NON-DISCLOSURE OF HIV STATUS TO INTIMATE SEXUAL PARTNERS:

ETHICAL AND MEDICO-LEGAL ISSUES

Dr Benny Mashegoanyane Choeu

Student no 17093296

Submitted in partial fulfilment of the degree

MPhil (Medical Law and Ethics)

Faculty of Law

University of Pretoria

Supervisor:

Professor Annelize Nienaber

December 2018

TABLE OF CONTENTS

ABSTRACT

The non-disclosure of HIV status to an intimate sexual partner creates an ethical dilemma in terms of the healthcare practitioner's duty to respect the patient's autonomy (right to privacy and confidentiality) and the duty to promote public health (duty to inform individuals of possible health risks). The study seeks to asses if non-disclosure creates legal liability on the part of the non-disclosing partner and ethical and medico-legal liability for the healthcare professional involved (if the sexual partner is known).

This is a descriptive desk-top study, analysing 14 studies with a study population of 7428 participants in respect of the extent of non-disclosure of HIV status to sexual partners. The overall rate of non-disclosure is a range of 15 to 49 per cent.

This study concludes that disclosure by a health worker of a patient's HIV status to a sexual partner is unjustified, except in the case of a clear intent by the patient to transmit HIV. It recommends that, in these circumstances, ethical and legal liability should not attach to the non-disclosing partner or to the healthcare provider.

CHAPTER 1: INTRODUCTION

1.1 Introduction

According to the World Health Organisation's (WHO) 2016 country profile, South Africa has a population of 50.6 million, of which 7.1 million people are estimated to be living with the Human Immune Deficiency Virus (HIV). The adult (15-49 age group) prevalence rate is estimated to be a staggering 18.9%.[1] Statistics South Africa's 2017 midterm estimates reflect a similar result; an overall prevalence rate of approximately 12.6% (7.06 million) and an 18% adult prevalence rate.[2] These figures indicate that HIV is a major problem in South Africa. Despite good progress (3.9 million people on treatment by the end of 2016 as per WHO's 2016 country profile) in the roll-out of antiretroviral treatment, the stigma that attaches to the disease remains a major issue.

It is argued that despite the high prevalence rate of HIV and the global challenge this pandemic poses, a person's HIV status should remain a private affair. The primary basis for the argument rests on the way in which the disease is generally transmitted and the lack of a cure. Particularly in the case of Southern Africa a majority of HIV transmissions occur sexually. A Le Roux-Kemp states: 'HIV is a condition related to sex, death and disease- topics that alludes to the most existential aspects of life and are therefore perceived as highly intimate.'[3]

Public health experts at the 2001 Health Summit agreed that HIV and Acquired Immune Deficiency Syndrome (AIDS) should not be notifiable conditions. The purposes in defining a disease as being notifiable are actively to control its dispersion and to identify potential contacts or people at risk of contracting the disease from the source patient so as to offer them treatment and/ or protection. In many countries, including South Africa, HIV infection and AIDS are not classified as notifiable conditions.

Generally, patient autonomy and confidentiality are regarded as the cornerstones of the doctor-patient relationship. In South Africa this concept is governed by the Constitution,

[1] Global AIDS monitoring (UNAIDS/WHO) and WHO HIV Country Intelligence Tool, 2007, (accessed 1 July 2018).
[2] Stats SA *Statistical release P0302: Mid-year population estimates, 2017* 1.
[3] A Le Roux-Kemp *'HIV/Aids, to disclose or not to disclose: That is the question'* (2013)(16) *PER/PELJ* 1.

1996, legislation, by case law and ethical rules. The Constitution, 1996 guarantees the right to privacy in section 14 and the right to dignity (autonomy) in section 10.[4] Section 14 of the National Health Act 61 of 2003 (NHA) declares 'all information concerning a user, including information relating to his/her health status, treatment or stays in a health establishment, is confidential'.[5] The Health Profession's Council of South Africa's (HPCSA) ethical rules state 'the health care practitioner should use his or her discretion when deciding whether or not to divulge the information to the patient's sexual partner, taking into account the possible risk of HIV infection to the sexual partner and the risks to the patient (e.g. through violence) that may follow such disclosure. The decision must be made with great care, and consideration must be given to the rights of all the parties concerned. If the health care practitioner decides to make the disclosure against the patient's wishes, the practitioner must do so after explaining the situation to the patient and accepting full responsibility at all times.'[6]

In South Africa HIV is mainly sexually transmitted and for a long time it was regarded as a life-sentence. For these reasons, coupled with the stigma attached to the condition, disclosure of their HIV status is likely to cause difficulties for some patients. *Ciccarone et al* remark: 'It is difficult to identify a more charged issue in AIDS prevention than that of disclosure of positive HIV status to sexual partners'.[7]

Stigma and discrimination have a significant effect on the lives of people living with HIV. It is a documented fact that on an on-going basis people living with HIV and AIDS experience stigma and discrimination. The fear of discrimination is a hindrance to disclosure of status even to potentially important or significant individuals such as intimate partners, and limits the possibility of certain safer sexual practices being used. The fear of discrimination arises in part because a common reaction to disclosure is rejection,

[4] The Constitution of the Republic of South Africa, 1996.
[5] National Health Act 61 of 2003.
[6] HPCSA *Ethical guidelines for good clinical practice with regard to HIV, Booklet 6*.
[7] DH Ciccarone *et al* 'Sex without disclosure of positive HIV serostatus in a US probability sample of persons receiving medical care for HIV infection' (2003) *Am J Public Health* 950.

leaving the person living with HIV alone.[8] It is against this background that issues of non-disclosure to intimate sexual partners must be analysed.

Non-disclosure of HIV status to an intimate sexual partner/s creates an ethical dilemma with regard to the healthcare practitioner's duty to respect the patient's autonomy (right to privacy and confidentiality) and the duty to promote public health (duty to inform individuals of possible health risks).

This study, therefore, seeks to ascertain the extent of the problem of non-disclosure of HIV status to intimate sexual partners and also to investigate the effect of non-disclosure on treatment outcomes. Further, the study explores the ethical and medico-legal implications of non-disclosure in respect of both the patient and the treating healthcare professional.

1.2 The study problem

The study is aimed at:

1) Assessing whether the non-disclosure of a person's HIV status to an intimate sexual partner creates a situation of criminal/legal liability for the non- disclosing partner.

2) Assessing whether a failure by a healthcare professional to disclose a patient's HIV status to an intimate sexual partner(when the partner is known to the healthcare professional) establishes ethical and medico-legal liability on the part of the healthcare professional and or the institution as represented by the provincial Department of Health.

1.3 Methodology

This is a descriptive desk-top study, which analyses studies on the subject of disclosure/non-disclosure of HIV status to intimate sexual partners in the era of widespread use of HIV-treatment in the form of highly effective anti-retroviral therapy

[8] S Maman *et al* (2001) *HIV and partner violence: Implications for HIV Voluntary Counseling and Testing Programmes in Dar es Salaam, Tanzania* 10.

(HART). The rationale for selecting studies in which patients were on HART is based on the belief that the use of HART has transformed HIV from a fatal disease to a manageable chronic disease. The assumption is that the widespread uptake of HART will lessen the stigma associated with a HIV-positive diagnosis and, hence, will promote the probability of disclosure of status to others, especially intimate sexual partners.

The study includes a literature review of studies on patients' reasons for disclosure or non-disclosure that have been reported in medical, ethics and medico-legal journals.

The criteria employed for a study to form part of this pool are as follows:

1) It must have obtained research ethics approval.

2) Patients studied must have been diagnosed with HIV for at least 12 months.

3) Patients studied must have had an intimate sexual partner(s) for at least 3 months.

1.4 Study objectives

The objectives of the study are as follows:

1) To ascertain the rate of HIV status disclosure by patients to sexual intimate partners in the studies assessed;

2) To discover patients' reasons for disclosing/non-disclosure;

3) To ascertain if non-disclosure affects the treatment outcome as measured by changes to sexual behaviour and/or viral suppression;

4) To assess the potential legal liability of the non-disclosing patient;

5) To assess the ethical and medico-legal obligations of treating healthcare workers to patients and their partners;

6) To evaluate the intimate balancing of the right to privacy of patients against the right of intimate sexual partners to be informed.

7) To perform an in-depth literature review on the topic of non-disclosure of HIV status to intimate sexual partners.

In Chapter 2, then, the scientific background information to HIV and HIV transmission is provided.

CHAPTER 2: BACKGROUND INFORMATION ABOUT HIV

1. Introduction

HIV was first identified (isolated) in 1981. HIV belongs to the genus Lentivirus of the family Retriviridae and has been classified into two types:[9]

1. HIV type 1, responsible for the global epidemic.
2. HIV type 2, less pathogenic than HIV type 1 and largely restricted to West Africa, with limited spread to other regions.

