

**UNIVERSITY OF NAIROBI  
FACULTY OF LAW**

**LEGAL INTERVENTIONS IN THE PREVENTION OF  
HIV/AIDS**

**A Dissertation in Partial Fulfilment of the Requirements for the  
Degree of Bachelor of Laws (LL.B) of the University of Nairobi**

**Submitted by:**

**Moni Wekesa**

**Supervisor: Mrs Joy K. Asiemu**

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"If we are really to be leaders for prevention, I suggest that we all need to shed a few layers of protective timidity, to emerge from that comfortable corner in which we talk mostly to each other. We need, in short, to address the big issues on the main stage where societal decisions are made"

*Roper, WL. Linking Science, Policy and Practice. Presented at Prevention '92 on March 24, 1992, Baltimore, Md.*

This work is dedicated:

To my loving wife Roselyn,

Son Wangia, and

Daughter Kgaborone

For enduring my absence from you especially, at supper time  
during the course of my studies

And

To all those professionals, volunteers, and significant others  
committed to the fight against HIV/AIDS

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## **EXECUTIVE SUMMARY**

HIV/AIDS is a pandemic that is sweeping through Kenya like a bush fire. Once infected, one is infected for life with the possibility of being infectious to others for life. There is neither a vaccination nor a cure for it. It is estimated that over 3 million Kenyans are living with HIV/AIDS. The number could be much higher due to difficulties with data collection. In the same vein, by 2001, 2.4 million have succumbed to AIDS and about 900 die therefrom daily. Efforts at combating its spread include abstinence, faithfulness to one sexual partner, use of condoms and HIV/AIDS awareness campaigns. These have been in place since over 20 years ago, yet the scourge continues to afflict more people. In addition to the above measures, other countries have put legislation in place to help in preventing the spread of HIV/AIDS. In Kenya, there are no such laws in place. HIV/AIDS, not being a disease, the current laws in the Penal Code or Public Health Act or elsewhere in the Statutes are not relevant. The major objective of this study was to find out what laws can help stem the spread of HIV infection and make recommendations accordingly. In particular, the following general hypotheses were examined:

- A legal regime on HIV/AIDS in Kenya is lacking.
- The current legal regime on communicable diseases is wanting as far as HIV/AIDS is concerned.

- The lack of a legal regime on HIV/AIDS is an obstacle in the prevention of the pandemic.
- Enactment of legislation on HIV/AIDS will result in a reduction of its spread

More specifically, this study considered the following hypotheses:

- The adherence to the Hippocratic rule on doctor-patient confidentiality about the HIV sero-positive status of a patient is a hindrance to its prevention of its spread as this leaves close contacts very vulnerable.
- The lifting of the veil of confidentiality will reduce the spread of HIV infection.
- The lack of laws criminalising the deliberate spread of HIV/AIDS hampers efforts to reduce its spread.
- Enactment of laws criminalising such behaviour will result in a reduction of the spread of the pandemic.
- There is discrimination against persons living with HIV/AIDS which has resulted in stigmatisation and secrecy about the pandemic.
- Current trends in Kenya appear to favour openness.
- Laws prohibiting discrimination and advocating for openness will result in destigmatisation and openness thereby facilitating voluntary counselling and testing and the provision of other services with a net result of reduction in the prevalence of HIV/AIDS.

The methodology adopted in this study is the triangulation method. This involved a combination of a library research based on legal, medical and other publications as well as an empirical (quantitative) study of the variables relevant to the hypotheses above. An attempt has been made to study the situation prevailing mainly in the USA and UK, and relate it to Kenya with a view to extracting the best practices that could be applicable locally. Approaches to contentious issues in these and other

countries have been critically studied and compared with the results of interviews conducted locally, and recommendations for law making derived from them.

Chapter one is a general introduction, which delves into the use of law in disease management through the ages, the definition of HIV/AIDS, its effects, its prevention and the legal consequences that flow therefrom. Two main conclusions can be arrived at in this chapter: Firstly, the use of law in medical practice is as old as mankind; and secondly, since neither an HIV infection nor AIDS is a disease by definition, and since HIV/AIDS is not a proximate cause of death, there is need for special laws on HIV/AIDS.

Chapter two tackles in a detailed manner contentious issues such as confidentiality including HIV testing, criminalization of deliberate offenders in HIV infection, and discrimination of persons living with HIV/AIDS. Chapter three presents the methodology of this work together with the results of the empirical study. In general, majority of Kenyans surveyed would like a special set of laws to be put in place to help fight the HIV scourge.

Chapter four gives conclusions and recommendations. The main conclusion is that there is need for special laws to help in the prevention



of the spread of HIV/AIDS. The essential recommendations are that the laws on HIV/AIDS should:

- Lift the veil off the doctor/patient confidentiality and promote the concept of "speaking out" at home, school, workplace, and in other social places;
- ◆ Deliberate infection of others ought to be criminalized and such criminalization should be accompanied with restitution. Such measures should apply to both natural and legal persons;
- ◆ Provide for VCT for the general population and mandatory testing in special instances such as prisons, persons charged with sexual offences, health care providers and commercial sex workers; and
- ◆ The laws should prohibit discrimination against persons living with HIV/AIDS.

It is hoped that this work will prove useful to the Parliamentary Health Committee, the Task Force on HIV/AIDS Laws, and other stakeholders involved in the area of HIV/AIDS.

## CHAPTER ONE: INTRODUCTION

This chapter presents the historical interaction of law and medicine, the definition of HIV/AIDS, the history and magnitude of the HIV/AIDS pandemic, the socio-economic impact of HIV/AIDS, current efforts at prevention, and it identifies the absence of a legal regime as a missing link in the ongoing efforts at prevention of HIV/AIDS.

### 1.1. Historical Snippets of Legal Intervention in Public Health Issues

Law and medicine have been bedfellows since time immemorial.

Leprosy is one of the oldest diseases that remained without a cure for many centuries. The approach taken to contain it therefore makes not only interesting reading but it is also quite illuminating in these times of HIV/AIDS without a vaccination or a cure. In the Hellenistic culture around 300 BC<sup>1</sup>, strict ritual exclusion laws of the book of Leviticus were applied to leprosy patients. One of the laws dealing with prevention of the spread of leprosy reads<sup>2</sup>:

*"The person with such an infectious disease must wear torn clothes, let his hair be unkempt, cover the lower part of his face and cry out, 'Unclean! Unclean!' As long as he has the infection, he remains unclean. He must live alone; he must live outside the camp."*

During the medieval period (about 300 - 1000 AD), the Roman Catholic Church was the only prominent institution. Leprosy patients of that time were treated very badly. They were considered legally dead and were isolated from the unaffected. During this period, the Roman Empire

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<sup>1</sup> Ell, SR. Leprosy in history. In: Hastings, RC and Opromolla, DVA. (eds.) *Leprosy*, 2<sup>nd</sup> ed., Longman, Edinburgh, 1994.

disintegrated. The church was the main bastion of learning. The rule of St. Benedict, which dominated the monastic life of this period, also subsumed medicine on religious grounds. The Rule states: *'Above all care for the sick ... for Christ said, "I was sick and you visited me"'*. Leprosy was the subject of a number of restrictive laws.

In the Middle Ages (1000 - 1347 AD), there existed an uneasy relationship between the sophisticated Moslem cultures and the rather savage Christian ones. The works of Aristotle were available in Moslem lands. These were translated into Latin and led to an explosion in learning. There was renewed interest in the study of Roman law. Two major phenomena that affect the history of leprosy emerged: (1) new wealth led to the revival of cities. The first Universities were founded. Medicine ceased to be the domain of the clergy. The church began to forbid the shedding of blood, something medicine required; and (2) clergy were not to be put in a position where they might cause death. Hospitals were established and laws multiplied<sup>3</sup>. By the 13<sup>th</sup> century, a leprosy patient would share neither church, nor home, nor market, nor cemetery with those unaffected. A person declared to have leprosy had three choices: (a) if he was wealthy, seclusion at home was acceptable; (b) entry into a leprosarium (secluded hospital); and (c) a life of wandering, begging, stealing, and trying to survive in a sea of hostility. The church developed an elaborate ceremony by which a person declared to be a leper was excluded from all forms of contact with

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<sup>2</sup> *Leviticus* 13: 45-46, New International Version, International Bible Society, Colorado Springs, 1984

other people. Legally, such a person was considered dead and his heirs would inherit his property. Canon law mirrored civil law in this respect. The only exception to legal death was marriage. The spouse was not free to re-marry until after the physical death of the partner. Leprosy was looked at as punishment for sin. These measures taken against leprosy patients seem to have contributed to the decline of leprosy in Europe during the 14<sup>th</sup> and 15<sup>th</sup> centuries<sup>4</sup>.

During isolation, leprosy patients were kept in leprosaria that were located on large tracts of land far from nearby populations. These institutions provided housing, food, health care, and clothing, spiritual help, social and economic activity as well as burial plots to the patients. They had strict rules, their own mayor, jail and currency<sup>5</sup>.

