Department of Justice
Canada

WORKING PAPERS ON PORNOGRAPHY AND PROSTITUTION

Report # 7

THE LADIES (AND GENTLEMEN) OF THE NIGHT AND THE SPREAD OF SEXUALLY TRANSMITTED DISEASES

by
M. Haug
and
M. Cini

POLICY, PROGRAMS
AND RESEARCH BRANCH

RESEARCH AND
STATISTICS SECTION

Canada

THE LADIES (AND GENTLEMEN) OF THE NIGHT AND THE SPREAD OF SEXUALLY TRANSMITTED DISEASES

Margot Haug
Maltaise Cini

May, 1984

Acknowledgements

We would like to thank all of the people who helped us in the preparation of this document especially Dr. Jessamine, Marion Todd, and Dr. Hockin, of the Laboratory Centre for Disease Control, Health and Welfare Canada for their expert advice, Sue Higgins for her invaluable help in finding publications, Daniel Sansfaçon for his infinite patience and for his perceptive comments, Bernard Starkman, Patricia Bégin, Yvon Dandurand, for their expert advice and John Clappe for his expertise in the field.

Executive Summary

The purpose of this paper is to determine whether prostitutes make a significant contribution to the spread of sexually transmitted diseases (STD's) and to determine which measures are most effective in controlling the problem.

The study concludes that female prostitutes do not make a significant contribution to the spread of STD's since although female streetwalkers* have a higher incidence of gonorrhea than do women to whom they were compared, four in every five cases of gonorrhea in the U.K. (Turner and Morton 1976) could be traced to a woman who was not a prostitute. In 1983, Dr. Neumann (1983:155) concluded that this figure has decreased and that prostitutes now contribute to less than one in every ten cases.

The reason for this finding is based upon common sense. Since prostitutes now form a very small percentage of the sexually active population, since they frequently engage in oral sex which infrequently results in the infection of a client**, and since most prostitutes regularly use prophylactics, they are not important transmitters of STD's even though they may be more frequently infected than the average person.

Common sense also leads us to the conclusion that it is perhaps the young male aged 20 to 24 which makes a significant contribution to the spread of STD's. In the U.K., Canada and the U.S., gonorrhea is diagnosed more frequently in this group than in other age groups composed of males and females. As well, this group forms a significant proportion of the sexually active population and is not particularly well informed about the prevention and treatment of STD's.

In focusing upon the prostitute we try to find an easy solution to a complex problem. Not surprisingly research studies and common sense show that this approach is not only ineffective in controlling the spread of STD's but also raises serious moral and human rights questions. The most effective control measures are based on public education and specialized, easy to access, health care facilities.

Therefore, the issue is not whether prostitutes significantly contribute to STD's but rather what should or can be done about a growing social problem. We conclude that, in Canada, this problem could be addressed in the following ways:

- Conduct multidisciplinary research, which does not discriminate against women, to determine which medical and social measures are effective in reducing the prevalence of STD's;
- Pay serious attention to the problem of incest and its relationship to STD's in Canadian children;
- Educate the Canadian public, STD patients, the medical and social welfare profession, high risk groups and politicians about STD'S and their prevention.

---

* Most studies ignore male prostitutes.

** Dr. Jessamine, personal interview.

TABLE OF CONTENTS

Introduction

The purpose of this paper is to examine whether prostitution makes a significant contribution to the spread of sexually transmitted diseases (STD's), and to determine which measures to control the spread of these diseases, by prostitutes, have been effective in the past (1).

STD's can engender a great deal of harm (2). They can pose a serious health problem for prostitutes as well as for the clients of prostitutes. Complications such as pelvic inflammatory disease, ectopic pregnancies, and involuntrary infertility, impose a large human and financial cost upon society. Pelvic inflammatory disease alone, costs the Canadian economy about $28 million dollars every year; $400,000 for office visits, $22.6 million for operative procedures and $5 million for loss of time from work, (Romanowski 1983:153). Uncomplicated STD's and their consequences, in the late 1970's, cost the Canadian economy over $200,000,000 annually, (Jessamine et al. 1983:164). This figure does not, however, even begin to measure the social and personal cost of STD's.

This paper focuses upon the relationship between sexually transmitted diseases and prostitution since some people have stated that prostitutes make a significant contribution to the spread of STD's while others say that promiscuity is more of a problem than prostitution. Although this paper can not determine once and for all how large a contribution prostitutes make to the spread of venereal disease in Canada, (since the data to prove such a statement do not exist), it can attempt to answer this question for other Western nations where such studies have been conducted.

If one can prove that prostitutes do make a significant contribution, then it can be argued that special measures are needed to control this problem. In order to answer questions policy makers have about control measures, this paper describes and evaluates the effectiveness of methods used to limit the spread of STD's by prostitutes.

---

1. See the section titled 'Definitions and Notes for an outline of the various infections that are traditionally classified under the title 'sexually transmitted diseases'.

2. Self-inflicted venereal disease is a recognized phenomenon. English prostitutes who offered their 'services' to members of the British Expeditionary Force to France during the First World War, charged higher prices when they knew they were diseased because a case of V.D. meant removal from the trenchs. (Adler 1980:208)

Methodology

In order to study these questions we reviewed the literature on prostitution and sexually transmitted diseases. To our knowledge no empirical work has been done in Canada on the possible link between prostitution and the spread of STD's. Most studies are either American or British. However, in Canada as in most Western countries, data are collected on the incidence of some STD's and their complications.

I. THE INCIDENCE OF STD's IN CANADA

The Department of Health and Welfare Canada publishes yearly data on the national incidence of sexually transmitted diseases, (i.e. the number of new cases every year)(3). This data is collected by the provinces and sent to Statistics Canada. The Department's 1982 report, Sexually Transmitted Diseases in Canada 1982, included data on gonorrhea, syphilis, infectious syphilis, latent syphilis, acquired immune deficiency syndrome (AIDS), herpes virus infections, and chlamydial infections. However, the magnitude of the STD problem in Canada is underestimated due to two factors: non-compliance with the reporting system; and the small number of reportable STDs, (only the 'traditional' venereal diseases are reportable.)

Canada's national reporting system does not include certain sexually transmitted infections such as non-gonococcal genital infection, trichomoniasis, and genital warts, which, according to this report, are estimated to occur at least as frequently as gonorrhea.

> "It is estimated that there are 3 cases of non-gonococcal urethritis and cervicitis for every case of gonorrhea seen, 1 case of herpes for every 5 cases of gonorrhea, and venereal warts are diagnosed as frequently as gonorrhea by private practitioners and VD clinics." (Department of Health and Welfare Canada 1983:1)

It is believed that about one third of all cases of gonorrhea are reported to provincial governments, and about 90% of all cases of syphilis are reported (4). The publically funded STD clinic is most likely to report a case whereas student health services, hospitals, and private M.D's

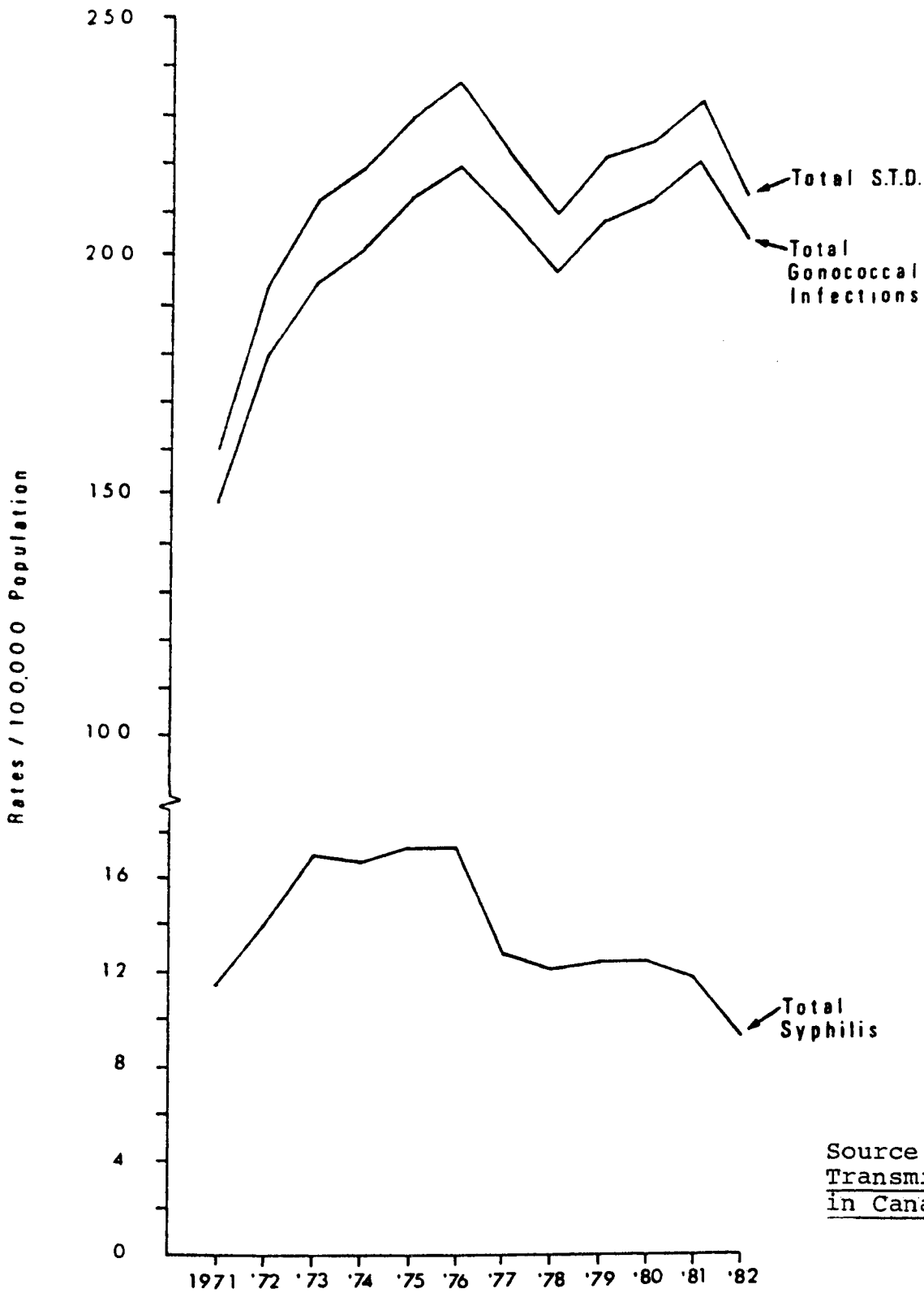
---

3. Note the difference between this term and 'prevalence'. See the section titled 'Definitions and Notes.' All of the statistics and information on STD's in Canada outlined in the following section comes from Health and Welfare Canada's report titled Sexually Transmitted Diseases in Canada 1982.

4. Personal interview with Dr. Jessamine, Marion Todd, and Dr. Hockin of the Laboratory Centre for Disease Control, Health and Welfare Canada.

Figure 1

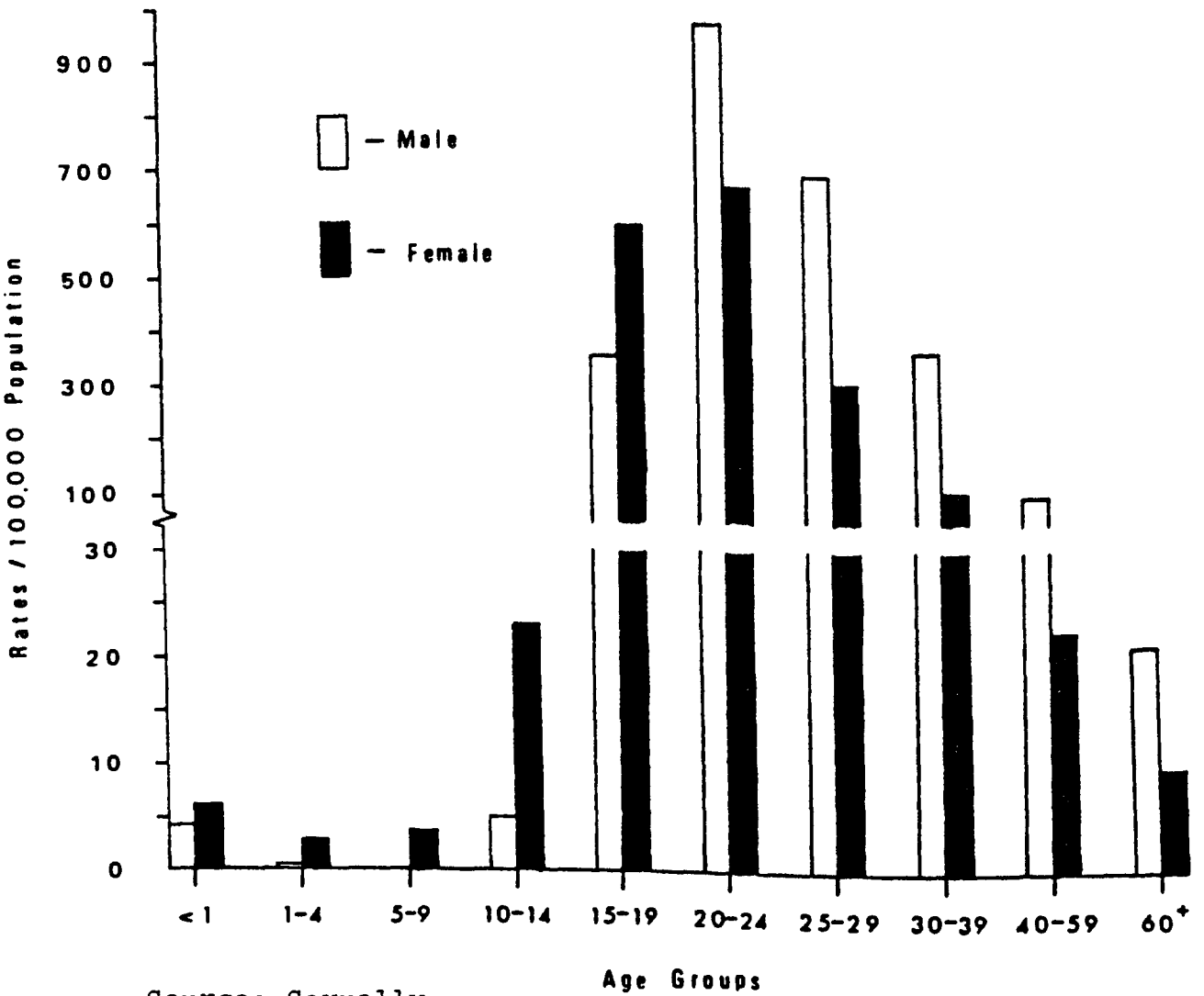
TOTAL NOTIFIABLE SEXUALLY
TRANSMITTED DISEASE (STD), CANADA, 1971-1982
- Rates/100,000 Population By Year



Source: Sexually Transmitted Diseases in Canada 1982

Figure 2

TOTAL NOTIFIABLE SEXUALLY
TRANSMITTED DISEASE (STD), CANADA, 1982
- Rates/100,000 Population By Age Groups and Sex



Source: Sexually Transmitted Diseases in Canada 1982

are less likely to do so (5). (Private M.D.'s usually do the least reporting.) As a result of these two factors - non-reporting and the small number of reportable diseases - the real incidence of sexually transmitted diseases in Canada is much higher than our national statistics indicate.

The following table calculates the real incidence of these diseases.

TABLE I: Incidence of STD's in Canada, 1982

	Reported*	Estimated**
Non-gonococcal urethritis and cervicitis	-	477,900
Gonorrhea	53,100	159,300
Syphillis	1,000	1,100
Genital warts	-	159,300
Herpes(genital isolates)	2,600	31,900
Total	56,700	829,500

(All figures rounded off to the nearest hundred.)
* Source: Sexually Transmitted Diseases in Canada 1982
** Derived from the estimated real incidence of each of these diseases outlined on page 1 of Sexually Transmitted Diseases in Canada 1982 and from information provided by Dr. Jessamine, Dr.Hockin and Marion Todd, Laboratory Centre for Disease Control, Health and Welfare Canada.

Since each STD has different characteristics and a unique incidence rate each one will be analyzed separately in the following section.

Gonorrhea in Canada

Gonorrhea is a very old disease - it was known to the early Chinese in the time of Emperor Huang-ti, 2637 B.C. Gonorrhea in males is usually symptomatic and it takes less than a week, after having contacted the infection, before the symptoms become evident. Females, on the other hand, often do not know they are suffering from this infection. Since the symptoms are often trivial, about 20 percent suspect they have the disease and 80 percent have no symptoms at all (6).

5. Ibid.

6. Dr. Jessamine, personal interview.

Figure 3 shows that the incidence of gonorrhea in Canada rose during the Second World War and sharply declined in the 1950s. By the early 1970's it was on the rise again. Gonorrhea has the highest reported incidence of all notifiable STD's in Canada with 95.9% of the total cases followed by syphilis (4%) with all others accounting for 0.1%.

Reported cases are highest in young males between the ages of 20 and 24 (946.4 cases per 100,000 persons in 1982) followed by women in this same age group (663.3) and males between the ages of 25 and 29 (657.0).(7).

A startling finding is the number of reported cases of gonorrhea in children. (See Table II) Three hundred and thirty-one cases were reported in 1982 in children under the age of 14. Eighty-three percent of these cases were recorded in females. Health and Welfare Canada believes that this figure would be even higher if it weren't for non-reporting. (Health and Welfare Canada 1984:51) If we adopt the rule of thumb used above to estimate the 'real' incidence of gonorrhea, we estimate that there were almost 1,000 cases in 1982. Although some cases involve newborns who catch the disease during delivery, Health and Welfare Canada (1983,1984) state that gonorrhea in children should be treated as an indicator of sexual abuse.

> "... most childhood gonorrhea is thought to be transmitted through sexual abuse. Very little information is available on the frequency of sexual abuse of children in Canada, but any venereal disease diagnosed in a child between 1 year of age and puberty should be considered an indicator of this problem until proven otherwise." (Health and Welfare Canada 1984:50)

Suzanne Sgroi (1982) would agree with this position. She states that except for neonatal infection and gonococcal eye infection, little evidence exists to support a theory of nonsexual transmission of gonorrhea to persons of any age group.

Syphilis in Canada

The name 'syphilis' has its origins in a poem written by Frascatorius in 1530. The poem describes a swineherd, named Syphilis, who acquired the infection. This infection is of great chronicity and can attack all parts of the body . The Registrar General recorded 1639 deaths in adults and 1200 in infants from this illness in 1910 in England and Wales. These figures were thought to be grossly underestimated since

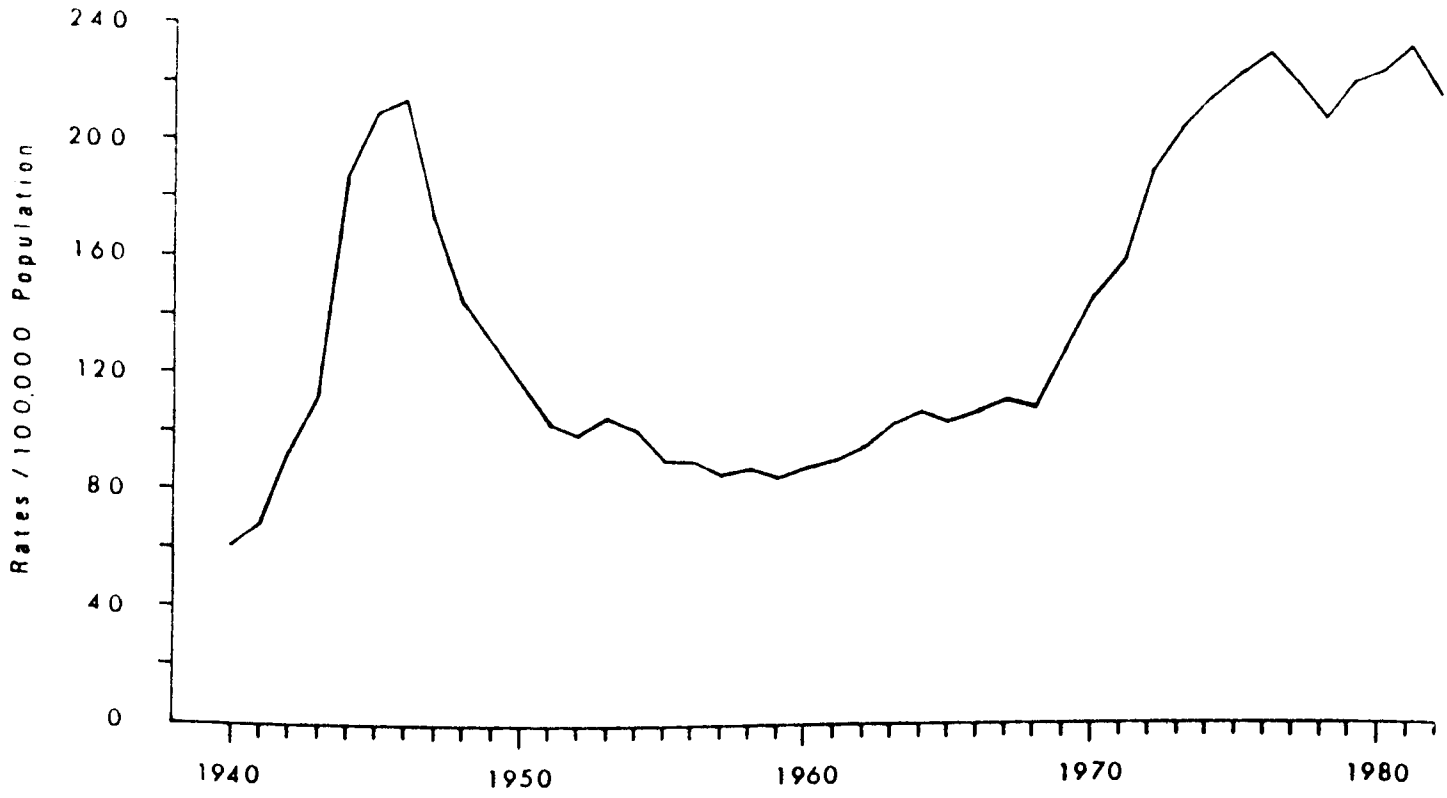
---

7. Males in the 20-24 year old age group have had a much higher rate of gonorrheah (about 30% higher) than any other group over the last five years. It has ranged from 871 to 1021 cases per 100,000 persons.

Figure 3

TOTAL GONORRHEA, CANADA, 1940-1982

- Rates/100,000 Population By Year



Source: Sexually Transmitted Diseases in Canada 1982

Source: Sexually Transmitted Diseases in Canada 1982 -

TABLE II

TOTAL GONORRHEA BY AGE AND SEX

CANADA, 1982

AGE	MALES		FEMALES		TOTAL[1]	
	CASES	RATE	CASES	RATE	CASES	RATE
< 1	7	3.7	9	5.0	16	4.4
1-4	3	0.4	22	3.1	25	1.7
5-9	1	0.1	32	3.7	33	1.9
10-14	46	4.7	211	22.9	257	13.6
15-19	4 063	353.8	6 563	598.8	10 626	473.4
20-24	11 239	946.4	7 816	663.3	19 058	805.5
25-29	7 310	657.0	3 363	299.5	10 675	477.5
30-39	6 399	335.9	1 899	0.4	8 298	218.6
40-59	2 169	85.8	422	16.6	2 591	51.1
60+	147	9.7	21	1.1	168	4.9
TOTAL*	32 081	262.8	20 894	168.1	53 076	215.4

NOTE: Rates are given per 100 000

1. Totals include cases not specified for sex.

* Includes cases not specified for age or sex.

many deaths were not certified as having been caused by syphilis. Sir William Osler, regius professor of medicine at Oxford, calculated in 1917 that adult deaths alone due to syphilis probably numbered 60,000 instead of the reported figure of less than 2,000. (Adler 1980:206) Today with the help of modern medicine, over 50 per cent of those infected will not suffer serious physical consequences as a result of this illness.

