A conviction in relation to a *Criminal Code* offence can only be invoked when there is proof of an offence beyond a reasonable doubt. Under a charge of criminal negligence causing bodily harm, there must be proof that bodily harm or death has occurred and that it was caused by the accused person's conduct. Intent to kill (e.g., charge of attempted murder) would be very difficult to prove.

Where the charge is criminal negligence causing bodily harm, the Crown must prove that the accused showed “wanton or reckless disregard” for the lives and safety of others or a marked and substantial departure from the norm expected by a “reasonable” person. The expectation that general community knowledge is high (what can be expected of a reasonable person) would be strong and the honestly held belief that “I was doing right” could be challenged if, for instance, the complainant or accused did not use condoms in spite of all the information in the community about reducing risk through condom use.

Part of the consideration to pursue a case of this nature is that if the complainant is claiming that he or she was infected through a sexual encounter, information about all his or her sexual partners could be extremely relevant (i.e., to prove that the accused person is the only person that could have infected the complainant) and his or her HIV status would be known since HIV transmission is at the heart of the charge. In addition, there could be problems of proving that the complainant was actually infected by the accused (i.e., can be very difficult to prove viral strains are the same and direction of transmission). In the Ssenyonga case, because the strain of the virus was rare and because none of the other sexual partners of the women were infected with HIV, it was possible to connect him with the women. In most cases, this is not going to be so.

PUBLIC HEALTH LAW VS CRIMINAL LAW

There are key differences between the use of the criminal law and public health law to intervene with alleged unsafe behaviour of a person with HIV.

Confidentiality

The consequences of using the *HPPA* could be a written order. All information is confidential. Public health is prohibited from publishing details of a case. The *HPPA*, however, can be awkward when it comes to warning others of their risk without the consent of the infected individual. In certain circumstances and when the partner(s) can be identified, public health may proceed with partner notification. When public health notifies a partner(s) of their potential risk, this is done without disclosing the person's identity, but there are clearly cases where the partner being notified will

obviously know or suspect. Information that has been gathered in the course of a public health investigation can be released in a court of law if the prosecutor knows the information exists and subpoenas it.

Information in open court in the criminal sphere is generally public. In certain circumstances, it is possible to ask the Court for a publication ban to protect the identity of the complainant. This may in turn have the effect of necessitating an order banning the publication of the identity of the accused. A court would be extremely unlikely to order a publication ban to protect the identity of the accused in any other circumstance. In the *Ssenyonga* case, although some of the complainants were not identified in the press, the accused person was identified. There was no request for a publication ban of information that would identify him. Media coverage of these criminal cases is common, including the identities of the accused.

Procedural Protections

There is a perception in the community that a section 22 order carries the same weight as a criminal sentence. This means that people against whom a section 22 order has been written are “guilty” and yet, are not afforded the right to “defend” themselves as they would in the criminal sphere. Therefore, it has been argued that the procedural protections under the *Criminal Code* are better than those under the *HPPA*. In some ways, it is true that the *HPPA* does not provide the same level of procedural protection as does the *Criminal Code*. For example, in the criminal justice system, the standard of proof is higher (“beyond a reasonable doubt”). It is important to note, however, that when a person has been charged with a criminal offence, the prosecutor is required only to “show cause” why the accused should be detained in custody pending a trial — a standard of proof that is comparable to “reasonable and probable grounds”.⁴² Moreover, a police officer may arrest *without warrant a person “who has committed an indictable offence or who, on reasonable grounds, he believes has committed or is about to commit an indictable offence.”*⁴³ Both aggravated assault and criminal negligence causing bodily harm — charges that have been laid against people with HIV— are indictable offences. The assertion that the criminal justice system provides a higher standard of procedural protection in such cases cannot, therefore, be accepted without qualification.

Before making a decision that results in a deprivation of liberty, the MOH is not required to prove that the person with HIV has infected others, just that he or she is posing a risk to others on “reasonable and probable grounds”. This relates to the prevention mandate of public health. The working group believes that the lower standard of proof required under the *HPPA* is a benefit to reducing HIV transmission. HIV transmission need not occur before public health can intervene. People with HIV also benefit as the range of interventions designed by public health do not necessarily have to be coercive (e.g., public health intervention does not automatically lead to a section 22 order) and, in fact, can provide a great deal of benefit for the person with HIV.

One of the identified procedural problems with the *HPPA* is that there is no express requirement for an individual to have notice of the case against him or her nor to have an opportunity to respond (with or without the help of counsel), either in writing, or in person, until after a section 22 order has been written. The working group agreed that there should be an interview between the MOH (or designate

⁴² Section 151(1), *Criminal Code*.

⁴³ Section 495(1)(a), *Criminal Code*.

who would be writing the order) and the person to whom an order is directed (with or without an advocate of their choice) prior to the writing of the order. This will increase the procedural protections for people with HIV against whom orders are written.

The person who is charged with a criminal offence is subject to arrest and jail. The result of a conviction under the *Criminal Code* may be incarceration for a lengthy term specific to the offence, whereas the results of section 22 orders usually only restrict people's liberty without incarceration. Even when the most coercive public health intervention of "detention" is used, the setting is a hospital, not a jail. Prisons cannot provide the kind of counselling, treatment and care that people living with HIV may need.⁴⁴

Finally, concerns have been raised about the fact that a section 22 order takes effect notwithstanding an appeal when it is issued unless a stay is sought and obtained. The working group believes that the inclusion of the names and telephone numbers of the local community-based AIDS organization and the HIV/AIDS Legal Clinic will assist people with HIV against whom orders are written to access appropriate advice in a timely fashion.

Which Approach is More Appropriate?

The working group believes that HIV is primarily a health issue, not a criminal issue. There will continue to be situations where people with HIV are brought into the criminal justice system but the criminal system should not be relied upon to prevent HIV infection. Progress on reducing the transmission of HIV is not best served by this system. The working group believes that attempts to criminalize HIV transmission can harm prevention efforts and increase the stigma associated with living with HIV/AIDS. Briefly, the working group believes that public health is the more appropriate system to address this difficult issue because of the following:

- There is far greater protection of confidentiality in the public health system than in the criminal system. Under the criminal system, the person's identity and personal sexual history becomes public property and therefore, may appear in the media.
- The public health system can offer more possibilities for prevention than the criminal system. Public health law allows officials to be proactive and take steps to reduce the likelihood of HIV being transmitted using a variety of interventions, tailored to meet the needs of the individual. Orders can be written that have the express purpose of changing behaviour to prevent transmission. The criminal justice system is too unwieldy to respond effectively to the majority of situations of alleged unsafe behaviour.
- The procedural safeguards in the criminal system versus those available in the public health system has some people preferring use of the criminal system as if the public health system is without safeguards. For example, after an order is written there is an opportunity for an appeal decided by a third party, the Health Protection Appeal Board (HPAB). However, the working group believes

⁴⁴ Correctional Services Canada, *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons and Background Papers*, 1994. (Note: Statements contained in conclusions of the report do not necessarily reflect the view or policies of Correctional Services Canada.)

that there are weaknesses in the public health process and that, with changes to the process leading up to and after a section 22 order, concerns about safeguards can be substantively addressed. The working group believes that changes to the public health system are preferable to any increased use of the criminal system.⁴⁵

CIVIL PROCEEDINGS

There have been civil lawsuits brought against health care professionals for failure to provide sufficient information to their patients. There have not, however, been any lawsuits by individuals in Ontario against people with HIV for transmitting HIV in the context of unsafe sexual or needle sharing practices. One civil case involved possible exposure to HIV (*Ginsberg*). In this case, a wife accused her husband of possibly exposing her to HIV infection as he did not disclose his bisexuality to her. There was no evidence that he was HIV-positive. The judge allowed the case to continue.

OTHER ISSUES

Information Sharing and Confidentiality - Public Health, Community Organizations and Other Professionals

A. Public Health: Lack of information sharing between health units can pose problems when dealing with a person who has been identified as unwilling or unable. Information about a section 22 order will probably only be known in the health unit in which it was written. Many people with HIV move around the province. If they know about it, another health unit might be able to use the contents of the original section 22 order as “reasonable and probable grounds” to issue a second order, but this is unlikely. It is possible for a person with HIV who is unwilling or unable to avoid the consequences of a breach of an order by moving to, or by engaging in unsafe behaviour in, another health unit area.

This may reduce the ability of public health to identify people who are unwilling or unable in a timely fashion and to develop appropriate interventions. It is not possible to ensure transfer of information unless it is known where the person is or is going and/or where they are engaging in unsafe behaviours. The failure to intervene may contribute to additional infections.

B. Community-Based Organizations: Community-based AIDS organizations have concerns about being consulted by public health about a specific person with HIV who is allegedly unwilling or unable. In these situations, sanctions may be applied to a person with HIV and the community-based organizations could be seen as contributing to public health coercion, for being in conflict with their advocacy role for clients and as breaching the confidentiality of a client. On the other hand, community-based organizations appreciate the advantages of an opportunity to change the possible outcome of a situation. Community-based organizations often have developed excellent rapport with marginalized people and may be in the best position to provide effective supportive counselling to a person who has been identified as unwilling or unable.

⁴⁵ For a more comprehensive outline of procedural protections available and concerns about protection in the public health system, see pages 15-16.

Many community-based AIDS organizations have had clients who they suspect are unwilling or unable. Most organizations do not have policies or guidelines for staff dealing with a person who may be unwilling or unable.

C. Physicians: Physicians have a legal obligation to report positive HIV results and cases of AIDS to public health (section 29). In the context of ongoing care, physicians may feel that they are in a position of conflict about releasing confidential patient information to public health with their concerns. After the initial report, it could be perceived to be breaching doctor-patient confidentiality. This is a particular dilemma for physicians who use non-nominal HIV reporting to public health. It may also be difficult for a physician to assess whether a patient is putting others at risk (e.g., consistently practising safer sex) based on the information given by the patient.

In practice, physicians rarely report a person after the initial report of HIV unless they have serious concerns. There is no express requirement that physicians report following the initial report (except for reporting AIDS).

Disclosure

The issue of disclosure is fundamental in the discussion of reducing HIV transmission by people who are unwilling or unable. There is no express legislative requirement for people with HIV to disclose their HIV status to others who might be in a position of risk (e.g., partners, health care workers). Public health officials are the only people who have a responsibility for contacting previous partners directly.

Disclosure by people with HIV to family, friends, co-workers can be a difficult and ongoing process. Disclosure to past, current and future sexual or needle-sharing partners may be even more difficult. A key element in the discussion about people who are unwilling or unable is whether all people with HIV are obliged to disclose this to current and future sex/drug partners and conversely, whether people without HIV have a right to know the status of their partners before engaging in any behaviour that might put them at risk of HIV infection. Opinions are highly polarized among people with HIV and those working with people with HIV.

The argument in favour of disclosure to partners is that it ensures they have the opportunity to make informed decisions about seeking counselling, testing and about the level of risk in which they are prepared to engage. Disclosure to future partners allows them to be fully informed when consenting to activities in which the risk of HIV transmission is greater than zero. If a person knows that their partner is infected with HIV, he or she will be more likely to engage in less risky activity than they might have otherwise (or may not consent to any risk activity at all).

In this context, it can be argued that a person cannot truly consent to an encounter that could lead to HIV infection if they are unaware of the potential risk. It is generally agreed that public education efforts are useful in raising awareness of the issues and of prevention strategies. Public education also emphasizes health promotion strategies, giving people the information, skills and supportive environment to protect themselves without knowing their own or their partner's HIV status. However, general education interventions are not sufficient to induce everyone to protect themselves all the time. The working group feels it may be unreasonable to expect people to take precautions if they have reason to believe their partner is not infected (e.g., in a long-term, presumed monogamous relationship).

On the other hand, it can be argued that requiring disclosure by all persons with HIV in situations in which HIV could be transmitted may ultimately create a barrier to testing and cause concerns about

possible sanctions (e.g., loss of employment, loss of housing, distancing of family relations). Some people may prefer not to get tested for HIV although they know that they have engaged in high-risk behaviours so that they can honestly tell their partners that they do not know their HIV status. People may also be reluctant to disclose in the context of intimate relationships where all possible precautions, short of disclosure, are being taken. There is some evidence that most people with HIV who know their status are more likely to engage in safer sex practices.

Encouraging people with HIV to disclose to future partners may be part of the discussion during pre- and post-test counselling and in the context of ongoing counselling (e.g., encouraging people with HIV to “do no harm”), but this topic is not clearly outlined in any of the guidelines. There is also no legislation requiring counsellors or physicians to counsel their clients in this area. The CMA guidelines stress the fact that HIV infection is lifelong and can be transmitted to others, but the issue of a person with HIV disclosing to future partners is never directly addressed.⁴⁶ The anonymous HIV testing guidelines do provide some advice to counsellors about the issue of disclosure and include future sexual/drug use partners under the discussion of disclosure, but stop short of specifically recommending disclosure to future partners.⁴⁷ Discussion about disclosure to future partners in guidelines would help achieve consistency in education, counselling and the exercise of public health responsibility.

