

at the funeral parlour. At the end of the week, the body was flown back to Rinpoche's monastery in India where the appropriate rituals and cremation were performed. There was considerable distress at the monastery at the incisions on the body and the manner in which it had been handled before the necessary rituals had been performed.

The right to religious freedom

Article 18 of the Universal Declaration of Human Rights provides that:

Everyone has a right to the freedom of thought, conscience and religion; this right includes freedom to change his [sic] religion or belief and freedom either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship or observance.

However, the Australian Constitution and Australian law do not provide a right to freedom of religion or cultural practices. Buddhism is the fastest growing religion in Australia, partly due to the high level of Asian immigration to Australia and partly because of the high number of Australian converts to Buddhism. In particular, many seriously ill patients, for example living with cancer or HIV/AIDS, practise Buddhism in anticipation of imminent death.

Buddhists are not the only cultural or spiritual group to have been critical of coronial laws. Jewish and Muslim communities have also been vocal about the inability of these laws to respect their beliefs and practices at the time of death.

The events surrounding Rinpoche's death in Canberra led to an immediate review of the *Coroner's Act* in the ACT. An Issues Paper was released in 1994 and an Exposure Draft of the proposed amendment Bill was issued in late 1995. The Exposure Draft recommends the introduction of a requirement that the Coroner consider

the desirability of minimising distress or offence to persons who, by reason of their cultural attitudes or spiritual beliefs, could reasonably be expected to be distressed or offended.

Under the draft proposal, the Coroner would be required to consider requests from the immediate family or other relevant information before making a decision. In addition, the immediate family would receive special rights, such as the right to view the body.

These proposed recommendations are problematic because they seek to expand the Coroner's discretion without guaranteeing a right to die according to one's cultural or spiritual beliefs. Ideally, the Coroner, coronial staff and the police should be made aware of the different cultural and spiritual practices around dying and be obliged to support such practices whenever possible. In addition, special rights to view the body and make requests to the Coroner should not merely rest with the immediate family'. These should be extended to partners, including *de facto* and same sex partners, and spiritual teachers and members of a spiritual community.

It seems strange that a diversely multicultural nation such as Australia has so far failed to address this area of cultural and spiritual rights. The unfortunate circumstances surrounding Rinpoche's death in November 1993 could have happened in any State or Territory — all have similar provisions to the ACT. The new Federal Human Rights Commissioner, Chris Sidoti, has indicated that the Human Rights and Equal Opportunity Commission will investigate this issue.² However, any such review must have the co-operation of the

States and Territories and their will to amend their coronial laws to respect a right to freedom of religion.

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DISCRIMINATION

Should people's rights die with them?

JULIA CABASSI describes a Federal Court decision as a blow to the effectiveness of federal discrimination remedies.

The Federal Court handed down a decision on 15 December 1995 which significantly undermines the effectiveness of federal anti-discrimination laws. The Court decided that a discrimination case, lodged with the Human Rights and Equal Opportunity Commission (HREOC), cannot proceed because the complainant died before the case was heard.

Alyschia Dibble lodged a discrimination complaint in November 1994 because she was denied the right to participate in an HIV drug trial and alleged that the decision constituted sex discrimination. Ms Dibble died before her complaint, under the *Sex Discrimination Act 1984* (Cth) was finalised by HREOC. The complaint was continued by the executor of Ms Dibble's estate. In April 1995, HREOC terminated the complaint because of the death of the complainant. The executor of Ms Dibble's estate appealed the decision to the Federal Court, but the Federal Court dismissed the appeal.

The Executor of Ms Dibble's estate has lodged an appeal to the Full Court of the Federal Court. The appeal is to be heard in May 1996.

The Federal Court's decision has far reaching implications because all federal anti-discrimination laws, the *Racial Discrimination Act 1975* (Cth), *Sex Discrimination Act* and *Disability Discrimination Act 1992* (Cth) are silent on whether an estate can continue a discrimination complaint.

While the decision is a blow to the effectiveness of federal discrimination remedies generally, it has particular significance for the rights of HIV positive people. It is common for HIV discrimination complaints to arise at a time when the complainant is ill, for example getting access to superannuation entitlements. If the complainant dies, then this decision means that the complaint cannot be continued by the complainant's estate. Given the delays so often a feature of discrimination complaints, what will stop superannuation companies from sitting on their hands and waiting for HIV-positive people to die? It is not hard to imagine numerous other scenarios under federal anti-discrimination legislation which will result in injustices where complaints terminate on

death. The unfairness that will result from this decision cannot be underestimated.

The result flies in the face of the purpose of anti-discrimination legislation. The fact that the complainant dies before the complaint is heard should not mean that those responsible for discriminatory conduct get off scot-free. Community organisations have responded quickly to alert people to the problems that will result from the decision and to ensure the consequences are addressed. In a joint media release the Australian Federation of AIDS Organisations (AFAO), National Association of People Living with HIV/AIDS (NAPWA) and solicitors for Ms Dibble's estate, Inner City Legal Centre, have called on the Federal Government to amend all federal anti-discrimination legislation.