In Canada, reported cases of syphilis rose sharply during the war years, declined in the late 1940s and has not risen since then. (See Figure 4) As is the case with gonorrhea, syphilis is generally a young person's disease - especially a young male's disease; 62% of all cases of infectious syphilis were reported in males 25-39 years of age in 1982. The incidence of this infection is much higher in males than females apparently due to homosexually acquired syphilis. (Health and Welfare Canada 1983:18)

Herpes in Canada

Herpes, or 'herpes simplex virus infection' (HSV) as it is known by the medical profession, produces not only cold sores but also a genital infection. The epidemiology* of the disease has been clarified by the detection of two antigenic* variants, HSV-1 and HSV-2. In most cases, HSV-1 causes lesions above the waist and HSV-2 causes herpes lesions below the waist. Unlike gonorrhea, herpes cannot be cured although its effects can be reduced through the use of medication and psychological support. (See Figure 5)

Although herpes is not a reportable disease twenty-two Canadian laboratories collaborating with the World Health Organization submitted 6,224 reports of herpes virus infection to the Laboratory Centre for Disease Control in Ottawa in 1982. Where the antigenic variant of the herpes case was reported, HSV-2 (lesions below the waist) were reported in 219 males (3.5% of reported cases) and 262 females (4.2%). The 20-24 year old age group was most frequently infected (22.3%) by both variants of herpes followed by the 30-39 (17.3%) and 25-29 year old age group (16.4%).

Chlamydial Infections

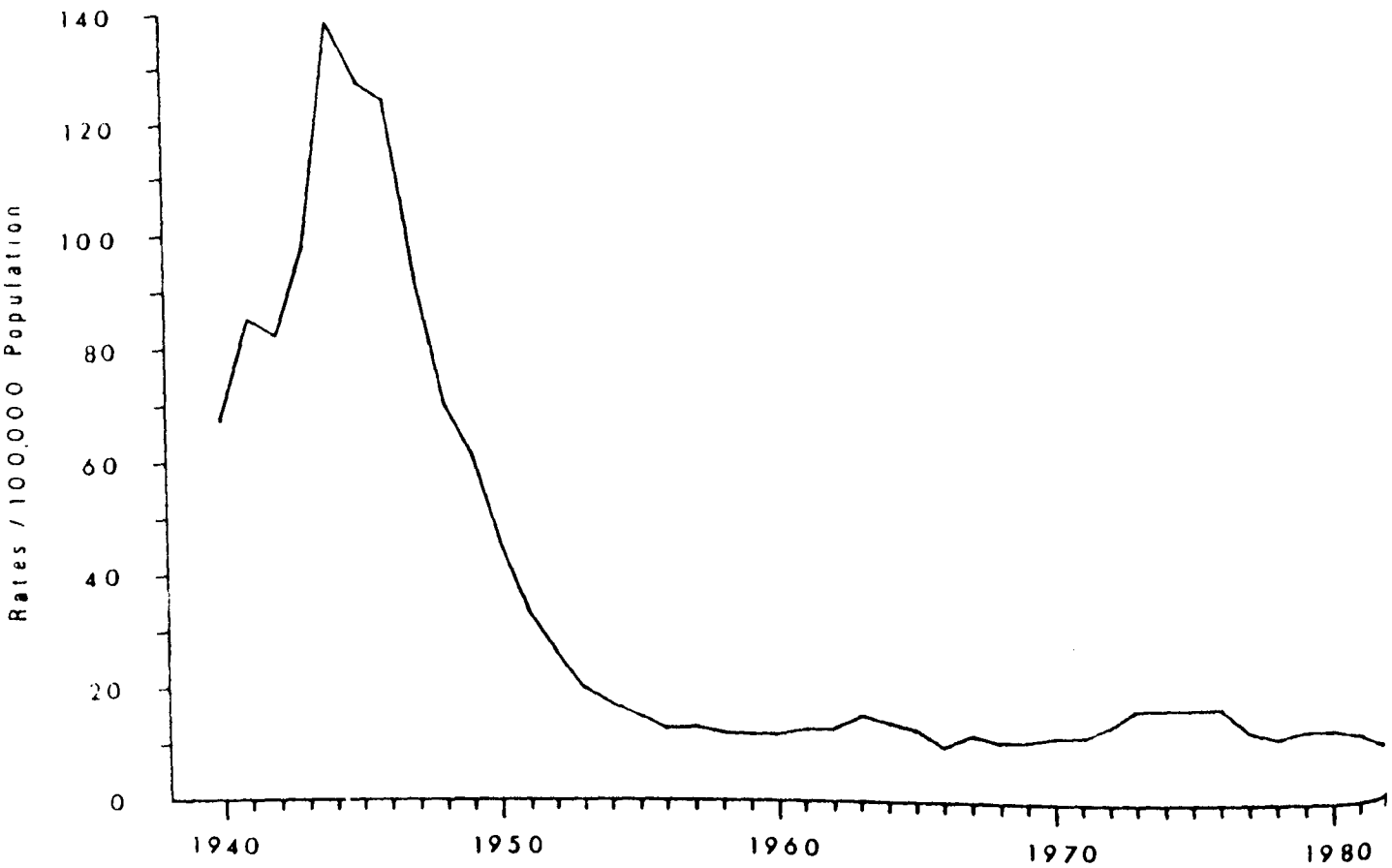
These infections are reported to the Bureau of Microbiology, Department of Health and Welfare Canada by twenty-two labs collaborating with the World Health Organisation. In 1982 there were

---

* See the section titled 'Definitions and Notes' for an explanation of this term.

Figure 4

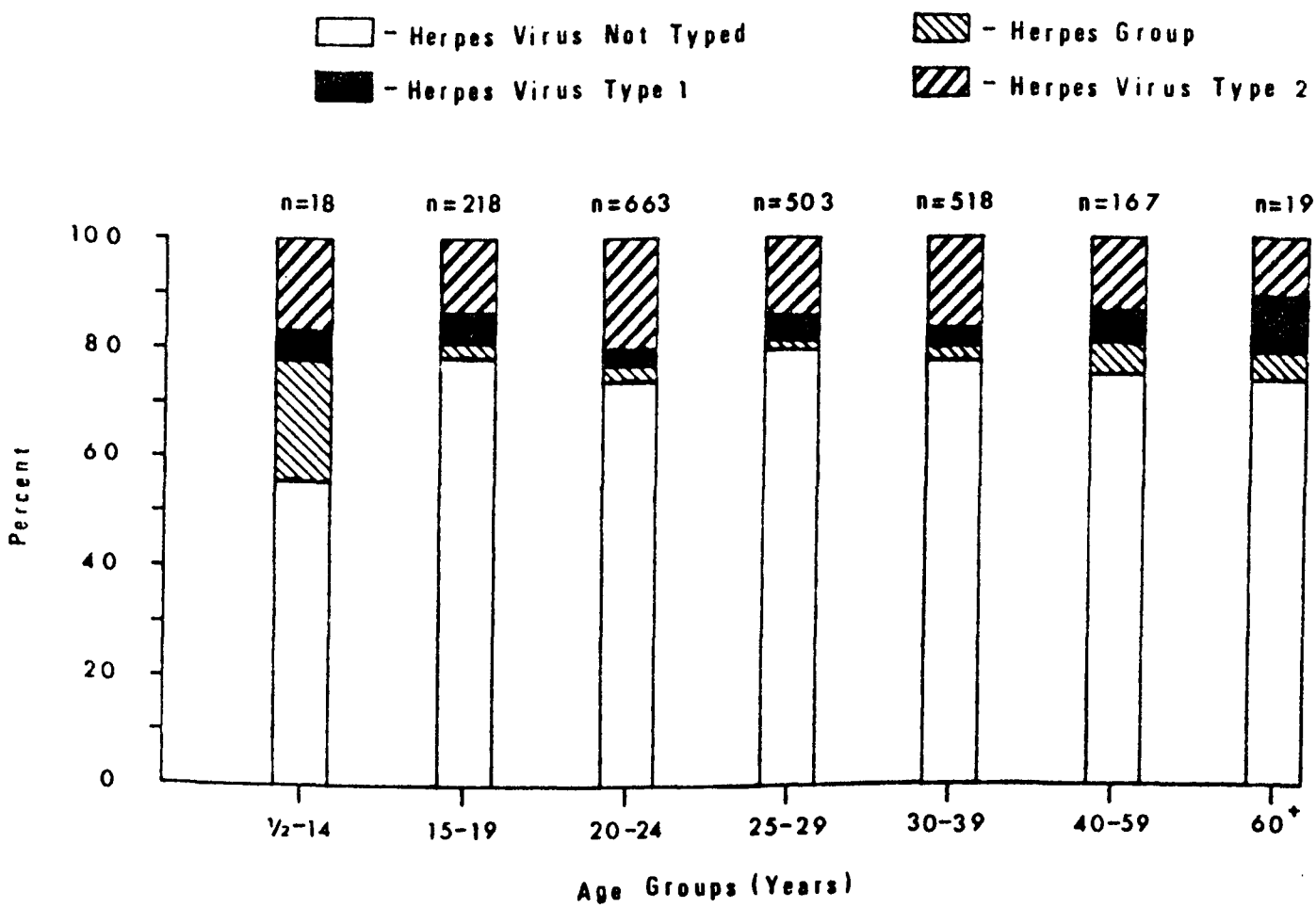
TOTAL SYPHILIS, CANADA, 1940-1982
- Rates/100,000 Population By Year



Source: Sexually Transmitted Diseases in Canada 1982

Figure 5

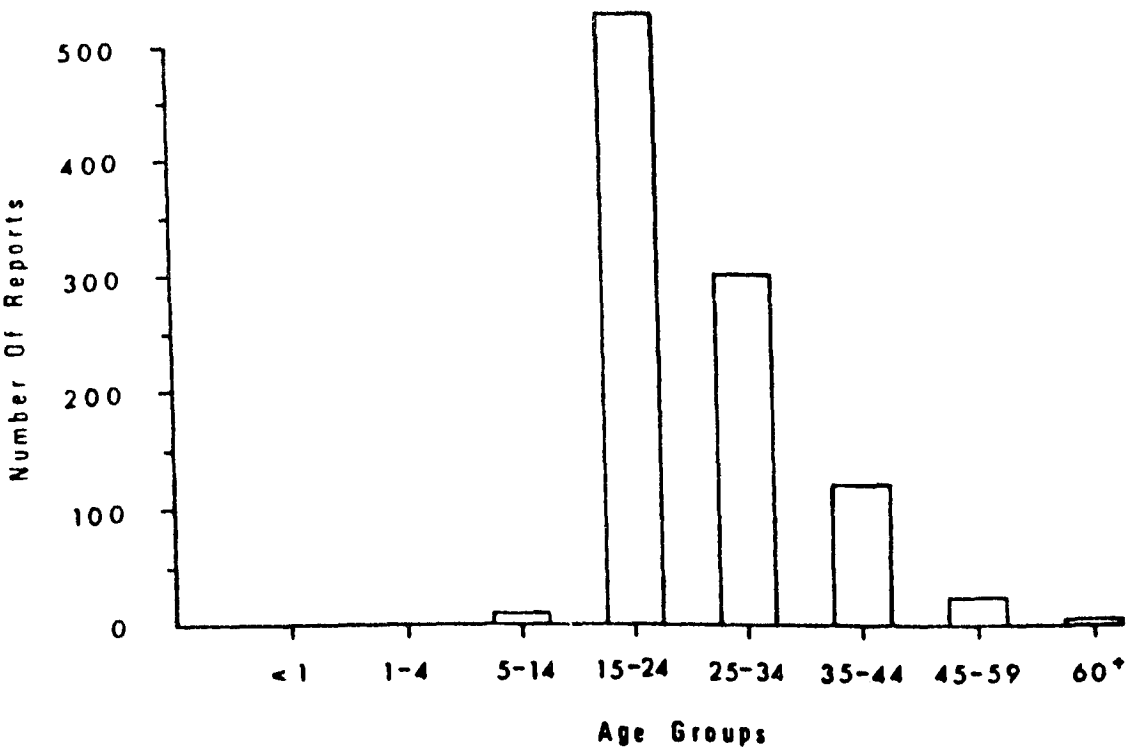
HERPES REPORTS OF GENITAL TRACT SPECIMENS
- Percent By Age Groups and Virus Type
- Canadian Virus Laboratories, 1982



Source: Sexually Transmitted Diseases in Canada 1982

Figure 6

CHLAMYDIA REPORTS OF GENITAL TRACT SPECIMENS
- Number of Reports By Selected Age Groups
- Canadian Virus Laboratories, 1982



Source: Sexually Transmitted Diseases in Canada 1982

1,724 reports of chlamydial infections in Canada. According to the Department's report the real yearly frequency of chlamydial infections, such as non-gonoccocal urethritis and cervicitis, is about three times higher than gonorrhea, (Health and Welfare Canada 1983:1).

Of the 1,724 cases reported, 68% involved females and 29% males. The 15-34 age groups accounted for 82.9% of all reports. Of the reports where the type of lesion was specified, 75% were from the genital track. (See Figure 6)

Acquired Immune Deficiency Syndrome (AIDS) and Penicillinase-Producing Neisseria Gonorrhoeae (PPNG)

Although only a small number of cases of both of these infections are reported annually the number of cases of penicillinase-producing neisseria gonorrhoeae (PPNG) is increasing in Canada. Since 1976 there have been 175 isolations reported by the Antimicrobials and Molecular Biology Unit, Laboratory Centre for Disease Control, Health and Welfare Canada, 41.7% of which occurred in 1982. Most PPNG were acquired in other countries, notably Asia.

As of April 1984, 74 cases of AIDS have been reported to the Laboratory Centre for Disease Control. Thirty-nine patients have died which totals a 52% case fatality rate. Thirty-seven patients were Canadian born, twenty were from Haiti and six were from other countries. A homosexual/bisexual orientation was recorded in 41 cases, heterosexual in 27 cases and in 2 cases the preference was unobtainable or not applicable. (One case was a four month old child of Haitian origin.)

Conclusion

Despite underreporting we can make a number of conlusions about STD's in Canada since the data reveal similar patterns from year to year. These conclusions are as follows:

- age and sex are significant factors in the transmission of STD's. Gonorrhea is most frequently diagnosed in young males aged 20-24. Most STD's are caught by males and females aged 15-30, and
- STDS's in children, especially female children under the age of 14, is not uncommon.

II. The Reported Incidence of STD's in other Western Countries

The reported incidence of STD's in Canada over the last five years reveals that males aged 20-24 are a high risk group. One might conclude that this group is responsible for a larger share of most STD's than other sex and age groups. However, since STD's in Canada are underreported, and since those agencies that do report are usually frequented more by males than by females, (8) we must examine the data from other Western countries. If the same patterns emerge, perhaps young males have a higher incidence of certain STD's and, therefore, make a larger contribution to the transmission of STD's than any other sex or age group.

The following table for the U.K. (Table IV) indicates that from 1976-1980 the highest rates for reported STD's were for gonorrhea in males 20-24 years of age. These rates varied from 728 cases per 100,000 population to 659. The highest female gonorrhea rates were in the 16-19 and 20-24 year old age groups. These rates hovered around 500 cases per 100,000 for the five year period.

Age and sex specific rates for gonorrhea in the U.S. show a similar pattern. From 1976 to 1979 the highest rates of gonorrhea were again found in males (whether white or nonwhite) in the 20-24 year age group. As well, these rates are significantly higher than rates for females in the same age group.

Conclusion

These data lead us to the conclusion that the incidence of gonorrhea appears to be highest in the young male aged 20-24 in Canada, the U.K. and the U.S. Since this group makes up a large percentage of the sexually active population we could conclude that it makes a larger contribution to the spread of gonorrhea than any age group, whether it be male or female. However, these official statistics tell us nothing about the contribution different 'occupational' categories (such as prostitutes) make to this problem. For this reason, we now turn to studies that have attempted to answer this specific question.

---

8. Dr. Jessamine, personal interview.

TABLE III

U.S.

Age-specific and Age-adjusted Gonorrhea Rates (per 100,000) for White Men and Women in the United States (excluding New York and California) 1967–1979

Sex, Age (Years)	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
Men													
≤14	1	1	1	2	2	2	3	3	3	3	3	3	4
15–19	156	170	203	251	316	365	369	377	393	370	341	336	340
20–24	553	638	703	780	901	1,004	1,007	1,028	1,060	1,007	955	922	909
25–29	329	350	381	399	470	507	549	580	642	622	638	629	626
30–39	118	128	133	145	163	174	183	198	229	238	251	250	255
40–49	37	38	39	44	45	46	47	50	59	62	68	69	75
≥50	13	13	13	14	14	15	14	17	18	19	20	20	21
Total													
Unadjusted	94	106	121	141	173	197	206	220	240	239	238	237	240
Age-adjusted	107	118	129	143	165	182	187	195	210	205	203	199	201
Women													
≤14	3	4	4	5	8	10	12	12	14	13	13	14	14
15–19	121	144	185	234	354	487	587	650	705	661	645	643	644
20–24	178	202	237	295	383	542	686	757	802	744	723	692	692
25–29	82	87	101	111	150	193	253	285	318	293	302	290	293
30–39	27	31	31	36	46	62	76	79	88	88	86	82	83
40–49	8	9	10	10	12	15	17	18	19	18	19	19	19
≥50	3	3	3	3	4	4	5	6	6	6	5	5	5
Total													
Unadjusted	38	44	54	67	95	131	164	184	201	191	189	185	186
Age-adjusted	36	41	48	58	80	109	136	149	161	151	149	145	145

Age-specific and Age-adjusted Gonorrhea Rates (per 100,000) for Nonwhite Men and Women in the United States (Excluding New York and California), 1967–1979

Sex, Age (Years)	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
Men													
≤14	33	42	44	51	50	56	56	57	57	56	55	53	53
15–19	4,223	4,551	5,121	5,295	5,322	5,559	5,724	5,772	5,687	5,326	4,958	4,711	4,446
20–24	11,578	12,984	13,967	14,007	13,600	13,693	12,780	13,173	13,991	13,225	12,678	11,853	10,809
25–29	7,430	7,570	7,877	7,760	7,825	8,012	8,184	8,651	9,073	8,487	8,487	8,154	7,543
30–39	2,750	2,866	2,950	2,989	2,947	2,992	2,960	3,092	3,266	3,172	3,193	3,077	2,942
40–49	810	817	834	835	813	816	804	836	894	888	870	886	832
≥50	186	181	204	202	205	201	219	231	266	256	292	275	250
Total													
Unadjusted	2,059	2,237	2,495	2,654	2,733	2,876	2,872	3,025	3,228	3,144	3,112	3,002	2,819
Age-adjusted	2,385	2,549	2,714	2,728	2,695	2,742	2,695	2,794	2,926	2,776	2,715	2,587	2,404
Women													
≤14	50	56	66	80	82	100	130	144	163	158	147	158	165
15–19	1,852	2,090	2,414	2,608	2,948	3,854	5,161	5,683	5,980	6,084	6,024	6,268	6,099
20–24	2,586	2,767	3,163	3,252	3,465	4,365	5,792	6,341	6,648	6,694	6,594	6,643	6,264
25–29	1,351	1,318	1,526	1,532	1,597	2,040	2,589	2,698	2,954	2,799	2,808	2,874	2,756
30–39	446	455	479	501	501	632	809	836	882	801	785	798	765
40–49	113	112	100	106	113	133	161	190	187	185	158	159	154
≥50	35	25	40	33	34	46	49	63	75	55	50	52	47
Total													
Unadjusted	573	628	739	802	889	1,159	1,555	1,723	1,852	1,873	1,864	1,922	1,847
Age-adjusted	551	581	660	688	737	941	1,232	1,338	1,418	1,399	1,377	1,409	1,353

Source: Sexually Transmitted Diseases, vol. 10 no. 2, p.73-74.

TABLE IV

U.K.

Venereal diseases—new cases per 100 000 population by age seen at hospital clinics in England 1976-80

	1976			1977			1978			1979			1980		
	Men	*Women*	*Total*	*Men*	*Women*	*Total*	*Men*	*Women*	*Total*	*Men*	*Women*	*Total*	*Men*	*Women*	*Total*
Early syphilis															
All ages	8·86	1·50	5·08	9·67	1·71	5·59	10·27	1·91	5·98	10·77	1·77	6·16	9·54	1·59	5·46
Primary and secondary only	6·40	0·87	3·56	6·58	1·04	3·74	6·69	1·04	3·79	6·38	0·08	3·52	5·94	0·87	3·34
Under 16 years	0·07	0·09	0·08	0·04*	0·04*	0·04	0·20	0·10	1·15	0·05	0·04	0·05		0·08	0·04
16-19 years	7·52	3·30	5·46	5·72	4·56	5·15	6·8	4·52	5·69	4·99	2·90	3·97	3·95	3·52	3·74
20-24 years	19·35	3·46	11·58	17·76	5·02	11·56	19·10	4·76	12·10	16·83	3·44	10·29	15·00	3·44	9·34
25 years and over	7·40	0·68	3·85	8·01	0·66	4·13	7·77	0·66	4·02	7·79	0·60	3·99	7·38	0·62	3·82
Late syphilis															
All ages	3·87	1·76	2·79	3·67	1·70	2·66	4·38	1·89	3·10	4·44	1·97	3·17	4·24	1·85	3·02
Congenital syphilis															
All ages	0·28	0·33	0·30	0·25	0·37	0·31	0·23	0·45	0·34	0·17	0·34	0·26	0·24	0·28	0·26
Gonorrhoea (post pubertal)															
All ages	163·91	89·60	125·79	164·70	92·23	127·54	161·38	89·94	124·73	154·67	85·84	119·36	155·40	86·64	120·14
Under 16 years	1·87	8·57	5·13	1·98	8·52	5·16	2·56	7·76	5·09	1·75	5·99	3·82	1·43	6·13	3·72
16-19 years	331·52	513·05	420·19	329·41	510·53	417·73	304·17	473·06	386·66	387·65	434·41	359·37	297·63	431·52	363·00
20-24 years	728·41	475·72	604·92	736·92	490·17	616·71	696·65	471·19	586·58	659·05	458·49	561·14	666·70	464·42	567·69
25 years and over	147·97	42·73	92·40	145·38	43·36	91·52	144·92	43·52	91·39	140·63	42·67	88·92	137·83	41·62	87·10
Chancroid															
All ages	0·03*	0·15	0·17	0·17	0·01*	0·09	0·19	0·02	0·10	0·20	0·02	0·11	0·19	0·03	0·11

*These rates were based on fewer than 10 events and consequently their reliability as a measure may be affected.

Source: British Journal of Venereal Diseases, vol.59,1983,p.134.