When to Disclose

The working group agrees that people with HIV who know their status have a responsibility either to disclose their status to their partner or to ensure that high-risk behaviour does not occur. The working group also agrees that if there is no possibility of HIV transmission in a given situation, the person with HIV is under no obligation to disclose HIV status (e.g., workplace setting, no-risk sexual encounters). There was also consensus that disclosure is appropriate prior to unprotected anal or vaginal penetration or needle sharing.

The exception would be if there are reasonable grounds that physical violence will occur if the person discloses that they are HIV-positive (e.g., history of abuse in the relationship). The counsellor’s job in this case would be to work with the client to ensure his or her safety until such time as the partner can be told. It is possible that this may not occur until the client is out of the relationship and disclosure would actually be partner notification by public health. It is very important that counsellors be able to work with their clients to recognize and balance the benefits and risks of disclosure. They must help those who cannot disclose to develop plans to deal with the issue of potentially infecting another person. If the counsellor or physician does not feel comfortable providing counselling in this area, referral to counsellors who have experience with similar situations should be made.

The question of when disclosure is required becomes more complicated when low risk activities are considered (e.g., penetrative sex with a condom, oral sex with or without a condom, needle sharing with cleaning). Some people maintain that any risk greater than zero requires disclosure. In addition, some bioethicists would state that even a slight risk of a serious harm (e.g., death, serious disease or

⁴⁶ Canadian Medical Association, *Counselling Guidelines for Human Immunodeficiency Virus Serologic Testing*, Ottawa, 1993, page 11

⁴⁷ Ontario Ministry of Health, *Guidelines for Pre- and Post-Test Counselling in Anonymous Testing*, Toronto, 1992, page 25.

disability) is a serious risk.⁴⁸ In the context of HIV, it would follow that if there is any risk of transmission, it should be considered a serious risk and disclosure should occur. Others argue that the actual risk of low risk activity is so low that it is no greater than risks people take in their everyday lives. Disclosure may also be complicated by an uninfected partner's fear or lack of knowledge about HIV transmission.

The working group did not reach a consensus about disclosure by people prior to low risk sexual or needle sharing activities. The lack of a consensus creates a complication in defining who is unwilling or unable, if the criterion of unwilling or unable includes disclosure (or lack thereof) as part of taking appropriate precautions to reduce HIV transmission.

Consent

There are two principles to 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 importance of informed consent by the patient is well recognized and protected by law. The standard of disclosure in law is high. In other contexts, the Courts have been reluctant to allow individuals to determine their own fates and have ruled that even if the activity is inherently dangerous (e.g., parachuting), the person offering the activity is responsible for any injuries a willing participant suffers. The prerequisite to finding that true consent to the risk has been given in either context is access to knowledge on the part of the participant. True consent is rarely presumed.

The question of whether a perceived lack of consent to the possible risk of HIV transmission requires state intervention may be more a question of public policy rather than of law. There is agreement that the state (public health or criminal) should not be involved in a case where, for example, both partners were already infected with HIV or where one partner knows the other partner is infected, is informed about risks and is aware of possible risk of transmission. Public health officials have stated that if the partner of the person with HIV infection knows of the infection, they would not intervene beyond offering counselling or support if appropriate.

In the criminal context, the general rule is that the “valid” consent of the victim is always a defence to criminal responsibility. The exception to this is that an accused may not use as a defence that the victim consented to death. In addition, “true” consent cannot be given if it has been induced on the basis of fear of force, or was obtained by false and fraudulent misrepresentations as to the nature and quality of the act characterized as criminal. The charges of aggravated sexual assault in the Ssenyonga case were not allowed since the Court held that the complainants freely and voluntarily engaged in sexual intercourse with the accused. Therefore, consent had not been given on the basis of fraudulent misrepresentation. The judge followed the legal precedents of STD cases finding that the presence of the STD (HIV) did not fundamentally alter the nature of the act to which the women consented (sexual intercourse).

⁴⁸ Brown, B.F., PhD *Comments on the Draft Report of the Ontario Advisory Committee on HIV/AIDS: Reducing HIV Transmission by People who are Unwilling or Unable to Take Appropriate Precautions*, Toronto, 1994.

Safe/Unsafe Behaviours and Interventions⁴⁹

The working group discussed safe and unsafe behaviours and when state intervention is appropriate. It is assumed that those who know they are infected are more likely to protect their partners from transmission. Various guidelines (Ministry of Health, *Guidelines for Pre- and Post-Test Counselling in Anonymous Testing*⁵⁰ and Canadian AIDS Society, *Safer Sex Guidelines*⁵¹) agree that unprotected anal or vaginal intercourse with an infected person is a high-risk activity. The working group agrees that if there is no risk of HIV transmission, there is no obligation for individual intervention by public health beyond public education nor is there any reason for the person with HIV to disclose his or her status. There is also agreement on the part of the working group that unprotected anal intercourse, vaginal intercourse and sharing unclean needles are high risk activities and the person with HIV has an obligation to disclose or to ensure it does not happen. The working group agrees that if there is no disclosure in high-risk situations, interventions may follow.

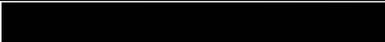
It is less evident what the appropriate response should be to low-risk activities (e.g., vaginal intercourse using a condom) and which activities would justify intervention. The working group did not agree about possible interventions if a person practises only low-risk activities. Nor is there any agreement about the need for disclosure in these instances.

There has been discussion about the wording of section 22 orders with respect to the prohibition of anal, vaginal and oral sex. Where sexual activity has been the identifying problem, some orders stipulate “no insertive sex”, rather than no penetration without a condom. These orders may not be the least intrusive. The working group feels that it is very important to be precise about the activities that are being proscribed so that there is no confusion on the part of the person against whom an order is written and with overall approach to reducing HIV transmission. The working group also agrees that the least intrusive orders should be written, but there are many factors that will influence the specifications in orders. There was no agreement about the appropriateness of orders that prohibit anal/vaginal intercourse with a condom or oral sex.

⁴⁹ This area of discussion remains the most contentious and OACHA decided not to make absolute definitions. It may be an issue that is never resolved.

⁵⁰ Ontario Ministry of Health, *HIV Antibody Testing, Guidelines for Pre- and Post-Test Counselling in Anonymous Testing*, February 1995.

⁵¹ Canadian AIDS Society, *Safer Sex Guidelines: Healthy Sexuality and HIV, A Resource Guide for Educators and Counsellors*, March 1995.



3

CONCLUSIONS

Members of the working group discussed a wide range of issues and options for reducing HIV transmission by people with HIV who are unwilling or unable. The first, fundamental agreement was that the number of people being identified to public health as apparently unwilling or unable could be reduced through increased community and physician efforts. There is agreement that some parts of the current system should be maintained. There is also agreement that changes are needed to make the system more responsive and relevant to HIV/AIDS. Throughout the discussions, the principles of balancing individual rights and responsibilities with those of society were kept in mind.

The working group discussed legislative changes. It was agreed that the system can be improved in the short-term without major legislative changes. In the longer term, consideration should be given to making changes to the legislation. It is also important to note that the changes being suggested are specific to HIV and do not necessarily apply to all communicable diseases listed under the *HPPA*.

NON-COERCIVE INTERVENTIONS

Non-coercive interventions are defined as those in which no legal sanction has been applied to the person (e.g., counselling is voluntary). Interventions that can be seen as non-coercive are education, support/counselling and psychotherapy. The intervention may be made by public health, a physician, a community-based organization, an outpatient clinic or a community-based professional. The intervention at this point may be totally voluntary (e.g., the person identifies behaviour that they want to change) or may be somewhat non-voluntary (e.g., counselling is highly recommended, but the person is not committed to counselling). While coercive interventions may follow non-coercive interventions, there is no expectation that this will always happen.

Prevention Education

General public education efforts will continue to play a proactive role in the overall reduction of HIV transmission and the working group recommends that it should continue. Prevention education can have an impact on reaching partners of people with HIV and those who do not know their HIV status. However, the working group agrees that general education efforts alone are unlikely to have a major impact on the behaviour of those who are unwilling or unable. Education and counselling strategies and mechanisms developed to manage the situation when people are unwilling or unable should be consistent with the overall messages, but will have to be flexible in order to meet the needs of the individual and the circumstances.

Pre- and Post-Test Counselling

The working group agrees that every effort should be made to standardize pre- and post-test counselling in the province. Guidelines should be developed and training offered.

The counselling guidelines that have been developed for use in the anonymous HIV testing program are widely used and, with minor changes, could become the provincial standard for pre- and post-test counselling as well as the standard for initial counselling interventions by public health.

In addition, the anonymous HIV testing program is the only HIV testing program in which pre-test counselling is a legal requirement. The working group agrees that consideration should be given to making pre- and post-test counselling a requirement for all HIV testing (anonymous, non-nominal and nominal).

Support/Counselling

Human behaviour is motivated by many personal and social factors. Behaviour is very difficult to change and it is difficult to accurately predict future behaviour. Counselling can provide part of the support necessary for people to change and maintain behaviour, but the environment in which the person resides is a very important factor in whether they will be successful in maintaining the changes. In addition, counsellors must recognize that although the counselling is technically voluntary, the client may not have sought it out. The effectiveness of the interaction may be limited in spite of the sensitivity of the counsellor when the person is receiving non-voluntary counselling.

Counselling interventions that are the most effective will be those that empower people to consistently protect themselves and others from HIV infection. It is possible that a counsellor's failure to use effective counselling interventions may have an impact on a person's willingness or ability to take appropriate precautions to prevent the transmission of HIV — in the worst case scenario, may even contribute to or reinforce a person's unwillingness or inability. In the counselling situation, there must be a balance between giving clear information and acknowledging the concerns and emotions surrounding the changes that are needed. It is important that counsellors be non-judgemental about their client's history and ensure that the counselling is relevant to the client's experience, including sexual and/or drug experience, sexual orientation, behaviours, age and cultural background. Counsellors must also deal with their own biases and attitudes toward sex, sexual orientation, drug use and death. The sessions can be used to provide information, teach skills, communicate openly and effectively and anticipate and prepare for situations that will arise over the course of the disease. Counsellors must also recognize that a person's unresolved problems may interfere with effective support/counselling (e.g., the peer counsellor may not be able to help if the person discloses sexual abuse) and make referrals when appropriate.

Interventions to increase a person's support can include peer support (individual or group), buddy systems, support in community-based AIDS organizations and counselling at an HIV outpatient clinic. Community and multi-media activities will increase the support in the surrounding environment. These interventions can enhance the climate in which behaviours that reduce HIV transmission are accepted.

The underlying reasons for being unwilling or unable to protect others from HIV transmission are varied and complex as are the counselling interventions that foster people's willingness or ability. The working group agrees that counselling/support can be beneficial to facilitate consistent preventive

behaviour for those that need it. Guidelines and strategies should be developed to help counsellors in the various settings across the province to maximize the counselling experience.

Provincial Community-Based Framework⁵²

One of the issues that came to the working group's attention is that there are a wide variety of people providing counselling or support services that are not covered under the *HPPA* or health professional legislation. These counsellors may have knowledge that a client is posing a risk to others and may experience ethical concerns or conflicts. Most agencies do not have policies about what to do in these situations. Reporting to public health may not be an option as it could be seen as breaking client confidentiality or as a breach of trust with the community the agency serves.

The working group agrees that a process to develop a framework for community-based organizations would be useful. The goal of the framework would be to help community-based organizations who do not have a reporting responsibility under the *HPPA* to understand and resolve competing ethical and legal responsibilities and to establish policies in their organizations.

Psychotherapeutic/Psychiatric Interventions

There may be people for whom more intensive interventions would be helpful. The unwillingness or inability may stem from drug or alcohol use, mental illness, delusions or irrationality, personality disorders, sociopathy or psychopathy. Changing the behaviour may be more amenable to a psychotherapeutic or psychiatric intervention than a public health intervention. It is important for psychologists and psychiatrists to be familiar with HIV counselling and recognize the impact of HIV infection on counselling. A person may also have HIV-related dementia or side effects of treatment drugs complicating the situation. These cases can be extremely difficult. In order to develop the best plan of action for the person, it is important that the psychiatrist or psychologist be able to distinguish between what is related to HIV and what is pre-existing. Psychiatric disorders should be treated as such, which may require using the *Mental Health Act (MHA)*. Where a person's unwillingness stems from sociopathy or psychopathy, other interventions, such as the *Criminal Code*, may be required.

TOWARD COERCIVE INTERVENTIONS

Beginning with pre-test counselling, the quality of the contact is extremely important in influencing a person's ability or willingness and also in identifying and assessing them. Public health intervention at this point will be initiated by routine public health follow-up, existence of a sexually transmitted disease or other indicator of unsafe behaviour, physician reporting or other community identification. The intervention is specifically designed to determine whether a risk exists and, if so, whether more coercive measures should be taken. It is important that public health make use of resources that will be able to help distinguish between those for whom non-coercive interventions will be effective and those for whom more coercive measures are necessary. There are no written criteria to establish whether a person is unwilling or unable. The use of section 22 orders by public health units varies greatly across the province. Some MOHs may issue them very quickly while others are reluctant to go further than

⁵² In the consultations, there were comments about the fact that community-based groups (including community-based AIDS organizations) are generally not required by law to report to public health. The process of creating a provincial framework will allow community-based AIDS organizations and others to determine their own policies and responsibilities in this issue.

counselling and monitoring the situation. There should be a concerted effort to establish consistency across the province concerning what would be considered valid reasons for assessing whether a person is unwilling or unable and what would actually be deemed unwillingness or inability.

