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Legal, Ethical and Socio-economic Issues relevant to HIV/AIDS

Professor E.R.Walrond

Executive Summary

A Review of the Legislation relevant to HIV/AIDS and the Attendant Socio-economic Impact was commissioned by the Office of the Attorney General in February 2004. The assignment was expected to produce a comprehensive report providing recommendations for changes in existing laws, laws that should be removed from the statute books and the socio-economic benefits of such actions. The detailed terms of reference are appended.

The work was expected to be completed in six-weeks and some of the detailed consultations that may have been desirable, particularly with other countries in the Caribbean could not be completed in the time framework.

The recommendations that are made in this study are primarily intended to remove the social barriers to the spread of HIV by:

- removing the legislative props that encourage the marginalisation of groups at high risk for transmission of the disease among themselves and into the wider community
- strengthening the legislative framework for an effective public health response to controlling the spread of HIV
- suggesting changes that will remove ambiguities in relation to the sexual conduct of minors and their exploitation by adults

The recommendations will impact on all areas of the society and challenge the prejudices, beliefs and fears of many; they call upon health care workers to work in a more calculated professional manner, and will require additional support in the public health sector in order to do so. The changes do not recommend any legislative changes that would further criminalise persons affected by HIV in the public's mind, for current legislation and a strengthened public health response can control any criminal behavioural tendency whilst preserving the rights of HIV infected persons within the community and when they are before the judicial system, as well as protecting the rights of sexual partners not to be put at undue risk.

In developing the following recommendations consultation with a wide range of persons and organisations was sought, the list of the persons met with is appended and does not represent all those with whom an appointment was sought.

RECOMMENDATIONS

Anti-discrimination legislation should be introduced that covers all the issues of discrimination. Such legislation should not be limited to the sphere of employment, but should cover all areas of public endeavour. Consequential legislative measures may have to be repealed. There is a risk that singling out HIV as the only disease quoted may in itself lead to problems and the wording should be such as to include other forms of illness.

.1 *' No person may unfairly discriminate, directly or indirectly, against any person in a public place or business; in any employment or procedure preliminary to employment; practice or service available to the public, on one or more grounds, including race, gender, sexual orientation, pregnancy, marital status, ethnic or social origin, age, disability, medical condition, religion, conscience, belief, political opinion, or culture'.*

1.2 *The provisions at 1.1 nullifies a provision in any other law that is counter to its spirit or effectiveness.*

Same Sex and other Sexual Conduct. There is a need to begin the process of de-stigmatising of marginalised groups such as homosexuals, prostitutes and sexually active adolescents, who are at high risk for HIV infection, in order to diagnose them earlier and reduce the prevalence of HIV among them.

Bringing into line same sex acts with those of other sexual acts between consenting adults. Anal intercourse like other sexual acts practised between consenting adults in privacy should no longer carry the threat of imprisonment for life but would remain a serious offence in the commission of sexual offences.

2.1 *The Sexual Offences Act Section 9, should be amended to read*
'Any person who commits buggery during the commission of a sexual offence as defined in this act is liable on conviction to imprisonment for....'

Deliberate transmission of HIV is a widely held concern and should be dealt with in a multi-pronged approach of sanctions within the criminal law, but with the emphasis on prevention through an enhanced public health approach. As regards the criminal law an additional section should be added to the Sexual Offences Act of deliberate transmission of a sexually transmitted disease. A similar addition to the

Offences against the Persons Act would clarify that harm does not constitute injuries only.

3.1 *Sexual Offences Act: The deliberate transmission of a disease in the commission of any sexual offence, aggravates the offence and is subject on conviction to.....*
The Offences against the Person Act could be amended to include the deliberate or reckless transmission of HIV and other diseases.

3.2 *' Any person who deliberately or recklessly transmits a disease which causes or can cause serious bodily harm , is guilty of an offence .....'*

Sexual Offences with Children. In Barbados, there are ambiguities related to children in the Sexual Offences Act which need to be examined, Section 3[3]. of the act states *' a person under the age of 14 is deemed incapable of committing the offence of rape'.* This appears to put other children in particular at risk without any clear redress in relation to a possible forcible sexual assault by a child 14 years of age or younger

4.1 *Section 3[3] should be repealed and replaced by sentencing guidelines for sexual offences committed by persons under the age of 14 years.*

- Section 4[1] of the act states: *'Where a person has sexual intercourse with another who is not the other's spouse and who is under the age of 14, that person is guilty of an offence—'.*
  This section appears to allow the exploitation of children under the age of 14 on the grounds of marriage. This creates a double standard in the community in relation to marriage and the sexual exploitation of a minor; this ambiguity is repeated in section 7[3].

4.2 *Section 4[1]; the phrase 'who is not the other's spouse and' should be removed and would read: 'Where a person has sexual intercourse with another who is under the age of 14, that person is guilty of an offence whether the other person consented to the intercourse and whether at the time of the intercourse the person believed the other to be over 14 years of age, and is liable on conviction ....'*

- Section 7 which deals with sexual intercourse with a step-child or other situations of a child's custody by an adult should be extended to protect children from all those who may be in authority or temporary guardianship over them such as camp leaders, health care workers, teacher's, priests, etc.

4.3 Section 7[1] should be amended to read

'An adult who has sexual intercourse with a minor who is

[a] the adult's adopted child,step-child, foster child, ward or dependant in the adult's custody, or

[b] who is under the adult's authority or temporary guardianship

is guilty of an offence.....'

4.4 *Section 7[3] which deals with minors being a spouse should be repealed as should any similar stipulation as to the age of a child under 16 years in the marriage act should also be repealed with provision for a grandfather clause to accommodate existing marriages to minors.*

- Section 17[1] deals with permitting the defilement of a minor under 16 years of age and should be extended to include the willing exploitation of children for direct or indirect financial support.

4.5 *Section 17[1] should be extended to include parents and guardians.*
'A person who
[a] being an owner, occupier or manager of premises; or
[b] having control of premises or assisting in the management or control of premises, or
'[c] being a parent or guardian and for direct or indirect financial gain
induces or knowingly suffers a minor under the age of 16 years to resort to or to be in or upon the premises for the purpose of having sexual intercourse with an adult is guilty of an offence, and ....'

Prostitution One could through the law try to bring prostitutes into a regulated public health framework, whilst trying to keep them off the street. This would involve the amendment of laws such as that related to brothels and other related activity. The Sexual Offences Act Sections 18-20 could be amended aimed at the regulation of brothels and other businesses supplying services which may involve sexual acts; it would stipulate their registration and compliance with the regulations under public health law.

5.1 *Section 18 of the Sexual Offences Act should be renamed Regulation of Brothels and* amended to read:
'A person who
(a) keeps or manages or acts or assists in the management of a brothel; or
(b-c),
who fails to register and comply under the Public Health Regulations [Communicable Diseases or a new Sexual and other Personal Services],
is guilty of an offence and is liable on summary conviction to .....'

5.2 *Amend Section 20, dealing with persons aiding prostitution, by inserting*

'A person who is not registered under section 18, and who for the purposes of gain exercises control, direction or influence over the movements of a prostitute etc...is guilty of an offence and is

liable on conviction to.....

Other Public Health Actions. Apart from bringing prostitutes under public health regulations, actions in this area can be used to diminish the risk of deliberate or reckless spread of HIV, through confidential contact tracing, disclosure and sanctions by the court. It could also be used to better facilitate and encourage children to use the health care system, and encourage the population in general to get tested in a framework of confidentiality and professional counselling.

Reckless or delberate transmission. The regulations in the public health act be amended to give public health officials the authority to bring before the court patients who recklessly endanger others to the spread of HIV or other serious disease, in a process which safeguards the confidentiality of others involved.

6.1 *Where a registered medical practitioner or public health official determines that a person is deliberately or recklessly endangering others by committing acts that could transmit a disease, they should:*

6.1.1 report the matter to the CMO or other designated public health officer

6.1.2. the CMO or other designated public health officer after further investigation and/or action may bring the matter before a judge of the high court.

6.1.3 the judge having conducted a hearing in chambers may issue an injunction against the person to desist from the conduct at issue, and/or impose sanctions which vary from community service to restriction for a period not exceeding a year in a place and manner designated by the court.

***Minors and consent to medical care*.** There are areas in the law related to minors and consent to medical care which could be amended to encourage sexually active youth to seek care at an early stage. The most obvious relates to the fact that a young person of 16 can consent to sexual intercourse, but cannot consent to dealing with its consequences. Thus amendments may be made to the Family law and /or the Public Health Law.

7.1 A person 16 years and older is able to consent to medical care without the consent of their parents or guardian.

7.2 *A minor between the ages of 12 and 16 years may be allowed access to advice and medical care, particularly for the treatment of a sexually transmitted disease or a sexually related condition, without the consent of their parents or guardian providing that the medical practitioner or other legally responsible health care professional is satisfied that:*

7.2.1 the minor fully understands the nature of the condition and is seeking treatment without the consent of the parent/s or guardian.

7.2.2 that the parent or guardian is unavailable or has shown insufficient interest and/or attention to the child's illness, or

7.2.3 after counselling the minor about involving the parent/s or guardian, that the minor will not accept treatment and is likely to default from care if the parent/s or guardian is made aware of their condition or treatment, and

7.2.4 that it is in the best interests of the minor to be treated without the consent of the parent/s or guardian.

Testing for HIV. Legislative measures should be aimed at strengthening the current framework of centralised HIV testing and the system of confidential reporting after voluntary testing and counselling.

8. 1 *The Public Health Regulations in regards to Laboratories be amended to determine what tests can be done in the granting or renewal of the licence, and require the results of certain communicable disorders [which should include HIV] to be reported under confidential cover to the CMO [or other designated public health officer/s]; such reporting to include the name and address of the requesting doctor as well as the available details of the patient tested.*

8.2 *The CMO or other designated public health officer/s will be responsible for obtaining and keeping confidential further information about the patient from the requesting doctor, and ensuring that the services required for further counselling and contact tracing are in place or are made available.*

8.3 The results of any tests shall not be divulged to any other parties or professionals

8.3.1 without the specific consent of the person tested; preferably written consent in the case of communicable disorders.

8.3.2 consent as in 8.3.1 is not required where the medical director of the laboratory determines in good faith that the result is required as an essential part of an emergency service carried out in the best interest of the person tested.

Mandatory testing for HIV or other transmissible disease may be required for the purposes of prophylactic treatment; the determination of compensation in accidental transmission; or for any other purpose related to a court proceeding. The tests are required to determine whether the alleged victim and assailant or the parties in possible accidental exposures were infected, or likely to have been, at the time of the incident. The results of any mandatory tests are confidential and can only be used in the provision of prophylactic therapy and in the determination by a court of compensation.

9.1 In accusations of rape or where it is alleged that there was a deliberate intent to or recklessly transmit HIV or other disease, the person who is the victim of the alleged assault should submit to relevant tests as soon as the complaint is made for the purposes of prophylactic therapy.

9.1.1 should the alleged victim refuse to be tested, they must be counselled as to the consequences of refusal and record their refusal in a prescribed form.

9.1.2 within 3 months of the incident alleging transmission of a disease the court may order that one or both parties be tested; the results of the tests to be kept confidential by the court except for the registered medical practitioner/public health officer responsible for any prophylactic treatment being carried out.

9.2 the results of testing obtained by a court order in pursuit of an order under 9.1 cannot be used as evidence in any court proceeding, either at trial or sentencing.

Subpoenaing Medical Records. The establishment of deliberate or reckless conduct in the transmission of a disease requires that the person accused of such conduct was aware at the time of the offence that they had the disease and how it could be transmitted. Therefore, when there is a determination that a sexual offence, or an offence against the person has been committed, as at 3.1 and 3.2, the court may subpoena the medical records of the convicted person to determine if the offence was an aggravated one.

In accusations of deliberate or reckless transmission of disease, the court may subpoena the

medical records of the convicted person to determine if the person knew their infected status at the time the offence was committed.

10.1 *where there is an allegation before the court that a person knowingly tried to transmit HIV or other disease in the commission of a sexual offence or an assault, the court may on conviction of the accused subpoena the medical records of the convicted person and such records may be considered as a factor in sentencing.*

In civil proceedings alleging reckless or deliberate transmission of HIV or other disease, the burden of proof rests with the accuser. However,

10.2 *the court may be petitioned in a civil proceeding to order such tests and/or subpoena medical records providing the judge has been convinced in a hearing in chambers that a sufficient case has been made, and that the accuser is not capricious in their accusation.*

11.2.1 The results of such tests or relevant parts of the medical records must be kept confidential by the court and not be revealed except by order of the court.

Counselling and professional conduct. Counselling is widely accepted as an essential tool in the management of HIV and other medical conditions. It is currently not part of the requirements for professional conduct of health care professionals and is open to being neglected or abused. There are also few practical sanctions in the current regulations for breaches of professional conduct.

11.1 *Counselling should be included in the professional conduct regulations of the health professions acts and others who may be involved in counselling.*

11.2 *All persons who are not registered medical practitioners, nurses or paramedical professionals and who engage in counselling of patients for medical conditions must register under the Paramedical Professions Act.*

11.3 *Fines should be introduced in the medical and other health professionals council regulations to provide for a broader range of sanctions than currently exists for breaches of professional conduct.*

Confidentiality is the bedrock of the health professional - patient relationship. There are a number of

challenges to preserving confidentiality which have been heightened in the awareness of both the public and health professionals. Exceptions to confidentiality should be made clear in the law and practices tightened in certain areas.

