Pregnant Women and the Testing for HIV-Infection:
Can the Practice of Coercive Testing Be Supported By Public Health Concerns
When Weighed Against the Privacy Interests of Those Tested.
Experience of Canada, Russian Federation and the United States.

by

Anna Alexandrova

A thesis submitted in conformity with the requirements
for the degree of Master of Laws
Graduate Department of Law
University of Toronto

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Determining the right balance between public health interests and personal liberties is an extremely complicated call for any government in the world. Despite the twenty years of HIV/AIDS existence, this balance is not yet found. The issue strongly emerges especially with regard to women for two main reasons: state’s interest in public health and human life and rights of women. The conflict becomes even more distinct with the availability of the new treatment, that is said to normalize HIV and turn it into “just another disease”. This thesis reaffirms the necessity of the unique treatment of the disease and takes on an approach known as “HIV/AIDS” exceptionalism. It looks into arguments for and against coercive testing of pregnant women for HIV, weighing each of them against possible public health outcomes and burdens on women’s rights. The thesis concludes that the policies of mandatory testing of women are undesirable as they would further discriminate against women and deter them from treatment.
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This thesis is dedicated to all those who live and struggle with HIV and AIDS.
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Introduction

The greatest challenge which the law faces with regard to the AIDS epidemic is the reconciliation of the dilemma between the private right of individual to conduct his own life with the right to public health.

A. Orr.¹

Background information and problem description

It has been twenty years since the Morbidity and Mortality Weekly Reports has published the US Centers for Disease Control report on a mysterious outbreak of pneumocystis pneumonia in Los Angeles.² The report suggested the possibility of a cellular-immune dysfunction³ related to a common exposure that would predispose individuals to opportunistic infections, such as pneumocystis carinii pneumonia.⁴ It was a symptom of a new disease, now known as AIDS, acquired immune deficiency syndrome. Since the epidemic began, over 18 million lives have been claimed by AIDS⁵ and the AIDS toll can be expected to double over the next decade. By the end of the year 2000, 36.1 million people were estimated to be living with HIV or AIDS, and around 5 million new infections occur annually.⁶ Despite the fact that 90 per cent of the infections occur in developing countries and 75 per cent in sub-Saharan

⁴ Pneumocystis carinii is a micro-organism that grows rapidly in the lungs of patients with immunosuppression, particularly due AIDS and is a leading AIDS-related cause of death. Online Medical Dictionary, ibid.
⁶ Ibid.
Africa, the disease struck different countries around the world, as well as different communities. In the United States some 800,000 to 900,000 people of all ages, ethnicities and sexual orientations are living with the virus. In Canada, by the end of 1999, 16,913 cases of AIDS were reported. In December 2000 the UN Joint Program on HIV/AIDS (UNAIDS) estimated that some 700,000 people in Eastern Europe were living with HIV/AIDS, compared with 420,000 only a year ago. Some areas, such as the Russian Federation and Estonia, reported far more cases for 2000 than in any previous year. These numbers are indeed alarming, however, they are likely to fall short of revealing the true severity of the problem, as the countries in the region also suffer from another epidemic - one of a drug use. Despite limited resources and weak political leadership, some countries of Eastern Europe and Central Asia are making efforts to pragmatically address the growing HIV/AIDS epidemic on their territories, but in many countries of the region, including Russia, HIV/AIDS prevention is not a priority.

11 See Agence France Press “Half of the Russian Population Could Have HIV in 10 Years: Top Official Says”, online: AFP: <http://www.afp.com> (date accessed: January 09, 2001) citing the head of the Russian AIDS Centre V. Pokrovsky saying that the unofficial number of cases in Russia at the end of 2000 reached 130,000, and is expected to reach 300,000 by the second half of 2001.
13 “The sad reality is that preventing AIDS is not a priority...not a political priority, not a priority for public spending, and community organizations are not very developed yet”, Peter Piot, the executive director to UNAIDS, interview A. Picard, “HIV Infection Rate Jumps Sharply in Former USSR”, The Globe and Mail (October 15, 1999) A7. The world has witnessed with grave concern the recent statement made by the Minister of Health of the Russian Federation, who declared that there was no HIV epidemic in the country yet. Ural Informational Bureau (June 11, 2001) 3:54 p.m., available on file with author.
ideology\textsuperscript{14} towards drug use and implemented needle exchange and methadone maintenance therapy\textsuperscript{15} programs in the hope to stop the epidemic. Some of these efforts were fruitful. For example, in Ukraine, the annual number of new cases appears to have declined since 1997, but recent evidence of HIV infection in pregnant women suggests that the virus has spread into the general population.\textsuperscript{16} This also shows that behind the rush to stop epidemic among men who have sex with men and intravenous drug users one very important group of population was completely forgotten: adolescent girls and women.\textsuperscript{17} Human Immunodeficiency Virus (HIV) is still a relatively new issue with regards to this group of population in many countries of the world. Despite the documented incidence of the disease among women, multilateral international organizations did not begin to address the significance of the HIV pandemic to women’s health until the early 1990-s\textsuperscript{18}. Following the United Nations General Assembly recognition of HIV/AIDS as a health crisis in women, in 1990, the World Health Organization (WHO) finally held its first consultation on research

\textsuperscript{14} Harm reduction approach to HIV prevention targets intravenous drug users (IDUs) and is based on the theory of continuum of frisks. The theory asserts that total elimination of drug use is impossible, thus the priority should be given to education and risk reduction, that will lead to less dangerous behaviour.

\textsuperscript{15} Methadone maintenance therapy is an important part of harm reduction philosophy and is applied towards those opiate users who cannot stop using drugs for different reasons. It is prescribed to IDUs in a liquid form or form of a pill not intended for use via injection. In this manner the injection is avoided and thus risks of acquiring HIV and hepatitis are reduced. Any operations with methadone are forbidden in Russia, this drug is forbidden for any type of circulation, including export and import. See “Об утверждении Перечня наркотических средств, психотропных веществ и их прекурсоров, подлежащих контролю в Российской Федерации”/ List of Drugs and Psychotropic Substances that are under Control in the Russian Federation, adopted by Decree of the Government 30.06.98 #681, online in Russian: CONSULTANT-Plus (Russian Legal Database) <http://www.consultant.ru/dbs/prof.phtml?BOCKQ> (date accessed August 28, 2001).


\textsuperscript{17} Harm reduction approach to injection drug use results in increased use of clean injection paraphernalia, however, existing needle exchange program are not overall successful in attracting women and there is little evidence that shows that these programs result in increased use of condoms. Thus, this approach cannot fully prevent sexual transmission of HIV. See generally: Harm Reduction: National and International Perspectives, J. Inciardi & L. Harrison, eds. (Sage Publications, Inc., Thousands Oaks, California, 2000); G. Stimson, “Syringe Exchange Programs for Injecting Drug Users” (1998) 3 AIDS 253-60.

priorities relating to women and HIV. In the latest special session of the United Nations the importance of paying special attention to women’s needs was again emphasized:

In many settings, women – and in particular young women – are especially vulnerable to HIV infection. They may be less able than men to avoid non-consensual or coercive sexual relations. Some cultural practices and stereotypes may dictate that women should not appear to influence the sexual behaviour of male partners. In contrast, many cultural norms promote responsible behaviour and ethical values.\(^{19}\)

As a result of this session, the UN Declaration of Commitment on HIV/AIDS was adopted. It called the state parties to bear in mind that globally women and girls are “disproportionately affected by HIV/AIDS” and with this in mind develop the appropriate health and policy strategies that:

[...] Promote the advancement of women and women’s full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.\(^{20}\)

The importance of this call is hard to underestimate. It took humanity twenty years and many avoidable deaths in young girls and women to finally admit that the approach to HIV/AIDS as a “male disease” was unacceptable.

Unfortunately, in many countries women are of interest to public health institutions only insofar as they are carriers of the disease and vessels for healthy children. Existing prevention programs, especially in countries in transition, do not adequately address the issue of negotiating safer sex between women and their sexual partners. The fear of physical harm and abandonment push women into practicing unprotected sex and other types of risky

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Doc. WHA43/1990/REC/1 (1990). In WHA Resolution 43.10, the World Health Assembly called upon WHO and member nations to strengthen AIDS prevention and control in respect of women and children.\(^ {19}\)

behavior. Economic poverty, lack of social support and low self-esteem force women into trading their bodies for money, drugs and dreams of better life.\textsuperscript{21} Prevention activities that target women mainly concentrate on sex-workers and consider them to pose a risk of infection without addressing the risks these individuals themselves assume. There are very few prevention programs designed by women and for women, programs that would take into account the social, cultural and psychological issues facing women. It should come as little surprise that women now constitute the fastest-growing group of people living with HIV/AIDS (PLWAIDS). In late 1999, UNAIDS estimated that women constituted 15.7 million out of 34.3 million of people living with HIV/AIDS worldwide and 7.7 million women have died since the beginning of the epidemic.\textsuperscript{22} Despite the extraordinary number of women infected with the virus (UNAIDS estimates that 55\% of PLWAIDS in Sub-Saharan Africa are women\textsuperscript{23}) still little is known about the progression of the disease in women, and in many countries simple measures for prevention of opportunistic infections in women are not available. For example, cervical cancer is closely associated with sexually transmitted infections (STIs) and is known to develop as an opportunistic illness in women who live with HIV.\textsuperscript{24} It is recommended for them to have PAP smears every six months instead of the usual practice of just once a year, as this type of cancer could be easily controlled and prevented.\textsuperscript{25}

\begin{itemize}
  \item UN Declaration of Commitment on HIV/AIDS, supra note 7, par. 59.
  \item The author is aware about another point of view with regards to risky behaviour, such as drug use, where it is perceived and respected as a personal choice. See generally, \textit{Harm Reduction: National and International Perspectives}, J. Inciardi & L. Harrison, eds. supra note 15. The author agrees that in many economically stable countries this might as well be the case, but reserves to her own opinion on the issue with regards to limited choices of women in somewhat patriarchal societies of Eastern Europe.
  \item Ibid.
\end{itemize}
However in many developing countries and countries in transition there are little or no facilities to detect and treat this condition.

Some argue that this lack of knowledge about the impact of HIV/AIDS on women resulted from definition of women’s health as maternal health only, which is why the prevailing norm for scientific studies was to exclude women from majority of clinical trials due to fear for their future children.26

Women living with HIV/AIDS face tremendous difficulties in their everyday lives and still must make decisions regarding their reproductive choices. The most effective anti-retroviral treatment is not available for many women, and some sero-positive women have no choice to avoid childbearing in their cultural contexts; at the same time, there is unrelenting pressure to require all pregnant women and their newborns to submit to HIV testing.27 In many countries of Eastern Europe the stereotype of a typical AIDS patient still exists; many believe that the disease is common only among drug users, prisoners or people with promiscuous sexual behaviour. This stereotype is fueled by the lack of free consensual anonymous testing, legally required in most countries yet unavailable in practice.28 In most Eastern European countries, there are no new policies or programs to combat the spread of the infection while broad

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categories of individuals, including pregnant women, are mandatorily tested for the presence of HIV virus.  

In Russia, which has been suffering from the HIV epidemic since the mid-1990s, the absence of a timely and adequate governmental response resulted in a dramatic increase in the scale of the epidemic by the late 1990s. In Moscow alone, there were three times as many reported instances of HIV, in the first nine months of 1999, as in the first two decades of the epidemic. The epidemic in Russia evolved in the same way it did in many other developed countries: the first wave hit the gay community; the number of new cases then rose stratospherically when the HIV virus got into the community of intravenous drug users (IDUs). The official response to it included wide-scale testing programs and poor designed educational campaigns that were developed without the due knowledge of the issue. The government’s unwillingness to employ internationally proven public health strategies (such as needle and syringe exchange, methadone maintenance therapy, successful educational campaigns among those most at risk) resulted in a dramatic change in the pattern

29 Ibid.
33 In March 1999, total number of registered cases of HIV infection in Russia was 12,436. Exactly 1 year later, this number nearly doubled — 32,872. See V. Pokrovsky, et al, HIV Infection in the Russian Federation, (Russian Federal AIDS Prevention Centre, Moscow, 1999), 10.
34 By the end of 1996, more than 200 million HIV tests were carried out in Russia. See Y. Amirkhanian, et al, "AIDS Knowledge, Attitudes, and Behaviour in Russia: Results of a Population-Based, Random-Digit Telephone Survey in St.Petersbourg", supra note 30, 50.
of HIV infection. In 1999, IDUs still constituted the majority of PLW AIDS in Russia, but heterosexual transmission became more prevalent among women.35 Research in nine African countries has revealed that 20 per cent more women than men are now infected with the disease, proof that women are at far greater risk when the epidemic moves from so-called “risk groups” into the general population.36 Social and economic situation of Russian women, coupled with a historically paternalistic attitude, puts women at a special risk of contracting HIV. Existing stereotypes, and the lack of social support only added to the severity of their situation:

The impact of HIV/AIDS on women demonstrates that women’s health status is not merely the outcome of scientific analysis or medical intervention. Rather, the disease highlights the social and cultural determinants of women’s health status. Economic inequalities and traditional attitudes and values limit the ability of women to protect themselves from infection.37

UNAIDS identifies several factors that put a country at risk of a heterosexual epidemic of HIV. One such factor is the economic dependence of women on marriage or prostitution, which deprives them of control over the circumstances or safety of sex.38 Taking into consideration the existing position of women in Russia,39 it is no wonder that the heterosexual way of transmission started to emerge quite recently.

36 A comparative study conducted in US, Canada and Puerto Rico, found that 62% of all HIV cases in surveyed women were attributed to heterosexual transmission. A. Erhardt & T. Exner, “Prevention of Sexual Risk Behaviour for HIV Infection With Women” (2000) 14 AIDS (Supp.2) S 53.
39 For further discussion of the existing attitude towards women in Russia, see R. Regan, Russia, Neither Jobs Nor Justice: State Discrimination against Women in Russia (Human Rights Watch Women’s Rights Project, New York, NY, 1995). Another point of view on the issue is that the existing position of Russian women and violation of their rights even within their families and their communities and the state is a logical consequence of the paternalistic legislation of prior regime combined with deeply rooted social practices. See J. Mertus, “Human Rights for Women in Central and Eastern Europe”, (1998) 639 (6) American Univ. J. of Gender and the Law 371, 373.
At the end of 2000, UNAIDS estimated that 25% of all adults living with AIDS in Eastern Europe and Central Asia were women.\textsuperscript{40} This may appear insignificant, especially compared to Africa. However, HIV does not slow down in the Russian Federation, and it was expected that the number of HIV-registered cases would reach 50,000 at the end of 2000.\textsuperscript{41} Russian medical officials estimate that there are many more people infected with HIV than there are registered - the national registration system catches just a fraction of infections. UNAIDS optimistically stated that political and legal reforms in the countries of Eastern Europe and Central Asia were creating more effective avenues to HIV prevention. The sad truth is, however, that existing laws are vague and make references to different conflicting regulations and rules approved by the Ministry of Health; what is written in the law is not \textit{de facto} enforced or respected in any way and budgetary restrictions are not the only barriers the countries are facing.

Pregnant women are especially vulnerable in societies where the state takes on a paternalistic approach, and where fatalism and obedience are among cultural factors rooted in the religious beliefs. As treatment is not available for the majority of Russian women, and knowledge of their sero-positive status will do little to improve their situation [on the contrary, it may lead to domestic violence, create additional barriers in their access to health care and result in unwanted medical procedures such as the performance of Caesarean delivery], it makes little sense to advocate overall HIV testing for pregnant women. Unfortunately, the HIV test is routinely performed on every pregnant woman in Russia without obtaining her specific informed consent to the procedure.

\textsuperscript{40} Ibid. 4.
The role of the law and the scope of this paper

It is established that the legal response to HIV/AIDS is important, the question is what should it be? Can legislation, whether it is HIV-specific, or otherwise, improve the health of those infected and reduce the further spread of HIV/AIDS? The role of the law has been previously analyzed in great detail, with the conclusion that it may actively "impede prevention efforts by alienating those people who are at risk of HIV and making it less likely that they will cooperate in prevention measures." It is the purpose of this paper to show that excluding pregnant women from the usually accepted policy of voluntary testing and counseling (VCT) and testing them obligatorily for the presence of the virus does not only violate their right to privacy and consent to medical treatment, but also is not supported by pragmatic public health outcomes. Moreover, legislation, demanding this type of testing, represents the prescriptive type and is likely to deter women from health services all together, thus resulting in an "underground" growing epidemic. The voluntary cooperation of the woman seems to be the most important factor in both, delivery of effective care and further disease prevention.

This paper looks at the legal implications arising from mandatory testing of pregnant women and the extent to which such tests are coercive. It takes on the approach often referred to as "AIDS exceptionalism" and argues that as HIV and AIDS are still exceptional and

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43 Ibid. S239.
44 As defined by J. Hamblin, supra note 43, S244.
"qualitatively different"\textsuperscript{46} for a variety of medical, social, and psychological reasons, it should not be regarded in the manner of other infectious diseases. It weighs state interest in public health and future life against the women's right to privacy and bodily integrity and concludes that due to some overriding factors, mandating testing for HIV only for pregnant women constitutes their discrimination on the grounds of gender and does not represent pragmatic public health policy. It is argued that the legislation can take a more pro-active role in disease prevention not only by safeguarding interests of those infected and carefully balancing them with the public health interests, but also by changing the underlying causes for vulnerability to the disease. It is asserted that the laws cannot eliminate stigma and prejudice, but can deter their effects. This paper analyzes the nature of the right to privacy, the state interest in potential human life, the relevant past and present legislation and policy of Canada, US and Russia. It looks into different approaches to testing as a component of HIV prevention and shows the existence of obligatory testing of other groups of population. This paper argues against the obligatory prenatal testing for HIV infection\textsuperscript{47}, and tries to identify the right balance between public health and private interests. The state interest in testing of women for HIV is also weighed against its human rights obligations, found in the major international documents. The conducted research leads to the conclusion that at this stage of scientific and social development, abandoning the exceptional approach and including the HIV test into the "routine blood-work" regularly performed on pregnant women is unacceptable.

\textsuperscript{47} The idea for this paper was triggered by recommendations for overall routine testing of pregnant women for HIV that came from the U.S. National Institute of Medicine. Please see National Institute of Medicine, \textit{Reducing the Odds}, supra note 27.
Chapter I.

This chapter dwells upon the issues of AIDS exceptionalism. It looks into the history and nature of the disease itself, its social and medical consequences. It also tries to determine what is meant by an HIV test and how is the test itself different from any other test for an infectious disease. It argues that AIDS has not become “less threatening” and effective treatment does not exist. This chapter also takes on a difficult task of sorting out the different terminology applicable to the issue and defines the terms “testing” and “screening” as well as “obligatory”, “compulsory”, “mandatory” and “routine” for the purposes of this research.

1.1. Why is HIV infection different from other infectious diseases?

One can say that HIV infection has awoken some primary instinctive fears in people: the fear of the unknown, death and suffering. We still do not know for sure where the virus itself came from. Many theories exist that try to explain the origin of the virus. Some of them are founded upon reason, others are rooted in ignorance, hysteria and prejudice. Some would stick to the “patient zero” theory, trying to blame one homosexual individual - Gaetan Dougas, Air Canada flight attendant, who might have infected approximately forty people. Others would reject the existence of HIV virus itself and hold that AIDS is the result of some combination of factors that altogether cause the suppression of immune system. Some linked AIDS to an experimental oral polio vaccine made from chimpanzee tissue that was contaminated with an ancestor of HIV virus called SIVcpz (simian immunodeficiency virus,

48 For the purposes of this paper “AIDS exceptionalism” is used to distinguish the approaches that are used in times of HIV/AIDS epidemic from other public health measures, commonly used for other infectious diseases.
The origins of HIV are still unknown, however the most detailed and widely advertised theory is that a single viral ancestor first infected humans around 1930 but it is still unknown how the virus "jumped" from chimpanzees to humans.52

The HIV virus itself is quite complicated: it consists of 2 main elements – an outer membrane and an inner cord and it incorporates its genetic code into cells that it infects.53 The infection caused by the virus is a productive infection in which new virus particles are produced for all or most of the duration of the infection, leaving the infected person infectious for life. The nature of the virus determines how it can be transmitted. The ways of the transmission were generally established already in 1982, shortly after the virus was discovered.54 Nowadays it is common knowledge that the virus cannot be transmitted through casual contact and that the transmission is likely to occur through an exchange of blood or other bodily fluids (such as semen and cervical secretions).

There are a number of possible outcomes following one’s exposure to HIV. Some people may be exposed but will not become infected (as is the case with many other infectious organisms). Those who become infected develop antibodies to the virus, not immediately, but within a quite unpredictable span of time (the time period can range from 1 month up to 1

51 This view is outlined in a controversial book by E. Hooper, The River: A Journey Back to the Source of HIV and AIDS (Boston, Ma: Little Brown &Co, 1999) and has been embraced by other theorists who believe that AIDS is a man-made epidemic.

52 See, for example, A. Picard, "Studies Debunk Suggestion that AIDS Linked to Polio Vaccine", Globe & Mail, Thursday (April 24, 2001) A14, where the journalist adopts the point of view that the virus came from chimpanzee to human through eating the animal’s brain, which is common west of equatorial Africa. The same article speaks about the recent studies conducted on some samples of the vaccine used back in 1950-s in Africa, that proved that the used tissue belonged to macaque, not chimpanzee.

53 For a detailed explanation of the nature and biological structure of the HIV virus, see H. Fan, et al, AIDS: Science and Society, 2d edt. (University of California, Jones & Barlett Pubs., Mass., 1998) 51-64. In AIDS Law in a Nutshell (supra note 51, 15) R.Jarvis et al adopt the quite controversial point of view. They claim that as HIV is not a simple virus, but a number of variations on a virus that is subject to frequent mutation, that originated from some other virus, one can await possibility of another mutation that will “fortuitously render AIDS non-deadly or will cause the virus to disappear naturally".
year and is also known as the "window period"). Following this period, people are usually asymptomatic; at the same time they have HIV and are able to transmit the virus to others. This long asymptomatic period is rare in human infectious diseases. It makes it difficult to detect and isolate infected individuals and to apply such well-known measures of disease control as quarantine, compulsory hospitalization and other restrictions to separate the HIV-carriers from the rest of the populace. Meanwhile, HIV progresses to cause damage to the carrier's immune and nervous systems, leading to different opportunistic infections. Some patients will never develop the chronic condition of Acquired Immunodeficiency Syndrome (AIDS), when more severe damage is caused to the cells. The virus will eventually result in dementia and disorders of sensation and motor control as well as incapability of the carrier's immune system to cope with any viruses attacking it on a daily basis, ultimately leading to serious illnesses and death.

The dangerousness of the virus precipitated some states introduction of criminal sanctions specifically for the transmission of the virus. UNAIDS recommended the states not to include specific offences against the deliberate and intentional transmission of HIV but rather to apply general criminal offences to these "exceptional cases", adding that:

Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.

56 Ibid. 11.
58 See Chapter 2 of this paper for further discussion on the issue.
There are other infectious diseases in the world causing the death of large numbers of people. In 1997, Tuberculosis accounted for more than three million deaths worldwide.\(^6\) It is also deadly and the treatment is costly, but public health authorities responded to it in traditional manner without much concern for civil liberties.\(^6\)\(^6\) HIV infection is often compared with syphilis. Like HIV, it is often difficult to detect, and testing is the best way for its detection. It also has many manifestations and can attack different organs in the body. It can also be transmitted through sexual intercourse and needle sharing as well as from mother to child. To prevent further spread of syphilis, some governments implemented programs of isolation and forced treatment of a particular segment of the population who was deemed carriers of the disease: prostitutes.\(^6\)\(^3\) Unlike HIV, mandatory testing of different populations for syphilis in modern countries is well accepted and has largely gone legally unchallenged.

1.1.1. The doctrine of “AIDS Exceptionalism”\(^6\)\(^4\)

One should ask herself a question on why is it so that AIDS is the disease that is treated with so many exceptions from others? Why did it provoke “veritable explosion in the courts of

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\(^6\) As cited in G. Stein, \textit{Acquired Immune Deficiency Syndrome}, supra note 56, 11.

\(^6\)\(^1\) “Therapy (TB) Short-Term Incarceration of Noncompliant Patients Works”, (Aug. 4, 1997), Tuberculosis &Airborne Disease Wkly., online: LEXIS, News Lib. (describing the incarceration of non-compliant patients and proving it consistent with existing public health laws. The method was successfully implemented in Denver, Colorado).