Principles of Interventions

There are a number of principles that should be applied to all contacts with people with HIV when assessing potential unwillingness or inability and determining actual unwillingness or inability. All interventions should:

- have the goal of preventing HIV transmission
- recognize that people with HIV may have heard conflicting messages about transmission and may find it difficult to assess their own risk and risk to others
- be the least invasive, least restrictive, reasonably available and likely to be effective
- aim to do more good than harm
- not discourage others to be tested
- maintain the balance between the rights of people with HIV and those who are not infected
- offer a range of choices
- be positive toward sexuality and sexual orientation
- be non-judgemental toward injection drug use
- encourage people to take responsibility for themselves and be aware of placing themselves or others at risk
- maintain confidentiality of information to the greatest degree possible.

Informal Guideline for Public Health

In order to address the inconsistency in assessment and intervention, the working group recommends that an informal guideline be developed through broad consultation with key stakeholders and be issued by the Chief Medical Officer of Health. One of the goals of the guideline would be to prevent unnecessary assessments or interventions. The importance of making the distinction between being unwilling or unable and types of interventions would be highlighted in the guideline. This guideline would also be helpful in creating a consistent process prior to the issuing of a section 22 order and also in the writing of section 22 orders if it gets to that stage. It is very important to note that the section 22 process can stop at any point when public health is satisfied that a risk does not exist or no longer exists.

Assessing People Who May be Unwilling or Unable

The working group agrees that the current system of bringing information about people who are unwilling or unable to the attention of public health is sufficient once clarification of section 34(1) of the *HPPA* is obtained which would allow physicians to report unsafe behaviour. The current methods of identifying people include routine public health follow-up; physician reporting, including subsequent reporting if there are indications that the person may be unwilling or unable; and reports from sexual or needle sharing partners.

The decision about whether or not interventions would occur would be based on a range of factors. Individual circumstances should be taken into account in the assessment. For example, if a partner is

fully informed and consents to risk activities, the working group believes that no coercive intervention should occur. Therefore, the following is not a list of determinants that a person is indeed unwilling or unable. It is a list of indicators that may signal the need for assessment.

- explicit⁵³ refusal to receive prevention counselling within a reasonable length of time
- explicit refusal to make appropriate changes in his or her behaviour (e.g., refusing to use condoms during anal/vaginal intercourse, refusing to use clean needles)
- explicit refusal to co-operate in informing identifiable current partners while continuing to engage in high-risk activities
- explicit refusal to disclose to partners while continuing to engage in high-risk activities
- clinical evidence that the person may be practising high-risk sex (e.g., after being diagnosed and appropriately counselled, the person presents with another sexually transmitted disease as a result of high-risk sex) or high-risk needle use (e.g., sharing unclean needles)
- the presence of other medical problems that might impair judgement (e.g., dementia, psychosis)
- a serious substance abuse⁵⁴ problem that might impair judgement (e.g., drug or alcohol addiction)
- a report from a physician indicating a clinical judgement that the person is not practising safer sex or needle use
- a credible report from a partner that the person, after being diagnosed and appropriately counselled, has not been practising safer sex or needle use.⁵⁵

Process of Public Health

The following outlines the suggested process for public health recognizing that many of these steps are already in place and practised across the province.

- The MOH should determine if the person is actually infected with HIV, although if the MOH has “reasonable and probable grounds” to intervene without confirmation of HIV, it can be done. The MOH could, if absolutely necessary, issue a section 22 order requiring that the person submit to nominal HIV testing. The working group recommends its use only as a last resort for confirming HIV status when there are sufficient grounds to proceed with issuing a section 22 order against a person based only on a presumption of HIV infection.

⁵³ In the consultations, there were comments about the use of the word explicit. A suggestion was made that it be replaced with "consistent non-compliance". OACHA agreed that it would be possible to remove the word "explicit" but reiterated that each situation must be determined on its own merits.

⁵⁴ In the consultations, concerns were raised that an assumption could be made that all people who use drugs would be more likely to engage in unsafe activities. While people who use drugs may have been dealt with unfairly in the past, the inclusion of a serious substance abuse problem is not an indication that all people who use drugs are engaging in unsafe activities.

⁵⁵ All members of the working group were concerned about the misuse and misunderstandings that could result from listing possible indicators for assessment. Therefore, there was no consensus on the inclusion of pregnancy on the list. However, the working group did agree that although pregnancy may be a sign of unsafe behaviour and may warrant follow-up, women with HIV have the right to make informed choices about reproduction.

- Focused test counselling should be conducted. The requirement that this counselling occur should not be regarded as a stalling technique. Public health may provide the counselling directly or may ask the assistance of the attending physician. Some people with HIV may not understand transmission information while others may have psychiatric or intellectual problems that interfere with protecting others. Counselling in this instance provides an opportunity to ensure that the person truly understands HIV transmission and prevention. It also allows the counsellor to identify factors that may be influencing the person's behaviour. It is important that the individual be informed about community resources (e.g., a written list of organizations, including HIV outpatient clinics, that may be helpful) available to them during this focussed test counselling. While it is up to the person to follow up on any referral, assistance may be requested by the person. With the person's consent, public health may facilitate the referral. The working group recommends that the individual also be given the option of bringing a person of their choice to any of the interviews or counselling.
- After a person has been counselled, it must be determined whether further steps need to be taken to reinforce safer sex and drug-using precautions. The following scenarios are examples of situations in which further steps, such as a section 22, would not be appropriate:
 - a person was genuinely unaware he or she putting others at risk and has modified their behaviour
 - a person was temporarily unwilling or unable as a result of stress or an underlying mental or emotional disorder that has been resolved
 - a person was unable to take precautions as a result of a reasonable fear of physical violence.

It is important to note that there has never been a section 22 order written in any of the above scenarios. Additional counselling could be recommended in any of these scenarios, but no coercion would be used to ensure that the person followed through.

- If there are sufficient concerns to proceed, it is likely that additional counselling will occur.
- If there are still sufficient concerns, the working group suggests that the MOH call a case conference that includes community representatives. This case conference can only be done with the informed consent of the person with HIV. The goal of the case conference is to bring together different perspectives and expertise to develop solutions to avoid the use of coercive measures if possible. The person with HIV may or may not be in attendance depending on the situation. A case conference may not always be appropriate, but should be considered before coercive measures are taken. Case conferences are being tried by the Ottawa-Carleton Regional Health Department and there are a number of models that should be examined to determine which is most appropriate for the situation.

The involvement of community representatives is highlighted at specific points during the process taken by public health. The working group agrees that referral to other agencies including HIV outpatient clinics and case conference can enhance the likelihood that the person with HIV who has been identified as possibly unwilling or unable will receive the assistance he or she needs to take appropriate precautions in the future. The working group believes that the informed, written consent of the person is appropriate and provides a sufficient safeguard for the person when public health contacts a community-based agency (or agencies) either in a referral capacity or for a case conference. However, a number of community-based AIDS organizations have serious concerns about public health contacting AIDS organizations directly. Their recommendation is that "any approach should be a

voluntary approach by the client only. Public health can refer the person to an ASO (AIDS service organization) for assistance, both in counselling and advocacy, but should not be the body to contact ASOs.⁵⁶ Underlying the recommendation of the PHA Caucus is a concern about power dynamics and whether a person would genuinely feel he or she had a choice when the referral is being proposed by public health in a situation of unequal power. In addition, the Caucus had concerns about the credibility of a community-based AIDS organization in the minds of clients during this process if the community-based AIDS organization was seen as an extension of public health in this process. The working group, however, was concerned that having to make the first contact would be a barrier for some individuals and agreed that public health could be very useful in facilitating the process for the client. The working group recognizes that community-based AIDS organizations can establish a “self-referral only” policy to cover circumstances where public health asks for assistance. This issue, the relationship between public health and community-based AIDS organizations and other aspects of understanding and resolving competing ethical and legal responsibilities in reducing HIV transmission by people with HIV who are unwilling or unable to take appropriate precautions could be addressed in the development of a provincial community-based framework.

Determining Unwillingness or Inability

The reasons for any person being unwilling or unable to take precautions are complex. It is important to understand underlying causes in order for an intervention plan to be as effective as possible. Lack of knowledge or understanding, emotions or attitudes, psychiatric disorders or substance abuse problems can create barriers to a person’s ability or willingness. It must also be acknowledged that the experiences of disenfranchisement and/or discrimination can foster alienation and suspicion of authority figures which can make assessment and intervention much more difficult.

There are differences between people who are unwilling and people who are unable and it is important to make the distinction in the assessment phase. Assessment of the duration of the problem (short or long term) is also important. If it is determined that the unwillingness or inability is of a more permanent nature, it may not be possible to reduce HIV transmission using non-coercive interventions and so, coercive steps may be necessary.

The working group agrees that persistent unprotected anal or vaginal sex, or sharing unclean needles by a person with HIV without consent of the partner(s) indicates an unwillingness or inability to protect others. Since the working group could not agree whether disclosure or interventions were appropriate for low-risk activities such as oral sex, no recommendations have been made about this. The working group acknowledges that this is a major point of contention between health care providers and public health and community-based representatives — one that was reflected in the working group itself.

The working group agrees that standards or guidelines developed for use by public health officials should outline a “reasonable standard” for behaviour (i.e., how would a reasonable person act in particular circumstances) and more specific criteria for assessing the barriers for the individual who is unwilling or unable. These guidelines will help ensure a more consistent approach to people who are unwilling or unable. It must be acknowledged that until there is consensus concerning what a reasonable standard of behaviour would be for low risk activities, there may be differences across the province in public health’s determination of who is unwilling or unable when low risk activities are involved.

⁵⁶ Correspondence from the PHA Caucus, Ontario AIDS Network, April 1996.

The working group agrees that it is important to use non-coercive methods before moving to coercive interventions. The working group also agrees that counselling and psychiatric assessments may be appropriate measures to help reduce HIV transmission.

COERCIVE INTERVENTIONS

Coercive interventions are defined as those in which legal sanctions are applied. The working group agrees that the first recourse should be through the health system rather than the criminal justice system. This does not negate a person or organization laying criminal charges against another person at any time.

It is the working group's opinion that public health is more knowledgeable about HIV and, therefore, better able to help people change their behaviour while avoiding the punitive aspects of the criminal justice system. In addition, if there are underlying or pre-existing conditions that inhibit a person's ability to take precautions, a variety of solutions can be developed. Criminal sanctions may be appropriate in certain circumstances, but it is unlikely that criminal sanctions would be effective to reduce HIV transmission. There are a number of situations in which they are not at all appropriate (e.g., a mental health problem that would not be dealt within prison). In addition, the working group was not convinced that a prison term would actually reduce the opportunity for HIV transmission, nor that the supports to reinforce preventive behaviour exist in a correctional facility.

Criminal Process

The working group recognizes that criminal charges may be laid against a person who may be unwilling or unable. Guidelines should be developed for Crown prosecutors. One goal of the guidelines would be to improve their decisions by increasing their knowledge about HIV. Another goal would be to reinforce public health interventions and legislation as the first recourse and the goal or prevention not punishment as the priority. To achieve these goals, the guidelines should include contacting local public health officials for consultation about the case (e.g., recommendations regarding counselling). There are confidentiality provisions restricting the release of information from public health, but there are clear advantages to a co-operative approach (i.e., improving the possibility of HIV prevention and avoiding inappropriate criminal proceedings). As with the discussion about information flow between health units, it may be possible to use either the *HPPA* or *MFIPPA* to allow flow of appropriate information between public health and the Ministry of the Attorney General.

The guidelines could also be used to increase the knowledge level of Crown prosecutors about HIV and transmission.

Mental Health Act (MHA)

The working group did not discuss all the options under the *MHA* in any detail. It agrees however, that there may be situations in which the *MHA* would be appropriate and should be explored by the MOH (e.g., a psychiatric disorder that was interfering with a person with HIV's ability to take appropriate precautions causing him or her to be a threat to others). HIV status alone should not be considered sufficient to invoke the use of the *MHA*. It also agrees that guidelines for MOHs should include exploration and clarification of when the *MHA* could be used (e.g., in cases where HIV is one of multiple diagnoses).

Health Protection and Promotion Act (HPPA)

A. Designation of AIDS: The working group agrees that AIDS (HIV as the agent) should not be designated as a virulent disease and should remain as a reportable, communicable disease under the *HPPA*. Medical officers of health have a great deal of authority with AIDS as a communicable disease. One of the identified problems in leaving AIDS as a communicable disease is that other legislation may require that staff of “institutions” be free from communicable disease. The list of communicable diseases used in these acts is usually the list of communicable diseases from the *HPPA*. This concern is not related to unwilling or unable and should be addressed elsewhere.

B. Reporting: The working group feels that legalization of non-nominal reporting in Ontario is an essential change to reporting requirements that must be made.