II. PROSTITUTION AND STD'S: RESEARCH IN THE U.S.A. AND IN THE U.K.

The 'Yes' Position

A number of learned articles state that prostitutes do make a significant contribution to the spread of venereal diseases (Conrad et al. 1981; Turner E.B., and Morton R.S. 1976; Frosner G.G. et al. 1975; Fanta D. et al. 1979; Seliborska Z. et al. 1979; Idsoe and Guthe 1967; Keighley 1960; and Potterat et al. 1979). For instance, in a recent article Conrad et al. (1981: 241) state the following:

> "Our review of all the published studies we could find and our retrospective study of sexual offenders in Atlanta force us to disagree with Rosenthal and Vandow. We believe that prostitutes in some areas of the United States, as well as elsewhere in the world, still are major transmittors of gonorrhea and other sexually transmitted diseases."

Although this group of authors recognizes that prostitution does not make as large a contribution to the spread of STD's as it once was reported to have done, they believe the change is only a relative one:

> " In epidemiological terms our findings show that the vector role of prostitutes continues undiminished. The alleged decline in their role is relative only and not real. They accounted for one in six of locally acquired gonoccoccal infections in heterosexual men" (Turner and Morton 1976:52)

The following table summarizes the results of studies undertaken by scientists who take this position.

TABLE V: Summary of Studies: The 'Yes' Position

Study	Type of prostitute	Locale	Comparison Group;other controls?	Time Period	Percentage with STD's Pros. | Other
Wren 1967	Inmates	State prison New S. Wales	other inmates; yes	Jan.-June 1966	(G)44% 4% (S) 2% 1%
Keighley 1960	Holloway Prison,	London	other inmates; yes age	1958	(G)34% 4%
Conrad et al. 1981	sexual offenders prostitutes	Atlanta Georgia	no	1978 Sept-Dec.	(STD men)44.1% (" women)29.3% (G) 28.3%
	prostitutes	Fresno County	no	76-77	(G) 19.8%
Potterat et al. 1979	Street prostitute attending V.D. clinic	Colorado Springs USA	V.D.clinic patients; yes	1958-1977	(G)29% 21%
					% of V.D.traced to prostitutes
Turner et al. 1976	Street walkers	Sheffield Eng.	-	1960-1973	(G) 17.7%

G stands for Gonorrhea
S stands for syphillis
STD stands for all sexually transmitted diseases

The 'No Position

Those scientists who disagree, (Hart 1977; Darrow 1976; Willcox 1963; Neumann 1983; Dunlop et al. 1971; and Rosenthal 1958), use the following arguments to support their position:

- Prositution is no longer a major contributor to the spread of STD's - the problem today is promiscuity;

> "Years ago, they were a prime source of infection. Nowadays, however, prostitution is experiencing a business slump except in some special situations, such as in large cities and around army posts, particularly overseas. The competition by non-professionals and para-professionals is keenly felt by the regular pros and estimates range that from only 5 percent to 10 percent of the new cases of S.T.D. are being spread by prostitutes." (Dr. Neumann 1983:155)

- Studies that assert that prostitution makes a significant contribution to the spread of STD's are methodologically inadequate (9).

The following table is a summary of the studies in this group.

TABLE VI: Summary of the 'No' Studies

	Type of prostitute	Local	Comparison Group;other controls?	Time Period	% of STD's traced to Prostitues
Willcox 1962A		U.K	yes	1962	15-19%
1962B*		rural,urban Eng.& Wales	yes;no	1954	30%
1954			yes		30%
Dunlop et al. 1971		London	yes	1960 1969	31% 14%
Rosenthal et al.1958		New York	yes yes	1946 1956	23.6% (G) 5.2% (G)

(*) Based on data collected by the British Clinical Co-operative Group
(G) stands for gonorrhea

9. As Willcox (1962A:37) states, "There is no sufficiently objective study to determine the place of prostitution in the spread of venereal disease, as compared with the spread of such diseases by girls of a lower social level who are not prostitutes. Until the total number of each in a population can be related to the male population at risk, and the cases of venereal diseases can be related to the number of exposures, this cannot be done."

The easiest way to settle this argument is to determine whether the studies, which take the 'yes' postition are sound enough, from a methodological point of view, to warrant such a conclusion. If they are not, then these authors do not have the data to be able to come to any conclusion about whether prostitutes do or do not make a significant contribution to the spread of STD's.

Methodological problems

a) Misuse of the 'inductive method'

All of these studies are based upon the inductive method. Research is done on a small group of individuals and then generalizations are made to a larger group whether they were part of the research group or not. The major problem with this method is that if one is to make generalizations about prostitutes, then the group of prostitutes that one studies must be representative of all prostitutes. For instance, the streetwalker, the brothel prostitute, and the call girl span a wide spectrum of human types. Each may have a different likelihood of contracting STD's and spreading these diseases. One can not study streetwalkers and then use this data to come to conclusions about prostitutes in general.

An examination of the first table (Summary of Studies : The 'Yes' Position) indicates that most of these studies did not focus upon a group of prostitutes that are representative of all prostitutes. Most studies focus upon the streetwalker. Therefore, the data are seriously biased - most likely the prevalence of disease for the prostitute population as a whole is overestimated since it is believed that streetwalkers tend to have higher infection rates than do 'higher class' prostitutes.

As well, these studies focus upon a group of prostitutes living in a very specific location - usually in a prison or in a city like London. Since it is believed that STD's are more prevalent in large cities, especially seaport cities, than in small cities, these studies would again tend to overestimate infection rates.

In conclusion, these studies focus upon a particular type of prostitute, living in a particular locale, at a very specific point in time. The results of these studies should not be used to make conclusions about the prostitute population as a whole, especially when the type of prostitute and locale studied tend to overestimate the incidence of STD's.

b) Failure to control for factors that have an impact on infection rates

When researchers are faced with the prospect of having to study the effect of a factor, like a disease, on a particular group they should try to control for all factors that might bias their results such as age, sex, occupation, type of protection used to avoid STD's, etc. They will first identify all factors which might bias their results

and then they will try to rule out all of these threats to the validity of their results through the use of various methodological tools.

> "In any geographic area, the number of prostitutes preported to have gonorrhea is a function of the frequency with which they are tested, the sensitivity and specificity of the diagnostic tests used, and the effectiveness of the therapy given, as well as of the number of unprotected exposures they have, the prevalence of disease in their partners, and the rates of transmission from hosts to susceptibles." (Conrad et al. 1981:242)

For instance, Potterat et al. (1979) compared STD disease occurrence in a prostitute group with disease occurence in a group of women who were not prostitutes. He was trying to prove that the prostitutes would be more likely to be infected than the women who were not prostitutes. Potterat was very careful to determine the racial composition and age of each of these groups. Although they were similar in terms of age they were not similar in terms of racial composition. Since the likelihood of catching an STD is dependent upon one's race, (Hooper et al. 1978), Potterat should have taken this factor into consideration when interpreting study results. Since he did not control for this factor, his findings are suspect because any difference found in the rate of infection in these two groups could be a result, not of their sexual habits, but rather a result of their racial differences.

Most of the above studies do not take into account that the prevalence or the incidence of a disease depends upon the number of times one is tested and treated for that disease. The better the testing and reporting procedures the higher the recorded incidence of a disease. Prostitutes who regularly attend V.D. clinics and receive treatment for an STD may report a higher incidence of the disease since reinfection can occur. However, if someone is not treated for the disease there is no risk of infection since infection has already occurred. For instance, the Potterat study noted that prositutes,on average, make more routine visits to a local V.D. clinic than did members of the non-prostitute group they were being compared to; (31% of current prostitutes stated that they came to the VD clinic for a routine visit whereas only 11% of the comparison group made up of non-prostitutes came to the clinic for a routine visit.) This means that the differences that Potterat noted in infection rates for these two groups might simply be due to differences in the frequency with which the two groups visited the clinic and not to real differences in their likelihood of catching and spreading STD's.

If one evaluates these studies on their effort to rule out threats to making a valid inference about prostitutes in general one finds that they are all seriously lacking, even in the most basic controls. For example, most do not control for sex, age, race, risk of transmission,

prevalence of STD's in partners, and for type of prophylactic used. This means that any differences observed between prostitutes and non-prostitutes may simply be a result of differences in these factors and not a consequence of the sexual activities of prostitution.

c) Gaps in logic and a lack of objectivity

One rather surprising finding is that most of the studies that take the position that prostitutes make a significant contribution to the spread of STDs use a different measurement technique than those that take the opposite position. The former (the 'Yes' studies) measure the rate of infection of a particular group of prostitutes but they fail to make the logical step that the latter group takes. They do not try to quantify the contribution these infected prostitues make to infecting customers as compared to the contribution infected women in general make to infections in males. The 'No' group of studies clearly shows that, at least for the prostitutes studied, about one in five STD infections are traced to prostitutes whereas the other four are traced to other groups, (i.e. casual acquaintances, friends, spouses and homosexuals.)

The 'Yes' studies suffer, therefore, from a serious gap in logic - they are not collecting the right type of data to allow them to conclude that prostitutes make a significant contribution to STD infections in male customers. The only exception to this statement is the Turner and Morton study (1976) which did try to link prostitutes to rates of infection in their customers.

As well, all of these studies, whether they take the 'yes' position or the 'no' position focus their attention on female prostitutes and females defined as 'non prostitutes'. The contribution males make to the spread of STD's is not compared to the contribution female prostitutes make to the spread of STD's. This is a serious gap in logic since males and females, whether they are defined as prostitutes or not, can be transmitters of STD's. As outlined earlier, official Canadian, American and British STD data reveals that young males between the ages of 20 and 24 have by far the highest incidence of STD of any age or sexual grouping. If they have the highest incidence of STD's, they might also be the group which makes the greatest contribution to the spread of STD's in Canada as well as in other countries. As Rothenberg notes, most studies focus upon prostitution because it is easy to do so, not because it is the most logical thing to do:

> "Does this mean that prostitutes are bound to be important transmitters in all areas? The answer is no. As with gonococcal pelvic inflammatory disease, prostitution is a marker for potential importance. The message to gonorrhea control programs is clear: Keep looking, even if the light is not very good. Look to women with pelvic inflammatory disease, to prostitutes, to young military recruits, to the specific clientele of a specific private practitioner, to some groups of gay men, to individiuals from a geographically defined area." (Rothenberg and Vandow 1958:94-99.)

Therefore, the failure to evalute the contribution that other high risk groups make to the spread of STD's and compare it to the contribution prostitutes make to this problem, throws serious doubt upon the objectivity of all of these studies, whether they take the 'yes' position or the 'no' postition.

d) Absence of criteria to determine the significance of the problem

These studies pose another problem in that the criteria used to prove or disprove their hypotheses are never clearly defined nor defended. For example, none of the 'Yes' studies state what infection rate would have to be achieved before one could conclude that prostitutes no longer make a significant contribution to the spread of STD's. The 'No' studies are also unclear on this point. At least, however, the 'No' studies give one an idea of the extent to which infected prostitutes infect their clients in comparison to other groups. However, clarification is still needed because the Turner and Morton study (1976) which found that 17% of gonorrhea in males could be linked to prostitutes, said that prostitutes were important transmitters of gonorrhea whereas the British Co-operative Clinical Group, (Willcox 1962B), noted higher rates but yet decided that the prostitute did not make an important contribution to this problem.

Conclusions

After having examined these studies we have come to the following conclusions:

- all of the studies we examined are methodologically flawed;
- prostitutes do not make as large a contribution to the spread of gonorrhea as do other females;
- we do not know how large a contribution prostitutes make to the spread of STD's in comparison to other high risk groups such as young males aged 20-24;
- streetwalkers, in some Western cities, are probably a high risk group since they tend to have a higher prevalence of gonorrhea than do other females; and

prevalence of STD's in partners, and for type of prophylactic used. This means that any differences observed between prostitutes and non-prostitutes may simply be a result of differences in these factors and not a consequence of the sexual activities of prostitution.

c) Gaps in logic and a lack of objectivity

One rather surprising finding is that most of the studies that take the position that prostitutes make a significant contribution to the spread of STDs use a different measurement technique than those that take the opposite position. The former (the 'Yes' studies) measure the rate of infection of a particular group of prostitutes but they fail to make the logical step that the latter group takes. They do not try to quantify the contribution these infected prostitues make to infecting customers as compared to the contribution infected women in general make to infections in males. The 'No' group of studies clearly shows that, at least for the prostitutes studied, about one in five STD infections are traced to prostitutes whereas the other four are traced to other groups, (i.e. casual acquaintances, friends, spouses and homosexuals.)

The 'Yes' studies suffer, therefore, from a serious gap in logic - they are not collecting the right type of data to allow them to conclude that prostitutes make a significant contribution to STD infections in male customers. The only exception to this statement is the Turner and Morton study (1976) which did try to link prostitutes to rates of infection in their customers.

As well, all of these studies, whether they take the 'yes' position or the 'no' position focus their attention on female prostitutes and females defined as 'non prostitutes'. The contribution males make to the spread of STD's is not compared to the contribution female prostitutes make to the spread of STD's. This is a serious gap in logic since males and females, whether they are defined as prostitutes or not, can be transmitters of STD's. As outlined earlier, official Canadian, American and British STD data reveals that young males between the ages of 20 and 24 have by far the highest incidence of STD of any age or sexual grouping. If they have the highest incidence of STD's, they might also be the group which makes the greatest contribution to the spread of STD's in Canada as well as in other countries. As Rothenberg notes, most studies focus upon prostitution because it is easy to do so, not because it is the most logical thing to do:

> "Does this mean that prostitutes are bound to be important transmitters in all areas? The answer is no. As with gonococcal pelvic inflammatory disease, prostitution is a marker for potential importance. The message to gonorrhea control programs is clear: Keep looking, even if the light is not very good. Look to women with pelvic inflammatory disease, to prostitutes, to young military recruits, to the specific clientele of a specific private practitioner, to some groups of gay men, to individiuals from a geographically defined area." (Rothenberg and Vandow 1958:94-99.)

Therefore, the failure to evalute the contribution that other high risk groups make to the spread of STD's and compare it to the contribution prostitutes make to this problem, throws serious doubt upon the objectivity of all of these studies, whether they take the 'yes' position or the 'no' postition.

d) Absence of criteria to determine the significance of the problem

These studies pose another problem in that the criteria used to prove or disprove their hypotheses are never clearly defined nor defended. For example, none of the 'Yes' studies state what infection rate would have to be achieved before one could conclude that prostitutes no longer make a significant contribution to the spread of STD's. The 'No' studies are also unclear on this point. At least, however, the 'No' studies give one an idea of the extent to which infected prostitutes infect their clients in comparison to other groups. However, clarification is still needed because the Turner and Morton study (1976) which found that 17% of gonorrhea in males could be linked to prostitutes, said that prostitutes were important transmitters of gonorrhea whereas the British Co-operative Clinical Group, (Willcox 1962B), noted higher rates but yet decided that the prostitute did not make an important contribution to this problem.

Conclusions

After having examined these studies we have come to the following conclusions:

- all of the studies we examined are methodologically flawed;
- prostitutes do not make as large a contribution to the spread of gonorrhea as do other females;
- we do not know how large a contribution prostitutes make to the spread of STD's in comparison to other high risk groups such as young males aged 20-24;
- streetwalkers, in some Western cities, are probably a high risk group since they tend to have a higher prevalence of gonorrhea than do other females; and

III. THE CONTROL OF STD'S IN PROSTITUTES

The major objective in controlling STD's in prostitutes has been to minimize the chances that they will spread these diseases to their customers. In the past, a number of options have been used. They usually fall into the following three main categories:

- registration of prostitutes usually accompanied by compulsory medical examinations;
- legislation permitting the arrest and compulsory treatment of prostitutes believed to have V.D.; and,
- voluntary programs run by local VD clinics which are not specifically directed at a prostitute clientele but which respect the special needs of the prostitute, accompanied by contact tracing, and identification and treatment of high risk groups.

We will examine each of these options in turn, and try to assess their reported effectiveness.

Registration of Prostitutes and Compulsary Medical Examinations

A typical example of this type of system is the Italian bordelo as described by Lentino, (Lentino 1955). The type of system he evaluated was a licensed operation complete with a medical examination room. Information on how to prevent V.D. was posted on the walls for the information of all patrons. Every two weeks a blood seriologic test was done for syphilis and a medical examination was done every two days for gonorrhea. When a women was found to have V.D. she was given treatment and not allowed to work until fully recovered.

The police registered prostitutes and they inspected the houses. As well they checked medical records and accompanied any individual who believed they had caught V.D. from a prostitute.

Lentino reported that this method was ineffectual due to the difficulty of diagnosing venereal disease in women. He reported that 80% of V.D. in soldiers was traced to licensed brothals. Other studies have judged this type of system to be ineffectual as well, usually for the following reasons: it cannot control clandestine prostitutes; frequent medical examinations may provide a false sense of security for prostitutes, clients and controllers; frequent medical examinations may provoke hostility and decrease cooperation on the part of prostitutes, such a system almost inevitably corrupts the individuals who are charged with its supervision, (Hart 1977:59-61) ; and the standards of compulsory

medical examination vary and tend to deteriorate with time (10).

Apart from empirical data suggesting that this method is ineffectual it has another drawback - its human rights implications. The registration of prostitutes has been opposed on the grounds that it infringes upon the civil rights of the individual and is contrary to modern conceptions of humanity (Article 6 of the United Nations Resolution on Prostitution, 1950). Such a licencing mechanism labels a woman and makes it more difficult for her to become reestablished in a more 'respectable' occupation after she leaves prostitution. (Hart 1977:59)

> "Growing concern for the alleged 'white slave trade' in women and girls led the League of Nations and later the United Nations to call for the abolition of licensed brothels, which were claimed to be the main sources of regular demand for the international commerce in women and girls. These international conventions, in conjunction with feminist arguments against the degree to which licensing unjustly regulated and stigmatized the lives of prostitutes, led to the abolition of state licensing in Europe." (Richards 1983:91)

Legislation permitting the arrest and/or compulsory examination of prostititues and other persons believed to have VD

A number of examples exist of such a system: the U.K. Criminal Justice Act of 1948, Section 54-121 of the Fulton county Health Regulations (Georgia, U.S.A), Section 25-4-404, GS amended of the Colorado Revised Statutes, and all Canadian provincial and territorial venereal disease legislation.

---

10. "It has been shown that what benefit is derived from the routine regular medical examinations of prositutes is obtained only at a very high cost. The procedure even when well done, it is argued, is not an economic proposition in relation to the results achieved...On the other hand, of female patients with gonorrhea, it has been indicated that prostitutes do comprise an appreciable proportion of the known reservoir of infection and it is logical that some effort should be made to control it. How to strike a proper balance remains the so far insoluble problem." (Willcox 1963:8)

In England, under the Criminal Justice Act of 1948 it was possible to send a woman to prison on remand for a physical and mental report if she was charged with an offence punishable by imprisonment.

In Canada, every province and territory has legislation to force people to be examined for V.D. In order to do this, public health officials have been given a great deal of power. According to Rozovsky (1982:71), this procedure removes rights that even those charged with serious criminal offences are guaranteed.

> "In a criminal trial the onus is on the Crown prosecutor to prove the accusation, not simply to the satisfaction of the judge and jury, but beyond a reasonable doubt."

In Atlanta Georgia, under the Fulton County Health Regulations, everyone arrested for prostitution or other related sexual offenses is suspected of being infected with a sexually transmitted disease and must report for an examination at the Fulton County Health Department.

Conrad et al. (1981) studied the medical charts of persons arrested under this regulation and concluded that screening sexual offenders is an effective way of identifying untreated cases of sexually transmitted disease in the community. (Conrad 1981:244)

However, Conrad stopped short of recommending that compulsory programs or legislation, be adopted as a means to screening sexual offenders.

In Colorado, state, county and municipal health officers, may detain and make examinations of persons suspected of having V.D. Upon arrest, a prostitute is held in custody without bail until a health officer can make a ruling about the liklihood of V.D. Potterat et al.(1979) studied these control measures and compared them to voluntary programs. They found that compulsory measures such as legal orders were significantly less effective in finding gonorrhea in prostitutes than were prostitutes' routine visits to a clinic or contact tracing.

TABLE VII: Rates of Gonorrhea in Prostitutes Listed by Reason for Attendance at Venereal Disease Clinic

	Past Prostitutes		Current Prostitutes	
Reason for Clinic Visit	No.	%	No.	%
Routine	127/444	29	62/198	31
Legal order	37/203	18	17/79	22
Contact with gonorrhea	62/135	46	32/61	52
Follow-up	12/116	10	6/61	10
Total	247/910	27	125/402	31

Source: Potterat et al. 1979.

Public Health Programs, Contact Tracing and Identification of High Risk Groups

a) Education programs

Little information exists on the effectiveness of education programs (Sacks et al. 1983) especially programs for high risk groups such as prostitutes. However, a number of Canadian experts believe that increased education is important to the improved control of STD's.

> " The development of educational programs will be vital in the fight to control sexually transmitted diseases. The goals of these programs should be to improve the therapy of the infected client and to have a positive impact at every level of control. With regard to STD education in this country, our analysis is that current education programs for all groups are inadequate. This conclusion is based not only upon our personal opinions but also on the opinions of several provincial venereal disease control directors who responded to a questionnaire that we distributed." (Sacks 1983:176)

b) Contact Tracing

Schofield (1979) states that the effectiveness of contact tracing depends upon the amount of accurate information that can be collected from the patient. This is particularily critical with highly promiscuous groups such as prostitutes.

> "The success of the medico-social management of sexually transmitted diseases in any area depends on the faith the local promiscuous people, especially the highly promiscuous, have in the clinic staff. This faith takes a long time to build up and it can be lost quickly by the mismanagement of these patients. There must be no moralizing and they must be made to feel free to attend for a check-up at any time... " (Shofield 1979:28)

Certainly the Potterat study (Potterat et al. 1979) indicated that of all the methods used to control STD's in prostitutes, contract tracing located the most cases of gonorrhea in a Colorado clinic.

c) Identifying high risk groups

Jessamine et al. (1983) state that the increasing incidence in reported gonoccocal infections in Canada indicates that current public health control programs are not effective. They suggest that the primary strategy for control should be contact tracing, case investigation, and identifying and locating sexual partners considered to be at highest risk. As well, they suggest that a self-referral system (11) might also be adopted as it has proven to be useful in Britain.

> "While established contact tracing and case investigation efforts must be continued, additional resourcefulness should be concentrated on 2 groups. These are the "core" population responsible, directly or indirectly, for every gonococcal infection occurring in the community, and the asymptomatic male cases often infectious for prolonged periods of time, and now closely identified with gonococcal PID in their sexual partners." (Jessamine et al. 1983:164)

In order to identify high risk groups one should identify their sociological characteristics (12) and the area in which they can be found. However, attempts to control STD's which focus on special areas such as hotels and residential area must be conducted without disrupting the underlying social structure of the area, and without resorting to oppressive measures which would only serve to scatter infected people.

Conclusion

Many different measures can be used to control the spread of STD's by prostitutes. Traditionally, 'utilitarian' arguments have been used to justify compulsory V.D. programs for prostitutes. This theory argues

---

11. Patients are encouraged to inform their regular partners and to urge them to seek medical help.

12. According to Hart (1979) examination of individual factors such as race, age, marital status,education, intelligence, socioeconomic status,parental influence, alcoholic intake, and personal prophylaxis is of value in considering control policies.

that the 'useful' is the 'good' and that the determining consideration of 'right conduct' should be the usefulness of its consequences. Utilitarianism suggests that the aim of action should be the largest possible balance of pleasure over pain or the greatest happiness of the greatest number of people. Specifically, in this case, it takes the position that the overall health of society is more important than the suffering or inconvenience which might be caused by compulsory medical exams. In a recent television show (CBS, Sixty Minutes) it was argued that the arrest and detention of a prostitute who had AIDS was necessary for public health reasons despite the economic and personal hardships that would result for the prostitute and her dependents.