\(^6\)\(^2\) The new Russian law on Tuberculosis in its article 10 foresees compulsory medical examination and treatment of TB patients, as well as it describes quite strict regimens of the treatment facilities where such patients are to stay until they are not infectious for the public. «О предотвращении распространения туберкулеза в Российской Федерации», Federal Law “On Prevention of the Tuberculosis in the Russian Federation”, adopted by the State Duma on 18.06.01, # 77, online in Russian: CONSULTANT-Plus (Russian Legal D-Base): <http://www.consultant.ru/dbs/prof.phtml?BOCKQ> (date accessed September 4, 2001).


civil liberties and individual rights"?  

It is only because the approach to the epidemic was shaped by, as some believe, "an alliance of gay leaders, civil libertarians, physicians, and public health officials"?6

The approach, now usually referred to as "HIV/AIDS exceptionalism" was suggested in the early 90-s to distinguish policies that have emerged in the face of AIDS epidemic from more common approaches usually adopted to public health threats.

R. Bayer was one of the first to challenge this doctrine at the time of its birth, when he had strongly opposed the theory that AIDS was different, and thus should be treated differently from both, social and legal perspectives.67 He had predicted the demise of this approach, arguing that since the panic of mid-80-s had passed, AIDS lost its salience as a public issue:

As AIDS becomes less threatening, the claims of those who argued that the exceptional threat would require exceptional policies have begun to lose their force. The most important factor in accounting for the changing contours of public health policy, however, has been the notable advances in therapeutic prospects. The possibility of managing HIV-related opportunistic infections and the hopes of slowing the course of HIV progression itself have increased the importance of early identification of those with HIV infection. That, in turn, has produced a willingness to consider traditional public health approaches to screening, reporting, and partner notification.  

Later on, Bayer returned to the issue of exceptionalism again, and affirmed his point of view through detailed analyzes of public health policy with regards to HIV testing of newborns and pregnant women, name reporting and access to public health care.69 He concluded that even if one does accept the uniqueness of HIV/AIDS as a disease, the necessity of the exceptional

65 H. Fernandez, "Is AIDS Different?" supra note 46, 1073.
68 Ibid.1503.
policy is highly debatable, as “the uniqueness of AIDS benefits renders them politically vulnerable”\(^7\) S. Burris opposed Bayer’s point of view on the “exceptionalism doctrine” as it “never quite existed”,\(^7\) and came up with a new approach to exceptionalism as beneficial to neither the people, affected by it, nor to public health policy.\(^7\) He argued that it was just an “-ism”, an enemy ideology, which discriminated against PLW AIDS.\(^7\) Burris suggested a rule of non-discrimination that would normalize a more quantitative approach to assessing risk in one’s behavior, and concluded about the importance to de-emphasize the difference between communicable and non-communicable health threats, thus, extending the achievements of the “exceptional” doctrine to other diseases causing fear. He argues that “exceptionalism” exists to simplify the complexity of the relationships between public health interest and individual liberties “to a bilateral conflict between gay men and civil libertarians, and traditionalists”.\(^7\)

Both approaches to the “exceptionalism doctrine” have their strong points, but it seems difficult to agree with Bayer that HIV is not different any longer. The approach suggested by Burris has its appeal in suggesting to treat all diseases equally. However, his approach seems to be quite detached from the reality of the disease itself, existing stigmatization and fear. Not all diseases are stigmatized, and there is a danger that once HIV/AIDS is declared as “just another disease” on a long list, in some countries where the privacy interests of people are not strongly protected, this will lead to abuse of rights of those with AIDS, and failure of such policy. The exceptionalism approach is not a conflict (between gay men and traditional

\(^70\) R. Bayer, “Clinical Progress and the Future of HIV Exceptionalism”, ibid. 1048.
\(^72\) Ibid. 251.
\(^73\) “This brand of “exceptionalism” is not an account of HIV and its many forms of meaning and being, but an “-ism”, and enemy ideology which systematically derives a public health policy against HIV from the premise that the disease is essentially different from any other”; S.Burris, Ibid. 255.
approaches to disease prevention); it is the consensus between individual liberties and epidemiological necessity.

HIV is a unique virus, which is lethal, is transmitted in ways that were usually scrutinized by public (use of illicit drugs, promiscuous sexual behavior, male-to-male sex). It affects people in their reproductive and most productive years. There is no treatment from the disease; the existing drugs can only stop its progression and they are highly expensive. There may be also other reasons for treating the disease differently from others: the disease mostly hits those who are already poor and socially unprotected, or isolated and discriminated. Historically, there already were a large number of infected people before the virus was identified, and the means of its transmission became common knowledge. However, there is still no consensus on the position of this disease among others. As it was shown above, some think that after twenty years of the epidemic, with new generation of drugs available HIV and AIDS should not be treated exceptionally any longer. Thus, the state should be able to use its power in order to control the disease in the manner in which other contagious diseases are controlled. This policy would arguably signal the "normalization" of the disease. Some argue that there should be no specific legislation protecting individuals with HIV, as there is none concerning cancer or heart diseases. 75 Some wonder whether there is a public health necessity in compulsory testing implemented at this stage of the epidemic. The extreme view is that

74 Ibid. 258-259.
individuals should be made available for testing whenever they use the health care system.\textsuperscript{76} These suggestions might be useful in part, but they also might turn out to be extremely dangerous. It might lead to public apathy with respect to HIV prevention, as it would be considered just one of many diseases. Also in countries where treatment is not available this approach will allow the governments to implement coercive measures against HIV-positive people, further fueling the infection. It seems that this policy will also lead to grave violations of the rights of the infected, especially in countries that are still new to the epidemic of HIV. Even in the United States, homeless people are rejected from shelters once they are known to be HIV-positive.\textsuperscript{77} Taking into account the fact that, in the United States the disease is most common among African Americans and other traditionally discriminated groups, such as drug users, Hispanic Americans, homeless,\textsuperscript{78} can one be sure that implementation of the traditional public health approach will not result in further discrimination against them? One should never forget that AIDS is a pandemic and despite the fact that the public knows more about it than it did twenty years ago, there is still much to learn, and the disease still “carries the potential to be the greatest natural tragedy in human history”.\textsuperscript{79} Undressing HIV of its

\textsuperscript{76} H. Fernandez, “Is AIDS Different”, supra note 46, 1076. He argues that since the change in the Public Health Law of New York to mandate the testing of newborns for HIV, “no one has yet shown that pregnant women have avoided the health care system since that amendment for fear of HIV-testing”.

\textsuperscript{77} M. Closen, “The Decade of Supreme Court Avoidance of AIDS: Denial of Certiorari in HIV/AIDS Cases and Its Adverse Effects on Human Rights”, supra note 76, 900, where he cites allegations in Doe v. Pacific Gardens Mission, No. 97-C-6566 (Sept., 17, 1997). M. Adams, in “HIV and Homeless Shelters: Policy and Practice” (2000) Am.Civil Liberties Union AIDS Project, online: ACLU<http://www.aclu.org/hiv/> (date accessed July 17, 2001), tells a story of a homeless Patrick Biggers who was forced out of a shelter to a motel where he spent alone his Christmas of 1997. The shelter administration argued that Patrick was separated from others due to his “dangerous behaviour”, such as: holding a baby, giving another resident a cup of coffee, using dishes from the kitchen. It seems like Patrick’s only mistake was to tell the administration about his HIV-seropositivity. This happened in the state of Maine, more than 10 years after the epidemic started and the knowledge about the ways of transmission of the virus became available.

\textsuperscript{78} See for example, R.Jarvis et al, AIDS Law in a Nutshell, supra note 51, 7, giving the figures of the incidence of AIDS being six times greater for African Americans than it is for whites.

exceptional medical, social, ethical and legal status could be otherwise described as a denial of the problem, and disregard for the dramatic consequences of the epidemic.\textsuperscript{80}

During the course of the epidemic the policy makers have already faced many ethical dilemmas.\textsuperscript{81} However more issues are yet to surface. With some forms of treatment becoming available, new ethical conflicts will arise, for example who should be saved first – the mother or her child - when there is simply not enough money to treat both? Unless there is affordable treatment available to every HIV-positive person who needs it; unless people stop putting blame on others and accept different kinds of human behavior; unless men and women are truly equal, and the disparity between rich and poor countries disappears, HIV infection and AIDS should be treated differently and exceptionally in its many respects. As it is quite obvious that the above required conditions will never occur altogether, HIV/AIDS should always treated exceptionally.

1.1.2.\textbf{HIV antibody test: what does it mean?}

Testing for Human Immunodeficiency Virus (the correct way to refer to the test is HIV antibody test) has been available to clinicians since 1985.\textsuperscript{82} Now, tests for the detection of HIV infection have a different range of formats; an individual’s HIV status may be diagnosed by a number of tests.

\begin{itemize}
\item It is obvious now that Russia has suffered so severely from the epidemic mainly because Russian government has been in denial for too long, when the indicators of a great disaster were obvious to Russian and international public health professionals. See for example, M. Closen & M. Wojcik, “Freedom in Eastern Europe and the Spread of HIV/AIDS,” (1990) 1 Touro J. Transnational L. 307; M. Specter, “At a Western Outpost of Russia, AIDS Spreads Like a Forest Fire”, N.Y. Times (Nov. 4, 1997) A1 (describing the epidemic in Kaliningrad and saying that the unfortunate city was among few places on earth where the infection has risen more rapidly).


\item For example, the conflict between a woman and her fetus re-emerged again. See Chapter III of this work for further discussion on the issue.

\item See G. Stine, \textit{AIDS: Biological, Medical and Legal Issues} (1998) supra note 56.
\end{itemize}
The Enzyme-Linked Immunosorbent Assay (ELISA)\textsuperscript{83} test does not detect the presence of HIV, but only the above-mentioned antibodies. The test is not very accurate as it assumes that all HIV-infected people will produce detectable HIV-antibodies; in fact, the HIV-infected population in general does not produce the necessary amount of antibodies for quite some time, due to the specific nature of the virus. Thus, there is the practice of re-testing positive results.\textsuperscript{84} The ELISA test is first performed on the patient's serum. If the test is positive (i.e. “reactive”) it is repeated on the same blood sample again. If positive again, the specimen is referred to as “repeatedly reactive” on the ELISA. 

The Western Blot test also acts to detect antibodies. It gives more accurate results, and is used for the second test. As it is more expensive than ELISA, it is not used as the primary one. A repeatedly reactive ELISA test that is confirmed positive by a Western Blot is generally diagnostic of HIV infection and is reported as positive.\textsuperscript{85}

Polymerize Chain Reaction (PCR) is an anti-gene test. It detects the presence of HIV virus in blood. It can also be used to identify other blood-borne viruses (such as hepatitis B and C for example). This is a much more expensive test, but it is more accurate, as it detects the presence of HIV virus in blood before sero-conversion, within the so-called “window period” when human immune system does not yet produce the number of antibodies that will be sufficient for tests to reveal.


\textsuperscript{85} U.S. National Institute of Medicine, Reducing the Odds, supra note 27, 20, 21.
Over the recent years, there were also other, less intrusive, rapid tests developed, that could be used on saliva or urine samples. These tests are relatively inexpensive, but can produce many false-positive results.\textsuperscript{86}

Since 1995, home-testing kits have been available for detecting HIV-infection and are now on sale in practically every pharmacy in the United States. In January 1986, the Food and Drug Administration (FDA) received its first notification of a pharmaceutical company’s intent to market such a test\textsuperscript{87}. However, due to the fear that the test would not be as accurate as the ones performed in medical laboratories, FDA refused its approval in 1988.\textsuperscript{88} There were also other factors that determined this decision, among them the fear that people would be unprepared to face the disease without proper counselling, would commit suicide.

The test kit includes instructions and a pamphlet with AIDS information, a lancet, special paper for the blood sample that is marked with an individual identification code, and a return envelope. The user of this test pricks her finger and places three drops of blood on the special paper. The sample is then mailed to a laboratory. In approximately one week, the user calls to receive the test results using the identification code. If the results are negative, a recorded message provides the information along with general HIV prevention advice. If the results are positive, a trained counselor comes on the phone and provides counseling and information concerning possible re-testing, treatment, and the location of medical, legal, and counseling services. The invention and marketing of such a home-testing kit was inevitable taking into account the specific of the epidemic. UNAIDS recommends that States exercise caution with regards to the home-testing option, even though admitting that the existence of this option is

\textsuperscript{86} Ibid.36.


important.\textsuperscript{89} It suggests the states to ensure quality control, maximize counseling and referral services together. States are also recommended to create a system of legal and other support services for those who might be victims of misuse of these tests.\textsuperscript{90} As these kits, and related services, are not yet widely available in Eastern European countries, such tests will not be discussed herein.\textsuperscript{91}

1.1.3. Why is HIV test different from any other?

No matter what kind of test is used to determine HIV status, this test cannot be treated like any other test for any other disease taken into consideration the stigma around HIV and its lethal consequences. HIV can be transmitted via conduct that was historically looked upon with suspicion (i.e. intravenous drug use, promiscuous sexual behavior, male-male intercourse). The subsequent stages of infection, known as full-blown AIDS, will have catastrophic effects on not just the physical and mental well being of the person. The mere discovery of one’s sero-positive status may heavily influence the mental health of a person. As it was noted above, the stigma and mental damage of the disease cannot be eliminated by laws, but the effects of it could be deterred, as long as this disease is treated exceptionally. On the other hand, testing for HIV might be a first step to ensuring a better quality of life for the infected person and, if done properly, may prevent further transmission of the virus.\textsuperscript{92}

\textsuperscript{89} UNAIDS, \textit{International Guidelines on HIV/AIDS}, supra note 60, 42.
\textsuperscript{90} Ibid.
\textsuperscript{91} Even if these kits do become available for sale in the Russian pharmacies, the existence of free anonymous testing is crucial, as these kits are quite costly (around fifty U.S. dollars). To compare: in 1999 there were less than 1% of the Russia’s population with the monthly income of over $167 and over 90% of Russia’s citizens had their income under $50, online: Business Informational Service for the Newly Independent States, \texttt{<http://www.bisnis.doc.gov/bisnis/country/00309uralis.htm>} (date accessed September 4, 2001).
However, obligatory testing\textsuperscript{93}, performed without due knowledge or valid consent, may go against the very purpose of testing, which is to prevent the further spread of HIV.

Since the beginning of the epidemic there were voices raised for compulsory HIV screening of the whole population, followed by identification and isolation of those who were infected. At different times during the epidemic, these suggestions have concerned different segments of the population, \textit{inter alia} migrants, pregnant women, sex-workers, health care providers, couples intending to marry, etc.\textsuperscript{94}

\textbf{1.2. Definition of terms:}

\textbf{1.2.1. Is testing mandatory, compulsory or routine?}

There is still no obvious consensus between different professionals dealing with HIV regarding the meaning of “mandatory” and “compulsory” testing, as well as the use of the term “screening”.

It seems difficult to draw a clear distinction between two terms: “mandatory” and “compulsory”. There is little doubt that both terms refer to testing performed with some level of coercion. UNAIDS defines mandatory testing as a “precondition for a service or benefit”, but also uses the term “obligatory testing” in its main policy documents to describe both, mandatory and compulsory testing.\textsuperscript{95} The Ontario Law Reform Commission interprets more broadly the understanding of the term “mandatory testing”: “testing is either a necessary prerequisite for a person to obtain a specified status, benefit, service or access to a given situation, or is a necessary consequence of being provided with one or more of these.”\textsuperscript{96}

\textsuperscript{93} UNAIDS in its “Recommendations for Formulating Legislation on AIDS” uses the term “obligatory testing”.
\textsuperscript{94} UNAIDS/IPU, Handbook for Legislators on HIV/AIDS, Law and Human Rights, supra note 60.
\textsuperscript{95} Ibid.
“Compulsory testing” refers to testing that cannot be refused by the person being tested, as it is either required by law, or there is simply no other choice. It is also described as "completely mandatory". It is often difficult to strictly categorize the type of testing as simply one or the other. For example, *prima facie* the requirement of an HIV-test, prior to admission to a government-funded pre-natal care program, can be regarded as a mandatory, a woman can either "take it or leave it", but how many pregnant women would be able to afford private care? How many will have a realistic alternative to it? In this case, for some women this kind of testing will be compulsory, as they would have no other choice.

“Routine testing” is another term that is widely used in relation to antenatal testing for HIV. A policy of routine testing demands that HIV testing is performed on all pregnant women by adding this test to standard forms used for all prenatal assays. This kind of policy might be divided into two sub-categories. The first, "routine testing without notification" describes a procedure that is automatically performed unless the individual expresses her clear desire not to undergo it. The second, "routine testing with notification" refers to a situation where an individual is informed about the procedure and may refuse it before it is performed. In theory, the use of the term “routine testing” in a policy paper does not automatically mean that it will be performed without informed consent of the woman tested. However, even the mere characterization of the test as routine may lead to the wrong perception of it, both from the side of the physician and from the side of the woman tested. This attitude may practically result in the testing of women without their informed consent. It may also result in a physician implying that consent to be tested for HIV was given when a woman came to seek

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prenatal care and gave a blood sample for the “routine bloodwork”. In addition, whatever safeguards are in place, there are likely to be instances when routine testing of pregnant women puts pressure on those who test positive to accept the treatment as well, even, in some cases, this “treatment” can include abortion.

The use of appropriate terminology seems also to depend on the attitude towards testing, of the writing author, and the political acceptance of obligatory testing at the time. In 1991, in their report on prenatal testing, screening and confidentiality, researchers from U.S. National Institute of Medicine (Committee on Prenatal and Newborn Testing for HIV) widely used such terms as “mandatory” and “compulsory testing”.98 The report clearly stated the Committee’s non-acceptance of involuntary testing and other coercive measures against pregnant women. In the 1999 report from the same organization, the researchers have mainly used the term “routine testing with notification”99, cautiously avoiding the definitions “mandatory” and “compulsory”. Eight years after the first recommendations were issued, the Committee has drastically changed its position on testing with informed consent, arguing that even the pre-test counseling should be reduced to providing basic information, as pre-test counseling is expensive and “embarrassing”.100

Routine testing has emerged recently as another danger for free decision-making of HIV-positive pregnant women. If the content of legal rules is often clear with regards to compulsory tests, than the provisions are often vague or silent with regard to the routine tests.101 If something is routine the physician may stop treating it with all due seriousness,

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98 See infra note.
99 U.S. National Institute of Medicine, Reducing the Odds, supra note 60
100 Ibid. 6.
101 Russian legislation in the field is an example where the position of the state towards any type of testing is unclear: Article 7 of the Federal Law “On HIV Prevention” clearly states that the testing is voluntary. However
and the weak safeguard of informed consent and a right to decide when, where and how to face their sero-positivity would not be enforced in practice.

For the purposes of this paper and to avoid any misunderstandings, the term “obligatory testing” will be defined as testing required for any reason and performed on a patient without first obtaining her informed consent to the procedure. This term would also be used when there is no realistic alternative to chose any other services if required as a pre-requisite and refused. The author believes that routine testing for HIV infection consists of coercive elements, and thus, is also included in the term “obligatory”. The term “compulsory” testing will be used when prescribed by a will of a governmental agency, and “mandatory” testing when referring to a testing as a pre-requisite of entering a service and when there is an alternative in case of refusal.

**1.2.2. Is it “testing” or “screening”?**

There is also no clear consensus on the difference between these two terms. Sometimes “screening” is used to refer to the application of a test or measurement to all individuals in a defined population.\(^\text{102}\) It can also be used to refer to the systematic testing of particular groups.\(^\text{103}\) It can also describe testing for HIV when done together with pre- and post-test

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counseling.\textsuperscript{104} Ontario Law Reform Commission identified screening as a strictly anonymous unlinked study of sero-prevalence rate in a given population used for epidemiological purposes.\textsuperscript{105} Some note that screening “reveals the identity of individuals and subjects them to potential stigma and discrimination”.\textsuperscript{106} UNAIDS refers to screening as a procedure to ensure blood supply safety.\textsuperscript{107} The 1999 Committee on Perinatal Transmission of HIV, when drawing a dichotomy between testing and screening, mentioned that there were 2 types of screening. The first is “screening commonly instituted for the purpose of case finding – identifying a previously unknown or unrecognized condition in apparently healthy or asymptotic persons or offering pre-symptomatic treatment to those so identified.”\textsuperscript{108} The second takes place when performed for surveillance purposes such as to monitor the incidence of the disease over time.\textsuperscript{109} Some distinguish types of screening depending on the level of coercion involved to compulsory, conditional, routine with notification (opt-in), routine without notification (opt-out).\textsuperscript{110} This paper suggests that all these adjectives cannot be applied to screening, only to testing.

Taking into account the existing confusion around the terminology, for the purposes of this paper, “screening” will refer to non-consensual unlinked testing of a given population, used for epidemiological purposes, and for the purposes of formulating better public health policies. In all other instances, including linked identification of infected individuals for

\textsuperscript{104} L. Samson, S. King, “Evidence-based Guidelines for universal counselling and offering of HIV testing in pregnancy in Canada” (June 2, 1998) 11 CMAJ 158.

\textsuperscript{105} Ontario Law Reform Commission, Report on Testing for AIDS, supra note 97, 71.


\textsuperscript{107} UNAIDS/IPU, Handbook for Legislators on HIV/AIDS, Law and Human Rights, supra note 60, 47.

\textsuperscript{108} Ibid. 22.

\textsuperscript{109} Ibid.

\textsuperscript{110} L. Gostin, Public Health Law, Power, Duty, Restraint, supra note 107,193-194.
epidemiological purposes, this paper uses the term “testing”, whether that is compulsory, mandatory, routine with notification or routine without notification.
Chapter II.

2.1. Different approaches to HIV Epidemic – Different Approaches to testing

There is little doubt that it is always cheaper to prevent a disease than to treat it. There are several ways for successful prevention of HIV/AIDS. The first one is to counsel individuals to change their risky behavior. The second one is to develop and implement explicit educational programs and ensure condom distribution. Needle exchange and methadone maintenance therapy have been the most controversial and politically debated since the beginning of the epidemic, however, they have proven to be successful, thus their implementation together with the above-mentioned prevention measure will be useful. Encouraging individuals to go through anonymous testing is an inalienable part of any successful strategy. There are also some examples of prevention strategies that proved to be unsuccessful: obligatory pre-marital testing, vague legislation with regards to criminalization of HIV transmission, screening of newborns to detect HIV antibodies that belong to their mothers. The low effectiveness of these strategies is based on the characteristics of the disease, such as: the long incubation period, lack of treatment, fear of stigma and hiding from testing. Different countries approached the issue of testing differently depending on the stages of the HIV epidemic evolving on their respective territories. As HIV test is the only way to determine whether an individual is infected, one can say that the attitude towards testing reflected the attitude towards the disease itself. For example, when the disease was just discovered the fear of it as of something unknown and lethal provoked calls for overall

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112 In People v. Bordowitz, 588 N.Y.S. 2d 507 (1991) the judge ruled that the activities of the activists providing needle and syringe exchange services for drug users fell within the medical necessity defence. For detailed discussion of the controversy of these programs, see, for example, D. Merrill, “Compassion for Drug Addicts or
compulsory testing and suggestions to use the quarantine measures. The attitude to the disease seemed to change with the increased knowledge about its ways of transmission. Nowadays, fewer calls of this nature could be noted. Availability of the new medication in some countries and its relative effectiveness led to suggestions from some advocates for the expansion of the requirement for testing to other groups of civilians, thus undressing HIV of its exceptional status.

This chapter will analyze different approaches to obligatory HIV testing, used for the prevention of the disease among different groups of civilians. The criminalization of HIV transmission is examined as a disease prevention mechanism. The purpose of this exercise is to show that mandatory testing for HIV already exists for different groups of civilians. It is often supported by the state’s duty to protect its citizens and maintain public health. These policies of mandatory testing preclude obligatory testing for women, as they will simply be added to the list of those already tested.

2.1.1. Overall Compulsory Testing, Identification of Sick Individuals and Their Isolation.

The first and obvious means of containing the spread of HIV, driven by fear of the disease, would be to introduce compulsory testing for HIV infection for the whole population and isolate those infected. The state has an interest in public health, and some suggest that the use of coercion must be part of an informed understanding of public health law in general.\textsuperscript{113} The courts have allowed this interest to trump individual liberties when such intervention was

necessary to contain epidemics and other widespread outbreaks.\textsuperscript{114} However, due to the nature of the virus, the time span that it takes to produce antibodies, the unreliability of the test\textsuperscript{115}, this task would seem to be extremely difficult and expensive to perform and the cost of the fruitless efforts would far outweigh any possible positive outcome. One may argue that possible outcome of saving lives under a regime of regular testing for HIV overcomes all the barriers for intervention of this kind found in the civil liberties of individuals. However, if one suggests for a moment that there is a public health policy in existence that requires compulsory testing of the general population (i.e. everyone living in the country) for the presence of the antibodies to the HIV virus, the following questions will arise.