C. Other Reporting (Reporting on the Basis of Unsafe Behaviour): Physician reporting to public health when a person with HIV is suspected of posing a risk to others after the first report to public health continues to be an issue. The working group agrees that the ability of physicians to report unsafe behaviour is very important. It recommends that clarification be sought about the use of section 34(1) allowing physician reporting of unsafe behaviour. Guidelines would be helpful to physicians to determine when such reporting would be required.⁵⁷

D. Section 22 Orders: There have been no written guidelines issued to address section 22 orders in relation to people with HIV or AIDS. The working group recommends that guidelines be developed and issued. The guidelines should allow for some flexibility as there may be cases in which it is desirable to issue a section 22 order expeditiously, but should also ensure a consistent approach across the province.

- **Content of Section 22 Orders:** The working group agrees that orders should be the least intrusive and least restrictive necessary to bring about the desired behaviour change. Orders requiring counselling or psychiatric assessment are appropriate as long as the purpose of these activities is to assist in reducing HIV transmission. Orders should be specific and in easily understood language.

Section 22 orders already contain a statement advising the person of their right to appeal. The working group recommends that additional statements be made that indicate that the person may wish to seek legal counsel.

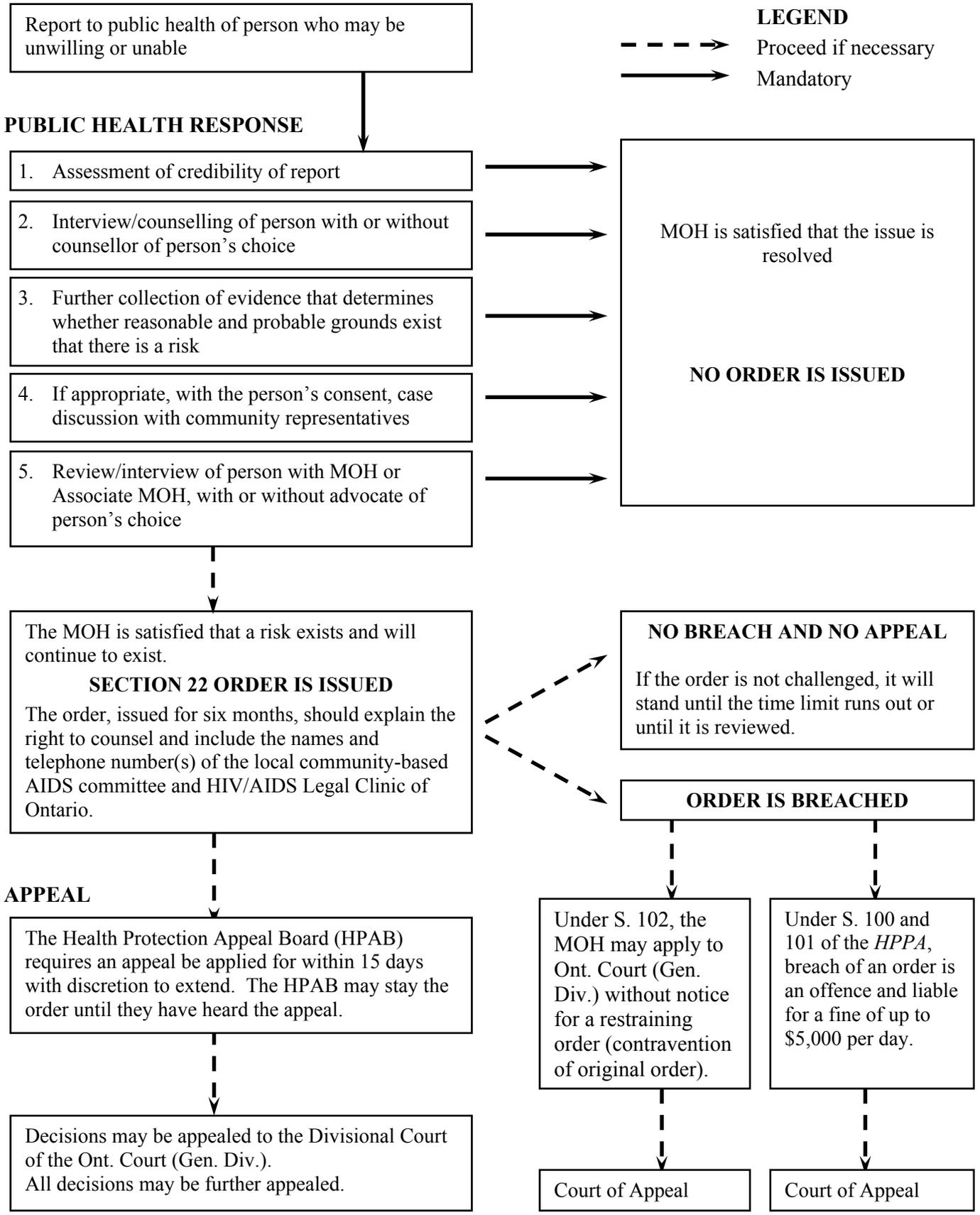
- **Scope of Section 22 Orders:** The working group feels that MOHs should have access to information from across the province. A confidential registry was discussed, but the working group did not come to a conclusion. However, the Health Protection Appeal Board (HPAB) could be a repository of such information. Confidentiality and access to information concerns would have to be addressed before proceeding with information flow to and from the HPAB.

⁵⁷ In the consultations, it was raised that people with HIV may be reluctant to seek out medical care if physicians are required to report unsafe behaviour and that this would violate the doctor-patient trust. The intention of the recommendation is to clarify the role of physicians in these situations and to provide legal protection for physicians who do report.

- **Pre-Order Hearing:** The working group discussed instituting a formal hearing before a section 22 order is written but does not recommend it at this point. The goal of the process before a section 22 order is written is to problem-solve so that additional steps are not required. The working group was very concerned that a pre-order hearing would move the activity to an adversarial arena and could involve a great deal of time and expense for the person with HIV with very little appreciable benefit.
- **Case Conference:** The working group agrees that it would be useful for the MOH to convene a case conference prior to the issuing of a section 22 order with the consent of the person. The purpose of the case conference would be to ensure that all avenues for intervention had been explored and to determine whether a section 22 order would contribute to a reduction in HIV transmission. The decision to proceed however would remain with the MOH.
- **Pre-Order Interviews:** The working group agrees that the person writing the order (MOH or associate MOH) should be required to interview the person prior to issuing a section 22 order. It is not clear whether this could be achieved through the issuing of guidelines or whether a change to section 92 of the *HPPA* would be needed. The person should be allowed to bring an advocate of his or her choice to this pre-order interview.
- **Appeal:** In the current system, the person initiates an appeal. The working group agrees that this should continue. With the addition of a community-based organization contact and/or the HIV/AIDS Legal Project telephone number on a section 22 order, it will be easier for people against whom section 22 orders are written to obtain the advice they need to appeal. In addition, a guideline should be issued requiring the HPAB to hear an appeal at any time during the time of an order.
- **Review of Section 22 Orders:** Setting a time limit for section 22 orders would help MOHs determine the ongoing relevance of the order — Is the person continuing to pose a risk? Are there additional steps that should be considered? Is the person no longer posing a risk and therefore, should no longer have an order against them? The working group suggests that orders be written for no longer than six months.⁵⁸

⁵⁸ In the consultations, it was recommended by some that the review of the section 22 order be at the discretion of the MOH. OACHA reiterated that the reason for issuing a section 22 order is a result of particular behaviour, not because a person is infected for life.

PROPOSED PROCESS FOR SECTION 22 INTERVENTIONS



LEGEND

- - - - -> Proceed if necessary
- > Mandatory

PUBLIC HEALTH RESPONSE

1. Assessment of credibility of report
2. Interview/counselling of person with or without counsellor of person's choice
3. Further collection of evidence that determines whether reasonable and probable grounds exist that there is a risk
4. If appropriate, with the person's consent, case discussion with community representatives
5. Review/interview of person with MOH or Associate MOH, with or without advocate of person's choice

MOH is satisfied that the issue is resolved

NO ORDER IS ISSUED

The MOH is satisfied that a risk exists and will continue to exist.

SECTION 22 ORDER IS ISSUED

The order, issued for six months, should explain the right to counsel and include the names and telephone number(s) of the local community-based AIDS committee and HIV/AIDS Legal Clinic of Ontario.

NO BREACH AND NO APPEAL

If the order is not challenged, it will stand until the time limit runs out or until it is reviewed.

ORDER IS BREACHED

APPEAL

The Health Protection Appeal Board (HPAB) requires an appeal be applied for within 15 days with discretion to extend. The HPAB may stay the order until they have heard the appeal.

Decisions may be appealed to the Divisional Court of the Ont. Court (Gen. Div.). All decisions may be further appealed.

Under S. 102, the MOH may apply to Ont. Court (Gen. Div.) without notice for a restraining order (contravention of original order).

Under S. 100 and 101 of the HPPA, breach of an order is an offence and liable for a fine of up to \$5,000 per day.

Court of Appeal

Court of Appeal

4

RECOMMENDATIONS

VALUES AND PRINCIPLES

The working group believes that reduction of HIV transmission is achievable and worth striving toward. The working group affirms the basic civil and human rights of people living with HIV and all Ontario citizens. We maintain the following values and principles.⁵⁹

- People with HIV are entitled to a quality of life that includes sexual intimacy.
- Where informed consent for risk of HIV infection exists, interventions are not necessary.
- All people with HIV should not be judged in light of those people who persistently expose others to HIV infection, especially in the climate of stigmatization.
- Interventions to reduce activities that put people who are not HIV-infected at risk of infection should strive to be the least intrusive, least restrictive, most readily available and most likely to be effective.
- The intent of measures must be to reduce risk, not to punish.
- While there are several organizations and individuals with explicit mandates, roles or responsibilities to reduce HIV transmission within society, people cannot realistically expect authorities to ensure complete protection from HIV infection. People must take responsibility for their own risk behaviour.

IMPLEMENTATION PRINCIPLES

The working group recommends that while implementing the recommendations that the following principles be maintained:

- recognition and respect for different mandates, responsibilities and roles of the various stakeholders
- broad consultation be conducted if additional changes with respect to policies, guidelines, standards or legislation are developed regarding the areas identified below
- respect the integrity of the recommended process for interventions suggested in the sequence while maintaining the principle of least intrusive, least restrictive, most readily available and most likely to be effective.

⁵⁹ There has been a great deal of discussion that there is not enough emphasis on protecting the rights of uninfected individuals. OACHA believes that the protection of uninfected individuals is implicit in the process and, as only people with HIV will be part of the section 22 process, it is important to ensure that the process protects their rights.

1. **Review:** The working group recommends that a review be conducted two years after the implementation of the recommendations. The purpose of the review is to evaluate the effectiveness of the changes and to determine whether additional steps are required to ensure the process is more consistent across the province and that the rights of people with HIV are maintained and the rights on all Ontarians are protected.
2. **Financial Resources:** Some of the recommendations below may require additional financial resources. These should be made available to the relevant branch.

NON-LEGISLATIVE CHANGES

3. **Prevention/Education Efforts:** The working group recommends continuing prevention/education efforts at the provincial and local levels to contribute to the acceptance of risk and harm reduction strategies and to foster a supportive environment in which to practise risk and harm reduction.
4. **Ongoing Counselling Resource and Strategies:** The working group recommends establishing a process to develop a counselling resource and strategies to be used by people providing ongoing counselling and support services. The resource would identify the complex factors that contribute to behaviours that contribute to risk behaviour. Suggested counselling techniques for intervention should be detailed. Strategies should be developed to implement the counselling techniques in the various settings across the province. Consideration should be given to the development of a mentor program to assist in case consultation.
5. **Test Counselling Guide:** The working group recommends developing standardized pre- and post-test HIV counselling guidelines for physicians and counsellors. At a minimum the guidelines should include discussion of:
 - sexual practices in explicit language
 - barriers to practising safer sex
 - disclosure
 - HIV transmission in detail
 - partner notification
6. **Pre- and Post-Test Counselling Training:** The working group recommends developing pre- and post-test HIV counselling training/information sessions based on the anonymous HIV testing model. Participants could include physicians as well as the people already providing pre- and post-test counselling. The AIDS Bureau should work in consultation with public health and community-based AIDS organizations. Financial resources may be required.
7. **Framework for Community-Based AIDS Organizations⁶⁰:** The working group recommends a process to develop a framework to help community-based organizations in the development of internal policies to engage a client who may be unwilling or unable. The goal of the framework would be to help community-based organizations who do not have a reporting responsibility under

⁶⁰ In the consultations, there were comments about the fact that community-based groups (including community-based AIDS organizations) are generally not required by law to report to public health. The process of creating a provincial framework will allow community-based AIDS organizations and others to determine their own policies and responsibilities in this issue.

the HPPA understand and resolve competing ethical and legal responsibilities and to establish policies in their organizations to manage the situation. The policy development guide would also be useful for other organizations that provide services to people with HIV and are uncertain about their obligations. There is no expectation on the part of the working group that laws should be changed to require community-based AIDS or other community organizations to report.⁶¹

8. **Directives for Crown Prosecutors:** The working group recommends developing directives for Crown prosecutors across the province. The directives should require consultation with public health before criminal charges are laid (e.g., ensure counselling has occurred, examine strategies other than criminal charges, educate about HIV/AIDS, share appropriate information).
9. **Guidelines for Medical Officers of Health:** The working group recommends issuing provincial guidelines to help establish processes for the exercise of public health authority in the least invasive, least restrictive, most effective and reasonably available way. All components suggested are integral to the process. The working group recommends that the following areas be included in the guidelines:

A. The working group agrees that the current system of bringing information about people who are unwilling or unable to the attention of public health is sufficient once clarification of section 34(1) of the HPPA is obtained which would allow physicians to report unsafe behaviour. The current methods of identifying people include routine public health follow-up; physician reporting, including subsequent reporting if there are indications that the person may be unwilling or unable; and reports from sexual or needle sharing partners.