These utilitarian arguments can be disputed if one uses human rights arguments. For instance, one can argue that it is not fair that a prostitute who has AIDS is jailed when other AIDS victims who are not prostitutes are allowed to go free. Does this not deprive prostitutes, as citizens of a country, of certain inalienable human rights? Does this not just boil down to discrimination against a select group of people based upon their 'low' social status? As well, the human rights argument points to the question of equality within society. Why should the prostitute with AIDS have fewer rights than the client who infected the prostitute, or fewer rights than other AIDS patients. In sum, human rights arguments point to the discriminatory nature in which prostitutes are be treated in the name of 'public health'.

> "Blaming someone else, usually women, for the spread of venereal disease is a phenomenon that in Britain had already been established by hounding prostitutes through the use of the Contagious Disease Acts. Clearly this tradition was successfully handed on to our colonial and North American allies, who could not conceive of their sons being anything but virginal or at worst the innocent party." (Adler 1980:208)

Apart from the human rights question, the utilitarian argument is losing ground, especially where compulsory treatment programs or legislation is concerned, simply because these control measures are not particularily effective.

> "Acceptance of the prostitute as an individual and interest in her physical and psychological needs may be expected to induce greater cooperation from her profession. Certainly little impact on the venereal disease problem can be expected without this cooperation." (Hart 1977:172.)

This begs the question as to why we should support compulsory control measures when they do not attain utilitarian objectives (i.e. they do not protect public health), and when they infringe upon human rights? We conclude that of these three types of measures, only the voluntary programs are justified. Registration of prostitutes has been dropped on human rights grounds. Venereal disease legislation, similar

to the type we have in Canada, not only appears to be less effective than voluntary public health measures, (Potterat et al. 1979) but also poses serious human rights questions. We, therefore, conclude that the only measure which can be justified on both effectiveness and human rights grounds are voluntary STD programs.

DEFINITIONS AND NOTES

Antigen

Allergen; immunogen; any substance that, as a result of coming in contact with appropriate tissues of an animal body, induces a state of sensitivity and/or resistance to infection or toxic substances after a latent period (8 to 14 days) and when reacts in a demonstrable way with tissues and /or antibody of the sensitized subject. Source: Stedman's Medical Dictionary, Fifth Edition, Anderson's Publishing Company, 1982.

The Core Group

This concept posits the existence of small groups of individuals who, by virtue of their sociodemographic characteristics, life styles, sexual activities, and health care-seeking behaviors, are key transmitters of STD's both inside and outside their immediate sexual milieux. The hypothesis that all cases of a particular STD may be directly or indirectly attributable to this core is being explored. Potterat et al. suggest the possibility that prostitutes in Colorado prings may be such a group. It should not be assumed, however, that all prostitutes are key transmitters. Yorke et al. (1978), who defined the core group as being made up of groups having a high prevalence (20% or more) of a disease, states that all cases of gonorrhea are either directly or indirectly caused by the core.

Epidemiology

The study of the prevalence and spread of disease in a community. Source: Stedman's Medical Dictionary, Fifth Edition, Anderson's Publishing Company, 1982.

The infected pool

This pool consists of a diverse group of individuals, both men and women, both symptomatic and asymptomatic. The concept of the asymptomatic female pool (typically called the female reservoir of infection) has been, according to Hart a gross oversimplification. Present evidence suggests that symptomatic infection in the male may be almost as significant.

Prevalence

The number of cases of infection in a community at any moment in time or during a particular specified time period.

PREVALENCE = INCIDENCE x DURATION of the illness

Given the relationship between incidence and duration the prevalence of a disease depends not only on the number of new cases but also on

the duration of the disease such that incidence may be low but if the disease is a chronic one prevalence may be high. For instance, in the case of asymptomatic gonorrhea in males there is a 1-3% incidence rate and a 20-50% prevalence rate (i.e. asymptomatic gonorrhea accounts for 1-3 percent of all male gonococcal infections , whereas at any given time 20 to 50 percent of all male gonococcal infections are asymptomatic. (Hart, 1977.)

The Promiscuity Argument

Prostitutes have traditionally been considered to be a high risk population. Common sense would seem to dictate that they have a greater likelihood than other groups of catching and spreading STD's since, in general, they are more promiscuous than other groups. The hypothesis underlying the promiscuity argument is that the greater the number of sexual partners within a given time period, the higher the transmission rate of STD's. This hypothesis may not hold since it has been shown (Darrow, 1976) that the relationship between number of partners and number of venereal infections is not always linear, nor is it conclusive.

Hooper et al. (1978) found a statistically significant relationship between the risk of transmission of gonorrhea and both the number of partners and the frequency of sexual intercourse for men. Unfortunately, Hooper does not publish the risk of transmission for more than three exposures whereas Darrow does. Since some prostitutes would have more than three exposures per day, Hooper's data does not tell us whether the risk of transmission levels off after a certain number of exposures.

Prostitutes

Most of the studies done on the relationship between prostitution and STD's define prostitutes as someone, usually a woman, who sells sexual favours for money.

Sexually Transmitted Diseases

This term has replaced the term venereal diseases in the literature. V.D. or venereal disease usually refers to the following infections: gonorrhea, syphilis, chancroid, granuloma inguinale and lymphogranuloma venereum. STD's refers to these infections plus non-gonoccocal urethritis, herpes genitalis, trichomoniasis, AIDS, candidiasis, molluscum contagiosum, pediculosis (pubic lice), scabies ('the itch'), genital warts, type B viral hepatitis, and intestinal parasites. Not all STD's are caught through sexual contact. For instance, pubic lice can be caught by coming in contact with bed clothes infested with the lice. (Meltzer 1981:1)

Risk of Transmission

Risk of transmission refers to the likelihood of acquiring a particular STD through sexual contact with an infected partner. Rates vary according to a number or variables such as race and sex. Hooper et al. (1978) found a statistically significant relationship between the risk of tranmission of gonorrhea and both the number of partners and the frequency of sexual intercourse. The calculated risk of transmission per exposure with an infected partner was .19 for white males and .53 for black males.

Venereal Disease

See the definition of sexually transmitted diseases.

BIBLIOGRAPHY

Adler, M.W. The terrible peril: a historical perspective on the venereal diseases, British Medical Journal, July, 19, 1980, p. 206-211.

Catterall, R.D., and Nicol, C.S. Sexually Transmitted Diseases, Academic Press, London, 1976.

Cini, Maltaise, Prostitution and Venereal Disease, 1983, (unpublished document).

Conrad, G.L., et al. Sexually Transmitted Diseases among Prostitutes and Other Sexual Offenders, Sexually Transmitted Diseases, vol. 8, no. 4, 1981, p. 241-243.

Darrow, William. Changes in Sexual Behavior and Venereal Diseases, Clinical Obstetrics & Gynecology, vol.18, 1975, p. 255-267.

Darrow, William. Approaches to the Problem of Venereal Disease Prevention, Preventive Medicine, vol. 5, 1976. p. 165-175.

Darrow, William. Venereal Disease and Victimless Crime, Conference of the Society for the Study of Social Problems, 1978.

Dunlop, E.M., Lamb, A.M., and King, D.M. Improved Tracing of Contacts of Heterosexual Men with Gonorrhoea, Relationship of altered female to male ratios, British Journal of Venereal Disease, vol. 47, 1971, p. 192-195.

Evans, R.J. Prostitution, State and Society in Imperial Germany, Past & Present, vol. 70, 1976, p. 106-128.

Hart, Gavin. Sexual Maladjustment and Disease: An Introduction to Modern Venereology, Nelson-Hall, Chicago, 1977.

Health and Welfare Canada. Sexually Transmitted Diseases in Canada 1982, Bureau of Epidemiology, Laboratory Centre for Disease Control, Health Protection Branch, 1983.

Health and Welfare Canada. Canada Diseases Weekly Report, vol. 10-13, March 31, 1984.

Holmes, King; Johnson, David; Trostle, Henry. An Estimate of the Risk of Men Acquiring Gonorrhea by Sexual Contract with Infected Females, American Journal of Epidemiology, vol. 91, no. 2, 1970, p. 170-174.

Hooper, R.R., et al. Cohort Study of Venereal Disease: The Risk of Gonorrhea Transmission from Infected Women to Men, American Journal of Epidemiology, vol.108, no.2, p. 136-144.

Idsoe, O., and Guthhe, T.The Rise and Fall of the Treponematoses; Ecological Aspects and International Trends in Venereal Syphilis, British Journal of Venereal Disease, vol.43, 1967, p.227-243.

Jessamine, A.G., Mathias, R., Sutherland, R. Epidemiology and Control of Sexually Transmitted Diseases, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 163-166.

Judson, F.N., et al. Comparative Prevalence Rates of Sexually Transmitted Diseases in Heterosexual and Homosexual Men, American Journal of Epidemiology, vol.112, no.6, 1980, p. 836-843.

Keighley, Elizabeth. Venereal Disease among Women Prisoners, The Lancet, vol. 7, 1960, p. 253-254.

King, Ambrose. Venereal Disease Problems and Adolescent Health, Clinical Pediatrics, vol. 5, 1966, p. 597-603.

Knox, Samuel, R., Mandel, Bea; Lazarowicz, Remy. Profile of Callers to the VD National Hotline, Sexually Transmitted Diseases, October-December 1981, p. 245-254.

Lentino, Walter. Medical Evaluation of a System of Legalized Prostitution, JAMA, vol. 158, 1955, p. 20-23.

Meltzer, Alan S., Sexually Transmitted Diseases, Eden Press Incorporated, Westmount Quebec and St. Albans, Vermont, 1981.

Pellegrin, M. Etude de la Morbidité Vénerienne dans les Alpes-Maritimes, La Prophylaxie Sanitaire et Morale, vol. 7, July 1966, p. 199-211.

Post, J.B. A Foreign Office Survey of Venereal Disease and Prostitution Control, 1869-70, Medical History, vol.22, 1978, 327-334.

Potterat, J. et al. Gonorrhea in Street Prostitutes: Epidemiologic and Legal Implications, Sexually Transmitted Diseases, vol.2, 1979, p. 58-63.

Richards David. Sex, Drugs, Death, and the Law, Rowman and Littlefield, New Jersey, 1983.

Romanowski, Barabara B. Sexually Transmitted Diseases: A Time for Action, Canadian Journal of Public Health, vol. 74, no.3, 1983, p. 153-157.

Romanowski, B., Meltzer, A.S., Rush, J. Treatment Guidelines for Selected Sexually Transmitte Diseases, Canadian Journal of Public Health, vol. 74, no. 3, 1983, p. 166-173.

Ronald, A.R., et al. Research on Sexually Transmitte Diseases in Canada, Canadian Journal of Public Health, vol.74, no.3, 1983, 173-177.

Rosenthal T., Vandow J. Prevalence of venereal disease in prostitutes, British Journal of Venereal Disease, vol. 34, 1958, p. 94-9.

Rozovsky, L.E. and F.A. Legal Sex, Doubleday Canada Limited, Toronto, 1982.

Sacks, S.L., Bowie, W.R., Stayner, M. Education and Public Awareness of Sexually Transmitted Diseases, Canadian Journal of Public Health, vol.74, no. 3, 1983, p. 176-179.

Sgroi, Suzanne. Pediatric Gonorrhea and Child Sexual Abuse: The Venereal Disease Connection, Sexually Transmitted Diseases, July-September 1982, p. 154-156.

Schofield, C.B.S. Sexually Transmitted Diseases, Churchill Livingstone, New York, 1979.

Turner, B., Morton, R.S. Prostitution in Sheffield, British Journal of Venereal Disease, vol. 52, 1976, p. 197-203.

Yorke, J.A., Hethcote, H.W., Nold, A. Dynamics and Control of the Transmission of Gonorrhea, Sexually Transmitted Diseases, vol. 5, 1978, p. 51-56.

Willcox, R.R. Prostitution and Venereal Disease: Proportion of Venereal Disease Acquired from Prostitutes in Asia: A Comparison with France, the United Kingdom, and the United States of America, British Journal of Venereal Disease, vol. 38, 1962A , p. 37-42.

Willcox, R.R. Factors Leading to a Failure of Control of Gonorrhoea, British Journal of Preventive Social Medicine, vol. 16, 1962B, p. 113-122.

Willcox, R.R. Prostitution and Venereal Disease: Medical 'Control' of Prostitutes', Antiseptic, vol. 60, 1963, p. 6-14.

World Health Organization, Venereal Disease Control: A Survey of Recent Legislation, Geneva, 1975.

Wren, Barry, G. Gonorrhoea among Prostitutes, The Medical Journal of Australia, vol. 5, 1967, 847-849.

Appendice I

Selected National and International STD Legislation

Source: World Health Organization, Venereal Disease Control, 1975.

Legislation

Argentina

Law No. 15465 of 24 October 1960 making compulsory, throughout the territory of the Nation, the notification of cases of infectious disease (see *Int. Dig. Hlth Leg.*, 1961, **12**, 677)

Australia

New South Wales

An Act (No. 37 of 1963) to make provision for the medical examination of persons suffering or suspected to be suffering from venereal disease; for these and other purposes to amend the Venereal Diseases Act, 1918, as amended by subsequent Acts; and for purposes connected therewith. Dated 15 October 1963. (The Venereal Diseases (Amendment) Act, 1963) (see *Int. Dig. Hlth Leg.*, 1966, **17**, 415)

Venereal Diseases Act, 1918, as amended.—Regulations. Dated 5 June 1964 (see *ibid.*)

Tasmania

An Act to consolidate and amend the law relating to public health. No. 75 of 1962. Dated 14 February 1963. (The Public Health Act 1962) (see *Int. Dig. Hlth Leg.*, 1965, **16**, 14)

Public Health (Venereal Diseases) Regulations 1966. Serial No. 102 of

1966. Dated 24 May 1966 (see *ibid.*, 1968, **19**, 693)

An Act (No. 35 of 1966) to amend the Public Health Act 1952. Dated 11 November 1966. (The Public Health Act 1966) (see *ibid.*, 695)

Brazil

Decree No. 4997-A of 21 January 1961 regulating under the name of the National Health Code Law No. 2312 of 3 September 1954 embodying general provisions for the defence and protection of health (see *Int. Dig. Hlth Leg.*, 1962, **13**, 607)

Bulgaria

Decree No. 225 of 16 March 1968 to promulgate the Family Code (see *Int. Dig. Hlth Leg.*, 1970, **21**, 533)

Order No. 2247 of the Minister of Public Health and Social Welfare with regard to the prenuptial certificate of health (see *ibid.*)

Regulations for the implementation of the Law on public health (approved by Resolution No. 23 of 23 March 1974) (see *ibid.*, 1974, **25**, 520)

Canada

Alberta

Alberta Regulation No. 492/61 of 28 December 1961 governing the control of communicable disease (see *Int. Dig. Hlth Leg.*, 1962, **13**, 643)

The Venereal Diseases Prevention Act, 1965 (see *ibid.*, 1966, **17**, 21)

Manitoba

Manitoba Regulation 120/68. A Regulation under The Public Health Act to amend Manitoba Regulation 91/45 (see *Int. Dig. Hlth Leg.*, 1971, **22**, 80)

Manitoba Regulation 51/70. A Regulation under The Public Health Act to amend Manitoba Regulation 91/45. Dated 26 March 1970 (see *ibid.*, 1973, **24**, 49)

Colombia

Decree No. 393 of 26 February 1963 enacting certain regulations concerning the notification of communicable diseases (see *Int. Dig. Hlth Leg.*, 1964, **15**, 71)

Decree No. 239 of 10 February 1965 to repeal Decree No. 158 of 31 January 1964 and to replace it by other provisions for the implementation of Section 66 of Decree No. 3224 of 1965 (see *ibid.*, 1967, **18**, 303)

Costa Rica

Decree No. 4573 of 4 May 1970 embodying the Penal Code (see *Int. Dig. Hlth Leg.*, 1975, **26**, 61)

Cuba

Ministerial Decree (Public Health) No. 7 of 16 March 1962 embodying regulations with regard to international health and to the national health services (see *Int. Dig. Hlth Leg.*, 1963, **14**, 12)

Czechoslovakia

Instruction No. 30 of 17 December 1968 of the Ministry of Health prescribing measures against venereal diseases (see *Int. Dig. Hlth Leg.*, 1969, **20**, 429)

Denmark

Order No. 21 of 22 January 1962 with regard to the control of venereal diseases in Greenland (see *Int. Dig. Hlth Leg.*, 1964, **15**, 103)

Law No. 287 of 23 May 1973 on the control of venereal diseases (see *ibid.*, 1973, **24**, 753)

Circular of 28 June 1973 of the National Health Service on the co-operation of physicians in the field of venereal disease control (see *ibid.*, 1975, 26, 91)

Circular of 28 June 1973 of the Minister of the Interior embodying guidelines on the organization of venereal disease control in accordance with Law No. 287 of 23 May 1973 (see *ibid.*, 92)

Fiji

Pure Food Regulations, 1961. Legal Notice No. 85. Dated 16 June 1961 (see *Int. Dig. Hlth Leg.*, 1964, **15**, 410)

An Ordinance (No. 10 of 1964) to amend the Public Health Ordinance. (The Public Health (Amendment) Ordinance, 1964). Dated 21 May 1964 (see *ibid.*, 1968, **19**, 188)

France

Ordinance No. 60-1246 of 25 November 1960 amending and supplementing the provisions of Chapter I of Part II of Volume III of the Public Health Code (see *Int. Dig. Hlth Leg.*, 1961, **12**, 529)

Decree No. 64-931 of 3 September 1964 to amend and supplement Decree No. 62-840 of 19 July 1962 relating to maternal and infant welfare (see *ibid.*, 1965, **16**, 103)

Order of 27 August 1971 of the Minister of Public Health and Social Security and the Secretary of State for Social Welfare and Rehabilitation concerning prenatal and postnatal medical examinations (see *ibid.*, 1972, **23**, 77)

German Democratic Republic

Ordinance of 23 February 1961 on the prevention and control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1962, **13**, 687)

Germany, Federal Republic of

Law of 25 August 1969 to amend the Law on the control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1970, **21**, 286)

Greece

Law No. 3310 of 13 July 1955 on the control of venereal disease, and matters related thereto (see *Int. Dig. Hlth Leg.*, 1958, **9**, 511)

Guatemala

Decree No. 17-73 of 5 July 1973 to promulgate the Penal Code (see *Int. Dig. Hlth Leg.*, 1974, **25**, 786)

Hungary

Ordinance No. 9 of 27 June 1972 of the Minister of Health for the implementation of the provisions of Law No. II of 1972 on health relating to epidemiology (see *Int. Dig. Hlth Leg.*, 1973, **24**, 808)

Ordinance No. 12 of 11 July 1972 of the Minister of Health concerning the medical examinations of workers and the expert appraisal of working (professional) capacity (see *ibid.*, 825)

Ordinance No. 15 of 5 August 1972 of the Minister of Health for the implementation of the provisions of Law No. II of 1972 on health relating to therapeutic and prophylactic care (see *ibid.*, 828)

Israel

The Public Health (Infectious Diseases) Order, 1960. Dated 24 November 1960 (see *Int. Dig. Hlth Leg.*, 1961, **12**, 772)

Italy

Law No. 837 of 25 July 1956 to reform the existing legislation relating to the prevention of venereal diseases (see *Int. Dig. Hlth Leg.*, 1957, **8**, 496)

Decree No. 2056 of the President of the Republic dated 27 October 1962 for the enforcement of Law No. 837 of 25 July 1956 to reform the existing legislation relating to the prevention of venereal disease (see *ibid.*, 1963, **14**, 637)

Luxembourg

Law of 19 December 1972 introducing a medical examination before marriage and amending Sections 63, 75, and 109 of the Civil Code (see *Int. Dig. Hlth Leg.*, 1973, 24, 881)

Regulations of the Grand Duke of 14 March 1973 specifying the examinations to be performed for the issue of a medical certificate before marriage (see *ibid.*)

Madagascar

Decree No. 67-032 of 17 January 1967 specifying the procedure for the control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1968, 19, 208)

Mexico

Decree of 19 November 1969 prescribing the conditions to be fulfilled for the issue of the prenuptial medical certificate referred to in Section 90 of the Health Code of the United Mexican States (see *Int. Dig. Hlth Leg.*, 1972, 23, 214)

New Zealand

The Health Act 1956. No. 65 of 1956. Dated 25 October 1956 (see *Int. Dig. Hlth Leg.*, 1957, 8, 643)

An Act to amend the Health Act 1956. No. 76 of 1962. Dated 6 December 1962 (see *ibid.*, 1964, 5, 124)

The Venereal Diseases Regulations 1964. Serial No. 209 of 1964. Dated 16 December 1964 (see *ibid.*, 1965, 16, 367)

Poland

Ordinance No. 276 of 29 August 1958 of the Minister of Health concerning occupations forbidden to persons suffering from venereal diseases (see *Int. Dig. Hlth Leg.*, 1960, 11, 342)

Ordinance of 2 September 1964 of the Minister of Health and Social Welfare with regard to medical examinations for the detection of cases of venereal disease (see *ibid.*, 1965, 16, 729)

Ordinance of 20 February 1971 of the Minister of Health and Social Welfare concerning the co-operation of State institutions and agencies and social organizations in the field of venereal disease control (see *ibid.*, 1973, 24, 374)

Romania

Instructions No. XII/C1/2758 of 24 July 1971 concerning the prevention and control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1972, 23, 318)

Senegal

Decree No. 62-0317 M.S.A.S. of 16 August 1962 to organize the control of venereal diseases (see *Int. Dig. Hlth Leg.*, 1964, 15, 828)

Spain

Decree of 4 July 1958 to approve the Regulations for the control of leprosy, venereal diseases, and dermatoses (see *Int. Dig. Hlth Leg.*, 1959, 10, 392)

Sweden

Law No. 231 of 26 April 1968. (The Communicable Diseases Law) (see *Int. Dig. Hlth Leg.*, 1969, 20, 136)

Crown Order No. 234 of 26 April 1968 on the control of communicable diseases. (The Communicable Diseases Order) (see *ibid.*, 142)

Circular of 9 September 1970 of the National Board of Health and Welfare concerning measures to prevent gonorrhoea (see *ibid.*, 1972, 23, 345)

Switzerland

Ordinance of 17 June 1974 on the notification of communicable diseases in man (Section 5) (see *Int. Dig. Hlth Leg.*, 1975, 26, 204)

Tunisia

Law No. 64-46 of 3 November 1964 instituting a prenuptial certificate (see *Int. Dig. Hlth Leg.*, 1966, **17**, 396)

United States of America

West Virginia

Act of 2 March 1959 to amend Section 6, Article 1, Chapter 48 of the Code of West Virginia, 1931, as amended, relating to application for an issuance of marriage license (see *Int. Dig. Hlth Leg.*, 1962, **13**, 186)

Upper Volta

Order No. 71-46 SP.P.AS. of 16 February 1971 of the Minister of Public Health, Population and Social Affairs establishing the list of diseases subject to compulsory or optional notification (see *Int. Dig. Hlth Leg.*, 1973, **24**, 674)

Yugoslavia

Decree of 28 December 1973 to promulgate the Law on the protection of the population against communicable diseases representing a threat to the country as a whole (see *Int. Dig. Hlth Leg.*, 1974, **25**, 866)

Criminal Code of Canada

the Person Act, 1861, which was virtually the same as former s. 238 [now s. 252] of the Criminal Code: "The question is, whether or not the intention of any other person besides the defendant himself, that the poison or noxious thing should be used to procure a miscarriage, is necessary to constitute the offence charged under the 24 and 25 Vict. c. 100, s. 59. We are all of the opinion that that question must be answered in the negative. The statute is directed against the supplying or procuring of poison or noxious things for the purpose of procuring abortion with the intention that they shall be so employed, and knowing that it is intended that they shall be so employed. The defendant knew what his own intention was, and that was, that the substance procured by him should be employed with intent to procure miscarriage. The case is therefore within the words of the Act." *R. v. Hillman, supra,* was followed in *R. v. Titley* (1880), 14 Cox. C.C. 502 (U.K.) and in *Irwin v. R.* (1968), 3 C.R.N.S. 377 (S.C.C.).