Research found that HIV is related to SIV (Simian Immunodeficiency Virus) and there are many similarities between the two viruses. HIV-1 is closely related to a strain of SIV found in chimpanzees, and HIV-2 is closely related to a strain of SIV found in sooty mangabeys.[10] The researchers who discovered this connection concluded that it proved chimpanzees were the source of HIV-1 and that at some point the virus crossed species from chimpanzees to humans.

The mature virus is spherical in structure with a diameter of 80-100 nanometers, with an outer lipid bilayer that is host in origin. Embedded in the lipid bilayer is the surface glycoprotein (gp 124) and transmembrane protein (gp 41) (see figure 1 below). The virus contains two identical pieces of viral RNA, and viral enzymes are located within the virions, including reverse transcriptase, protease and intergrase.

HIV enters cells via interaction between the HIV envelope glycoproteins and cellular receptors. HIV uses different receptors, primarily CD4 cells and chemokine receptors, to infect many cell types distributed across the body, both in lymphoid and non-lymphoid tissue. The receptors govern which cells HIV will infect, and are known to play an important role in HIV transmission and subsequent disease progression.

[9] D Wilson *et al* (2005) *Handbook of HIV medicine* 15.
[10] PM Sharp *et al 'Origins of HIV and the AIDS* pandemic' (2011) 1 *Cold Spring Harbour Perspectives in Medicine* a006841.

HIV primarily infects and destroys cells in the immune system, particularly CD4 (helper) T-lymphocytes, causing profound immune suppression that gradually develops over a period of years and ultimately renders the patient vulnerable to opportunistic infections

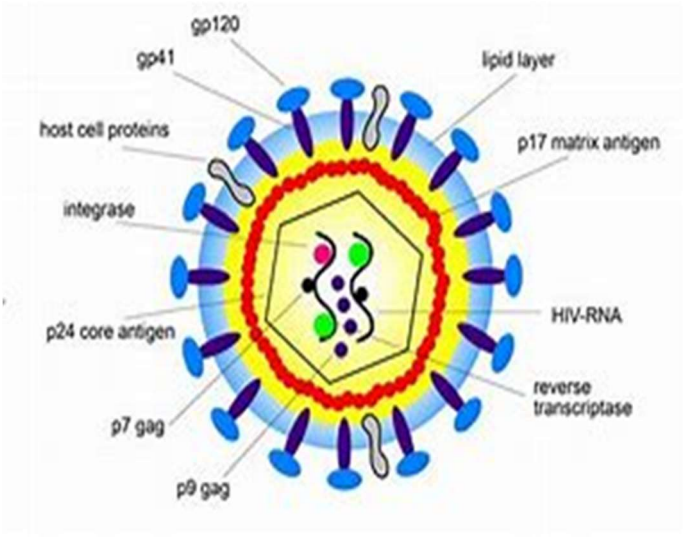
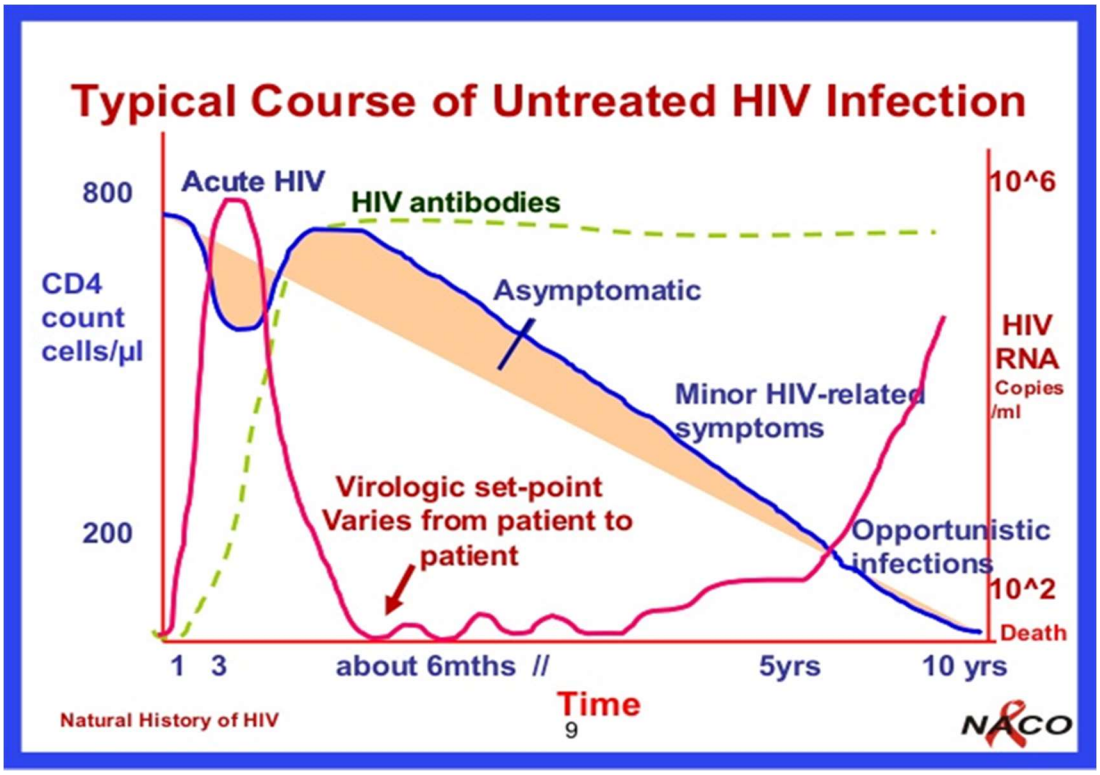


Figure 1: Structure of HIV[11]



[11] Adapted from Hiv.com (accessed 31 July 2018).

Figure 2: Natural history of untreated HIV[12]

and malignancy and resulting in a condition called Acquired Immune Deficiency Syndrome (AIDS). The rate of viral replication directly relates to the rate at which the immune system is destroyed (see figure 2 above). In addition to the immune system, HIV also infects nerve, renal, and bone marrow cells with important clinical consequences.[13]

On HIV infection a vigorous immune response occurs to provide cellular and humoral immunity. In the majority of patients the system cannot contain the on-going viral replication, which results in the ultimate collapse of the immune system and death unless there has been effective therapeutic intervention.[14]

About half of individuals infected with HIV experience a non-specific viral illness resembling flu-like symptoms, which develops between one and six weeks after infection. This condition is also called seroconversion illness and is characterized by the following symptoms: Fever; sweats; malaise; myalgia; pharyngitis; gastrointestinal disturbances; headaches; generalized lymphadenopathy; and hepatosplenomegally.[15]

The remaining half of individuals infected is asymptomatic throughout this stage until the immune response has weakened sufficiently to allow proliferation of opportunistic diseases and malignancy.[16] The rate of viral replication relates directly to the rate at which the immune system is destroyed. And the majority of patients remain asymptomatic for a period up to 10 years (see figure 2 above).[17]

HIV can be transmitted from one individual to the other through contact with blood or blood products, semen, vaginal secretions, breast milk and other body fluids containing blood. And in sub-Saharan Africa the majority of individuals infected with HIV acquired the infection heterosexually.[18] Hence the key to an effective strategy to reduce HIV

[12] AC Fauci *et al* (1996) *Typical course of HIV infection in Humans* available from www.*researchgate.net* (accessed 3 June 2018).
[13] D Wilson *et al* (2005) *Handbook of HIV medicine* 48.
[14] As above, 26.
[15] As above, 50.
[16] As above, 49.
[17] As above, 50.
[18] As above, 61.

transmission in this region is safer sexual practices, in particular the following: abstinence, commitment to one partner, use of male and female condoms.[19] In most contexts antibody tests are the mode of choice to make an accurate diagnosis of HIV infection.[20]

There is a significant body of data which shows that suppression of HIV replication through Anti-Retroviral Therapy (ART) allows host immunity to return to a more normal state. Life-long use of ART also has been advocated as a strategy for the prevention of the transmission of HIV.[21]

A South African study which employed a mathematical model to examine the impact and cost-effectiveness of different strategies, including earlier initiation of ART and/or PrEP (pre-exposure prophylaxis) for HIV-1 prevention for serodiscordant couples, showed that strategic use of PrEP and ART substantially and cost-effectively could reduce HIV-1 transmission in HIV-1 serodiscordant couples, especially among couples with multiple partners, low condom use and a high risk of transmission.[22]

The TEMPRANO trial, conducted in Western Africa and presented at the annual Conference on Retroviruses and Opportunistic Infections (CROI) 2015, showed that a combined approach to immediate ART and oral PrEP (Pre Exposure prophylaxis) was 96% effective in preventing HIV infection among serodiscordant couples. As a result of the above findings, the WHO reports 'the science related to the use of ART as an additional prevention tool is clear', and that 'there is no evidence that individuals who have successfully achieved and maintained viral suppression through ART transmit the virus sexually to their HIV-negative partner(s)'.[23]

---

[19] As above, 62.
[20] As above, 38.
[21] As above, *33*.
[22] TB Hallett *et al 'Optimal Uses of Antiretroviral for Prevention in HIV-1 Serodiscordant Heterosexual Couples in South Africa: A modeling study'* (2011) *PLOSMedicine* available at https://doi.org/10.1371/journal.pmed.1001123 (accessed 31 July 2018).
[23] J Del Romero *et al* '*Combined antiretroviral treatment and heterosexual transmission of HIV-1: Cross sectional and prospective cohort study'* (2010*)* 340 *BMJ* c2205.