The decision about whether or not interventions would occur would be based on a range of factors. Individual circumstances should be taken into account in the assessment. For example, if a partner is fully informed and consents to risk activities, the working group believes that no coercive intervention should occur. **Therefore, the following is not a list of determinants that a person is indeed unwilling or unable. It is a list of indicators that may signal the need for assessment.**

- explicit⁶² refusal to receive prevention counselling within a reasonable length of time
- explicit refusal to make appropriate changes in his or her behaviour (e.g., refusing to use condoms during anal/vaginal intercourse, refusing to use clean needles)
- explicit refusal to co-operate in informing identifiable current partners while continuing to engage in high-risk activities
- explicit refusal to disclose to partners while continuing to engage in high-risk activities
- clinical evidence that the person may be practising high-risk sex (e.g., after being diagnosed and appropriately counselled, the person presents with another sexually transmitted disease as a result of high-risk sex) or high-risk needle use (e.g., sharing unclean needles)

⁶¹ In the consultations, a suggestion was raised to change the legislation to include all health practitioners in the "duty to report" section. While this may be desirable, the implications would extend beyond HIV reporting and would not necessarily cover people working in community-based organizations (e.g., social workers).

⁶² In the consultations, there were comments about the use of the word explicit. A suggestion was made that it be replaced with "consistent non-compliance". OACHA agreed that it would be possible to remove the word "explicit", but reiterated that each situation must be determined on its own merits.

- the presence of other health or psychological problems that might impair judgement (e.g., dementia, psychosis)
- a serious substance abuse⁶³ problem that might impair judgement (e.g., drug or alcohol addiction)
- a report from a physician indicating a clinical judgement that the person is not practising safer sex or needle use
- a credible report from a partner that the person, after being diagnosed and appropriately counselled, has not been practising safer sex or needle use.⁶⁴

B. Interventions to Be Used Prior to Issuing a Section 22 Order including:

- referral to community-based organizations (e.g., AIDS organizations, HIV outpatient clinics)
- requirement for counselling of a person with HIV who appears to be unwilling or unable to take appropriate precautions (If the person chooses, a community-based counsellor of the person's choice could attend these sessions with them.)
- consideration of involvement of appropriate community-based input for consultation purposes (organization and individual) with the person's consent
- investigation as to whether previous section 22 orders have been written in another health unit area
- guidance about moving quickly to a section 22 order if warranted
- requirement for review/interview of the person with HIV by the MOH or Associate MOH who is issuing the order with an advocate of the person's choice.

C. Process to Be Used After Issuing a Section 22 Order including:

- **Appeal:** Appeal of a section 22 order issued under the HPPA against a person with HIV should remain as it exists. With the addition of a community-based organization contact and the HIV/AIDS Legal Project telephone number on a section 22 order, it will be easier for people against whom section 22 orders are written to obtain the advice they need to appeal. The HPAB should hear an appeal at any time during the term of the order. Additional resources for the HPAB may be required.
- **Review/Endpoint:** Each section 22 order should specify an endpoint (maximum six months). However, the MOH also has a responsibility to ensure that the person is no longer posing a risk to others. Review of the continuing relevancy of a section 22 order should be initiated prior to the endpoint.⁶⁵

⁶³ In the consultations, concerns were raised that an assumption could be made that all people who use drugs would be more likely to engage in unsafe activities. While people who use drugs may have been dealt with unfairly in the past, the inclusion of a serious substance abuse problem is not an indication that all people who use drugs are engaging in unsafe activities.

⁶⁴ All members of the working group were concerned about the misuse and misunderstandings that could result from listing possible indicators for assessment. Therefore, there was no consensus on the inclusion of pregnancy on the list. However, the working group did agree that although pregnancy may be a sign of unsafe behaviour and may warrant follow-up, women with HIV have the right to make informed choices about reproduction

⁶⁵ In the consultations, it was recommended by some that the review of the section 22 order be at the discretion of the MOH. OACHA reiterated that the reason for issuing a section 22 order is a result of a particular behaviour, not because a person is infected for life.

- **Review of Process:** The process of appeal and review of section 22 orders should be reviewed on an annual basis.

D. Content: Discussion of the content of section 22 orders should be included in the guidelines to ensure that the orders are the least invasive and least restrictive to achieve the desired behaviour change based on the individual circumstances of the situation. The goal of a section 22 order written under the HPPA against a person with HIV should clearly be to prevent HIV transmission by a person who is unwilling or unable to take appropriate precautions. It may be possible to develop a sample section 22 order in plain language that would include explicit information about which activities are prohibited.

Section 22 orders already contain a statement advising the person of their right to appeal. The working group recommends that additional statements be made to indicate that the person may wish to seek legal counsel.

E. Evaluation: The working group recommends that evaluation of the use of section 22's and the outcome measurements of their effectiveness be conducted. The information gained from the evaluation will be essential in determining next steps when the two-year review of the entire process is conducted.

LEGISLATIVE RECOMMENDATIONS

- 10. Designation:** The working group does not recommend that AIDS be designated as a virulent disease under the HPPA. AIDS should remain designated as a reportable, communicable disease. In the future, a new designation under the HPPA to address life-long infectious diseases should be created. The current designations are designed primarily for short-term interventions that result in an elimination of risk to self or others. A new designation is worth pursuing if interventions that would be more effective in responding to long-term infectiousness or better protections of individual civil liberties for people facing potentially long-term interventions could be developed.
- 11. Pre- and Post-Test Counselling Requirements:** The working group recommends changing the regulations to require pre- and post-test counselling in all HIV testing. A section should be added to the HIV laboratory requisition to be checked after pre-test counselling has been completed.
- 12. Physician Reporting of Unsafe Behaviour to Public Health:** Amendment of section 34(1) to remove ambiguity about physician reporting of unsafe behaviour to public health should be obtained to allow physicians to report people who are engaging in unsafe behaviour to public health. Guidelines for physicians should be developed to assist them and include a statement on informing patients of reporting requirements.⁶⁶
- 13. Behavioural Counselling Orders Under Section 22 of the HPPA:** Amendment to section 22 to allow for the issuing of behavioural counselling orders for the purpose of preventing HIV transmission should be obtained.

⁶⁶ In the consultations, it was raised that people with HIV may be reluctant to seek out medical care if physicians are required to report unsafe behaviour and that this would violate the doctor-patient trust. The intention of this recommendation is to clarify the role of physicians in these situations and to provide legal protection for physicians who do report.

14. **Non-Nominal Reporting:** Legalization of non-nominal reporting of HIV should be obtained.

LEGAL CLARIFICATIONS REQUIRED

15. **Appropriateness of the Use of the *Mental Health Act*** in situations in which there are psychiatric issues that are inhibiting the person with HIV from taking appropriate precautions in contrast with the HPPA should be clarified. However, HIV status alone should not be considered sufficient to invoke the use of the MHA.

16. **Development of a Mechanism to Make Information about Section 22 Orders for Medical Officers of Health** to allow them to cross reference a person with HIV who is suspected to be unwilling or unable and previous section 22 orders.

17. **Development of a Mechanism to Release Appropriate Information Between Public Health and the Ministry of the Attorney General** in order for information to be shared between public health and the Attorney General prior to criminal charges.

18. **The Issue of Conflict between the *Health Protection and Promotion Act* and the *Municipal Freedom of Information and Protection of Privacy Act*** should be resolved.

Recommended Activity/Responsibility

Activity	Primary Responsibility	Secondary Involvement
Review of Progress	AIDS Bureau	Public Health Branch, Legal Branch
Prevention/education efforts	Communications Branch, AIDS Bureau	Community-Based AIDS Organizations, Public Health Units, HIV Outpatient Clinics
Counselling resource and strategies	AIDS Bureau	Community-Based AIDS Organizations, HIV Outpatient Clinics
Test counselling guide	AIDS Bureau, Public Health Branch	Anonymous HIV Testing Sites
Pre- and post-test counselling training	AIDS Bureau, Public Health Branch	Anonymous HIV Testing Sites, Public Health Units
Framework for community-based AIDS organizations	AIDS Bureau	Community-based AIDS Organizations
Directives for crown prosecutors	Legal Branch, AIDS Bureau, Public Health Branch, Ministry of the Attorney General	
Guidelines for MOHs	Public Health Branch, AIDS Bureau	ALOHA, Community-based AIDS Organizations, Health Protection Appeal Board
Designation	No Action Required Now	
Pre- and post-test counselling requirements	Legal Branch	AIDS Bureau, Public Health Branch, HIV Laboratory
Regulation to allow physicians to report unsafe behaviour	Legal Branch	Public Health Branch, AIDS Bureau
Regulation to allow for section 22 behavioural counselling orders	Legal Branch	Public Health Branch, AIDS Bureau
Clarification of use of the <i>Mental Health Act</i>	Legal Branch	AIDS Bureau, Public Health Branch, Mental Health Branch
Clarification of release of appropriate information between public health and the Ministry of the Attorney General	Legal Branch, Public Health Branch, Freedom of Information and Protection of Privacy Branch, Ministry of the Attorney General	
Clarification of the uses the <i>Health Protection and Promotion Act</i> and the <i>Municipal Freedom of Information and Protection of Privacy Act</i> with respect to confidentiality and duty to warn	Legal Branch	Public Health Branch, AIDS Bureau, Freedom of Information and Protection of Privacy Branch

5

APPENDICES

Appendix 1 - Select Sections of the Health Protection and Promotion Act

HEALTH PROTECTION AND PROMOTION ACT
Revised Statutes of Ontario, 1990
Chapter H.7

as amended by:
1992, Chapter 32, s.16

September 1993

7. - (1) The Minister may publish guidelines for the provision of mandatory health programs and services and every board of health shall comply with the published guidelines.
- (2) Guidelines shall be transmitted to each board of health and shall be available for public inspection in the Ministry.
- (3) A guideline is not a regulation within the meaning of the *Regulations Act*.
- (4) In the event of conflict between a regulation and a guideline, the regulation prevails.

PART IV

COMMUNICABLE DISEASES

22. - (1) A medical officer of health, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease.
- (2) A medical officer of health may make an order under this section where he or she is of the opinion, upon reasonable and probable grounds,
- (a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health;

- (b) that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and
- (c) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.

(3) In an order under this section, a medical officer of health may specify the time or times when or the period or periods of time within which the person to whom the order is directed must comply with the order.

(4) An order under this section may include, but is not limited to,

- (a) requiring the owner or occupier of premises to close the premises or a specific part of the premises;
- (b) requiring the placarding of premises to give notice of an order requiring the closing of the premises;
- (c) requiring any person that the order states has or may have a communicable disease or is or may be infected with the agent of a communicable disease to isolate himself or herself and remain in isolation from other persons;
- (d) requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order;
- (e) requiring the destruction of the matter or thing specified in the order;
- (f) requiring the person to whom the order is directed to submit to an examination by a physician and to deliver to the medical officer of health a report by the physician as to whether or not the person has a communicable disease or is or is not infected with an agent of a communicable disease;
- (g) requiring the person to whom the order is directed in respect of a communicable disease that is a virulent disease to place himself or herself forthwith under the care and treatment of a physician;
- (h) requiring the person to whom the order is directed to conduct himself or herself in such a manner as not to expose another person to infection.

(5) An order under this section may be directed to a person,

- (a) who resides or is present;
- (b) who owns or is the occupier of any premises;
- (c) who owns or is in charge of any thing; and
- (d) who is engaged in or administers an enterprise or activity,

in the health unit served by the medical officer of health

(5.1) An order under this section that requires the person to whom it is directed to submit to an examination by a physician as described in clause (4) (f) or to place himself or herself under the care and treatment of a physician as described in clause (4) (g) is binding on the person, even if consent is not given in accordance with the *Consent to Treatment Act, 1992*.

(6) In an order under this section, a medical officer of health,

- (a) may specify that a report will not be accepted as complying with the order unless it is a report by a physician specified or approved by the medical officer of health;
- (b) may specify the period of time within which the report mentioned in this subsection must be delivered to the medical officer of health.

(7) An order under this section is not effective unless the reasons for the order are set out in the order.

26. - A physician who, while providing professional services to a person, forms the opinion that the person is or may be infected with an agent of a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided.

27. - (1) The administrator of a hospital shall report to the medical officer of health of the health unit in which the hospital is located if an entry in the records of the hospital in respect of a patient in or an out-patient of the hospital states that the patient or out-patient has or may have a reportable disease or is or may be infected with an agent of a communicable disease.

(2) The superintendent of an institution shall report to the medical officer of health of the health unit in which the institution is located if an entry in the records of the institution in respect of a person lodged in the institution states that the person has or may have a reportable disease or is or may be infected with an agent of a communicable disease.