252§5 Evidence — Dying declaration. Where there are two counts in the indictment, one charging homicide, and the other for administering and supplying drugs, and a dying declaration is admitted in evidence, the judge must instruct the jury that the declaration must be disregarded except on the charge of manslaughter: *R. v. Inkster* (1915), 24 C.C.C. 294 (Sask. C.A.).

Venereal Diseases

Venereal disease — Defence — Corroboration — "Venereal disease".

253. (1) Every one who, having venereal disease in a communicable form, communicates it to another person is guilty of an offence punishable on summary conviction.

(2) No person shall be convicted of an offence under this section where he proves that he had reasonable grounds to believe and did believe that he did not have venereal disease in a communicable form at the time the offence is alleged to have been committed.

(3) No person shall be convicted of an offence under this section upon the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused.

(4) For the purposes of this section, "venereal disease" means syphilis, gonorrhea or soft chancre.

---

253 History. Formerly 1953-54, c. 51, s. 239; 1927, c. 36, s. 307; 1906, c. 146, s. 316A [en. 1919, c. 46, s. 8].

253 Related sections. Code ss. 202-204 — Criminal negligence; 720 — Definitions; 722(1) — General penalty; 722(3) — Time for payment; 722(4) — What to be considered; 722(5) — What to be considered; 722(6) — Warrant of committal; 722(7) — Reasons for committal; 722(8) — Surrender by accused; 722(9) — Young offenders; 722(10) — Extension of time; 722(11) — "Fine"; 744 — Costs.

253 Related statutes. Interpretation Act, R.S.C. 1970, c. I-23, s. 27.

253§1 **Communicating diseases.** This section was first enacted as s. 316A in 1919. Before that time, it was not criminal to communicate any form of disease, including venereal disease: *R. v. Clarence* (1888), 22 Q.B.D. 23 (U.K. C.C.R.). Since the enactment, making it an offence to communicate these diseases, it was held that if death resulted from a venereal disease communicated by accused, he would be guilty of manslaughter: *R. v. Leaf* (1926), 45 C.C.C. 236 (Sask. C.A.).

Offences Against Conjugal Rights

Bigamy — Matters of defence — Incompetency no defence — Validity presumed — Act or omission by accused.

254. (1) Every one commits bigamy who

(*a*) in Canada,

(i) being married, goes through a form of marriage with another person,

(ii) knowing that another person is married, goes through a form of marriage with that person, or

(iii) on the same day or simultaneously, goes through a form of marriage with more than one person; or

(*b*) being a Canadian citizen resident in Canada leaves Canada with intent to do anything mentioned in subparagraphs (*a*)(i) to (iii), and, pursuant thereto, does outside Canada anything mentioned in those subparagraphs in circumstances mentioned therein.

(2) No person commits bigamy by going through a form of marriage if

(*a*) that person in good faith and on reasonable grounds believes that his spouse is dead,

(*b*) the spouse of that person has been continuously absent from him for seven years immediately preceding the time when he goes through the form of marriage, unless he knew that his spouse was alive at any time during those seven years,

(*c*) that person has been divorced from the bond of the first marriage, or

(*d*) the former marriage has been declared void by a court of competent jurisdiction.

(3) Where a person is alleged to have committed bigamy, it is not a defence that the parties would, if unmarried, have been incompetent to contract marriage under the law of the place where the offence is alleged to have been committed.

(4) Every marriage or form of marriage shall, for the purpose of this section, be deemed to be valid unless the accused establishes that it was invalid.

(5) No act or omission on the part of an accused who is charged with bigamy invalidates a marriage or form of marriage that is otherwise valid.

---

254 **History.** Formerly 1953-54, c. 51, s. 240; 1927, c. 36, s. 308; 1906, c. 146, s. 307; 1892, c. 29, s. 275.

Sir James Clarke's Female Pills, with direction to take twenty-five at a dose, and that it would have that effect. In that number of pills there was sufficient oil of savin, an article used to procure abortion, to be greatly irritating to a pregnant woman and perhaps to cause an abortion. Held, that A supplied a noxious thing with the statute; *R. v. Stitt*, 30 U.C.C.P. 30.

[3] *R. v. Hillman*, L. & C. 343.

Criminal Code, 1892, c. 29.

Supplying means of procuring abortion.

274. Every one is guilty of an indictable offence and liable to two years' imprisonment who unlawfully supplies or procures any drug or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she is or is not with child.

Criminal Code, R.S.C. 1906, c. 146.
Section 274 was re-enacted unchanged as section 305.

Criminal Code, R.S.C. 1927, c. 36.
Section 305 was re-enacted unchanged as section 305.

Criminal Code, 1953-54, c. 51.
Section 305 was re-enacted as section 238 using the wording which is now contained in R.S.C. 1970, c. C-34, s. 252.

Criminal Code, R.S.C. 1970, c. C-34.
Section 238 was re-enacted unchanged as section 252.

VENEREAL DISEASE — SECTION 253

An Act to amend the Criminal Code, 1919, c. 46.
The Criminal Code was amended by 1919, c. 46, s. 8 by inserting immediately after section 316 the following section:

Communicating venereal disease.

316A. (1) Any person who is suffering from venereal disease in a communicable form, who knowingly or by culpable negligence communicates such venereal disease to any other person shall be guilty of an offence, and shall be liable upon summary conviction to a fine not exceeding five hundred dollars or to imprisonment for any term not exceeding six months, or to both fine and imprisonment.

Provided that a person shall not be convicted under this section if he proves that he had reasonable grounds to believe that he was free from venereal disease in a communicable form at the time the alleged offence was committed.

Provided, also, that no person shall be convicted of any offence under this section upon the evidence of one witness, unless the evidence of such witness be corroborated in some material particular by evidence implicating the accused.

(2) for the purposes of this section, "venereal disease" means syphilis, gonorrhea, or soft chancre.

Criminal Code, R.S.C. 1927, c. 36.
Section 316A was re-enacted unchanged as section 307.

Criminal Code, 1953-54, c. 51
Section 307 was re-enacted as section 239 using the wording which is now contained in R.S.C. 1970, c. C-34, s. 253.

Criminal Code, R.S.C. 1970, c. C-34.
Section 239 was re-enacted unchanged as section 253.

DEFINITION OF BIGAMY — SECTION 254

Burbidge — Digest of the Criminal Law of Canada.

[1]*Definition and punishment of bigamy*

[2]**Article 330.** [3]Every one is guilty of the felony called bigamy and liable to seven years' imprisonment who, being married, marries any other person during the life of the former husband or wife, whether the second marriage takes places in Canada, or elsewhere.

[The expression being married" means being legally married. The word "marries" means goes through a form of marriage which the [4]law of the place where such form is used recognizes as binding, whether the parties are by that law competent to contract marriage or not, and although by their fraud the form employed may, apart from the bigamy, have been insufficient to constitute a binding marriage.]

Nothing in this Article extends to—

(*a.*) [5]any second marriage contracted elsewhere than in Canada by any other than a subject of Her Majesty resident in Canada and leaving the same with intent to commit the offence;

(*b.*) [6]any person marrying a second time whose husband or wife has been continually absent from such person for the space of seven years then last past, and who was not known by such person to be living within that time;

(*c.*) [7]any person who, at the time of such second marriage, was divorced from the bond of the first marriage; or

(*d.*) any person whose former marriage has been declared void by the sentence of any court of competent jurisdiction.

[8]A person who marries again during his wife's or her husband's lifetime, but in the honest belief on reasonable grounds that she or he is dead, is not guilty of bigamy.

that the death of, or bodily harm to, the hostage will be caused or that the confinement, imprisonment or detention of the hostage will be continued

with intent to induce any person, other than the hostage, or any group of persons or any state or international or intergovernmental organization to commit or cause to be committed any act or omission as a condition, whether express or implied, of the release of the hostage.

b) de quelque façon, menace de causer la mort de l'otage ou de le blesser, ou de continuer à le séquestrer, l'emprisonner ou le retenir de force

dans l'intention d'amener une personne autre que l'otage, ou un groupe de personnes, un État ou une organisation internationale ou intergouvernementale à faire ou à omettre de faire quelque chose comme condition, expresse ou implicite, de la libération de l'otage.

Punishment

(2) Every one who takes a person hostage is guilty of an indictable offence and is liable to imprisonment for life.

Peine

(2) Quiconque se livre à une prise d'otage est coupable d'un acte criminel et est passible de l'emprisonnement à perpétuité.

Non-resistance

(3) Subsection 247(3) applies to proceedings under this section as if the offence under this section were an offence under section 247."

Non-résistance

(3) Le paragraphe 247(3) s'applique aux procédures intentées en vertu du présent article comme si l'infraction que ce dernier prévoit était celle que prévoit l'article 247.»

(2) The said Act is further amended in the manner and to the extent set out in Schedule I.

(2) La même loi est en outre modifiée de la façon et dans la mesure exposées à l'annexe I.

50. Section 253 of the said Act is repealed.

50. L'article 253 de la même loi est abrogé.

51. The definition "document" in section 282 of the said Act is repealed and the following substituted therefor:

51. La définition de « document» à l'article 282 de la même loi est abrogée et remplacée par ce qui suit :

"credit card" *«carte de crédit»*

" "credit card" means any card, plate, coupon book or other device issued or otherwise distributed for the purpose of being used upon presentation to obtain on credit money, goods, services or any other thing of value;

«carte de crédit» désigne notamment les cartes, plaquettes ou coupons délivrés afin de procurer à crédit, sur présentation, des fonds, des marchandises, des services ou toute autre chose de valeur;

«carte de crédit» *"credit card"*

"document" *«document»*

"document" means any paper, parchment or other material used for writing or printing, marked with matter capable of being read, and includes a credit card, but does not include trade marks on articles of commerce or inscriptions on stone or metal or other like material;"

«document» signifie tout papier, parchemin ou autre matière employée pour l'écriture ou l'imprimerie, marquée d'une chose capable d'être lue y compris une carte de crédit, mais ne comprend pas les marques de commerce sur des articles de commerce, ni les inscriptions sur la pierre ou le métal ou autre matière semblable;»

«document» *"document"*

1974-75-76, c. 93, s. 25

52. (1) Paragraph 294(*a*) of the said Act is repealed and the following substituted therefor:

52. (1) L'alinéa 294*a*) de la même loi est abrogé et remplacé par ce qui suit :

1974-75-76, c. 93, art. 25

"(*a*) is guilty of an indictable offence and is liable to imprisonment for ten

«*a*) est coupable d'un acte criminel et passible d'un emprisonnement de dix

(2) These amendments are consequential on the new offence proposed by subclause (1).

Clause 50: This amendment would recognize venereal disease to be a health problem rather than a crime.

Section 253 reads as follows:

"**253.** (1) Every one who, having venereal disease in a communicable form, communicates it to another person is guilty of an offence punishable on summary conviction.

(2) No person shall be convicted of an offence under this section where he proves that he had reasonable grounds to believe and did believe that he did not have venereal disease in a communicable form at the time the offence is alleged to have been committed.

(3) No person shall be convicted of an offence under this section upon the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused.

(4) For the purposes of this section, "venereal disease" means syphilis, gonorrhea or soft chancre."

Clause 51: This amendment would add the definition "credit card" taken from the present subsection 301.1(3) and, in the definition "document", would add the underlined words to make it clear that the definition "document" includes "credit cards".

Clause 52: These amendments, which would substitute the underlined amount for the amount of "two hundred dollars", are consequential on the amendment to section 483 proposed by clause 114.

(2). — Découlent de la nouvelle infraction créée au paragraphe (1).

Article 50. — Reconnaît le fait que les maladies vénériennes sont un problème de santé et non un crime.

Texte actuel de l'article 253 :

«**253.** (1) Est coupable d'une infraction punissable sur déclaration sommaire de culpabilité, quiconque, étant atteint d'une maladie vénérienne transmissible, la communique à une autre personne.

(2) Nul ne doit être déclaré coupable d'une infraction visée par le présent article s'il prouve qu'il avait raisonnablement lieu de croire, et croyait effectivement, qu'il n'était pas atteint d'une maladie vénérienne transmissible à l'époque ou l'infraction aurait été commise.

(3) Nul ne doit être déclaré coupable d'une infraction prévue au présent article sur la déposition d'un seul témoin, à moins que la déposition de ce témoin ne soit corroborée sous un rapport essentiel par une preuve qui implique le prévenu.

(4) Aux fins du présent article, l'expression «maladie vénérienne» signifie la syphilis, la gonorrhée ou le chancre mou.»

Article 51. — Adjonction de la définition de «carte de crédit» prise au paragrahe 301.1(3) actuel, et adjonction des mots soulignés à la définition de «document» pour établir clairement que la définition de «document» comprend les «cartes de crédit».

Article 52. — Substitution du montant souligné au montant de «deux cents dollars»; découle de la modification de l'article 483 proposée par l'article 114.

PE I

CHAPTER V-2

VENEREAL DISEASES PREVENTION ACT

1. In this Act — Definitions

(a) "Chief Health Officer" means the Chief Health Officer appointed under the *Public Health Act*, R.S.P.E.I. 1974, Cap. P-29; — Chief Health Officer

(b) "Minister" means the Minister of Health; — Minister

(c) "physician" means a legally qualified medical practitioner; — physician

(d) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, training school, or any place designated as a place of detention by the Lieutenant Governor in Council; — place of detention

(e) "prescribed" means prescribed by the regulations; — prescribed

(f) "regulations" means the regulations made under this Act or the *Public Health Act*, R.S.P.E.I. 1974, Cap. P-29; — regulations

(g) "venereal disease" means syphilis, gonorrhoea, chancroid, granuloma inguinale or lymphogranuloma venereum. 1974(2nd),c.92,s.1. — venereal disease

2. (1) Every person infected with venereal disease upon becoming aware or suspecting that he is so infected shall place himself forthwith under the care and treatment of a physician. — Infected person to submit to treatment

(2) Every person referred to in subsection (1) shall conduct himself in such a manner as not to expose other persons to the danger of infection, and shall take and continue treatment in a manner and to an extent considered to be adequate by the attending physician and the Minister. 1974(2nd),c.92,s.2. — Duty not to expose others to infection, treatment

3. (1) It is the duty of — Duty to report cases

(a) every physician;

(b) every superintendent or head of a hospital, sanatorium or laboratory; and

(c) every person in medical charge of any correctional institution, lock-up, training school, school or college or other similar institution;

to report within twenty-four hours every case of venereal disease coming under his diagnosis, treatment, care or charge for the first time to the Chief Health Officer.

Method of reporting

(2) Every person required to report a case of venereal disease under subsection (1) shall make the report in writing, by telephone, or in person to the Chief Health Officer. 1974(2nd),c.92,s.3.

Action of Chief Health Officer on reasonable belief

4. (1) Where the Chief Health Officer has reasonable grounds for believing that a person is or may be infected with venereal disease or has been exposed to infection, the Chief Health Officer may give notice in writing in the prescribed form to such person directing him to submit to an examination by a physician designated by or satisfactory to the Chief Health Officer, and to procure and produce to the Chief Health Officer within the time specified in the notice, a report or certificate of the physician that such person is or is not infected with venereal disease.

Offence

(2) Every person who without reasonable excuse, the proof of which is upon him, fails to comply with a direction made under subsection (1) is guilty of an offence and liable to imprisonment for a term of not less than seven days and not more than twelve months.

Powers of Chief Health Officer on report

(3) If by the report or certificate mentioned in subsection (1) it appears that the person so notified is infected with venereal disease, the Chief Health Officer may

(a) deliver to such person directions in the prescribed form as to the course of conduct to be pursued and may require such person to produce from time to time evidence satisfactory to the Chief Health Officer that he is undergoing adequate medical treatment and is in other respects carrying out such directions, and where such person fails to comply with the course of conduct prescribed for him or to produce the evidence required, the Chief Health Officer may exercise all the powers vested in him by clause (b) or may proceed under section 6; or

(b) with the approval of the Minister, order in writing that such person be removed and detained in a place of detention for the prescribed treatment until such time as the Chief Health Officer is satisfied that an adequate degree of treatment has been attained.

Duties of peace officer on order of Chief Health Officer

(4) Where the Chief Health Officer makes an order under clause (3)(b) he shall deliver the order to a peace officer who shall thereupon take the person named in the order into his custody and remove him to the place of detention named in the order, and the person for the time being in charge of the place of detention, upon receiving the order, shall receive such person and shall detain him until he is authorized by the Chief Health Officer to release him.

Where person certified within one year

(5) The Chief Health Officer may adopt the procedure or do any of the acts referred to in subsection (3) with regard to any person

who has been examined by a physician at any time within one year previously and has been certified by such physician to be infected with syphilis.

More than one examination may be required

(6) The Chief Health Officer may require a person who he believes may be infected with venereal disease to undergo more than one examination in order to determine the presence or absence of the infection. 1974(2nd),c.92,s.4.

Authority of Chief Health Officer

5. (1) Where

(a) any person has been named under oath as a source or contact of venereal disease or is believed by the Chief Health Officer to be a source or contact of the venereal disease; and

(b) in the opinion of the Chief Health Officer the clinical findings and history of such person indicate that such person is or may be infected with venereal disease;

the Chief Health Officer may, whether or not laboratory findings indicate the presence of venereal disease, proceed in the manner prescribed in clauses 4(3)(a) and (b).

Chief Health Officer may take statement under oath

(2) For the purposes of subsection (1), the Chief Health Officer may administer an oath and take a statement under oath. 1974(2nd),c.92,s.5.

Information or complaint

6. (1) The Chief Health Officer may make a complaint or lay an information in writing and under oath before a provincial judge charging that the circumstances set out in clause (5)(a) or (b) exist with regard to any person named in the complaint or information.

Issue of summons

(2) Upon receiving a complaint or information, the provincial judge shall hear and consider the allegations of the complainant, and if he considers it desirable or necessary, the evidence of any witnesses, and if he is of the opinion that a case for so doing is made out, he shall issue a summons directed to the person complained of requiring the person complained of to appear before him at a time and place named therein.

Issue of warrant

(3) Where a person to whom a summons is directed does not appear at the time and place named therein or where it appears that a summons cannot be served, a provincial judge may issue a warrant directing that the person named in the summons be brought before him.

Provincial judge's inquiry

(4) Where a person appears or is brought before a provincial judge under this section, the judge shall inquire into the truth of the matters charged in the complaint or information and for such person shall proceed in the summary manner set forth in Part XXIV of the *Criminal Code* of Canada, R.S.C. 1970, Chap. C-34 and has all such powers as may be necessary to enable him to exercise that jurisdiction.

Order for detention

(5) Where a provincial judge finds that any person

(a) is infected with a venereal disease and is unwilling or unable to conduct himself in such a manner as not to expose other persons to the danger of infection; or

(b) is infected with a venereal disease and refuses or neglects to take or continue treatment as required by this Act and the regulations;

he shall order that such person be admitted to and detained in a place of detention for such period not exceeding one year as the provincial judge may consider necessary.

Laboratory certificate *prima facie* evidence

(6) In any inquiry under this section, a certificate as to the result of any test made, signed or purporting to be signed by the director of a laboratory approved by the Minister is *prima facie* evidence of the facts stated therein and of the authority of the person giving such certificate without any proof of appointment of signature.

Extension of detention

(7) Any person detained under this section may, with the approval in writing of the Minister, be brought before a provincial judge at any time during the last thirty days of the period for which he is so detained, and if the judge finds that he is still infected with venereal disease and in need of further treatment, he may order that such person be further detained for a period not exceeding one year as the judge may consider necessary.

Discharge by Minister

(8) Where the Minister is of the opinion that any person detained under this section is no longer infected with venereal disease or has received an adequate degree of treatment, he may direct the discharge of such person. 1974(2nd),c.92,s.6.

Examination by physician in charge of institution

7. (1) Where any physician in medical charge of any correctional institution, lock-up or training school, has reason to believe that any person under his charge may be infected with venereal disease or has been exposed to infection with venereal disease, he may, and if he is directed by the Chief Health Officer, he shall cause such person to undergo such examination as may be necessary to ascertain whether or not he is infected with venereal disease or to ascertain the extent of venereal disease infection, and if the examination discloses that he is so infected, the physician shall report the facts to the Chief Health Officer who may thereupon exercise the powers vested to him by section 9.

Duty of physician in charge of institution

(2) Where an examination has not been made under this section, every physician in medical charge of any correctional institution, lock-up or training school, shall report to the Chief Health Officer the name and place of confinement of any person under his charge whom he suspects or believes to be infected with venereal disease and the report shall be made within twenty-four hours after he suspects or believes such person to be so infected.

Duplicate report

(3) A copy or statement of every report made under this section shall be forwarded to the Minister and the Chief Health Officer by the physician making the report. 1974(2nd),c.92,s.7.

Examination of person in custody or committed to prison

8. When the Chief Health Officer believes that any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, has been or may be infected or has been exposed to infection with venereal disease, he may cause such person to undergo such examination as may be necessary in order to ascertain whether or not such person is infected with venereal disease, and may direct that such person shall remain in custody until the results of the examination are known. 1974(2nd),c.92,s.8.

Treatment where disease found to exist

9. Where any person under arrest or in custody, whether awaiting trial for any offence under, or contravention of, any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder or serving the sentence of a court upon conviction of any such offence, or contravention, is found to be infected with venereal disease, the Chief Health Officer may by order in writing direct that such person undergo treatment therefor and that such action be taken as the Chief Health Officer or the Minister may consider advisable for his isolation and the prevention of infection by him, and that he be detained in custody until cured or until he has received a degree of treatment considered adequate by the attending physician and the Minister, notwithstanding that he may be otherwise entitled to be released, and any order made under this section is sufficient warrant to the person to whom the order is addressed to carry out the terms thereof. 1974(2nd),c.92,s.9.

Physician to report person refusing to continue treatment

10. (1) Where a person who has been under treatment for venereal disease refuses or neglects to continue treatment in a manner and to a degree satisfactory to the attending physician and the Minister, the physician shall report to the Minister the name and address of such person together with such other information as may be required by the regulations.

Failure to attend within seven days

(2) A person who fails to attend upon his physician within seven days of an appointment for treatment shall be presumed to have neglected to continue treatment and the attending physician shall report this failure in writing to the Minister and the Chief Health Officer within fourteen days of the appointment.