As a consequence of the scientific evidence above now it is widely accepted that a HIV positive patient adherent on life-long ART poses little if any risk of sexually transmitting the virus to a HIV negative partner.

2. Stigma and violence

Major focuses for identifying discrimination have been on race, gender, sexual orientation, handicap, religion and age, among others. The attachment of discrimination to illness has a long history, and has had an impact on people with mental illness, as well as physical disorders such as cancer, tuberculosis, sexually transmitted disease and leprosy.[24]

In society stigma plays a major role in creating "difference" and social hierarchy, which, in turn, legitimize and perpetuate social inequality. At a national level there are many examples of discrimination introduced by socially-conservative governments, including policies which restrict admission, the deportation of foreigners and the mandatory testing of those seeking work permits or tourist visas.[25] For example, Cuba restricts those with HIV to sanatoria.[26]

South Africa reports a large number of incidents of stigma. These include the murder of Gugu Dlamini in December 1998 for openly stating that she was HIV-positive, and the murders of Mpho Motloung and her mother by her husband after she disclosed her HIV status.[27]

3. HIV exceptionalism

HIV "exceptionalism" is the term given to the trend to treat HIV and AIDS in law and policy differently from other diseases, including other sexually transmitted, infectious, or lethal diseases. The term first appeared in print in an article in the *New England Journal of*

[24] D Skinner and S Mfecane 'Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa' (2004) 1 *Journal of Social Aspects of HIV/AIDS* 157.
[25] P Aggleton *et al* (1989) *AIDS: social representations, social practices* 38.
[26] H Hansen & N Groce 'From quarantine to condoms: Shifting policies and problems of HIV control in Cuba' (2001) 19 *Medical Anthropology* 259-292.
[27] A Baleta (1999) 'Widespread horror over killing of AIDS activist in South Africa' (1999) *Lancet* 130.

Medicine in 1991.[28] HIV exceptionalists emphasise the human rights of people living with HIV/AIDS, particularly their rights to privacy, confidentiality, and autonomy. HIV exceptionalists believe that despite advances in HIV-disease treatment, compelling evidence indicates a social stigma is associated with HIV/AIDS that continues to cause frequent discrimination against and rejection of people with HIV/AIDS.[29]

The opponents of this notion argue that as treatment regimens evolve and the understanding of the pandemic and awareness of HIV/AIDS stigma and discrimination increases, there is a need for an end to be put on HIV exceptionalism. They aver that HIV exceptionalism in testing increases the bureaucratic burden, reduces the level of availability of HIV-testing and stigmatises it as something "special" rather than a normal part of healthcare. The strongest argument against AIDS exceptionalism centres on the claim that responses undermine health systems in developing countries.[30]

Roger England declares that HIV and AIDS are not the "global catastrophe[s]" claimed by "AIDS exceptionalists", and that donor aid for HIV and AIDS has been disproportionate to the contribution of HIV and AIDS to the global disease burden. Rodger England asserts that it would have been more cost effective to put the money into bed nets, immunization and dealing with childhood diseases. He accuses The Joint United Nations Programme on HIV/AIDS (UNAIDS) of creating 'the biggest vertical programme in history', which diverted human resources from the public sector, created additional reporting requirements and poorly coordinated donor activities for governments to cope with, and removed national control over spending priorities.[31]

Rodger England writes:

> '[i]t is no longer heresy to point out that far too much is spent on HIV relative to other needs and that this is damaging health systems. Although HIV causes 3.7 percent of mortality, it receives 25 percent of international healthcare aid and a big chunk of domestic

[28] GM Oppenheimer & R Bayer 'The Rise and fall of AIDS Exceptionalism' *Virtual Mentor* 11 (12) 988 – 992, available at https://journalofethics.ama-assn.org/article/rise-and-fall-aids-exceptionalism/2009-12 (accessed 30 August 2018).
[29] RM Veatch (1997) *Medical Ethics* 399.
[30] JH Smith *et al* 'The history of AIDS exceptionalism' (2010) 13 *J Int AIDS Soc* 47.
[31] R England 'Writing is on the wall for UNAIDS' (2008) 13 *British Medical Journal* 1072.

expenditure ... Until we put HIV in its place, countries will not get the delivery systems they need.'[32]

[32] As above.

CHAPTER 3: ANALYSIS OF DATA GATHERED

1. Introduction

14 studies with population sizes ranging from 63 to 2954 and a total study population of 8293 subjects were analysed. In studies in which being sexually active was not necessarily an entry criteria, data was analysed of only a sexually active subgroup, resulting in a qualifying study population of 7428 subjects (see table 1 on the next page). In assessing these studies and subsequent data, I have not differentiated between partners engaging in heterosexual activities and those that engage in homosexual activities (men having sex with men). The range of the overall percentage of non-disclosure to intimate sexual partners is 15 to 49. The study did not differentiate disclosure rates among males and females. The results are similar to those reported in studies with more diverse samples which report percentage rates of 13 to 41.[33]

The reasons of non-disclosure mentioned in some studies include the following (in no order of frequency):

1. Privacy;
2. Self-blame;
3. Fear of rejection;
4. Fear of emotional abuse;
5. Fear of divorce/abandonment;
6. Protecting the other partner;
7. Fear of domestic violence; and
8. Fear of accusation of infidelity.

Domestic violence and fear of possible death clearly are of a serious nature. I decided on that basis to undertake further research on the subject of domestic violence. The fear or potential fear of domestic violence and ultimately death certainly is a serious impediment in encouraging HIV-positive patients to disclose their status to their sexual partners.

[33] ME O'Brien *et al* 'Prevalence and correlates of HIV serostatus disclosure' (2003) 30 *Sex Transm Dis* 734.

STUDY NAME	STUDY POPULATION	**% NON-DISCLOSURE**
1. Self-disclosure of HIV to sexual partners after repeated counselling. **SW Perry *et al*: (1994) 6 *AIDS Education and Prevention* 403 - 411.**	129	30
2. Determinants of non-disclosure of HIV status among women attending the prevention of mother-to-child transmission programme, Makonde district, Zimbabwe, 2009. **P Mucheto *et al*: (2011) 8 *Pan African Medical Journal* 51.**	334	43
3. Disclosure of HIV status to sex partners among HIV-infected men and women in Cape Town, South Africa. **VU Lung: (2012) 16 *AIDS and Behavior* 132-138.**	630	20
4. Prevalence and correlates of HIV serostatus disclosure. **ME O'Brien *et al*: (2003) 30 *Sexually transmitted diseases* 731-735.**	269	25.8
5. Processes and outcomes of HIV serostatus disclosure to sexual partners among people living with HIV in Uganda. **R King *et al*: (2008) 12 *AIDS Behavior* 232-43.**	1092 (459 sexually active)	31
6. Disclosure of HIV status to sexual partners: Predictors and temporal patterns. **LM Niccolai *et al*: (1999) 26 *Sexually transmitted diseases* 281-285.**	229 (147 sexually active)	24
7. Disclosure of HIV status and psychological well-being among Latino gay and bisexual man. **MC Zea *et al*: (2005) 9 *AIDS and Behavior* 15-26.**	301	22