(3) The administrator or the superintendent shall report to the medical officer of health as soon as possible after the entry is made in the records of the hospital or institution, as the case may be.

28. - The principal of a school who is of the opinion that a pupil in the school has or may have a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the school is located.

29. - (1) The operator of a laboratory shall report to the medical officer of health of the health unit in which the laboratory is located each case of a positive laboratory finding in respect of a reportable disease, as soon as possible after the making of the finding.

(2) A report under this section shall state the laboratory findings and shall be made within the time prescribed by the regulations.

(3) In this section "laboratory" has the same meaning as in section 59 of the *Laboratory and Specimen Collection Centre Licensing Act*.

32. - (1) A medical officer of health may transmit to another medical officer of health or to the proper public health official in another jurisdiction any information in respect of a person in relation to whom a report in respect of a reportable disease has been made under this Act.

(2) Where the person in respect of whom a report is made under this Part to a medical officer of health does not reside in the health unit served by the medical officer of health, the medical officer of health shall transmit the report to the medical officer of health serving the health unit in which the person resides.

34. - (1) Every physician shall report to the medical officer of health the name and residence address of any person who is under the care and treatment of the physician in respect of a communicable disease and who refuses or neglects to continue treatment in a manner and to a degree satisfactory to the physician.

(2) A report under subsection (1) shall be made to the medical officer of health serving the health unit in which the physician provided the care and treatment.

(3) Where the person does not reside in the health unit served by the medical officer of health mentioned in subsection (2), the medical officer of health shall transmit the report to the medical officer of health serving the health unit in which the person resides.

(4) A physician who makes a report under subsection (1) shall report to the medical officer of health at such times as are prescribed by the regulations any additional information prescribed by the regulations.

35. - (1) Upon application by a medical officer of health, a judge of the Ontario Court (Provincial Division), in the circumstances specified in subsection (2), may make an order in the terms specified in subsection (3).

(2) An order may be made under subsection (3) where a person has failed to comply with an order by a medical officer of health in respect of a communicable disease that is a virulent disease,

- (a) that the person isolate himself or herself and remain in isolation from other persons;
- (b) that the person submit to an examination by a physician;
- (c) that the person place himself or herself under the care and treatment of a physician, or
- (d) that the person conduct himself or herself in such a manner as not to expose another person to infection.

(3) In an order under this section, the judge may order that the person who has failed to comply with the order of the medical officer of health,

- (a) be taken into custody and be admitted to and detained in a hospital named in the order;
- (b) be examined by a physician to ascertain whether or not the person is infected with an agent of a virulent disease; and
- (c) if found on examination to be infected with an agent of a virulent disease, be treated for the disease.

(4) The judge shall not name a hospital in an order under this section unless the court is satisfied that the hospital is able to provide detention, care and treatment for the person who is the subject of the order.

(5) An order under this section is authority for any person,

- (a) to locate and apprehend the person who is the subject of the order; and
- (b) to deliver the person who is the subject of the order to the hospital named in the order.

(6) An order under this section may be directed to a police force that has jurisdiction in the area where the person who is subject of the order may be located, and the police force shall do all things reasonably able to be done to locate, apprehend and deliver the person in accordance with the order.

(7) An order under this section is authority to detain the person who is the subject of the order in the hospital named in the order and to care for and examine the person and to treat the person for the virulent disease in accordance with generally accepted medical practice for a period of not more than four months from and including the day that the order was issued.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 35 is amended by the Statutes of Ontario, 1992, chapter 32, subsection 16(2) by adding the following subsection:

(7.1) An order made under this section is authority to examine the person and treat him or her for the virulent disease in accordance with generally accepted medical practice, even if consent is not given in accordance with the *Consent to Treatment Act, 1992*.

See: 1992, c. 32, ss.16 (2), 28 (1).

(8) The person authorized by the by-laws of the hospital shall designate a physician to have the responsibility for the treatment of the person named in the order or, where the by-laws do not provide the authorization, the administrator of the hospital or a person delegated by the administrator shall designate a physician to have responsibility for the person named in the order.

(9) The physician responsible for treating the person in the hospital shall report in respect of the treatment and the condition of the person to the medical officer of health serving the health unit in which the hospital is located.

(10) The physicians shall report in the manner, at the times and with the information specified by the medical officer of health and the medical officer of health may specify the manner and times of reporting and the information that shall be reported.

(11) Where, upon motion by the medical officer of health serving the health unit in which the hospital is located, a judge of the court is satisfied,

(a) that the person continues to be infected with an agent of a virulent disease, and

(b) that the discharge of the person from the hospital would present a significant risk to the health of the public,

the judge by order may extend the period of detention and treatment for not more than four months, and upon further motions by the medical officer of health the judge may extend the period of detention and treatment for further periods each of which shall not be for more than four months.

(12) A person detained in accordance with an order under this section shall be released from detention and discharged from the hospital upon the certificate of the medical officer of health serving the health unit in which the hospital is located.

(13) The medical officer of health shall inform himself or herself as to the treatment and condition of the person and shall issue his or her certificate authorizing the release and discharge of the person as soon as the medical officer of health is of the opinion that the person is no longer infected with an agent of the virulent disease or that the release and discharge of the person will not present a significant risk to the health or members of the public.

(14) An application mentioned in subsection (1) or a motion mentioned in subsection (11) shall be heard in private, but, if the person in respect of whom the application or motion is made requests otherwise by a notice filed with the clerk of the court before the day of the hearing, the judge shall conduct the hearing in public except where,

(a) matters involving public security may be disclosed; or

(b) the possible disclosure of intimate financial or personal matters outweighs the desirability of holding the hearing in public.

(15) An application under this section applies to stay a proceeding before or an appeal from a decision or order of the Board in respect of the same matter until the application is disposed of by the judge of the Ontario Court (Provincial Division) and where the judge makes an order under this section, no person shall commence or continue a proceeding before or an appeal from a decision or order of the Board in respect of the same matter.

(16) Any party to an application or motion under subsection (1) or (11) may appeal from the decision or order to the Ontario Court (General Division).

(17) The filing of a notice of appeal does not apply to stay the decision or order appealed from unless a judge of the court to which the appeal is taken so orders.

(18) Any party to the proceeding may appeal from the judgement of the Ontario Court (General Division) to the Court of Appeal, with leave of a judge of the Court of Appeal on special grounds, upon any question of law alone.

(19) No leave for appeal shall be granted under subsection (18) unless the judge of the Court of Appeal considers that in the particular circumstances of the case it is essential in the public interest or for the due administration of justice that leave be granted. R.S.O. 1990, c. H.7, s. 35.

36. - (1) Where a medical officer of health has made an order in respect of a communicable disease that is a virulent disease requiring a person to place himself or herself under the care and treatment of a physician or to take other action specified in the order and the person withdraws from the care and treatment or fails to continue the specified action, section 35 applies with necessary modifications and for the purpose, the person shall be deemed to have failed to comply with an order of the medical officer of health.

(2) Where a person who is infected with an agent of a communicable disease has failed to comply with an order by a medical officer of health that the person isolate himself or herself and remain in isolation from other persons, section 35 applies with necessary modifications. R.S.O. 1990, c. H.7, s. 36.

39. - (1) No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent.

(2) Subsection (1) does not apply,

- (a) in respect of an application by a medical officer of health to the Ontario Court (Provincial Division) that is heard in public at the request of the person who is the subject of the application;
- (b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;
- (c) where the disclosure is made for the purposes of public health administration;
- (d) in connection with the administration of or a proceeding under this Act, the *Health Disciplines Act*, the *Public Hospitals Act*, the *Health Insurance Act*, the *Canada Health Act* or the *Criminal Code* (Canada) or regulations made thereunder; or
- (e) to prevent the reporting of information under section 72 of the *Child and Family Services Act* in respect of the abuse or suspected abuse of a child.

PART V
RIGHTS OF ENTRY AND
APPEALS FROM ORDERS

44. - (1) An order by a medical officer of health or a public health inspector under this Act shall inform the person to whom it is directed that the person is entitled to a hearing by the Board if the person mails or delivers to the medical officer of health or public health inspector, as the case requires, and to the Board, within fifteen days after a copy of the order is served on the person, notice in writing requiring a hearing and the person may also require such a hearing.

(2) An oral order or an order directed to a person described but not named in the order need not contain the information specified in subsection (1) but a person to whom the order is directed may require a hearing by the Board by giving the notices specified in subsection (1) within fifteen days after the day the person first knows or ought to know the contents of the order.

(3) Although a hearing is required in accordance with this Part, an order under this Act takes effect,

(a) when it is served on the person to whom it is directed; or

(b) in the case of an oral order or an order directed to a person described but not named in the order, when the person to whom it is directed first knows or ought to know the contents of the order,

but the Board, upon application with notice, may grant a stay until the proceedings before the Board are disposed of.

(4) Where the person to whom an order is directed requires a hearing by the Board in accordance with subsection (1) or (2), the Board shall appoint a time and place for and hold the hearing and the Board may by order confirm, alter or rescind the order and for such purposes the Board may substitute its findings for that of the medical officer of health or public health inspector who made the order.

(5) The Board shall hold a hearing under this section within fifteen days after receipt by the Board of the notice in writing requiring the hearing and the Board may, from time to time, at the request or with the consent of the person requiring the hearing, extend the time for holding the hearing for such period or periods of time as the Board considers just.

(6) The Board may extend the time for the giving of notice requiring a hearing under this section by the person to whom the order of the medical officer of health or the public health inspector is directed either before or after the expiration of such time where it is satisfied that there are apparent grounds for granting relief to the person following upon a hearing and that there are reasonable grounds for applying for the extension, and the Board may give such directions as it considers proper consequent upon the extension.

45. - (1) The medical officer of health or public health inspector who made the order, the person who has required the hearing and such other persons as the Board may specify are parties to the proceedings before the Board.

(2) Any party to the proceedings before the Board shall be afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced or any report the contents of which will be given in evidence at the hearing.

(3) Members of the Board holding a hearing shall not have taken part before the hearing in any investigation or consideration of the subject-matter of the hearing with any person or with any party or representative of the party except upon notice to and opportunity for all parties to participate, but the

Board may seek legal advice from an advisor independent from the parties and in such cases the nature of the advice shall be made known to the parties in order that they may make submissions as to the law.

(4) The oral evidence taken before, the Board at a hearing shall be recorded and if so required, copies or a transcript thereof shall be furnished upon the same terms as in the Ontario Court (General Division).

(5) No member of the Board shall participate in a decision of the Board following upon a hearing unless he or she was present throughout the hearing and heard the evidence and argument of the parties.

(6) Documents and things put in evidence at a hearing shall, upon the request of the person who produced them, be released to the person by the Board within a reasonable time after the matter in issue has been finally determined.

46. - (1) Any party to the proceedings before the Board may appeal from its decision or order to the Divisional Court in accordance with the rules of the court.

(2) Where an appeal is taken under subsection (1) in respect of an order that was stayed by the Board, a judge of the Ontario Court (General Division) upon application may grant a further stay until the appeal is disposed of.

(3) Where any party appeals from a decision or order of the Board, the Board shall forthwith file with the Divisional Court the record of the proceedings before it in which the decision was made, which, together with the transcript of evidence if it is not part of the Board's record, shall constitute the record in the appeal.

(4) The Minister is entitled to be heard, by counsel or otherwise, upon the argument of an appeal under this section.

(5) An appeal under this section may be made on questions of law or fact or both and the court may confirm, alter or rescind the decision of the Board and may exercise all powers of the Board to confirm, alter or rescind the order as the court considers proper, or the court may refer the matter back to the Board for rehearing in whole or in part, in accordance with such directions as the court considers proper.

PART VII

ADMINISTRATION

92. - The Minister, the Chief Medical Officer of Health, a medical officer of health or a public health inspector need not hold or afford to any person an opportunity for giving a hearing before making an order or giving directions under this Act.

PART IX

ENFORCEMENT

100. - (1) Any person who fails to obey an order made under this Act is guilty of an offence.

(2) Any person who contravenes a requirement of Part IV to make a report in respect of a reportable disease, a communicable disease or a reportable event following the administration of an immunizing agent is guilty of an offence.

(3) Any person who contravenes section 16, 17, 18, 20, 39 or 40, subsection 41 (9), subsection 42 (1), subsection 74 (2) or section 105 is guilty of an offence.

(4) Any person who contravenes a regulation is guilty of an offence.

101. - (1) Every person who is guilty of an offence under this Act is liable on conviction to a fine of not more than \$5,000 for every day or part of a day on which the offence occurs or continues.

(2) Where a corporation is convicted of an offence under this Act, the maximum penalty that may be imposed for every day or part of a day on which the offence occurs or continues is \$25,000 and not as provided in subsection (1).

(3) Where a corporation is convicted of an offence under this Act,

(a) each director of the corporation; and

(b) each officer, employee or agent of the corporation who was in whole or in part responsible for the conduct of that part of the business or corporation that gave rise to the offence,

is guilty of an offence unless he or she satisfies the court that he or she took all reasonable care to prevent the commission of the offence.

102. - (1) Despite any other remedy or any penalty, the contravention by any person of an order made under this Act may be restrained by order of a judge of the Ontario Court (General Division) upon application without notice by the person who made the order or by the Chief Medical Officer of Health or the Minister.