First, how often will individuals with negative results be re-tested (every three months; every six months; once a year)? How much would it cost and who would bear the expense? If we do accept this scenario than one should also accept that pre-test counseling in these circumstances is likely to be abandoned (due to the number of tested individuals and the costs involved). In this case, another question is whether those who test positive should be informed about their result and, if they are to be informed of it, then in what manner.

United Nations Joint Program on HIV/AIDS (UNAIDS) has specifically addressed the issue of involuntary testing. It recommended that involuntary obligatory testing should not be used for, \textit{inter alia}, the following reasons:

- Obligatory testing is costly when its effect is very low, as the results cannot be 100\% true due to so-called “window period” when HIV antibodies cannot be detected;


\textsuperscript{115} Although ELISA tests detect HIV antibodies very effectively in HIV positive populations, their use in non-infected populations has presented the challenge of some false-positive rate. See K. Meyer, et al, “Screening for HIV: Can We Afford the False-Positive Rate?” (1987) 317 New England J. of Medicine 238.
• If conducted it will be used for discriminatory purposes, such as denial of health care, or refusal of employment;

• It will send a wrong message to the community that HIV/AIDS is a disease that belongs only to particular populations, thus creating a false sense of security and promoting stigma around HIV as a disease of specific “risk groups”.

Indeed, it is obvious that, unless strictly controlled by appropriate legislation, employers and health insurance companies (among others) might discriminate against those who are HIV positive once regular testing for HIV becomes compulsory. An individual may face tremendous discrimination at his workplace resulting in discrimination in compensation, terms, conditions or privileges of employment, including promotion, as due to his/her immune status these individuals might need more days for sick leave and better health coverage. The successful operation of health insurance companies is built on preserving the risk level in its insured populations and by securing exclusionary mechanism into insurance policies. The insurance system is supposed to make health care affordable for individuals by spreading the risk over such large population groups that the cost to individual participants is quite manageable. After ELISA testing was developed in the United States, the health insurance companies started to require testing for applicants for health insurance. As HIV rates are higher among drug users, commercial sex workers and other socially vulnerable and historically stigmatized populations, denying them of health insurance and employment will lead to catastrophic results: further stigmatization, sense of false security, and further spread of the infection.

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UNAIDS affirmed HIV/AIDS exceptionalism by suggesting a special way of treating testing for HIV. The *International Guidelines on HIV/AIDS and Human Rights* state:

[... ] Apart from surveillance testing and other unlinked testing done for epidemiological purposes, public health legislation should ensure that HIV testing of individuals should only be performed with specific informed consent of that individual.119

The recommendation for obtaining specific informed consent prior to the test affirms the importance of the pre- and post-test counseling. Pre-test counseling, if done properly, insures compliance with the requirements of informed consent. Post-test counseling is needed to ensure that the person understands all consequences of the result, no matter whether it is positive or negative. If the result is positive, the goal of post-test counseling is to help the affected person understand and accept her status, as well as reduce the risk of further spread of the epidemic.120

Although few people reject, in principle, the necessity of identifying and isolating sick individuals with potentially contagious diseases, public resistance to these measures might arise depending on the "combination of social vulnerability, mistrust of government, characteristics of the disease itself, and past practice".121 Historically, societies would feel justified in isolating sick contagious individuals and implementing the most harsh and unpleasant measures towards them for the sake of protecting the healthy. There are many

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118 R. Jarvis, et al, *AIDS in a Nutshell*, supra note 51, 121-128 (discussing the past and present situation with HIV testing for applicants for health insurance).
examples to that, such as leprosy and plague, yellow fever and cholera. People's behaviour in times of epidemic is hard to predict, it varies from denial of the danger to alienation of those infected. This discriminatory attitude persists to the present day. For example, people themselves have played an active role and tried to "protect" themselves from HIV, and isolate those infected, when the home, of HIV-positive teenager Ryan White, was burnt down when his mother insisted he attend a local public school.

The notion of imposing quarantine over individuals with HIV has not been seriously discussed in the United States, Canada or Russia (mainly owing to AIDS exceptionalism and the costs discussed above). The above-mentioned countries agreed that there was no public health justification "for imposing civil detention solely on the basis of HIV status, rather than individual behavior". Cuba, however, did impose a regime of compulsory testing and quarantine measures to stop the further spread of HIV; this had the reported outcome of limiting the progress of the epidemic in the early 1990s. Cuba is the only nation so far that has implemented "classic public health interventions" (i.e., routine testing, contact tracing and the isolation of those infected). Cuba is an island country and until recently its contacts


123 For example, when plague hit Moscow in the 1770-s, Muscovites were more afraid of quarantines than of the plague itself and they were hiding the sick. Despite the efforts of high religious leaders and the government to forbid some deeply rooted traditions in order to prevent further spread of the plague, the masses did not obey and opposing this killed one of the religious leaders. K. Tokarevich, & T. Grekova, Po Sledam Minuvshih Epidemi/ Following the Past Epidemics (Lenizdat, Leningrad, 1996), 20.

124 This discriminatory attitude bloomed in the beginning of HIV epidemic in the early 1980-s. When Ryan White's mother insisted that her HIV-positive son attended a local public schools, her neighbours, driven by their fear burnt down her house. As described in L. Gostin, Public Health Law: Power, Duty, Restraint, supra note 107, 208.

125 Ibid. 208.


with the surrounding world were very limited due to its politics. A climate of hostility towards the gay population there forced many homosexual persons to flee the country. It is also easier to limit civil rights in authoritarian societies, than in those that refer to themselves as “democracies”. Another factor to be considered when weighing the “success” of this policy might simply be the under-reporting of cases.

2.1.2. Testing policies in Canada

The major players in the struggle surrounding Canadian AIDS Policies have generally agreed that the testing should be voluntary. The Ontario Law Reform Commission, in its 1992 Report on AIDS, analyzed existing policies and practices with regard to HIV-testing, its cost-effectiveness and legal justification. It came to the conclusion that compulsory or mandatory testing [with the exception of blood testing, organ, tissue or sperm donors, as well as unlinked testing for research purposes] was unwarranted in all cases. The current federal legislation does not authorize the mandatory testing of the whole population; mandatory blood tests would affect citizens’ constitutional rights to liberty and security of the person, and to be free from unreasonable search or seizure. As it will be shown further, there are proposals to introduce a policy of mandatory testing for immigrants and newcomers and shift to routine offering of tests to pregnant women and those women who want to conceive.

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128 Some Russian Health officials argue that the fact that HIV hit Russia much later than other countries was due to the “iron curtain” and the limited movement to and from the USSR. See, for example, M.Narkevitch, “HIV Infection in the Russian Federation”, supra note 30.
129 However, it is not the Cuban Health Care policy, as outrageous as it is in violation of human rights, should get the attention of the HIV/AIDS activists, but the joyous reaction of some Western public health professionals to it and suggestions not to treat AIDS as a special case “gingerly for fear of offending high-risk populations....Cuba’s is the most comprehensive HIV screening programme of any nation. Screening is routine in Cuba’s health system, and the HIV test was merely added to the work-ups....” N.Shepper-Hughes, “AIDS, Public Health, and Human Rights in Cuba” (1993) 342 The Lancet 965.
131 Canadian Charter of Rights and Freedoms, enacted by the Canada Act 1982 [U.K.], c.11, paras.7, 8.
2.1.3. Testing Policies in the US

Under the Fourth Amendment of the United States Constitution, people have the right “to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures”. In the US, by the end of 1991, 36 states have introduced legislation demanding informed consent from any individual tested for HIV. New York State, for example, has passed legislation requiring written informed consent. In *N.Y.State Soc. of Surgeons v. Axelrod*, the New York Court of Appeals examined a case in which the Commissioner of Health and State Public Health Council chose not to add HIV infection to the list of communicable and sexually transmitted diseases, “based on concern that mandatory testing and contact tracing would prevent infected persons from cooperating with public health officials”. Four physicians’ organizations claimed that HIV should be placed on the official list of communicable or sexually transmitted infections dangerous to public health. Although it is difficult to argue with the fact that HIV is sexually transmissible, and might pose a risk to public health, placing it on the list would have significant public health implications: listed diseases are subject to state statutory provisions requiring isolation and quarantine, as well as case reporting, mandatory testing and contact tracing. Simons, J., delivering the majority opinion, observed that the request of New York State Society of Surgeons, to include HIV in the list of communicable and sexually transmitted diseases, was “contrary to the health of the public because it would discourage cooperation of affected individuals and would lead to the loss of confidentiality for those affected with the

132 U.S. CONST. Amend. IV, LEXIS/US STATUTES AND LEGISLATION.
134 Ibid, 608
135 Ibid.
disease". This decision seemed like a significant victory at the time. Even though it might seem that civil liberties in this case were used more like a bait than primary concern in order to make it more appealing for infected persons to report their illness so that uninfected population can monitor the spread of HIV, the decision provided necessary protection for those infected with the disease.

Another significant victory was won when the United States Court of Appeal, in Abbott v. Bragdon, held that asymptomatic HIV constituted disability within the meaning of the Americans with Disabilities Act (ADA) and that, consequently, no one could discriminate against individuals in the full and equal enjoyment of services on the basis of their immune status. The Court concluded that as reproduction was a “major life activit[yl” and was substantially limited by HIV-infection, asymptomatic HIV constitutes a disability within the meaning of ADA. One can say that to some extent, ADA modified the common practice of physicians in the United States. Under this statute, no insured health-care provider can refuse to provide a disabled patient with all the services and benefits provided to other patients, unless it can be shown either that the treatment required is outside the provider’s area of specialty or that the person poses a direct threat to the health or safety of others.

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136 Ibid, 609. It is also obvious that physician’s challenge was motivated as much by their care for the health of the public as it was by fear of infection from patients with HIV. See D. Webber, AIDS and the Law, 3d ed.(Wiley Law Publications, John Wiley & Sons, Inc., Toronto, 1997), 51.
138 42 U.S.C. Section 12132 (1992)
139 Ibid
140 For example, the Principles of Medical Ethics of American Medical Association (1984) stated that “a physician is not required to accept as patients all who apply to him for treatment. He may arbitrarily refuse to accept any person as patient even though no other physician is available”(as cited in R. Uwe, “Letter to Arnold Relman,”(Summer 1986) 6 Health Affairs 16.
Without question, ADA prohibits physicians from refusing to treat patients based only on their HIV-positive status.\(^{141}\)

In *Doe v. Ohio State University Hospitals and Clinics*\(^{142}\) the Ohio Court of Appeals affirmed the necessity of obtaining consent prior to HIV-testing. However, the United States nowadays have far more aggressive legislation with regards to disease prevention. For example, several states legally affirmed health policies, that involved obligatory testing of different segments of the population.\(^{143}\)

The Family Code of California still requires an HIV test prior to obtaining the marriage license, as:

> It is the intention of the Legislature that the results of the tests shall be transmitted to the marriage license applicant, and that follow up counseling by a knowledgeable and experienced person shall be made available.\(^{144}\)

The Draft CDC guidelines (2000) on Testing for HIV, Counseling and Referral recommend HIV testing for all clients in settings “where the client population is generally at increased behavioral risk of acquiring or transmitting HIV infection, regardless of setting prevalence”.\(^{145}\) Examples of such settings are STD clinics; adolescent health clinics with high STD rates; clinics serving men who have sex with men; drug or alcohol prevention and

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141 The question is whether ADA guarantees access to health care or simply prohibits denial of equal access based on a fact that a person has HIV. It needs further clarification, which is not the task of this paper. See E. Rosenthal, “Abortion Clinics Often Reject Patients with the AIDS Virus” (Oct. 23, 1990) *New York Times* A1. Most of the clinics cited “medical factors” in order to justify their refusals of AIDS patients.

142 663 N.E.2d 1369 (Ohio App. 10 Dist. 1995)


treatment programs; homeless shelters; correctional facilities; juvenile detention centers; and outreach programs. The necessity of such targeted testing is still to be questioned; it may seem to further discriminate vulnerable populations, and stigmatize HIV as a disease of so-called “risk groups”. Nonetheless, these populations should have access to voluntary testing and counseling as part of pragmatic public health strategy.

2.1.4. Testing Policies in Russia

Chapter 2 of the Federal Law “On Preventing the Spread of a Disease Caused by Human Immune Deficiency Virus in the Russian Federation”146 (hereinafter referred to as Law On HIV Prevention) speaks about testing and health care for people with HIV in Russia, as well as state’s obligations and guarantees with regard to the disease. This law was approved in 1995, and replaced two Soviet legal decrees adopted in 1987 and in 1990 respectively.147

According to the Constitution of the Russian Federation,148 the coordination of public health issues falls into joint jurisdiction of the Russian Federation and its subjects. Federal laws regulate the subjects of joint jurisdiction of the Russian Federation and its subjects.149 Being a federal statute, this law identifies all rights and duties, with regard to HIV infection, on the

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147 The importance of this law is obvious: there is data available that shows that before 1994 only 0.004% of all HIV tests performed in Russia were voluntary. AIDS InfoShare, “Report on Human Rights Violations with Regard to AIDS in Russia”, online: AIDSInfoShare <http://www.spiral.com/infoshare/Article2.html> (date accessed: June 29, 2001).
149 Ibid. article 76.
whole territory of the Russian Federation. It can be amended only by another federal law, and all existing legal acts and decrees that contradict this law are to be amended or not to be active.  

This law guarantees its citizens free access to testing for HIV antibodies as well as free medical care if they are found HIV-positive. It guarantees the second test for those who are tested positive in any medical institution they chose.

The Law on HIV Prevention mandates testing only for donors of blood and other biological fluids and organs, as well as those who are coming to stay in the Russian Federation for more than 3 months. In practice, however, all doctors and nurses who work with HIV infected patients are required to undergo obligatory testing for HIV every year. Prisoners are automatically tested for HIV when they enter correctional facilities. Inter alia, the list of those obligatory tested includes: people who are known to be drug users, homosexuals and bisexuals, people with STDs other than HIV, individuals who have casual sex and pregnant women. Some legislators and lawyers expressed concern that important provisions of the law were not implemented in the required manner. The Federal Program on HIV Prevention (1995-2000), that was supposed to help in the implementation of the law, has not been properly funded since 1996. In 1997 the program did not receive any governmental funds at all. Violations of the law took the form inter alia of mandatory testing without proper

\[\text{150 Ibid. article 4.}\]
\[\text{151 Ibid. article 15.}\]
\[\text{152 Ibid. article 4.}\]
\[\text{153 Ibid. article 11.}\]
\[\text{154 This provision is found in the List of Several Medical Professions to be Compulsory Tested for HIV during the Required Pre-Employment Medical Examination and Periodical Medical Examination. Adopted by the Government of the Russian Federation, September 4, 1995, # 877.}\]
\[\text{155 Materials for the State Duma Hearings "On Emergency Measures to Combat Spread of AIDS, Disease Caused by Human Immunodeficiency Virus (June 8, 1998), available in Russian on file with author.}\]
\[\text{156 Speech of chief sanitary doctor of the Russian Federation Gennady Onischenko, ibid.}\]
counseling and denying access to health care to PLWAIDS. Many people, not legally required to undergo HIV testing, are still tested, sometimes without their consent. Legally, the rights of people with HIV may be limited only by other federal legislation; in practice, they are limited by ministerial decrees and the whims of private employers. Non-governmental organizations, working in the field of HIV-prevention, face tremendous difficulties and barriers set up by local authorities. In some regions, mandatory testing for specific populations was imposed, a breach of federal law. Until now there have been no constitutional challenges of existing regulations and decrees that contradict the Federal Legislation.

The existing policy of HIV testing in countries of interest was described here in order to establish that despite the absence of compulsory overall testing for HIV, it is still acceptable for different groups of population depending on the state interest in them (discussed below). Mandatory and/or compulsory testing for HIV infection exists in many countries around the world. One may suggest that such testing represents coercive powers that the state uses to honour its duty of public health protection. It is usually limited to different groups of identifiable populations. Further, existing policies for testing of three groups of people will be analyzed and public health justification for them provided where possible.

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157 S. Polubinskaya & E. Vassilieva, “HIV-Specific Legislation in the Russian Federation” (1999) 18 Medicine and Law (2&3) 336, where S.Polubinskaya gives an example of this kind of legislation enforced in Nizhny Novgorod. It is one of the many examples. The same violation of Federal Law was done on other territories (Tatarstan, Kalinigrad region, Novosibirsk etc).
2.2. Mandatory testing of different groups of population:

2.2.1. Immigrants

Countries like individuals, are egoistic: those, inside the castle walls will always seek to protect what they have against those outside.

B. Hoffmaster & T. Schrecker\(^{158}\)

To prevent further spread of the infection on their territories many states enacted statutes requiring an HIV test before granting foreign persons admission into the country. Allowing HIV positive refugees and immigrants to enter the country might be perceived as a threat to public health. It is also believed that newcomers with HIV/AIDS will require extensive treatment that would entail high medical costs. Unless the immigrant is able to afford covering these expenses himself/herself, these costs will be a burden for the state.\(^{159}\)

Russian legislation requires HIV testing for all those who come to stay in the country for a period over three months. They are to provide representatives of Russian Consulates with valid certificates stating their immune status, before they can be issued a visitor’s visa.\(^{160}\) It is obvious, that all those applying for a refugee or immigrant status in Russia are coerced to have an HIV-test. The law is silent with regard of the future of those newcomers who are

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\(^{159}\) In case of Canada, provinces would be responsible for bearing the medical expenses of the sick individuals. See for example, *Charran v. Canada*, 28 Imm. L.R. (2d) 282, 89 F.T.R 113 (1995), when a family was refused a landed immigrant status as their child was suffering from a disease that would require expensive and extent treatment in Canada. The family did not have enough financial means to support it. Their application was refused as insufficient humanitarian and compassionate considerations existed to permit an application for landing. The judicial review dismissed the case.

found to be HIV positive. However, those who decline mandatory testing might be expelled.\textsuperscript{161}

The Immigration and Naturalization Act of the United States bars entry into the U.S. if the aliens have “a communicable disease of public health significance”.\textsuperscript{162} The Department of Health and Health Services has deemed HIV to be a “communicable disease”\textsuperscript{163} and now the Immigration and Naturalization Act of the United States specifically refers to it as the “infection with the etiologic agent for acquired immune deficiency syndrome” among the criteria for inadmissibility.\textsuperscript{164}

The definition of HIV as a “communicable disease of public health significance” decided the fate of many refugees from Haiti who fled their home country after the coup in 1991, only to find themselves living in isolation in a remote refugee camp, in Guantanamo, for HIV-positive individuals.\textsuperscript{165} Outraged human rights activists litigated against this situation, and the litigation successfully ended with closure of the camp.\textsuperscript{166} Several claims for asylum have been considered, and some have been granted, on the basis of being HIV-positive and a member of a persecuted social group.\textsuperscript{167} Under United States law, the HIV exclusion applies to all aliens whether they seek immigrant or non-immigrant status.\textsuperscript{168} Currently, however, the

\textsuperscript{161} Правила медицинского освидетельствования на выявление заражения вирусом СПИД, Приказ МЗ СССР, 04.09.1987 №1002 (Rules of Medical Examination to Identify AIDS Virus, approved by Decree of the Ministry of Health of the USSR, Sept.04, 1987, #1002 (CD-ROM: GARANT, Moscow 2001). The same approach to foreigners is exercised in other CIS countries, for example, Belarus, Ukraine.

\textsuperscript{162} Immigration and Naturalization Act, §212 (a) (1) (A) (I), 8 U.S.C. §1182 (1992).

\textsuperscript{163} 42 C.F.R. §34.2 (b) (4) (Westlaw 2000).


\textsuperscript{166} On June 8, 1993, Judge Sterling Johnson, Jr. ordered the closure of the camp and the release of the Haitian refugees imprisoned there. Ibid., 187.

\textsuperscript{167} See Maradiga v. Immigration and Naturalization Serv., 95 F.3d 1158 (Westlaw 2001). Maradiga’s asylum petition was denied, but he was able to avoid deportation with the suspended status given to him by Attorney General.

\textsuperscript{168} 8 U.S.C § 1182 (a) (1) (A) (I) (Westlaw, 2001).
Immigration and Naturalization Service only tests for HIV exclusion those individuals seeking immigrant or refugee status.\textsuperscript{169}

Section 19 of the Canadian Immigration Act\textsuperscript{170} identifies as inadmissible on medical grounds:

(a) persons who are suffering from any disease, disorder, disability or other health impairment as a result of nature, severity or probable duration of which, in the opinion of a medical officer concurred in by at least one other medical officer,

(i) they are or are likely to be a danger to public health or to public safety, or

(ii) Their admission would cause or might reasonably be expected to cause excessive demands on health or social services [...]\textsuperscript{171}

Up till now HIV testing is not automatically included in the medical examination that will determine whether a person is admissible to come to Canada. However, recent polling conducted for Health Canada showed that most Canadian residents believed the costs of caring for HIV-infected immigrants was too high, and that those, applying for immigration, should be tested for HIV and prohibited to enter the country for health reasons.\textsuperscript{172}

Unlike U.S. legislation, Canadian law does not automatically bar aliens with HIV. However, Canadian law does, in theory, authorize the exclusion of prospective immigrants who are HIV positive, either because they pose a threat to public health or because their care and support would consume too many resources. Russian legislation demands testing as a pre-requisite to giving a visitor’s status if a person is to stay over three months. Even if testing of immigrants for HIV infection can be explained by utilitarian reasons of economy,


\textsuperscript{170} Immigration Act: An Act Respecting Immigration to Canada, R.S.C (1985), c. I-2, as am. R.S.C. 1985, c.31 (1\textsuperscript{st} Supp). s.99.

\textsuperscript{171} Ibid, s. 19.
and prevention of the disease, it is obvious that one has to carefully balance the possible outcomes of these strategies with anti-discrimination provisions in domestic and international law.173

2.2.2. Donors of blood, semen, organs and bodily tissue

With regards to blood donors, the term “screening” is more appropriate, as usually it is not the individual donor who is tested, but his blood sample that is screened for antibodies; it is not the person who is rejected, rather the sample of his blood is rejected as infected in order to protect the blood supply.

The protection of a country’s blood supply is extremely important. Many of the first AIDS cases were among hemophiliacs who were infected as a result of blood transfusions174, and these cases signaled that the virus got into blood supplies. Without a means of testing for contamination, blood supplies were vulnerable, and blood transfusions from anonymous sources were extremely risky. The risk of infection by the transmission of contaminated blood is over 90%, and many donations worldwide are not tested for HIV even nowadays.175

Widespread contamination of blood prior to 1985, caused HIV infection rates in the early years of the epidemic to be higher among hemophiliacs, who often required blood

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173 UN Commission for Human Rights (UNCHR) affirmed that “discrimination on the basis of HIV status, actual or presumed, is prohibited by existing human rights standards”. See The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), UNCHR Resolution 1996/43 1; preamble to UNCHR Res. 1999/49 of the same title, online: UNHCR <www.unhchr.ch/huridoca/huridoca.nsf> (date accessed May 1, 2001).

174 For example, the most well known case is the one of Ryan White, a teenager from Indiana, who was infected through blood transfusion. The story of his short life and the courage with which he and his family fought against the disease and prejudice made him a hero all over the world. National AIDS Information Clearinghouse “I Have AIDS”: A Teenager’s Story, Children’s Television Workshop, Rockville: 1990 (a videotape). See generally, D. Gonzales, AIDS: 10 Stories of Courage, (Springfield, NJ, Enslow, 1996).

175 UNAIDS/IPU, Handbook for Legislators, supra note 60, 47.
transfusions, than among any other group. Until the test for antibodies to HIV was developed, blood banks were literally “left alone” with the task of screening potential donors for the disease. The only possible way for the donors to be excluded from donating blood was through their medical histories of exposure to hepatitis, syphilis and other blood-borne diseases. They were also asked about cancer, unexplained weight loss and what medications they were taking. As a result, blood donations were only screened for hepatitis B, syphilis and antibodies to other infections, excluding HIV.