General Sir William MacArthur, a medical historian wrote in 1953<sup>6</sup> that:

*"...the only measure in statutory books directed against lepers was that which enabled a writ De Leproso Aniovendo to be issued. " The writ De Leproso Aniovendo lieth, where a man is a Lazar or a leper, and is dwelling in any town, and he will come into church, or among his neighbours where they are assembled, to talk with them, to their annoyance and disturbance - then he or they may sue forth that writ for to remove him from their company. But it seemeth, if a man be a leper or a lazarus, and will keep himself within his house, and will not converse with his neighbours, then he shall not be moved out of his house" "*

Early in the 20<sup>th</sup> century, US courts often ruled on public health regulations that restricted the freedom of individuals. They established that

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<sup>3</sup> Ell, p.6

<sup>4</sup> *ibid.*, p.10

<sup>5</sup> Frist, TF. The social integration of people with Hansen's disease. In: Hastings, RC. and Opromolla, DVA (eds.). *Leprosy*, 2<sup>nd</sup> ed., Longman, Edinburgh, 1994, p.450

the preservation of public health was a proper concern of state legislatures. In *Jacobson v Massachusetts*<sup>7</sup>, the Supreme Court upheld compulsory vaccination of adults against smallpox although the statute infringed on personal liberty. Courts applied the "minimum scrutiny standard" applied to economic regulation and civil rights infringement when considering public health issues. This standard presumes legislation to be valid unless it bears no reasonable relationship to the achievement of a proper objective of government<sup>8</sup>. In *Jacobson*, the Supreme Court stated:

*"...the legislature has the right to pass laws which, according to the common belief of the people, are adapted to prevent the spread of contagious diseases. A common belief, like common knowledge, does not require evidence to establish its existence, but may be acted upon without proof by the legislature and the courts."*

In more modern times, courts rarely found regulation enacted to protect public health to be "unreasonable," "arbitrary" or "oppressive." For instance, in *People ex rel. Barmore v Robertson*<sup>9</sup>, a quarantine order was upheld.

In the 1920's the courts began to require some showing of medical necessity as the science of public health progressed. In *Robertson*, the court stated that "*quarantine regulations are sustained on the law of necessity, and when the necessity ceases the right to enforce the regulations ceases.*" Nevertheless, they continued to allow class membership alone to justify public health restrictions when a disfavoured class was the subject of the

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<sup>6</sup> Mac Arthur, Lt-Gen. Sir William, "Medieval" leprosy in the British Isles, In: *Leprosy Rev.* 1953, 24:8

<sup>7</sup> 197 US 11 (1905)

<sup>8</sup> *Miller v Wilson*, 236 US 373, 380 (1915)

regulation. For instance, in *Ex parte Clemente*<sup>10</sup>, the court held that quarantine was justified because information about a woman's acts of prostitution furnished a reasonable ground to believe she carried disease. Similarly, in *Krohn v Thomas*<sup>11</sup>, the Supreme Court upheld a statute authorising examination for venereal disease of persons arrested for vagrancy.

In certain instances, judicial opinions assumed that victims were to blame for their illnesses. In *Ex parte Dayton*<sup>12</sup>, the court justified the jailing of a woman until she submitted to a physical examination for disease "on the ground that she is a lewd and dissolute person, and, in fact, a prostitute." In *Ex parte Company*<sup>13</sup>, the court stated that "those who by conduct and association contract such diseases as makes them a menace to the health and morals of the community must submit to such regulation as will protect the public".

The attitude of considering the diseased as a menace to society and morals continued until the 1950s when isolated tuberculosis patients challenged state authority to quarantine (*Moore v Draper*<sup>14</sup>).

Before the 1960s, the courts rarely applied the concept of "strict scrutiny." This concept was defined in *Dunn v Blumstein*<sup>15</sup> as one that

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<sup>9</sup> 302 Ill. 4222 (1922)

<sup>10</sup> 61 Cal. Appl. 666 at 698 (1923)

<sup>11</sup> 133 Misc. 145 (1928)

<sup>12</sup> 52 Cal. App 635 (1921)

<sup>13</sup> 106 Ohio St. 50 at 57

<sup>14</sup> 57 so. 2d 648, 1952)

requires the state to prove that the chosen action was the least restrictive alternative. The state must show that the legislation is drawn with precision, that it is closely tailored to serve the objective, and that there is no other reasonable way to achieve the goal with a lesser burden on constitutionally protected activity.

Court decisions on equal protection in the 1960s established that laws infringing fundamental rights should be subjected to more demanding test of "strict scrutiny". Courts also introduced a middle tier to equal protection analysis - "the intermediate scrutiny." This requires that legislation burdening certain "quasi-suspect" classes or impairing important, but not fundamental rights are substantially related to an important state interest. This was so held in *Craig v Bowen*<sup>16</sup> in which gender classification was treated as quasi-suspect, and in *Ball v Bursen*<sup>17</sup> in which a law depriving individuals of driver's licences was subjected to intermediate scrutiny.

The above is just an illustration to show that rules (read laws) have always existed alongside forms of medical care from the earliest point of history recorded. Further, for diseases with no known cure, special rules were put in place to facilitate their management. Does HIV/AIDS require special rules? The answer to this question lies in the nature of HIV/AIDS

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<sup>15</sup> 405 US 330 [1972]

<sup>16</sup> 429 US 190 (1976)

<sup>17</sup> 402 US 535 (1971)

and the adequacy or otherwise of the measures for its management currently in place.

## **1.2. Definition and nature of HIV, ARC and AIDS**

AIDS is the acronym for acquired immunodeficiency syndrome. AIDS destroys the immune system<sup>18</sup>. Once people are infected with AIDS, their bodies become less and less able to fight off diseases until, one or more of the diseases prove fatal. It is erroneous to refer to AIDS as a disease<sup>19</sup>. It is a syndrome that paves way for various diseases to attack and conquer the body. The virus that causes AIDS is called HIV (human immunodeficiency virus). It infects cells called lymphocytes, especially the T cells, which are a crucial part of the human immune system. HIV is a retrovirus, i.e. a virus with the ability to become part of the genetic material of the host cell. This means when the host cell reproduces, it produces more HIV. With time, HIV destroys the T cells and the body becomes unable to fight off certain opportunistic infections and diseases, which an otherwise health immune system could easily ward off<sup>20</sup>.

HIV consists of two main elements: an outer membrane or envelope and an inner core<sup>21</sup>. The outer membrane is taken from cells of the person it infects. This membrane determines the physical properties of the virus, i.e. how it is transmitted and inactivated. This membrane is largely made of

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<sup>18</sup> Communicable diseases: *Symptoms, diagnosis, treatment*. MacMillan: New York, 1995, pp.4-5

<sup>19</sup> Such an error can be found at page 1 of the *Sessional paper No. 4 of 1997 on AIDS in Kenya* where AIDS is referred to as " ...a new disease"

<sup>20</sup> Communicable Diseases, p.4



fat. This lipid membrane of HIV is extremely fragile being easily disrupted by environmental influences. Since the virus cannot repair its membrane, disruption amounts to inactivation. Hence, the virus survives very poorly outside the body. Heat, drying, detergents, and most standard disinfectants easily destroy it. HIV is found in body fluids and secretions of infected persons such as blood, semen, vaginal secretions and in small quantities in saliva and sweat. The legal significance of this outer membrane is that its DNA analysis can identify a person who may have infected another, if such a test is carried out immediately after exposure to the virus, i.e. after a sexual assault or encounter.

The core/middle of the virus has its nucleic acid containing its genetic code, and its proteins, whose formation is instructed by the genes<sup>22</sup>. These genes confer the biological properties of the virus which include:

- (i) latency - once the virus has infected a cell or person it persists, i.e. once infected, one is infected for life;
- (ii) Infection caused by the virus is a productive infection; i.e. new virus particles are being produced for the duration of the infection. This means a person is infectious for life, whether they are well or ill; and
- (iii) Its specific attack on certain cells of the body, i.e. the T cells and the macrophages of the immune system. This gives it capacity to cause disease.

The result is of two types:

- (1) progressive immune deficiency as seen in the AIDS-related complex (ARC); and

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<sup>21</sup> Pinching, A.: AIDS: Clinical & Scientific Background. In: Almond, B.(ed.). *AIDS - A moral issue. The ethical, legal and social aspects*. MacMillan, London, 1990, p. 26

<sup>22</sup> Pinching, p. 26

- (2) due to the loss of T cells and their functions, a person then becomes susceptible to certain infections, tumours and progressive damage to the nervous system (AIDS). ARC is therefore a milder form of AIDS.

The legal importance of the core/middle part of the virus is that infection with HIV is comparable to a "death sentence" in these times when there is neither a cure nor a vaccine. Reliance on anti-retrovirals becomes a lifelong activity.

Some people may be exposed but not become infected<sup>23</sup>. Those who become infected develop antibodies to HIV within a few months. It is the testing for the antibodies that is used to identify people as being HIV positive or HIV negative. The reasoning is that anyone who develops antibodies to HIV must have acquired persistent infection.

Following infection, some people are initially asymptomatic for several years and may remain so indefinitely. They have HIV infection and are able to transmit it although showing no signs of the disease. Progression from HIV infection to AIDS may take 3-10 years. The risk of progression is influenced by immunosuppressive influences such as other sexually transmitted diseases acquired after HIV, more than one pregnancy, infancy, malnutrition, other infections and immunosuppressive drugs<sup>24</sup>.

The mean incubation period for children infected with HIV varies between 4-7 years, but for those below 5 years of age, this is reduced to 2-3

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<sup>23</sup> Pinching, p. 30

<sup>24</sup> *ibid.*, p.31

years. An estimated 83% of infected children show laboratory or clinical evidence of HIV infection by 6 months of age<sup>25</sup>.

### **1.3. Mode of transmission of HIV**

HIV does not thrive outside the body. The human skin is known to be an effective barrier. Hence, HIV is not transmitted by casual contact such as living with or caring for an infected person, sharing utensils with an infected person, using a toilet after an infected person has used it, breathing the same air as an infected person, and touching or shaking hands with or embracing an infected person<sup>26</sup>.

The most common modes of transmission of HIV infection are: sexual, blood-borne and peri-natal<sup>27</sup>.