Offence

(3) A physician who fails to report as required by this section is guilty of an offence and is liable to a fine of not less than one hundred dollars and not more than five hundred dollars, and in default of payment thereof to imprisonment for a term of not more than twelve months. 1974(2nd),c.92,s.10.

Supply of drugs, etc., by unqualified persons prohibited

11. (1) No person other than a physician shall attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease for the purpose of the alleviation or cure of such disease.

Offence

(2) Every person who contravenes subsection (1) is guilty of an offence and is liable to a fine of not less than one hundred dollars and not more than five hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than twelve months.

Exception as to chemists

(3) Subsection (1) does not apply to a registered pharmaceutical chemist who dispenses to a patient of a physician upon receipt of a written prescription signed by the physician or who sells to any person any patent, proprietary or other medicine, drug or appliance prescribed by a physician for the cure or alleviation of venereal disease, but no prescription shall be filled more than once except upon the written direction of the prescribing physician. 1974 (2nd),c.92,s.11.

Offences

12. (1) Every person who

(a) willfully neglects or disobeys any order or direction given by the Chief Health Officer or the Minister or Deputy Minister under this Act or the regulations;

(b) hinders, delays or obstructs any health officer, public health nurse, peace officer or other person acting in the performance of his duties under this Act;

(c) publishes any proceedings taken under this Act or the regulations contrary to subsection (2);

(d) willfully represents himself as bearing some other name other than his own or makes any false statements as to his ordinary place of residence during the course of his treatment for any venereal disease with the purpose of concealing his identity;

(e) during the course of his treatment for any venereal disease changes his place of residence without giving due notice of the proposed change with his new address to the attending physician; or

(f) fails to comply with this Act or the regulations;

is guilty of an offence and, where no other penalty is prescribed, is liable to a fine of not less than twenty-five dollars and not more than one hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than three months.

Prosecutions

(2) Part XXIV of the *Criminal Code* of Canada, R.S.C. 1970, Chap. C-34 is included herein as part of this Act and applies to prosecutions under this Act or the regulations but all proceedings for the recovery of penalties under this Act and proceedings authorized by section 6 shall be conducted *in camera* and no person shall publish or disclose any such proceedings except under the authority of this Act or the regulations.

Summons by personal service

(3) Notwithstanding the provisions of subsection (2), service of any summons issued for a contravention of this Act may be effected by personal service. 1974(2nd),c.92,s.12.

Statements as to existence of disease

13. (1) Every person who publicly or privately, verbally or in writing, directly or indirectly, states or intimates that any other person has been notified or examined or otherwise dealt with under this Act, whether such statement or intention is or is not true, is guilty of an offence, and in addition to any other penalty or liability, is liable to a fine of two hundred dollars and in default of immediate payment shall be imprisoned for a term of not more than six months.

Exception

(2) Subsection (1) does not apply

(a) to a communication or disclosure made in good faith,

(i) to the Minister, Deputy Minister of Health or Chief Health Officer,

(ii) to a health officer or public health nurse for their information in carrying out this Act,

(iii) to a physician,

(iv) in the course of consultation for treatment for venereal disease,

(v) to the superintendent or head of any place of detention;

(b) to any evidence given in any judicial proceedings of facts relevant to the issue; or

(c) to any communication authorized or required to be made by this Act or the regulations;

Information to family

(3) Notwithstanding subsection (1), a physician may give information concerning the patient to other members of the patient's family for the protection of health. 1974(2nd),c.92,s.13.

Obligation to observe secrecy

14. Every person engaged in the administration of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment and shall not communicate in such matter to any other person except in the performance of his duties under this Act or when instructed to do so by the Chief Health Officer or the Minister and in default he shall in addition to any other penalty forfeit his office or be dismissed from his employment. 1974(2nd),c.92,s.14.

Laboratory reports

15. No person shall issue or make available to any person other than a physician or such persons as are engaged in the administration of this Act any laboratory report either in whole or in part of an examination made to determine the presence or absence of venereal disease. 1974(2nd),c.92,s.15.

Hospitals to make provision for treatment etc.

16. Every hospital receiving payment from the Province of Prince Edward Island shall make adequate provision for the reception, examination and treatment, upon such terms as may be prescribed, of such persons or classes of persons infected with venereal disease as may by this Act or the regulations be required or permitted to be treated at such hospital, and in case of default the Minister of Finance of Prince Edward Island may withhold from any hospital

the whole or any part of any moneys that would otherwise be payable. 1974(2nd),c.92,s.16.

Places of detention, maintenance, conduct

17. Where a person is admitted to a place of detention under this Act, whether the admission is voluntary or under the order of a provincial judge or the Chief Health Officer

(a) subject to the regulations, the provisions of law relating to the liability for and payment of maintenance of patients, inmates or pupils in such place of detention apply; and

(b) such person is subject to all rules, regulations, and provisions of law governing the conduct of patients, inmates or pupils of such place of detention. 1974(2nd),c.92,s.17.

Consent of persons 16 or over to treatment

18. (1) The consent of any person of the age of sixteen years or over to being examined or treated or both for venereal disease shall be deemed to be sufficient consent for such purposes and where such consent is given no action or other proceeding lies against a physician for acting upon such consent.

Under sixteen years

(2) No action or other proceeding lies against a physician for acting upon a consent given by a person under sixteen years of age to be examined or treated or both for venereal disease if the physician had no reason to believe that the person giving the consent was under sixteen years of age. 1974(2nd),c.92,s.18.

Where person infected is under 16 years of age

19. Where any person infected or believed to be infected with venereal disease is a child under the age of sixteen years, all notices, directions or orders required or authorized by this Act or by the regulations to be given in respect of the child shall be given to the father or mother or to the person having custody of the child for the time being and it is the duty of the father, mother or other person to see that the child complies in every respect with every such notice, order or direction and in default thereof the father, mother or other person, as the case may be, is liable to the penalties provided by this Act or the regulations for non-compliance with any such notice, direction or order unless on any prosecution in that behalf it is proven to the satisfaction of the court that the father, mother or other person did everything in his power to cause the child to comply therewith. 1974(2nd),c.92,s.19.

Regulations

20. (1) The Lieutenant Governor in Council may make regulations

(a) prescribing the method and extent of the examination of any person for the purpose of ascertaining whether or not such person is infected with venereal disease or the extent of the infection;

(b) prescribing the course of conduct to be pursued by any person infected with venereal disease in order to effect a cure and to prevent the infection of other persons;

(c) prescribing the hospitals that shall furnish treatment to persons or any classes or persons infected with venereal disease;

(d) prescribing rules for the treatment of persons infected with venereal disease in hospitals, places of detention and other places;

(e) for preventing the spread of infection from persons suffering from venereal disease;

(f) for distributing to physicians and hospitals information as to the treatment, diet and care of persons infected with venereal disease and requiring physicians and hospitals to distribute the information to such persons;

(g) providing for the approval by the Minister of methods and remedies for the treatment, alleviation and cure of venereal diseases;

(h) providing for the display of notices and placards dealing with venereal disease, its cause, manifestation, treatment and cure;

(i) prescribing the forms of notices, certificates and reports required or authorized to be given or issued under this Act;

(j) requiring every physician to furnish reports with respect to the condition and treatment of persons infected with venereal disease who are or who have been under his diagnosis, treatment, care or charge;

(k) prescribing the procedure to be followed and the evidence required in case of an appeal to the Minister from any action or decision under this Act;

(l) approving patent, proprietary or other medicines, drugs or appliances for the cure or alleviation of venereal disease;

(m) prescribing the mode of sending or giving any notice, report or direction required or permitted to be sent or given by this Act or the regulations;

(n) generally for the better carrying out of this Act, and for the prevention, treatment and cure of venereal disease.

Expenses of free distribution

(2) The Minister may, out of any moneys appropriated by the Legislature for the purposes of this Act, provide for the payment of the expenses incurred in carrying out this Act and the regulations including the manufacture and free distribution to physicians of any drug, medicine, appliance or instrument that the Minister may consider useful or necessary for the alleviation, treatment or cure of venereal disease or the prevention of infection therewith. 1974(2nd),c.92,s.20.

Appeal to Minister

21. (1) Every person who considers himself aggrieved by any action or decision of the Chief Health Officer under this Act may appeal therefrom to the Minister by giving such notice in writing to the Minister and to the Chief Health Officer.

Evidence on appeal

(2) The Minister may require the appellant to furnish such information and evidence and to submit to such examination as may be prescribed or as the Minister may consider necessary to determine the matter in dispute.

Decision final

(3) The decision of the Minister is final. 1974(2nd),c.92,s.21.

Right of entry

22. The Chief Health Officer or a physician or public health nurse designated by him in writing for the purpose may, with a warrant issued by a provincial judge, enter in and upon any house or premises for the purpose of making inquiry and examination with respect to the state of the health of any person therein and may cause any person found therein who is infected with any venereal disease to be removed to a place of detention or may give such direction as may prevent other persons in the same house or premises from being infected. 1974(2nd),c.92,s.22.

Powers of Deputy Minister

23. The Deputy Minister of Health and any officer of the department designated by the Minister are health officers within the meaning of this Act. 1974(2nd),c.92,s.23.

Delegation of powers

24. The Minister may delegate to the Deputy Minister of Health or any other officer of the Department of Health any of the powers vested in him under this Act or the regulations. 1974(2nd),c.92,s.24.

Administration of Act not to interfere with course of justice

25. The administration of this Act and the regulations shall not interfere with the course of justice in the case of any person under arrest or in custody previous to trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, bylaw or order made thereunder, but where it is necessary for the purpose of any examination authorized or required by this Act, such person may be held in custody until the results of the examination are known. 1974(2nd),c.92,s.25.

	Subsection 34(2) is amended by the deletion of the words "Public Works and Highways" and the substitution therefor of the words "Highways and Public Works".
Rural Community Fire Companies Act, R.S.P.E.I. 1974, Cap. R-16	Clause 1(b) is amended by the deletion of the words "Department of Community Services" and substitution therefor of the words "Department of Community Affairs". Clause 1(c) is amended by the deletion of the words "Minister of Community Services" and the substitution therefor of the words "Minister of Community Affairs". Section 3 is amended by the deletion of the words "Provincial Secretary" and the substitution therefor of the words "Director of Corporations".
Securities Act, R.S.P.E.I. 1974, Cap. S-4	Sections 1(c)(vi), 2(2), 3(1), (2), (4) and (5), 4(3), 5(2) and (3), 6(1), (2) and (3), 7(1), (2) and (3), 16(1), (2), (3) and (4), 17, 18(1), (2) and (3), 19(1) and (3), 20, 21, 22, 23, 24(2) and (3), 25, 27(4) and 28 are amended by the deletion of the words "Provincial Secretary" wherever they appear and the substitution therefor in each case of the words "Director of Corporations".
Summary Trespass Act, R.S.P.E.I. 1974, Cap. S-11	Clause 1(c) is amended by the deletion of the words "Minister of Industry and Commerce" and the substitution therefor of the words "Minister of Tourism, Industry and Energy".
Venereal Diseases Prevention Act, R.S.P.E.I., 1974, Cap. V-2	Clause 1(b) is amended by the deletion of the words "Minister of Health" and the substitution therefor of the words "Minister of Health and Social Services". Section 24 is amended by the deletion of the words "Department of Health" and the substitution therefor of the words "Department of Health and Social Services".
Village Service Act, R.S.P.E.I. 1974, Cap. V-5	Subsection 3(3) is amended by the deletion of the words "Minister of Municipal Affairs" and the substitution therefor of the words "Minister of Community Affairs". Subsections 41(4) and (5) are amended by the deletion of the words "Department of Public Works and Highways" and "Minister of Public Works and Highways" and the substitution therefor of the words "Department of Highways and Public Works" and "Minister of Highways and Public Works" respectively.
Vital Statistics Act, R.S.P.E.I. 1974, Cap. V-6	Subsection 26(1) is amended by the deletion of the words "Department of Health" and the substitution therefor of the words "Department of Health and Social Services".

Alberta

VENEREAL DISEASES PREVENTION ACT

CHAPTER V-2

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

Definitions

1 In this Act,

(a) "clinical examination" means an examination for venereal disease consisting of a physical examination, the taking of samples or specimens from the body on the same occasion as the physical examination and the testing of the samples or specimens at the place where the samples or specimens were taken;

(b) "Director" means the Director of the Division;

(c) "Division" means the Division of Social Hygiene of the Department of Social Services and Community Health;

(d) "infected" means having a venereal disease in a communicable stage;

(e) "jail physician" means a physician in attendance in his professional capacity at a correctional institution, lock-up, reformatory or similar place;

(f) "laboratory tests" means tests of samples or specimens from the body made in a laboratory at a place other than where the samples or specimens were taken;

(g) "Minister" means the Minister of Social Services and Community Health;

(h) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, reformatory, or any place designated as a place of detention by the Lieutenant Governor in Council;

(i) "provincial clinic" means a venereal disease clinic operated by the Division;

(j) "venereal disease" means syphilis, gonorrhoea, chancroid, granuloma inguinale or lymphopathia venereum.

RSA 1970 c382 s2;1971 c25 s19(1);1975(2) c12 ss8,9

Duties of Infected Persons

Duty to take treatment

2 Every person who knows or suspects or has reason to believe that he is or may be infected with venereal disease

(a) shall immediately consult a physician or attend at a provincial clinic to determine whether he is infected or not, and

(b) if he is found to be infected, shall submit to the treatment that is directed by a physician or at a provincial clinic until he is no longer infected with venereal disease in the opinion of the physician consulted or the physician in charge of a provincial clinic.

RSA 1970 c382 s3

Change of address or physician

3 Every person who is required by section 2 to submit to treatment for venereal disease

(a) shall inform the physician consulted or the provincial clinic, as the case may be, of any change of his address occurring during the period of treatment, or

(b) if he is under treatment by a physician and wishes to discontinue treatment under that physician, shall immediately consult and submit to treatment by another physician or at a provincial clinic.

RSA 1970 c382 s4

Duties of Physicians and Others

Duty re reports

4(1) It is the duty of

(a) every physician,

(b) every superintendent or head of a hospital or sanatorium, and

(c) every person in charge of medical services in a correctional institution, lock-up or reformatory or similar place or in an educational institution,

to report to the Director every case of infection with venereal disease coming under his diagnosis, treatment, care or charge for the first time.

(2) The report shall be completed and forwarded to the Director within 48 hours after the first diagnosis, treatment or knowledge by or of the physician, superintendent, head or other person.

RSA 1970 c382 s5

Report of laboratory tests

5 The person in charge of a laboratory shall report to the Director

(a) all positive and negative results of tests for syphilis made in the laboratory, and

(b) all positive results of tests for gonorrhoea made in the laboratory,

within 48 hours of the time the results are determined.

RSA 1970 c382 s6

Directions to patient

6 Every physician who examines or treats a person for or in respect of venereal disease shall instruct him in measures for preventing the spread of the disease and inform him of the necessity for regular treatment until cured.

RSA 1970 c382 s7

Report re delinquent patient

7(1) If an infected person under treatment for venereal disease by a physician refuses or neglects to continue his treatment in a manner and to a degree satisfactory to the physician, the physician shall forward a report to that effect to the Director unless he is sooner notified that the infected person is under treatment at a provincial clinic.

(2) A person who fails to attend on his physician within 7 days of an appointment for treatment for venereal disease shall be presumed to have neglected to continue his treatment and in that case the physician shall forward the report to the Director within 14 days of the appointment.

RSA 1970 c382 s8

Notice to Attend for Examination and Treatment

Notice to attend

8(1) When the Director has reasonable grounds for believing that a person is infected with venereal disease by virtue of

(a) a report forwarded to him pursuant to section 4, 5 or 7,

(b) the refusal or neglect of that person to continue treatment at a provincial clinic,

(c) that person being named in a statutory declaration as a probable source or contact of venereal disease, or

(d) any other proof or information in the possession of the Director,

the Director or a person authorized by the Director to do so may serve a notice on that person requiring him to attend at the provincial clinic nearest his residence or at the office of a named physician for examination for venereal disease and, if he is found to be infected, for treatment of the disease.

(2) A notice under subsection (1)

(a) shall specify the time at or within which the person is to attend, and

(b) may require more than one attendance for examination.

(3) When the notice requires attendance at the office of a named physician, the Director shall send a copy of it to that physician with directions to

(a) conduct a clinical examination of the person suspected of being infected,

(b) send any samples or specimens taken from the person's body to a laboratory for testing, and

(c) forward a certificate to the Director within a prescribed time stating whether or not, on the basis of the clinical examination and the laboratory tests, if any, the person examined is infected with venereal disease.

(4) When a person notified pursuant to subsection (1) is found to be infected by virtue of the certificate of a physician in charge of a provincial clinic or the named physician, as the case may be, or by virtue of the certificate of the person in charge of the laboratory where the tests were made, the Director or a physician in charge of a provincial clinic may by notice give directions to that person as to the course of conduct to be pursued by him in undergoing treatment for venereal disease.

(5) When it is intended to name a physician in a notice under this section, the Director shall consult that physician before doing so.

RSA 1970 c382 s9

Persons Required to Undergo Treatment

Detention for treatment

9(1) The Director or an officer of the Division authorized by the Director to do so may lay an information before a provincial judge stating that he has reason to believe that the person named therein is infected with venereal disease on any of the following grounds:

(a) that the person has failed to comply with a notice served on him under section 8(1) or (4);

(b) that the person has been found to be infected on the basis of a clinical examination or laboratory tests and has refused or neglected to submit to treatment or to continue treatment;

(c) that the person has been named in a statutory declaration as a probable source or contact of venereal disease;

(d) that in the opinion of the Director the clinical findings and history of the person indicate that he is or may be infected with venereal disease.

(2) On receiving the information the provincial judge shall hear and consider the allegations of the informant and if he considers it necessary or desirable the evidence of any witness, and if he is of the opinion that a case for so doing has been made out he shall issue his warrant to take the person named therein into custody and cause him to be taken to a place of detention and detained there

(a) for a clinical examination to determine whether he has venereal disease, and

(b) if he is found to be infected, for treatment for venereal disease until he is no longer infected.

(3) A person detained under subsection (2) shall be given a clinical examination forthwith on being so detained.

(4) The attending physician, immediately on completion of the clinical examination, shall issue and forward to a provincial judge a certificate stating that the person named therein either

(a) is infected with venereal disease, in which case he shall be detained for treatment until he is no longer infected,

(b) is not infected with venereal disease, in which case the provincial judge shall order his immediate release, or

(c) is not infected with venereal disease on the basis of the clinical examination only and without the result of laboratory tests being determined, in which case the provincial judge shall order his immediate release.

(5) When a provincial judge is in receipt of a certificate of a physician stating that a person detained for treatment under subsection (4)(a) is no longer infected with venereal disease, the provincial judge shall forthwith order the immediate release of that person.

RSA 1970 c382 s10

Warrant after laboratory tests

10(1) If a person is released pursuant to section 9(4)(c) and the laboratory tests subsequently show that the person is infected, a further information may be laid under section 9(1)(b) and if the provincial judge issues his warrant,

(a) no clinical examination is necessary, and

(b) on being detained in a place of detention, the person is deemed to be detained pursuant to section 9(4)(a).

(2) In any case to which subsection (1) refers, the provincial judge may refuse the information if the application is made later than 7 days after the results of the laboratory tests are known.

RSA 1970 c382 s11

Physician's certificate as evidence

11 In proceedings under section 9, the certificate of a physician stating that the person named therein is infected with venereal disease

is and shall be admitted in evidence as prima facie proof of that fact and that the person making it is a physician, without the necessity of proving the qualifications or signature of the physician making it.

RSA 1970 c382 s12(1)

Name of contact

12 When the ground or one of the grounds on which an information is laid under section 9 is that the person against whom the proceedings are taken has been named in a statutory declaration as a probable source or contact of venereal disease

(a) it is not necessary that the declaration be an exhibit to the information, and

(b) neither the person against whom the proceedings are taken, his counsel or agent is entitled in those proceedings, or in any proceedings in the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of proceedings under section 9, to inspect the declaration or ascertain the name of the declarant,

but the judge may request that the declaration be produced to him for examination as to its validity or sufficiency.

RSA 1970 c382 s12(2);1978 c51 s28

Examination of persons under arrest

13(1) When a person is under arrest or in custody and charged with a criminal offence, a jail physician may cause him to undergo a clinical examination to determine whether or not he is infected with venereal disease

(a) if that person is charged under any of the following provisions of the *Criminal Code* (Canada):

(i) paragraph 175(1)(d) by reason of living wholly or in part on the avails of prostitution;

(ii) subsection 193(1);

(iii) paragraph 193(2)(a) or (b);

(iv) subsection 195(1),

or

(b) in any other case, if the Director or the jail physician has reason to believe that the person is or may have been exposed to infection with venereal disease.

and may order that the person remain in custody until the clinical examination is completed.

(2) When a physician certifies that the person examined is infected, the infected person shall undergo medical treatment for venereal disease but only while he is in custody and if he is not otherwise entitled to be released.

RSA 1970 c382 c13;1978 c13 s29

Examination of convicted persons

14(1) When a person is in custody serving a sentence imposed on a conviction, a jail physician may cause him to undergo a clinical examination to determine whether or not he is infected with venereal disease and may order that the person remain in custody until the clinical examination is completed.

(2) When a physician certifies that a person in custody serving a sentence imposed on a conviction is infected

(a) the infected person shall undergo medical treatment for the disease and any action shall be taken that the jail physician considers advisable for his isolation and prevention of infection by him, and

(b) notwithstanding that he may otherwise be entitled to be released, he shall be detained in custody for treatment until he is no longer infected.

(3) When a physician is of the opinion that a person detained for treatment under this section is no longer infected with venereal disease, the physician shall forthwith issue a certificate to that effect and cause it to be delivered immediately to the jailer, director, superintendent, constable or officer having the care and custody of the person so detained.

(4) A certificate issued under subsection (3) is sufficient warrant and authority to the jailer, director, superintendent, constable or officer having the care and custody of that person to release him from custody if he is otherwise entitled to be released.

1965 c99 s14

Physician's certificates, orders

15(1) A certificate made under section 13(2) or 14(2) shall be based either on the clinical examination or on the results of laboratory tests.

(2) An order of a jail physician or a certificate of a physician under section 13 or 14 is sufficient warrant to the jailer, director, superintendent, constable or officer having the care and custody of the person so charged or convicted to detain that person until the clinical examination is completed and, in the case of a convicted person found to be infected, to carry out the provisions of section 14(2).

(3) An infected person required to undergo medical treatment under section 13 or 14 shall comply with all directions given by a jail physician as to treatment and every jailer, director, superintendent, constable and officer having the care and custody of an infected person shall see that the directions of the jail physician are carried out.

1965 c99 s15

Release from detention

16(1) In this section "person detained for treatment" means a per-

son detained in custody for treatment for venereal disease pursuant to

(a) section 9(4), or

(b) section 14(2) and who is otherwise entitled to be released.

(2) Notwithstanding anything in section 9 or 14, a provincial judge may, on application of which the Director has been given notice sufficient in the opinion of the provincial judge, order the release of a person detained for treatment on the conditions that the person

(a) attend for treatment at a specified provincial clinic or on a physician named in the order, and

(b) comply with the directions for treatment prescribed by the physician in charge of the provincial clinic or the named physician, as the case may be, until he is no longer infected with venereal disease.