American screening of blood donors, for the presence of HIV antibodies, started in the beginning of 1985 when the licensing of ELISA test was approved. In Canada, blood donors were not screened for HIV until May 1985, and testing of semen donors was not available until later that year. In Russia, testing donors of blood and other biological material as well as screening of already-donated blood started in 1987, when the first Rules of Medical Examination to Identify AIDS Virus were established by the Ministry of Health of the USSR. The same provision was later pasted in the Federal Law on HIV Prevention in 1995. Article 9 states that blood donors, as well as donors of “biological fluids, organs and tissues” are to be “compulsor[y] examined” for the presence of the antibodies to the

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virus.\textsuperscript{181} Those who reject this "examination" (i.e. testing) cannot be donors of blood and other biological material''.\textsuperscript{182/183}

Screening of donor's blood is very important in preventing the further spread of HIV. There is general consensus that this should be done to protect the health of the whole population. In \textit{Walker Estate v. York-Finch Hospital},\textsuperscript{184} dealing with alleged negligence by blood agency that failed to conduct adequate screening of donated blood, the trial judge recognized the duty of care, that the blood agency had to determine transfusion-associated risk and warn users of the risk as well as take appropriate measures to minimize and eliminate it. It was also held that the adequacy of screening procedures was not an issue that fell exclusively within the domain of medical experts.\textsuperscript{185}

It is important to note that unlinked screening of the donor's blood should be separated from the testing of the individual in the manner, that it is the blood that is screened, not the individual who is compulsorily tested. As health care budgets can be very constrained in some transitional countries, some governments have been unable to implement policies that mandate consistent screening of donated blood and ensuring the security of their blood supplies.\textsuperscript{186} Protection of public health is not only a state's right but also its duty and responsibility. UNAIDS directly recommends screening of donated blood for HIV and other

\begin{flushright}
\textsuperscript{181} Ibid. article 9.
\textsuperscript{182} Ibid. article 9, p. 2.
\textsuperscript{183} A doctor who orders a blood transfusion of non-screened blood if it results in infecting the recipient is likely to be found responsible for "causing death through negligence" or "causing grave or average gravity harm to health through negligence". Article 109, Criminal Code of the Russian Federation, supra note 221.
\textsuperscript{185} Ibid.
\textsuperscript{186} In Russia the text of the legislation itself focuses on the donor of blood, who is given an official "certificate" that states his/her HIV status that he is to present when donating blood. Ibid., Federal Law "On HIV Prevention in the Russian Federation", supra note 147, article 7, s. 2.
\end{flushright}
blood-borne diseases and lists it as one of responsibilities of the Public Health Legislation.\textsuperscript{187} Screening of donor's blood samples for HIV infection represent the least debated public health duty of the state,\textsuperscript{188} as:

[…] The right to health is clearly violated by the use of contaminated blood and there is no countervailing or legitimate interest in donating infected blood.\textsuperscript{189}

2.2.3. Testing of Prisoners.

As a majority of correctional facilities in the world are limited spaces with many people living closely to each other, prison populations are very susceptible to different kinds of epidemics.\textsuperscript{190} Disease remains the leading cause of death for many prisoners around the world.\textsuperscript{191} HIV prevalence in prison may be higher than in the general community, especially if there are many convicted drug users.\textsuperscript{192} The risk of transmission is likely to be higher in prison also due to potentially unsafe behavior (violent sex, tattoos, etc). The International Guidelines on HIV/AIDS and Human Rights mention that prison facilities should

\textsuperscript{187} "Public health law should ensure that the blood/tissue/organ supply is free of HIV and other blood-borne pathogens", International Guidelines on HIV/AIDS and Human Rights, Handbook for Legislators, supra note 60, 122. Partly, this could be done by ensuring voluntary versus paid blood donations.
\textsuperscript{188} What fuels the debate around blood/organ donors and HIV infection are the confidentiality issues and whether those tested positive should be reported. See, for example, K. Hopkins, “Blood, Sweat and Tears: Toward a New Paradigm for Protecting Donor Privacy”, supra note 179, 141.
\textsuperscript{189} UNAIDS/菩U, Handbook for Legislators, supra note 60, 50, and this is why “criminal penalties for making false blood-donor declarations do not have the same negative policy implications as private behaviour where transmission may occur”.
\textsuperscript{190} This is especially true of airborne viruses, which explains why Tuberculosis (TB) is such a problem in the correctional facilities
\textsuperscript{192} The Chief Sanitary Doctor of the RF Gennady Onischenko noted that overwhelming majority of prisoners with HIV infection were incarcerated due to illicit operations with drugs and psychotropic substances. Ministry of Health of the Russian Federation, Decree #19 (29.12.99) available in Russian on file with author.
[...] Ensure confidentiality and prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programs for HIV positive prisoners.193

In the United States, federal prisoners upon the entry of a federal correctional facility are to be screened to identify those who might be HIV/HBV (hepatitis B virus) positive.194 The screening takes place in a form of interview with medical personnel; they request any prisoner so identified to submit to an HIV or HBV test. The Bureau of Prisons also tests a sample of inmates annually.195 The Code of Federal Regulations196 contains the following definition of those inmates who are to be mandatory tested:

Inmates who are pregnant, inmates, receiving live vaccines or inmates being admitted to community hospitals, if required by the hospital, shall be tested. Inmates demonstrating sexual behavior which is promiscuous, assaultive, or predatory shall also be tested.197

It can be argued that HIV testing of inmates in the United States should does not represent a pragmatic public health measure, but can be interpreted as an addition to already ordered punishment. It seems that the prisoner’s right to consent to medical treatment, as part of the right to privacy is limited together with their freedom upon their conviction.

In Dunn v. White198 the court stated that involuntary testing of the plaintiff was not a violation of his constitutional rights to privacy and to be free from cruel and unusual punishment.

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194 See 28 C.F.R 549, §549.18 (a) (A) (66 FR 19402, 2001).
195 Ibid., §549.18 (d).
197 Ibid., §549.18 (f).
198 Dunn v. White, 880 F.2d 1188 (10th Cir. 1989).
In *Walker v. Summer*,
199 the judges also came to the conclusion that an inmate who was forced into testing was not denied his constitutional rights.

In Russia, the Ministry of Interior Affairs in 1996 took into consideration the epidemic of HIV in the country and issued Regulations that mandated those prisoners who are found to be HIV-positive to be provided with the "condition, eliminating the possibility of the infection".
200 These Regulations limited those prisoners who could be obligatory tested for the presence of HIV virus to those, who wanted to be donors of blood and other biological material; those who perform functions of workers, included in the appropriate List; those who have clinical conditions.

Successfully vague term "those who have clinical conditions" together with the direct demand that those infected are to be isolated from others
202 led to overall obligatory screening of the prison population upon entrance of prisons and creation of so-called "special zones" for HIV-positive inmates.
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201 Ibid. par. 2.
203 It seems that there was a widespread belief among prisons' officials that providing HIV-positive inmates with special care and "conditions, eliminating the possibility of further transmission" as defined by the above mentioned Regulations, demanded segregating them from the rest of the prison population for the reasons of "protecting their safety." See "In a Voronezh Prison HIV-Positive Criminals are Gathered Together in An Isolated Group," (January 28, 2001), online: RIA Novosti: <http://lenta.ru/english/2000/01/28/aids.htm> (date accessed February 12, 2001).
In Canada, it is generally agreed that involuntary testing of prisoners is not consistent with the provisions of the *Canadian Charter of Rights and Freedoms*. In all Canadian prison systems, testing for HIV is undertaken only voluntarily. Support for this policy is nearly unanimous. However, from time to time, there are calls for mandatory or compulsory testing of the inmates; these are successfully rebuked by HIV/AIDS activists as well as the Justice Department. Some suggested an amendment to the *Corrections and Conditional Release Act* in order to make those, who are conditionally released, consent to HIV testing and partner notification. As it was shown earlier the practice of testing prisoners for HIV before their conditional release exists in the United States. On one hand, it seems that this policy might be justified as it aims to protect the general public from "dangerous" HIV-infected prisoners, who are released before their term. The goal of this policy is to make the information about HIV-status of the inmates available to their possible victims if, for example, they commit an assault. On the other hand, this policy seems to punish those who already served their time, by distinguishing them from the general population. Moreover, the effectiveness of this is extremely doubtful for the same reasons explained above that relate to any mandatory testing policy of general population, i.e. difficulties with the "false-negative results" and lack of commitment to be treated.

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205 See R. Jurgens, *HIV Testing and Confidentiality*, ibid., where R. Jurgens cites Commissioner of Correctional Services of Canada stating that the conclusion that CSC and the Justice Department had came to so far was that implementation of compulsory testing of inmates would be difficult with regards to some sections of the Charter.


207 Ibid.
There are also proposals to test inmates in order to protect the personnel working with them in the correctional facilities. However, it seems unlikely that service personnel will come into intimate contact with the inmates, such that they would be exposed to HIV.

The Canadian Expert Committee on AIDS in Prisons\textsuperscript{208} strongly opposed suggestions for the mandatory testing of prisoners in Canada, instead recommending that testing should be readily accessible to all inmates in Canada.

The Canadian approach to HIV/AIDS prevention in prisons is the most pragmatic of the three discussed above. It is difficult to justify mandatory testing of prisoners from the perspective of reducing the general epidemic. This policy distinguishes between the prison population and other "vulnerable" groups for the purposes of mandatory testing; and it does not improve efforts to prevent HIV. Unfortunately, this policy of testing inmates and segregating those who are infected creates a sad precedent that can entail the same for other identifiable groups at risk of infection.

\textbf{2.3. Criminalization of HIV Transmission}

\textbf{2.3.1. Transmission through Sexual Contact}

State control over the dangerous personal behavior of individuals that leads to further spread of the disease might seems likely to result in curbing the epidemic. This might be done with the help of Criminal Law and specific HIV-related statutes, or alternatively, by prosecuting the risky activity (such as male to male intercourse) under already existing legislation. Already, by 1987, numerous states had enacted criminal laws specifically relating to HIV exposure and transmission; as well, they tried to prosecute risky activities through traditional

criminal law. The underlying purpose of criminal law is to ensure that people do not engage in a conduct that the state deems undesirable, and to dissuade them from engaging in certain kinds of conduct. The HIV-specific statutes in many instances were drafted to give clear notice of "socially unaccepted" behavior and provide means for punishment. This fueled "unwarranted discrimination" against PLWAIDS and those perceived to have the disease. However, criminal law cannot be the only answer to the all complex issues around HIV.

In the case of Nushawn Williams, who knowingly concealed his sero-positivity from his sexual partners and, as a result, infected many women and teenage girls, criminal responsibility is obvious. This was, plainly, reckless behavior that resulted in the transmission of a lethal disease. The Grand Jury indicted Williams on two counts of second degree statutory rape, and later on he was also indicted on two felony charges: Reckless Endangerment in the First Degree and Attempted Assault in the Second Degree. The Williams case triggered many responses and calls for mandatory notification of sexual partners of those infected with HIV, contact tracing and name reporting. Nevertheless, this case represents a pragmatic approach to such delicate issues as regulation of sexual conduct and transmission of a lethal disease. When Nushawn Williams was voluntarily tested for

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209 See generally, M.Closen et al., "AIDS: Testing Democracy – Irrational Responses to the Public Health Crisis and the Need for Privacy in Serologic Testing" (1986) 19 Marshall Law Rev., 924. It is noted that many early cases were prosecuted under traditional criminal law statutes of homicide assault and attempt. One should note here that there are quite a few offences available for prosecution of knowing HIV transmission in many countries: homicide, attempted homicide, reckless endangering, criminal assault, etc.

210 R. Jarvis et al., AIDS Law in a Nutshell, supra note 51, 2.


213 The question whether Williams had really given his informed consent to the test can still be questioned as he was tested for the antibodies at the urging of staff at a local STD clinic, and as it is explained later on in Chapter IV, medical professionals being figures of authority can involuntarily press one’s decision to consent. See G.
HIV in 1996, public health officials were given an opportunity to explain to him the need to notify his sexual partners and he was counseled about the possibility of being held criminally liable for exposing them to HIV.

In *R. v. Cuerrier*[^214], the Supreme Court of Canada came to the conclusion that consent to unprotected sexual intercourse was consent to sexual congress with a certain person and to an exchange of bodily fluids with him/her.[^215] The issue in *Cuerrier* was somewhat similar to the one in New York State. The accused was tested positive for HIV infection and was instructed about condom use and informing sexual partners about his status. However, he angrily rejected this possibility and had unprotected sex with two women, one of whom he assured of his HIV-negative status. The Court recognized the importance of extending the existing legislation for future prevention of the epidemic:

> It may be that criminalizing deceit as to sexually transmitted disease inducing consent may prevent some people from seeking testing and treatment out of fear that if they learn about their disease they will be forced to choose between abstaining from unprotected sexual relations and becoming criminals. On the other hand, it may foster greater disclosure.^[216^]

The Court noted that the extension of existing legislation was narrow and:

[...] Catching only deceit as to venereal disease where it is established, beyond the reasonable doubt, that there was a high risk of infection and that the accused knew or ought to have known that the fraud induced consent to unprotected sex.^[217^]

McLachlin, J. (as she then was), delivering her dissenting opinion, expressed worries about broadening criminal legislation to penalize this specific non-disclosure of risk or deceit.

[^215]: Ibid., 517.
[^216]: Ibid., 518.
[^217]: Ibid.
inducing consent. She disagreed with the view expressed separately by L'Heureux-Dube and Cory, JJ that criminal law had a role to play; that it could deter those infected with HIV from “putting the lives of others at risk and in protecting public from irresponsible individuals who refuse to comply with public health orders to abstain from high-risk activities”.\textsuperscript{218} McLachlin J. urged the Court to exercise caution when expanding criminal statutes to HIV transmission as:

\begin{quote}
[...] Homosexuals, intravenous drug users, sex trade workers, prisoners and people with disabilities are those most at risk of contracting HIV... [and] the burden of criminal sanctions will impact most heavily on members of these already marginalized groups.\textsuperscript{219}
\end{quote}

Russian legislation mentions different liability for exposure to AIDS (not HIV) and its actual transmission.\textsuperscript{220} However, both terms are ill-defined and vague. If a person knowingly places another “in danger of being infected with AIDS”\textsuperscript{221}, he/she can be punished with imprisonment for up to three years. If the person knowingly infects another with AIDS, the punishment is up to five years in prison.\textsuperscript{222}

UNAIDS recommends not to implement specific HIV-related offences, but rather apply existing legislation to these specific crimes.\textsuperscript{223} It can be argued that HIV-specific statutes are usually either too vague or too narrow and they are likely to have a detrimental effect on prevention of the disease. The individuals most at risk are least likely to get tested for the fear

\bibitem{218} Ibid., opinion delivered by Cory, J, 565.
\bibitem{219} Ibid., 541.
\bibitem{221} Ibid. article 122. It is obvious that the terminology, used in the Criminal Code is incorrect. One cannot be infected with AIDS, which is a chronic condition of immune suppression caused by HIV.
\bibitem{222} Ibid. article 122, s (1), (2).
of all the legal issues that entail this "simple" process of blood testing. Despite the debatable effect of HIV-specific statutes on disease prevention, the desire to punish for knowing transmission of the virus as one of the means of preventing individuals from risky behavior is widely accepted, arguably based on the sense of justice.

An important step in controlling the disease is punishing those who intentionally expose others to HIV. The public has a right to be protected from those who effectively sentence others to death by their own reprehensible behavior.224 Putting all the blame on one individual when the transmission occurs as a result of a sexual intercourse or use of injection paraphernalia, seems to be a highly debatable point of view, as with regards to exposure to the virus through sexual transmission, for example, it takes at least two people “to tango”. Nevertheless, criminalization of intentional exposure to HIV and adoption of HIV-specific statutes should be regarded only as a small part of overall prevention strategies:

Coercion is a crude tool in educating for behaviour change, particularly in areas of intimate private activity [...]225

2.3.2. Transmission through Drug Use

In cases of needle/syringe sharing, the intent to transmit the disease is not obvious; rather there is intent to consume illicit substances with the use of illicit paraphernalia.226 Political strategies to curb these two interconnected epidemics – of drug use and HIV usually involve two traditional approaches. The first – law enforcement and interdiction - designed to limit

the supply of illicit drugs on the market. Unfortunately, this strategy is often advanced by broad criminal sanctions against individual drug users for possession or use of illicit substances.

Before the HIV epidemic hit the drug-using community in 1996, the Russian Parliament had approved (and the President signed) a new Criminal Code of the Russian Federation. Previously existing criminal liability for the use of drugs (that could be found in the old Criminal Code of the RSFSR of 1960) was taken out from the new Code. However, as soon as the epidemic started among IDUs, the new law “On Drugs and Psychotropic Substances” was adopted that put all needle and syringe exchange programs under great stress. First of all, this law re-established the long-forgotten formula of the 1960 Criminal Code and, in article 40, forbade the “non-medical use of substances the use of which is limited on the territory of the Russian Federation”. Taking into account the absence of definition of this activity as a “crime” in the criminal code, this norm was a stillborn. Moreover, the law forbids any propaganda of drug use and the term “propaganda” is so ill-defined that any harm reduction activities might be regarded as violating this statement of the law. Unlike the United States, Russian laws do not ban possession of drug-injecting paraphernalia. However Russian policy to curb the epidemic of drug use consists of

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227 This approach is also known as the “crime and punishment approach model of controlling illicit drug use”. For further discussion on different models of dealing with drug use see E.Hagan & J.Gormley, *HIV/AIDS and the Drug Culture: Shattered Lives* (New York, The Haworth Press, 1998) 3-8.
228 Criminal Code of the Russian Federation, supra note 221.
230 Ibid. article 45.
231 Some rightly claim that the absence of pragmatic public health approach to the regulation of drug-related paraphernalia in the United States, fueled the epidemic of HIV in the country in the early 1990-s. (See L.Gostin, “The Interconnected Epidemic of Drug Dependency and AIDS”, supra note 111, 135; M.Parts, “Disease Prevention as Drug Policy: A Historical Perspective on the Case for Legal Access to Sterile Syringes as Means
arresting drug users on a regular basis on the charges of possessing of large quantities of illicit substances (article 228, part 1 of the Criminal Code). These quantities are defined by Constant Committee on Drug Control and the maximum weight of marijuana one can have is 0.3 grams and it is 0.001 gram for heroine. For these "hard" crimes drug users face punishment for up to three years of deprivation of freedom. Russian legislators soon realized that they were too quick to adopt "liberal" attitude towards drug use and came up with a draft Federal Law "On Amending the Criminal Code of the Russian Federation", where a separate article was dedicated to illicit consumption of drugs and psychotropic substances. This law is still a draft. Some restrictive provisions of the law On Drugs (discussed earlier) were challenged on constitutional grounds by several members of the Russian Parliament. The decision of the Constitutional Court of Russia on this matter is yet to be announced.

UNAIDS recommends criminal law not to be "an impediment to measures take by States to reduce the risk of HIV transmission among injecting drug users". In Canada there is an understanding that for further prevention of HIV among IDUs the government should provide injection sites. The "war on drugs" that was announced by the Reagan administration in the United States has provoked a massive needle-born HIV epidemic in the country.

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232 Criminal Code of the RF, supra note 221, article 228 s (1).
235 UNAIDS/IPU, Handbook for Legislators, Supra note 60, 123.
Criminalization of HIV-related behavior seems to be very costly and highly ineffective.\textsuperscript{238} It also leads to further discrimination of HIV-infected individuals and deters those most at risk from testing due to fear of being punished for their activity. At the beginning of the epidemic government officials thought that restricting sexually oriented commercial activities, especially those, aimed at gay men might stop the epidemic. This resulted in numerous cases that tried to challenge these decisions on constitutional grounds.\textsuperscript{239} There is no evidence that state control over intimate behaviour limited the epidemic. Vice versa, these populations became more marginalized and more hidden and more difficult to reach.\textsuperscript{240}

2.4. Conclusion

As one can see there have been different approaches to HIV prevention both through testing and criminalization of HIV transmission and related behavior. Existing legislation in all three of the discussed countries accepts mandatory testing policies towards donors of blood, organs and tissue, on the basis of guarding health of the whole population. Indeed, there is extreme danger of transmission through contaminated blood transfusion and thus, the blood supply has to be screened for HIV and other blood borne diseases on a regular basis. Those, willing to donate any bodily fluids or organs, are to be tested due to the absence of any legitimate interest in donating infected blood or organs. Obligatory testing of newcomers and

\textsuperscript{238} For example, A. Wodak, “To Take Arms Against a Sea of Drugs”, (1997), 9 J. of Contemporary Health Law and Policy, 323, opposes the theory that states that harms from drug use (including HIV) can be eliminated by strong prohibitionist national policy (for an example of this policy see R. Du Pont, & E.Voth, “Drug Legalization, Harm Reduction and Drug Policy”, (1995). 123 Annals of Internal Medicine (6): 461-465) and builds his argumentation on the health costs associated with illicit drug use (including HIV) and concludes the ineffectiveness of supply reduction policies as the only public health policy to prevent harms from drug use.

\textsuperscript{239} See City of New York v. New Saint Mark’s Baths, 497 N.Y. S 979 (Supp.Ct. N.Y.County 1986), where based on the evidence of high-risk activities the court upheld the closing of a bathhouse, and in regard with the First Amendment issues implicated by the closure, the court dismissed them.

\textsuperscript{240} And this, in turn, would limit the possibility for educational interventions that constitute an important part of successful HIV prevention strategy.
immigrants, as well as federal prisoners, raises questions of legitimacy of such policies. In case of newcomers, by imposing a requirement for the HIV test, that state tries to balance the interests of protecting the health of its own population, and securing the just distribution of the resources on health care needs with its willingness to attract new people to its territories or provide asylum on humanitarian grounds in accordance with its international treaties. In case of prisoners, the compulsory testing seems to represent an unnecessary extra limitation of rights of the inmate. There is no evidence to prove the success of the compulsory testing of prisoners and its effect on the spread of the epidemic among the general population. Segregation of the infected from general prison population based on the reasoning of "their own security" fuels fear and stigmatization, as well as shows lack of desire to conduct relevant HIV prevention programs in prisons.

The goal of the presented review of different approaches to curbing HIV epidemic through testing exercise was to show that pre-dispositions for obligatory testing of women exist in at least two of the above discussed countries: Russian Federation and the United States. In these countries, there are already other groups of population that are tested on the grounds of fear and discrimination without necessarily connection to public health significance and civil liberties.

As it was shown, criminalization of HIV transmission is a complex issue, as there are already tendencies to prosecute people, who engage in activities that might be risky to their health. However, coercive response seems to bring more harms than good. Criminal prosecutions are unlikely to deter people from engaging in needle sharing, commercial sex, unprotected sexual intercourse and pregnancy. A policy based on punishment is likely to further deter those in need from accessing health services. Statutes mandating penalties for HIV transmission
should either not be enforced, or narrowed down to exclude HIV-positive women from punishment for intentional exposure of third parties to HIV. Non-specific and vague provisions of existing criminal law with regards to HIV may fuel obligatory testing of pregnant women, which, in turn, will deter them from antenatal care.
Chapter 3. Why implement coercive testing for HIV for pregnant women.

This chapter analyzes the most commonly given reasons for HIV testing of pregnant women. Some of these arguments are deconstructed in attempt to show that they do not have either public health, or legal significance.

3.1. Pregnant women are easy to test.

The first and most obvious argument in favor of testing is that pregnant women are easy to identify and test. They represent a relatively small part of population, and it is feasible to test all of them, particularly since, during antenatal care, they are routinely tested for other diseases (such as rubella and syphilis) and thus provide many blood samples.

3.2. Empowering decision-making

The question of routine antenatal testing for HIV of pregnant women came into existence when it was found that around 30% of children born to HIV positive women would be infected. The possibility of perinatal transmission could be further reduced by discouraging mothers from breastfeeding and by performing Caesarian operation for the purpose of delivery. Empowering women, by giving them sufficient information to make informed reproductive choices, may serve as an argument in favor of testing, “even if such knowledge does not change her final decision” to have a baby. It is indeed quite important to make an informed choice about one’s situation, especially when faced with a deadly disease. However,

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242 See for example, Committee on Prenatal and Newborn Screening for HIV Infection, HIV Screening of Pregnant Women and Newborns, supra note 103. The current obstetric practice recommends Caesarian delivery in order to reduce the viral exposure during the birthing process. It is also recommended in cases when placental membranes remain ruptured for more than four hours. See W. Landesman, et al, “Obstetrical Factors and the Transmission of Human Immunodeficiency Virus Type 1 from Mother to Child” (1996) 344 New Eng. J. Med. 1617.
taking into account the extremely vulnerable position of many women and the unconditional trust placed in their doctors, one may wonder whether this choice will be made out of their own free will and will not be influenced by the attending physician. Some argue that unwanted HIV diagnosis in a doctor’s office represents a high level of directive counseling that will not empower any informed decision-making process in women, and is likely to limit it and reinforce stereotypes and discrimination. There is research available suggesting that knowledge of women’s HIV status does little to change their respective decisions to go on with their pregnancies. A substantial number of pregnant women, when informed about their HIV status, chose to go on and carry their fetuses to term. Empirically speaking, it is open to question whether information, once forced upon pregnant women, can empower them in their decision-making. Furthermore, if one accepts that autonomy is a value worthy of protection, and it would seem that any argument grounded in the empowerment of women must take autonomy as a fundamental value, it is difficult to justify compulsory testing of pregnant women.