Contact tracing and the Warning of Third Parties at Risk. Confidence in counsellors and health care authorities is vital if HIV infected persons are to reveal their sexual contacts and change the behaviour which will protect others. However, existing stigma and fear of violence often inhibit the HIV-infected person from cooperating fully in this vital task of sexual contact tracing. There are occasions where the health care professional is convinced that it is in the individual and/or public interest to break confidentiality. It is recommended that under the public health regulations, the conditions under which confidentiality may be broken in the contact tracing of disease be codified.

12.1 *A registered medical practitioner or other legally responsible health care professional may warn a third party at risk for harm by transmission of HIV or other disease from a patient provided that:*

12.1.1. The affected patient has been tested, counselled, knows of the result of the test, and how the disease is transmitted or can cause harm to another person

12.1.2. The counsellor has made all efforts to have the person inform those who are at risk or have been at risk for transmission of the disease, and has offered confidential assistance in doing so.

12.1.3 The counsellor is convinced that a specific third party or parties are being put at risk for transmission of the disease, and has so informed the CMO [or designated public health officer/s] and has been instructed by that officer to break confidentiality to the specific third party/ies.

Other breaches of confidentiality. A breach of confidentiality is professional misconduct in the health professions' regulations. If the recommendation at 11.3 as regards to fines is adopted there is a greater likelihood that breaches of confidentiality will be dealt with.

However, there are no regulations in law that cover those who are not health professionals and who may be privy to confidential health information. It is recommended that the Employment Rights Act 2001 [draft] be amended to cover this situation.

13 *It is an offence to divulge confidential medical or other information of an employee or a client. Allegations of such breaches may be brought before a tribunal or the court and on conviction are subject to .....'*

Insurance and other applications. There are a number of complaints that confidentiality is broken to persons who are not health professionals in the insurance and employment sectors. The usual complaint is that the insurance applicant first receives sensitive information such as the result of an HIV test from an insurance agent. When challenged some medical practitioners point out that the applicant has given written consent to sending on the information to the insurance company; the 'consent' in such circumstances is the practice of asking insurance applicants to sign a blank medical examination form. In addition, diagnoses are often revealed to employers by the use of duplicate national insurance forms to inform employers of sick leave granted.

The medical professional regulations should be amended to make it a breach of professional conduct to transmit any information on a patient without their consent.

14 It is a breach of confidentiality to transmit patient information to another without their consent

14.1 the signing of a blank or partially blank form does not constitute informed consent for the purposes of this regulation

14.2 the use of a duplicate form for informing an employer does not constitute informed consent for the purposes of this regulation

Medical records**,** particularly in the public sector, are currently easily compromised in relation to the confidentiality of patients. Particular attention has to be paid to security in the storage of records electronically and their linkage to readily available identification numbers or codes. However, the security of patient records should not interfere with essential patient care or obtaining records for research purposes

15.1 A Medical Records Act should be enacted which would ensure the confidentiality of records, except for patient care and research purposes.

15.2 National Identification numbers should not be attached to databases which store medical records.

Research. Confidentiality of patient information is an essential part of ethical conduct in medical research. Currently ethical review of medical research in Barbados appears to be done on an ad-hoc basis. It is recommended that in a Medical Records Act as recommended above [15.1] provisions be made for ethics review mechanisms in medical research.

Immigration. There is considerable public comment related to HIV testing of persons for entry into the

country, particularly for purposes of permanent residency and the protection of expenditures in health. There is no evidence that such measures are an effective preventive measure in the spread of HIV. Furthermore, medical treatment without the payment of fees is not available to temporary visitors to the country

16 *It should be explicit in the health service regulations, that on accessing government financed services, only citizens and permanent residents of 5 yrs duration or more are entitled to those services without the payment of fees.*

HIV and Employment There is widespread international agreement that discrimination against HIV infected persons should not occur in the workplace, particularly when the person is well and there is no demonstrable risk of transmission in work related activities. It has already been recommended [1.1] a broad anti-discrimination statute in relation to employment and other sectors in the community. In addition the Employment Rights Act 2001 [draft] should be amended as follows:

17.1 *An employer may not screen or cause to be screened an applicant for employment or an employee for HIV or other medical condition unless permitted under the public health regulations.*

17.2 *Employers, particularly those in health, are required to provide training and adequate facilities for the prevention and treatment of accidental risks in the workplace.*

17.2.1 The provision of such education and facilities may be used as a defence/mitigation in any action brought against the employer.

HIV Transmission in Criminal Settings. The prevention of HIV transmission in corrections facilities and in criminal activities, such as intravenous drug abuse, is an important measure to protect the health of the community. Transmission in the commission of illegal activities endangers others who interact with such persons in legal pursuits.

Condoms in Prison. Anal intercourse in overcrowded prisons is a well recognised albeit undesirable activity that occurs in such circumstances. There is a duty placed on those in charge of prisons to prevent the spread of disease among inmates and this is particularly important in relation to HIV and the overall prevention and control in the community as a whole

18.1 Condoms should be designated in the correction facilities as toilet articles, and made available through the correction's health care/ counselling facilities.

Needle Exchange. Sharing needles for intravenous drug abuse is a well-recognised way of spreading HIV and other diseases among such abusers and also to the wider community through sexual intercourse. The public health effectiveness of the provision of clean needles and syringes for used ones is well established and should be brought under the law

18.2 *Needle exchange officers should be designated among the public health care workers/counsellors.*

18.2.1 Any 'evidence' collected from, preparatory to or in the course of such exchanges cannot be seized or subpoenaed and used in a court proceeding related to a drug offence.

These recommendations are indicative of the changes sought rather than setting out to be the exact legislative drafting. However, the rationale and the intent of the changes are made clear in the full body of the document. There is no specific mention of a review of disability legislation as this term of reference was taken in the context of the overall consultation on HIV/AIDS and the inclusion of the latter in disability legislation in the USA.

If these recommendations are adopted it would be prudent to have further discussions with interested parties and in particular those who could not be consulted for one reason or another.

Legal, Ethical and Socio-economic Issues relevant to HIV/AIDS

Background

AIDS [The Acquired Immune Deficiency Syndrome] was recognised in 1981among a group of male homosexuals in the USA as a highly fatal disease which destroyed the body's defences against diseases that one would not normally succumb to. It immediately drew a lot of adverse attention and fear, was dubbed the gay plague, and was characterised by some as the wrath of God against homosexuality. With the discovery in 1983 of HIV as the causative agent and the fact that those affected could be well, the adverse reaction was extended from those who were ill with AIDS to those who were well with HIV.

The reaction to the disease by many of the public, health professionals, priests, attorney's and politicians was that of: -

Intensification of homophobia, which led to stigmatisation of all those affected within the community as well as the characterisation of those affected as criminals since it was assumed that they were practising anal sex.

Criminalisation of the disease was reinforced by the identification of groups at high risk for acquiring the disease such as prostitutes, intravenous drug abusers, and prisoners who are sexually active within the prison. This reaction led to calls for repressive measures, including the denial of rights to individuals or groups thought to be infected. The denial of rights included denial of medical care, calls to breach the confidentiality of those infected with HIV, denial of shelter, the right to work, to be educated, and to finance through obtaining insurance. In some countries affected persons were arrested, quarantined, denied the right to marry and there was even a law passed making it an offence to have sexual relations with 'foreigners' in one country.
The denial of rights was rationalised by those who demanded it on the premise that this was an infectious disease which should be treated like other contagious diseases in the past. The false premise of contagiousness was reinforced by assertions, particularly in the press, about modes of transmission by normal social contacts, in food and by insect bites.

Calls for a humanitarian and rational approach to the disease have been met with distrust and resistance. Sensationalism in the media was also a reaction and included the falsification of stories of persons deliberately spreading the disease; prognostications about the spread of the disease which heightened fear and loathing for those affected; and assertions that safer sexual practice through the use of condoms was as unsafe as to be committing suicide.

The fear generated and 'criminalisation' of the disease has resulted in resistance to preventive efforts such as the promotion and use of condoms, sexual health education for youth, confidentiality and counselling and their place in sexual contact tracing. In many instances

resistance there was also to the provision of resources for the care and comfort of those who are ill.

HIV and AIDS affects predominantly the young person and in particular those who are marginalised in the community because of poverty, including its attendant overcrowded housing conditions and frequency of involvement in the drug culture and its trade. These conditions are often associated with poor education and early sexual activity which make the issues among such vulnerable children of particular importance. Infection with HIV as an adolescent is of particular importance for there is the greatest potential for spread at a time of greatest physical and sexual vigour. Then there is the tragedy of the illness of AIDS when they reach young adulthood and should be in the productive working population.

The socio-economic impact of the AIDS epidemic has become starkly apparent in sub-Saharan Africa, where without the resources to treat HIV or mount a sufficient prevention effort, the young adult productive element of the population has been dying disproportionately. The economic impact of such changes has propelled some governments to recognise that actions are required at all levels in the society to stem the mortality of young adults and to control and/or prevent the spread of HIV. In this regard the Caribbean region is listed as second only to sub-Saharan Africa in the prevalence of HIV.

In Barbados, the first indigenous case of AIDS was recognised in 1984 and shortly thereafter the government and the Barbados Association of Medical Practitioners recognised its importance and started to put education and medical measures in place. A National Advisory Committee on AIDS [NACA] was formed in 1987 with a recognition of the multi-faceted nature of the response required, for apart from the health professionals on the committee there was a counsellor from the Ministry of Education, the Chief Welfare Officer, The Youth Council, an advertising executive and a member of the press. Position papers were developed on all aspects of the epidemic, including the legal and ethical issues, and opinions sought from all sections of the community, professional, religious, legal etc. In the report of the NACA presented to the government in 1988 the issues identified at that time were outlined and the report adopted as a policy document [1]. No legislative changes were envisaged at that time, but the preservation of the rights of those affected was clearly highlighted. As time has gone on it has become apparent that exhortations to maintain the rights of those affected may have to be reinforced by legislative changes.

The formation of the NACA was indicative of the recognition of the socio-economic impact this disease could have. This was also expressed on a global basis with the formation of the Global Programme on AIDS within WHO in 1987. A representative from Barbados represented the Caribbean Region on the GPA .

A Global Summit of Health Ministers was held in London in 1988 and in the Caribbean the 1988 Conference of Ministers Responsible for Heath requested a paper on the social and economic issues of the epidemic. In that year at the World Health Assembly a resolution was adopted on the 'Avoidance of Discrimination in Relation to HIV-Infected People and People with AIDS' [2]. In 1989 an international consultation on AIDS and human rights was convened by the Global Programme on AIDS and it called on governments to ensure that measures related to combatting HIV/AIDS conformed to human rights standards [3].

In the year 2000, the Prime Minister of Barbados assumed the responsibility for directing the programme on HIV/AIDS and set as objectives a 50% reduction in mortality of the AIDS patients by 2003 and a similar reduction in HIV prevalence by the year 2005. The National HIV/AIDS Commission was set up in 2001 to coordinate the multi-sectoral effort required to achieve these objectives.

At a United Nations Special Session on HIV/AIDS in June 2001, Heads of Government agreed on a Declaration of Commitment on HIV/AIDS and addressed the Human Rights dimension of the pandemic in the following terms: [4]

> ***'Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response.***
>
> Governments agreed to ***'enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter-alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;'***

It is in this context that the Attorney General of Barbados has commissioned this study to provide a *Comprehensive review of legislation relevant to HIV and AIDS and its attendant socio-economic impact*.

Legal and ethical issues have pervaded the public, noational and global discourse on the HIV/AIDS pandemic. In 1988 Jonathan Mann, the first director of the Global Programme on AIDS, described the adverse societal response as the Third Epidemic and opined that without tackling it effectively neither the epidemic of AIDS nor the silent epidemic of HIV will be controlled. The 1988 World Health Assembly

tackled the issue of discrimination in relation to HIV-infected people and people with AIDS [2]. In that year Justice Kirby of Australia pointed to the tendency of countries to formulate *'highly ineffective laws [HIL]'* as a response to the epidemic.Unfortunately this third epidemic of stigma and discrimination has proven to be the most difficult to tackle, for the issues raised strike at the very root of our individual and the community's prejudices, fears and beliefs. Under these circumstances rational thought and action frequently give way in the face of evidence that is contrary to what many in the community wish to believe.

Many countries have agonised over how the law may be used to 'control' the epidemic and the persons infected with HIV. Legislative initiatives have varied from attempts at comprehensive HIV/AIDS legislation, such as the Tasmanian HIV/AIDS Preventive Measures Act 1993 [5], or the Philippines AIDS Prevention and Control Act of 1998, [6] to the layering of HIV statutes into criminal or public health law as has occurred in the Bahamas [7], in Australia [8] and in Canada [9]. Such attempts have given rise to their own problems and there are several analyses of the Canadian experience which question the efficacy of the use of criminal law as the best tool to help in the prevention of HIV transmission.
In general the response of those prepared to advocate a humanitarian and traditional health response of caring has been muted in this area, for they have been reluctant to face the community and its leaders, both political and religious, with the difficult and often emotive issues underlying the community's response of stigma, discrimination and the call for criminal sanctions for HIV-infected persons and in particular the detention of those affected.

The issues that determine the individual and community's responses are not new, either in relation to the AIDS epidemic, normal social discourse, or the historical response to disease. The same responses, including responding to the ill as if they were criminals, have been seen historically with infections such as tuberculosis and syphilis. While many are prepared to characterize those historical responses as due to ignorance and fear, there are those who are reluctant to deal with the current knowledge available on disease and the social responses to it, and instead revert to their deepest fears and prejudices.