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<sup>25</sup> Mok, J. HIV infection in children. *British Medical Journal* 1991, 302:921

<sup>26</sup> Communicable Diseases, p.5

<sup>27</sup> Simond, RJ & Rogers, MF. HIV Prevention - bringing the message home. *The New England Journal of Medicine* 1993, 329:1983-1985; Centre for Diseases Control: Progress toward elimination of perinatal HIV infection - Michigan, 1993-2000. *Morbidity and Mortality Weekly Report* 2002, 51:93-97

### Regional HIV/AIDS statistics and features, end of 2001

	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate *	% of HIV positive adults who are women	Main mode(s) of transmission for those living with HIV/AIDS **
Sub-Saharan Africa	late '70s early '80s	28.1 million	3.4 million	8.4%	55%	Hetero
North Africa & Middle East	late '80s	440 000	80 000	0.2%	40%	Hetero, IDU
South and South-East Asia	late '80s	6.1 million	800 000	0.6%	35%	Hetero, IDU
East Asia & Pacific	late '80s	1 million	270 000	0.1%	20%	IDU, Hetero, MSM
Latin America	late '70s early '80s	1.4 million	130 000	0.5%	30%	MSM, IDU, Hetero
Caribbean	late '70s early '80s	420 000	60 000	2.2%	50%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	1 million	250 000	0.5%	20%	IDU
Western Europe	late '70s early '80s	560 000	30 000	0.3%	25%	MSM, IDU
North America	late '70s early '80s	940 000	45 000	0.6%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s early '80s	15 000	500	0.1%	10%	MSM
<b>TOTAL</b>		<b>40 million</b>	<b>5 million</b>	<b>1.2%</b>	<b>48%</b>	



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\* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2001, using 2001 population numbers  
 \*\* Hetero: heterosexual transmission - IDU: transmission through injecting drug use - MSM: sexual transmission among men who

have sex with men



World Health Organization

HIV infection is reported to have resulted from contact between skin and mucous membranes and infected blood<sup>28</sup>. Contact with blood is likely to go unnoticed especially, where the amount is small and the exposed person is inattentive to the exposure. There is therefore a risk of infection between household members in the absence of sexual, percutaneous or documented blood contact. One of the reports of such transmission involves transmission from an HIV-infected child to a sibling through a

<sup>28</sup> Ippolito, G., Puro, V., & De Garli, G. Italian study group on occupational risk of HIV infection. The risk of occupational immunodeficiency virus infection in health care workers: Italian multicenter study. *Archives of Internal Medicine* 1993, 153:1451-8; Simonds, R.J. & Chanok, S. Medical issues related to caring for human immunodeficiency virus-infected children in and out of the home. *Paediatr Infect Dis J.* 1993, 12:845-52

bite<sup>29</sup>. However, the vast majority of HIV-infected persons do not transmit the virus except by the well-recognised routes.

Since HIV is present in very low levels in saliva, some experts warn that "wet" kissing, also known as deep kissing or "French" kissing may be a risky activity because of the exchange of saliva<sup>30</sup>. A Federal Court of Appeals decided that the mouth and teeth of an HIV infected person should be regarded as a "dangerous" or "deadly" weapon (US v Moore)<sup>31</sup>

#### **1.4. History and magnitude of the HIV pandemic**

AIDS was first identified in 1981<sup>32</sup>. Nearly all those infected were homosexual men and intravenous drug users in the US. Later, other groups were identified, i.e. haemophiliacs and immigrants from Haiti and Central Africa. In Africa, the disease seems to affect mostly heterosexual persons, especially those with multiple partners. Sixty percent of all AIDS cases in the Caribbean are attributable to heterosexual contact<sup>33</sup>.

By 1988, it was established that about 10 million people were infected with HIV<sup>34</sup>. Presently, it is estimated that 36 million people world-

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<sup>29</sup> Fitzgibbon, J.E., Gaur, S., Frenkel, L.D., Laraque, F., Edlin, B.R., Dubin, D.T. Transmission from one child to another of human immunodeficiency virus type 1 with a zidovudine-resistance mutation. *New England J Med* 1993, 329:1835-41

<sup>30</sup> Communicable Diseases, p.8

<sup>31</sup> 669 F Supp 289 (D Minn., 1987)

<sup>32</sup> Communicable Diseases, ibid.

<sup>33</sup> Voelker, R. HIV/AIDS in the Caribbean. *Journal of the American Medical Association* 2001, 285:2961-3

<sup>34</sup> Goldsmith, M.F. AIDS around the world: Analysing complex patterns. *Journal of the American Medical Association* 1988, 259:1917-9

wide are HIV positive<sup>35</sup>. This figure is more than the population of Kenya. By 2000, a whopping 22 million had succumbed to AIDS. In the same year alone, 5.4 million people were infected, representing 14, 500 infections in a day. In that same year, 2.4 million died of AIDS<sup>36</sup>. In the US there was an estimated 900,000 Americans who were HIV positive in 1997. Africa is said to be home to 70% of the 36 million people living with HIV/AIDS. Epidemiological studies put 3.1 million Kenyans as being HIV positive, 2.7 million have already died of AIDS and that AIDS is claiming 900 lives daily<sup>37</sup>.

The chart below shows the global distribution of HIV/AIDS by the year 2001. sub-Saharan Africa (with over 28 million out of 40 million) is the worst affected. This region happens to be one of the poorest in the world. Whether there is a relationship between the high numbers seen here and the level of poverty is a matter of economic research. Suffice to say that due to the high numbers, it may as well be that one needs measures that go beyond those in the other regions in order to effectively combat the spread of HIV/AIDS. Hence, the need to look to the law for possible support.

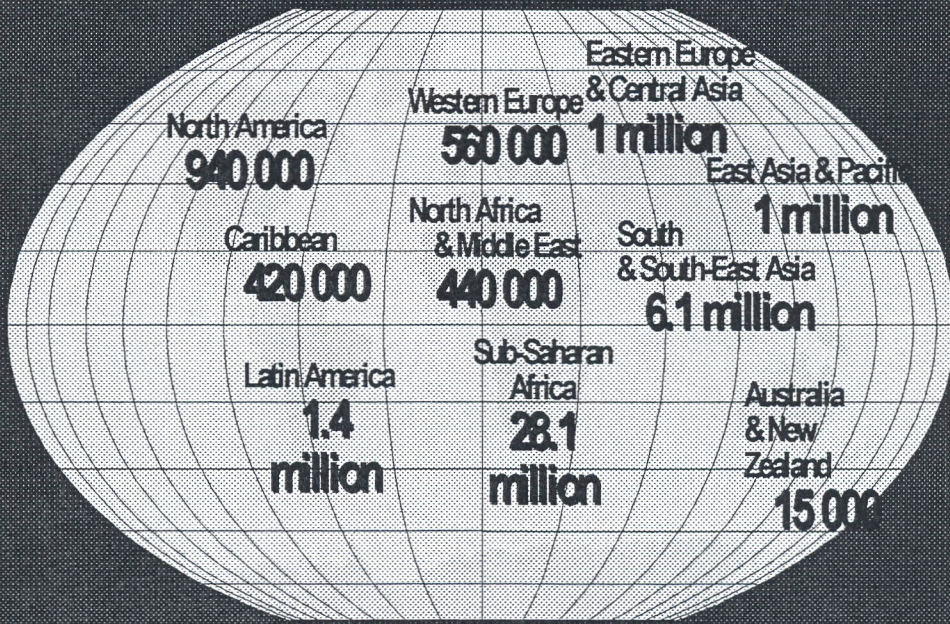
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<sup>35</sup> Begley, S. Special report - AIDS at 20. *Newsweek*, June 11, 2001, at 40; Mutume, G. AIDS. Experts question obsession with condoms. *East African Standard*, Wed. 30 May, 2001

<sup>36</sup> Mutume, *ibid.*

<sup>37</sup> Prof. Peter Kenya, personal Communication, National AIDS Conference, Mbagathi/Nairobi 12 Oct, 2001

# Adults and children estimated to be living with HIV/AIDS as of end 2001



## Total: 40 million



UNAIDS  
United Nations Programme on HIV/AIDS

00002-E-4 - 1 December 2001



World Health Organization

About 13 million children world-wide under the age of 15 years are orphaned<sup>38</sup>. Such children are vulnerable to discrimination, sexual exploitation, trafficking and homelessness. The chart below, though based on a Zambian study is a reflection of what the situation is in many countries, including Kenya. The legal consequences that flow from this is that legal provisions need to be made to mitigate the effects of HIV/AIDS on orphans.

AIDS has developed into an epidemic. AIDS is always fatal and there is no known cure to date<sup>39</sup>. Although the world has had epidemics and pandemics before, AIDS has certain uniqueness about it<sup>40</sup>:

- It combines two features not previously found together in quite such stark and absolute terms, i.e. it is sexually transmitted and presently lacks medication for cure or prevention.
- Once infected, one is infected for life.
- It has a window period during which there are no visible effects for a number of years and a person is increasingly more infectious to others. It is a virus infection and modern medicine has not produced a cure for virus infections.
- Current medical treatment of virus illnesses consists of alleviating the symptoms of the illness until the sufferer's immune system itself overcomes the infection. However, AIDS attacks this natural immunity and thus creates a problem that was hitherto unknown.

Many analysts of the AIDS scene in Africa are worried that the urban concentration of AIDS may deplete the educated ruling elite, pushing back

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<sup>38</sup> Reuters, 13 Million Youngsters Worldwide have lost parents to AIDS, *Daily Nation*, Wed. 18 Oct. 2001

<sup>39</sup> Communicable Diseases, p.5

<sup>40</sup> Almond, p.4



the entire continent's economy and social development<sup>41</sup>. In Africa, a special difficulty with both gathering of data and informing people about AIDS is seen in the fact that the majority live in villages and use a variety of languages and dialects<sup>42</sup>. The figures shown above could represent a serious underreporting.

The US Public Service recognised AIDS as the nation's number one health priority<sup>43</sup>. In Kenya, AIDS was declared a National disaster in 1999 although the legal instruments have been slow in coming.