243 Committee on Prenatal and Newborn Screening for HIV Infection, HIV Screening of Pregnant Women and Newborns, *HIV Screening of Pregnant Women and Newborns*, supra note 103, 35.

244 This should be an issue of special concern in countries where historical attitude towards women was that of only a vessel for healthy children. The NAMES Foundation in Report on HIV/AIDS in Women in Russia, prepared by Women’s Network, present interviews with HIV-positive women, who had to face doctors demanding that they had an abortion and many women were put in situations when they simply could not refuse. Online: NAMES Foundation <http://www.aids.ru> (date accessed: April 24, 2001).

245 See K. Gallagher-Mackay, “Routine Offering of HIV Tests to Pregnant Women: Foetal Supremacy, Medical Authority, and Invisible Effects on Women” (1997) 9 Canadian Journal of Women and the Law (CJWLF/RFD) 352. She also cites the 1985 CDC Guidelines for prevention of perintal transmission, that urge women to postpone their pregnancy and review their options quite seriously given the risks to the foetus.

246 The recent study conducted in Brazil with regards to sexuality of HIV positive women and their reproductive choices, found that 31% of surveyed women had their children after they learnt about their HIV status. N. Santos, et al, “HIV Positive Women, Reproduction and Sexuality in Sao Paolo, Brazil” (1998) 6 (12) Reproductive Health Matters 31, 35.
3.3. Availability of Treatment

Availability of preventive medical care that will reduce the possibility of transmission to the fetus, at the same time benefiting the mother, may serve as another argument for testing pregnant women for HIV. The calls for overall testing of pregnant women for HIV-infection became louder after U.S. National Institute of Health announced interim results from Pediatric AIDS Clinical Trial Group (ACTG) 076 [hereinafter the Study]. The study was conducted on HIV-positive pregnant women who had not received any antiretroviral therapy during pregnancy and had CD4-cell counts above 200 at the time of entering the study. The announced results of the study showed that a regimen of AZT (zidovudine or ZDV) given orally to pregnant women, beginning between fourteenth and thirty-fourth weeks of gestation; intravenously to the mother during labor or delivery; and orally to the infant for six weeks after birth, was effective in reducing perinatal transmission of HIV down to 8.3%. The evidence suggests, however, that there is no absolutely harmless preventive medication available on this stage.

Since the conclusion of the study, Centers for Disease Control have recommended zidovudine (also known as AZT) for therapy during pregnancy and the first months of life of a baby. Protocol 076's success has prompted some doctors to openly call for mandatory HIV testing of all pregnant women. Some doctors argue that there was no ethical dilemma regarding the issue of mandatory testing of pregnant women: women would be required to take a simple blood test and by doing so a greater evil of increasing the risk of HIV

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248 Ibid.
249 Eight percent of the infants in the control group became infected versus twenty-five percent in the placebo group. Ibid, 285, 286.
transmission to an infant will be prevented.251 However, there are still a number of disturbing scientific questions about the use of AZT monotherapy per se, as it is only a “suboptimal regimen and treatment should be reevaluated in any patient who is receiving it (the AZT monotherapy – A.A.).”252 It is now obvious, that the use of combination therapy is more effective than zidovudine monotherapy, and if a woman receives only the AZT regimen, she might be excluded from other more progressive therapies that could help maintain her health. Now there are more and more calls to expand only ZDV (AZT) therapy to women in “less developed” countries, as the regimen is quite cheap.253

The long-term effects of the AZT monotherapy should still be studied with much caution, taking into consideration the danger of developing resistance to the drug, which may lessen its therapeutic effect.254 Only the short-term safety of prenatal and neonatal exposure to the drug is reassuring. Deaths of neonates that were exposed to ZDV treatment were reported in France, and the neuralgic disorder that they have developed could be related to the therapy to which they were exposed in utero and immediately after birth.255

Women who participated in the study (as it was mentioned above) were relatively healthy, and it is still not clear what the results would be if ZDV (AZT) is administered as the only type of therapy to a woman whose CD-4 cell count is under 200 or who has any of the HIV-accompanying diseases. This may limit possibilities for poor women, adolescents, women of

253 See for example, L. Mofenson, “Perinatal Exposure to Zidovudine – Benefits and Risks”(2000) editorials in 343 NEJM 803, 805.
color, immigrants and women in countries in transition as they have less access to appropriate
treatment and facilities, and thus their HIV status is likely to be discovered on later stages of
the disease.

The therapy itself is highly toxic and many women will experience side effects, such as
anemia and vomiting, which may drive them away from the regimen as well. For many
women in the Russian Federation, as it was explained above, even the monotherapy AZT
(ZDV) treatment is not available in every region, and the combination therapy is available
only in Moscow and St. Petersburg. One can only wonder whether the “availability of
treatment” argument is valid for Russian women.

Taking into account all the above mentioned risks and existing doubts about the success of
the regimen, this paper takes the position that no absolutely successful and harmless
treatment is available, and that the existing one is quite toxic and may have unknown risks.
Therefore, the argument that mandatory testing could lead to better preventive care and better
quality of life of infected women, is unpersuasive.

3.4. Fetal Rights and the Health of a Fetus.

Another argument, in favor of the mandatory testing for HIV, relates to the state’s interest in
the health of the fetus. Indeed, should one suggest that the unborn have a right to life then the

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255 As cited in L. Mofenson, supra note 255, 804.
256 "Although in most cases the toxic effects are reversible, in some cases evidence of toxicity persists after the
drug has been discontinued, and in rare instances the effects have been fatal”, Ibid, at 804.
257 A clinic on perinatal transmission of HIV in Ust-Izhora (St.Petersbourg) is the only clinic in Russia that
provides full prevention treatment for pregnant women infected with HIV. See interview with the head of
Russian AIDS Prevention Centre Vadim Pokrovsky, online: NAMES Foundation,<http://www.aids.ru> (date
258 This should not be read as saying that the prevention treatment does not exist per se, but only as that it is
important to carefully weigh the possibilities of its risks and benefits, and is up to the woman to make the final
decision.
state plainly has a legitimate interest in their protection.259 Even if the fetus itself has no interest of its own at stake, the state still might claim state interest in unborn human life only because the state has a duty to protect life where there is a possibility of one. Therefore, coercive measures towards women may be appropriate and justified by public health concerns. Some American states actually do regard a viable fetus as a person de jure, convicting women of killing their fetuses, if such "deaths" resulted from the respective woman’s behavior.260 There are also some very recent legislative and judicial developments, in some jurisdictions that, in conferring legal personhood upon the fetus, have expanded the state’s interest in protecting fetal life. In \textit{Aka}\textsuperscript{261} the Arkansas Supreme Court, avoiding any direct discussion of a fetal right to life at common law, ruled that a fetus was a person within the meaning of the Arkansas criminal code. The code defines a person in the following terms:

\begin{quote}
(13)(B)(i)(a) For the purposes of \$ \$ 5-10-101 -- 5-10-105 ["Homicide"], "person" also includes an unborn child in utero at any stage of development;

(b) "Unborn child" means a living fetus of twelve (12) weeks or greater gestation.\textsuperscript{262}
\end{quote}

The Court in \textit{Aka} noted that "we are no longer constrained by the common law definition of a person", which implies the requirement of a live birth.\textsuperscript{263} Thirty-two jurisdictions in the United States allow wrongful death actions on behalf of a viable fetus and, by doing so, "honor subsequent legislative developments suggesting that a viable fetus is a "person."\textsuperscript{264} This policy development in the United States has been further supported by a draft bill \textit{252-}\textit{...}
172, *The Unborn Victims of Violence Act*, which was passed by the U.S. House of Representatives on April 26, 2001. This Act would make it a federal crime to harm a fetus, defined as a “member of the species of the Homo sapiens, at any stage of development, who is carried in the womb”.

Earlier, in 1987, the District of Columbia Superior Court in *Re: AC* ordered the performance of a Caesarean delivery on a terminally ill patient out of concern over the health of the fetus. Even though this decision was later overruled, it did nothing to stop the operation.

The District of Columbia Court of Appeals, reviewing the lower court judgment, recognized that a pregnant woman has obligations with regards to a viable fetus, stating:

[... as a matter of law, the right of a woman to an abortion is different and distinct from her obligations to the fetus once she has decided not to timely terminate her pregnancy [...]. With a viable fetus, a balancing of interests must replace the single interest of the mother, and as in this case, time can be a crucial factor.

This paper takes the position that a fetus is not a juridical person and that fetal interests cannot offset the constitutional rights of pregnant women. When the law is concerned with protection of the fetus rather than the child, it bears little of conflict to the woman who carries it, thus minimizing the duality of maternal-fetal relationship. This relationship was known at different times as maternal-fetal conflict, maternal-fetal interaction and the conflict

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266 Ibid.
268 Twenty-seven year old Angela Carder died two days after the surgery was performed, having regained consciousness long enough to learn of the death of her child. The child died two hours after the operation. This account is taken from *Re A.C.* (supra note) and from C. Daniels, *At Women’s Expense, State Power and the Politics of Fetal Rights* (Cambridge, Massachusetts, Harvard University Press, 1993) 32.
269 In *Re A.C.*, supra note 269, 615.
between the mother and the medical professional.\textsuperscript{271} The term maternal-fetal conflict has been in existence since early 1980-s;\textsuperscript{272} at the center of the maternal-fetal conflict debate the question of when and whether it is appropriate for the law to dictate a pregnant woman’s behavior in an effort to benefit her fetus. Majority of lawyers and ethicists when discussing this issue came to the conclusion that except for extreme cases the infringement of the rights of pregnant women would be impermissible.\textsuperscript{273} The reasoning for this paper is based on the argument that as the fetus is not a person, and thus, has no legal rights until born alive, than there is no conflict between the fetus and the mother.\textsuperscript{274}

In order to come to this conclusion, different approaches to fetal personhood will be analyzed in an effort to interpret existing legislation with regards to this issue. If it is the case that a fetus possesses legal personhood, then women’s right to privacy and autonomy must be weighed against any state interest and duty to protect fetal life. Indeed, some jurisdictions in North America recognize that protection of the fetus is a legitimate State interest.\textsuperscript{275} Moreover, public health interests have historically constrained the rights of individuals and


\textsuperscript{272} M. Oberman, ibid.


\textsuperscript{274} The author does acknowledge the existence of maternal-physician conflict, as in many instances the doctor is deemed to owe “two duties of informed consent, one to the mother, and one to the fetus, based on medical and social reality. The social reality is that a mother who wishes to bear a child generally intends to ensure its health; the medical reality is that a fetus can be adversely affected by something that might be harmless or even beneficial to the mother”. (In the Matter of Unborn Child, supra note 30, 370).

\textsuperscript{275} For example, New York State legislation, regulations and case law, as cited in In the Matter of Unborn Child, a Child Alleged to be Neglected (Re: Sierra K), 197 Misc. 2d 1; 638 N.Y.S. 2d 366; 1998 N.Y.Misc. LEXIS 599.
organizations. The state has primary responsibility to assure the well-being of its population and protection of human life, and women's collective interest in their own liberty is not so unlimited that it can necessarily trump concerns for the life and security of citizens.

Thus, if one does admit that the right to life of the unborn deserves to be weighed against the woman's right to privacy, then one should recognize the possibility that the state may legitimately intervene in women's private lives, and exercise its coercive powers to constrain the epidemic. In *Jacobson v. Massachusetts* the United States Supreme Court came to the conclusion that the restraints that were allowed on personal freedom should be "reasonable" and the state's power is rather limited. Thus it is still unclear to what degree fetal rights would trump women's rights (if presumed that a fetus is a person).

This paper takes on a radical approach that denies a fetus right to life, consent to medical (or any other treatment) treatment and personhood (for the reasons discussed below).

### 3.4.1 Is it a fetus or a child?

Historically, the fetus was considered part of the woman bearing it and thus it had no rights of its own, except in some discrete areas of law. For example, the Romans respected the

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276 See discussion of different coercive public health measures in the previous chapter.

277 *Planned Parenthood v. Casey*, 112 S.Ct 2791, (1992), 2816. O'Connor, J. stated when delivering the Court's opinion:

> The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the state's interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted.

278 *Jacobson v. Massachusetts*, 197 U.S. 11 (1905)

279 In the case of smallpox vaccination, if Jacobson had severe allergic reaction to it and these were the grounds upon which he refused the vaccination, but still was forced to have it done, this would constitute unreasonable restraints.

280 According to Black's Medical Dictionary, "fetus" is the name given to the unborn child after eight weeks of development. Blacks Medical Dictionary, 1995 ed. V "fetus".

right of an unborn child to inherit property and land. However the property rights of the fetus could be realized only after the fetus was born alive, which represents not a right of a fetus in itself, but a condition of no longer being a fetus. The requirement of live birth allowed courts to consider fetal rights as if they were those of a child who was born and independent from his mother. No maternal-fetal conflict emerged.

There are two major approaches to fetal rights: the first one derives from the view that a fetus has rights and interests that should be protected. Another approach, described by Dworkin as the "detached" approach, depends on no such view but declares that human life has fundamental intrinsic value. In Life's Dominion, Dworkin expresses a strong view that merely being "en route" to becoming a human being is not enough for rights and interests, adding that it makes no sense to suppose that something can have interests of its own unless it possesses some form of consciousness in the form of mental and physical life. Dworkin analyzes positions of extreme pro-choice and extreme pro-life activists and comes to the conclusion that their positions were internally confused; for him, the crucial question is

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283 Legislation of all Soviet Republics in the time of USSR recognized the right of the unborn child of the deceased to inherit upon birth. See art. 530 Civil Code of Russian Federation, Civil Code of Ukrainian Soviet Republic, art.527, Uzbek Code, art. 577 etc.

284 See the description of "maternal-fetal conflict" above.

285 Jude Ibegbu with his work Rights of the Unborn Child in the International Law, vol. 1 (Lewiston, New York: Edwin Mellen Press, 2000) clearly represents this approach, freely operating with such terminology as the right to life and unborn child when referring to fetus and saying that as right to life is the most important right in the hierarchy of rights, all other rights such as right to privacy, for example are derived from it. "If the right to life of every human person is not protected, including that of the pregnant woman, the right to privacy cannot exist. Without the right to life, no other human right can exist", Rights of the Unborn Child in the International Law, 380. One has to admit that this statement represents a rationalization of Dr. Ibegbu's religious views rather than legal and philosophical scholarship that he wants the reader to believe in.

286 R. Dworkin, Life's Dominion, infra note, 11.


whether a belief in life’s sacred quality can be imposed by the state on everyone.\textsuperscript{289} He distinguishes reproductive decisions as closed to coercive state imposition. Given that legal practice and history prevent responsible constitutional interpretation of fetal rights and given that a fetus is not a person with moral rights and interests, recognition of his personhood would detach law from morality.\textsuperscript{290}

It is possible to regard a woman as utterly separate from her fetus and regard them as two completely different entities, and two completely different bodies.\textsuperscript{291} Mackenzie suggests a more complex philosophical approach to the maternal-fetal relationship, in which he admits and proves the existence of both the connection between the mother and a fetus and their disjointedness.\textsuperscript{292} He demonstrates how the woman’s understanding of her pregnancy gradually changes from initially denying her unity with the fetus to experiencing “an increasing emotional attachment of the woman to the fetus, and attachment which is based both in her physical connection with the fetus and in anticipation of her future relationship with a separate being who is also intimately related to her.”

Another approach would be to vaguely define the fetus as an “unborn child,” and regard the state’s interest in its life on a “sliding scale,” attributing a greater state interest as the pregnancy proceeds, an approach undertaken by the Supreme Court in \textit{Roe v. Wade}.\textsuperscript{293} The issue in this case was whether a statute of the state of Texas forbidding abortion, as well as any other statute of that sort, was constitutional.\textsuperscript{294} The Court divided the term of gestation

\textsuperscript{289} Ibid, 109.
\textsuperscript{290} Ibid, 111-12.
\textsuperscript{293} \textit{Roe v. Wade}, 410 U.S. 113 (1973).
\textsuperscript{294} Ibid.
into trimesters and determined the extent of the state interest in protecting a giver fetus' life on the particular stage of gestation of that fetus. The Court affirmed the state's interest in protecting the life of unborn fetuses:

[the State] has legitimate interests in protecting both the pregnant woman's health and the potentiality of human life, each of which interests grows and reaches a "compelling" point at various stages of the woman's approach to term

However, in spite of this remark, the Supreme Court of the US came to the conclusion that:

In nearly all these instances (in the Constitution of the US and its Amendments – A.A.) the use of the word ["person"] is such that it has application only postnatally. None indicates, with any assurance, that it has any possible prenatal application.

This decision was lately echoed in the Daigle decision in Canada. The Court in the US found that the state's interest in the fetus depended on its viability, i.e. on the term of pregnancy; during the first trimester, all decisions about the fetus are left to the mother and the physician.

295 There are opinions that this particular decision influenced greatly the modern understanding of maternal-fetal conflict: by saying that the value of the unborn fetus increases with time and provoked statements approving of court-ordered Caesarean, because it involves "a verge-of-birth fetus, one can reasonably argue that this fetus should have the rights of a born person" (J. Finer, "Toward Guidelines for Compelling Caesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity" (1991) 76 Minn. L. Rev. 239, 247-250.

296 410 U.S. 113, 708 (1973)

297 Ibid, 729

298 One can argue that this conception will become even less clear than it is now as the technology of birth continues to develop. The Court's definition of viability does not exclude the possibility of artificial support, 93 S.Ct at 730 and later the Court indicates its awareness of the developments in the field. Some ask the question how these developments will fit into the trimester program adopted by the Court. For further discussion see J. Ely, "The Wages of Crying Wolf: A Comment on Roe v. Wade" (1973) 82 The Yale Law Journal, 920.

299 Ibid, 732. In the US some states not requiring prenatal test for HIV have also introduced a paragraph in their health statutes speaking about immunity of health care provider from being held liable in "any cause of action related to a woman's decision to consent or not to consent to have an HIV test" (Md. Health-General Code Ann. §18-228.2, subsection d.). One can interpret this provision as follows: if a health care professional has offered the test and the woman did not consent to it, than he cannot be held liable for the possible HIV transmission to the infant. This way the practitioners are protected from the possibilities of "wrongful birth" claims in the future. This clause in the statutes can also be interpreted as affirming the freedom in decision-making that woman has over her body and the fetus in that body.
In *Daigle*\(^\text{300}\) the Canadian Supreme Court, without deciding whether the fetus could be considered part of "everyone" under section 7 of the *Canadian Charter of Rights and Freedoms*,\(^\text{301}\) concluded that the fetus is not an independent human being and that no legal personhood could be conferred upon it. Thus, it should be treated as part of the mother. Analyzing existing legislation the Court came to the conclusion that a fetus can be regarded as a child only when born. Logically, this conclusion can be interpreted further to mean that the decisions about the fetus are up to the mother to take.

The question of whether fetuses were persons under the *Charter* was raised again, but again not addressed by the Supreme Court in *Borowski v. Canada*.\(^\text{302}\) Mr. Borowski challenged the Criminal Code provisions on abortion, arguing that they violated fetal rights to life and equality. The Court of Appeal has dismissed Mr. Borowski's appeal, arguing that the case was moot and the applicant has lost his standing after the *Morgentaler* decision.\(^\text{303}\) concluded that both historically and legally, the fetus had no rights of its own and that the relevant provisions of the statute could not violate its rights.

The Supreme Court of Canada affirmed that the case became moot a year before, when *Morgentaler*\(^\text{304}\) struck down the abortion provisions. The Court noted that a ruling on fetal rights would be contrary to the public interest in the absence of a legislative context:

A decision as to whether ss.7 and 15 of the Charter protect the rights of the fetus is not in the public interest due to the potential uncertainty that could result from such a decision absent a legislative context.\(^\text{305}\)


\(^\text{301}\) Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, being schedule B to the Canada Act, 1982 (U.K), c. II.


\(^\text{303}\) *Borowski v. Canada*, 57 D.L.R. (4th), 233 [1989].

In *R. v Sullivan*\(^{306}\) the Supreme Court reaffirmed its previous ruling on the status of fetuses this time in the context of criminal law. Two midwives were charged with criminal negligence when the infant they helped to deliver died at birth. The Supreme Court affirmed that a fetus could not be a person within the meaning of the criminal negligence provisions of the Criminal Code. The Criminal Code provides the following requirements for a child\(^{307}\) to be considered a human being for the purposes of the act: first, the Canadian Criminal Code supports the common-law definition\(^{308}\) of human being and requires being born alive, regardless of whether or not:

(a) it has breathed,
(b) it has an independent circulation,
or
(c) the navel string is severed\(^{309}\)

The Criminal Code foresees “killing of a child” as a special crime.\(^{310}\)

A person commits homicide when he causes injury to a child before or during its birth as a result of which the child dies after becoming a human being.\(^{311}\)

In other words, the Criminal Code has a vague definition of a “child”, not clearly distinguishing in its language between a child, born alive, and a fetus, existing inside a woman’s womb. The appropriateness of the term “child” itself with regard to the fetus is quite questionable. On one hand, the Criminal Code requires the child to be “completely

\(^{305}\) *Borowski v. Canada*, 1 S.C.R. [1989], 345.


\(^{308}\) For further discussion on this issue, see B. Dickens, “Maternal-Fetal Conflict”, supra note 270, 37-41.

\(^{309}\) The Criminal Code of Canada, supra note 69, s. 223 (1)

\(^{310}\) Ibid. S. 223 (2).

\(^{311}\) Ibid.
proceeded in a living state from the body of its mother."\(^{312}\) On the other - its description of
the fetus allows it the possibility of becoming a child, and foresees a separate crime
definition, which involves responsibility for causing injury to a child "before or during its
birth."\(^{313}\)

In \textit{R. v. Sullivan}, the Supreme Court stated that a child that still was in the birth canal
remained part of its mother. Therefore, the midwives in question could be liable for criminal
negligence that caused bodily harm to the mother, but not the death of the infant.

In \textit{R. v. Prince}\(^{314}\), the Court came to the conclusion that a person who attacked a pregnant
woman could be found guilty of manslaughter, but only if the child was born and died as the
result of the injury.

Canadian Courts rejected the definition of viability of the fetus, which was introduced by \textit{Roe}
v. \textit{Wade}. However, by doing so, the Canadian law-makers seem to have failed to come up
with a clear definition of "everyone" within the meaning of Canadian Charter, and thus to
distinguish between a child and a fetus. If one applies the same logic of reasoning to the
Russian legislation on the issue, it becomes clear that unlike Canadian and US jurisprudence,
Russian lawmakers did not consider a fetus a human being.

Article 20 of the Constitution of the Russian Federation affirms that everyone has a right to
life.\(^{315}\) There is no evidence available that Russian courts ever discussed whether a fetus
could fit under the definition of "everyone" within the understanding of Article 20 of the
Constitution. However, the comments to the Constitution state that the right to life "is

\(^{312}\) Ibid., S. 223 (1).
\(^{313}\) Ibid., S. 223 (2).
inalienable and belongs to everyone from birth".\textsuperscript{316} The Federal Law on Health Care in the Russian Federation,\textsuperscript{317} when speaking about abortion, clearly states that it is a woman’s right to decide herself on her motherhood, and that an abortion can be performed upon her desire to do so until 12 weeks of pregnancy.\textsuperscript{318} If a woman does not want to carry out her pregnancy to its full term, she can have an abortion at a later stage (up to 22 weeks of gestation) on so called "social grounds".\textsuperscript{319} The Ministry of Health order explains this definition as follows: the illness of the husband; the death of the husband; imprisonment of either one of the spouses, unemployment of either spouse, previous loss or restriction of parental rights, the woman's marital status, criminal origin of the pregnancy (\textit{i.e.}, sexual assault); the woman's status as a migrant or forced migrant; the existence of three or more children; disability of a child; or income below the regional poverty line.\textsuperscript{320} An abortion can be performed upon medical conditions regardless of the term of gestation.\textsuperscript{321} One can foresee a possible argument about limitations of a woman's right to an abortion after 12 weeks, as in order to perform abortion for "social reasons" the law foresees that a woman apply to a commission to decide whether she may terminate her pregnancy. However, as it was shown above, the grounds for this abortion are very wide and include a majority of the reasons a woman might


\textsuperscript{317} Federal Law 	extit{Основы Законодательства по Охране Здоровья Граждан/The Basics for Health Care of the Population in the Russian Federation}, enacted 22.07.1993, #5487-1, with corrections from 02.03.1998, (hereinafter referred to as the Law on Health Care).

\textsuperscript{318} Article 36, Law on Health Care, ibid.

\textsuperscript{319} Ibid, see also List of Social Indicators that are Grounds for Abortion, enacted by the Order of the Ministry of Health #567, May 8, 1996.

\textsuperscript{320} List of Social Indicators that are Grounds for Abortion, ibid.