AFAO, NAPWA and the Combined Community Legal Centres Group of NSW intend to involve other non-government organisations, whose communities will be affected by the decision in a broad-based campaign to lobby the Government. Solicitors for the estate of Ms Dibble are currently considering the merit of an appeal to the Full Court of the Federal Court.

It is a particular disappointment for HIV-positive women that Ms Dibble's complaint has not been heard by HREOC. Ms Dibble's case was one of great significance as it was set to test the issue of HIV-positive women's access, or lack thereof, to clinical drug trials, an issue long on the agenda for HIV-positive women.

Alys Dibble had lodged a discrimination complaint because she was denied the right to participate in an HIV drug trial, solely on the grounds of her child bearing capacity. Ms Dibble sought to participate in the stage one trial of a protease inhibitor, developed by Abbott Laboratories. The trial was conducted by St Vincent's Hospital. Clinical drug trials are conducted in accordance with clinical trial protocols provided by the drug manufacturer. The relevant clinical trial protocol in Ms Dibble's case includes patient selection criteria, study procedures, and methods of data analysis.

Interestingly, the protocol for the trial sets out *inclusion* criteria, so called, providing for very limited access by women. The protocol states that a female must *not* be able to bear a child for at least one of the following reasons:

- she has been post-menopausal for at least one year
- she has had a hysterectomy, or
- she has had a tubal ligation followed by a negative pregnancy test.

Ms Dibble was 49 years of age at the time the tests were undertaken to determine her eligibility for the trial and was not post-menopausal at that stage. In early June 1994 she was advised that she was ineligible for the trial on the basis of the protocol.

Ms Dibble died in March 1995, before learning of the outcome of her complaint to the HREOC under the *Sex Discrimination Act*.

Ms Dibble instructed that there was no risk of pregnancy as she had not engaged in sexual activity with men for many years and identified as a lesbian. She also advised that she was willing to have a tubal ligation to ensure no risk of pregnancy in order to have access to the trial and made this known to those conducting the trial.

Women's lack of access to drug trials generally and the implications of this are not new issues. In 1990, *Time* magazine reported concerns about the lack of women-specific data

and flagged the significance of this in the context of HIV/AIDS.¹ Andrew Purvis reported that 'medical testing done entirely on male subjects may be adequate when a disease strikes women and men in the same way, but a growing body of research shows that this is often not the case'. He went on to examine the implications of women's exclusion from HIV drug trials elucidating the central issue of concern:

At a time when women are the fastest growing group affected by AIDS, there is troubling uncertainty about whether treatments or the disease itself are affecting women differently from men. Some studies for example, have suggested that women with the virus die more quickly than men, and from a somewhat different range of opportunistic infections.

Strict inclusion criteria for women are not uncommon in clinical trial protocols. The question is, why are the protocols so strict regarding the inclusion of women in drug trials? Unfortunately the answer is often that drug companies do not want to risk the possibility of legal action against them. The fact a woman has provided her informed consent to the risk involved in participation in a drug trial, as all participants are required to do, would not prohibit a child born with birth defects as a result of the mother's use of the drug, from suing the drug manufacturer. In application of the protocols, there is often no consideration of whether the *potential* to become pregnant is a real one, and what means can be adopted to ensure that a woman can participate in the trial.

Generally speaking the inclusiveness of HIV drug protocols for women in Australia has improved in recent years, but the Abbott example shows how it is still possible for one company to be significantly out of step with what is considered reasonable and responsible. The responsibility for ensuring equitable access for men and women has fallen to community representatives on ethics committees. Ms Dibble's case could make drug companies responsible for complying with anti-discrimination laws in Australia.

The implications of this situation are twofold. First, women are often unable to access new HIV treatment options and second, HIV drugs are often not being tested on women, and accordingly little material is available as to the specific effects of such drugs on women.

There have been considerable advances in the issue of women's access to drug trials in the USA and these developments shed light on the need for Australia to be wary of accepting very restrictive trial protocols being applied here. The Food and Drug Administration (FDA) published new guidelines for the enrolment of women in clinical trials in the USA in 1993. In revising the 1977 policy that had excluded women of child bearing potential from the early stages of drug trials, the FDA stated:

In order to fully evaluate the potential for gender differences in drug effects, FDA urges that women of all ages be studied, including early in drug development. There is no longer any restriction on the enrolment of women of child bearing potential in even the earliest phase of clinical trials . . . The new guidelines call for appropriate measures for minimising the risk of foetal exposure, such as pregnancy testing, contraception and provision of full information about potential foetal risks.²

The rationale for the change to FDA's guidelines was to ensure that there is adequate assessment of the impact of drugs on women. The move to amend the guidelines was a response to the fact that the 1977 policy was paternalistic because it denied women the right to make decisions on the risks they wish to take.