### x **1.5. Socio-economic impact of HIV/AIDS**

The AIDS epidemic poses not only a serious threat to public health but its impact goes far beyond health. A deeper dimension of the AIDS epidemic is political and it is manifested in legislation. In the US<sup>44</sup>, the volume and content of state AIDS legislation has increased considerably. Legislation related to AIDS has been enacted in every state and the District of Columbia with over 170 statutes passed. The AIDS specific legislation is superimposed on a large body of existing often obsolete communicable disease legislation. The 100<sup>th</sup> Congress enacted the Health Omnibus Programs Extension Act of 1988<sup>45</sup>, which directed \$1.2 billion toward AIDS treatment, services and research. States have also made provision for

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<sup>41</sup> Goldsmith, *ibid*.

<sup>42</sup> Goldsmith, *ibid*.

<sup>43</sup> Anonymous: The Constitutional rights of AIDS carriers. *Harvard LR* 1986, 99:1274; US Public Health Service, Facts About AIDS 1 (1984).

<sup>44</sup> Gostin 1989, 1621

<sup>45</sup> Debates on Amendment to the Public Health Service Act. *Congressional Record*, Oct 13, 1988, 134:S15690-S15712

medical, mental health, social, housing, testing or financial services available to patients with AIDS.

In the US, it is estimated that the first 10,000 AIDS cases cost US\$6.3 billion in hospital expenses and earnings lost because of disability and premature death<sup>46</sup>. Further, HIV/AIDS is lowering food production and consumption in Africa. For instance, in Ethiopia, studies show that households spent 50-66% less time working on farms. In Tanzania, the per capita food consumption fell by 15% per household when an adult died of AIDS<sup>47</sup>. Kenya is said to be losing over US\$200 million daily due to AIDS, yet less than 2,000 people can afford anti-retrovirals<sup>48</sup>. In 1996, it was estimated that the care of an HIV-infected patient was US\$1,792 (Kshs. 143, 360/=) per month on average<sup>49</sup>. The cost of anti-retrovirals (AVRs), which have helped reduce AIDS deaths in developed countries by about 75% is well beyond the reach of about 2.2 million Kenyans living with HIV/AIDS. It is estimated that only 2,000 of them can afford these drugs<sup>50</sup>. In addition, it is well known that HIV is better controlled in-patients who undergo phenotypic testing (for example, the antivirogram). The test gives insight into how patients will respond to each drug. It is very useful to

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<sup>46</sup> *New York Times*, Jan 10, 1986, at A15, col.1

<sup>47</sup> Reuters, AIDS ravages Africa's Food Output. *East African Standard*, Wed. 30 May 2001

<sup>48</sup> Akolo, J. Shs 3b needed for AIDS drugs, *East African Standard*, Thursday 20 Sept. 2001

<sup>49</sup> Bozzette, S.A., Joyce, G., McCaffrey, D.F., Leibowitz, A.A., Morton, S.C., Berry, S.H., Rastegar, A., Timberlake, D., Shapiro, M.F., Goldman, D.P. Expenditures for the care of HIV-infected patients in the era of highly active antiretroviral therapy. *N Engl J Med* 2001, 344:817-823

<sup>50</sup> Gruduah, O. Bruising Intellectual property Rights Wars, *East African Standard*, Monday, Nov. 26, 2001

patients not responding to conventional drug cocktails<sup>51</sup>. However, the test has two setbacks: it costs Kshs 62,400 (USD 800) and it takes about one month to get results. Then there arises the need for a genetic test in patients who have become resistant to drugs. This is faster and costs about half the price.

It has been observed that:

*"The high cost of treating people positive for HIV is a drain on resources in developing countries and makes it unlikely that the same standard of treatment will be available to most of those infected in developing countries. HIV infection places its own separate demands on limited third world resources."*<sup>52</sup>

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<sup>51</sup> Virco 1995-2000, Treatment without sensitivity tests a waste of time - study. *East African Standard*, Monday, Nov. 26, 2001

<sup>52</sup> Woolley, P. We cannot afford an AIDS epidemic. *British Journal of Medicine* 1991, 302:962

## Global estimates for adults and children - end 2001

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- People living with HIV/AIDS..... **40 million**
- New HIV infections in 2001..... **5 million**
- Deaths due to HIV/AIDS in 2001..... **3 million**



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The above chart presents a global picture on new HIV infections in the year 2001 as well as the number of deaths related to HIV/AIDS. The figures for new infections world-wide exceed the populations of certain countries and in some cases, of certain cities. This high figure is a clear indication that the current measures of HIV/AIDS prevention that have been in use for the past 20 or so years alone may not be effective. This gives room for the thinking along introducing some legislation to complement the already existing measures.

### About 14 000 new HIV infections a day in 2001

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- More than 95% are in developing countries
- 2000 are in children under 15 years of age
- About 12 000 are in persons aged 15 to 49 years, of whom:
  - almost 50% are women
  - about 50% are 15–24 year olds



UNAIDS  
1990 1995 2000 2005 2010

00002-E-10 – 1 December 2001



World Health  
Organization

The above chart confirms that developing countries are worst affected by the HIV pandemic. Further, that children are also in the loop and that women are more affected than men. This would seem to indicate that in case of any measures aimed at prevention, children and women should be given special attention. This goes for all measures, including any legal measures. It is gratifying to note that the National AIDS Control Council has put measures in place to have information on HIV/AIDS included in the school curriculum in Kenya.

### End-2001 global HIV/AIDS estimates Children (<15 years)

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● Children living with HIV/AIDS	-----	<b>2.7 million</b>
● New HIV infections in 2001	-----	<b>800 000</b>
● Deaths due to HIV/AIDS in 2001	-----	<b>580 000</b>



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00002-E-11 - 1 December 2001



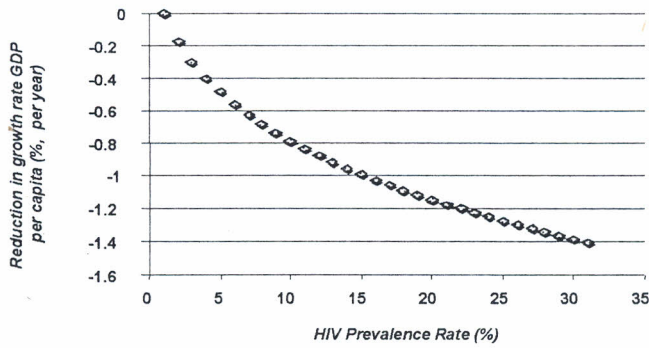
World Health  
 Organization

The number of children living with HIV/AIDS is worrying. Most of these are in sub-Saharan Africa and a large proportion was infected through the mother to child infection. If sufficient efforts aimed at this mode of transmission are put in place, they should help reduce the numbers of children infected with HIV/AIDS. The measures currently in place to combat infection through this route include the use of the caesarean section and the administration of anti-retrovirals to the expectant mother and the newborn baby. Some of the legal measures to go alongside these ones could include

HIV/AIDS has impacted negatively on economic growth of developing countries, in the process worsening the already bad economic situation.

## Economic Growth Impact of HIV (1990-97)

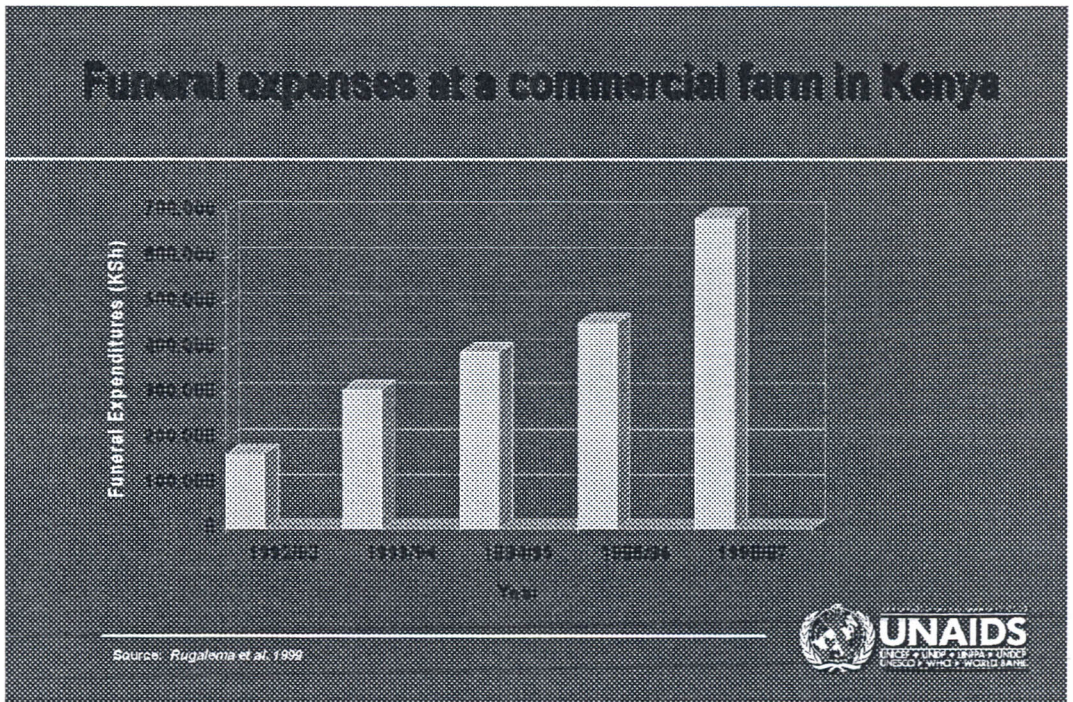
Figure 2: Growth Impact of HIV (1990-97) (80 developing countries)



Source: R. Bonnel (2000) *Economic Analysis of HIV/AIDS*, ADF2000 Background paper, World Bank