\textsuperscript{321} Article 36, Federal Law on Health Care, supra note 319; see also List of Medical Conditions that are Grounds for Abortion, enacted by the Governmental Decree #302, December 28, 1993.
take into consideration when she decides to have an abortion. It is true that the procedure for gaining permission, to obtain an abortion, involves the submission of a written statement by the woman giving reasons for requesting an abortion; nonetheless, the importance of having the option of pregnancy termination on “social grounds” is hard to underestimate. Similar statutes requiring a special permission for abortions at a later term of gestation exist in the other parts of the world.322 One can argue that these requirements reflect the view that the state has a legitimate interest in the health of the fetus and therefore indirectly assign the fetus personhood. However, there is a belief, among Russian medical professionals, supported by the scientific data on the issue, that late-term abortions may be dangerous for women and may have adversely affect future reproductive capacities.323 Thus one can argue that lawmakers, when including the requirements for a medical commission to assess a woman’s situation, were more concerned with her health, than the personhood of the fetus.

Article 105 of the Criminal Code of the Russian Federation,324 in its para 2, contains the list of aggravations that, once committed, serve as grounds for extension of the term of incarceration of the guilty and in some cases may lead to the death penalty or deprivation of freedom for life. It separates a homicide of two or more persons from that “of a woman known by the guilty person to be in a state of pregnancy.”325 With regard to the illegal performance of abortion, the aggravating factor is causing the death of the victim, or grave harm to her health.

323 K. Danishevsky, MD, MPH, Russian Academy of Medical Sciences, personal communications.
324 Criminal Code of the Russian Federation, supra note 221.
325 Ibid., Article 105, para 2 (a) (d)
It seems that the U.S. clearly accept the position of legitimate state interest in the fetus in its landmark decision of *Roe v. Wade*, whereas Russian legislation is silent with regard to where such a state interest, in the protection of human life, begins. Canadian courts seemed to have successfully avoided this discussion and admitted that a fetus was still part of the mother until born alive. A short legal analysis of Russian statutes shows that the state distinguishes a fetus from a “human being”. Thus, it is difficult to argue that, within the current understanding of Russian lawmakers, the fetus could have rights and interests of its own.

It is important to mention here, though, that Russia has shown some alarming developments that suggest a shift in its policy with regard to the unborn. One of them is the growing influence of the Russian Orthodox Church over the exercise of women's reproductive autonomy; there is an increasing tendency to view abortion as a murder of an unborn child. The population growth in the country has declined sharply, and some “pro-life” activists use this fact to demonstrate the wickedness of pragmatic reproductive health policy. This resulted in the introduction of the Draft Federal Law On Bioethics the goal of which was to ensure individual safety and promote the interconnection between physical and spiritual health. The draft law suggested treating a woman and a human embryo as one “human being” and forbidding the performance of abortions on social grounds. Had this draft law been approved and entered into force, then one could suggest that the Russian lawmakers affirmed

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their interest in the health of the populace, a human embryo being part of it.329 In the absence of any jurisprudence to confirm the legality of fetal personhood, one comes to the conclusion that, in Russia, the fetus has no independent rights of its own. If there are no independent rights, then for the purposes of this paper, one should agree that a mother and her fetus is one human being and that no “maternal-fetal conflict” exists.330 In this scenario, it makes no sense to advocate mandatory testing for HIV of pregnant women if this benefits a being that is non-existent under the law. However, courts in the past have traded the rights of the mother to benefit the non-existent fetal persons through the doctrine of parens patriae. Here is a summary of several decisions of courts in the US and Canada ordering performance of Caesarian delivery on women to benefit their fetuses, that shows that the courts may be likely to trump women’s rights in favor of their interest in a possible life.

3.4.2 Parens Patriae Power of the Court: Caesarian delivery and Compulsory Treatment from Drug Addiction

One could argue that the way in which a woman gives birth to her child is a decision that is extremely intimate in nature (as is the whole process of giving birth). Nonetheless, courts in both the U.S. and Canada have interfered in this very personal decision quite a number of times with the intention to save the fetus. The danger of this policy in times of HIV-epidemic is often overlooked.331 Ordering Caesarian delivery for terminally ill women might seem like

329 Up till now the Law has still stayed in its draft version, it was presented to the Parliament, but have not been approved.
330 One can argue that using the principle of denying the foetus of any rights of its own might over-emphasize the separateness between a mother and her fetus and lead to a deeper conflict of interests. (See C. Wells, “On the Outside Looking In: Perspectives on Enforced Caesareans”, supra note 324, where she argues that the connection approach rather than the denial of rights approach seems more useful). It seems that in relation to HIV/AIDS and its exceptionalism this approach will only states everything, but answers nothing. It does not seem to assist in deciding whether and why women should be tested for HIV.
331 Delivery by Caesarian operation is known to reduce the risk of HIV transmission to the fetus (see W. Landesman, et al, Obstetrical Factors and the Transmission of Human Immunodeficiency Virus Type 1 from
a cheap and easy way out and could be introduced as a “successful” public health policy. Another danger of such policy with regards to women with HIV consists of medical complications after caesarian delivery, specifically in women with HIV who did not take antiretroviral therapy. The recent study that took place in Germany compared morbidity in 62 HIV positive and 62 negative women who had elective caesarian delivery and found a considerably increased risk of post-operational morbidity in HIV positive women who were not taking the therapy.332

The decision of the District of Columbia Superior Court in the case of Angela Carder (as discussed above in Re: AC) to order a Caesarian delivery on a terminally ill patient as if she herself had no important interests because her death was imminent in any event is very troubling. Even though this decision was made in 1987, was later overruled and did not concern a patient with AIDS it means that courts are capable of trading off mother’s interests in order to protect the fetus, even though fetus is not a person, and thus “treating a fetus against the will of the mother degrades and dehumanizes her, reducing her to the status of a mere container or gestational organ for the fetus”.333

In Canada, one approach to defending the rights of the unborn would be to ask a court to declare a fetus a child in need of care under provincial child welfare legislation.

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333 Ibid, 40.
In *Re: Baby R* the provincial court of British Columbia granted the Superintendent of Family and Child Services permanent custody and guardianship of the fetus as the woman did not consent to Caesarian section delivery. The Superintendent took into consideration the imminent danger the fetus was facing if the delivery was to happen in its natural way, and consented to “emergency medical treatment of the child”. The mother of Baby R. did not know about this, but verbally consented to the operation. The British Columbia Supreme Court when faced with this case, held that the order of the Provincial Court should be set aside as the fetus was not a child within the meaning of child welfare legislation. It also held that the powers of authorities and the Court for that matter, were limited to “living children that have been delivered” and the powers to interfere with the rights of women “if granted, and if lawful, must be done by specific legislation and anything else will not do”.

In *Re: A (in utero)* that followed the Baby R. case the Ontario Unified Family Court came to the conclusion that nothing in the Child and Family Services Act, 1984 would give the fetus “any status as a person or right to protection under the Act”. Steinberg, J analyzing possibilities of applying the Court’s *parens patriae* powers to this case, found that “the *parens patriae* jurisdiction is just not broad enough to envisage the forcible confinement of a parent as a necessary incident of its exercise”. He also noted that even if Courts could...
apply this jurisdiction they should be very careful doing this as it would lead to abuse of pregnant women.  

As it was proven above it is highly unlikely that the Courts either in the US, or in Canada will order performance of Caesarian delivery on an HIV-positive woman. Hopefully, the recently available scientific evidence about the danger of caesarian delivery for HIV-positive women without antiretroviral therapy will stop Courts in developing countries from ordering this medical procedure to be performed on women. However, when one looks at the issue of testing for the purposes of diagnosing the disease (and let us presume this procedure can be referred to as "treatment", or at least its beginning), the questions whether the courts can exercise its parens patriae powers is debatable. As it is demonstrated below, there is no obvious agreement between different judges with regards to whether the above mentioned doctrine could be extended to the cases where pregnant women were ordered to undergo any treatment to benefit their resulting child.

In Winnipeg Child and Family Services v. D.F.G an action was brought to impose treatment from drug dependency on a pregnant aboriginal woman in the absence of her consent. The Manitoba Court of Appeal reversed the previous decision to detain Ms. G and order treatment. MacLachlin, J writing for the majority in the Supreme Court of Canada held that parens patriae doctrine could not support an order for involuntary detention and treatment. She reaffirmed the Daigle decision by stating that fetus was not to be considered as a legal person and it had no legal rights until born. In this way, the organization (Winnipeg

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342 Supra note, p.732
345 Ibid. at 937
Child and Family Services) was operating in the interests of no legal person when they applied for the mother’s detention order.\textsuperscript{346} McLachlin, J. tried to put an end to the what was previously described as the maternal-fetal conflict by noting that the fetus and the woman were one entity \textit{de jure} as well as \textit{de facto}:

Such a legal conception (that the unborn child and his mother are regarded like separate juristic persons in a mutually separable relation – A.A.), moreover, is belied by the reality of the physical situation; for practical purposes, the unborn child and its mother-to-be are bonded in a union separable only by birth.\textsuperscript{347}

Major, J opposed that the common law \textit{parens patriae} jurisdiction should be expanded on this case, arguing that all the facts were the notions of choices.\textsuperscript{348}

In \textit{Nouveau Brunswick (Ministre de la Sante et des Services Communautaires) v. D (A)},\textsuperscript{349} the Minister of Health was granted a supervisory order for 6 months in respect of irresponsible mother and her fetus. In this case the best interests of the fetus were considered together with those of a 1-year old child. Lack of Court’s consideration towards the consequences of such state’s interference in a woman’s life are quite troubling:

The suggestion that women should be subjected to surveillance and control over their pregnancies arguably would extend to include the whole of women’s reproductive lives, from adolescence to menopause. This would impose a unique set of obligations upon women not imposed upon men. It would preclude women from undertaking activities that are legal for others on the basis of biological difference.\textsuperscript{350}

\textsuperscript{346} \textit{Winnipeg Child and Family Services v. D.F.G.}, supra note 47, at 939
\textsuperscript{347} Ibid at 945
\textsuperscript{348} Ibid, 961, 962
\textsuperscript{349} \textit{Nouveau Brunswick (Ministre de la Sante et des Services Communautaires) v. D (A)}, 109 N.B.R. (2d), 192 (1990), 273 A.P.R 192 (Q.B.)
Quite recently, in the United States there have been series of cases involving pregnant drug abusing women, who were put in prison to undergo compulsory treatment while still pregnant in order to preserve the health of the fetus. The most common grounds for their arrest would be "fetal abuse". The issue of consent to medical treatment (in this case – testing for presence of illicit substances in blood) was easily overridden and justified by the need to protect the fetus.

*Ferguson v. Charleston* is one of the most well-known cases in the field and the history of this lawsuit started 10 years ago. The most recent decision of the Supreme Court on the case overturned the 1999 decision of the Court of Appeals that ruled that regardless of whether the arrested women provided informed consent for the urine test to identify traces of cocaine to be conducted, the warrantless drug testing program could be justified by the "special needs" test, that consisted of stopping drug use by pregnant women and getting them into treatment. The US Supreme Court ruled, that performance of this non-consensual test was unconstitutional as it constituted search that was not authorized by a valid warrant After long deliberations on the requirement of "special needs", the court came to the conclusion that "the searches were conducted without informed consent of the patients" focusing more on the "reasonable expectation of privacy" that the results would not be given to the third party rather than on the legitimacy of conducting such test without consent per se.

The *parens patriae* doctrine with regards to pregnant women and their fetuses was shortly described here to show that there were times when courts could override a woman's decision

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352 Ibid.

to benefit the fetus. However, in most of the cases the courts would rule against unwarranted treatment and delivery and the extension of the *parens patriae* doctrine on fetuses.

3.5. **To protect medical professionals and to prevent horizontal transmission** *(nosocomial transmission in hospitals)*.

Another reason for testing pregnant women might be to inform the attending obstetrician about the risk of the infection; this is particularly true in countries where the use of Universal Precautions recommended by CDC is limited, or where they are not implemented at all. One can suggest that if a physician knows about the immune status of his patient he/she may take appropriate measure in order to minimize the possibility of transmission. In 1999, an evaluation of the knowledge of medical personnel with regard to HIV was conducted in the Ukrainian city of Odessa.  

Odessa was one of the first cities on the territory of the Newly Independent States faced with the HIV epidemic due to its location (a big port on the Black Sea), the high number of intravenous drug users using “chorny” (an opium derivative, that is related to “kompot”-type drugs popular in Poland and Belarus) and a large population of sex-workers. This research showed that 54% of those surveyed feared working with HIV-infected; 33% named kissing as a way to contract HIV; and 28% stated that working with a positive colleague would lead to their infection. This research showed the attitude towards the infection among medical professionals, and unfortunately, this attitude can be expanded to other NIS countries. The study taken in the UK in 1996 showed that 81% of the surgeons

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354 Ibid. pp. 8 - 18  
356 Ibid. Many said that they always used the disposable gloves to perform examinations, but the authors of the study concluded that this use was questionable as the gloves have to be ordered far in advance, and thus, were not always accessible to the health professionals.
surveyed would prefer to know their patients' status and 51% favoured some form of compulsory or routine preoperative testing.\textsuperscript{357}

The tone of the Russian Law On HIV/AIDS Prevention suggests the great care of lawmakers for public health professionals, especially for those who work with HIV-infected people. Mandatory testing for HIV infection is performed on every health worker who works with HIV-positive patients.\textsuperscript{358} One can interpret this provision as the one of concern for the health of the medical professionals, especially given that article 21 of the Law on HIV/AIDS Prevention provides for additional state insurance for those workers, who care after people with HIV/AIDS. There is no doubt that mandatory testing of pregnant women and the testing of the health care personnel, attending them will protect doctors from acquiring HIV when performing their duties. Moreover, this approach is likely to lead to false sense of security among medical professionals, and is not likely to succeed taking into consideration the nature of the disease itself (the "window period", for example, that can last up to 6 months, expenses for testing and re-testing, number of false-positive and false-negative results). There are precautions available that are designed for the care of all patients in hospitals regardless of their diagnosis or presumed infectious status. Implementation of Standard Precautions is the most successful strategy for nosocomial disease control.\textsuperscript{359} As a general rule, medical professionals are advised to act as if all patients were HIV-positive and take appropriate precautions with every patient they treat. There is no scientific evidence suggesting that a separate set of precautions should be implemented to control the spread of HIV in the


hospital settings, as the “transmission-based” precautions are designed for patients known or suspected to be infected with epidemiological important pathogens that can be transmitted by airborne/droplet transmission, or by contact with dry skin or contaminated surfaces. The UN Declaration on Commitment on HIV/AIDS recommends the State Parties to implement universal precautions in health care settings by 2003, admitting their importance in preventing horizontal HIV transmission. Finally, testing of pregnant women for HIV in order to prevent horizontal transmission diverts scarce health care resources into activity that can produce few useful results and is more likely to deter patients from treatment, than attract them. Even if one was to suggest that the health care professionals are exposed to greater risk when working with pregnant women than with any other group of the population and this is the reason for women to be tested, it still will not be possible to determine which woman is infected due to the window period, and than how many times during a pregnancy should a woman be tested. Thus, there seems to be no rational public health objective to demand testing on the grounds of prevention of horizontal transmission of HIV (transmission in the hospital settings).

3.6. To Prevent Further Transmission: Public Health Interest of the State in protecting health and well-being of the general population.

A lot of public health law and philosophy scholars admitted and proved the existence of legitimate interest in protection of community health and safety.}

359 J. Gardner, “Guidelines for Isolation Precautions in Hospitals” (1996) 17 (1) Infection Control and Hospital Epidemiology 53.
360 Ibid.
As it was discussed previously, isolation and quarantine, immunization, sanitary controls, – these are all health regulations that were introduced by governments at different times. With regards to HIV/AIDS, for example, the states are requiring testing of blood donors to protect the blood supply of the country (as discussed in Chapter 2), basing it on a significant public health benefit. One can suggest for the purposes of further debate, that if a state regards a woman as a vector of transmission, than it has an obligation to test her to prevent the spread of the infection. One can argue the importance of this test as follows: if a woman is tested positively for HIV and knows about her status, she will take precautions against transmission of the disease to her sexual partners. Following the logic of the argument, the woman in question is to be tested only because, once pregnant, she becomes part of the “vulnerable population” that are easy to detect and test. This public health policy is likely to fail for the reason that is usually given against overall compulsory testing of the whole population (those most at risk are likely to avoid it by any means possible) and will openly discriminate against women. If one follows this logic, the state can also impose available treatment on a woman, as well as order a performance of Caesarian delivery at the later stages of pregnancy. To take it even further, if such policy is accepted than there seem to be no barriers for its extension to other groups of population and the whole population in general.

In this part, reasons that are often given in favor of obligatory testing of pregnant women were analyzed from the angle of their public health benefits. The main focus of this chapter is on the “rational public health objective” test, that suggests that in the absence of outweighing public health benefits, mandatory testing is inconsistent with international obligations of the country.
As a result of this analysis the following conclusions can be drawn. It is quite possible that obligatory testing may enable some women to make more informed decisions about their future, regardless of the grounds for testing. The increase of the number of people tested and knowing about their status might be deemed as the due compensation for the infringement of autonomy. In this case, if this reasoning is accepted, one should be prepared to extend testing to other populations as well. In this manner, those who advocate for routine testing of pregnant women also advocate for overall routine testing of all members of society. If successful and harmless treatment did exist, the argument to test women to benefit their health, could have been acceptable on the grounds of its overriding effectiveness. Unfortunately, as it was shown above, up till now, the existing knowledge about the AZT treatment is not sufficient to conclude this. The argument that women should be tested to benefit the resulting child is moot, as according to the studied legislation, a fetus has no rights of its own and a policy, demanding testing of women to benefit non-existent being is likely to fail the rational public health objective test.

If one looks at the testing from another perspective, it is also clear that the principle of autonomy and the right to privacy contradict the interest of the state, and thus, a question arises whether this policy would be consistent with the understanding of autonomy and privacy in the national legislation and with the international obligations of the state.
Chapter IV. Why Coercive Testing Should Not Be Implemented.

This chapter argues that mandatory testing for HIV infection violates the woman's right to privacy and consent to medical treatment. Mandatory testing also violates international obligations of the country, as stipulated in different international treaties. These are regarded as the main arguments against the policies of mandatory testing of pregnant women for HIV infection without their consent.

4.1. Women's Right to Privacy

He who can intrude upon another at will is the master of the other, and, in fact, intrusion is a primary weapon of the tyrant.

E. Bloustein

There is an international acceptance that privacy is a fundamental human right and it underpins human dignity and other values. This right is protected in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and other international and regional treaties. This section does not aim to provide an exhaustive definition of privacy as this task was already fulfilled by many respected scholars. It aims to provide a background information for the debate over the informed consent doctrine, which is rooted in the principle of autonomy and is considered to be the pragmatic paradigm of autonomy in health care. This part aims to present a brief overview of existing trends on the issue and the arguments in favour of the importance of privacy as one of the main arguments against compulsory performance of testing on pregnant women.

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**What is privacy?**

First one has to establish what is meant under privacy interests of a pregnant woman in the given setting, and why this right is central to the freedom and democracy.\(^{366}\) It seems logical to provide some explanation on what this term means and what human rights the right to privacy covers.

A. Westin defined privacy as the desire of people to choose freely when and under what circumstances, as well as to what extent they will expose themselves to others.\(^{367}\) L. Gostin defines "privacy" as an individual claim to limit access by others to some aspect of her personal life.\(^{368}\) The term is very vague\(^{369}\) and embraces the freedom of decision-making about one’s bodily integrity without interference, and the right not to be viewed and photographed as well as "informational privacy" as an individual's right to control the disclosure of her personal health information. E.Bloustein has emphasized that privacy protected human personality: the individual's independence, integrity and dignity.\(^{370}\) Thus, it is obvious that privacy is closely connected with individuality of a person:

> The fundamental fact is that our Western culture defines individuality as including the right to be free from certain types of intrusions. This measure of personal isolation and personal control over the conditions of its abandonment is of the very essence of personal freedom and dignity, is part of what our culture means by these concepts.\(^{371}\)

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\(^{369}\) L. Weinreb shows close correlation between privacy and autonomy, saying that right to privacy is a right to a "space" in which one is autonomous. L. Weinreb, "The Right to Privacy" in E.Paul, F.Miller, P.Jeffrey, eds., *The Right to Privacy* (New York, Cambridge University Press, 2000)34.


\(^{371}\) Ibid., 973.
E. Bloustein concludes that the gist of the wrong in the cases of privacy intrusion is the blow to human dignity, "an assault on human personality". J. Cohen added to this poetic description of privacy: "a constitutionally protected right to personal privacy is indispensable to any modern conception of freedom".

J. Thomson argues that there is no right to privacy per se, it is not defined and cannot be defined, as all the various protections to which the right to privacy may entitle already exist under other rights. She comes up with the following examples to support her point:

Someone uses an X-ray device to look at you through the walls of your house? He violates your right not to be looked at, and you have that right because you have rights over your person analogous to the rights you have over your property – and it is because you have these rights that what he does is wrong.

Thus, she concludes that the right to privacy is derivative, and does not exist on its own.

J. Reiman, as well as J. Rachels argued that there was indeed something unique and special protected by the right to privacy. J. Reiman’s argument on privacy as a special interest and on a right to privacy, as a unique right is based on personhood, i.e. on the human interest:

[....] in becoming, being and remaining a person. It is thus a right that all human individuals possess.... It is a right which protects my capacity to enter into intimate relations, not because it protects my reserve of generally withheld information, but because it enables me to make the commitment that underlies caring as my commitment uniquely conveyed by my thoughts and witnessed by my actions.

372 Ibid., 974. He had also referred to privacy invasions as “the feeling of being naked before the world”, that describe best the feelings of the person, whose privacy was violated and human dignity intruded, 1006.
375 Ibid. 313.
Thus, there is variety of views on what privacy means, and as it is a construction of society, one can conclude that its meaning might differ depending on a given social context. One can crudely divide the understanding of privacy into the following concepts: informational privacy, as understood by L. Gostin (as cited above), which includes collecting and handling personal information, such as health information, for example, as well as privacy of telephone lines and mail. The other group of an individual’s interests that are protected by the concept of privacy includes one’s physical privacy and of one’s territory, whether it is house, working environment, public place etc. This includes different aspects of searches and seizures. For the purposes of this paper, most attention will be paid to the latter group of interests, especially the interest of physical privacy, as allowing one to decide against touching and invasive medical procedures. Despite all their importance, the personal interests are not absolute, thus privacy is not either. The right to privacy is an instrument to strike a tentative balance between societal interests and personal values and thus the question arises where to put appropriate limitations to it.

Each individual must, within the larger context of his culture, his status and his personal situation, make a continuous adjustment between his needs for solitude and companionship; for intimacy and general social intercourse; for anonymity and responsible participation in society; for reserve and disclosure.

Despite the different varieties of privacy descriptions, it is obvious that this concept is extremely difficult to define, and may be there is no need to do so. Although many legal and philosophy scholars admit the necessity to achieve the right balance between privacy

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377 J. Reiman, ibid. 314.
378 F. Cate described it especially well: “What is needed is a balance, of which privacy is a part. Determining what that part is in any specific context requires a careful evaluation of subjective, variable and competing interests”. F. Cate, Privacy in the Informational Age, (Washington D.C.: Brookings Institutions Press, 1997) 31.
379 A. Westin, Privacy and Freedom, supra note 368, 42.
interests, justification for this may differ, but the basic approach undertaken by the majority is quite straightforward: privacy is a value that has to be carefully balanced with the common good in a way that rights are counter-balanced with duties, but not overburdened with them to the extent when fulfilling one’s right becomes impossible.

4.1.1. The Legal Approach to Privacy.

Some American scholars define the following decisions of the Supreme Court as landmark with regards to privacy: *Griswold v. Connecticut* (1965), *Eisenstadt v. Baird*\(^{380}\) (1972), and *Roe v. Wade*\(^{381}\) (1973), all of which dealt with reproductive choices. A.Etzioni argues that these cases generated and privileged a right to privacy, which is not much mentioned in the Constitution of the United States.\(^{382}\)

In the first of these famous cases, *Griswold*, the Court ruled that a state law forbidding the use of contraceptives violated the right of marital privacy. The Court did not set any obvious limitations for that right in this judgement. In *Roe v. Wade*,\(^{383}\) the Court explicitly addressed the woman’s right to privacy and struck down the bans on abortion. However, this case was somewhat unclear. On one hand, this seems to be an important case in which a behaviour, that was once prohibited, was freed to be subject to personal choice. On the other, it affirmed state’s interest in potential life as “compelling” to the woman’s right to privacy. The Court in *Wade* ruled:

> The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus...[sic]...it is reasonable and appropriate for a State to decide that at some point in time another interest, that of health of the mother or that of potential

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\(^{383}\) *Roe v. Wade*, supra note 378.
human life, becomes significantly involved. The woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly.384

Thus, the Court has rejected the unbounded approach to privacy. Blackmun, J, delivering the opinion of the Court, directly affirmed the right of the state to limit women's interests:

A state may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life.385

By introducing different distinctions of privacy, the Court endorsed more control over the third trimester, than the second, and subsequently, more state interest in the second trimester than the first.