8. Non-disclosure of a pregnant women's HIV status to her partner is associated with non-optimal prevention of mother-to-child transmission. **C Jasserone *et al*: (2013) 17 *AIDS and Behavior* 488 - 497.**	2952	15
9. Sexual ethics: Disclosure of HIV positive status to partner. **MD Stein (1998) 158 *Arch of intl med* 253 - 257.**	203 (129 sexually active)	40
10. Factors associated with non-disclosure of HIV infection status of new mothers in Bangkok. **N Skunodom *et al*: (2006) 37 *Southeast Asian J of Trop Med and Publ Health* 690 - 703.**	647	22.6
11. Self-disclosure of HIV infection to sexual partners **G Marks *et al*: (1991) *Am J of Publ Health* 1321–1322.**	138 (62 sexually active)	48
12. Disclosure of HIV Serostatus to Sex Partners: A New Approach to measurement. **LM Niccolai et al: (2006) 33 *Sexually Trans Disease*s 102 - 105.**	63	24
13. Disclosure of HIV status to sex partners and sexual risk behaviors among HIV-infected men and women in Cape Town, South Africa. **LC Simbayi *et al*: (2007) 83 *Sexually Trans Infections* 29 – 34.**	903	42
14. Factors associated with disclosure of HIV serostatus to sexual partners of patients receiving HIV care in kabale, Uganda. **MO Osinde *et al*: (2012) 118 *Intern'l J of Gynaecology & Obstetrics* 61 – 64.**	403	49

Table 1

2. Domestic violence

A further analysis of the literature in order to quantify and better appreciate the threat or presence of domestic violence revealed the following results (among others). A study by Karen Rothenberg reports that each year in the United States of America (USA) approximately three to four million women are physically abused by male partners. Pregnant women are particularly vulnerable to physical violence, which may include blows to the abdomen and injuries to the breasts and genitals.[34] In 2017/18 a total of 2930 women were murdered in South Africa and a total of 50 108 sexual offences were recorded by the police.[35] Household surveys by the South African Medical Research Council (MRC) found that 40% of men have hit their partners and one in four men has raped a woman.[36]

Research demonstrates a correlation between domestic violence and the use of illicit drugs by women or their partners.[37] Many women first learn they are HIV positive during peri-natal care, and intravenous drug use by women or their partners represents a significant risk of HIV infection and domestic violence.[38]

On the basis of these findings the conclusion has been reached that the problem of domestic violence is most likely to be higher among women infected with HIV as compared to non-infected women. In 17 studies from peer-reviewed journals and international conference abstracts - 15 from sub-Saharan Africa and 2 from south-east Asia - between 3.5 and 14.6% of women reported experiencing a violent reaction from a partner following disclosure of HIV status.[39]

---

[34] KH Rothenberg *et al* 'Domestic violence and partner notification: Implications for treatment and counseling of women with HIV' (1995) 50 *J Am Med Women Assoc* 87-93.
[35] Africa Check 'FACTSHEET: South Africa's crime statistics for 2017/18' 11 September 2018.
[36] The South African College of Applied Psychology 'The growing epidemic of domestic violence in South Africa' 20 July 2018, available from https://www.sacap.edu.za/blog/counselling/domestic-violence-south-africa/ (accessed 31 October 2018).
[37] H Amaro *et al* 'Violence during pregnancy and substance abuse' (1990) 80 *A J Publ Health* 575- 579.
[38] Centre for disease control and Prevention *HIV/AIDS Surveillance report.*
[39] A Medley *et al* 'Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes' (2004) 82 *Bull World Health Org* 299-307.

These statistics are indeed alarming.

CHAPTER 4: LITERATURE REVIEW

1. Introduction

The review employs a multi-layered approach which considers the Constitution, 1996, legislation, case law, common law, medical ethics and review articles on the subject.

2. The Constitution, 1996

The South African Constitution in chapter 2 (the Bill of Rights) section 10 declares that everyone has inherent dignity and the right to have their dignity respected and protected. Section 12(b) guarantees the right to bodily and psychological integrity, which includes the right to security in and control over one's body. Section 14 states that everyone has the right to privacy. The above-mentioned constitutional imperatives mean that informed consent must be granted by a patient to have his/her HIV status disclosed to his/her sexual partner.

It is stated that the rights in the Bill of Rights may be limited in terms of a law of general application only to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. Except for the above mentioned, and any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights (according to section 36).

3. Legislation

The South African National Health Act 61 of 2003 mandates that informed consent is necessary for the disclosure of any patient's health information. Section 14(1) states: 'all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential'. Section 14(2) stipulates: 'no person may disclose any information contemplated in health status, treatment or stay in a health establishment, unless:

(a) The user consents to that disclosure in writing;
(b) A court order or any law requires that disclosure; or
(c) Non-disclosure of the information represents a serious threat to public health.'

As a consequence, a breach of these regulations is justified only if there is patient consent and or a legal duty on the part of the medical practitioner involved, or on the following recognised grounds of justification / legal defences:[40]

1. Statutory authority;

2. A court order;

3. Therapeutic privilege; and

4. Public interest.

It is important to note that South Africa does not have HIV and AIDS-specific legislation. The South African Law Commission in 2000 published a report titled Project 85 (Fifth Interim Report on Aspects of the Law Relating to AIDS (The need for a statutory offence aimed at harmful HIV-related behaviour).[41] In deciding against the enactment of HIV-specific law, the report makes the following points:

- Criminal law essentially punishes the conduct of human beings. In the HIV/AIDS context this could mean that where a person with HIV fails to inform a sexual partner of his or her infection, and/or does not take other steps to prevent harm (e.g. by using a condom), such conduct may result in criminal liability.
- The greatest evidentiary hurdle in proving criminal charges in HIV transmission cases would be in substantiating the element of causation.
- The requirement of unlawfulness requires that there must be no defence available to the accused which could exclude unlawfulness. One of the relevant defences, in the context of HIV transmission or exposure would be consent by the victim. In the case of consent to unprotected sexual intercourse knowing that the partner is HIV positive, it is uncertain what conclusion a court would reach on whether such consent was in fact valid.

[40] PA Carstens & D Pearmain (2007) *Foundational Principles of South African Medical law* 17.
[41] South African Law Commission 92000) *Project 85 Fifth interim report on aspects of the law relating to AIDS*.

- It is a general principle of South African criminal law that a guilty mind (the element referred to as fault or culpability) is required for criminal liability.
- The general principle in criminal cases is that the legal burden of proving the perpetrator's guilt rests upon the prosecution. Therefore, the state must prove every element of the perpetrator's guilt beyond a reasonable doubt: the commission of the act charged; its unlawfulness; the identity of the perpetrator; fault; and the causation of the unlawful consequences.
- Negligence is in all likelihood the state of mind which will be applicable in the majority of cases of HIV-related behaviour. The test of negligence is formulated in such a way as to require an investigation into whether, in the circumstances, the conduct of the perpetrator in bringing about the death or harm of the victim complied with established social norms of care in undertaking an activity which carries a risk of harm to other persons.
- The objective test of foreseeability could present insurmountable problems of proof in instances where the perpetrator alleges that he or she relied on the probability that the victim would not become infected with HIV. If it is taken into account that the risk of infection from a single sexual exposure is less than 1%, it will be difficult to rebut the perpetrator's defence. A further problem would be whether the use of condoms would amount to "reasonable preventive steps" which would exclude negligence.
- That the use of coercive measures in dealing with the HIV/AIDS epidemic is controversial. In comparable legal systems where the creation of criminal offences for HIV-related harmful behaviour was at issue, the suitability and desirability of the criminal law to deal with a health-related issue have invariably been part of the debate.
- The Constitutional Court has acknowledged that the enforcement of criminal law involves the state acting in its executive and administrative capacity and, therefore, that the rules of the criminal law would have to be compatible with the provisions of the Bill of Rights contained in the 1996 Constitution.

4. A Model Law on HIV in Southern Africa

4.1 General

The Southern African Development Community's (SADC) Parliamentary Forum adopted a Model Law on HIV on 24 November 2008. Among others the objectives of this framework are stated to be as follows:[42]

- To provide a legal framework for the review and reform of national legislation related to HIV in conformity with international human-rights law standards;
- To promote the implementation of effective prevention, treatment, care and research strategies and programs on HIV and AIDS; and
- To ensure that the human rights of those vulnerable to HIV and people living with or affected by HIV are respected, protected and realized in the response to AIDS.

On special measures of prevention the framework emphasises: 'member states shall consider the decriminalization of commercial sex work and consensual sexual relationships between adult persons of the same sex as specific measures that enhance HIV prevention'.[43] Dealing with the results of HIV testing, it states that test results shall be treated as confidential at all times and it offers the following guidelines on disclosure to third parties:[44]

A person providing treatment, care or counselling services to a person living with HIV may notify a third party of the HIV status of that person only where the notifying person is requested by the person living with HIV to do so; or **all the following circumstances** exist:[45]

[42] SADC Parliamentary forum *Model Law on HIV in Southern Africa* 5.
[43] As above, 13.
[44] As above 16.
[45] As above, 16.

(i) The third party to be notified is at immediate risk of HIV transmission.