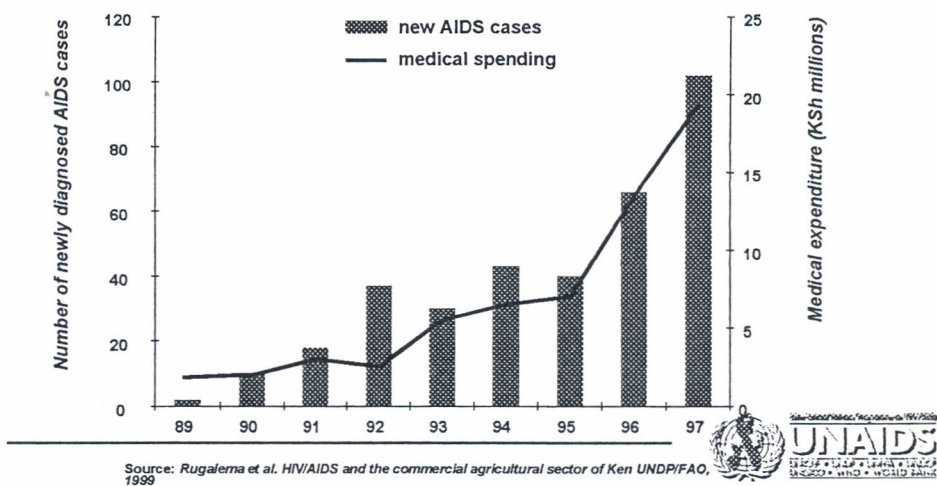
The chart below shows the impact of HIV/AIDS on the funeral expenses of a commercial farm in Kenya. These expenses cover the coffin, transport and other support given to those left behind. Clearly, such expenses are not only eating into the profits of the companies but they also reduce the tax payable to the state and thereby, contributing to economic decline.





The figure below shows the relationship between newly diagnosed cases of HIV/AIDS and medical expenditure. The costs clearly show a steep

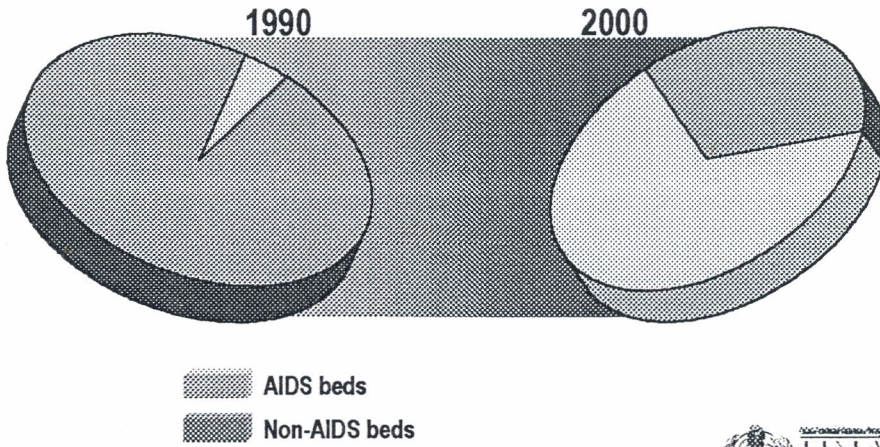
### Newly diagnosed AIDS cases and medical expenditure on an agricultural estate in Kenya, 1989 to 1997



increase in line with the increase in the numbers of HIV/AIDS cases.

The chart below shows the pattern of bed occupancy in hospitals in Zambia. In a span of just 10 years, the percentage shot from about 8% to over 60%. The situation is not any different in any sub-Saharan country in Africa.

## Bed occupancy required for AIDS patients, Zimbabwe



Source : UNAIDS, 2000



Part of the resultant social problem is that many children have been reduced to orphans and destitutes<sup>53</sup>. Homes are deserted. Over 50% of hospital beds are occupied by AIDS patients, thereby putting a heavy strain on the health budget. Another part of the social-emotional impact of HIV/AIDS is illustrated by the case of *S v Moses*<sup>54</sup>. Here, a gay man bludgeoned, stabbed and cut the deceased to death on learning from the deceased that the deceased was HIV positive after they had had unprotected anal intercourse. The accused lost self-control on hearing the news. The accused was charged with murder, which charge was reduced to manslaughter. He was convicted for manslaughter and sentenced to three years imprisonment. In the case of *John Midwa v Olivia A. Midwa*<sup>55</sup>, the petitioner, being the husband sought a divorce on the grounds of cruelty, whose particulars were that, the wife, who had tested HIV sero-positive, was endangering his life. The other instances of abuse were assaults and other matrimonial offences, which he alleged, were committed by the wife. The wife was paying the mortgage to the house. The trial court ordered the respondent to move to the servant quarters. On appeal, the Court of Appeal ordered her to go back to the matrimonial home pending determination of the suit. The substantive suit is still pending in court.

#### 1.6. **Current efforts at prevention**

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<sup>53</sup> Otieno, K. HIV infections ravaging Sori. *East African Standard*, Wed 30 May 2001

<sup>54</sup> [1996] 1 SACR 701 C

<sup>55</sup> H.C. Divorce Cause No. 8 of 2000

Prevention is seen to be the most effective strategy for controlling the spread of sexually transmitted diseases<sup>56</sup>. Until a cure is developed, the only way to control the epidemic is through prevention strategies directed at the main modes of spread of infection with HIV<sup>57</sup> namely:

- Infusion or inoculation of blood - making blood products safe;
- Peri-natal spread - by testing prospective mothers for HIV antibodies and advising them accordingly;
- Sexual contact, and
- Intravenous drug abuse

Most studies have recommended a decrease in the number of sexual partners, elimination of high-risk practices such as anal intercourse, abstinence, lifelong monogamy and provision of condoms<sup>58</sup>. The other suggestion advises against sex with anyone who has not been tested and shown to be uninfected with HIV<sup>59</sup>.

The Republic of Tasmania has made some headway in terms of legislation<sup>60</sup>. Section 22 prohibits the promotion of sexual behaviour likely to lead to HIV infection. Part III of that Act (sections. 24-39) regulate the supply and disposal of syringes and needles.

### **1.6.1. Abstinence**

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<sup>56</sup> National Institutes of Health, Condoms for prevention of sexually transmitted diseases. *Journal of the American Medical Association* 1988, 259:1925-1927

<sup>57</sup> Hearst, N. & Hulley, S.B. Preventing the heterosexual spread of AIDS. Are we giving our patients the best advice? *Journal of the American Medical Association* 1988, 259:2428

<sup>58</sup> Hearst & Hulley, 2428

<sup>59</sup> Goedert, J.J. What is safe sex? Suggested standards linked to testing for human immunodeficiency virus. *New England Journal of Medicine* 1987, 316:1339-42

<sup>60</sup> HIV/AIDS Preventive Measures Act 1993 (Tasmania)

Abstinence and sexual intercourse with one mutually faithful uninfected partner are considered the only effective prevention strategies<sup>61</sup>. This method is not unproblematic. For instance, by the early 1940s, syphilis and gonorrhoea were essentially untreatable and were considered an important public health problem. There was no vaccine either. The prevention of disease relied on efforts to control sexual behaviour and or encourage the use of prophylaxis<sup>62</sup>. The British Expeditionary Force in France during World War I distributed a leaflet advising sexual continence thus:

*"In this new experience you may find temptations both in wine and women. You must entirely resist both temptations, and, while treating all women with perfect courtesy, you should avoid any intimacy. Do your duty bravely, Fear God, Honour the King".*

Despite this message, 20% of 5,000 troops on two-month leave in Paris became infected<sup>63</sup>.

A Kenyan media study in which 3000 people were sampled showed that 38.6% had abstained from sex<sup>64</sup>. A question that begs for an answer is: "for how long?"

### **1.6.2. Faithfulness to one partner**

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<sup>61</sup> National Institutes of Health, *ibid*.

<sup>62</sup> Peterman, T.A. & Curran, J.W. Sexual Transmission of Human Immunodeficiency virus, *Journal of the American Medical Association* 1986, 256:2222; prophylaxis means preventive measures.

<sup>63</sup> Peterman & Curran, p.2223

<sup>64</sup> Mwangi, M. & Mugonyi, D. AIDS Campaign setback. *Daily Nation*, 24 Sept 2001

A media study in Kenya showed 27.6% of the respondents had reduced their sexual partners<sup>65</sup>. This low percentage goes to illustrate the difficulty of this approach as a preventive strategy.

### 1.6.3. Use of condoms

Some relevant legislation has seen the change of emphasis of condom use from contraceptive to prophylactic. **France** and **Belgium** have passed laws to legalise condoms and the **UK** now allows condom advertisements on TV. In **Kenya**, condoms are advertised on TV and in other media.

The proper use of condoms with each act of sexual intercourse can reduce, but not eliminate the risk of a sexually transmitted disease. The preventive effect of condoms is mainly two-fold: mechanical and chemical<sup>66</sup>. On the one hand, condoms provide a mechanical barrier that could reduce the risk of infections acquired through penile exposure to infectious cervical, vaginal, valvular or rectal secretions or lesions for the wearer. For the wearer's partner, the proper use of condoms could prevent semen deposition, contact with urethral discharge, and exposure to lesions on the head or shaft of the penis. However, condoms may not offer effective prevention for infectious agents spread from lesions rather than fluids because areas of skin not covered by the condom may be infectious or vulnerable to infection<sup>67</sup>. Laboratory results have shown condoms to be

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<sup>65</sup> *ibid.*

<sup>66</sup> National Health Institutes, *ibid.*

<sup>67</sup> National Health Institutes, 1925

effective mechanical barriers<sup>68</sup>. The latex condom has been found more effective than the natural membrane condoms, which contain small pores<sup>69</sup>. Research findings show that consistent previous condom use was associated with sero-negativity during the 1- to 3-year follow-up period in an HIV antibody negative heterosexual spouses of patients with AIDS<sup>70</sup>. In a study done in Zaire on prostitutes, it was found that there existed a protective association between a history of condom use and HIV sero-negativity<sup>71</sup>.