The trend in the USA in recent years has also emphasised the need to target a cross-section of the HIV community in all drug trial research. It is unlikely that such a cross-section of participants is possible while the criteria for inclusion remain restrictive and drug companies continue to offer trials on the basis of such protocols.

AFAO's current position on trials is to argue:

for increased access to trials for women, to address the dearth of gender-specific data by actively moving towards the collection of women-specific data in all trials; and

that 'child bearing capacity' should not be a valid criterion for participation in any trial.³

This is essential to AFAO's view that the demography of drug trial profiles should reflect the demographic of epidemic and that the National Health and Medical Research Council should develop a policy to ensure that this occurs.⁴

The net effect of restrictive inclusion criteria is that women are often ineligible for participation in HIV drug trials. While there have been developments in increasing compassionate access to drugs in the trial stage, compassionate access is not a substitution for inclusion in drug trials.⁵ Compassionate access may enable HIV-positive women to access drugs being trialled, but will not result in inclusion in trial data and therefore does not ensure an assessment of the impact of new drugs for women.

While the appeal to the Full Court of the Federal Court is pending, it remains to be seen whether this case will proceed to test the waters on whether the protocol in Ms Dibble's case contravenes the *Sex Discrimination Act*. The case raises issues of public importance. It is imperative for HIV drug testing to investigate the impact of new drugs on women and to ensure that HIV-positive women have equal capacity, alongside HIV-positive men, to access new treatments at the experimental stage.

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INTERNATIONAL LAW

Women and war

KARYN ANDERSON and HELEN DURHAM discuss sexual assault and rape of women in wartime.

The history of war betrays the regularity with which rape and sexual assault are used as physical and psychological weapons. During times of armed conflict, women's bodies are violated for numerous reasons: as prizes and spoils of war; in the destruction of the enemy's 'property' and pride; under

orders and without orders; as revenge; and sometimes mere opportunism.¹ Waging war is about gaining territory. The raping of women is a very effective and cheap way to dispose of citizens by spreading fear and humiliation and making people flee from their homes and land. Time and again women's bodies are used as a battle-field — in East Timor, Afghanistan, Cambodia, Vietnam, Burma, China, Rwanda, Bangladesh, during World Wars I and II and during the more recent conflict in the former Yugoslavia.

Even after the conflicts are over, women's experiences of war are often not recognised or acknowledged. Drive through any small country town in Australia and you will see tall rows of poplar trees and stone monuments to fallen soldiers, their names chiselled with family pride. These memorials can be found throughout most countries in the world in some form or another. A woman does not get a medal if she is raped, or a stone monument for dying of dysentery. Women's experiences of war do not translate into thrilling fire-side stories, action packed movies or exciting novels. More than mundane, many of the events which happen to women during war are silencing, particularly rape.

This 'silencing process' is evident in the lack of prosecutions of rape as a war crime, despite the numerous instruments of international legislation and documentation deeming rape and sexual assault to be unacceptable behaviour.² In the Nuremberg trials no defendant was charged with 'rape' despite the presentation of sexual assault as evidence of crimes against humanity.³ During the Tokyo trials a limited number of officers were prosecuted for sexual assault under Articles of the Charter dealing with 'inhumane treatment', not as an offence of itself. While there are scattered examples of domestic war crimes trials trying soldiers for sexual assault offences,⁴ there is no clear, practical international legal precedent that rape is an internationally recognised war crime. The current *ad hoc* tribunals for Rwanda and the former Yugoslavia are the first opportunity in many years to clarify international humanitarian law in relation to the illegality of rape and sexual assault. If rape is not clearly defined as a war crime by these tribunals, especially in the case of the former Yugoslavia following significant media attention on the atrocities of the 'rape camps', how will women in East Timor and other nations convince authorities that what they have suffered is a war crime and not an 'inevitable consequence' of armed conflict that may go unpunished?

Yet despite the possibilities of clarifying the law, there are technical difficulties in the drafting of the Statute for the International Tribunal Established to Prosecute Persons Responsible for Serious Violations of International Humanitarian Law in territory of the former Yugoslavia since 1991 (the Yugoslavia Tribunal). There is no mention of rape under Article 3 which defines 'war crimes'. Nor are rape or sexual assault listed under Article 2 dealing with 'grave breaches' of the Geneva Conventions. The list of crimes under Article 2 is not exhaustive and there is much debate about whether rape should be deemed a 'grave breach' or whether non-grave breaches such as Article 27 of the Geneva Convention could be included.⁵ However, this is an issue of interpretation that will be left to the discretion of the Tribunal's judges and there is no international legal precedent that rape should be deemed a 'grave breach' rather than a mere breach of the Convention.

The only place that rape is specifically mentioned in the Statute is under Article 5(g) as a 'crime against humanity'. The evidence necessary to prove a crime against humanity is