(ii) The person living with HIV, after appropriate counselling, does not personally inform the third party at risk of HIV transmission.

(iii) The person providing treatment, care or counselling services has properly and clearly informed the patient that he or she intends to notify the third party under the circumstances and ensured that the person living with HIV is not at risk of physical violence resulting from the notification.[46]

Despite this commendable effort by SADC, the African Regional Dialogue of the Global Commission on HIV and the Law reported on 4 August 2011 in Pretoria:

> 'Criminal law has been used as part of national responses to HIV in several African countries. Some countries use the criminal law directly by targeting the behaviour of people living with HIV through, for example, passing provisions which criminalize exposure to or infection with HIV or the compulsory HIV testing of sexual offenders ... In some instances, criminal law provisions, although not directly targeting persons living with HIV, may have an indirect impact on responses to HIV. For example, criminalizing sex work or men who have sex with men may hinder the delivery of HIV prevention and care services to such populations'.[47]

The International Guidelines on HIV and Human Rights issued by the Office of the High Commissioner on Human Rights and the Joint United Nations Programme on HIV and AIDS (UNAIDS) in Guideline 4 provide: that 'states should review and reform their criminal law to ensure that it is not inappropriately used in the context of HIV, and it does not target vulnerable populations'. These guidelines recommend further that specific HIV offences should not be introduced and advocate the use of existing general criminal offences.[48] Further, the guidelines emphasise the point:[49]

> 'Many countries have specific criminal offenses for the intentional exposure or transmission of HIV. The existence of these offenses has little impact on the spread of the virus. . . . Such laws divert the attention and resources from measures which do make a difference in curbing the epidemic, and can in fact be counterproductive because of the danger of further stigmatizing alienated groups, already treated as outsiders by society. By placing blame on one party, the criminal law undermines public campaigns aimed at

[46] As above, 16.
[47] 'Criminal Law and HIV: For the African Regional Dialogue of the Global Commission on HIV and the Law' 4 August 2011, Pretoria, South Africa.
[48] UNAIDS (1999) *Handbook for Legislators on HIV/AIDS, Law and Human Rights* 50.
[49] As above.

placing responsibility for adopting preventive measures on both parties engaging in risky behaviour'.

The International Guidelines provide further, if HIV-specific offences are created, they should exclude criminal liability for situations where a person living with HIV:[50]

(a) Was unaware of his/her HIV status.
(b) There is no significant risk of transmission.
(c) The sexual partner has given informed consent to the sexual act and/or
(d) Precautions are taken to significantly reduce the risk of HIV transmission.

In Amsterdam, Global Network of People Living with HIV reported in 2010 that the following African countries have laws criminalising transmission and/ or exposure to HIV:[51]

1. Southern Africa: Angola, Lesotho, Madagascar, Malawi, Mozambique, Swaziland Zambia and Zimbabwe.
2. East Africa: Burundi, Comoros, Kenya, Rwanda, Tanzania and Uganda.
3. West Africa: Benin, Burkina Faso, Cameroon, Cape Verde, Ivory Coast, Equatorial Guinea, Guinea, Guinea-Bissau, Mali, Niger, Senegal, Sierra Leone and Togo.
4. Central Africa: Central African Republic, Congo and Democratic Republic of Congo.
5. North Africa: Chad, Djibouti, Liberia and Mauritania.

An assessment of HIV-specific laws in sub-Saharan African countries shows that most (21 out of 26) have provisions allowing for involuntary partner notification (see Table 2 next page).[52] In 17 of these countries involuntary partner notification can occur only after the person living with HIV has first been given the opportunity to inform the sexual partner but does not.

[50] As above, 51.
[51] S Cameron & L Reynolds (2010) *The Global Criminalization Scan Report: Documenting trends, presenting evidence*.
[52] PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) 15 African Human Rights Law Journal 224-262.

New laws, though not HIV-specific, have been introduced which could be used to prosecute persons living with HIV for wilful infection in some countries in Africa. For example, in Botswana, section 184 of the Penal Code Amendment Act makes it an offence to 'unlawfully or negligently' perform any act which he/she knows or believes could spread a disease which is 'dangerous to life'.[53]

[53] Botswana Act 5 of 1998.

Countries allowing for involuntary partner notification (21 countries)	Opportunity first given to HIV positive person to notify (17 countries)	Option to notify for health care worker (17 countries)	Risk of HIV infection as reason for notification (11 countries)	Fear of violence as reason for not notifying (4 countries)	Timeline for notification (7 countries)
Angola	No	Yes	Yes	No	No
Benin	Yes	Yes	Yes	No	No
Burkina Faso	Yes	No (obligation)	No	No	Yes (immediately, on-ART 7 weeks)
Burundi	Yes	No (obligation)	No	No	No
Cape Verde	Yes	Yes	No	No	Yes(6 weeks, on-ART 22 weeks)
Chad	Yes	No (obligation)	No	No	No
Central African Republic	No	Not provided	Yes	No	No
Comoros	Yes	Yes	Yes	Yes	No
Cote d'Ivoire	Yes	Yes	No	No	Yes(3 months, on-ART 12 months)
DRC	Yes	Yes	No	No	Yes (immediately, on-ART 41 weeks)
Guinea	Yes	Yes	Yes	Yes	No
Guinea-Bissau	Yes	Yes	No	No	Yes (6 weeks, on-ART 26 weeks
Kenya	Yes	Yes	No	No	No
Liberia	Yes	Yes	Yes	Yes	No
Madagascar	Yes	Yes	Yes	No	No

Mali	Yes	Yes	No	No	Yes (6 weeks, on-ART 27 weeks)
Niger)	Yes	Yes	Yes	No	Yes (6 weeks, on-ART 15 weeks)
Senegal	Yes	Yes	Yes	No	No
Tanzania	No	Yes	No	No	No
Togo	Yes	Yes	Yes	Yes	No
Uganda	No	Yes	Yes	No	No

Table 2 HIV-specific laws in sub-Saharan African countries

In the following section I briefly mention and comment on some country-specific laws that have been enacted as a direct response to the HIV epidemic.

4.2 Country-specific laws

4.2.1 The Republic of Tanzania Act no 28 of 2008[54]

Section 21 of the above-mentioned Act stipulates: 'Any person who has knowledge of being infected with HIV after being tested shall immediately inform his spouse or sexual partner of the fact; and take all reasonable measures and precautions to prevent the transmission of HIV to others'. Section 33 makes it obligatory on any person living with HIV and AIDS to protect others from infection and to participate in efforts for scientific advancement and benefit. The Tanzanian Act is problematic and/or contradictory for the following reasons:

1. It makes it obligatory to participate in scientific advancement (can be interpreted to imply research), while section 41(2) of the same Act prohibits any form of research without the informed consent of the person involved.

2. Any person who intentionally breaches any practices which leads to the spread of HIV commits an offence and on conviction shall be liable to a fine or imprisonment.

[54] Republic of Tanzania Act 8 of 2008.

3. Any person who abuses his spouse or sexual partner physically, verbally or by conduct in connection with compliance to the provisions of this Act commits an offence; in that this provision negates the fact that consequences of unsafe disclosure can be wider than abuse (as reported above).

4.2.2 Malawi

Section 192 of the Malawi Penal code states: 'any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be guilty of a misdemeanor'.[55]

In 2008 the Malawi Law Commission developed the HIV and Aids (Prevention and Management) Bill.[56] Some provisions in this Bill are regarded by civil society as counterproductive and discriminatory against people living with HIV. Contentious provisions are sections 42 to 44 which criminalize HIV infection, a person who wilfully infects another is liable to 21years imprisonment and 14 years imprisonment is the sentence for negligently infecting another person. In 2017 the Malawian Parliament resolved to delete the provisions in this HIV and Aids (Prevention and Management) Bill which proposed criminalizing wilful HIV transmission and introduced mandatory testing for domestic workers and officers in uniform.[57]

4.2.3 Kenya

Section 24 of the HIV and AIDS Prevention and Control Act of Kenya[58] declares it is mandatory for a person who is aware of being infected with HIV to:

1. Take all reasonable measures and precautions to prevent the transmission of HIV to others.

2. Inform in advance, any sexual contact or person with whom needles are shared of that fact.

[55] Penal Code of Malawi.
[56] Malawi Law Commission HIV Management Bill, 2008.
[57] HIV/AIDS (Prevention and Management) Act 12 of 2017 of Malawi.
[58] Act 14 of 2006 of Kenya.

3. Not knowingly and recklessly place another person at risk of becoming infected with HIV unless that other person knew the fact and voluntarily accepted the risk of being infected.

A person who contravenes the above-mentioned provisions of the law commits an offence and shall be liable upon conviction to a fine not exceeding five hundred thousand shillings or to imprisonment for a term not exceeding seven years or to both a fine and imprisonment.