(3) The Director or an officer of the Division authorized by the Director to do so may lay an information before a provincial judge stating that he has reason to believe that the person released pursuant to an order made under subsection (2) has failed to comply with a condition of the order.

(4) On receiving the information the provincial judge shall hear and consider the allegations of the informant and if he considers it necessary or desirable the evidence of any witness, and if he is of the opinion that a case for so doing has been made out, he shall issue his warrant to take the person named therein into custody and cause him to be taken to a place of detention and detained there for treatment until he is no longer infected with venereal disease.

(5) When a provincial judge is in receipt of a certificate of a physician that a person detained pursuant to subsection (4) is no longer infected with venereal disease, the provincial judge shall forthwith order the immediate release of that person.

(6) A person detained under subsection (4) is not precluded from making a further application for an order under subsection (2).

1965 c99 s16

General

Regulations

17 The Lieutenant Governor in Council may make regulations

(a) prescribing a schedule of fees payable to physicians for services performed in reporting, diagnosing or treating cases of venereal disease and for drugs, medicines or appliances supplied to their patients;

(b) authorizing the Minister to pay fees to physicians in ac-

cordance with the schedule prescribed under clause (a) and prescribing the terms and conditions on which the fees may be paid;

(c) prescribing the forms of informations, certificates, warrants and orders to be used for the purpose of this Act;

(d) generally, for the carrying out of the provisions of this Act and for the prevention, treatment and cure of venereal diseases.

1965 c99 s17

Powers of Minister

18 The Minister may

(a) establish and maintain one or more venereal disease clinics in Alberta to be operated by the Division,

(b) subject to the *Public Service Act*, appoint physicians to be in charge of or to conduct examinations or to carry out or supervise treatment of persons for venereal disease at provincial clinics, and

(c) provide for the free distribution to hospitals and other institutions of any drug, medicine or thing for the diagnosis, treatment or cure of venereal disease or the prevention of infection therefrom.

1965 c99 s18

Powers of Director

19 The Director may

(a) prescribe the form of reports and notices required or authorized to be given to or by the Director under this Act,

(b) appoint or engage physicians to conduct clinical examinations or perform or supervise the treatment for venereal disease of persons to whom notices are given under section 8, and persons released pursuant to section 16,

(c) provide for the distribution to physicians and hospitals of information as to the treatment and care of persons suffering from venereal disease, and

(d) provide for public advertising and placarding of information relating to the treatment and cure of venereal disease and the places where proper treatment can be obtained.

1965 c99 s19

Hospitals to provide accommodation

20(1) Every approved hospital within the meaning of the *Hospitals Act* shall provide accommodation satisfactory to the Director for those persons infected or suspected of being infected with venereal disease that are assigned to it.

(2) The treatment for those persons shall be carried out under the directions given by the Director.

(3) The Lieutenant Governor in Council may designate any hospital

or other public institution, any portion of any hospital or institution under its jurisdiction or any house or building as a place of detention for the purposes of this Act.

1965 c99 s20

Protection against action

21 No action, prosecution or other proceeding lies against any person by reason of the making by him of any certificate, report, notice, information, oral or written statement, statutory declaration, communication or record indicating directly or indirectly that any other person is or was or may be or may have been infected with venereal disease, if it is made in good faith and in the course of the administration of this Act or the regulations.

1965 c99 s21

Administration of Act

22 This Act shall be administered so as not to interfere with the course of justice in the case of a person under arrest or in custody prior to trial for a criminal offence except to the extent that it is necessary, for the purpose of this Act, to detain that person in custody until the clinical examination is completed.

1965 c99 s22

When proceedings in private

23(1) All proceedings

(a) under sections 9 and 16, or

(b) pertaining to applications to the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of any proceeding under section 9 or 16,

shall be conducted in private.

(2) In any proceedings

(a) pertaining to a prosecution for an offence against this Act or an appeal therefrom, or

(b) pertaining to applications to the Court of Queen's Bench for an order in the nature of a prerogative writ arising out of any prosecution for an offence against this Act, or an appeal from the granting or refusing of the order,

the court shall order that the whole or any part of the proceedings shall be held in private when is is shown to the court that the evidence to be given in the proceedings or part thereof will or is likely to indicate any person as being or having been infected with venereal disease and to reveal his identity and that the giving of that evidence in public will cause unnecessary hardship to the person in the circumstances.

(3) All records, transcripts and documents pertaining to any proceedings referred to in subsections (1) and (2) are confidential and shall not be made accessible for public inspection.

(4) No person shall make or publish a report or transcript of any

proceedings referred to in subsection (1) or (2) unless the report or transcript forms part of the reasons for judgment given by a judge, is contained in a publication devoted primarily to the reporting of judicial decisions and does not disclose the name of any person who in those proceedings was alleged or shown to be or to have been infected with venereal disease.

RSA 1970 c382 s23;1978 c51 s28

Secrecy of information

24(1) In the public interest, any file, record, document or paper kept by any person in any place

(a) that indicates in any way that any person is or was infected or is or was suspected of or alleged to be infected, and

(b) that came into existence through any thing done under or pursuant to this Act or its predecessors,

shall not, without the written consent of the Minister, be disclosed to any person except to a person to whom its disclosure is or was necessary in the course of the administration of this Act or its predecessors.

(2) A person who is or has been employed or engaged in the administration of this Act shall not disclose or be compelled to disclose any information obtained by him in the course of the performance of his duties under this Act

(a) except at a trial of an accused for an offence against this Act or in proceedings under section 9, and

(b) in any other case, except on the written consent of the Minister.

1965 c99 s24

Service of notice

25 Any notice permitted or required to be given under this Act may be given personally or by registered mail addressed to the addressee's last known address.

1965 c99 s25

Offences and Penalties

Treatment by unqualified person

26(1) No person other than a physician shall attend on or prescribe, recommend, supply or offer to supply to or for any person any drug, medicine, treatment or thing for the alleviation or cure of venereal disease.

(2) Subsection (1) does not apply to

(a) a registered pharmaceutical chemist who dispenses a physician's prescription, or

(b) a registered nurse who acts on the instructions of or under

the supervision of a physician.

1965 c99 s26

Offences

27 A person is guilty of an offence who

(a) fails to comply with section 2, 3, 4, 5 or 7, or a notice or direction given to him under section 8,

(b) without justification or excuse, publishes, discloses, exhibits or makes accessible to the public any report or document relating to proceedings required by this Act to be conducted in private or discloses any file, record, document, paper or information in contravention of section 24,

(c) contravenes section 26, or

(d) wilfully represents himself as bearing some other name than his own or makes any false statement as to his ordinary place of residence during the course of his treatment for venereal disease with the purpose of concealing his identity.

1965 c99 s27

Penalty

28 A person who is guilty of an offence under this Act is liable to a fine of not more than $200 and in default of payment to imprisonment for a term of not more than 90 days.

1965 c99 s28

Prosecution

29 No prosecution shall be taken against any person for an offence under this Act except with the consent of the Minister.

1965 c99 s29

Ontario

CHAPTER 521

Venereal Diseases Prevention Act

Interpretation

1. In this Act,

(*a*) "medical officer of health" means a medical officer of health appointed under the *Public Health Act*; R.S.O. 1980, c. 409

(*b*) "Minister" means the Minister of Health;

(*c*) "place of detention" means a hospital, sanatorium, correctional institution, lock-up, Ontario training school, or any place designated as a place of detention by the Lieutenant Governor in Council but does not include an isolation hospital for the care of communicable diseases, other than venereal disease, as defined by the *Public Health Act*;

(*d*) "physician" means a legally qualified medical practitioner;

(*e*) "prescribed" means prescribed by the regulations;

(*f*) "regulations" means the regulations made under this Act or the *Public Health Act*;

(*g*) "venereal disease" means syphilis, gonorrhoea, chancroid, granuloma inguinale or lymphogranuloma venereum. R.S.O. 1970, c. 479, s. 1; 1971, c. 33, s. 1.

Infected person to submit to treatment

2.—(1) Every person infected with venereal disease upon becoming aware or suspecting that he is so infected shall place himself forthwith under the care and treatment of a physician, and if unable to obtain such care or treatment he shall apply to the medical officer of health for the place in which he is ordinarily or temporarily resident.

Idem

(2) Every such person shall conduct himself in such a manner as not to expose other persons to the danger of infection, and shall take and continue treatment in a manner and to an extent considered to be adequate by the attending physician and the Minister. R.S.O. 1970, c. 479, s. 2.

Duty to report

3.—(1) It is the duty of,

(*a*) every physician;

(*b*) every superintendent or head of a hospital, sanatorium or laboratory; and

(*c*) every person in medical charge of any correctional institution, lock-up, training school, school or college or other similar institution,

to report within twenty-four hours every case of venereal disease coming under his diagnosis, treatment, care or charge for the first time to the medical officer of health in the locality in which such diagnosis, treatment, care or charge is made.

Method of reporting

(2) Every person required to report a case of venereal disease under subsection (1) shall make such report in writing, by telephone, or in person to the medical officer of health.

Report to Minister

(3) The report referred to in subsection (2) shall within one week of being received by the medical officer of health be forwarded in the prescribed form to the Minister. 1971, c. 33, s. 2.

Action of m.o.h. on reasonable belief

4.—(1) Where a medical officer of health has reasonable grounds for believing that a person within the municipality is or may be infected with venereal disease or has been exposed to infection, the medical officer of health may give notice in writing in the prescribed form to such person directing him to submit to an examination by a physician designated by or satisfactory to the medical officer of health, and to procure and produce to the medical officer of health within the time specified in the notice, a report or certificate of the physician that such person is or is not infected with venereal disease.

Offence

(2) Every person who without reasonable excuse, the proof of which is upon him, fails to comply with a direction made under subsection (1) is guilty of an offence and liable to imprisonment for a term of not less than seven days and not more than twelve months.

Powers of m.o.h. on report

(3) If by the report or certificate mentioned in subsection (1) it appears that the person so notified is infected with venereal disease, the medical officer of health may,

(*a*) deliver to such person directions in the prescribed form as to the course of conduct to be pursued

and may require such person to produce from time to time evidence satisfactory to the medical officer of health that he is undergoing adequate medical treatment and is in other respects carrying out such directions, and where such person fails to comply with the course of conduct prescribed for him or to produce the evidence required, the medical officer of health may exercise all the powers vested in him by clause (*b*) or may proceed under section 6; or

(*b*) with the approval of the Minister, order in writing that such person be removed and detained in a place of detention for the prescribed treatment until such time as the medical officer of health is satisfied that an adequate degree of treatment has been attained.

Duties of peace officer on order of m.o.h.

(4) Where a medical officer of health makes an order under clause (3) (*b*), he shall deliver the order to a peace officer who shall thereupon take the person named in the order into his custody and remove him to the place of detention named in the order, and the person for the time being in charge of the place of detention, upon receiving the order, shall receive such person and shall detain him until he is authorized by the medical officer of health to release him.

Where person certified within one year

(5) A medical officer of health may adopt the procedure or do any of the acts referred to in subsection (3) with regard to any person who has been examined by a physician at any time within one year previously and has been certified by such physician to be infected with syphilis.

More than one examination may be required

(6) A medical officer of health may require a person whom he believes may be infected with venereal disease to undergo more than one examination in order to determine the presence or absence of such infection. R.S.O. 1970, c. 479, s. 4.

Authority of M.O.H.

5.—(1) Where,

(*a*) any person has been named under oath as a source or contact of venereal disease or is believed by the medical officer of health to be a source or contact of such venereal disease; and

(*b*) in the opinion of the medical officer of health the clinical findings and history of such person

indicate that such person is or may be infected with venereal disease,

the medical officer of health may, whether or not laboratory findings indicate the presence of venereal disease, proceed in the manner prescribed in clauses 4 (3) (*a*) and (*b*). 1971, c. 33, s. 3.

Medical officer of health may take statement under oath

(2) For the purposes of subsection (1), a medical officer of health may administer an oath and take a statement under oath. R.S.O. 1970, c. 479, s. 5 (2).

Information or complaint

6.—(1) Any medical officer of health may make a complaint or lay an information in writing and under oath before a justice of the peace charging that the circumstances set out in clause (5) (*a*) or (*b*) exist with regard to any person named in such complaint or information.

Issue of summons

(2) Upon receiving any such complaint or information, the justice of the peace shall hear and consider the allegations of the complainant, and if he considers it desirable or necessary the evidence of any witness or witnesses, and if he is of the opinion that a case for so doing is made out he shall issue a summons directed to the person complained of requiring him to appear before a provincial judge at a time and place named therein.

Issue of warrant

(3) Where a person to whom a summons is directed does not appear at the time and place named therein or where it appears that a summons cannot be served, a provincial judge may issue a warrant directing that the person named in the summons be brought before him.

Provincial judge's inquiry

(4) Where a person appears or is brought before a provincial judge under this section, the judge shall inquire into the truth of the matters charged in the complaint or information and for such purpose shall proceed in the manner prescribed by the *Provincial Offences Act* and has the powers of a provincial judge holding a hearing under that Act.

R.S.O. 1980, c. 400

Order for detention

(5) Where a provincial judge finds that any person,

(*a*) is infected with a venereal disease and is unwilling or unable to conduct himself in such a manner as not to expose other persons to the danger of infection; or

(*b*) is infected with a venereal disease and refuses or neglects to take or continue treatment as required by this Act and the regulations,

he shall order that such person be admitted to and detained in a place of detention for such period not exceeding one year as the provincial judge may consider necessary.

Laboratory certificate *prima facie* evidence

(6) In any inquiry under this section, a certificate as to the result of any test made, signed or purporting to be signed by the director of a laboratory approved by the Minister is *prima facie* evidence of the facts stated therein and of the authority of the person giving such certificate without any proof of appointment or signature.

Extension of detention

(7) Any person detained under this section may, with the approval in writing of the Minister, be brought before a provincial judge at any time during the last thirty days of the period for which he is so detained, and if the judge finds that he is still infected with venereal disease and in need of further treatment, he may order that such person be further detained for such period not exceeding one year as the judge may consider necessary.

Discharge by Minister

(8) Where the Minister is of the opinion that any person detained under this section is no longer infected with venereal disease or has received an adequate degree of treatment, he may direct the discharge of such person. R.S.O. 1970, c. 479, s. 6.

Examination by physician in charge of institution

7.—(1) Where any physician in medical charge of any correctional institution, lock-up or training school, has reason to believe that any person under his charge may be infected with venereal disease or has been exposed to infection with venereal disease, he may, and if he is directed by the medical officer of health, he shall cause such person to undergo such examination as may be necessary to ascertain whether or not he is infected with venereal disease or to ascertain the extent of venereal disease infection and if the examination discloses that he is so infected the physician shall report the facts to the medical officer of health who may thereupon exercise the powers vested in him by section 9.

Duty of physician in charge of institution

(2) Where an examination has not been made under this section, every physician in medical charge of any correctional institution, lock-up, or training school, shall report to the medical officer of health the name and place of confinement of any person under his charge whom he suspects or believes to be infected with venereal disease

and the report shall be made within twenty-four hours after he suspects or believes such person to be so infected.

Duplicate report

(3) A copy or statement of every report made under this section shall be forwarded to the Minister and to the medical officer of health of the municipality in which such person resided before being admitted to such institution by the physician making the report. R.S.O. 1970, c. 479, s. 7.

Examination of person in custody or committed to prison

8. When a medical officer of health believes that any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, has been or may be infected or has been exposed to infection with venereal disease, he may cause such person to undergo such examination as may be necessary in order to ascertain whether or not such person is infected with venereal disease or to ascertain the extent of infection with venereal disease, and may direct that such person shall remain in custody until the results of the examination are known. R.S.O. 1970, c. 479, s. 8.

Treatment where disease found to exist

9. Where any person under arrest or in custody, whether awaiting trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder or serving the sentence of a court upon conviction of any such offence or contravention, is found to be infected with venereal disease, the medical officer of health may by order in writing direct that such person undergo treatment therefor and that such action be taken as the medical officer of health or the Minister may consider advisable for his isolation and the prevention of infection by him, and that he be detained in custody until cured or until he has received a degree of treatment considered adequate by the attending physician and the Minister notwithstanding that he may be otherwise entitled to be released, and any order made under this section is sufficient warrant to the person to whom the order is addressed to carry out the terms thereof. R.S.O. 1970, c. 479, s. 9.

Physician to report person refusing to continue treatment

10.—(1) Where a person who has been under treatment for venereal disease refuses or neglects to continue treatment in a manner and to a degree satisfactory to the attending physician and the Minister, the physician shall report to the Minister the name and address of such person together with such other information as may be required by the regulations.

Failure to attend within seven days

(2) A person who fails to attend upon his physician within seven days of an appointment for treatment shall be presumed to have neglected to continue treatment and the attending physician shall report such failure in writing to the Minister and the medical officer of health within fourteen days of the appointment.

Offence

(3) A physician who fails to report as required by this section is guilty of an offence and is liable to a fine of not less than $25 and not more than $100. R.S.O. 1970, c. 479, s. 10.

Supply of drugs, etc., by unqualified persons prohibited

11.—(1) No person other than a physician shall attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease for the purpose of the alleviation or cure of such disease.

Offence

(2) Every person who contravenes subsection (1) is guilty of an offence and is liable to a fine of not less than $100 and not more than $500 and in default of immediate payment shall be imprisoned for a term of not more than twelve months.

Exception as to pharmacist

R.S.O. 1980, c. 196

(3) Subsection (1) does not apply to a pharmacist licensed under Part VI of the *Health Disciplines Act* who dispenses to a patient of a physician upon a written prescription signed by such physician or who sells to any person any patent, proprietary or other medicine, drug or appliance approved by the regulations for the cure or alleviation of venereal disease, but no prescription shall be filled more than once except upon the written direction of the prescribing physician. R.S.O. 1970, c. 479, s. 11.

Offences

12.—(1) Every person who,

(*a*) wilfully neglects or disobeys any order or direction given by a medical officer of health or the Minister or Deputy Minister under this Act or the regulations;

(*b*) hinders, delays or obstructs any medical officer of health, peace officer or other person acting in the performance of his duties under this Act;

(*c*) publishes any proceedings taken under this Act or the regulations contrary to subsection (2);

(*d*) wilfully represents himself as bearing some other name than his own or makes any false statements as to his ordinary place of residence during the

course of his treatment for any venereal disease with the purpose of concealing his identity;

(e) during the course of his treatment for any venereal disease changes his place of residence without giving due notice of such proposed change with his new address to the attending physician; or

(f) fails to comply with any of the provisions of this Act or the regulations,

is guilty of an offence and, where no other penalty is prescribed, is liable to a fine of not less than $25 and not more than $100 and in default of immediate payment shall be imprisoned for a term of not more than three months.

Prosecutions R.S.O. 1980, c. 400

(2) The *Provincial Offences Act* applies to prosecutions under this Act or the regulations but all proceedings for the recovery of penalties under this Act and proceedings authorized by section 6 shall be conducted *in camera* and no person shall publish or disclose any such proceedings except under the authority of this Act or the regulations.

Summons by personal service

(3) Notwithstanding the provisions of the *Provincial Offences Act*, service of any summons issued for a contravention of this Act may be effected by personal service. R.S.O. 1970, c. 479, s. 12.

Statements as to existence of disease

13.—(1) Every person who publicly or privately, verbally or in writing, directly or indirectly, states or intimates that any other person has been notified or examined or otherwise dealt with under this Act, whether such statement or intimation is or is not true, is guilty of an offence, and in addition to any other penalty or liability, is liable to a fine of $200 and in default of immediate payment shall be imprisoned for a term of not more than six months.

Exceptions

(2) Subsection (1) does not apply,

(a) to a communication or disclosure made in good faith,

(i) to the Minister or Deputy Minister of Health,

(ii) to a medical officer of health for his information in carrying out the provisions of this Act,

(iii) to a physician,

(iv) in the course of consultation for treatment for venereal disease,

(v) to the superintendent or head of any place of detention;

(*b*) to any evidence given in any judicial proceedings of facts relevant to the issue; or

(*c*) to any communication authorized or required to be made by this Act or the regulations.

Information to family

(3) Notwithstanding subsection (1), a physician may give information concerning the patient to other members of the patient's family for the protection of health. R.S.O. 1970, c. 479, s. 13.

Obligation to observe secrecy

14. Every person engaged in the administration of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment and shall not communicate any such matter to any other person except in the performance of his duties under this Act or when instructed to do so by a medical officer of health or the Minister and in default he shall in addition to any other penalty forfeit his office or be dismissed from his employment. R.S.O. 1970, c. 479, s. 14.

Laboratory reports

15. No person shall issue or make available to any person other than a physician or such persons as are engaged in the administration of this Act any laboratory report either in whole or in part of an examination made to determine the presence or absence of venereal disease. R.S.O. 1970, c. 479, s. 15.

Hospitals to make provision for treatment, etc. R.S.O. 1980, c. 409

16. Every hospital receiving aid from the Province of Ontario, except isolation hospitals for the care of communicable diseases as defined by the *Public Health Act* shall make adequate provision for the reception, examination and treatment, upon such terms as may be prescribed, of such persons or classes of persons infected with venereal disease as may by this Act or the regulations be required or permitted to be treated at such hospital and in case of default the Treasurer of Ontario may withhold from any hospital the whole or any part of any grant or subsidy that would otherwise be payable. R.S.O. 1970, c. 479, s. 16.

Provision for treatment

17. The medical officer of health of each municipality shall make provision for the adequate treatment of all

persons infected with venereal disease within such municipality when such persons apply or are referred to him or when requested to do so by the Minister. R.S.O. 1970, c. 479, s. 17.

Payment of expenses by municipalities

18.—(1) The treasurer of the municipality shall forthwith upon demand, pay the amount of any account for services performed, materials or supplies furnished, or any expenditure incurred under the direction of the medical officer of health in carrying out the provisions of this Act and the regulations.

Secrecy as to name

(2) The name of any person infected or suspected to be infected with any venereal disease shall not appear on any account in connection with treatment therefor, but the case shall be designated by a number and it is the duty of every local board of health to see that secrecy is preserved.

Offence

(3) Every person who contravenes the provisions of subsection (2) is guilty of an offence and is liable to the penalties provided by sections 13 and 14. R.S.O. 1970, c. 479, s. 18.

Transfer to other municipality

19. Where any direction or order of a medical officer of health or provincial judge involves the transfer of a person infected with venereal disease from one municipality to another municipality,

(*a*) the medical officer of health of the second municipality shall, upon such transfer being effected and until the return of such person to the first municipality, exercise all the powers and perform all the duties conferred or imposed by this Act or the regulations upon a medical officer of health with respect to such person;

(*b*) the liability of the first municipality under section 18 shall extend to any account for services performed, materials or supplies furnished, or any expenditure incurred in respect of such person under the direction of the medical officer of health for the second municipality in carrying out the provisions of this Act and the regulations; and

(*c*) a duplicate original of every written report made by the person in medical charge of a place of detention in which such person is placed in the second municipality to the medical officer of health

thereof shall be sent forthwith to the medical officer of health of the first municipality. R.S.O. 1970, c. 479, s. 19.

Places of detention, maintenance, conduct

20. Where a person is admitted to a place of detention under this Act, whether such admission is voluntary or under the order of a provincial judge or medical officer of health,

(*a*) subject to the regulations, the provisions of law relating to the liability for and payment of maintenance of patients, inmates or pupils in such place of detention apply; and

(*b*) such person is subject to all rules, regulations, and provisions of law governing the conduct of patients, inmates or pupils of such place of detention. R.S.O. 1970, c. 479, s. 20.