In the Caribbean concerns about the societal response have been recognized and expressed by leaders in health, in politics and in the church; studies have been commissioned on these issues, and the Executive Summary of one such study under the aegis of CARICOM is appended to this report. The fact that this study was commissioned in 1992 as a matter of urgency, was not pursued until 1995, and appears to have been unknown when workshops were convened in the region as recently as Nov. 2003 is an illustration of the reluctance to come to grips with the issues involved, difficult though they may be. The issues that affect the ability to deal with the epidemic, and in particular the ability to give effect to prevention of the spread of HIV, are outlined in that study and will be examined in some greater detail in this report.

Discrimination and HIV-affected Persons

- ***Discrimination*** against and stigmatization of HIV infected or affected individuals is at the root of the inability to effect meaningful sexual behaviour change in the community, change that is essential for effective prevention efforts in the spread of HIV. The effects of stigma and discrimination are most acute for the men in the community who are reluctant to find out their HIV status for fear that they will be labelled as bullers [homosexuals]. In most forms of discrimination the persons who engage in the discrimination will seek to justify themselves and most often cite the lingering doubts about the dangers of transmission by casual contacts, or the moral right to act against sexual 'deviants'.

- Persons infected with HIV were denied access to housing, schooling and the right of employment in situations where there is no known risk of transmission of HIV. In addition, any attempt to promote safer sexual practice among homosexuals is opposed by many on the grounds that one is encouraging sexual deviancy and criminal acts. In those countries where there has been stabilization or a turn around of the HIV epidemic, changes have been catalysed when the groups who have been stigmatized, such as homosexuals, have fought for and gained the right not to be discriminated against. However, much of the fight against laws outlawing buggery/sodomy in North America and some European countries was engaged in before the HIV epidemic emerged.

- Acts of discrimination are best combatted by governmental policy decisions backed by appropriate legislation. As with issues such as abortion one can expect vigorous opposition from religious groups at any suggestion of reform, but once in place such opposition tends to become muted, particularly if the fears of further moral decline are not realised and the benefits of reducing discrimination become apparent. Furthermore, changes in legislation cannot and should not inhibit in any way priests or other religious leaders from influencing the community by expressing their beliefs and enjoining persons to follow their teaching.

- In 2003 the state laws against sodomy in the United States were rendered ineffective by the US Supreme Court judging such laws to be an unconstitutional invasion of privacy [10]. In changing the law in the UK and Europe, arguments hinged on protection of the privacy of consensual behaviour among adults, e.g. The Wolfenden Report 1957 [11]. Although changes in the law in those countries has not eliminated prejudice and discrimination all together, it has been a major advantage for homosexual groups in their fight for other rights related to HIV, such as the right to work, obtain care, insurance, and even to enter into the ministry and become a Bishop [12].

- There are few anti-discrimination laws in the Caribbean. In 1996 the report of the Caribbean Task Force on the Legal and Ethical Issues related to the HIV/AIDS Epidemic recommended the introduction of anti-discrimination legislation that would encompass areas such as housing, schooling and employment [See Appendix.] Many countries, like Barbados, have general clauses against discrimination in their constitutions. However, as has been pointed out by constitutional scholars, these provisions govern discrimination by the state and are not strictly applicable to individuals and organisations outside of the state apparatus. In addition, it is notoriously difficult for an aggrieved individual to challenge the state particularly on constitutional matters.

- Some countries have enacted anti-discrimination statutes related to HIV in recruitment and employment, these include the Bahamas [13[, South Africa [14], Zimbabwe [15], Tasmania [5], and in Barbados limited only to unfair dismissal in the draft Employment Rights Act Sect:24[c][v] [16].
- In South Africa, The Employment Equity Act [14] was enacted in the post-Apartheid period and under the section Prohibition of Unfair Discrimination deals with a wide range of societal issues including HIV.' It states:

  'No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice; on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.'

- On the other hand anti-discrimination statutes have been enacted to cover a wider area of public life than employment. The Namibia HIV/AIDS Charter of Rights [17], provides for access to all facets of public and private life, and similar provisions have been made in the Phillippines [6]. There is a need for a similar wider protection of rights for the HIV-affected person and others in Barbados.

- In Barbados, Chapter III of the Constitution [18] sets out the protection of fundamental rights and freedoms of the individual. Section 11 of the constitution sets out these rights and freedoms and they include life, liberty and security; protection for the privacy of home and other property, from deprivation of property without compensation; the protection of the law; and freedom of conscience, of expression and of assembly and association. Section 19 [1] dealing with protection of freedom of conscience states:

  'Except with his own consent, no person shall be hindered in the enjoyment of his freedom of conscience and for the purpose of this section the said freedom includes freedom of thought and religion'

- The provisions in the constitution clearly envision that individuals and the community should not be bound by any particular religious belief and therefore laws based on religious teachings should not be used to infringe on the rights of individuals to *'the enjoyment of his freedom of conscience and thought'.* Thus it could be argued, as it has been in North America and many countries in Europe, that the enjoyment of sexual expression in privacy is within the provisions of the Constitution of Barbados. The provisions in section 19 of the constitution of freedom of conscience, and religious belief carry the clear implication that persons with a same sex preference should not be hindered in the enjoyment of their freedom of conscience or be subject to the beliefs of any religion. But as with any right or freedom there must be responsibility and any freedom of conscience or expression of thought must not be done to the detriment of the rest of the community and in particular when it affects minors or any other vulnerable person in the community such as the mentally disabled.

- The provisions in the Constitution of Barbados do not expressly include other provisions that are in the Geneva and other conventions to which Barbados is a signatory and Barbados has enacted piecemeal anti-discrimination legislation to deal with women and more recently in employment where in section 24[c][v] in the draft Employment Rights Act it is considered unfair dismissal if the reason is *'that the employee had, or was perceived to have the HIV virus or AIDS' [16]*. This provision has narrow applicability and does not deal with the discrimination that might be practised against those who are seeking employment.

- In the United States the legislative debate that occurred over discrimination against persons with HIV was overshadowed by the homophobia that existed among some prominent legislators at the time. The legislative device that was used was to include HIV/AIDS under disability legislation that was under consideration and passed in 1990 as the Americans with Disabilities Act [19]. In this act persons with disabilities have special protections under the law from being discriminated against in all aspects of societal endeavour including employment, health care and other services available to the public.
- In Barbados the government has sought from the outset of the epidemic to prevent discrimination against persons affected by HIV but have not until recently sought to put in place legislative measures to that effect. The opportunity is therefore there to deal with discrimination outside of the simple confines of employment or disability, particularly since in the latter instance there are arguments being raised that the HIV- infected person as against those with AIDS has no demonstrable physical disability.

- ***The Right to Participate in Society***. Without the strength of stigmatized groups to fight for the right to participate in the basic activities of a society, it has been an uphill struggle to hold onto a modicum of rights for HIV affected persons. Thus from the time the AIDS epidemic was recognized HIV-infected persons have been discriminated against and attempts have been made to exclude them from housing, schools, the workplace, health care, insurance and even a dignified burial.

- HIV-infected persons have been ostracized by making up rumours about them deliberately spreading the virus; their danger to others through transmission by casual contact or accidental exposure to blood and 'bodily fluids' [20]. It must be recognised that such attitudes are in part due to some education messages and the impression they convey. Indeed, there is a great deal of concern expressed about the widespread assumption that anyone can be an HIV/AIDS educator provided they are willing and have obtained some information in a few hours of training or by reading material that they may not have the basic knowledge to fully understand.

- In the health care setting there have been fifteen years of struggle to gain rights to care with dignity for HIV-infected persons. Those who have discriminated against HIV affected persons no longer feel that they can still do so openly, but some do discriminate without any realistic prospect of sanction. In Barbados what change in atmosphere there has been is the result of an education effort mounted since 1985 and continuing efforts particularly among the health care staff of the Queen Elizabeth Hospital since 1990. Until recently, due to a lack of resources for anti-retro-viral treatment, there had been 'discriminatory' treatment in the provision of care for HIV-infected persons, where in the public sector treatment was only offered to reduce mother-to-child transmission and to those who could afford to buy the medications available.

- There has been laudable success in saving some infants from transmission of HIV from their mothers but the policy did not recognize the inherent problem of signalling that one cared only about the infants but not about their mothers or fathers. In a recent study Kumar et al [21], found that 21 percent [1 in 5] of HIV infected mothers became pregnant again after they knew of their HIV status, some of them repeatedly. These repeated pregnancies may be due to a failure of counselling or the mothers working out that if the unborn baby is helped so are they and another pregnancy becomes the way to get help.

- In addition it has long been a feature in the society that women in an attempt to get support in the home may move from partner to partner and try to tie them into financial support of a child. This situation clearly raises the risk of transmission from women to men in unprotected intercourse but

it also raises the issue of a woman's right to bear children. However, in most of the social discourse about the spread of HIV it is suggested that men are the agents of spread of the virus either deliberately or recklessly through unprotected intercourse. It is indeed a perception that is one of the greatest worries among those who are HIV- infected.

- As regards insurance it must be recognized that this is one of the biggest gatekeepers to economic activity in the society. The National Advisory Committee on AIDS in 1987 sought and gained an agreement to limited activity for HIV affected persons within the industry and agreed on mechanisms to ensure the confidentiality of HIV-infected persons applying for insurance [1]. By and large the provision for confidentiality has worked well, yet we still hear from time to time of persons stating that they heard of their HIV status for the first time from insurance agents.

- Most persons who were not insured before HIV could be detected are not insured for any purpose once their HIV-positive status is known. It is also clear that an infelicity of long standing has been missed in which the insurance industry asks for and members of the community comply with signing blank forms which may subsequently contain information that may have made them rethink their application. Thus if an HIV positive status or other condition automatically denies one's application for insurance, the prospective client risks a loss of privacy without any possibility of being insured. The risks to the insurance industry have clearly changed with the availability of treatments that prolong life, and this should be taken into account by the industry in the provision of cover.

Recommendation: Anti-discrimination legislation should be introduced that covers all the issues of discrimination. However, such legislation should not be limited to the sphere of employment, but should cover all areas of public endeavour. There is also a risk that singling out HIV as the only disease quoted may in itself lead to problems and the wording should be such as to include other forms of illness.

Suggested wording:

' No person may unfairly discriminate, directly or indirectly, against any person in a public place or business; in any employment or procedure preliminary to employment; practice or service available to the public, on one or more grounds, including race, gender, ***sexual orientation****, pregnancy, marital status, ethnic or social origin, age, disability,* ***medical condition****, religion, conscience, belief, political opinion, or*

culture'.

The provisions in this section nullify a provision in any other law that is counter to its spirit or effectiveness.

- The question has been posed as to whether a law against discrimination on the grounds of sexual orientation would oblige priests to perform same sex marriages. Clearly priests cannot be obliged to perform same sex marriages if they were lawful as they have a right of a conscientious objection in the pursuance of their religious freedom. Such a right is exercised by some priests in relation to the marriage of divorced persons.

HIV, Sex and the Law

- ***Same Sex and other sexual conduct.*** Sex is a natural and vital part of living, yet in the religious values of the Barbadian society there is a great deal of ambivalence related to sexual activity. Sex is largely characterised as sinful except within marriage, yet the majority of our children are born out of wedlock. Unfortunately, the strictures placed by most religions on human sexual activity are such that a number of priests find them difficult to maintain.

- Homosexual acts have been characterised in the Bible and in the Koran as deserving of death by stoning and there are some priests who continue to use such texts as they were written. It is not well known that same sex orientation as it relates to women is also abhorred by the church and therefore it is not only anal sex between men that attracts the opprobrium of the church. It is a view still adhered to steadfastly by many in their religious teaching that sexual acts should only be engaged in for the purposes of procreation. Indeed, it is the barrier to conception that first attracted the ire of the church to condoms and the 'encouragement' of promiscuity has been added to bolster the case against condoms

- Ancient religious texts written in vastly different societal structures and without modern scientific knowledge, could not be expected to account for the fact that same sex orientation/preference would be like lifetime abstinence at the outer limits of biological behaviour and is not of necessity a perverse choice. It is therefore not surprising that when AIDS was first described among homosexuals that there was sharp condemnation from many in the church and this attitude was extended to resistance to any measures to make same-sex activity safer on the grounds that this would encourage ' immoral and abominable' sexual activity.

- When one combines this with the fact that buggery / sodomy was made an illegal activity at the behest of religious groups and is still an illegal activity in many countries, like Barbados, the stigma that is attached to HIV/AIDS has been a great inhibition to both detection of those affected and the implementation of safer sexual practices. As a result many persons, particularly men who are at risk, prefer not to find out their status knowing that they will be stigmatised and labelled as homosexuals whether they are or not.

  Archbishop Desmond Tutu, Nobel Laureate and a hero in the fight against Apartheid and Chairman of the post apartheid Reconciliation Commission, had this to say in a Sermon in 2003: [22] *'The Jesus I worship is not likely to collaborate with those who vilify and persecute an already oppressed minority. I myself could not have opposed the injustice of penalizing people for*

something about which they could do nothing - their race - and then have kept quiet as women were being penalized for something they could do nothing about - their gender, and hence my support inter alia, for the ordination of women to the priesthood and the episcopate. And equally, I could not myself keep quiet whilst people were being penalized for something about which they could do nothing, their sexuality. For it is so improbable that any sane, normal person would deliberately choose a lifestyle exposing him or her to so much vilification, opprobrium and physical abuse, even death. To discriminate against our sisters and brothers who are lesbian or gay on grounds of their sexual orientation for me is as totally unacceptable and unjust as Apartheid ever was.'