In Planned Parenthood v. Casey386 the U.S. Supreme Court resiled from the trimester framework and suggested the "undue burden" test. It affirmed an individual's right to make intimate and personal choices that are central for personal dignity and autonomy, at the same time affirming the existence of a legitimate states' interest in restricting rights of a pregnant woman:

The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State's interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted.387

In R. v Morgentaler388 the Canadian Court came to the conclusion that American jurisprudence regarding the Fifth and Fourteenth Amendments to the Constitution of the US was inapplicable to the Canadian Charter despite the similarity of the language. In Daigle

384 410 U.S. 159, 730 (1973)
385 Ibid., 150.
386 505 U.S. 833 (1992)
387 Ibid, at 869
388 42 D.L.R (3d) 424, at 432
decision the Court avoided further mooting of the appellant's argument that "regardless of the rights [the respondent may claim]...these rights cannot outweigh a woman's right to control her own body", and thus it did not analyze the issue of "long-standing legal principle that a person may not be compelled to use his or her body at the service of another person, even if the other person's life is in danger". There is also an acceptance of the right to refuse treatment, both intended for one's and for another person's benefit. The law is usually intolerant to such conflicts and the Courts in the US have evoked the "sanctity of the individual" doctrine that does not allow to order a person to undergo a medical procedure in order to benefit another one.

The Constitution of the Russian Federation following the great traditions of the civil law system, speaks about the right to privacy as a personal inviolability and inviolability of private life, personal and family secrecy and defence of one's honour and good name.

Man, his rights and freedoms are the highest value.

Further on, the Constitution explicitly protects the inviolability of the person, connecting it to a right to freedom:

Each shall have a right to freedom and personal inviolability.

The understanding of inviolability in the Russian legal academy includes both physical inviolability (the life of the person, his health) and so-called moral inviolability (human

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389 Tremblay v. Daigle, 62 D.L.R. (4th), at 646
390 Ibid
393 Constitution of the Russian Federation, article 2.
394 Ibid, Article 9.
dignity, honour). Following this conception, article 21 of the Constitution says that human dignity ("the dignity of a person") is protected by the state. The Russian legislators do not explain what exactly is meant under this term. The Commentary to the Constitution offers quite a crude explanation of this interesting philosophical conception: "human dignity is defined not only with the help of self-assessment of the person, but also with all the totality of his other qualities that characterize his/her reputation in a society". As the examples of these qualities the following are given: morality, prudence, knowledge and socially useful skills. In the next sentence the commentary rejects its first definition by implying that the social value of people differs, but the state has a responsibility for the protection of human dignity of each person regardless of his/her "real social value". The commentators interpret this position of the Constitution from a quite debatable point of social usefulness. The understanding of human dignity by Russian legislators seems to be closely related to the right to privacy and can be somewhat related to the due process clause within the understanding of the US legislators. For example, article 172 of the Criminal Procedure Code (CPC) states that personal search can be performed on a suspect only by a person of the same sex, and the examination which involves nudity of the examined is to be performed in the presence of the witnesses who are of the same sex as the examined person. Article 181 of the CPC directly addresses the issue of human dignity within the understanding of the Code and forbids any

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396 Commentary to the Constitution of the Russian Federation, ibid.
397 Ibid.
398 Ibid. "deistvitelnaya sotsialnaya tsennost", translated as "real social value" by the author.
examinations performed for the purposes of this Law that will be regarded as degrading human dignity or will be dangerous for the health of the examined. The Commentary to the Constitution interprets this provision as a general one that relates to all processing activities performed by an investigator, police officer and a judge. It addressed directly the law-enforcement branch of power in this provision, as the human dignity and good name, even though being ethical conceptions, they are inseparable from personality and understanding of a human being, and thus are protected by the norms of criminal and civil legislation. The Criminal Code of the Russian Federation foresees liability for slander and insult. Slander is described as “defaming honour and dignity of another person or undermining his reputation”, and insult as “demeaning the honour and dignity of another person expressed in indecent form.” These interests are also known as non-proprietal interests of a person, and are also found in a provision of the Civil Code of the Russian Federation.

The rights to personal freedom and inviolability of a person, as described earlier, are concordant with the provision of Article 9 of the International Covenant on Civil and Political Rights. The Russia Constitution extends the conception of inviolability providing the following explanation for it:

1. Each shall have the right to inviolability of private life, personal and family secrecy, and defence of his honour and good name

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400 Commentary to the Constitution of the Russian Federation, supra note 397, 65.
402 Article 129, para 1, ibid. 74.
403 Article 130, para 1, ibid. 75.
404 Article 7, Civil Code of the Russian Federation, states that a person can demand a disclaimer of the information that degrade his honour and dignity, if they are false.
405 International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI), 21 UN GAOR, Supp No. 60, 52, UN Doc A/6316 (1966). Hereinafter referred to as the ICCPR.
2. Each shall have the right to secrecy of correspondence, telephone conversation, postal, telegraph, and other communications. Limitation of this right shall be permitted on the basis of a judicial decision.\textsuperscript{406}

It seems that this provision logically summarizes the two previous articles about human dignity and personal inviolability. The Commentary explains this provision that a person is given a right to control information about oneself, as “relations between people in their personal lives are mainly regulated by the norms of morality”.\textsuperscript{407} The conception of human dignity is further found in the Law on Public Health\textsuperscript{408} that state that a patient when referred to a medical institution has a right to “respectful and humane attitude from doctors and other health professionals”.

\textbf{4.1.2. Instruments of International Law about the Right to Privacy}

Of all the human rights in the international catalogue the right to privacy is undoubtedly among the most difficult to define. In the international law of human rights “privacy” is clearly established as a fundamental right to be protected. The Universal Declaration of Human Rights asserts:

\begin{quote}
No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference and attacks.\textsuperscript{409}
\end{quote}

Privacy is usually classified as one of the civil and political rights, mainly because it is included in the relevant Covenant.\textsuperscript{410} The \textit{International Covenant on Civil and Political

\begin{footnotes}
\textsuperscript{406} Constitution of the Russian Federation, supra note 394, article 23, 9.
\textsuperscript{407} Commentary to the Constitution of the Russian Federation, supra note 399, 70.
\textsuperscript{408} Article 30, Law on Health Care, supra note 319.
\textsuperscript{410} J. Michael, \textit{Privacy and Human Rights. An International and Comparative Study with Special References to Developments in Information Technology} (UNESCO Publishing, 1994) 3. It could be argued that nowadays, due
Rights (ICCPR) provides for the right to “liberty and security of the person”, the right to be free from “arbitrary or unlawful interference” with privacy, home, family or correspondence. Neither the Covenant itself, not the General Comment to Article 17 define what is understood by the term. The comment mentions surveillance, “whether electronic or otherwise”, interceptions of telephonic, telegraphic and other forms of communication, wire-tapping and recording of conversations, searches of homes, personal searches and dissemination and handling of personal data. At the same time the Comment notes that “the protection of privacy is necessarily relative”, implying that the authorities may lawfully limit it, but only to the extent to which the knowledge of one’s private life “is essential in the interests of society as understood under the Covenant.” The International Guidelines on HIV/AIDS and Human Rights suggest that the right to privacy includes an obligation to seek informed consent to HIV tests and maintain the privacy of HIV-related information. The Guidelines specifically address mandatory HIV testing as inconsistent with the right to privacy:

(b) Apart from surveillance testing and other unlinked testing done for epidemiological purposes, public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of that individual. Exceptions to voluntary testing would need specific judicial authorization, granted only after due evaluation of the important privacy and liberty considerations involved.

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412 ICCPR, ibid. article 17.
413 ICCPR, General comment 16, 08/04/88, 32-d session.
414 Ibid. para 8, 10.
415 Ibid. para 7.
However, this is not to mean that there are no boundaries to the right, exceptions are allowed but have to be carefully balanced between the privacy interests of the person and the possible public health outcome.

The European Convention for the Protection of Human Rights and Fundamental Freedoms contains similar provision with regard to the right to “respect for private and family life” and the right to “liberty and security of the person”. The Convention has an effective mechanism of its implementation – the European Court of Human Rights. Any party to the Convention may refer to the Court an alleged breach of the Convention by another party. The Court can also receive applications from persons and non-governmental organizations, who claim to be victims of such a breach. The Court has already dealt successfully with a number of cases that related to HIV/AIDS, however none concerning Russia specifically.

As it was shown above, the invasion of privacy represents a serious offence, both from the moral and legal standpoint. It seems that Russian legislation is not exceptional and does recognize the right to privacy as part of rights to personal freedom, inviolability, protection of human dignity and right to private life. International treaties specifically address the right to privacy both as a more broad conception, and narrower, with regards to HIV/AIDS. Invasions

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417 European Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, 213 U.N.T.S 221, ETS No. 5. The text of the Convention was amended according to the provisions of Protocol No. 3 (ETS No.45), Protocol No. 5 (ETS No. 55), Protocol 8 (ETS No. 118), comprising the text of Protocol No. 2 (ETS No.44), Protocol No. 11 (ETS No. 155), Protocol No. 9 (ETS No.140) was repealed and Protocol No. 10 (ETS No. 146) has lost its purpose. Hereinafter referred to as the European Convention on Human Rights.


419 Ibid. article 5.1.

420 Ibid. article 33.

421 Ibid. article 34.

of personal privacy seem to endanger autonomy, which is a central principle in democratic societies. There are many theories that explain why is it so, but the main argument usually given, is that privacy allows further development of thoughts and ideas and leads to more tolerance than the one where one’s thoughts are exposed to the public and personal choices are undermined. Informed consent to medical treatment is often referred to as “the basic paradigm of autonomy in healthcare”. Respect for autonomy might be seen as a tool that sets legitimate barriers to compulsory testing of populations and routine testing that does not involve obtaining specific informed consent from the patient. In order to prove that informed consent to medical treatment is an important part of one’s right to privacy, it is important to look closer at the issue of consent to medical treatment in general, and to the exceptions from the informed consent doctrine in order to establish whether pregnancy itself, as a physical state of a woman can constitute such an exception.

4.2. Informed consent to medical treatment

It has been noted by many that the informed consent to medical treatment is quite a recent phenomenon that came into existence mainly because the doctor-patient relationship itself has changed a lot over the last years. Indeed, we have gone a long way from family doctors making house calls to look after their patients to the whole variety of medical specialists available to look after our needs, the whole army of nurses and very complicated machines and procedures. Patients look forward to a successful treatment and do not want to accept any errors that may affect their well-being. At the time of “black bag” doctors treatment and the decision-making process were only doctor’s responsibility. The patient was inferior to the

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423 E. Bloustein, “Privacy as an Aspect of Human Dignity: an Answer to Dean Prosser” (1964) 39 NY Univ. Law Rev. 973.
doctor and could not resist a paternalistic approach, that those with medical knowledge undertook towards the "common mortals". It may seem that today this is no longer the case. Medical treatment in many countries in the world (and Russia is of no exception) was turned into one of the regular consumer goods. Thus, it is often subject to the same rules as any purchase agreement: if something breaks down, it should be replaced, or otherwise someone has to bear liability for the costs involved. The patient has more access to information concerning her health, as nowadays this information is very easy to obtain. One does not need to spend hours and days in the libraries, it is enough just to go on the website and type the key-word of your disease into a search engine to get thousands of articles and expert's opinions on the subject. This opportunity changed historical patients' inferiority and made them more informed, and as a result of it, today's patients are not satisfied with a short explanation of what will be done to them. They demand more information with regards to risks and benefits and feel empowered to make informed choices themselves. The promotion of the principle of respect for personal autonomy, and further recognition and wider interpretation of the right to privacy also changed the doctor-patient relationship. It altered its inferiority-superiority aspects, and brought it to somewhere closer to partnership, where the decision about treatment is now a matter falling within the scope of patient's responsibility upon the doctor providing the patient with the information she needs for an informed decision.\footnote{Not all decisions fall as a matter of patient's responsibility. For example, one of the most debatable issue is whether a terminally ill patient has right to die, is still in question as the state’s interest in life overrides any other interest, including the patient's interest in his own death, thus the state has a compelling interest at preventing suicides and resisting euthanasia.\footnote{T. Beauchamp & J. Childress, \textit{Principles of Biomedical Ethics}, 4-th edition, (New York, Oxford University Press, 1994), 128.}} This duty to inform the patient and to disclose the information about the
treatment, and to obtain patient's consent to every medical procedure is known in law as the doctrine of informed consent.

The growing acceptance and understanding of the notions of autonomy led to further acceptance of the argument that the right to chose the way one lives her life is not merely medical and thus it cannot be left for the sole considerations of the physicians. They connect medicine and law, and autonomy, being an important part of human's life, should be protected by law. Thus, the requirement for patient's consent exist and is deeply rooted into the understanding of personal autonomy and privacy. One can distinguish different types of consent to medical treatment: informed consent, express consent and implied consent.

Express consent is described as "verbal or written consent clearly and directly given on the subject such that interpretation is not required." For example, upon admission to a hospital, a patient signs a consent form where she clearly expresses her will to be treated in this hospital. However, it seems that express consent due to its nature cannot be regarded as covering all the invasive procedures that will be performed on a patient in this hospital, and does not protect the hospital from a possible suits on negligence or malpractice, simply because a patient cannot consent to it.

Implied consent is usually used when a person is unconscious or incapable of giving consent. This is when a doctor has to make a decision on behalf of a patient in the patient's best interest. This type of consent is usually limited to the emergencies.

Informed consent was already described above, and shortly, it represents the belief that a patient can make a knowledgeable decision about her treatment, once provided with all the information about it. The most widely used standard mass-produced informed consent
information about most frequent procedures is usually based on a "reasonable physician standard" and even though is referred to as informed consent, it usually lacks personal explanation. The other standard of informed consent, that will be discussed for the purposes of this paper, is the one, where the information given is based on the patient’s desire and need to know about the procedure, in order for her to evaluate its risks and benefits. Consent to medical treatment can be derived from different conceptions depending on cultural traditions and legal systems. In Quebec, for example, the doctrine of informed consent is derived from the concept of inviolability of a person: “La persone humaine est inviolable”. Under common law, treating a patient without his or her consent might constitute battery, and treating a patient on the basis of inadequately informed consent might be interpreted as negligence. Any invasion on one’s physical integrity constitutes assault and in order to legitimize it obtaining consent is required.

Canadian Law generally acknowledges a duty of a physician to inform the patient about all consequences of the medical “touching” in a general range, including all possible side effects and unavoidable risks so that the patient can exercise informed decision-making about his/her health. Consent is a process and means far more than just acquiring a signature on a form. Certain criteria are to be met for an agreement to become valid consent. Two landmark

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431 Individuals cannot consent to all types of injuries, for example, one cannot consent to be killed in a barroom brawl. See Re v Jobidon, 2 S.C.R., (1991), 714, where the accused was charged with manslaughter through the offence of assault following a fist fight in the bar. At trial the accused was found not guilty of a manslaughter as the victim has consented to a “fair fight”, and this consent negated assault. The Supreme Court stated that there are limitations to consent in assault in criminal law and found the accused guilty.
432 See for example Health Care Consent Act, SO 1996, c.2.
decisions of the Supreme Court of Canada – *Hopp v Lepp*\(^{434}\) and *Reibl v Hughes*\(^{435}\) separated from each other only by several months articulated the doctrine and its meaning in Canadian jurisprudence.

In *Hopp v Lepp* the Court had to determine for the first time in Canadian jurisprudence whether obtaining formal written consent could be interpreted as an informed consent. The issue in *Hopp* was permanent disability that followed the surgery and the patient sued the practitioner for damages in negligence and battery. The trial judge dismissed both actions but the appeal was allowed on the basis that consent given prior to surgery was not informed. The Court did not develop any specific test for what constituted information that should be disclosed to the patient, however Laskin, J delivering the opinion of the Court, came to the conclusion that:

[...] in obtaining consent of a patient for the performance upon him of a surgical operation, a surgeon generally should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.\(^{436}\)

The Supreme Court of Canada has set the standards for what exactly the patient is expected to be told in order to be able to give his “informed consent”.\(^{437}\) These standards are known as the “reasonable person test”\(^{438}\). This test is applied to facts in a particular case, as what can be

“material” and pose risks in one case may not be considered as such in another. As held by Laskin, J in Reibl v. Hughes:

[...] it is now undoubted that the relationship between surgeon and patient gives rise to a duty on the surgeon to make disclosure to the patient of what I would call all material risks attending the surgery which is recommended.439

The issue in Reibl was that the plaintiff suffered a stroke during or right after the surgery that was performed on him. The stroke resulted in paralyzing Reibl. Fear of stroke was one of the main reasons why the plaintiff has agreed to the procedure performed, as Hughes informed him that the chance of paralysis would be greater if he would not undergo the surgery. In answering the patient’s query about the stroke the practitioner did not inform him about the possibility of the paralysis. Reibl’s paralysis could be foreseen as a possible consequence of the surgery before it was performed on him. Since the case was decided, the doctrine of informed consent is applied to a much broader range of medical interventions.440 From a practical perspective, the legal norms affirmed in Reibl v. Hughes require disclosure of specific information. The patient should not only be told about the nature of proposed intervention, probable risks to his health and possible benefits, alternatives to the treatment, but also should be informed about the impact of treatment on the patient’s lifestyle, economic considerations and consequences of refusal of the procedure. Obtaining consent from a patient is compulsory except in a medical emergency, that is life or health threatening when the health care practitioner has to provide emergency treatment.441 Analyzing the existing practice and legislation in Canada one can say that the general principles of consent require

439 Reibl v. Hughes, supra note 432, 884.
441 B. Hoffman, The Law of Consent to Treatment in Ontario, 2d ed. (Markham, Ontario, Butterworths, 1997) 34; See also L. Rozovský & F. Rozovský, supra note 435.
obtaining of informed consent prior to taking any blood samples. Informed consent generally does not require a written statement, except for risky and invasive procedures.

In case of testing for HIV/AIDS a written statement of consent is recommended. It should be signed by the consenting person and say that she has been told that her participation was voluntary, that her consent may be withdrawn and that she has been informed of the purpose of the test, its meaning, its benefits and any provisions in existing legislation that would allow disclosure of a status to a third party.\textsuperscript{442} The lethal nature of the AIDS, discrimination, name reporting, partner notification and other legal and social consequences of being found HIV-positive constitute the material risks of which doctors are required to advise the patient.

The Counselling Guidelines for HIV Testing developed by the Canadian Medical Association (CMA, 1995) have clarified the standard of care expected from a physician when conducting HIV testing.\textsuperscript{443} They state that "testing for HIV should always be voluntary and carried out only after the patient has given informed consent".\textsuperscript{444} However, in emergency cases the same exceptions from the informed consent doctrine might apply.

As it was shown above there is consensus among medical professionals in Canada with regards to the fact that prenatal testing for HIV should be voluntarily and that calls for compulsory testing are usually political rather than public health oriented.\textsuperscript{445}

Currently, Canada and some states of the US share the same pragmatic prenatal testing policy of routinely offering it to pregnant women. It is up to the attending physician or OB/GYN to make sure that the consent to the test was given by filling in the place in the form for all tests.

\textsuperscript{442} N.Y.P.H.L §2781(a)
\textsuperscript{444} Ibid. 5.
for pregnant women. The safeguard of such informed consent was doubted quite a number of
times as the ideal of informed consent differs from its implementation in practice and usually
obtaining such a consent places additional burdens on medical personnel, which they are
most likely to avoid.  

The Canadian Medical Association recommends offering testing and counselling for all
pregnant women, it also requires informed consent for such procedure. There is a
widespread belief among medical and public health professionals in Canada, that the sooner
the woman is informed about the advantages and disadvantages of testing and available
treatment, the more likely she is to make a decision that will ultimately benefit herself and the
child, as well as enhance the trust necessary for establishing a collaborative relationship with
the physician. 

In the United States the patient's right to control medical access to his or her body evolved
gradually through twentieth-century court decisions. The first cases to articulate a patient's
right to be free from unwanted medical treatment involved physicians who treated patients
successfully, but failed to secure the patient’s consent prior to treatment. The courts found
that such treatment constituted battery and patients could recover damages against the

445 See R. Jurgens, “HIV/AIDS Policy and Law in Canada”, S.Frankowski, ed., Legal Responses to AIDS in
446 K.Galagher-Mackey, “Routine Offering of HIV Tests to Pregnant Women: Foetal Supremacy, Medical
Authority and Invisible Effects on Women”, supra note 247, 358.
447 See CMA, Counselling Guidelines for HIV Testing , supra note 445.
448 Canadian HIV/AIDS Legal Network, Infosheet, online: Canadian HIV/AIDS Legal Network/ Infosheets
physicians even despite the successful outcomes. Nowadays most states have enacted legislation that clearly defines the autonomous right of the patient to self-determination.

The New York statute, as the most common example of other state legislation, foresees liability of the provider for conducting non-emergency medical procedures without prior obtaining informed consent from the patient. It also states that the provider who treats the patient has a duty to disclose to her the diagnosis, the proposed treatment, the treatment options and all reasonably foreseeable risks and benefits of treatment.

In *Truman v. Thomas* the Supreme Court of California again affirmed that it is up to the patient, not physician to make the decisions about proposed medical treatment, however there is a positive duty on behalf of the physician to disclose all the foreseeable risks "measured by amount of knowledge patient needs in order to make an informed choice". The issue in *Truman v. Thomas* was the physician's failure to explain all risks and benefits of not having an indicated PAP smear test to Mrs. Truman, who did not understand the implications of not having the test and later on died from detectable cervix cancer at the age of 30. If discovered earlier, the tumour could have been removed and the progression of the disease arrested. Appellants brought a wrongful death action against Dr. Tomas for failure to perform the test.

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449 See *Pratt v. Davis*, 118 Ill. App. 161, aff'd, 79 N.E. 562 (Ill. 1906); *Schloendorff v. Society of N. Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)
450 This may vary from state to state, but the underlying principle unifying these statutes is that the decision of the patient must be respected. See N.Y.Pub. Health Law § 2805 d (McKinney 1993); Fla. Stat. Ann. § 766103 (West, 1997). Wash. Rev. Code Ann §7.70.060 (West, 1992).
451 See N.Y.Pub. Health Law §2805 d (2) (McKinney 1993): "The Right action to recover for medical, dental or podiatric malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the body".
452 N.Y.Pub. Health Law §2805 d (1) defines lack of informed consent as "the failure of the person providing the professional treatment or diagnosis to disclose to the patients such alternatives thereto and the reasonable foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed in a manner permitting the patient to make a knowledgeable evaluation".
453 Sup., 165 Cal.Rptr, 308
454 Ibid, 308.
The Court held that Dr. Tomas did indeed breach his duty of care to Mrs. Truman when failing to inform her of the potential fatal consequences of undetected cervix cancer. It stated:

If a patient indicates that he or she is going to decline the risk-free test in treatment then the doctor has the additional duty of advising of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. On the other hand, if the recommended test or treatment is itself risky, then the physician should always explain the potential consequences of declining to follow the recommended course of action.\(^{(455)}\)

The Court declined the appellants' allegation that the physician should have performed the test even without Mrs. Truman’s consent:

The suggestion that a physician must perform a test on a patient who is capable of deciding whether to undergo the proposed procedure, is directly contrary to the principle that it is the patient who must ultimately decide which medical procedures to undergo.\(^{(456)}\)

American jurisprudence also recognizes voluntariness of given consent as an important element of valid informed consent.\(^{(457)}\)

Currently, many states of the United States require consensual testing for HIV, mandating it only for several groups of population (see Chapter II). None of the states creates any specific statutory provisions regarding testing for this disease for pregnant women, as obviously it would violate the notion of equality. However, the understanding of “consent” to an HIV test differs from a “written statement”\(^{(458)}\) in Oklahoma to informed written consent with pre- and post-test counselling in the state of New York\(^{(459)}\).