4.2.4 Zimbabwe

Section 79 of the Criminal Law (Codification and Reform) Act criminalizes intentional conduct and those who suspect they are HIV-positive but are undiagnosed. It provides:

(a) Any person who knowing that he or she is infected with HIV; or

(b) Realizing that there is a real risk or possibility that he or she is infected with HIV; intentionally does anything or permits the doing of anything which he or she knows will infect, or does anything which he or she realizes involves a real risk or possibility of infecting another person with HIV, shall be guilty of deliberate transmission of HIV, whether or not he or she is married to that other person. And shall be liable to imprisonment for a period not exceeding twenty years.[59]

5. Case law

This section of the dissertation reviews cases where informed consent/dignity, disclosure of HIV status and potential criminal liability of the treating healthcare worker are at issue.

In *Hyundai Motor Distributors (Pty) Ltd v Smith NO and Others*,[60] Judge Langa DP stated: 'Privacy is a right which becomes more intense the closer it moves to the personal sphere

[59] E Cameron E *et al* 'HIV is a virus not a crime: Ten reasons against criminal statutes and criminal prosecutions' (2008) 11 *Journal of the International AIDS Society* 7.
[60] *Hyundai Motor Distributors (Pty) Ltd v Smith NO and Others* (CCT1/100) (2202) ZACC 12; 2000(10) BCLR 1079; 2001 (1) SA 545 (CC) (25 August 2000).

of the life of human beings, and less intense as it moves away from that core'.[61] The HIV status of an individual must be regarded as being much closer to the personal sphere.[62]

In *NM and Others v Smith and Others*, the judge stated: 'The disclosure of an individual's HIV status, particularly in the South African context, deserves protection against indiscriminate disclosure due to the nature and negative social context the disease has as well as the potential intolerance and discrimination that results from its disclosure'.[63]

On the issue of whether healthcare practitioners should breach the confidentiality of patients to others, in the case of *Jansen Van Vuuren and another v Kruger*; the court held 'that a physician's legal duty to respect the confidentiality of his patient, the legal nature of which was today accepted as axiomatic was not absolute, but relative: but a doctor could be justified in disclosing his knowledge where his obligations to the society were of greater weight than his obligations to the individual'.[64]

In *Malawi (in EL v Republic)*[65] a woman with HIV and on ART was convicted under section 192 of the Penal code for an 'unlawful, negligent or reckless act that is likely to spread a disease dangerous to life' for breastfeeding a child while living with HIV. Although the child did not contract HIV she was sentenced to nine months imprisonment.[66] Although the case dealt with an issue of breastfeeding the principle applied here implies the possibility of being criminalised for infecting an intimate partner sexually. Relying on evidence drawn from Malawi's HIV policy, the WHO and UNICEF (United nations International Children's Emergency Fund) guidelines and the fact that she was on ART, she successfully appealed the sentence and conviction.

In a Working Paper prepared for the Global Commission on HIV and Law, Weait reports:

> In 2008 a Zimbabwean woman was prosecuted for "deliberately infecting another person" even though her partner did not test positive and she was on anti-retroviral

[61] *Hyundai Motor Distributors (Pty) Ltd v Smith NO and Others* (CCT1/100) (2202) ZACC 12; 2000(10) BCLR 1079; 2001 (1) SA 545 (CC) (25 August 2000).
[62] *Hyundai Motor Distributors (Pty) Ltd v Smith NO and Others* (CCT1/100) (2202) ZACC 12; 2000(10) BCLR 1079; 2001 (1) SA 545 (CC) (25 August 2000).
[63] *NM and Others v Smith and others* (CCT69/050 (2007) ZACC 6; 2007 (7) BCLR 751 (CC) (4 April 2007).
[64] *Jansen Van Vuuren and another v Kruger* 1993 (4) SA 842 (A).
[65] *EL v Republic (Criminal case no 36 of 2016)* MWHC 656 (19 January 2016).
[66] Global commission on HIV and the law (risks, rights &health) supplement July 2018.

treatment at the time. Furthermore her partner did not want to participate in the prosecution. She was convicted and sentenced to 5 years imprisonment which was wholly suspended.[67]

6. Ethical considerations

Twenty centuries ago, Hippocrates, a doctor and great advocate for ethics in medicine, said: 'In my attendance of the sick, or even apart therefrom, whatsoever things I see or hear, concerning the life of man, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets'. The Declaration of Geneva adopted by the World Medical Association in 1983 goes further, stating: 'I will respect secrets which are confided in me even after the patient has died'.[68]

The notion of confidentiality often is discussed within the framework of privacy. In sharing private information with their practitioners, patients choose to relinquish some aspects of their privacy. Patients have a reasonable expectation that such information will be shared only with specific people to further their (patients') welfare and with no one else. Confidentiality involves a relationship, whereas privacy does not. There are three sources upon which the high value attendant on confidentiality relies; these are autonomy, respect for person and trust.[69]

The HPCSA rules on informed consent state: 'Successful relationships between healthcare practitioners and patients depend upon mutual trust. To establish that trust practitioners must respect patients' autonomy – the right to decide whether to undergo any medical intervention, even where a refusal may result in harm to themselves or in their own death. Patients must be given sufficient information in a way that they can understand, to enable them to exercise their right to make informed decisions about their care'.[70]

---

[67] M Weait *The criminalization of HIV exposure and transmission*: A global review Working Paper prepared for the Global Commission on HIV and the Law, UNDP, New York, USA.
[68] K Moodley (2017) *Medical ethics, law and human rights. A South African perspective* 2nd ed) 62.
[69] A Dhai A & D McQuoid-Mason (2011) *Bioethics, Human Rights and Health Law Principles and practices* 86 - 87.
[70] HPCSA *Guidelines for good practice in the healthcare professions: Seeking patient consent. Booklet 4*.

They further state:

> If the patient refuses consent, the health care practitioner should use his or her discretion when deciding whether or not to divulge the information to the patient's sexual partner, taking into account the possible risk of HIV infection to the sexual partner and the risks to the patient (e.g. through violence) that may follow such disclosure. The decision must be made with great care, and consideration must be given to the rights of all the parties concerned.[71]

Should the healthcare practitioner decide on disclosure against the patient's wishes, the practitioner must do so after explaining the situation to the patient and accepting full responsibility for the consequences of disclosure at all times. The HPCSA recommends the following steps should be followed when a healthcare practitioner discloses HIV status to sexual partners without patient consent:

1. Counsel the patient on the importance of disclosing to his or her sexual partner and on taking other measures to prevent HIV transmission.

2. Provide support to the patient to make the disclosure.

3. If the patient still refuses to disclose his or her HIV status or refuses to consider other measures to prevent infection, counsel the patient on the health care practitioner's ethical obligation to disclose such information.

4. If the patient still refuses, disclose information on the patient's HIV status to the sexual partner and assist them to undergo VCT.

5. After disclosure, follow up with the patient and the patient's partner to see if disclosure has resulted in adverse consequences or violence for the patient, and

6. If so, intervene to assist the patient appropriately.[72]

7. Criminalisation of HIV transmission

[71] HPCSA *Guidelines for good practice in the healthcare professions: Ethical guidelines for good practice with regard to HIV*. Booklet 6.
[72] As above, 5.

As of July 2018 the Global Commission on HIV and the Law reports that 68 countries criminalise HIV non-disclosure or transmission or allow the use of HIV status to enhance charges or sentences on conviction. HIV prosecutions have been reported in 69 countries. Belarus, Canada, Russia and the United States of America lead in the number of prosecutions.[73]

Article 35 of the Law on Prevention, Care and Control of HIV/AIDS in Guinea addresses the crime of 'wilful HIV transmission'. This law is very broad and does not require the actual transmission of HIV provided there is the intent to transmit HIV. The crime exists regardless of whether the person knew she or he had HIV or was aware of the risk of transmission; the actual risk of transmission associated with the activity; whether the person living with HIV disclosed to the other person or the other person was aware in some way of the HIV infection; whether the person took any steps to reduce the risk of transmission (e.g., condom use, other safe practices, cleaning of drug injecting equipment); and whether in the circumstances the person living with HIV had control over the degree of risk (e.g. use by husband or partner of a condom).[74]

A HIV-infected homeless man in Texas was convicted and sentenced to 35 years in jail for committing a serious offence while being arrested for drunk and disorderly conduct, namely, harassing a public servant with a deadly weapon; the "deadly weapon" he used against the public servant was his saliva.[75]

With reference to Canadian criminalization of HIV transmission, Weinberg[76] argues 'there is no way to defend the actions of individuals who transmit HIV to others while knowing that they themselves are HIV- infected'. But he states that the current criminalisation of HIV transmission probably acts as a deterrent to HIV testing, in effect, 'by promoting HIV transmission by people who do not know or don't want to know that they are infected. And

[73] Global commission on HIV and the law (risks, rights &health) supplement July 2018.
[74] Canadian AIDS Legal Network (2007) *A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea*.
[75] GC Kovach 'Prison for Man with HIV Who Spit on a Police Officer' *New York Times* 2008.
[76] MA Wainberg (2009) 180 'Criminalizing HIV transmission may be a mistake' *CMAJ* 688.

we also need to accept that having sexual relations involves a personal responsibility to know one's partner on much more than a superficial level'.[77]

9. Non-disclosure and safe sex practices

A review of 15 studies which examine the association between disclosure and safer sex provides contradictory results, often demonstrating a significant effect limited to a subgroup of participants, such as HIV-seronegative or non-primary partners.[78] These findings offer little justification for concluding, as Chen and colleagues concur,[79] that there is an 'urgent need' for prevention messages promoting disclosure of HIV status to sexual partners.