- Religious taboos and their legal links have proven to be the most powerful inhibition to effecting the changes in human sexual conduct which could lead to the prevention of HIV. The values expressed by the church stress prohibition of sexual activity outside of marriage and the danger of education of children about and the use of measures available for safer sexual conduct. On the other hand sexual activity is promoted in every other sphere of society's endeavours through the most modern and effective of communication facilities. The Anglican church, which was the religion of the state in Barbados before independence in 1966, has as its religious leader the Archbishop of Canterbury appointed by the government of the UK. The Archbishop does not overtly oppose the change in the law in the UK, which since 1967 removed sodomy from the Sexual Offences Bill as an illegal act between consenting adults in private [23]. Nevertheless, when an avowed homosexual Episcopal [Anglican] priest was elected to be a bishop in the United States there was a great deal of doctrinal controversy over the issue [12].

- The Bishop of Cork in a sermon in 2003 tackled the issue head on: [24]
  'The present controversy about homosexuality within Anglicanism is now calling the Church's bluff about this professed preference to be, like Christ, among those on that edge. We have claimed to be on the side of those who were oppressed by society and consigned to its margins. This edge place is where most homosexuals were forced to live prior to decriminalisation and the arrival of equality legislation, but where, in spite of immense changes in society, many still find themselves - especially those within the Church. The Church has been complicit in the resulting injustice and immense human suffering.
  Part of our responsibility centres on our acquiescence in the misuse of Scripture, caused by our inertia on the one hand and by our fear on the other of giving intelligent people of faith the tools for handling God's word rationally.'

- The Archbishop of Canterbury in a sermon at Christmas 2003 alluded to the doctrinal issue [25]. '*Historically, the answer, is, alas, that religious faith has too often been the language of the powerful, the excuse for oppression, the alibi for atrocity. It has appeared as itself intolerant of difference, as a campaigning, aggressive force for uniformity, as a self-defensive and often corrupt set of institutions indifferent to basic human welfare. Yet religion has appeared as something fighting to take over territory in the human soul and the human world - an empire pushing at the frontiers, struggling to defeat the independence and dignity of people.'*

- In a statement in 2003 by the Anglican Bishop of Barbados on 'Human sexuality in the light of recent developments in the Anglican communion', it is stated [26]:
  'Homosexuality is as old as human existence. Some societies down the ages have accepted the practice, others have tolerated it and some have rejected it as an abomination. These approaches are still with us. The Church is called to minister to all including homosexuals, within the context of ambivalent approaches and varied understandings of the practice.'

- There are those who realise that scriptural 'reverse' in the 'Christian' Church has occurred in the past for it has had to reverse itself on slavery, on racism and on women in the Ministry. Indeed, although the members of the church were leaders in the movement to abolish slavery, the law had to be changed on slavery before the doctrinal issue was laid to rest and members of the church gave up their own slaves. It is said that the doctrinal issue in one branch of the Church was not settled until 1890 decades after the law had been changed. The battle over racism in Apartheid in South Africa was vociferously supported by some professing the Christian faith on the basis of the scripture until a violent change of government and the law came about.
- Although there was no such climatic change in the law related to women in the Ministry, the change can hardly be divorced from the widespread social and legal promulgation of the rights of women that occurred at the same time. Thus, for those who hold fastest to scriptural 'laws', changes in secular law have allowed them to release themselves from what they clearly accept as abuses in modern society.

- Nevertheless, changes in the law related to homosexual practise will not be supported by the Christian Church or the minority religions in Barbados. The fear of the church as expressed by many denominations is that changes in the law will damage the morality of the whole society and that it will encourage the abuse of boys. However, a change in the law in no way prevents the

church from continuing to promulgate their interpretation of the scriptures in pursuance of the proper exercise of their freedom of religion and its expression.

- On the other hand the state has a responsibility when necessary to exercise its responsibilities under the constitution of 'the freedom of conscience, expression and of religion' in which is inherent the separation of church and state. There could be no greater catastrophe for the society than to allow different religions to demand the imposition of their religious laws. Indeed, the imposition of such laws would destroy the very religious freedom guaranteed to them under the constitution. In addition, the change in the current law would in no way remove or encourage sexual offences against boys or girls for that matter. Experience has shown that in areas where scriptures appear to conflict with proposed changes in the secular law that the controversy subsides once the law is changed. Indeed, as quoted above many prominent clerics have embraced the spirit of the law in the UK and the US by bringing homosexuals openly into the communion/community of the church.

- Some religions hold fast to the view that religious and secular law must be the same. Although this is still the view held among some religious groups, most states, including Barbados, have constitutionally separated the State from the Church. Before that a Roman Catholic could not be the Pricipal of leading schools in Barbados. The separation is not done without a struggle and the struggle continues today in many countries. This is expressed in Trinidad and Tobago where there are three different laws related to marriage, where in the Muslim and Hindu Acts a distinction is made between contracting marriage and marriage itself and marriages can be contracted for girls from age 12 in one instance and age 14 in the other and the legal age for consent to sexual intercourse outside of marriage is 16 years [27,28,29]. The age of consent to sexual intercourse is 16 years in most Caribbean countries but in Guyana it is stated that the age for consent for girls is 13 years [30]. These inconsistencies in the age of consent for sexual intercourse or marriage are based on religious precepts and they are particularly prejudicial to the development of girls. Such anomalies are inconsistent with all of the developments that have occurred in our society in relation to the elimination of inequities in relation to females in the society and our accession to the Convention on the Rights of Children [31].

- It is clear that where the separation of state and religion is not maintained it can lead to violations of human rights, particularly of women and children, that most people and their governments accept today. It also appears to lead to strife between religious groups, particularly when the differences are also allied to ethnic groups, as they vie for what they see as their rightful place in the apparatus of the state. Thus one cannot ignore what appears to go on in theocratic states,

where women are still sentenced to death by stoning for adultery but there is no culpability for the man involved; where children can be forced into marriages before they can reach their full potential at school or even physical maturity; and where the religious law of 'an eye for an eye' remains.

- There are many of faith who would accept that sinners such as homosexuals, adulterers and prostitutes can be redeemed by becoming abstinent. Ignoring the oxymoron as it applies to prostitutes, abstinence is indeed very safe sexual conduct from the point of view of the risk of acquiring HIV. However, it is conduct that is unlikely to be heeded by those most at risk for HIV transmission, namely the young adult. Indeed, it is clear that a number of those who have taken religious vows to be celibate/abstinent have not found it possible to adhere to those vows and have unfortunately broken those vows by preying on the most vulnerable, the children in their charge.

- Communities have responded by and large to the choices offered of no sexual activity or unsafe sexual activity by choosing unsafe sex. There is therefore a need to break the barriers that have been set up and offer the third choice of safer sex. Safer sex is inherent in the Christian and other religion's advocacy of sex within the confines of marriage, however, the point of safety relates to sex with one faithful partner and not necessarily the vows or contract of marriage. This relationship of faithfulness is one that many male homosexuals have adopted in protecting themselves from HIV, and this message and approach has been most successful in countries such as Western Europe and North America where buggery / sodomy is no longer a criminal offence per se and men can be open about their relationships.

- In those communities where safer sex has been a realistic and genuine choice, it has been generally, though not exclusively, been chosen over no sex at all or unsafe sex. Although other factors such as higher incomes contribute, it is salutary to note that in those countries where the laws of sodomy have been repealed that the prevalence of HIV/AIDS is at its lowest in the country as a whole as well as among homosexuals. This is in spite of them being the group as highest risk at the beginning of the epidemic in those countries.
- This favourable change is a result of the ability of the homosexuals to empower themselves to take actions that reduce the spread of HIV among themselves and to fight for equal access to care and other services in their mostly affluent communities. In less affluent communities where homosexuals are under threat by the law as well as the marked stigma, the prevalence of HIV among them has remained high.

Recommendation: There is a need to begin the process of destigmatising homosexuals by bringing into

line same sex acts with that of other sexual acts between consenting adults. Anal intercourse like other sexual acts practised between consenting adults and in privacy should no longer carry the threat of imprisonment for life. Therefore, the law against buggery/sodomy Sexual Offences Act [32] should be amended and be replaced by one that makes buggery an aggravated offence in a sexual assault.

Sexual Offences Act Section 9, should be amended to read

> *'Any person who commits buggery <u>during the commission of a sexual offence as defined in this act</u> is liable on conviction.....'*

- The retention of 'buggery' as an aggravated offence in the commission of a sexual assault may assuage the popular feeling where stories, some of them false, of deliberately spreading HIV by this means have been so readily accepted [20].

- ***Deliberate or Reckless Transmission of HIV****.* There is a widely held view that as an act of revenge HIV infected persons, particularly men, are deliberately spreading HIV through sexual intercourse. The deliberateness of spreading HIV is hardly ever conceived as occurring outside of consensual sexual intercourse between a man and a woman and has both the elements of fear and discrimination about men as homosexuals and the innocence and vulnerability of women. Whatever may be the vulnerability of women in many poor communities, this is not the perception in Barbados among the community of HIV-infected persons, who see some women as well as men deliberately or recklessly endangering others through unprotected intercourse.

- Whatever may be the gender perceptions of culpability for transmission of HIV one cannot escape the reality that in Barbados most adults are in control of their sexual conduct and can refuse to accept the risk of unprotected sexual intercourse should they choose to do so. Probably the greatest inhibiting factor to empowering persons to protect themselves during sexual intercourse by the use of condoms has been the demonisation of condoms by some religious teaching and the stigma that those men who use them are most likely HIV-infected. There is no legislative response that can compel people to use condoms, however, every opportunity should be seized to remove any legislative barriers to increasing their use in high risk sexual encounters.

- *HIV-Positive and Bearing Children****.*** Sex between men and women is the natural way in which children are brought into the world and the right to do so is as natural as the right to breathe. Communities of living things reproduce naturally and try to do so particularly when they are under threat. Therefore, there is no adversity which can diminish the desire to bring children into the world through unprotected intercourse.

- Since the use of condoms to protect against HIV transmission also inhibits the ability to mother or father children, there is an inherent dilemma for the HIV-infected person between protection of others and the desire and right to have offspring. This dilemma is further compounded by the fact that the mother may pass HIV onto the child and many have questioned the morality of knowingly endangering the life of a child born under such circumstance.

- The provision of medications that reduces the risk of transmission from mother to child is clearly a helpful response but does not solve the inherent question of spreading infection, particularly when the HIV infected woman knowingly repeats a pregnancy with a different partner. There is a temptation to try and find a legislative response to this dilemma, but there is no legislative response that will not infringe on this most natural of human right. However, recommendations can be made that will enhance the public health preventive response to such behaviour as well as

pointing out where sanctions can be employed.

- *The Sexual Offences Act* [32] as well as the Offences Against the Person Act [33] may be considered as vehicles for the prosecution of persons who deliberately or recklessly transmit HIV or other STD's by sexual or other acts. In the Bahamas the Sexual Offences and Domestic Violence Act 1991 [7], states that a person who knows they are infected with HIV and who has sexual intercourse with another person without disclosing their infection is guilty of an offence. In Bermuda, the Criminal Code [sexual offences] Amendment Act 1993 [34] states that a sexual assault has been committed if the person has a sexual disease and does a sexual act with another without informing the other party about the disease.

Recommendation: An additional section should be added to the Sexual Offences Act; Deliberate Transmission of a Sexually Transmitted Disease.

Deliberate transmission of a disease in the commission of any sexual offence, aggravates the offence and is subject to additional penalties.

- *Offences Against the Person Act.* In a number of jurisdictions, accusations of deliberate transmission of HIV have been dealt with under the criminal code varying from aggravated assault to attempted murder. In Canada, in R v Currier [35] the accused was charged with aggravated assault for having transmitted HIV following unprotected sexual intercourse with two women without informing them of his status. This and other cases and their varied outcome is discussed in Canadian Criminal Law and the Non-Disclosure of HIV-positive status prepared by the Canadian HIV/AIDS Legal Network [36]. The biggest legal problem appears to have been the establishment of the deliberateness, *'mens rea'*, of the act under the criminal code.

- Sections 19 and 26 of the Barbados Offences Against the Person Act [33] could be used to prosecute persons who in Section 19 *'endanger life and safety'* and in section 26 for *'assaults another occasioning harm'*. It is recommended elsewhere [see Public Health Actions in HIV/AIDS Control] that a court action in relation to reckless transmission or other STD's, committed outside the parameters of the Sexual Offences Act [32], should be initiated by the public health practitioners rather than the police. Public health officials would be in a position to know what education, counselling and advice was given to the person and be better able to establish *'mens rea'* than would the police. They would also be in a better position to preserve the confidentiality of the other person/s involved.

- There may be occasions where an aggrieved person may wish to bring an action under the criminal code. Therefore, the Offences Against the Person Act [33] may be amended to make it explicit that the deliberate or reckless transmission of a disease which can cause or causes harm, is an offence under the act. This amendment would serve to signal to the public that such transmission is an offence under the act rather that the impression that most persons have that the act relates to injuries only.

Recommendation: an additional section to the Offences Against the Person Act/

' Any person who deliberately or recklessly transmits a disease which causes or can cause serious bodily harm , is guilty of an offence ....'

- In a number of countries it is said that in order to try and rid oneself of a sexually transmitted disease, including HIV, there is a practice of having sex with a virgin, who is usually a child. The extent of such practice in Barbados is not known. However, sexual abuse of children is thought to be commonplace and there is a need for the legislation related to the sexual abuse of children to be strengthened and clear.