On the other hand, the chemical aspect of the condom in relation to surfactants, the active ingredients in commercially available spermicides have been shown to inactivate sexually transmitted agents, including HIV<sup>72</sup>. Further, the use of spermicide-containing condoms may provide additional protection against sexually transmitted disease in case of condom leakage or seepage. However, such protection cannot be available if the condom breaks<sup>73</sup>. In a 1986-87 survey of female prostitutes in the US, only 4% reported condom use with each vaginal exposure<sup>74</sup>.

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<sup>68</sup> Conant et al. Condoms prevent transmission of AIDS associated retrovirus. *Journal of the American Medical Association* 1986, 255:170-176

<sup>69</sup> Van de Perre et al. The latex condom, an effective barrier against sexual transmission of AIDS-related viruses, *AIDS* 1987, 1:49-52; Goldsmith, M. Sex in the age of AIDS calls for common sense & "condom sense". *Journal of the American Medical Association* 1987, 257:2261-6

<sup>70</sup> Fischl et al. Evaluation of heterosexual partners, of children and household contacts of adults with AIDS. *Journal of the American Medical Association* 1987, 257:640-4

<sup>71</sup> Man et al. Condom use and HIV infection among prostitutes in Zaire. *Lancet* 1986, 316:345

<sup>72</sup> Stone et al. Personal protection against sexually transmitted diseases. *American Journal of Gynaecology* 1986, 155:180-8; Hicks et al. Inactivation of HTLV/LAV-infected culture of normal human lymphocytes by nonoxynol-9 in vitro. *Lancet* 1985, 2:1422-31

<sup>73</sup> National Institutes of Health, 1926

<sup>74</sup> Centres for Disease Control. Antibody to human immunodeficiency virus in female prostitutes. *Morbidity & Mortality Weekly Report* 1986, 35:152-5

For condoms to be effective, they ought to be used properly from start to finish. It has been observed that even with a condom, anal intercourse between an infected individual and an uninfected partner poses a risk of transmitting HIV and other sexually transmitted diseases because the condom may break<sup>75</sup>. The legal consequence that flows from the mechanical characteristics of condoms is that manufacturers have a -two-fold duty: (1) to ensure high quality of manufacture and (2) to provide clear instructions for the users.

The major problem with the use of condoms is that prevention aims at the men whereas the females are more vulnerable. Firstly, socially, it is the man who decides where, when and how often to have sex, and whether it will be safe or not. Secondly, anatomically, compared to the male, the female sexual organ has a larger surface area, which increases the chances of an HIV infection by several factors. Thirdly, the female condom has not proved easy to handle, it costs about ten times more than the male one, it is not readily available, and its effectiveness in preventing sexually transmitted disease has not been fully studied. A method that will empower women to make choices regarding safe sex involves the use of microbicides that can be applied vaginally to prevent infection. These are however still at the developmental stage. There is therefore need to put legislation in place that would make the use of the condom mandatory in certain cases. Such

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<sup>75</sup> National Institutes of Health, 1928



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legislation is likely to enjoy support if it targets those who have already tested positive for HIV antibodies.

#### 1.6.4. Awareness campaigns

It has been generally recognised that in the absence of a cure or a vaccine, prevention is the only way of preventing the spread of HIV/AIDS, which prevention is seen largely as a function of education<sup>76</sup>. In the US, education and counselling on the prevention of HIV transmission are among the government's chief public health priorities<sup>77</sup>.

In the UK, a report from a genitourinary clinic offering counselling services notes that

*"... we were still finding acute uncomplicated gonococcal infection in homosexual men who knew they were infected with HIV. This group of men has been repeatedly counselled over safer sexual practices. Clearly, the transmission of gonorrhoea to these patients indicates failure to change their unprotected sexual activity."*<sup>78</sup>

A similar study targeting women attending the same clinic found that 75% were not using an adequate regular method of contraception. This study concludes by saying that there is a need for better strategies that would lead to a reduction of risky behaviour patterns. In spite of such reports, the most recent HIV strategy still emphasises public awareness<sup>79</sup>.

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<sup>76</sup> Mrs Christie, Head of the AIDS Centre at the SA Institute for Medical Research cited in *Jansen van Vuuren and Anor NNO v Kruger* [1993] (4) SA 842 at 852 F-G.

<sup>77</sup> Debates on the Amendment of the Public Health Service Act. *Congressional Record*, Oct 13, 1988, 134:S15690-S15712; see also: Fineberg, H.V.: Education to prevent AIDS: prospects and obstacles. *Science* 1988, 239-596

<sup>78</sup> Singaratnam et al. Preventing the spread of HIV infection.. *British Medical Journal* 1991, 302:469

<sup>79</sup> Kinghorn, G. A sexual health and HIV strategy for England. *British Medical Journal* 2001, 323:243-4

Some authors are of the opinion that emphasising feminist sex education will have the following advantages<sup>80</sup>:

- ◆ it will reduce the incidence of forced sex or coerced sex because teenage girls will learn to say "no" to unwanted sex, and thereby be able to control what happens to their bodies; and
- ◆ girls can learn to insist that boys use condoms before agreeing to engage in sex.

It is submitted that awareness campaigns are a useful support to other measures. Such campaigns ought to be expanded to include legal education.

### **1.7. The Missing link: The legal aspects**

Admittedly, the above strategies are imperfect as pragmatic guidelines for the public health of a nation because they are very difficult to follow<sup>81</sup>. As HIV is transmitted largely through volitional behaviour widely regarded as immoral or criminal, the problem can be regarded as susceptible to a legal rather than a public solution. The use of compulsion can be a visible political symbol of seriousness of purpose in controlling AIDS<sup>82</sup>.

Some researchers have identified the following, as the possible legal measures necessary to combat the spread of HIV/AIDS: quarantine, compulsory testing and notification<sup>83</sup>. Other areas requiring legislation

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<sup>80</sup> Steinberg, F.N. Feminist sex Education. To reduce the spread of AIDS, *17 Women's Rights Law Reporter* 63 (1995) No. 1 at 64

<sup>81</sup> Hearst & Hulley, 2428

<sup>82</sup> Gostin 1989, 1626

<sup>83</sup> Kibara, G.G.: AIDS Control: Legal implications on the liberty of victims. LL.B. Dissert. 1988, University of Nairobi.

include<sup>84</sup>: confidentiality/privacy, employment and the right to work, matrimonial obligations in the face of HIV/AIDS, criminal justice, negligence, access to drugs, human rights violations, and biomedical research. Indeed the media survey<sup>85</sup> showed that 32.6% and 22.4% respondents were for mandatory testing and punishment of those who infect others, respectively.

Unlike the actions taken by other countries, Kenya's response to the threat of HIV/AIDS has been rather slow and guarded. For instance, in 1987 HIV/AIDS was declared a notifiable disease. This was an attempt to bring HIV/AIDS under the control of the Public Health Act<sup>86</sup> in which HIV/AIDS was classified as a sexually transmitted disease. However, unlike other sexually transmitted diseases under the Public Health Act, HIV/AIDS is not solely transmitted through sexual contact, it is not strictly speaking a disease, and it has no cure. All these factors made the implementation of that legislative amendment difficult. These differences can impact negatively on the success of any suit on HIV/AIDS that may be brought before a court of law under the Public Health Act. The only positive gain from this move was that it enabled health institutions to monitor the trends in HIV/AIDS infection patterns. In short, very little or nothing can be achieved from the said actions above.

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<sup>84</sup> Rachier, ADO. HIV/AIDS and the Law, *The Lawyer*, 2001, No. 39, pp.10 - 13

<sup>85</sup> Nation Reporter, Study finds varied ways to contain the scourge. *Daily Nation*, 24 Sept 2001

<sup>86</sup> Cap 242 of the Laws of Kenya

Sessional Paper No. 4 of 1997 on AIDS in Kenya was published with the major objective of providing a policy framework for AIDS prevention and control efforts for the next 15 years. Following its publication, the National AIDS Control Council with a fully-fledged Secretariat was established under the Office of the President. This in turn set up other structures at provincial, district and constituency levels.

In 1999, AIDS was declared a National disaster. This declaration was neither gazetted nor was it followed up with concrete legal measures. Parliament passed the Industrial Property Act in June, 2001. This Act contains provisions, which include mechanisms such as compulsory licensing and parallel importation<sup>87</sup>. The former allows the country's drug manufacturers to produce generic versions of branded drugs in case of a medical emergency such as the AIDS pandemic whereas the latter enable the government to import drugs from the cheapest sources. As an illustration, the cost of fluconazole, a vital treatment for HIV associated candidiasis and cryptococcal meningitis, whose cost is currently placed at Kshs. 662 (USD 8.3) a tablet, is likely to come down to Kshs. 18 (USD. 0.25) a tablet. The cost of triple therapy is estimated to decrease from the current Kshs. 78,000 (USD 1,000) to Kshs. 27,000 (USD 346) a month<sup>88</sup>. The tragedy is that the government is dragging its feet in implementing this law.

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<sup>87</sup> Kimani, D. Move now on Industrial property Bill. *Daily Nation*, Wed., Nov. 28, 2001; *The Industrial Property Act, 2001* (ss. 72-79: Compulsory Licensing; s. 80: Parallel importation)

<sup>88</sup> Nyambala, M. Enforce Bill, Government urged, *East African Standard*, Monday, Nov. 26, 2001

In the year 2001, a Task Force to make recommendations on possible legal measures regarding HIV/AIDS was set up. It is hoped that the recommendations of this Task Force will open the way for legislation on this subject. Further, there is yet another Taskforce on Labour Laws. This later Taskforce should be able to address concerns of persons living with HIV/AIDS at the workplace more specifically.