10. HIV transmission risk

A review of 43 published studies conducted in various countries that report per-act heterosexual HIV-1 transmission probability-estimates in the absence of ART was published by the Lancet in 2009.[80] The authors concluded that average rates of HIV transmission are as follows:

1. Female to male: 0.4% per vaginal sexual act.
2. Male to female: 07- 0.8% per vaginal sexual act.
3. Receptive anal sex: 1.7% per act.

The estimated risk of HIV transmission are higher for sexual acts during the early (9.2 times higher) and late phases (7.3 times higher) of a partner's HIV infection than for sexual acts during the asymptomatic phase of HIV disease, as well as in the presence of other sexually-transmitted infections. In 2005 Castilla and others reported that a study of sero-discordant couples showed a reduction of 80% in HIV transmission when ART is

[77] As above, 691.
[78] JM Simoni & DW Pentalone 'Secrets and Safety in the Age of AIDS: does HIV disclosure lead to safer sex?' (2004) 12 *Top HIV Med* 109-18.
[79] SY Chen *et al* 'Unprotected anal intercourse between potentially HIV-serodiscordant men who have sex with men' (2003) 33 *J Acquir Immune Defic Syndr* 166 - 170.
[80] MC Boily 'Heterosexual risk of HIV-1 infection per sexual-act: systematic review and meta-analysis of observational studies' (2009) 8 *Lancet Infect Dis* 118 – 29.

used.[81] The landmark 052 trial conducted by the HIV Prevention Trials Network reported that ART reduced the risk of heterosexual transmission by 96%.[82]

In the next chapter I turn to a discussion of these results.

[81] J Castilla *et al* 'Effectiveness of Highly Active Antiretroviral Therapy in Reducing Heterosexual Transmission of HIV' (2005) 50 *Journal of Acquired Immune Deficiency Syndromes* 96 - 101.
[82] MS Cohen *et al* 'Prevention of HIV-1 infection with Early Antiretroviral Therapy' (2011) 365 *N Engl J Med* 493 - 505.

CHAPTER 5: DISCUSSION

In agreement with other studies this study finds that a significant number (15 to 49%) of HIV-infected persons do not disclose their HIV status to their sexual partners. This finding raises several issues and medico-legal challenges, both for the patient and the treating healthcare professional. Some of these challenges are discussed here.

1. Despite the views of some opponents of HIV exceptionalism, the stigma that attaches and continuation of discrimination against people living with HIV in some quarters warrant protection of a vulnerable population group.
2. The right to privacy and dignity (informed consent):
   The principles underlying these rights are enshrined in the Bill of rights of the South African Constitution, 1996, the National Health Act and in many international guidelines on patient care. These rights can be limited only in the interest of the public. In the case of HIV I maintain that the small risk of HIV transmission, even in the absence of ART, cannot justify the public-interest argument.
3. Ethical challenges:
   The guidelines of UNAIDS and HPCSA require that the treating healthcare professional performs a risk assessment of the decision to disclose information to a known sexual partner without the patient's consent. With limited time and resources it is impractical to expect the average healthcare professional to satisfactorily carry out a thorough risk assessment. The guidelines are more problematic in stating that the disclosing healthcare professional must assume responsibility for the consequences of such a disclosure.
4. Impact on treatment outcomes:
   Studies reviewed failed to demonstrate a statistical correlation between non-disclosure and a change in sex behaviour, which implies disclosure might not necessarily benefit the HIV-infected person and the partner.
5. Risk of HIV transmission:
   Research has shown that the risk of HIV transmission sexually is minimal (0.4 to 1.7%) in the absence of treatment. Recently, it has been demonstrated there has

been a reduction of this risk by 96%, which means the risk of transmission by a virally-suppressed HIV-infected person on ART is almost zero.

6. Criminalisation of HIV transmission:

   Despite international guidelines prohibiting it, several countries have HIV-specific criminal laws and others rely on their criminal justice system to criminalise HIV transmission. In the majority of cases these laws have not been applied consistently and are not guided by generally-accepted scientific knowledge about HIV transmission. The low rate of reported and convicted cases (compared to the reported rate of non-disclosure) implies these laws do not have the intended effect. A great opponent of laws of this kind, Justice Edwin Cameron, lists the following 10 reasons in support of the case against criminalization of HIV transmission:[83]

   - "These laws and prosecutions do not prevent the spread of HIV. In the majority of cases the virus is transmitted when two people have consensual sex, neither one knowing that the other (who may be in the early, highly-infectious stage during and soon after seroconversion) has HIV;
   - Criminal laws and criminal prosecutions are a shoddy and misguided substitute for measures that protect those at risk of contracting HIV. These measures include strong leadership, effective prevention, protection against discrimination, measures to reduce stigma and greater access to testing and treatment;
   - Criminalisation victimises, oppresses and endangers women. In Africa most people who know their HIV status are female because most testing occurs at ante-natal healthcare sites. Inevitably, as a result most of those who will be prosecuted because they know or ought to know their HIV status will be women;
   - Criminalisation often is unfairly and selectively enforced. Prosecutions and laws single out already vulnerable groups, such as sex workers, men who have sex with men and, in European countries, black males;

[83] E Cameron *et al* 'HIV is a virus, not a crime: Ten reasons against criminal statutes and criminal prosecutions' (2008) 13 *J Int'l AIDS Society* 64.

- Criminalisation places blame on one person instead of fixing responsibility on two. For nearly three decades the universal public information message has been that no one is exempt from HIV. So the risk of getting HIV (or any sexually transmitted infection) must now be seen as an inescapable facet of having sex;
- These laws are difficult and degrading to apply because they intrude on the intimacy and privacy of consensual sex. When it comes to sex, with its potent elements of need, want, trust, passion, shame, fear, risk and heedlessness, normal, reasonable people simply do not always follow public health guidelines;
- Many of these laws are extremely poorly drafted. Because it is difficult to prove an offence that involves consensual sex and because of the difficulties of applying the categories of the criminal law to these offences, many of these laws end up being a hodge-podge of confused legislative intent and bad drafting;
- Criminalisation increases stigma. Prosecutions for HIV transmission and public exposure, and the chilling content of enactments themselves, reinforce the idea of HIV as a shameful, disgraceful, unworthy condition, requiring isolation and ostracism. Tragically, this situation only adds fuel to the fires of stigma;
- Criminalisation is a blatant discouragement of testing. It is radically incompatible with a public-health strategy that seeks to encourage people to come forward and find out their HIV status;
- Criminalisation assumes the worst about people with HIV, and in doing so it punishes vulnerability."

CHAPTER 6: SUMMARY AND CONCLUSION

In light of the above and in an attempt to answer the study questions, the following are the conclusions reached.

The study supports all efforts to educate and counsel, but finds that the disclosure of HIV status by healthcare professionals to sexual partners without informed consent should be discouraged. This conclusion is made more important by the fact that guidelines place the responsibility for such actions and their consequences on the healthcare professional. Disclosure of status to an identified partner at risk is justified only if there is clear evidence that the HIV-infected person intentionally or plans intentionally to transmit HIV.

Treating healthcare professionals should not be held ethically responsible or medico-legally guilty for non-disclosure of HIV status to the patient's sexual partner if consent has not been given for such disclosure. An exception to the practice should arise only if it is ascertained that there is a clear intent to transmit HIV despite all efforts at counselling.