- ***Young Persons and Sex.*** Studies have shown that the most likely age for becoming infected with HIV is as a teenager or young adult when the majority of persons start their sexual lives. It is therefore imperative that children learn about safe/r sexual practices before they begin their sexual lives. There is an unfortunate myth that educating children about sex would make them wish to engage in sexual acts prematurely. In fact all studies have shown that this does not occur and in many cases the onset of sexual activity is delayed, whilst those who are already sexually active learn safer sexual conduct [37]. In spite of these studies there is often resistance by religious leaders and teachers, particularly those in primary school, to the sexual education of children. This leaves children to be 'educated' by other children and by unscrupulous adults.

- It is a paradox that in a society which professes to value education so highly, education about sexual conduct is the only sphere where intelligent well-meaning persons maintain that ignorance will enlighten and protect. Those religious leaders who have the greatest experience among the deprived in our communities recognise without question the early exposure of children in those circumstances to sexual abuse and its consequential effects in adult life, including the increased exposure to HIV infection.

- Many studies have shown that many children start their sexual lives before there are adults, the first such study in Barbados was done in 1989 by Walrond et al [38] and showed that by 16 years of age a third of the children attending secondary schools had started their sexual lives. Other recent studies by Carter among youth [unpublished] have similar findings.

- *Age of Consent.* The finding about 'early' sexual activity is not new and indeed it is reflected in the laws where the age for being able to consent to sexual intercourse varies from country to country. It is as young as 12-years-old in some countries, an age supported by some religions. In the CARICOM countries the age of consent is 16 yrs except in Guyana where the lowest age is 13 years for girls [39]. Some countries have older ages of consent for males and in particular for male homosexual acts similar to the law in Britain before its recent amendment.

- In some instances it is thought that, in spite of legal strictures, girls in particular are encouraged to engage in sexual intercourse as a means of supporting themselves and the home. In addition, boys are initiated into sexual intercourse by some adults, both male and female. This places both girls and boys at increased risk for HIV and may be combatted by removing any impediments to

the education of children about their future sexual lives. Any ambiguities that there may be in the laws related to sexual conduct involving children should be removed.

- It is often said that the barrier to effective sexual education of children in schools rests with the parents who would not want their children exposed in such material. Whilst it is true that some parents would hold that view, many are uncomfortable with doing the task themselves and would prefer a responsible teacher to do so. Unfortunately, making teachers comfortable with sexual education of children goes beyond the provision of curriculum time and materials for it challenges the inhibitions and religious proscriptions of many and are not easily subject to legislative initiatives. However, providing clearer laws related to childhood sexual abuse may encourage adults to reexamine their role in the prevention of such abuse.

- *Children as Sexual Offenders.* In the Sexual Offences Act in Barbados [32], there are ambiguities related to children which need to be examined,

  Part 1. 3 [3] states *'a person under the age of 14 is deemed incapable of committing the offence of rape'*.

- This may relate to another time when it was thought that a child age 14 or younger did not know right from wrong and therefore were incapable of committing such offences. This can hardly be sustained today and the law appears to put other children, in particular, at risk without any clear redress in relation to a possible forcible sexual assault by a child 14-years-old or less.

Recommendation: Section 3[3] of the Sexual Offences Act should be repealed and replaced by sentencing guidelines for sexual offences committed by persons under the age of 14 years.

- *Children as Spouses.* Section 4 of the act states. *'Where a person has sexual intercourse with another who is not the other's spouse and who is under the age of 14, that person is guilty of an offence'.*

  This section allows the exploitation of children under the age of 14 on the grounds of marriage, it also leaves open to doubt what is legally possible as regards sexual intercourse with a child 14yrs and older. This ambiguity is repeated in section 7[3] where in dealing with sexual intercourse with a minor by a guardian it is stated that 'An adult shall not be guilty of an offence under this section if the minor is a spouse'.

- Allowing children to be married at such a young age interferes with the child's development, particularly that of girls, who are the main target of such laws. It also sets a double standard in the

community where one household can claim to have a child as a spouse, whilst the other may be in violation of the law.

Recommendation: Section 4[1]. the words 'who is not the other's spouse and' should be removed

- *Guardians and Sexual Offences.* Apart from the spousal age issue, section 7 deals with sexual intercourse with a minor by persons in the position of guardians in which the child is in the adult's custody. This section should be extended to protect children from all those who may be in authority over them or in temporary guardianship such as teachers, priests, health care workers, camp leaders, etc.

Recommendation: Section 7[1] should be amended to read

'An adult who has sexual intercourse with a minor

[a] who is the adult's adopted child, step-child, foster child, ward or dependant in the adult's custody or

[b] who is under the adult's authority or temporary guardianship is guilty of an offence'

Section 7[3] which states 'An adult shall not be guilty of an offence under this section if the minor is a spouse' should be repealed.

Any similar stipulation as to the age of a child under 16 years in the Marriage Act should also be repealed with provision for a grandfather clause to accommodate existing marriages to minors.

- Section 17[1] deals with permitting the defilement of a minor under 16 years of age and should be extended to include the willing exploitation of children for direct or indirect financial support.

Recommendation: Section 17[1] should be extended to include parents and guardians.

'A person who

[a] being an owner, occupier or manager of premises; or

[b] having control of premises or assisting in the management or control of premises, or

'[c] being a parent or guardian and for direct or indirect financial gain

induces or knowingly suffers a minor under the age of 16 years to resort to or to be in or upon the premises for the purpose of having sexual intercourse with an adult is guilty of an offence, and ....'

- It is well recognized that children who are sexually abused often have dysfunctional sexual lives and may become promiscuous or enter prostitution. Both of these states place them at high risk for HIV infection. Furthermore, many children from deprived areas are exposed to sexual conduct in their crowded homes, and sometimes these homes are used for the purposes of prostitution.

- ***Prostitution*** is a high risk occupation for HIV transmission and like homosexual acts has persisted, even thrived, despite laws against it and in spite of occasional attempts at enforcing the law. Like buggery, suggestions to decriminalise prostitution evoke very adverse societal responses particularly from the religious community. Nevertheless, there is a need to reduce the risks of transmission in this sector and there is little doubt that its 'criminal' nature inhibits, although not nullify, actions that can control the spread of HIV in and through this sector.

- It is reported that in those countries in Europe where prostitution is legal that the rates of HIV and crimes related to prostitution are markedly less than in those countries where it is illegal [40]. Netherlands is well known for its red light district in Amsterdam, prostitution is legal only in brothels and the HIV prevalence in the country is one of the lowest in Europe; in the UK prostitution is only legal for individuals. In the United States where prostitution is generally illegal, there is an example within the state of Nevada where regulation of prostitutes under the law has enabled authorities to introduce public health measures which have reduced the prevalence of HIV infection in this sector to near zero.

- Many organisations have discussed this as an issue, for example in Jamaica the recommendations to the HIV prevention and control programme from their legal consultants include *'Legislation to give formal recognition to this group so that the public health response can be enhanced'*. [41] This tentative proposal reflects the fact that there is no easy solution to this problem. For example, The HIV prevalence in Senegal in West Africa is low and prostitution is regulated, however, the causal relationship is disputed since it is largely a Muslim country [42].

- For any change to be effective it would be necessary to bring prostitutes under the Public Health Regulations of the Health Services Act [43], and will of necessity also require changes in the criminal law in the Sexual Offences Act Sections 18-20 [32]. One could through a change in the law try to bring prostitutes into an institutional framework, whilst attempting to keep them off the street. This would involve the repealing or amending laws such as that related to suppression of brothels Section 18 of the Sexual Offences Act. Laws that try to keep prostitutes off the streets

would be retained with a suitable rewording of Sections 19-20 of the Act.

- To be effective this and other businesses which offer personal services, which could involve sexual services, would be required to register under the Health Services Act and to abide by amended Communicable Disease Regulations 12, and the Third Schedule [44], or under new regulations such as Personal and Sexual Services.

Recommendation: Section 18 of the Sexual Offences Act [32] should be renamed Regulation of Brothels and read:

'A person who
(a) keeps or manages or acts or assists in the management of a brothel; or
(b-c),
who fails to register and comply under the Public Health Regulations [Communicable Diseases or a new Sexual and other Personal Services],
is guilty of an offence and is liable on summary conviction to .....'

Amend Section 20, dealing with persons aiding prostitution, by inserting

A person who is not registered under section 18 and who for the purposes of gain exercises control, direction or influence over the movements of a prostitute etc... is guilty of and offence etc.....`

- There are many in the community who will look on the proposal above as pandering to and encouraging criminal behaviour in the community and point to other areas of concern where HIV-infected persons are thought to be acting in a criminal manner. In particular there is concern about the deliberate transmission of HIV to others and the need by health officials to warn the community about such persons. Improvement in the public health cannot be brought about by coercion alone and in matters of private conduct, such as sexual conduct, the cooperation of affected persons must be elicited through the public health system.

Public Health Actions in HIV/AIDS Prevention and Control

- ***Reckless Transmission of HIV***. The approach through the criminal law in dealing with accusations of deliberate or reckless transmission of HIV has already been dealt with under the section on sexual conduct. Recommendations have been made to make the deliberate transmission of HIV or other disease an aggravated offence under the Sexual Offences Act [32] and to amend the Offences Against the Persons Act [32] to make it explicit that the transmission of disease stands on a par with inflicting an injury on a person.

- The approach through the criminal law is flawed by the fact that actions are taken after the event, and the establishment of *mens rea* is often difficult to prove [9]. Furthermore, complainants have to explain their own compliance in engaging in unprotected sexual acts with someone without satisfying themselves as to whether they are infected with HIV or other sexually transmitted disease. This issue of consent has had varied judicial interpretation when used as a defence by the accused. In addition bringing such actions may shatter the confidentiality of the complainant themselves and actions are often delayed until more than one person is affected.

- It has been proposed in some jurisdictions, as has been done in Tasmania, that the onus should be placed on the HIV-infected person to inform their sexual partner about their status and if they do not they are guilty of an offence, HIV Preventive Measures Act [Section 20] [5]. This approach seeks to take the issue of consent out of the defence. However, it does not solve the problem for it assumes that the HIV-infected person has skills of negotiation and persuasion that many professionals in the field of negotiation have never mastered. They are also being called upon to act honestly, responsibly and with rationality when they may be embroiled in a complex of emotions, which require expert professional help in terms of counselling and possibly psychiatric care. In the absence of such care and the threat of criminal prosecution it tends to drive people away from finding out about their status, for one cannot be reasonably blamed in law for what one did not know.

- There is therefore a need to find an approach that is more likely to be preventive rather than punitive; an approach that gives encouragement to finding out one's HIV status and one that assists in the complex of emotions that accompany the discovery of this condition. As with prostitution the public health approach offers a better opportunity of preventing the further spread of the disease and it has the residual powers to deal with those persons who do not comply with public health actions. This approach is one of voluntary testing and counselling, cooperative and confidential sexual contact tracing, and continuing access to both psychological and medical care .

Recommendation: The Communicable Disease Regulations [44] in the Health Services Act [43] be amended to give public health officials the authority to bring before the court patients who recklessly endanger others to the spread of HIV or other serious disease, in a process which safeguards the confidentiality of others involved.

Where a registered medical practitioner or public health official determines that a person is deliberately or recklessly endangering others by committing acts that could transmit a disease, they should:

[a] report the matter to the CMO or other designated public health officer

[b]. the CMO or other designated public health officer after further investigation and/or action may bring the matter before a judge of the high court.

[c] the judge having conducted a hearing in chambers may issue an injunction to desist from the conduct at issue and/or impose sanctions which vary from community service to restriction for a period not exceeding a year in a place and manner designated by the court.

- if this mechanism fails, and there is reason to believe that the conduct continues, consideration should be given to initiating a criminal prosecution with all its attendant difficulties regarding confidentiality of those involved and the possible loss of confidence in the health professionals' reputation for confidentiality.

- There are other situations where current law inhibits a preventive or an early response by public health action and this is particularly evident in the management of minors in situation of sensitivity such as HIV-infection..

- ***Minors and Consent***. There are areas of the law related to minors which should be addressed and in particular those that inhibit an effective response to minors in the health care sector. These health problems are often related to sexually active youth. For example, a young person of 16 can in law consent to sexual intercourse but cannot consent to dealing with the possible consequences of intercourse such as HIV, other sexually transmitted diseases or pregnancy without the consent of their parents or guardian.

- There is an exception to this in the Termination of Pregnancy Act [45] and in the judicial concept of the liberated minor arising out of Gillick vs West Norfolk Health Authority in 1985 [46]. In the Termination of Pregnancy Act provision is made for a 16-year-old to consent to a termination of pregnancy within the first 12 weeks of the pregnancy. In the Gillick decision health authorities were given the authority to treat certain minors without the consent of, and indeed over the objections of the parents.

- However, there are many health care workers who, in spite of knowing of the provision in the law, will insist against the wishes of a 'minor' that they will not be able to access the health care system without the knowledge of their parents. This inhibits such young persons from accessing available services in a timely manner. In the UK The Family Law Reform Act 1969 [47] provides for `minors between the ages of 16 and 18 to consent to medical interventions without the consent of their

parents.