\(^{(455)}\) Ibid, 312.
\(^{(456)}\) Ibid, 314.
The traditional Russian approach of the medical professionals to informed consent could be briefly described as medical paternalism and implied consent. Once a patient enters an inpatient facility, it is implied that she agrees to all the procedures that will be performed on her, and the separate written consent is required only for some types of surgical procedures. Despite the existing practice, it would be wrong to say that Russian legislation is not aware about the latest trends in doctor-patient relationships with regards to autonomy of the latter. The Law on Public Health in Russia states that it is a patient’s right to be treated respectfully and humanely by doctors and other health care professionals. Thus, it is of no surprise that the law directly foresees informed voluntary consent as a requirement for any medical procedures. It affirms that voluntary consent of the patient to the medical procedure constitutes “the basis for any medical invasion.” When the patient cannot decide upon the treatment due to her physical condition, the law foresees that consent is to be given by conference of specialist doctors, or if it is not possible – than solely by the physician. The patient is also given a right to reject the medical treatment or to stop it. However, there are also some exceptions to the rule:

Provision of the medical care (medical examination, hospitalization, surveillance and isolation of a person) can be performed without consent of the person in question, or without consent of his/her legal representative. It is allowed with regards to those who suffer from diseases that are dangerous to others, or have severe psychiatric disorders, or those, who have committed dangerous offences.

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460 K.Danishevski, MD, MPH, Sechenoff Medical Academy of Moscow, personal communications with author. More or less the same approach is to be found in other countries of Eastern Europe, for example, in Poland, see K. Zelinska & S. Frankowski, “Legal Responses to AIDS – A Polish Perspective”, S.Frankowski, ed., Legal Responses to AIDS in Comparative Perspective (New York, Kluwer Law International, 1998) 339.
461 Law on Health Care, supra note 319, article 30.1.
462 Ibid. article 32.
463 Ibid. article 33.1.
464 Ibid. article 43.1.
It seems that this exception from the informed consent doctrine does not apply to the case of HIV/AIDS, otherwise the Federal Law on HIV/AIDS would not have a specific provision directly limiting compulsory testing to blood donors, leaving the decision of mandatory testing of other groups of population up to the Government. In this way, the law does not address pregnant women, not distinguishing them from other groups of population. The Law consists of provisions that speak about voluntariness of decision to go through an HIV test and obligatory pre- and post-test counselling, even if the test is done compulsorily. This proves that Russian legislation does not allow compulsorily testing of pregnant women for HIV infection. However, one can wonder whether HIV/AIDS was included by Russian lawmakers under the definition of the “disease dangerous for others” within the understanding of the Law on Public Health. If one is to suggest that it was so, than the necessity of a separate Law on HIV/AIDS prevention directly limiting compulsory testing to a segment of a population (blood donors), is unclear.

Informed consent to HIV/AIDS testing should be regarded as an important part of the right to privacy. It is in existence to make sure this right is respected. As it was shown above, the right to privacy even though extremely important for personal well-being in democratic societies is not absolute and is likely to be limited when the interests of the third persons or society at large are endangered. The doctrine of informed consent is in place in order to secure the freedom of decision-making in people, but cannot be regarded as the only possible solution around HIV testing and privacy issues. Many supporters of the doctrine recognize

\footnote{Law On HIV Prevention in the Russian Federation, article 9.1, supra note 147.}

\footnote{Ibid. article 9.4.}
that the practice of obtaining consent rarely meet the ideal standards.\textsuperscript{467} In order to serve its purpose of affirming that the individual makes an informed decision about her body, consent should be freely given and the information fully provided and well understood. This seems like a weak safeguard with regards to a pregnant woman or a woman in labour. Doctors usually suffer from extensive medical paternalism towards women, and especially pregnant women (see the discussion of doctor-maternal conflict). This feeling of medical supremacy can easily affect the patient’s decision, which is quite easy for a physician to alter through indirect coercion.\textsuperscript{468} Sometimes such coercion takes on a form of direct manipulation. One can suggest that this happens mainly because of the attitude many medical professionals have towards consent, when it is regarded as just a signature on an appropriate form, instead of a whole process that implies that “decisions about the medical care a person will receive, if any, are to be made in collaborative manner between patient and physician”.\textsuperscript{469} If presumed that each physician tries to meet the existing standards for informed consent, established in her country by providing the patient with the information about the proposed intervention, the implications of refusal and alternative forms of management of the circumstances, it becomes difficult to argue against informed consent and in favour of obligatory testing. In Russia, the Law on HIV/AIDS guarantees people both, pre-test and post-test counselling for HIV testing.\textsuperscript{470} It seems that one of the goals of pre-test counselling should also be providing sufficient information to the patient, and making sure she understands all the consequences of


\textsuperscript{468} See K. Galagher-Mackey, supra note 247, 358, for further discussion on the issue.


\textsuperscript{470} Law on HIV/AIDS Prevention, supra note 147, article 7 (6).
such test. In other words, pre-test counselling for HIV secures the necessity to obtain informed consent to testing, even in the countries, where the tradition of medical paternalism still exists.

4.3. International obligations towards women with/or at risk of HIV/AIDS.

International obligations of the state with regards to protection of human rights can be regarded as another strong argument against routine testing of women for HIV infection. International human rights law provides general rules for the states with regards to HIV/AIDS. The most recent UN Declaration of Commitment on HIV/AIDS once again underlined the importance of "full realization of human rights and fundamental freedoms for all" as an "essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS." The same declaration also stressed the importance of gender equality and the empowerment of women as fundamental elements in the reduction of their vulnerability to the virus. The Global Strategy Framework on HIV/AIDS includes the issue of addressing gender inequalities fuelling the epidemic as one of its guiding principles.

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472 K. Danishevski, MD, MPH, Sechenoff Medical Academy of Moscow, personal communications with the author. For another example of a system that does not share the Western understanding of consent to medical treatment, see P. Walter, "The Doctrine of Informed Consent: A Tale of Two Cultures and Two Legal Traditions", (Spring 1999). Issues in Law and Medicine, 357, where she provides a comparative analyses of Israeli and US attitudes on the issue.
474 Para 14, UN Declaration of Commitment on HIV/AIDS.
The Russian Federation is a signatory to quite a number of international treaties on legal and social issues, including: *The Universal Declaration on Human Rights*,\(^{476}\) *The International Covenant on Civil and Political Rights (ICCPR)*,\(^{477}\) *The International Covenant on Economic, Social and Cultural Rights (CECSR)*,\(^{478}\) *Convention on Elimination of All Forms of Discrimination against Women*.\(^{479}\)

Russia is also a party to the main human rights document of the European Union: the *European Convention for the Protection of Human Rights and Fundamental Freedoms*.\(^{480}\)

*Women’s Right to Health and health care.*

Article 12 of the CESCR speaks about right to the highest attainable standard of physical and mental health, this right is also recognized by the Women’s Convention, that obliges the state parties to eliminate discrimination against women in the field of health care.\(^{481}\) Furthermore, article 12 (c) states the right to prevention, treatment and control over diseases. The Comment to this article, issued by the Committee on Economic, Social and Cultural Rights specifically mentions the importance of HIV/AIDS prevention programs. This Comment expands the understanding of the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, so it includes the principle of respect of medical ethics and gender sensitivity, “as well as being designed to respect confidentiality and improve the health status of those concerned”.\(^{482}\) Mandatory HIV testing of pregnant women

\(^{476}\) Universal Declaration on Human Rights, supra note 410.

\(^{477}\) ICCPR, infra note.

\(^{478}\) ICCPR, supra note 412.

\(^{479}\) Convention on Elimination of All Forms of Discrimination against Women, G.A.Res.34/180, 34 U.N.GAOR Supp No. 46, 193, UN Doc A/34/46 (1980). Russian Federation is Party to the Convention since 03/09/81, when the Convention entered into force for the USSR.

\(^{480}\) European Convention on Human Rights, supra note 418.

\(^{481}\) Article 12 of the Women’s Convention, supra note 480.

\(^{482}\) CESR, General Comment 14, UN ESCOR, 2000, Doc.No. E/C.12/2000/4, 12 (c).
does not satisfy the requirements, set up in this Comment as it is neither respectful of medical ethics nor gender sensitive or improves women’s health.

The Committee on Elimination of All Forms of Discrimination against Women (CEDAW) came up with a specific recommendation on avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)\textsuperscript{483} that emphasized the importance of paying special attention to “the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection”.\textsuperscript{484}

The European Convention on Human Rights also prohibits any kind of discrimination, and the right to health and state’s responsibility to prevent epidemics and diseases are found in the European Social Charter.\textsuperscript{485}

As pregnancy is a physical condition, that is found only in women, testing them for HIV infection only because of their unique physical ability, will directly discriminate against women and deter them from health care services, and thus, alter their access to health care and increase their vulnerability to HIV/AIDS.

Unfortunately, Russian approach to human rights and international treaties seems to be different from the one, which is most common in the Western world - the one that emphasizes the basic civil and political rights of individuals, as claims, limiting the power of the government over its people.\textsuperscript{486} Historically, the approach of the Soviet Union has been to note the importance of basic rights and freedoms for international peace and security but to

\textsuperscript{484} Ibid. para (c).
\textsuperscript{485} Article 11, European Social Charter, ETS No. 035, opened for signature in Turin, 18/06/61, entered into force 26/02/65. Russian Federation has not yet ratified the Charter,
emphasize the role of the state. The state was seen as the source of human rights.\textsuperscript{487} Soviet scholars have advocated that international human rights treaties do not represent rights directly enforceable by the individual.\textsuperscript{488}

In other words, the focus is put not on the individuals but on the state, as human rights are not directly regulated by international law and individuals are not regarded as subjects of international law. It was emphasized that “conventions on human rights do not grant rights directly to individuals”.\textsuperscript{489} This approach that was used by the Soviet Union in the past, and it seems that it was as well transferred to the new Russia.\textsuperscript{490} Despite the constitutional provision of the superiority of human rights obligations of Russia over its national legislation, it seems that having stressed the central function of a state the point is also made that the context of the international human rights obligations is defined solely by the state in the light of its economic and social advancement.

The Soviet Union was able and willing to enter into many international agreements on human rights on the basis that only a state obligation was incurred, with no direct link to the individual, and that such an obligation was one that the country might interpret in the light of its own socio-economic system.\textsuperscript{491}

Thus there is no wonder that even though the Constitution does foresee the supremacy of international treaties, there is still no mechanism in place in the national legislation that will secure implementation of human rights norms. Such an attitude towards human rights obligations seems to be prevalent among Russian legal scholars, and it is obvious that it will

\textsuperscript{489} I. Tunkin, Theory of International Law, 1974, 81.
\textsuperscript{490} The US approach to human rights seems to slightly differ: as any international treaties US signs become part of the national legislation, the country is a party to only very few human rights instruments.
have to change, if Russia wants to proclaim the rule of law and democracy. However, this is not to say that now there is no use in the treaties, as many of them foresee individual complaint procedures that allow the individual to bring the claim directly to an international agency after the domestic remedies were exhausted.

Both, the ICCPR and the Women's Convention have the legal force of treaties to their parties, and both of them have Committees that are responsible for monitoring their implementation and reporting procedure. The provisions of the European Convention are enforced by the decisions of the European Court on Human Rights, that allows individual complaints. The Optional Protocol to the Women’s Convention foresees the mechanisms allowing individuals to complain directly to the respective committees about alleged violation of their rights.

In this paper a lot of references were made to International Guidelines on HIV/AIDS and Human Rights. These Guidelines were a result of a cooperative effort between the UN High Commissioner for Human Rights and the Joint United Nations Program on HIV/AIDS. They were drafted by a group of experts in the fields of human rights and HIV/AIDS. Despite the fact that these guidelines (as well as the Comment and Recommendations mentioned earlier) do not have the legal status of a treaty and are not legally binding, they set up examples of successful policies and practice, which are most consistent with the international human rights obligations of the states. Guideline 3 states:

492 The Joint United Programme on HIV/AIDS (UNAIDS) is co-sponsored by seven agencies within the UN system: UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO and the World Bank. It’s overall aim is to coordinate UN activities on HIV/AIDS prevention. “Although UNAIDS does not have a direct implementation role, it can influence policy making through: its convening power, which can result in the setting of standards; the advocacy role at global and country level, and its ability to offer technical expertise to actors such as governments”. Annex D, UNAIDS/IPU, Handbook for Legislators on HIV/AIDS, Law and Human Rights, (Geneva, Switzerland, 1999), UNAIDS/99.48E, 133.
[...] It is not recommended by the international agencies to violate the rights to privacy and bodily integrity, which are parts of the rights to liberty and security of a person found in the UN Declaration on Human Rights. 493

4.4. Conclusion:

In this chapter the rights to privacy and consent to medical treatment were analyzed as the basic arguments with regards to why (other than for the lack of public health benefit) women should not be tested for the presence of HIV virus when they seek prenatal care. To summarize, it seems that right to privacy is so central to human well-being and personhood, that it defines our view on democracy. Testing for HIV infection should be regarded as a fundamental personal choice, belonging to the sphere of private and family life. To take the issue even further, any coercive procedures undermine human dignity that is protected by many international treaties, and is found in national legislation as well. There is also evidence that once a woman is tested HIV positive she might be refused further services and coerced into abortion by her physician.494 National legislation as well as the international treaties directly prohibits this behaviour.495 The World Health Organization (WHO) stated that:

494 In Doe v. Jamaica Hospital the Supreme Court of New York State found the physician who refused to continue treating an HIV-positive pregnant woman and referred her for an abortion liable for negligently giving erroneous advice. See Carol Doe v. Jamaica Hospital, et al., 608 N.Y.S., 518. See also the NAMES Foundation report “Human Rights and HIV in Women”, online: NAMES Foundation <http://www.aids.ru> (date accessed: April 24, 2001), that provides an interview with a young HIV-positive woman, who was reminded every day of her pregnancy about the necessity of having an abortion by her physician and the Sanitary Surveillance Department. See also N. Santos, et al., “HIV Positive Women, Reproduction and Sexuality in Sao Paulo, Brazil”, supra note 247, 35 (interview with an HIV-positive Brazilian woman who was sterilized after being told that it was a crime to infect babies with HIV. It is not against the law for an HIV-positive woman to have a child. The law does not allow compulsory testing).
495 See article 11 of the Women's Convention that states that women have the same right as their spouses to freely decide upon the number and spacing of their children. The danger to have their reproductive choices limited by coerced contraception or sterilisation is even greater for drug using women who constitute a big part of PLW AIDS. Some argue that society has a right to force women who persist in abusing drugs during pregnancy to undergo abortions, see: G. Scheduler, “Does Society Have the Right to Force Pregnant Addicts to Abort Their Fetuses?”, (1991) 17 Social Theory and Practice 369, 384. He argues that as the abortion experience is “brief and painless” it is better for a drug-using woman as well as for the society to have her aborted the fetus than to suffer the “avoidable birth defects” later.
not only is it unethical to pressure or force women to make reproductive or breast-feeding decisions for any reason including their HIV status, but those women, likely to be infected may try to avoid mandatory testing, precisely to avoid pressure in such decision-making. Such avoidance may have the additional unwanted result of discouraging pregnant women from attending antenatal services. 496

From a public health perspective it may seem that compulsory treatment (such as routine testing for HIV with further compulsory treatment) benefit the society as well as individuals: it provides the cure for an individual and reduces level of infectiousness in the community. However, compulsory treatment of any sort represents a serious intrusion into person’s bodily integrity and right to refuse medical treatment that is rooted in the right to privacy. 497 Unless otherwise required by the statutes, public health authorities have to respect patient’s rights to refuse it. Whether testing of pregnant women for HIV can be required by statues is an ethical question, involving the issue of exercising state power in “the most intimate and personal choices a person may make in a lifetime”. 498 The jurisprudence of Courts both in the US and Canada provides reasons to believe that Constitution and Charter safeguard treatment decisions of people. 499 However, as it was shown there is some evidence that decision of pregnant women might be singled out from both informed consent doctrine and constitutional scrutiny. The Constitution of the Russian Federation as well as the Federal Law On Public Health and Federal Law on HIV/AIDS Prevention do not allow non-consensual testing of women on the grounds of benefiting their fetuses. The law-makers in Russia seem to respect the right to privacy and informed consent to medical treatment. However, the practice is

496 See also International Guidelines on HIV/AIDS and Human Rights, supra note 60. “Apart from surveillance testing and other unlinked testing done for epidemiological purposes, public health legislation should ensure that HIV testing of individuals should be performed with the specific informed consent of that individual. Exceptions to voluntary testing would need specific judicial authorisation, granted only after due evaluation of the important privacy and liberty considerations involved.”
497 See above in Chapter IV for the discussion of informed consent to medical treatment.
498 Planned Parenthood v. Casey, 505 US at 851
different. If Russia wants to invoke the principle of the democratic rule of law (Rechtsstaat)\textsuperscript{500} than the government has to directly address the issues of gender inequality and discrimination with regards to HIV/AIDS. However, there is a danger that due to the recent developments of fetal rights in Russia\textsuperscript{501} it seems feasible that a policy of routine testing women for HIV might be legally allowed. Than the question is whether this policy will constitute the right balance between the state interest in the health of the population and its interest in protecting the future life and the privacy interests of women. L. Gostin suggests the following test to identify the balance between the interests of the state and the interests of individuals with regards to public health policies: one should demonstrate the infectiousness of the disease and the availability of treatment in order for mandatory treatment to sustain Constitutional scrutiny.\textsuperscript{502} HIV is an infectious disease and it can be transmitted from mother-to-child. The risk of transmission is around 25-30%. The state has interest in preventing transmission of the disease. There is evidence that this transmission can be significantly reduced (8,3%) through antiretroviral therapy. There is evidence that transmission can be slightly reduced by performing Caesarian section rather than natural birth. However, this approach leads to collision of public health interests and ethical concerns. As it was shown, a fetus is not considered to be a person, so if one takes this approach, one cannot argue that the highly questionable treatment will benefit the non-existent being. In this case, women will be singled out as the only civilian population undergoing through the test because of the condition specific to women only (pregnancy). If one argues that the available treatment

\textsuperscript{499} See Planned Parenthood \textit{v.} Casey, ibid, for example.

\textsuperscript{500} Principle, developed in the German legal doctrine, that refers to the conception of a state based on the rule of law. This principle is found in Article 1 of the Constitution of the Russian Federation, supra note 149, that states that "Russian Federation – Russia is a democratic federated rule-of law State...."

\textsuperscript{501} The Draft Law “On Bioethics”, supra note 328.
prolongs women's life, and thus all women should be tested, than this argument may well be extended to the general population as well.

So far, it seems that testing of women can not be demanded on the grounds of helping their fetuses. As one scholar put it:

Any effort by the states to mandate specific courses of behaviour for pregnant women, particularly for the benefit of their fetuses, raises grave concerns for the remaining degree of reproductive autonomy left for women by increasingly less sympathetic courts.\(^{503}\)

The very nature of HIV virus, its difficult social consequences and expensive treatment, which is still unavailable in many countries may temporarily prevent legislators and Courts from imposing overall testing on pregnant women "to benefit the women".

It is extremely hard to achieve the right balance between concern for women, especially those poor and marginalized and the state's interest in promoting public health. The present work does not advocate for excluding women from testing for HIV. Voluntary Testing and Counselling (VTC) constitute an important strategy in HIV/AIDS prevention, which has its advantages both for sero-positive and sero-negative women, as well as for reducing HIV-related stigma and increasing awareness and acceptance of HIV.\(^{504}\) Taking all this into consideration, it seems that the policy of routine offering every woman this test, with thorough pre-test counselling, followed by post-test counselling and further treatment that will benefit first of all the woman and her needs seems to be the most acceptable solution.

One should acknowledge the existence of other views on this matter, opinions that find that

even routine offering of the test violate the women’s rights to make their own choices.\textsuperscript{505}

However, if the safeguard of informed consent for testing is ensured it seems to make more sense to go with the above suggested policy. The US Institute of Medicine recommends the following:

\textit{[...]} the committee believes that a policy of universal, routine testing with notification reflects an appropriate balance among public health goals, justice, and individual rights. This policy would increase HIV testing, and hence improve outcomes, by striking a balance in the doctor/patient interaction as well as in the broader society.\textsuperscript{506}

Unfortunately the report calls for elimination of the costly requirement of pre-test counselling, and thus, by doing this, minimizes the acceptability of its recommendation. This provision has a danger of turning an extremely useful prevention tool into very effective tool of coercion, turning routing testing with notification into what can be described as the obligatory one (see chapter I for the explanation of the definition), as there is “a significant risk [...] that some providers with less than stellar records in discussing HIV with pregnant women will not inform women either that HIV testing will occur or of their right to refuse.”\textsuperscript{507}

It was shown that not only Russia, but the United States as well, are a long way from developing comprehensive public health strategies that will take into account all possible effects (direct and indirect) on women’s rights and freedoms. The mobilization of the gay community as a response to the epidemic helped to overcome some stigma and prejudice attached to the disease and to develop appropriate public health interventions for this


\textsuperscript{505} See, for example, K. Galagher-Mackey, supra note 247, 336-364.

\textsuperscript{506} US National Institute of Medicine Reducing the Odds, supra note 27, 111.
particular group. Women are usually too overburdened with their social duties to participate in such a discussion:

An infected woman must often cope simultaneously with the illness and a death of a spouse or life partner; the HIV infection, illness and death of her children; the children’s grief upon losing or anticipating the loss of a parent, establishing legal custody of her children when she dies; her own feelings of failure as a mother because she will not live to provide protection for her children as they grow up....

All these and many other factors, such as historical vulnerability of a woman and her position in a society, paternalistic attitude of legislators and doctors, make it virtually impossible that issues regarding pregnant women and their health and their rights would be properly addressed in the nearest future. The most difficult task for legislators and policy makers is to find and enforce the right balance and the "proper" way of addressing the problem which will be sound from all these perspectives: public health, ethical, legal and social.


The present work made an effort to find the right balance between a legitimate state’s interest in public health of its population and women’s right to privacy. The core arguments of the thesis evolved around comparison of public health benefits of voluntary and involuntary testing policies and recommendations of international agencies in the field (WHO and UNAIDS in particular). In connection to this, the importance of HIV/AIDS exceptionalism was once again affirmed. Chapter I was dedicated to determining what an HIV test actually meant, why this test is different from any other only to prove that uniqueness of the disease. It

508 For example, the Federal Law on HIV/AIDS Prevention in Russia was developed in close cooperation with the gay community in the country. Gennady Roschupkin, AIDS-Infoshare, Medecins Sans Frontieres-Holland, personal communications.
was also shown that there is lack of clarity with regards to terms used around HIV testing and that the use of different terminology with regard to testing depended on one’s political views rather than scientific description. Thus, even though the personal feeling of the author is so that it is important to have an opportunity for a free anonymous test for HIV once pregnant, this work advocates against routine testing of pregnant women for HIV for the fear that due to the vagueness of the existing terminology and scarce resources “routine” test will eliminate pre- and post-test counselling. Chapter II analyzed the existing policies of mandatory testing to discover whether the states of interest were ready to adopt another testing policy that would not be supported by significant public health outcomes. In Chapter III the effort was made to line up the core arguments in favour of coercive testing of pregnant women for HIV and weigh them against possible public health results and existing jurisprudence. The author also looked into the state’s interest in potential life, and even though there seems to be an interest in preserving human life per se, the existing jurisprudence does not allow one to conclude that interest in fetal health should overcome the interests of the mother. It was argued that a fetus was not a human being, and thus a policy of non-consensual testing to benefit the resulting child could not be considered as a sound legal policy, as it would violate rights of the only human being in question: the mother. Chapter IV being the concluding chapter to the paper made an attempt to analyze the right to privacy and describe some of the different approaches to it. It was found, that Russian legislation was not an exception to other democratic societies and it did recognize and protect the right to privacy, as well as consent to medical treatment. Russian legislation seems to be in tact with its international obligations and prima facie seems to be progressive and provide those at risk with the necessary protection. However, the government and the prosecutors in Russia continue to ignore the
widespread illegal practices of non-consensual testing for HIV. Involuntary testing is forbidden by law, however in practice, the rules are different for women, drug users and prisoners, - those who are most vulnerable to the disease.

Next step should be to determine the scope of this practice, its causes and develop effective mechanism for its prevention. New questions will arise with regards to this: is this practice motivated by the governmental inability to implement the “rule of law” regimen in the country, or does it have anything to do with the traditional Russian attitude to law which is best described by a Russian saying: “Laws are made in order to be avoided”. It would be interesting to look into the role of the United States in Russian gender-based and disease-specific discriminatory practice. The author admits, that non-consensual testing is only the “tip of the iceberg” of all the discrimination that takes place against women living with/at risk of HIV in Russia as well as in North America, and more problems are yet to surface. For example, with the new treatment becoming available, the emerging question of whose life to save first: the woman’s or the baby’s is likely to surface once again. The other issues include the effectiveness of the existing prevention and treatment programs, availability of social support for those women who are found to be HIV-positive, and still decide to go on with their pregnancies. It is now obvious that development of special educational campaigns for Russian women in order to empower them with knowledge about their rights, guaranteed by international treaties and national legislation is not enough. The time has come to challenge the illegal practice in the courts of Russia, and to raise international awareness of the issue.