From the foregoing, it is apparent that our legal regime on HIV/AIDS is totally wanting. There is need to come up with clear legislation on the following:

- ◆ Confidentiality of the HIV positive status in life and on death certificates
- ◆ Confidentiality of the doctor/patient relationship with regard to HIV
- ◆ Segregation/quarantine of persons living with HIV/AIDS
- ◆ Preventive measures relevant for institutions like prisons, boarding schools, colleges etc.
- ◆ Non-discrimination of persons who test HIV positive at the workplace, insurance and in recruitment
- ◆ Possible classification of HIV/AIDS patients under the category of disabled persons
- ◆ Criminalisation of risky behaviour associated with the spread of HIV

This research seeks to address itself to the following contentious legal issues: confidentiality, criminalisation of risky behaviour, and discrimination of persons living with HIV/AIDS.

The major hypotheses to be tested are:

- A legal regime on HIV/AIDS in Kenya is lacking.
- The current legal regime on communicable diseases is wanting as far as HIV/AIDS is concerned.
- The lack of a legal regime on HIV/AIDS is an obstacle in the prevention of the pandemic.
- Enactment of legislation on HIV/AIDS will result in a reduction of its spread

More specifically, this study considered the following hypotheses:

- The adherence to the Hippocratic rule on doctor-patient confidentiality with regard to the HIV sero-positive status of a patient is a hindrance to its prevention of its spread as this leaves close contacts very vulnerable.
- The lifting of the veil of confidentiality will reduce the spread of HIV infection.
- The lack of laws criminalising the deliberate spread of HIV/AIDS hampers efforts to reduce its spread.
- Enactment of laws criminalising such behaviour will result in a reduction of the spread of the pandemic.
- There is discrimination against persons living with HIV/AIDS which has resulted in stigmatisation and secrecy about the pandemic.
- Current trends in Kenya appear to favour openness.
- Laws prohibiting discrimination and advocating for openness will result in destigmatisation and openness thereby facilitating voluntary counselling and testing and the provision of other services with a net result of reduction in the prevalence of HIV/AIDS.

## CHAPTER TWO: HIV/AIDS AND CONFIDENTIALITY, CRIMINALIZATION AND DISCRIMINATION

### 2.1. Confidentiality

#### 2.1.1. The Hippocratic corpus and its transformation

"...Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret".  
**(Hippocratic Oath<sup>89</sup>)**

The Hippocratic oath imposes confidentiality on the doctor in all his dealings with his patients<sup>90</sup>. The Hippocratic oath has undergone a lot of transformation. Initially, the doctor had all the authority in the doctor/patient relationship. This code has been severally challenged since the mid 1960's to the present<sup>91</sup>. This transformation has been in four phases: (1) the Quiescent period - the Hippocratic Ethic, (2) The period of Principalism, (3) The period of Antiprincipalism, and (4) The period of Crisis. In *the Quiescent period*, the Hippocratic corpus consisted of the Oath and dentological books. The ethics of the corpus reflects a mosaic of moral ideas written at different times and influenced by Greek thinkers. The Oath is linked to Pythagoras<sup>92</sup>. It contains ethical precepts such as obligations of beneficence, nonmaleficence<sup>93</sup>, and confidentiality as well as prohibitions against abortion, euthanasia, surgery and sexual relationships with patients. The dentological books deal with the etiquette expected of a

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<sup>89</sup> Hutchins, RM (ed.-in-Chief). Great Books of the Western World, 10. *Hippocrates by Galen*; William Benton Publishers, Chicago:1952, p. xiii

<sup>90</sup> Orr, p.116

<sup>91</sup> Pellegino, ED. The metamorphosis of Medical Ethics. A 30-year Retrospective. *Journal of American Medical Association*, 1993, 269:1158-62

<sup>92</sup> Carrick, P. *Medical Ethics in Antiquity*. Dordrecht, The Netherlands, D. Reidel Publishing Co., 1985

<sup>93</sup> beneficence: doing everything for the benefit of the patient; nonmaleficence: do no harm

gentleman. Emphasis during this period was on the overall aims of a moral life, that is, defining the good and the just, and cultivation of the virtues. A good physician was one who was able to discern the right and good thing to do in the face of a particular moral choice. Although there were some doctors who were also philosophers like John Locke and William James, they never questioned the basis of the ethics they were trained in<sup>94</sup>.

The first modification of the Hippocratic Oath came from religious influences and the *noblese oblige* expected of a gentleman. This synthesis formed the basis of the first Code of Ethics of the American Medical Association in 1847. This synthesis served as a basis for medical practice in America and in the UK. This Hippocratic ethic was authoritarian and paternalistic. The patient had no say in clinical decisions. Societal changes challenged this mosaic of philosophical constructs. Such changes included a more educated society, the spread of participatory democracy, decline in communally shared values, heightened sense of ethnicity and a mistrust for authority and its institutions. At the same time, specialisation, fragmentation, institutionalisation and depersonalisation of health care were altering the character of medicine. In addition, the advances in medical technology expanded the ethical issues tremendously. These led to a demand for alternative ways of teaching and practising medical ethics. And in came moral philosophers.

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<sup>94</sup> Pellegrino, ED. The Metamorphosis of Medical Ethics: A 30 year retrospective. *Journal of the American Medical Association* 1993, 269:1158-62.



The *period of Principalism* was characterised by the erosion of the Hippocratic synthesis that left many physicians in a state of helplessness. They sought guidance in the courts and in legislation. Some lost faith in the ethics completely while others turned to moral philosophers. Moral philosophy provided a systematic and relatively objective way of approaching ethical questions. Its analytic rigour found favour with academic clinicians that sought to teach ethics effectively in a morally pluralistic society. This approach was free from faith commitments. The theory of *prima facie* principles developed by Ross<sup>95</sup> was adapted to medical ethics by Beauchamp and Childress<sup>96</sup>. These authors chose principles especially suitable for medical ethics such as nonmaleficence<sup>97</sup>, beneficence, autonomy, and justice. This tetrad (the four principles above) was useful in clinical medicine in the following ways:

1. It promised to reduce some of the looseness and subjectivity that characterised so many ethical debates when the Hippocratic Oath was challenged;
2. It provided fairly specific action guidelines;
3. It offered an orderly way to "work up" an ethical problem, a way similar to the clinical work-up of a diagnostic or therapeutic problem; and
4. The tetrad avoided direct confrontation with divisive issues such as abortion, euthanasia etc.

Two of the *prima facie* principles, beneficence and nonmaleficence were similar to the Hippocratic obligations to act always in the best interests

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<sup>95</sup> Ross, WD. *The right and the good*. Indianapolis, Ind: Hackett Publishing Co. Inc, 1988

<sup>96</sup> Beauchamp, TL & Childress, JF. *Principles of Biomedical Ethics*, 3<sup>rd</sup> ed., NY:Oxford University Press, 1989

<sup>97</sup> Nonmaleficence: do no harm; beneficence: do everything for the benefit of the patient.

of the patient, and to avoid doing harm. The principle of autonomy directly contradicted the traditional authoritarianism and paternalism of the Hippocratic corpus. This principle is central to "informed consent," privacy and self-determination. Some clinicians think this principle would work against the best interests of the patient. The principle of justice is new to the Hippocratic ethic. This principle speaks to disparities in the distribution of health care and cutting down of costs<sup>98</sup>. A major limitation of the tetrad lies in the application of any set of abstract principles to particular cases and in reducing conflicts between the *prima facie* principles. In this period therefore, the patient began to exert his/her rights and to question the authority of the doctor. The doctor can no longer defend his/her actions based solely on the Hippocratic corpus. The doctor in turn, therefore, seeks help in the statutes to justify some of his/her actions and to protect himself against unforeseen litigation.

In the *period of Antiprinciplism*, some scholars criticised the tetrad saying that principles are too abstract, too rationalistic and too removed from the psychological milieu in which moral choices are actually made<sup>99</sup>. They further argued that principles ignore a patient's character, life story, culture and gender. There is therefore a growing concern for alternatives to principal based medical ethics, indicating that the metamorphosis continues.

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<sup>98</sup> Rawls, J. *A Theory of Justice*. Cambridge, Mass: Harvard University Press, 1971.

<sup>99</sup> Rorty, R. *Philosophy of the Mirror of Nature*. Princeton, NJ: Princeton University Press, 1979

The *period of Crisis* refers to the years ahead. The difficulties of the principles and any alternatives lie in the fact that contemporary philosophy is currently in a parlous state. Philosophers themselves cannot agree on what constitutes the "truth." For example, Rorty<sup>100</sup> says there is no chance of arriving at the truth through philosophy. This line of thinking finds support in Derrida<sup>101</sup>, who denies there being any truth, but that there is only an appearance of truth. Further, there is a global surge of cultural hegemony which views medical ethic originating from the Hippocratic ethic as a Western product and therefore incompatible with other cultures, especially, with regard to autonomy. Whatever stand one takes, there are moral ethical questions that beg for answers in a practical way. Indisputable is that conceptual conflicts in ethics and scepticism of moral philosophers challenge the very idea of a universal, normative ethic for medicine.