Recommendation: A law should be put in place that allows young persons 16 years and older to be able to consent to medical care without the consent of their parents and guardians. The law should also codify the circumstances under which a young person under the age of 16 may access *medical care without the consent of their parents or guardians.*

- *A person 16 years and older is able to consent to medical care without the consent of their parents or guardian.*

- *A minor between the age of 12 to 16 years may access advice and medical care, particularly for the treatment of a sexually transmitted disease or sexual related condition, without the consent of their parents or guardian providing that the medical practitioner or other legally responsible health care practitioner is satisfied that:*

  - *the minor fully understands the nature of the condition and is seeking treatment without the consent of the parents or guardian.*
  - *that the parent or guardian is unavailable or has shown insufficient interest and/or attention to the child's illness*
  - *after counselling the minor about involving the parent/s or guardian, that the minor will not accept treatment and is likely to default from care if the parent/s or guardian is made aware of their condition, and*
  - *that it is in the best interests of the minor to be treated without the consent of the parent/s or guardian.*

- These provisions are particularly important in providing HIV diagnostic testing for minors who may not wish their parents to know that they are seeking such testing. The dilemma of the minor and the reluctance to being tested is mirrored in adults by the current atmosphere of stigma and in particular concerns about the confidentiality of the results of their test.

- ***Testing for HIV***. In spite of all assertions to the contrary persons infected with HIV, if effectively counselled, are more likely to be protective of others in the spread of HIV than those who do not know their HIV status. However, it is natural that in facing a hostile world that those who do not know their status may decide that it is too disadvantageous to find out if they are infected with HIV and those who know their infected status to decide to hide it from others; this may include not changing their behaviour patterns in case that makes them come under suspicion of having HIV.

- Whilst the latter concern is a grave one, those who are not yet diagnosed is of even greater import since most of the HIV infected persons in the community, are well and unaware of their infection. Since it is estimated that 1.5-2% of our population are infected with HIV and some 1400 persons are diagnosed and alive in the community, it means that 2,500-3,500 persons have HIV in the community and are not aware of it [48]. These persons are therefore likely to be spreading the virus oblivious to the matter. It is therefore of the greatest importance that testing be offered in a framework that will alleviate the concerns of those who have not been tested.

- Many feel that forcing people to be tested is the answer and point out that finding out who is affected is a pillar of public health action, and so it is. However, public health authorities have themselves warned against this measure, pointing out that voluntary testing is more likely to induce compliance with the actions that have to be taken subsequently. It can also be pointed out that HIV is unlike other epidemics and will not run its course because of a build up of immunity in the community. Therefore, issues like quarantine become an impractical matter in the face of no curative treatment. The economics of testing everyone, what periodicity it must be repeated at, and the sheer suicidal intent of testing visitors to the island is just another dimension of that oft suggested course. If the current estimate that 1.5-2% of the population in Barbados has HIV infection is accurate [48], it would mean the detection and quarantining of some 4-5,000 persons and the continued testing of the population. The attendant cost of such measures would be compounded by removing 5% of able bodied persons from the work force and would logically call for testing visitors to the island. The economic ruin of trying to guard our borders from visitors and ourselves when we travel needs no elaboration.

- Nevertheless, because of the nature of HIV, its life long infection and infectivity, it is important to find out as many persons as possible in the community who are infected and to provide them with counselling services, available medical care and to trace their sexual contacts in order to arrest the cycle of transmission. Given the state of stigma and discrimination there is no simple tool of regulation that will accomplish this task. Therefore, voluntary testing and confidential reporting, rather than providing a public notification list, is considered by most health authorities as the most efficacious method of encouraging testing and being able to know who is infected.

- Many persons allude to the Cuban experience and point out that the Cuban authorities tested their population and quarantined all those found to be positive. They also point out that Cuba reports the lowest rate of HIV infection in the Western Hemisphere. What is not well known is that Cuba has abandoned this course which cannot be sustained economically [49]. It also loses all sense of

rationale with the more open doors that they are being encouraged to promote Cuba's tourism industry

- . In fact the Cuban epidemic although estimated as having the lowest prevalence in the Caribbean [0.05% of the population], is also described as being the fastest growing in the Caribbean [48].

- *Laboratories.* The legislative changes that can make the testing for HIV more effective involve some direct measures and some that relate to many other spheres. Barbados is a small community and the localisation of testing to approved laboratories under public health regulations, would ensure that quality assurance can be monitored thus reducing the possibilities of false negatives or positives in test results.

- Approved laboratories would have a statutory obligation of confidential reporting to public health officials as well as to the doctor requesting the test. In the case of a positive test occurring in persons who have donated blood, the medical director of the blood donor service is considered the doctor requesting the test. The person being tested should be informed of the result, whether positive or negative, with all precautions as regards confidentiality and the provision of appropriate counselling by the doctor ordering the test or by another designated health professional.

Recommendation: The Health Services Pathological Laboratories Regulations 1976 [50] be amended to determine what tests can be done in the granting or renewal of the licence. It would require the results of certain communicable disorders [which would include HIV] to be reported under confidential cover to the CMO [or other designated medical officer]; such reporting to include the name and address of the requesting doctor as well as the available details of the patient tested.
The CMO or designated public health medical officer/s will be responsible for obtaining further information about the patient from the requesting doctor, and ensuring that the requirements for further counselling and contact tracing are in place or made available.

The results of any tests shall not be divulged to any other parties or professionals without the specific consent of the person tested, particularly in the case of communicable disorders such as HIV. Such consent is not required where the medical director of the laboratory in good faith determines that the result is required as an essential part of an emergency medical service carried out in the best interest of the person tested.

- *Pre-and post-test counselling*. Counselling is a most important measure in HIV management. Although it is accepted in principle, the practice is often observed in the breach. Counselling is

recognised as good professional management for a variety of medical conditions, however, it is not listed as a part of professional conduct, neither are counsellors recognised as a specific health professional discipline.

- Even if as recommended below counselling is recognised as part of professional conduct and counsellors brought under the aegis of the health professionals councils, regulations for professional conduct are not easily enforced under current regulations. Breaches of professional conduct under the health professions' acts can only be dealt with by censure, suspension or removal from the register. Censure appears to be an ineffective measure and councils appear reluctant to order suspension or erasure from the register for breaches of professional conduct.

Recommendation: Counselling as a part of professional conduct should be included in the regulations of the health professions acts and others who may be involved in counselling .

All persons who are not registered medical practitioners, nurses or para-professionals and who engage in counselling of patients for medical conditions must register under the Paramedical Professions Act [51].

The medical and other health professional council regulations should be modified to provide for a broader range of sanctions than currently exists for breaches of professional conduct; specifically fines should be introduced.

- *Consent for testing*. The question of *voluntary or mandatory testing* speaks to the issue of consent. The right to consent to whatever is done to our bodies is a fundamental right given to us under the constitution and in the conventions on human rights that our government is signatory to. There is a view that such rights should not be accorded to persons outside the main stream of society, such as prisoners and others accused of crimes such as rape. However, any abrogation of a right must not be capricious and must be seen unequivocally to be in the best interest of the society.

- *Mandatory testing* is typified by the call for persons accused of rape to be forcibly tested for HIV. It expresses outrage at the act of rape but destroys the presumption of innocence of the accused and is totally irrelevant to how the victim of the attack should be treated, for to abort a possible infection antiviral treatment should be started right away. This is particularly important since it is unlikely that the perpetrator of a rape would be available immediately for testing. However, for the

purposes of continuing or stopping prophylactic treatment it is necessary to establish whether the victim was infected before the attack, or to obtain testing of the two parties within the time framework for a build up of the antibodies used to test for the virus.

- Such testing for the purposes of prophylactic treatment may also be required in cases of accidental exposure, particularly in the health care setting, where occupational exposure to HIV is well documented [52]. It is reported in the United States that over 24,000 persons employed in health care are infected with HIV [53]. Over 50 of these workers have proven occupational transmission of the virus in accidental exposures to a patient's blood such as by hollow needle stick injuries, explosive breakage of a container or exposure of injured hands to blood or other body fluid.

- These exposed health care workers would have been offered prophylactic treatment and would have been subjected to testing of their status, and if the patient involved is known such testing should also occur. If the patient whose blood was involved in the exposure is identified they should also be tested. The patient should consent to such testing and if there is an objection obtaining a court order should be entertained. Under such circumstances patients should be accorded all the facilities related to counselling that are required.

- As regards trial and sentencing where there are accusations of deliberate or reckless transmission of HIV or other disease, the status of and knowledge of the disease status at the time of the incident is the important matter. This can only be determined from medical records rather than by testing ordered after the event.

Recommendations: In accusations of rape or where it is alleged that there was a deliberate intent to or recklessly transmit HIV or other disease, the person who is the victim of the alleged assault should submit to relevant tests as soon as the complaint is made for the purposes of prophylactic therapy.

In the case of an alleged transmission of HIV, the court may within 3 months of the incident order that both parties be tested; the results of the tests to be kept confidential by the court except for the public health officer responsible for the prophylactic treatment being carried out.

In cases of accidental exposure where a party is known to be involved and is refusing to be tested, the

other party may request the court to order such testing.

The results of testing obtained by a court order cannot be used in any court proceeding, either at trial or sentencing.

If there is an allegation that a person knowingly tried to transmit HIV or other disease then the court may subpoena the medical records of the accused person to determine whether the person knew of their infected status before the offence was committed.

In allegations of rape, subpoenaed records should not be used at trial but may be used in the sentencing phase of the convicted person.

In civil proceedings alleging reckless or deliberate transmission of HIV or other disease, the burden of proof rests with the accuser. However, the court may be petitioned to order such tests and/or subpoena medical records providing the judge has been convinced in a hearing in camera that a sufficient case has been made, and that the accuser is not capricious in their accusation.

The results of such tests or relevant parts of the medical records must be kept confidential by the court and not be revealed except by order of the court.

- the provisions above are intended to preserve the confidentiality of accused persons under the presumption of innocence and preservation of the rule of law, rather than trial by innuendo or assumption of guilt because of one's HIV status.

- There are other concerns about confidentiality that should be addressed to prevent abuses that some affected persons see as commonplace.

HIV/AIDS and Confidentiality

- ***Confidentiality of HIV Status.*** Confidentiality is the bedrock of professional relationships in medicine, law and the priesthood. It is rooted in the laws governing health care professionals and attorneys and there is a constitutional right to privacy. The right to confidentiality can be taken away by the courts if it is abused and in particular if such a right is misused to put others in mortal danger. This was established in the landmark Tarasoff case which arose out of a psychiatric case [54]. This principle of warning a third party at risk has been applied to cases involving the transmission of infection [55] but the judicial interpretation in such circumstances has varied with some judges relying on the absolute privacy of the patient and the confidentiality of medical information. The issue of confidentiality arises in many aspects in relation to HIV positive patients and in particular the question of who has the right to know their HIV status.

- Apart from their principal medical care professionals and designated public health officers, those who should have the right to know would be those in danger of deliberate or reckless transmission of the virus by the HIV positive person. In practice the latter only applies to active sexual partners and this cannot always be assumed to be the spouse. In this regard there is a delicate balance that has to be maintained between confidentiality and the protection of sexual partners. Furthermore, there is evidence that coerced notification of a patient's HIV status leads to greater problems in HIV control as well as increasing the probability of domestic violence [56].

- Because of the lifelong nature of HIV infection, there is also the issue of former sexual partners and how far back one should attempt to trace such partners. If former partners are infected it is important that they do not themselves inadvertently spread their HIV infection further. The balance for effective prevention and control will depend on the expertise of the counsellor and the bond of trust forged between the patient and the health care professionals, for only the affected person can really reveal who their sexual partners are and were.

- Persons diagnosed as having HIV infection can have real difficulties in being able to inform their sexual partners and may require the confidential help of health professionals in doing so. Many fear rejection and violent reactions and often delay unduly in informing their sexual partners. Furthermore, patients are not skilled in counselling, and putting the burden on them to inform their partners is not only difficult for them but potentially dangerous to the well-being of those being told. It is therefore vital that sexual partners be informed in a confidential health care setting with the aid of skilled counsellors. Nevertheless, in spite of the offer of such help, there are situations where

the HIV-infected patient has continued to put their sexual partners at risk by engaging in unprotected sexual intercourse.

- *Duty to Warn.* If risk behaviour, particularly unprotected sexual intercourse with an unsuspecting partner, does come to the attention of the health care worker there is a duty by the health care worker to warn the 'third party at risk'. In such circumstances the health care worker/counsellor can only defend themselves from civil action for breaking the patient's confidentiality by showing that the patient was knowingly and actively endangering the 'third party' without that person's knowledge and therefore consent. This situation raises real difficulties in proof and court judgements in such cases have varied.

- There is also an issue related to fathers. Health care workers have not been inclined to consider the father involved in the pregnancy of an HIV-infected woman as a 'third party at risk' and fathers are kept in the dark under the mantra of protecting the confidentiality of the woman who is pregnant. Such a stance may well have some rationale in that it may not be viewed as an appropriate time to inform the father for fear of withdrawal of economic support for the mother. However, the rights issue takes on a different dimension in relation to the parental right of the father to know about the condition of his child. It is therefore imperative that this issue be faced squarely with the availability of expert counselling for the father in such situations.

- Confidentiality is of paramount importance in being able to protect the right of individuals who are tested and there are a number of complaints about such breaches in testing for insurance purposes, and for immigration to the USA. These situations have an additional dimension in that clients have had information sent forward to insurance agencies and to US immigration authorities without their knowing what that information is.

- HIV-infected persons who attend for care see their confidentiality compromised in a number of different ways, from the provision of specially known clinics, to their isolation in wards or special parts of wards, to the whisperings or euphemisms used about their condition, to the special marking of records. There is even the provision of a large board in the Accident and Emergency Department at the QEH which gives details of the condition of patients and their location within the department and which can be read by lay visitors to the department. HIV positive persons who have visited the department feel compromised even in the absence of specifically stating that they are HIV positive.