Consent of persons 16 or over to treatment

21.—(1) The consent only of any person of the age of sixteen years or over to being examined or treated or both for venereal disease shall be deemed to be sufficient consent for such purposes and where such consent is given no action or other proceeding lies against a physician for acting upon such consent.

Under 16

(2) No action or other proceeding lies against a physician for acting upon a consent given by a person under sixteen years of age to be examined or treated or both for venereal disease if the physician had no reason to believe that the person giving the consent was under sixteen years of age. 1971, c. 33, s. 4.

Where person infected is under 16 years of age

22. Where any person infected or believed to be infected with venereal disease is a child under the age of sixteen years, all notices, directions or orders required or authorized by this Act or by the regulations to be given in respect of the child shall be given to the father or mother or to the person having the custody of the child for the time being and it is the duty of the father, mother or other person to see that the child complies in every respect with every such notice, order or direction and in default thereof the father, mother or other person, as the case may be, is liable to the penalties provided by this Act or the regulations for non-compliance with any such notice, direction or order unless on any prosecution in that behalf it is proven to the satisfaction of the court that the father, mother or other person did everything in his power to cause the child to comply therewith. R.S.O. 1970, c. 479, s. 21.

Grants

23. The Minister may make grants out of such moneys as may be appropriated by the Legislature for the purpose,

(*a*) for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the hospitalization, maintenance, treatment and special treatment of persons infected or suspected of being infected with venereal disease in addition to or in lieu of any other moneys that may be payable for such purposes; and

(*b*) so as to reimburse municipalities for expenses incurred by such municipalities in supplying treatment to persons infected or suspected of being infected with venereal disease,

in such amounts, at such times and upon such conditions as may be prescribed by the regulations. R.S.O. 1970, c. 479, s. 22.

Regulations

24.—(1) The Lieutenant Governor in Council may make regulations,

(*a*) prescribing the method and extent of the examination of any person for the purpose of ascertaining whether or not such person is infected with venereal disease or the extent of the infection;

(*b*) prescribing the course of conduct to be pursued by any person infected with venereal disease in order to effect a cure and to prevent the infection of other persons;

(*c*) prescribing the hospitals that shall furnish treatment to persons or any classes of persons infected with venereal disease;

(*d*) prescribing rules for the treatment of persons infected with venereal disease in hospitals, places of detention and other places;

(*e*) for preventing the spread of infection from persons suffering from venereal disease;

(*f*) for distributing to physicians and hospitals information as to the treatment, diet and care of persons infected with venereal disease and requiring physicians and hospitals to distribute the information to such persons;

(g) providing for the approval by the Minister of methods and remedies for the treatment, alleviation and cure of venereal disease;

(h) providing for the display of notices and placards dealing with venereal disease, its cause, manifestation, treatment and cure;

(i) prescribing the forms of notices, certificates and reports required or authorized to be given or issued under this Act;

(j) requiring every physician to furnish reports with respect to the condition and treatment of persons infected with venereal disease who are or who have been under his diagnosis, treatment, care or charge;

(k) prescribing the procedure to be followed and the evidence required in case of an appeal to the Minister from any action or decision of a medical officer of health under this Act;

(l) approving patent, proprietary or other medicines, drugs or appliances for the cure or alleviation of venereal disease;

(m) providing for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the treatment of persons infected or suspected of being infected with venereal disease;

(n) requiring the approval of the Minister to the appointment of legally qualified medical practitioners, nurses and other technical staff employed in clinics for the treatment of venereal disease;

(o) prescribing the amounts of, the times at which and the conditions upon which grants may be made for the establishment, equipment, operation and maintenance of clinics for the treatment of venereal disease and for the hospitalization, maintenance, treatment and special treatment of persons infected or suspected of being infected with venereal disease and for reimbursing municipalities for expenses incurred by such municipalities in supplying treatment to persons infected or suspected of being infected with venereal disease;

(p) prescribing fees that shall be paid under this Act;

(q) prescribing the mode of sending or giving any notice, report or direction required or permitted to be sent or given by this Act or the regulations;

(r) generally for the better carrying out of the provisions of this Act and for the prevention, treatment and cure of venereal disease.

Expenses of free distribution

(2) The Minister may, out of any moneys appropriated by the Legislature for the purposes of this Act, provide for the payment of the expenses incurred in carrying out this Act and the regulations including the manufacture and free distribution to local boards of health, physicians and hospitals of any drug, medicine, appliance or instrument that the Minister may consider useful or necessary for the alleviation, treatment or cure of venereal disease or the prevention of infection therewith. R.S.O. 1970, c. 479, s. 23.

Appeal to Minister

25.—(1) Every person who considers himself aggrieved by any action or decision of a medical officer of health under this Act may appeal therefrom to the Minister by giving notice in writing to the Minister and to the medical officer of health.

Evidence on appeal

(2) The Minister may require the appellant to furnish such information and evidence and to submit to such examination as may be prescribed or as the Minister may consider necessary to determine the matter in dispute.

Decision final

(3) The decision of the Minister is final. R.S.O. 1970, c. 479, s. 24.

Actions

26. No action or other proceeding shall be brought against any physician in respect of any examination or certificate given or required to be given by him under this Act, without the consent in writing of the Minister. R.S.O. 1970, c. 479, s. 25.

Right of entry

27. The medical officer of health or a physician designated by him in writing for the purpose may enter in and upon any house, outhouse or premises in the day time for the purpose of making inquiry and examination with respect to the state of the health of any person therein and may cause any person found therein who is infected with any venereal disease to be removed to a place of detention or may give such directions as may prevent other persons in the same house, outhouse or premises from being infected. R.S.O. 1970, c. 479, s. 26.

Powers of Deputy Minister

28. The Deputy Minister of Health and any officer of the Ministry designated by the Minister are medical officers of health for Ontario within the meaning of this Act. R.S.O. 1970, c. 479, s. 27; 1972, c. 1, s. 1.

Delegation of powers

29. The Minister may delegate to the Deputy Minister of Health or any other officer of the Ministry of Health any of the powers vested in him under this Act or the regulations. R.S.O. 1970, c. 479, s. 28; 1972, c. 1, s. 1.

Administration of Act not to interfere with course of justice

30. The administration of this Act and the regulations shall not interfere with the course of justice in the case of any person under arrest or in custody previous to trial for any offence under or contravention of any statute of Canada or of the Legislature or any regulation, by-law or order made thereunder, but where it is necessary for the purpose of any examination authorized or required by this Act, such person may be held in custody until the results of the examination are known. R.S.O. 1970, c. 479, s. 29.

Appendice II

A Survey of STD Clinics in Canada

Canada Diseases Weekly Report

Rapport hebdomadaire des maladies au Canada

ISSN 0382-232X

Date of publication: September 25, 1982
Date de publication: 25 septembre 1982

Vol. 8-39

CONTAINED IN THIS ISSUE:

CONTENU DU PRÉSENT NUMÉRO:

A SURVEY OF SEXUALLY TRANSMITTED DISEASE CLINICS IN CANADA

Introduction: During the summer of 1982, a preliminary investigation of the facilities, personnel, and services provided in Canada's sexually transmitted disease (STD) clinics was undertaken. It was hoped that the compilation of a national list of STD clinics with an examination of their facilities would open the lines of communication between the clinics and provide data for a national overview.

A questionnaire was sent to each of the 94 STD clinics located across the country and the results are based on the analysis of data from 73 completed questionnaires.

RESULTS

Public utilization: Per capita utilization of the clinics varied from 1/32 in the Yukon to 1/2854 in New Brunswick (this clinic will cease to operate soon because of low utilization). The actual number of patients seen per clinic in 1981 ranged from 20 to 23 688. The number of visits (which included follow-up visits) by patients ranged from 20 at a clinic in British Columbia to 24 901 at one in Alberta. An average of 92% of the patients attending STD clinics were heterosexual. Homosexual attendance varied widely, ranging from less than 0.5% to 80% per clinic. The average proportion of female patients (37%) was lower than that for male patients (63%).

Public accessibility: Public accessibility depends not only on location but also on the availability of public transit, parking facilities, and hours of operation. The clinics were housed in various types of buildings. Fifty-two percent (52%) were located in health unit offices, 32% in hospital complexes, 6% in primary health care clinics, and 10% in other types of buildings. The main floor of these buildings was the location for 59% of the clinics. Only 33% were specifically identified as "VD Clinic" or "STD Clinic". Thirty-four percent (34%) of the clinics did not have free parking although 92% were easily accessible by public transit. Approximately 38% operated 5 days a week for an average of 5 hours a day. While evening and weekend hours would increase accessibility for clients working full-time, most of the clinics operated primarily during the day. However, 36% did have evening hours and 3% operated during the weekend. Of those clinics with evening hours, 73% were open for less than 5 hours per week during the evening. The range of operating hours varied from 1.5 hours per week in an Ontario clinic to 88 hours per week in one in Manitoba.

ÉTUDE SUR LES CLINIQUES DE MALADIES TRANSMISES SEXUELLEMENT AU CANADA

Introduction: Au cours de l'été 1982, on a entrepris, au Canada, une étude préliminaire sur les locaux, le personnel et les services des cliniques de maladies transmises sexuellement (MTS). En compilant une liste nationale des cliniques MTS et en examinant leurs locaux, on espérait ouvrir la communication entre les cliniques et fournir des données permettant d'obtenir un aperçu de la situation à l'échelle nationale.

Un questionnaire a été envoyé à chacune des 94 cliniques MTS dispersées dans tout le Canada. Les résultats reposent sur l'analyse des données recueillies dans les 73 questionnaires remplis.

RÉSULTATS

Fréquentation: La fréquentation des cliniques par habitant varie de 1/32 au Yukon à 1/2854 au Nouveau-Brunswick (cette dernière fermera d'ailleurs bientôt ses portes pour cause de faible fréquentation). En 1981, le nombre réel de patients par clinique allait de 20 à 23 688. Le nombre de visites par patient (y compris les visites de post observation) allait de 20, pour une clinique de Colombie-Britannique, à 24 901, pour une clinique d'Alberta. Une moyenne de 92% des patients ayant recours aux cliniques MTS étaient hétérosexuels. La fréquentation par les homosexuels variait énormément, soit de 0,5% à 80% par clinique. La proportion des femmes (37%) était, en moyenne, plus faible que celles des hommes (63%).

Accessibilité: L'accessibilité dépend non seulement du lieu, mais aussi de la disponibilité des services de transport en commun, des espaces de stationnement et des heures d'ouverture. Les cliniques se trouvent dans divers endroits: 52%, dans des bureaux d'unités sanitaires; 32%, dans des ensembles hospitaliers; 6%, dans des centres de soins primaires et 10%, dans d'autres types d'installations. En tout, 59% sont installées au rez-de-chaussée. Les appellations précises "Clinique MV" ou "Clinique MTS" ne désignent que 33% des cliniques. Trente-quatre pourcent (34%) n'offrent pas de stationnement gratuit; cependant, 92% sont d'accès facile par transport en commun. Environ 38% sont ouvertes 5 jours par semaine, en moyenne 5 heures par jour. Bien que des heures d'ouverture en soirée et en fin de semaine permettraient à ceux qui travaillent à plein temps de s'y rendre plus facilement, la plupart des cliniques n'ouvrent que pendant la journée. Toutefois, 36% reçoivent des patients en soirée et 3%, en fin de semaine. Parmi les cliniques ouvertes le soir, 73% ne le sont que pendant moins de 5 heures par semaine. Les heures d'ouverture par semaine varient entre 1,5 heure, dans une clinique de l'Ontario et 88 heures, dans une du Manitoba.

Funding: Most of the clinics (90%) had funding from their provincial governments while 8% were solely or additionally funded by local health units and 2% by a different source. Approximately 22% of the clinics had a second source of funding.

Personnel: Fourteen percent (14%) of the clinics, located in Quebec, Ontario, Saskatchewan and British Columbia, had only 1 staff member and 68% had no more than 5. Physicians were classified according to their training: 38% were family physicians, 28% listed a specialty in STD, 13% had another specialty, and 10% were Medical Officers of Health. Twenty-nine percent (29%) of the clinics, 67% of which are situated in British Columbia, had no physician on staff.

Nurses accounted for 49% of the time worked by all personnel in all of the clinics. On average, nurses spent 29% of their time on contact tracing; however, this time ranged from 0% to 80%.

Only 11% of the clinics, the majority of which were located in Ontario, had laboratory technicians.

Automated data handling: Only 1 of the clinics had a computerized filing system and only 2 of the respective health units had a computerized reporting system for STDs.

Diagnostic procedures: The percentage of STD clinics capable of carrying out specific laboratory procedures is presented in Table 1. The majority (42-68%) utilized the standard laboratory procedures, with the exception of the rapid plasma reagin test for syphilis; only 19% of the clinics used this procedure.

Financement: La plupart des cliniques (90%) sont subventionnées par leur gouvernement provincial, tandis que 8% sont financées entièrement ou partiellement par des unités sanitaires locales et que 2% ont d'autres sources de financement. Environ 22% reçoivent des fonds d'une deuxième source.

Personnel: Au Québec, en Ontario, en Saskatchewan et en Colombie-Britannique, le personnel se compose d'un seul (1) membre dans 14% des cliniques et d'un maximum de 5 dans 68% des cas. Les médecins ont été classés selon leur formation: 38% sont médecins de famille; 28% se sont inscrits comme spécialistes dans un domaine des MTS, 13% dans une autre branche et 10% sont médecins-hygiénistes. Dans 29% des cliniques, dont 67% en Colombie-Britannique, aucun médecin ne fait partie du personnel.

Les heures de travail des infirmières et des infirmiers représentent 49% du temps total consacré au travail par le personnel de toutes les cliniques. En moyenne, les infirmières et les infirmiers passent 29% de leur temps au dépistage des sujets contacts; le pourcentage varie toutefois de 0 à 80%.

Seulement 11% des cliniques, pour la plupart en Ontario, ont des techniciens de laboratoire parmi leur personnel.

Traitement de données automatisé: Une seule (1) clinique possède un système de fichiers informatisé et 2 des unités sanitaires concernées, un système informatisé de déclaration des MTS.

Méthodes diagnostiques: Le Tableau 1 donne le pourcentage des cliniques MTS effectuant des analyses de laboratoire précises. La majorité (42-68%) se servent des méthodes standard, exception faite du test rapide de réagine sur plasma pour déceler la syphilis qui ne se pratique que dans 19% des cliniques.

Table 1 - Percentage of STD Clinics Using Laboratory Procedures
Tableau 1 - Pourcentage des cliniques MTS se servant de méthodes d'analyse précises

Laboratory Procedure/ Méthode de laboratoire	Clinics Using Laboratory Procedure/ Cliniques se servant de la méthode d'analyse	
	Number/ Nombre	Percentage/ Pourcentage
Gram stain (**Neisseria gonorrhoeae**)/ coloration de Gram (Neisseria gonorrhoeae)	43	59% a)
darkfield exam (syphilis)/ examen à l'ultramicroscope (syphilis)	32	44%
wet mount (**Trichomonas vaginalis**)/ préparation humide (**Trichomonas vaginalis**)	39	53%
wet mount (**Candida albicans**)/ préparation humide (**Candida albicans**)	31	42%
rapid plasma reagin test/ test rapide de réagine sur plasma	14	19%
transport medium (for **N. gonorrhoeae**)/ milieu de transport (pour **N. gonorrhoeae**)	50	68%
direct media inoculation (for **N. gonorrhoeae**)/ inoculation directe des milieux (pour **N. gonorrhoeae**)	35	48%

a) includes 2 clinics who used methylene blue stain for **N. gonorrhoeae**/
comprend 2 cliniques qui se servent de la coloration au bleu de méthylène pour **N. gonorrhoeae**

The majority of the laboratory procedures for culturing organisms, serology and virology were available to the clinics in their own building or locality. Sixty-one percent (61%) of the hospital STD clinics were able to obtain the necessary services in the same building, a percentage considerably higher than for those in other locations.

Facilities for culturing **Chlamydia trachomatis** were reportedly available to the clinics in all provinces except British Columbia and Newfoundland.

Les cliniques peuvent faire faire la majorité des tests de laboratoire (cultures, sérologie et virologie) dans l'immeuble ou dans la localité où elles se trouvent. Quant aux cliniques MTS logées dans un hôpital, 61% d'entre elles peuvent faire effectuer les tests nécessaires dans l'immeuble même, soit un pourcentage considérablement plus élevé que pour celles situées ailleurs.

Selon les rapports, toutes les cliniques ont à leur disposition les installations nécessaires pour cultiver **Chlamydia trachomatis**, sauf celles établies en Colombie-Britannique et à Terre-Neuve.

Patient examinations: In 99% of the clinics where personnel took intraurethral specimens from male patients, 67% used cotton wool swabs, 44%, calcium alginate swabs, and 10%, bacteriologic loops.

Although 93% of the clinics reported that visualization of the cervix in female patients was routinely done, bimanual pelvic examinations were routinely performed in only 53%. Ninety-seven percent (97%) had suitable examining tables. When taking specimens from women for **N. gonorrhoeae**, cultures were taken sometimes or always from the vagina in 67% of the clinics, from the cervix in 67%, from the endocervix in 78%, from the urethra in 75%, from the anus in 84%, and from the pharynx in 92%.

Suggestions and comments: Of the 56 clinics who suggested possible improvements to their services, 29% listed a need for more current STD literature, 53% for the establishment or improvement of facilities, 5% for better record-keeping systems, and 11% for more convenient clinic hours. The most urgent need for 27% of the clinics was a microscope.

Acknowledgement: The cooperation and assistance of the participating STD clinics was greatly appreciated.

SOURCE: R Kung, N Olsen, L Pisko, AG Jessamine, MB, ChB, Bureau of Epidemiology, LCDC, Ottawa.

Comment: The geographic disparities described above indicate that Canada still has a long way to go to achieve a "standardized" system of STD diagnosis and treatment. The variations in per capita utilization merit further investigation. Most Canadian STD clinics prefer to operate under a cloak of anonymity. Perhaps they should attempt to "attract" clients. Their variation in location and hours of operation is as expected. As to whether clinics should be open during the evening or on the weekend is debatable. Nevertheless, clinics which operate for 1 or 2 hours a week serve no useful purpose.

The percentage of clinic physicians claiming a "specialty" in STD is interesting, particularly as there is no formal postgraduate STD training program in Canada. Nurses carry out most of the basic clinic work. It is disturbing that a significant number of clinics have no physician on staff, and only a few clinics include the services of a laboratory technician. The lack of essential laboratory equipment in "third world" laboratories is commonplace, but one does not expect to see a similar situation in Canada. Hence the finding that 27% of the clinics had an "urgent" need for a microscope needs investigation. The number of clinics that actively "pursued" the **Chlamydia trachomatis** organism should also be determined.

The results of the survey are both stimulating and encouraging and indicate some useful avenues for future STD research in Canada. The findings should also encourage the various clinics to open their lines of communication with each other.

In general, the results suggest that the infrastructure of many Canadian STD clinics could be improved. Hopefully, the professionals involved with the administration and day-to-day running of these clinics will pay heed to the survey findings.

The excellent response to the questionnaire is a testimony to the enthusiasm of the clinic personnel.

SOURCE: Alan S Meltzer, MB, ChB, Dip Venereology, Associate Director, Health Sciences Division, International Development Research Centre, Ottawa, Ontario.

Examens médicaux: Dans 99% des cliniques où le personnel prélève des échantillons intra-urétraux chez les patients masculins, 67% se servent d'écouvillons de coton hydrophile; 44%, d'écouvillons d'alginate de calcium et 10%, d'anses bactériologiques.

Bien que 93% des cliniques aient déclaré que la visualisation du col chez les patientes était un examen de routine, seulement 53% ont déclaré pratiquer de façon courante un examen pelvien bimanuel. Quatre-vingt-dix-sept pourcent (97%) possèdent des tables d'examen appropriées. Pour isoler **N. gonorrhoeae** chez les femmes, 67% des cliniques prélèvent parfois ou toujours des cultures du vagin; 67%, du col; 78% de l'endocervix; 75%, de l'urètre; 84% de l'anus et 92% du pharynx.

Suggestions et commentaires: Parmi les 56 cliniques qui ont proposé des moyens pour améliorer leurs services, 29% mentionnaient le besoin d'une documentation pertinente à jour; 53%, la création de nouvelles installations ou l'amélioration des locaux; 5%, de meilleurs systèmes de tenue des dossiers et 11%, des heures d'ouvertures plus appropriées. Se procurer un microscope est, pour 27% des cliniques, d'une importance primordiale.

Remerciements: Nous tenons à remercier les cliniques MTS qui ont répondu au questionnaire.

SOURCE: R Kung, N Olsen, L Pisko, AG Jessamine, BM, BCh, Bureau d'épidémiologie, LLCM, Ottawa.

Commentaires: Les disparités géographiques décrites ci-dessus démontrent que le Canada a encore beaucoup de chemin à faire avant d'en arriver à un système "normalisé" de diagnostic et de traitement des MTS. Les variations quant à la fréquentation par habitant méritent d'être étudiées plus à fond. La plupart des cliniques MTS au Canada ont choisi de fonctionner sous le couvert de l'anonymat; elles devraient peut-être essayer "d'attirer" la clientèle. La diversité qui existe entre l'emplacement des cliniques et leurs heures d'ouverture n'a rien d'étonnant. L'opportunité d'ouvrir des cliniques en soirée ou en fin de semaine est toutefois discutable. Néanmoins, celles qui n'ouvrent que pendant 1 heure ou 2 par semaine ne sont d'aucune utilité.

Le fait qu'un pourcentage de médecins travaillant dans ces cliniques ait déclaré avoir une "spécialisation" en MTS est particulièrement intéressant, étant donné qu'il n'existe au Canada aucun programme d'études supérieures dans ce domaine. Ce sont les infirmières et les infirmiers qui se chargent de la plus grande partie du travail de base. Il est inquiétant de constater qu'un nombre important de cliniques ne compte pas de médecin parmi leur personnel et que seules quelques cliniques ont un technicien de laboratoire. L'absence d'équipement essentiel dans les laboratoires du "tiers monde" est chose courante, mais on ne s'attend pas à rencontrer une telle situation au Canada. Le fait que 27% des cliniques avaient un besoin "pressant" de microscope mérite donc qu'on s'y attarde. Il faudrait aussi déterminer le nombre de cliniques qui "recherchaient" activement le microorganisme **Chlamydia trachomatis.**

Les résultats de l'étude sont à la fois stimulants et encourageants; ils mettent aussi en évidence les points qui devraient, à l'avenir, faire l'objet de recherches sur les MTS au Canada. Les conclusions de cette étude devraient également inciter les diverses cliniques à communiquer entre elles.

Dans l'ensemble, les résultats suggèrent qu'il y aurait lieu d'améliorer l'infrastructure de beaucoup de cliniques MTS au pays. Il est à souhaiter que les spécialistes chargés de la gestion et du fonctionnement quotidien de ces cliniques y verront.

L'excellente réponse au questionnaire témoigne de l'enthousiasme du personnel des cliniques.

SOURCE: Alan S Meltzer, BM, BCh, Vénéréologue, Directeur-adjoint, Division des sciences de la santé, Centre de recherche et de développement international, Ottawa (Ontario).