(2) Where any provision of this Act or the regulations is contravened, despite any other remedy or any penalty imposed, the Minister may apply to a judge of the Ontario Court (General Division) for an order prohibiting the continuation or repetition of the contravention or the carrying on of any activity specified in the order that, in the opinion of the judge, will or will likely result in the continuation or repetition of the contravention, and the judge may make the order and it may be enforced in the same manner as any other order or judgment of the Ontario Court (General Division).

Appendix 2 - Anonymous HIV Testing Regulations

**Regulation to Amend
Ontario Regulation 490/85
Made Under the
*Health Protection and Promotion Act, 1983***

1. Ontario Regulation 490/85 is amended by adding the following section:

5a. - (1) In this section,

“AIDS” means Acquired Immune Deficiency Syndrome; (“sida”)

“HIV” means Human Immunodeficiency Virus. (“VIH”)

(2) A physician who provides professional services to a patient in a clinic set out in subsection (4) and who is required to report under section 26 of the Act following a test to determine if the patient is infected with an agent of AIDS is exempt from reporting the patient’s name and address if, before the test was order, the patient received counselling about preventing the transmission of HIV infection.

(3) The operator of a laboratory is exempt from reporting, under section 29 of the Act, the name and address of a person who has tested positive for an agent of AIDS if the test is in relation to professional services provided at a clinic described in subsection (4).

(4) The following are the clinics referred to in subsections (2) and (3):

1. Anishnawbe Health Toronto, 22 Queen Street East, Toronto.
 2. Barrie STD Clinic, 370 Dunlop Street, Barrie.
 3. Birth Control & STD Information Centre, 2828 Bathurst Street, North York.
 4. Brampton-Caledon STD Clinic, 180B Sandalwood Parkway East, Brampton.
 5. Centretown Community Health Centre, 340 MacLaren Street, Ottawa.
 6. Hassle Free Clinic, 556 Church Street, Toronto.
 7. Mississauga East STD Clinic, 3038 Hurontario Street, Mississauga.
 8. Mississauga West STD Clinic, 2227 South Millway, Mississauga.
 9. Sandy Hill Community Health Centre, 24 Selkirk Avenue, Vanier.
 10. SITE, 480A Somerset Street West, Ottawa.
 11. Somerset West Community Health Centre, 755 Somerset Street West, Ottawa.
 12. STD Clinic, 237 Barton Street East, Hamilton.
 13. STD Clinic, 250 Besserer Street, Ottawa.
2. This Regulation comes into force on the 1st day of January, 1992.

**Regulation to Amend
Regulation 569 of the Revised Regulations of Ontario, 1990
Made Under the
*Health Protection and Promotion Act***

Note: Regulation 569 has not been amended in 1994 and 1995. For prior amendments, see the Table of Regulations in the Statutes of Ontario, 1993.

(1) Subsection 5.1 (2) of Regulation 569 of the Revised Regulations of Ontario, 1990 is amended by striking out “subsection (4)” in the second line and substituting “the Schedule”.

(2) Subsection 5.1 (3) of the Regulation is amended by striking out “described in subsection (4)” in the last line and substituting “set out in the Schedule”.

(3) Subsection 5.1 (4) of the Regulation is revoked.

2. The Regulation is amended by adding the following Schedule:

Schedule

1. The District of Algoma Health Unit, Sexual Health Clinic, 99 foster Drive, Sault Ste. Marie.
2. Anishnawbe Health Toronto, 22 Queen Street East, Toronto.
3. Barrie STD Clinic, 370 Dunlop Street, Barrie.
4. Bay Centre for Birth Control, Regional Women’s Health Centre, 790 Bay Street, Toronto.
5. Birth Control & STD Information Centre, 2828 Bathurst Street, North York.
6. Brampton-Caledon STD Clinic, 180B Sandalwood Parkway East, Brampton.
7. Centre médico-social communautaire, 22 College Street, Toronto.
8. Centretown Community Health Centre, 340 MacLaren Street, Ottawa.
9. Community Health Department, HIV Clinic, 99 Regina Street South, Waterloo.
10. Elgin - St. Thomas Health Unit, AIDS Division, 99 Edward Street, St. Thomas.
11. Hassle Free Clinic, 556 Church Street, Toronto.
12. HIV Care Program Clinic, Metropolitan General Hospital, 2240 Kildare Road, Windsor.
13. InterCommunity Health Centre, 659 Dundas Street East, London.
14. Kingston, Frontenac and Lennox and Addington Health Unit, STD Clinic, 221 Portsmouth Avenue, Kingston.
15. Mississauga East STD Clinic, 3038 Hurontario Street, Mississauga.
16. Mississauga West STD Clinic, 2227 South Millway, Mississauga.

17. Peterborough County-City Health Unit, Sexual Health Clinic, 10 Hospital Drive, Peterborough.
 18. Regional Niagara Health Services Department, Falls Clinic, 5710 Kitchener Street, Niagara Falls.
 19. Rexdale Community Health Centre, 2267 Islington Avenue, Rexdale.
 20. Sandwich Community Health Centre, 749 Felix Avenue, Windsor.
 21. Sandy Hill Community Health Centre, 24 Selkirk Avenue, Vanier.
 22. SITE, 480A Somerset Street West, Ottawa.
 23. Somerset West Community Health Centre, 755 Somerset Street West, Ottawa.
 24. STD Clinic, 237 Barton Street East, Hamilton.
 25. STD Clinic, 250 Besserer Street, Ottawa.
 26. Sudbury and District Health Unit, STD Clinic, 1300 Paris Crescent, Sudbury.
 27. Thunder Bay District Health Unit, STD Clinic, 999 Balmoral Street, Thunder Bay.
 28. Wellington-Dufferin-Guelph Health Unit, Sexual Health Clinic, 125 Delhi Street, Guelph.
 29. West Central Community Health Centres, Alexandra Park Health Centre, 64 Augusta Avenue, Toronto.
 30. West Central Community Health Centres, Niagara Neighborhood Health Centre, 674 Queen Street West, Toronto.
 31. West Central Community Health Centres, SHOUT Clinic, 467 Jarvis Street, Toronto.
 32. Windsor-Essex County Health Unit, HIV Clinic, 1005 Ouellette Avenue, Windsor.
 33. City of York Health Unit, Sexual Health Clinic, 662 Jane Street, York.
 34. City of York Health Unit, Sexual Health Clinic, 524 Oakwood Avenue, York.
3. This Regulation comes into force on April 3, 1995.

APPENDIX 3 - Mandatory Core Programs and Services Guidelines - April 1989

Sexually Transmitted Diseases

Statutory Authority:

Health Protection and Promotion Act, 1983 S.O. 1983, C. 10 Section 5 paras 2 and 7

Goal:

To reduce the incidence of and complications from all sexually transmitted diseases.

Objectives:

1. To reduce the incidence rate of primary and secondary syphilis to one per 100,000 population by the year 2000.
2. To reduce the incidence rate of gonorrhoea to 50 per 100,000 population by the year 2000.
3. To reduce the incidence of genital chlamydia.
4. To reduce the incidence of human immunodeficiency virus (HIV) infection.
5. To reduce the incidence of congenitally acquired STDs.

Program Requirements and Standards:

A. Requirements

1. The board of health shall ensure a system of data collection and reporting which shall include as a minimum:
 - (a) identification of cases of reportable STDs based on Ministry of Health definitions;
 - (b) maintenance of a local data base that is consistent with provincial and federal communicable disease reporting requirements and Ministry of Health protocols; and
 - (c) notification of cases to the Ministry of Health or other medical officers of health according to Ministry of Health protocols.
2. The board of health shall encourage the provision of appropriate case management. This shall be accomplished, at a minimum, through:
 - (a) adoption of procedures and protocols for the management and treatment of cases within STD clinics managed by boards of health, according to Ministry of Health protocols;
 - (b) distribution, to physicians treating STDs, of procedures and protocols for the management and treatment of cases, consistent with Ministry of Health protocols;
 - (c) assurance of the availability of facilities for diagnosis and treatment services which should, where appropriate, include designated STD clinics; and
 - (d) provision of individual counselling, identification of contacts, tracing of contacts and referral, according to Ministry of Health protocols.
3. The board of health shall provide or ensure the provision of health promotion activities designed to develop knowledge, skills, attitudes and behaviours aimed at prevention STDs, including AIDS. The activities shall, as a priority, be targeted at the following groups:

- (a) school-aged children from at least grade 7 on. The board of health shall, with the consent of the person or organization that operates the school, provide assistance in carrying out mandatory education about AIDS and education about other STDs. Where such consent is not given, activities targeted to school-aged children are to be delivered through other community settings (refer to Sexual Health);
- (b) those in community colleges, universities, workplace settings and elsewhere in the community;
- (c) people with high-risk behaviours; and
- (d) health care workers, in order that they may be effective in case finding and management.

B. Staffing

The board of health shall ensure that the program is planned by an interdisciplinary team with knowledge and skills appropriate to the program, and that the program is delivered by appropriately qualified staff.

C. Monitoring and Evaluation

The board of health shall provide the Ministry of Health with such information as the ministry may request, in the form and manner and at the time or within the period of time specified.

APPENDIX 4 - Other Jurisdictions

PUBLIC HEALTH LAW WITH RESPECT TO REDUCING HIV TRANSMISSION BY PEOPLE WHO ARE UNWILLING OR UNABLE (December 1993)

The working group reviewed information from other jurisdictions about how they handle these situations as part of the background to developing a response for Ontario. It must be acknowledged that the public health and criminal laws are often very different in other jurisdictions, so their responses are not necessarily transferrable to the Ontario context.

CANADA

British Columbia:

The Ministry of Health has issued a paper, **Public Health Guidelines for Managing Difficult HIV Cases**. The guidelines cover the spectrum of issues including protection and duty to warn and the changes that were made to the Health Act to allow for incarceration (quarantine) of individuals who breach public health orders. In addition, provisions in their Freedom of Information and Protection of Privacy Act allow for exchange of information between their Attorney General and the Ministry of Health. There have only been two cases in which criminal charges were considered. In both cases, the Ministry of Health was able to convince the Attorney General that the people would be better served with counselling and support rather than jail. Both instances involved prostitutes who continued working after testing HIV-positive.

Newfoundland:

The Department of Health is working with the Department of Justice to address the issue of recalcitrant individuals with HIV.

UNITED STATES

Report of the Presidential Commission (1988) recommended that states adopt resolutions of non-compliant HIV-infected persons.

Public Health Law

- More than 12 states revised their disease control laws between 1987 and 1990 to impose restrictions through quarantine for AIDS.
- Twenty states revised their criminal laws between 1987 and 1989 making it a felony to knowingly transmit HIV.

Illinois:

Department of Public Health Regulations provide for isolation of non-compliant HIV carriers.

Colorado:

Specific restrictive measures or orders on individuals with HIV infection when other measures have failed are included.

Florida:

HIV-infected prostitutes have been quarantined (several other states have also done this). An HIV-positive prostitute was charged with manslaughter for having sexual intercourse.

Nevada:

A Los Vegas prostitute was sentenced to 20 years imprisonment under a state statute that mandates a felony charge for soliciting after testing HIV-positive.

Idaho and Kentucky:

These states have enacted statutes that extend quarantine or isolation to those who persist in engaging in HIV-transmitting behaviour.

Louisiana:

It is a criminal offense to "intentionally expose another to the AIDS virus through sexual contact without the knowing and lawful consent of the individual".

AUSTRALIA

New South Wales:

A person who, knowing that he or she has the disease, has sexual intercourse with another person without notifying his or her partner of the risk is subject to a fine.

Several other countries have introduced measures in their criminal laws to deal with "recalcitrant" individuals with HIV. One jurisdiction in Southeast Asia has issued a legislative provision for isolation.

APPENDIX 5 – References

Books

AIDS Bureau. *AIDS and HIV Infection, Statement No. 4: Guidelines on the management of people with HIV/AIDS who knowingly place others at risk of infection*. Australia: NSW Department of Health, 1990.

Australian HIV/AIDS Legal Guide. Australia: Foundation Press, 1993.

Closen, Michael & Associates. *Criminalization of HIV Exposure/Transmission in the USA* Chicago, Illinois: John Marshall Law School, 1993.

Health Department Victoria. *Guidelines for the Management in Victoria of HIV Infected People who are Likely to Infect Others*. Australia: 1990.

Kirp, David L. and Ronald Bayer. *AIDS in the Industrialized Democracies*. Montreal, Quebec: McGill-Queen's University Press, 1992.

Office of the Provincial Health Officer. *Public Health Guidelines for Managing Difficult Cases*. Public Health Officer: Victoria, British Columbia, November 1993.

Ontario AIDS Advisory Committee, STD/AIDS Unit, Public Health Branch. *Reducing HIV Transmission by Individuals who are Unwilling or Unable to take Appropriate Precautions*. 1991.

Pierce, Christine, and Donald Vandever. *AIDS: Ethics and Public Policy*. Belmont, California: Wadsworth Publishing Company, 1988.

Tremear's Criminal Code. Toronto, Ontario: Carswell, 1994.