- Many persons in the community for fear that their HIV status will not be kept confidential are reluctant to be tested or to notify their sexual partners or relatives. It is therefore necessary to provide legislative initiatives that will increase the confidence of the public and promote a greater response to voluntary testing.

Recommendations: It is recommended that under the Health Services Communicable Diseases Regulations [44], the conditions under which confidentiality can be broken, in disease tracing, be codified. These are:

- *The infected person has been tested, counselled, knows the result of the test, and how the disease is transmitted or can cause harm*
- *The counsellor has made all efforts to have the person inform those who are at risk or have been at risk for transmission of the disease, and has offered assistance in doing so, through confidential means.*
- *The counsellor is convinced that a specific third party or parties are being put at risk for transmission of the disease, and has so informed the CMO [or designated public health medical officer/s] and has been instructed by that officer to break confidentiality to the specific third party/ies.*

Where public health officials determine that a person is deliberately endangering others, they may with the permission of the CMO or the designated public health medical officer [rather than the police] bring the matter before the court. The court in a hearing in camera may impose sanctions which may vary from community service to restrictions in a manner and place designated by the court.

It is recommended that confidentiality be included in the regulations or contracts of all relevant health workers/ counsellors and that provisions for fines be included in such regulations.

Medical professional regulations should be amended to make it a breach of professional conduct to transmit any information on a patient without their consent, noting that the signing of a blank or partially blank form does not constitute informed consent.

- it is important to prevent the courts from being used to pry into the privacy and confidentiality of others by the use of false or capricious accusations. Thus previous recommendations have been made about the subpoenaing of records after a hearing in court in the section dealing with consent to testing and mandatory testing.

- ***Confidentiality of Medical Records.*** Medical records and the maintenance of confidentiality is an important issue particularly in institutions. In order to maintain confidentiality, information related to the HIV status of a patient is often omitted from the records. This can lead to defects in patient care, although on balance the omissions are thought to be in the patient's best interests in the present social atmosphere of stigma and discrimination.

- One of the earliest cases to be adjudicated in relation to the HIV/AIDS epidemic was related to the confidentiality of medical records. In *X v Y and others in 1988 in the UK* [57], the judge ruled that there was no public interest to be served by publishing the names of an HIV-infected doctor, since there was no known case where infection had been transmitted from a health care worker and the doctor was entitled to confidentiality and privacy like anyone else. The subsequent reporting of possible transmission of HIV from a dentist to patients [58] is balanced by many investigations where no evidence of transmission has been found from HIV-infected health care workers to patients [52] .

- Recently it was reported that in the Bahamas the database of patients was broken into and the names of HIV-infected persons published [oral communication]. There is therefore a need to reinforce the principle of confidentiality of records and to put in place legislation that would preserve confidentiality, but allow for the ability to transfer information to be used in the best interests of the patient or for the research necessary in the control and prevention of HIV and other health conditions.

- Medical records are being stored more and more in electronic format and national identification numbers are being used in Barbados as identifiers without adequate security of the databases. Indeed, there are some records and request forms which only carry a national identification number. This is a most obvious point of weakness in the records' system and should be remedied forthwith. There are recent examples of medical records protection acts that have been enacted in both the UK and the US [59,60].

Recommendation: A medical records act should be enacted which would ensure the confidentiality of medical records, except for patient care and research purposes.

National Identification numbers should not be attached to databases which store medical records.

A research review board should be constituted in a Medical Records Act or as an amendment to the Health Services Act.

- there are other issues related to testing for HIV such as for immigration purposes where issues of confidentiality have also been raised.

HIV testing for Immigration Purposes

- The question of guarding one's border's is one that is very evocative. In the United States AIDS was added to the Public Health Service list of dangerous and contagious diseases to be excluded from entry into the US in 1988 [61]. It is not well known that there has not been an International AIDS Conference held in the USA since 1990 because such regulations mean that HIV infected persons, who are an integral part of such conferences, could be turned away. This was done for the conference in 1990 and resulted in several organisations boycotting the conference. In practice the United States only applies this regulation now to intending permanent residents and a number of other countries in the CARICOM have adopted similar laws/regulations namely, Belize, Montserrat, St. Kitts, St Vincent and Turks and Caicos.

- In Canada the prohibition is less overt for they have included exclusionary clauses in the Immigration Act that would prohibit those persons who might be *'cause excessive demand on health or social services' [62].* Migrant farm workers to the USA and more recently to Canada are required to be tested for HIV, the rationale for which is not obviously apparent.

- The Immigration department in Barbados has proposed that the Canadian position on permanent residents be adopted i.e that an HIV-infected person could become an excessive charge on the health services. The suggestion is that the First Schedule of the Immigration Act [63] which deals with prohibited persons should be used to include HIV as one of the communicable diseases designated within the Health Services Communicable Diseases Regulations [44]. Adopting this policy would set up an additional barrier to the proposed free movement of Caribbean Nationals. It also raises questions as to how persons who have diabetes or hypertension or family histories of these and other diseases should be treated, for such diseases may involve high lifetime expenditures in the health sector comparable with those currently expended in the treatment of HIV/AIDS.

- There have also been suggestions raised in the media that there may be a need to do selective screening of persons from high risk/prevalence areas for HIV. This would be in contravention of section 23[2] of the Constitution [18] which provides protection from *'different treatment of different persons attributably wholly or mainly to their respective descriptions by race, place of origin, political opinions, colour or creed.....'*

- In spite of these constitutional provisions, nationalism is a profound force and where other issues coalesce it is often difficult for rationality to be maintained. It can also be expected that the media

may exploit these situations to get across a point of nationalism and in the case of Barbados the provision of expensive anti-retro-viral drugs is seen as a reason for demanding that only Barbadians be treated. However, only nationals and permanent residents are entitled to access the services provided by government without payment at source.

- If expenditures in the health sector are likely to be a drain on national resources for migrants, then it may be better to handle this matter in a different way.

Recommendation: It should be explicit in the Health Service Regulations that on accessing government financed services, only citizens and permanent residents of 5 yrs duration or more are entitled to those services without the payment of fees.

- guarding one's boundaries at the workplace is another area where HIV screening is requested, particularly by those in the uniformed services.

Screening for or in Employment

- Apart from 'sex workers' there is no occupation where it is known that there is a definitive risk of transmission on the job. At the United Nations Special Session on HIV/AIDS, Heads of Government in addressing the dimension of Human Rights agreed to

  '*enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure access to, inter alia education, inheritance, employment, health care ..... while respecting their privacy and confidentiality'* [4].

- This reiterates Article 23 of the Universal Declaration of Human Rights [64] and statements by the World Health Organisation and the International Labour Organisation that screening for jobs is unnecessary and discriminatory [65]

- Denial of employment to able-bodied persons places a burden on the entire economy and society. Denial of the right to be employed also abrogates a right enshrined in the constitutions of some countries, such as Guyana [66], and in the International Human Rights conventions [64].

- It is known that with the availability of anti-retro-viral treatment HIV can now be viewed as a

chronic disease where persons have remained well and able to work for the 15 years that such treatment has been available. Denial of such persons of the right to work can inevitably lead to despair and the contemplation of acts that are not in the best interest of the society which is viewed by those affected as oppressive and uncaring.

- In spite of these known facts and the advice tendered by WHO and the ILO, screening for employment has been selectively employed in some countries. For example, the US armed forces insist on pre-employment screening but do not discharge those who are in the service and are HIV infected [67]. In Barbados, in spite of the stated policy of government, the police force has insisted on pre employment HIV screening of its recruits and it is believed that the defence force intends to do so if it is not already doing so. In Canada, farm labour recruits are being screened for HIV and in Britain the Department of Health has just ruled that all new entrants into invasive [surgical] disciplines will be screened for HIV [68]; entrants into other disciplines will not be screened, neither will those already in the surgical disciplines. Each of these policies has been imposed without any clear evidence of transmission by persons in these occupations.

- There have also been situations where pre-employment screening has been utilised to satisfy enrollment into health insurance schemes which are part of the conditions of employment. However, the advice of the International Community has been followed by a number of less developed countries who have enacted specific statutes making it illegal to screen for HIV during employment or as a condition for employment. These include the Bahamas [13], South Africa [14], Zimbabwe [15] Namibia [17], and the Phillippines [6].

- *Health Care Workers.* Suggestions for screening of workers in the health care setting have important implications for the management of HIV-infected persons and other patients in the emergency setting. Screening of 22,000 patients who had been treated with invasive procedures by HIV-positive health care workers has shown no evidence of transmission of HIV [69]. If against all the scientific evidence of the lack of or rarity of transmission from health care workers to patients, it is insisted upon the health care workers be HIV free, then it is logical that health care workers will demand that patients be HIV free before engaging in invasive procedures. It is also likely that they would proceed with greater caution in emergency settings involving bleeding or the use of resuscitative procedures.

- Although this would appear to be contrary to a duty to care of health professionals, such apparently irrational regulations put a burden on the health care worker who is at greater risk for being infected by an HIV patient [52]. This is particularly important in the treatment of emergencies when there is a lot of blood about and rapid invasive procedures have to be done. One could ask

a reasonable health care worker why should they risk infection and the loss of their job, when it has been a requirement that they be HIV free to be in the job.

- *Transmission in Health Care Settings.* Contrary to the implications of what has been recently ordered by the department of Health in the UK, it is the health care worker who is at risk for transmission of HIV in the workplace for such transmission is usually by hollow needle stick injuries or other accidents in the laboratory. Contractual arrangements should be made to provide care and compensation to health workers who through no fault of their own contract HIV or other disease in the workplace.

- There is one instance where it is reported [Annals of Internal Medicine 1992] [43] that there was transmission from a dentist to 5 out of 8 patients with AIDS in the dentist's practice; the presumption of transmission from the dentist is entirely based on comparing patterns of HIV DNA sequencing similarities, for investigators could not identify any *' Breaches in infection control and other dental office practices to explain these transmissions'.* Investigations of many other HIV infected surgeons and dentists have found no other alleged instance of transmission among thousands of patients treated and the possible mechanism of transfer of HIV from the Florida dentist to patients remains conjectural [Centers for Disease control 1991] [44].
- The implication for the health care system of accepting that there is a risk of transfer of HIV in spite of the use of universal precautions would be the vulnerability of the health care worker themselves who could refuse to do any procedure including those required in emergencies on HIV-infected patients. Nevertheless, it is recommended that health care workers should undergo voluntary HIV screening and if infected withdraw from performing 'invasive' procedures where there is a risk of injury to the health care worker.

- In Barbados the Employment Rights Act 2001 in section 24[v] [13] makes a case of unfair dismissal on the ground of HIV infection or AIDS. There is no clause related to refusing to employ on such grounds. This was dealt with in the section dealing with Discrimination above.

Recommendation: The law should prohibit screening for HIV in all aspects of employment and conditions of employment unless determined under the Health Services Act Regulations.

Employers, particularly those in health, should be required to provide training and to provide adequate facilities for the prevention and treatment of accidental risks in the workplace.

The provision of such education and facilities may be used as a defence/mitigation in any action brought against the employer.

HIV Transmission in Criminal settings

- In previous sections proposals were made to deal with situations currently considered 'criminal' under the law. It was pointed out that the stigma attached to male homosexuals is crucial in inhibiting preventive efforts among males and is reinforced by the blanket designation of anal sex/'buggery' as an illegal act. Similarly, the actions that could be implemented to prevent the spread of HIV and other STD's through prostitution are inhibited by the structure of criminality that attends the most ancient and durable of the 'professions'. Although not a current problem in Barbados, the spread of HIV by intravenous drug abusers sharing syringes and needles is facilitated by the 'underground' criminal nature of the activity.

- *Needle Exchange for IVD users.* The efficacy of reducing HIV transmission among prostitutes by placing them under public health regulations has been shown [40], as well as the opportunity to diminish some of the worse demonstrated effects of prostitution such as violence and entrapment for a lifetime [42]. There is also a growing recognition that effective interventions should not be denied to other persons because they are involved or thought to be involved in criminal behaviour [70]. Thus IV drug abusers have been given clean needles in exchange for used ones and the opportunity of the contact taken to provide other interventions to try and change their behaviour. The success of such programs is documented in studies done for the CDC and by the Department of Human and Health Services in the US [71,72].In some countries, authorities have simply been asked to look the other way, whilst in others like Tasmania, the HIV Preventive Measures Act has designated specific needle exchange officers [5]. Such interventions have been extended to persons who are in prison in clear recognition that the prison authorities have been unable to stop inmates engaging in undesirable activities which are at high risk for the spread of HIV [73].
- *Sexual Activity in Prisons*. Most prisons are overcrowded and inmates are incarcerated in cells designed for one inmate but accommodating two or more, Barbados is no different in this regard. There is widespread acknowledgement that sexual activity goes on in prisons in both overcrowded cells and in areas such as showers. The sexual activity may be forced or consensual and is primarily by unprotected anal intercourse between men. This a recipe for the spread of HIV from one person to the other in prison, and for spread to the wider community on the inmates release from prison. The spread in the community is not going to be by homosexual activity alone for it is thought that anal sex is often opportunistic among incarcerated males and they will resume heterosexual activities on their release from prison.

- Whilst many prison authorities have refused to acknowledge that unauthorised sexual activity occurs in the prisons under their control, others have proposed alternatives to what they see as a

problem of rape and the spread of disease. The two most commonly discussed actions are conjugal visits and the availability of condoms to prisoners. Conjugal visits are a feature of a number of corrections facilities in the United States and elsewhere and has even been extended in New York City jails to prisoners known to be HIV infected [74,75].