It is felt that after three decades and the widespread availability of information about the modes of transmission and prevention of HIV, anyone who engages in a consensual sexual act should be aware of the risks of acquiring the disease or any other sexually-transmitted infection. Ignorance in relation to such information or of the risk cannot justify criminalising HIV transmission; in the same way that ignorance of the law cannot be used as justification for not complying. This belief, coupled with the fact that the risk of HIV transmission from sexual acts is low and is almost non-existent when the HIV infected is virally suppressed on ART, lead me to advocate against the criminalisation of HIV transmission.

The criminalisation of HIV transmission is justified if it can be established there is an intentional transmission of HIV and transmission did occur. However, prosecution should rely on existing criminal law, as it is submitted that enacting HIV-specific laws will increase stigma and is counterproductive in relation to HIV prevention measures.

BIBLIOGRAPHY

Books

1. Aggleton P *et al*. *AIDS: social representations, social practices*, 1989. The Falmer Press, New York.
2. Carstens PA and Pearmain D. *Foundational Principles of South African Medical law,* 2007 Butterworths LexisNexis, Durban.
3. Dhai A and McQuoid-Mason. *Bioethics, Human Rights and Health Law; Principles and practises*, 2011. Juta, Claremont.
4. Moodley K. *Medical ethics, law and human rights. A South African perspective*, 2011 2nd ed) Van Schaik Publishers, Pretoria.
5. Veatch RM. *Medical Ethics,* 1997. Jones & Bartlett Publishers, London.
6. Wilson D *et al. Handbook of HIV Medicine*, 2005. Oxford University Press, Oxford.

Case law

1. *EL v Republic (criminal case no 36 of 2016)* MWHC 656 (19 January 2016).
2. *Hyundai Motor Distributors (Pty) Ltd v Smith NO and* Others (CCT1/100) (2202) ZACC 12; 2000(10) BCLR 1079; 2001 (1) SA 545 (CC) (25 August 2000).
3. *Jansen Van Vuuren and another v Kruger* 1993 (4) SA 842 (A).
4. *NM and Others v Smith and others* (CCT69/050 (2007) ZACC 6; 2007 (7) BCLR 751 (CC) (4 April 2007).

Journal articles

1. Amaro H *et al. Violence during pregnancy and substance abuse*. AM JPublic Health 1990; 80;575-579
2. Baleta A. (1999).*Widespread horror over killing of AIDS activist in South Africa.* Lancet, 353(9147), 130.

3. Cameron E, et al. *HIV is a virus, not a crime: ten reasons against criminal statutes and criminal prosecutions*; Journal of the International AIDS Society; 2008;11;7
4. Castilla J, et al. *Effectiveness of Highly Active Antiretroviral Therapy in Reducing Heterosexual Transmission of HIV*; Journal of Acquired Immune Deficiency Syndromes: September 1st, 2005; Volume 40; Issue 1; p 96-101.
5. Ciccarone DH, *et al*. *Sex without disclosure of positive HIV serostatus in a US probability sample of persons receiving medical care for HIV infection*. Am J Public Health. 2003.
6. Chen SY, *et al. Unprotected anal intercourse between potentially HIV-serodiscordant men who have sex with men*, *San Francisco*. J Acquir Immune Defic Syndr. 2003; 33:166-170.
7. England R. *Writing is on the wall for UNAIDS*; British Medical Journal. 2008; 13:1072.
8. Cohen MS*, et al. Prevention of HIV-1 infection with Early Antiretroviral Therapy;* N. Engl. J. Med. 365; 493-505 (2011).
9. Del Romero J, et al. *'Combined antiretroviral treatment and heterosexual transmission of HIV-1: Cross-sectional and prospective cohort study'*. (2010) BMJ 340:c2205.
10. Eba PM. *HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis (2015) 15*; African Human Rights Law Journal 224-262.
11. England R. *Writing is on the wall for UNAIDS*; British Medical Journal. 2008; 13:1072.
12. Hansen, H. & Groce, N. (2001). *From quarantine to condoms: Shifting policies and problems of HIV control in Cuba*. Medical Anthropology, 19(3), 259-292.
13. Marie-Claude B, *et al. Heterosexual risk of HIV-1 infection per sexual-act: systematic review and meta-analysis of observational studies*. Lancet Infect Dis 2009; 9:118–29.
14. O'Brien ME, *et al. Prevalence and correlates of HIV serostatus disclosure*. Sex Transm Dis. 2003; 30:731-735.

15. Rothenberg KH*, et al. Domestic violence and partner notification: Implications for treatment and counseling of women with HIV*; J Am Med Women Assoc;1995 May – August; 50; (3-4); 87-93.
16. Sharp PM & Hahn BH (2011). *'Origins of HIV and the AIDS pandemic'.* Cold Spring Harbour Perspectives in Medicine 2011 September; 1(1):a006841.
17. Simoni JM and Pentalone DW. *Secrets and Safety in the Age of AIDS: does HIV disclosure lead to safer sex*? Top HIV Med. 2004 October/November; 12 (4): 109-18.
18. Skinner D & Mfecane S. '*Stigma, discrimination and the implications for people living with HIV/AIDS in SA'*. Journal of Social Aspects of HIV/AIDS. 1(3) (2004) page 2.
19. Smith JH, et al. *The history of AIDS exceptionalism*; J Int AIDS Soc 2010; 13; 47.
20. *The growing epidemic of domestic violence in South Africa*. The South African College of Applied Psychology: July 20' 2018.
21. Wainberg MA. *Criminalizing HIV transmission may be a mistake*; CMAJ March 17, 2009 180 (6) 688.

Legislation

South African

1. Constitution of the Republic of South Africa, 1996.
2. National Health Act 61 of 2003.

International

1. Act 14 of 2006 of Kenya.
2. Botswana Act 5 of 1998.
3. HIV/AIDS (Prevention and Management) Act 12 of 2017 of Malawi.
4. Malawi Law Commission HIV Management Bill, 2008.
5. Penal Code of Malawi.
6. Republic of Tanzania Act 8 of 2008.

International instruments

1. Cameron, S and Reynolds, L (2010), The Global Criminalization Scan Report: Documenting trends, presenting evidence, Global Network of People Living with HIV (GNP+), Amsterdam, Netherlands.
2. Canadian AIDS Legal Network (2007), A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, UNDP, New York, USA, 2012.
3. Criminal Law and HIV: For the African Regional Dialogue of the Global Commission on HIV and the Law. 4 August 2011, Pretoria, South Africa.
4. Global commission on HIV and the law (risks, rights &health) supplement July 2018.
5. Global AIDS monitoring (UNAIDS/WHO) and WHO HIV Country Intelligence Tool, 2007.
6. HIV/AIDS Surveillance report, Atlanta, Ga: Centre for disease control and Prevention
7. Model Law on HIV in Southern Africa : SADC Parliamentary forum , adopted 24 November 2008
8. UNAIDS (1999), Handbook for Legislators on HIV/AIDS. Law and Human Rights, Geneva, Switzerland.
9. Weait M. The criminalization of HIV exposure and transmission: A global review, Working Paper prepared for the Global Commission on HIV and the Law (2012), UNDP, New York, USA

Internet sites

1. A Le Roux-Kemp. *'HIV/Aids, to disclose or not to disclose: That is the question'* 2013(16) PER/PELJ 1. (accessed 1 July 2018)
2. Fauci AC, et al (1996). *Typical course of HIV infection in Humans*; Researchgate.net. (Accessed 3 June 2018)

3. Hallett, TB et al. *'Optimal uses of antiretrovirals for prevention in HIV-1 serodiscordant heterosexual couples in South Africa*: A modelling study' available at https://doi.org/10.1371/journal.pmed.1001123 (accessed 1 July 2018).
4. Maman, S et al (2001). *HIV and partner violence: Implications for HIV Voluntary Counseling and Testing Programmes in Dar es Salaam, Tanzania*. SAFAIDS Online Catalogue. (Accessed 3 July 2018).
5. Medley A, et al. *Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes*. Bull World Health Organ.2004 April, 82(4), p 299-307
6. Oppenheimer GM & Bayer R. "*The Rise and Fall of AIDS Exceptionalism*". Virtual Mentor. 11 (12): 988–992. 1 December 2009. (Accessed 3 July 2018)
7. *Structure of HIV*; HIV.com. (Accessed 3 June 2018)

Others

1. FACTSHEET: South Africa's crime statistics for 2017/18; Africa Check, 11 September 2018
2. HPCSA Ethical guidelines for good clinical practice with regard to HIV, Booklet 4.
3. HPCSA Ethical guidelines for good clinical practice with regard to HIV, Booklet 6.
4. Kovach GC. "Prison for Man with H.I.V. Who Spit on a Police Officer". New York Times. 16 May 2008.
5. South African Law Commission published Project 85, 2000: Fifth interim report on aspects of the law relating to AIDS.
6. Stats SA, Statistical release P0302: Mid-year population estimates, 2017