Newspaper Articles

“AIDS carrier convicted of murder bid.” *The Toronto Star*. March 16, 1994: A26.

“AIDS in court.” *The Toronto Star*. January 17, 1994: A14.

Bender, Eric. “HIV-infected woman gets go-ahead for suit against health unit.” *The London Free Press*. November 17, 1994: B10.

Blackwell, Tom. “Law outlawing deliberate spread of AIDS virus is studied.” *The Gazette*. May 19, 1993: B1.

Brennan, Richard. “Boyd appeals Ssenyonga award.” *The London Free Press*. November 18, 1994: B3.

“Donors of HIV blood can be prosecuted.” *The Globe and Mail*. June 5, 1993: A8.

Egan, Mary-Jane. “Doctors walking an ethical tightrope.” *The London Free Press*. May 19, 1994: A1.

Herbert, John. "Child-porn suspect has HIV." *The London Free Press*. March 18, 1994: A1.

Herbert, John. "Police lay two more charges against HIV-infected suspect." *The London Free Press*. March 19, 1994: A1, A3.

Hess, Henry. "HIV infected women awarded damages." *The Globe and Mail*. February, 8, 1994: A3.

"Infected by man with HIV, women gets \$25,000 each." *The Globe and Mail*. February 13, 1995: A3.

Mackie, Iain D. "Erecting barriers to slow the spread of AIDS." *The Globe and Mail*. August 31, 1993:

Massecar, Bob and Liebner, Judy. "Legislation eyed to make testing mandatory for sex offenders." *The London Free Press*. March 21, 1994: B1.

Mickleburgh, Rod. "Severity of sentence questioned after HIV carrier infects women." *The Globe and Mail*. August 13, 1993: A4.

Oakes, Gary. "Lover who removed his condom jailed 45 days for sexual assault." *The Toronto Star*. February 4, 1994: A1.

"Our Opinion: How do we handle the damage done?." *The London Free Press*. March 21, 1994: B6.

"State-supervised sex." *The Toronto Star*. February 10, 1994: A18.

Tyler, Tracey. "HIV carrier's victim compensated - and criticized." *The Toronto Star*. February 8, 1994: A1.

Tyler, Tracey. "AIDS trial victims angry after no verdict given." *The Toronto Star*. December 18, 1993: A22.

Magazines/Journals

Carter, Emily. "PWA - Person Who's Accountable." *PWA live*. Spring 1993: 1 - 6.

Etzioni, Amitai. "HIV sufferers Have a Responsibility." *Time*. December 13, 1993: 76.

Gostin, Larry and Curran William J.. "The Limits of Compulsion in Controlling AIDS." *Hastings Center Report*. Hastings-on-Hudson, New York. Volume 16, No. 6. December 1986: 24 - 29.

Holland, Winifred H.. "HIV/AIDS And The Criminal Law." *Criminal Law Quarterly*. Aurora, Ontario: Canada Law Book. Volume 36. 1994: 279 -316.

Johnston, Cameron. "AIDS and the law: Do courts have a place in the bedrooms of the nation?." *Canadian Medical Association Journal*. Ottawa, Ontario: Canadian Medical Association. Volume 146, No. 11. June 1, 1992: 2065 - 2070.

North, Richard L. and Rothenberg, Karen H. "Sounding Board: Partner notification and the threat of domestic violence against women with HIV infection." *The New England Journal of Medicine*. Waltham, Massachusetts: Massachusetts Medical Society. Volume 329, No. 16. October 13, 1993: 1194 - 1196.

Riley, D. *The Harm Reduction Model: Pragmatic Approaches to Drug Use from the Area between Intolerance and Neglect*. Canadian Centre on Substance Abuse. Ottawa.

Riley, D. *The Policy and Practice of Harm Reduction: The Application of Harm Reduction Measures in a Prohibitionist Society*. Canadian Centre on Substance Abuse. Ottawa, 1993.

Signorile, Michelangelo. "Negative Pride." *Out*. Out Publishing, Inc. March 1995. 22 -24, 106.

Legal Documents

"Bell-Ginsburg v. Ginsburg." *Law Society of Upper Canada Ontario Reports*. Markham, Ontario: Butterworths, 1993. 3d.

"Regina v. Lee." *Law Society of Upper Canada Ontario Reports*. Markham, Ontario: Butterworths. 1993. 3d.

"R. v. Mercer", File No. 1992, No. 138, Newfoundland Court of Appeal, 20 W.C.B.2d 604; 84 C.C.C. 30 41, August 12, 1993, 093252003.

Mowatt, Dr. David L. and Confidential Respondent. Affidavit. Ontario Court (General Division).

"R. v. Ssenyonga", Court File No. 1560, Ontario Court, (General Division), 81 C.C.C. d 257, April 30.

Unpublished Articles

AIDS Committee of London. *Effective Education Strategies To Change Knowledge, Attitude and Behaviour*. London, Ontario: AIDS Committee of London, 1990.

Brown, B. F., PhD *Comments on the Draft Report of the Ontario Advisory Committee on HIV/AIDS: Reducing HIV Transmission by People who are Unwilling or Unable to take Appropriate Precautions*. Toronto, Ontario: Dept of Philosophy, University of Toronto, 1994.

APPENDIX 6 - Invitees to December 1995

Consultation on Reducing HIV Transmission

Ms. Jo-Anne Ackery
City of Toronto Department of Public Health

*Mr. Darcy Albert
Two-Spirited People of the First Nations

*Ms. Maggie Atkinson
AIDS Action Now!

Ms. Gloria Aykroyd
St. Joseph's Health Centre

Ms. Patricia Balogh
Consultant

*Ms. Julia Barnett
City of York Health Unit

Mr. Ian Barton
Wellesley Health Centre

Dr. Sheela Basur
East York Health Unit

Mr. Michael Battista
AIDS Committee of Toronto

Ms. Sheila Berry
AIDS Committee of Thunder Bay

Ms. Louise Binder
Voices of Positive Women

*Dr. Robin Bolton
Sudbury and District Health Unit

Ms. Anne Bowlby
AIDS Bureau, Ministry of Health

*Mr. Scott Bowler
Sunnybrook Health Science Centre

*Dr. Barry Brown
Department of Philosophy, University of Toronto

Mr. David Brown
HIV Laboratory, Ministry of Health

Mr. Glen Brown
AIDS Action Now!

Ms. Rosemary Brown
SIS Clinic, Chedoke-McMaster Hospitals

Dr. J. A. Browne
AIDS Bureau, Ministry of Health

Mr. Mark Bulbrook
Ontario AIDS Network

*Mr. John Campey
Toronto Board of Education

Ms. Ruth Carlisle
Women's Health Bureau, Ministry of Health

Mr. Douglas Cave
Addiction Research Foundation

*Dr. Jeff Cohen
HIV Clinic, Metropolitan General Hospital

Mr. Clarence Crossman
AIDS Committee of London

Mr. Patrick Cupido
AIDS Committee of Cambridge, Kitchener,
Waterloo and Area

Ms. Janet Dakins
Haven Program, Laurentian Hospital

Mr. Theo deBruyn
National AIDS Secretariat, Health Canada

*Mr. Barry Deeprise
Ontario Advisory Committee on HIV/AIDS

*Ms. Celia Denov
Community Health Division, Ministry of Health

*Dr. Peter DeRoche
Clinic for HIV-Related Concerns, Mount Sinai
Hospital

Mr. Tony di Pede
Toronto PWA Foundation

Ms. Danielle Dorschner
Ottawa-Carleton Health Department

*Mr. Eric Dow
Toronto PWA Foundation

Dr. Geoff Dunkley
Ottawa-Carleton Regional Health Department

*Ms. Margaret Dwyer
Mental Health Division, Ministry of Health

*Ms. Judith English
Sandyhill Community Health Centre

Ms. Lesley Fleming
Youth Services Bureau of Ottawa-Carleton

*Mr. Mark Fremo
AIDS Action Now!

*Dr. Gary Garber
Ottawa General Hospital

Ms. Linda Gardner
Bay Centre for Birth Control

*Ms. Rose Gillingham
Toronto Counselling Centre for Lesbians and Gays

*Dr. John Goodhew
Toronto Primary Care Physician's Group

Dr. Richard Gould
City of Toronto Department of Public Health

Mr. Dennis Haubrich
Ryerson Polytechnical University

Ms. Kathryn Haworth
Scarborough Health Department

Dr. Alan Heimann
Windsor-Essex County Health Unit

Ms. Christine Henderson
Legal Branch, Ministry of Health

*Mr. David Hoe
Ontario Advisory Committee on HIV/AIDS

*Dr. Jon Hunter
Clinic for HIV-Related Concerns, Mount Sinai
Hospital

*Ms. Hardeep Kaur
Alliance for South Asian AIDS Prevention

*Mr. David Kelley
Ontario Advisory Committee on HIV/AIDS

Mr. David Keselman
North York Health Unit

*Dr. Donna Keystone
Toronto Primary Care Physician's Group

*Dr. Alex Klein
Toronto Primary Care Physician's Group

*Mr. James Kreppner
Toronto PWA Foundation

Mr. Andrew Lafontaine
Ontario Advisory Committee on HIV/AIDS

Mr. Bil Laing
AIDS Committee of Windsor

*Dr. Stephan Landis
SIS Clinic, Chedoke-McMaster Hospitals

Ms. Deborah Leach
Facilitator

*Ms. Christine Leonard
Black Coalition for AIDS Prevention

*Dr. Alan Li
Regent Park Community Health Centre

Ms. Elissa Lief
Department of Justice (federal)

* Invited, could not attend

Mr. Bruce Long
Ministry of the Attorney General

*Dr. Iain Mackie
HIV Care Program, St. Joseph's Health Centre

Mr. David Marshall
Positive Youth Outreach

Ms. Ann Matte
AIDS Committee of Sudbury

*Mr. Tim McCaskell
Ontario Advisory Committee on HIV/AIDS

Ms. Joan McDonald
SIS Clinic, Chedoke-McMaster Hospitals

Mr. Frank McGee
AIDS Bureau, Ministry of Health

Dr. David McKeown
City of Toronto Department of Public Health

Ms. Genvieve McMath
Clinic for HIV-Related Concerns, Mount Sinai
Hospital

Ms. Liz McNeil
Kingston, Frontenac and Lennox and Addington
Health Unit

Mr. John McTavish
Kingston AIDS Project

Ms. Simone McWatt
Etobicoke Health Unit

Mr. Bill Mindell
City of York Health Unit

*Dr. J. W. Mitchell
City of York Health Unit

*Dr. David Mowat
Kingston, Frontenac and Lennox and Addington
Health Unit

Ms. Penny Nelligan
Hamilton-Wentworth Health Department

Ms. Suzanne Newmark
Hamilton-Wentworth Health Department

Mr. Rob Nicol
Minister's Office, Ministry of Health

Dr. Howard Njoo
City of Toronto Department of Public Health

Ms. Francoise Pelletier
AIDS Committee of Ottawa

Ms. Yvette Perreault
AIDS Bereavement Project of Ontario

Dr. Anne Phillips
The Wellesley Hospital

*Mr. Rui Pires
Hamilton AIDS Network

*Mr. John Plater
Ontario Advisory Committee on HIV/AIDS

Dr. Graham Pollett
Middlesex-London Health Unit

*Dr. Anita Rachlis
Sunnybrook Health Science Centre

Mr. Richard Rainville
AIDS Committee of Sudbury

*Dr. Stan Read
Hospital for Sick Children

Dr. Elizabeth Richardson
Hamilton-Wentworth Regional Department of
Public Health Services

Mr. Mark Roberts
Waterloo Regional Department of Health

*Dr. Irving Salit
Immunodeficiency Program, The Toronto Hospital

*Dr. Peter Sarasfield
Northwestern Health Unit

*Dr. Richard Schabas
Public Health Branch, Ministry of Health

Mr. Derek Scott
East York Health Unit

* Invited, could not attend

*Dr. Bill Seidleman
Wellesley Health Centre

*Ms. Margaret Shaw
Hassle Free Women's Clinic

Ms. Barbara Sims-Tidy
Substance Abuse Bureau, Ministry of Health

Ms. Diana Smith
Thunder Bay District Health Unit

*Ms. Juanita Smith
Black Coalition for AIDS Prevention

Mr. Michael Sobota
AIDS Committee of Thunder Bay

Ms. Tracy Stevenson
Kingston General Hospital

Mr. Douglas Stewart
Facilitator

Ms. Lori Stoltz
Goodman and Carr

*Ms. Darien Taylor
AIDS Committee of Toronto

Ms. Esther Tharao
African Community Health Services

*Ms. Rai Therrien
Northwestern Health Unit

Ms. Betty Anne Thomas
AIDS Committee of London

Ms. Janis Tripp
AIDS Bureau, Ministry of Health

Mr. Robert Trow
Hassle Free Men's Clinic

Ms. Karen Verhoeve
Waterloo Regional Department of Health

*Ms. Janet Victor
Public Health Branch, Ministry of Health

Ms. Joan Wall
Etobicoke Health Unit

Dr. Evelyn Wallace
Public Health Branch, Ministry of Health

*Dr. Barbara Yaffe
North York Health Unit

Mr. Rudy Zimmer
Middlesex-London Health Unit