- The availability of condoms to prisoners has evoked a great deal of debate world wide, where it has either been seen as encouraging sexual activity and even rape by making them safe, to the idea of mollycoddling prisoners who should be punished rather than enjoying life. The debate in the UK is a good example of how the law is used to support one side or the other in this debate [76]. When it was mooted that homosexual prisoners should be allowed the use of condoms since sex between consenting adults in private was legal in the UK [23], the authorities responded that the prisons were a public place not a private place.

  However, there was a provision in the law that required prison doctors to treat diseases and prevent their spread within the prison, and this has been used to justify condoms being made available through the doctors attending prisoners. In the United States the practice is allowed in prisons in the states of Vermont and Mississippi and in some cities including New York, Washington and San Francisco [77,78].

- The availability of condoms to prisoners has occasioned much emotional debate, largely centred in Barbados on the contention that this would condone an illegal act, namely buggery. Such debate has changed little since it was first mooted a decade or more ago [20]. Such contention not only ignores an important reality but sustains a situation where the spread of HIV and other STD's among prisoners not only endangers them but the community at large when they are released after serving their sentences. However, there is a responsibility placed on prison authorities under Section 66 of the Prisons Act to stop the spread of any contagion in the prison [79]; and it could be argued that allowing the use of condoms by prisoners falls within the boundaries of the law.

- It has been argued that prisoners would not stop to use a condom during rape and that they would riot at the mere suggestion that they are practising buggery, as apparently happened in Jamaica. This ignores how the riot was precipitated, and that the warders were also involved in the protest after an inflammatory remark was made that implied the need for the warders to take the same measures [oral communication].

- Like needle and syringe exchange, condom availability can be done in a confidential matter and should also be used as a further opportunity for counselling in relation to the transmission of HIV

and other disease.

Recommendations: Condoms should be designated in the correction facilities as toilet articles, and made available through the corrections health care / counselling facilities.

Needle exchange officers should be designated among the public health care workers/counsellors. Any 'evidence' collected from such exchanges cannot be subpoenaed in a court proceeding related to a drug offence.

Conclusion

This report has been approached with a view to finding practical means of limiting the spread of HIV within a framework of preserving the human rights and dignity of those affected. With the pervasive stigma and discrimination that has attended those who are a greatest risk for acquiring HIV, it was thought that the logical starting point was anti-discrimination legislation. It is proposed that such legislation should be broad in scope, covering all aspects of community functions and all of the characteristics of man including sexual orientation. HIV is not specifically mentioned in this proposed legislation, for although it is the focal point of this study it is important that it should not be singled out as a problem that appears to deserve more 'rights' than all of the other problems that beset our society.

A wide range of stakeholders have been consulted, primarily those in policy making positions, religious leaders and those in the health sector dealing with the HIV/AIDS epidemic. It would have provided a more complete picture to have gathered the experiences of our Caribbean partners with the legislative measures they have put in place in relation to the HIV epidemic. However, this was not possible within the time available and in fact there is little that has been done in the region from a legislative point of view in relation to this problem. In addition the general legislative framework in which our neighbours function is similar to our own. Nevertheless, those laws that differ from our own are noted and the approaches in other regions to the problem have been gleaned from the north in Canada to the south in Tasmania as well as the hot spots for HIV in Africa and elsewhere.There could have been a wider consultation in the education, legal and other sectors touched on in the report, but time and other factors did not allow for such consultation which must be engaged if these proposals are to be taken into the wider society.

The recommendations summarised in the executive summary are wide ranging and are aimed at altering the social, legal and professional approaches that are required to limit the spread of HIV, as well as changing the atmosphere in which other societal problems are handled. The approach seeks to find another path that can complement the 'crime and punishment' model used to combat immorality. Thus there is a pluralistic approach emphasising the preservation of the right to health of those who dwell in the dark corners of the society. The approach will at times appear to conflict with religious texts, but the approaches are intended to reach those who have not been reached by the churches and will if successful provide an opportunity for such influences to be brought to bear on their problems. The separation of state law and religion is emphasised, recognising that this is the only way in which the constitutional guarantee of freedom of religion and respect for the International Conventions on Human Rights and the Rights of Children can be a reality.

There are some suggested alterations in the laws related to the sexual abuse of children which may appear to be more severe on parents, guardians and other authority figures. However, the point of view has been taken that the protection and education of our children is the key to altering the society in the directions that every sector consulted desires.

In spite of sharing the values expressed in the desired outcomes, there are many who will find severe fault with the approaches. To some extent this is related to the persistence in the belief that a rod of correction will solve the society's problems. The philosophy underlying this report is that the rod has its place for the most egregious of behaviour and when all professional and persuasive approaches have failed. Therefore the approach is intended to be reasonable and empathetic to the persons affected by HIV, eschewing judgement of their lifestyles and behaviour, for in most instances those persons have had little control over what the wider society finds to be immoral or criminal.

The recommendations therefore set a climate for change rather that an instant solution. Anti-discrimination legislation which will not change bigots overnight, if at all. However, it will encourage HIV affected persons and others to start shedding the mantle of stigma and take their place in a society which they can really value and therefore help to make it safer and better.

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The Prime Minister, The Rt. Hon. Owen Arthur MP and
Senator John Williams, Minister of State, Prime Minister's Office
The Leader of the Opposition, The Hon. Clyde Mascoll MP
The Attorney General, the Hon. Mia Mottley, QC. MP
The Minister of Health, The Hon. Dr. Jerome Walcott MP
The Chief Medical Officer – Dr. Beverley Miller
Chairman - Dr. Carol Jacobs and staff of the National HIV Commission
Medical Council of Barbados
Dr. D. Padmore; President, Barbados Association of Medical Practitioners
Ms. M. Howard, President of the Barbados Registered Nurses Association
Dr. H. Ellis. President of the AIDS Society, Barbados
President and executive committee of CARE, Barbados
Dr. T. Roach, Director of the AIDS management team, QEH
Ms. Vashti Inniss, Health Education Officer, AIDS management team, QEH

Ms. Lydia Waterman, Infection Control Officer, QEH;AIDS management team, QEH

Dr. N. Adamakoh. Senior Medical Officer [HIV/AIDS]

The Barbados Christian Council

The Anglican Bishop of Barbados - The Reverend John Holder

Bishop Galt and Father Paul, Roman Catholic Church.

Rev. James Rock, Methodist Church and President Barbados Christian Council

Kes Yaicob of the Ethiopian Orthodox Church and a member of the HIV commission

Dr. Deo Sharma of the Hindu community

Dr. Y. Nagdee and Mr. S. Bubulia of the Muslim community

Col. Burrowes of the Salvation Army

Rev. Hurley, Church of God

Sir Roy Marshall; Chairman, Law and Order Commission.

Professor Albert Fiadgoe; Faculty of Law, University of the West Indies, Cave Hill

Chairman, Mr. Joey Harper, Director and Ass. Director of the Child Care Board

Mr. Belgrave; Supervisor of Insurance

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Prof. E.R.Walrond

4 June 2004

Acronyms and Abbreviations

ACLU	American Civil Liberties Union
AIDS	Acquired Immune-Deficiency Syndrome
ANCHARD	Australian National Council on AIDS, Hepatitis C and Related Diseases
CARICOM	Caribbean Community
CDC	Centres for Disease Control, United States
CMO	Chief Medical Officer
GPA	Global Programme on AIDS -WHO
HIV	Human Immuno-Deficiency Virus
HMSO	Her Majesty's Stationary Office
ILO	International Labour Organisation
IVD	Intravenous Drug User
JAMA	Journal of the American Medical Association
NACA	National Advisory Committee on AIDS
QEH	Queen Elizabeth Hospital, Barbados
STD	Sexually Transmitted Disease
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Sponsored Program on AIDS
US	United States
WHO	World Health Organisation

Appendix
CARICOM Task Force on the Ethical and Legal Issues of the HIV/AIDS epidemic

Executive Summary

The Thirteenth Conference of Ministers Responsible for Health (CMH) held in Barbados in 1992 "agreed to address special attention to the rights of individuals affected by HIV/AIDS and groups and communities affected by the epidemic".

As a result of that mandate the Caricom Secretariat convened an AIDS Task Force in February 1993. The Task Force recommended that the secretariat convene a meeting of knowledgeable persons to consider the legal and ethical issues which impact on HIV/AIDS prevention and control programmes and to make recommendations to CMH on these matters. That meeting was convened in December 1994 and received reports from two consultants who had been engaged by the secretariat to examine the Ethical and Legal Issues of the HIV/AIDS epidemic.

The meeting reviewed the reports and

(a) identified and discussed those Ethical and Legal issues which pose challenges to the implementation of National AIDS programmes in the region; and

(b) made proposals contained in the report for policies and legislation to protect the rights of individuals, families and communities affected by HIV/AIDS.

The issues identified were:

(i) Confidentiality of a person's HIV status

(ii Screening of workers (including police and security personnel) for employment

(iii) Discrimination against HIV infected individuals at work, in housing and in access to health care

(iv) Consent for HIV testing

(v) The duty of health care professionals to warn relatives or sexual partners of the HIV infected status of patients under their care.

(ii The impact of laws on sexual practices and their relationship to the prevention of the spread of HIV in the community.

(ii The duty and rights of health care professionals in the care of HIV/AIDS patients

(viii) Resource allocation in the prevention and control programmes

(ix The regulation of laboratories and blood banks in relation to testing practises and the provision of safe blood for transfusion.

(x) The prevention of wilful transmission of HIV infection

(ii The impact of existing public health legislation on prevention and control programmes

The conference developed recommendations on most of the issues outlined. The conclusions reached are

summarised in the following.

(1) **Confidentiality,** is a central feature of the relationship between health professionals and their patients and should be maintained as far as is humanly possible.

Health care professionals should be disciplined for deliberate breaches of confidentiality and regulations should be put in place to better manage patient records.

(2) **Screening** for disease is an important tool in public health. However if misapplied in sensitive situations, such as HIV disease, it may only serve to drive infected persons 'underground'. Voluntary screening is preferred to mandatory screening since compliance with advice is much more likely to occur.

The costs and benefits of mass screening for HIV need to be carefully analysed and should only be undertaken if pre and post test counselling are available to all persons tested.

Screening should not be used as a basis for discriminatory practises, such as being a bar from employment, when HIV transmission is not an identified risk in the occupation under consideration.

(3) **Discrimination** only serves to reduce the compliance of affected persons with the desired control measures and to diminish the rights and humanity of the entire community.

Discrimination should be tackled through the introduction of specific anti discrimination legislation related to all persons with disabilities and should specifically include persons affected with HIV/AIDS. Such legislation should address the issues of schooling, housing and employment.

(4) **Consent** to the examination of one's body is a fundamental right of privacy. When violated in any examination is an unlawful assault.

Consent should be obtained from all persons or their legal guardians for HIV testing.

It should be made explicit that it is the duty of the health professional, carrying out testing for HIV, to ensure that the person has access to pre and post test counselling.

(5) **The duty of health professionals to warn third parties** of a patient's HIV status is complicated by the rights of the patient to confidentiality.

It should be made clear that health professionals, whilst respecting the confidentiality of patients under their care, have a duty to warn a third party who they know to be at risk for

transmission of HIV. Such warnings can only be given when all other measures to protect the third party have been exhausted and the health care professional has ensured that the HIV infected patient

- **has been adequately counselled,**
- **has been offered assistance in the notification of the third party at risk in the context of confidentiality, and**
- **is sure that the third party is being placed at risk through sexual intercourse or the sharing of needles for intravenous use.**

(6) **Duty to Treat.** Health care professionals have a duty to treat all ailments, including persons affected by HIV/AIDS, within the limits of their competence. Where the professional feels that the patients condition falls outside their sphere of competence, the professional has a duty to ensure that the patient is referred to a service which can deal with the condition.

Basic, post-basic and continuing education of health professionals about HIV/AIDS need to be assured within countries.

Professionals who are accused of infractions of their duty to treat should be examined before professional boards or ethics committees.

(7) **HIV infected Health Professionals.** It has NOT been shown that there is a significant risk of transmission of HIV to patients from an HIV infected health care professional. However, those workers who have HIV dementia or certain opportunistic infections as a result of AIDS may pose a risk to patients.

Mechanisms need to be put in place to ensure the continued physical and mental fitness of health care providers to continue to provide patient services.

A medical practitioner who is ill should have their fitness to work determined by another practitioner and not by themself.

The issues of **Control of Prostitution** need further study in relation to the possibility of regulation of the industry for control of HIV and other STD's.

(8) Time did not allow for a meaningful discussion of the ethical issues in regards to resource allocation.

(9) The consequences of inaccurate testing for HIV are grave. Therefore private and public laboratories and blood banks should be required to comply with established procedures and standards. Mechanisms of quality control of standards should be set with the support of CAREC.

(10) Although public concern about the wilful transmission of HIV is disproportionate to any such occurrence, it was felt that specific statute related to sexual transmission would have a beneficial effect on the general public's response to HIV/AIDS education efforts. It is felt that deliberate transmission by infection is adequately covered under existing law.

(11) It was agreed that countries need to review their public health legislation and bring it up to date to deal with modern circumstances.

(12) Overcrowded prisons are acknowleged to be an environment that is conducive to the spread of HIV amongst inmates and subsequently in the wider community studies should be undertaken to reduce overcrowding in prison, and education and prevention measures should be vigorously promoted amongst prison inmates.

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