All these changes have thrown medical ethics into a state of confusion, rather than a crisis. These transformations of the Hippocratic corpus have been propelled by necessity. One thing that clearly emerges from the above is that the Hippocratic corpus, including the Oath was not written in stone. It continues to undergo modification. As of now, the medical profession cannot set standards for medical practice and follow them<sup>102</sup>. The medical profession no longer has the authority to make these

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<sup>100</sup> *ibid*

<sup>101</sup> Madison, GB. Coping with Nietzsche's Legacy - Rorty, Derrida, Gadamer. *Philosophy Today*, Spring 1990:3-19

<sup>102</sup> Whitney, SN. An iconoclastic view of Medical Ethics. *The Georgetown Law J.* 2000, 88:719

decisions unilaterally. There is no guarantee that the courts will support the view of the medical profession of what should be done. Only parliament has the power to redraw the distribution of power among the medical standards, religious beliefs and the interpretation of the law. This situation is best illustrated by the case of *re Baby K*.<sup>103</sup> Baby K was born at Fairfax Hospital in Virginia with a condition known as anencephalic. She had no higher brain. Babies in this condition are incapable of consciousness and die within a few hours of birth. The usual practice is to explain gently to the parents that the baby has an abnormality and will not live long, to wrap the baby in a towel so that the abnormality, which can be quite grotesque, is hidden, and to allow parents to hold the baby as long as they wish. Without life support, death ordinarily follows. Due to her strong religious convictions, Baby K's mother felt that the doctors must do everything possible for her baby, including providing ventilatory support. For a while, they complied hoping the baby would die. When the baby continued to live, her physicians and Fairfax Hospital went to court. They sought a ruling that further aggressive support was not required. However, the court ruled that the treatment must continue.

In 2002, physicians from the UK and USA came up with a Revised Version of the Hippocratic Oath. In this Revised Version, confidentiality should only be maintained where it does not put in danger the lives of

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<sup>103</sup> 832 F. Supp. 1022 (E.D. Va 1993), *aff'd* 16 F. 3d 590 (4<sup>th</sup> Cir. 1994)

others<sup>104</sup>. However, many physicians in Kenya are still detained in the prison of the older version of the Hippocratic Oath.

The nature of HIV/AIDS has thrown the doctor/patient relationship into a crisis. There has been a lot of silence and secrecy. The Hippocratic Oath has often been cited as a barrier to disclosure. At the same time, this apparent "silence" may be responsible for the further spread of HIV infection. With the looming danger of HIV/AIDS, questions that require some reflection are:

1. Where a doctor attends to a patient who tests HIV positive, should he/she disclose to the spouse or the next of kin, or employer as a way of preventing further spread? [This is now provided for under the amended Public Health Act making HIV/AIDS a noticeable "disease", although its application is rather slow in coming]
2. Should AIDS be indicated as a non-proximal cause of death on death certificate where the final ailment is AIDS related?
3. Does the confidentiality between a doctor and a patient enjoy legal protection?
4. Does the current HIV/AIDS pandemic present sufficient necessity to put laws in place that modify the Hippocratic Oath regarding secrecy?

### **2.1.2. Doctor/patient relationship - current status**

People come forward to seek care on the understanding that the clinician has the obligation to offer care without discrimination and will respect and secure confidentiality. Patients thus feel free to reveal a lot of

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<sup>104</sup> The other major highlight of the Revised Version of the Hippocratic Oath is that abortion is allowed where the country's laws so permit. Overall, the wording in this Version is reflective of the current developments in the world.

personal information, as it relates to AIDS. This information can be used as a basis for offering advice and education regarding prevention<sup>105</sup>.

In the US, the right to privacy is not explicit in the constitution. However, earlier decisions (before the advent of HIV/AIDS) were in support of confidentiality. For instance, in *Hague v Williams*<sup>106</sup>, the Supreme Court of New Jersey observed that:

*"A patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled."*

In *Roe v Wade*<sup>107</sup>, a right to privacy in making certain personal decisions about abortion up to the point of viability of the foetus was upheld. With the advent of HIV/AIDS, the approach of US courts is very guarded and unpredictable and the practice in her states is quite variable. Courts in the US require HIV testing of criminal defendants in cases of rape (*Cmwlth v Winkelspecht*<sup>108</sup>, *Cmwlth v Mason*<sup>109</sup>) and in other sexual assaults (*Shelvin v Lykos*<sup>110</sup>, *State v Bullock*<sup>111</sup>). This is on the basis that the victims' right to know outweighs the defendant's right to privacy (*People v Cook*<sup>112</sup>).

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<sup>105</sup> Pinching, p.32

<sup>106</sup> 181 Atlantic Reporters 2D 345 at 349 [1962]

<sup>107</sup> 410 US 113 (1973)

<sup>108</sup> 538 A2d 498 [1988]

<sup>109</sup> 538 A2d 498 [1988]

<sup>110</sup> 741 SW2d 178 [Texas App Hous 1<sup>st</sup> Dist 1987]

<sup>111</sup> Sup Ct Wis. AIDS Lit Rptr 11-11-1988

<sup>112</sup> 533 NE2d 678 [1988]

The states of Illinois, California and Wisconsin have adopted legislation that safeguards the confidentiality of individuals who are tested for HIV at blood banks and other sites. Wisconsin, California and Florida prohibit the use of the test result to determine eligibility for disability, health or life insurance or to terminate employment. With regard to test results, it has been argued that such information should not be disclosed without a written consent<sup>113</sup>.

The early statutes in US states explicitly prohibited disclosure of an HIV test result without written consent (e.g. in California and Massachusetts). Modern statutes broadly protect the identity of individuals seeking an HIV test, their sero-positive status, all unauthorised disclosures of the medical record, and information obtained in interviews for the purposes of partner notification. These statutes also permit disclosures thought necessary for public health<sup>114</sup>.

So far, there is some uncertainty between patients' rights to confidentiality and the right of others to know whether they have been exposed to infection or not. Public policy protects the records of carriers of infectious disease who present themselves for treatment. This is an attempt to encourage persons to seek testing or treatment and to confide in their physicians<sup>115</sup>. Health care providers are obligated to maintain

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<sup>113</sup> Weldon-Linne, M.M., Weldon-Linne, C.M. & Murphy, J.L. 'AIDS-Virus Antibody Testing: Issues of informed consent & patient confidentiality' (1986) 75 *Illinois Bar J*, p.206

<sup>114</sup> *ibid.* 1989, 1627

<sup>115</sup> Gostin, 1965

confidentiality (*Penn v Doe*<sup>116</sup>). Where Health care providers have posted names of HIV positive patients on a laboratory bulletin to allay technicians fears, they have been held liable for breach of confidentiality (*In re Worcester Hospital*<sup>117</sup>). They have equally been held liable for disclosing a patient's HIV status to family, friends, or employers (*Urbaniak v Newton*<sup>118</sup>, *Auon v Baughman*<sup>119</sup>, *Kautz v Orizondo*<sup>120</sup>)

A number of states in the US have established an exemption to the confidentiality of HIV test results for the purposes of epidemiological research, which must however exclude names of infected individuals<sup>121</sup>. The Legislatures in the US are equally sensitive to the public interest. In *Tarasoff v Regents of the University of California*<sup>122</sup>, a psychiatrist was held to have a duty to warn a woman that his patient was contemplating killing her. It is unclear how US courts will deal with the issue of liability for failure to inform a third party of a patient's HIV antibody positive status<sup>123</sup>.

The US position regarding confidentiality is therefore one of guarded approach, based on the necessity presented by the desire to protect the larger public. Secrecy is not as absolute as originally envisaged in the Hippocratic corpus.

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<sup>116</sup> Nurse & Meroy Hospital, Ct of Common Pleas, Lackawanna Cty, Pa, AIDS Lit Rptr 13-01-1989

<sup>117</sup> *Mass. Sup Ct, Suffolk Cty, Boston Globe* 24-09-1987

<sup>118</sup> *Sup Ct No. 87-0679, San Fran City, ACLU*

<sup>119</sup> *Circ Ct Baltimore, Md, AIDS Lit Rptr* 28-12-1987

<sup>120</sup> *9<sup>th</sup> Jud Cir Ct, Fla, AIDS Lit Rptr* 27-05-1988

<sup>121</sup> *Gostin* 1989, 1621

<sup>122</sup> *551 P 2d 340 [1976]*

<sup>123</sup> *Orr*, p.126



In the UK, the general acceptance of the Hippocratic Oath is reflected in the words of the court in *X v Y*<sup>124</sup> where the court said:

*"In the long run, preservation of confidentiality is the only way of securing public health, otherwise doctors will be discredited as a source of education, for future individual patients will not come forward if doctors are going to sequel them. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care."*

However, it is recognised that a doctor's duty to respect a patient's confidentiality is not absolute. A doctor can be ordered by the court to breach confidentiality<sup>125</sup>. Where the courts are not involved, the General Medical Council has outlined a number of guidelines concerning disclosure of confidential information. As a rule, a doctor has no business disclosing his/her patients' information to third parties. This is as it has always been in the Hippocratic tradition. One of the guidelines regarding disclosure is where the 'public interest' demands that the doctor's duty to maintain confidentiality should be overridden. The doctor is therefore called upon to balance against his patient's interest the risk to other individuals. In disclosing, the doctor should first attempt to obtain permission of the patient. The British Medical Association ruled in December, 1985 that doctors have a right to tell a spouse or lover that their partner has AIDS, even if the patient does not agree to the disclosure<sup>126</sup>.

The UK National Health Service (Venereal Diseases) Regulations 1974 make specific exceptions to the duty on health authorities to ensure that the

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<sup>124</sup> [1988] 2 All ER 648 at 653

identity of a sexually transmitted disease sufferer is kept confidential.

Exceptions apply in cases where such revelation would either facilitate treatment or prevent the spread of the disease<sup>127</sup>. Some authors argue that such exception should apply to HIV even where it is not contracted as a result of sex<sup>128</sup>.

In the UK, it has been decided to store people's HIV status on police computers<sup>129</sup>. The person concerned either provides the information, or if it comes from an external source, permission to store it is not sought from the individual concerned. This information is fed into centralised and local computer records. These records are centrally controlled. The objectives for this approach are:

*"... it is desirable for the relevant police officers to have full information as early as possible to enable them to discharge their responsibility for the wellbeing of people in their custody. They consider it important that they are aware of any information that may affect how they deal with a person or how they handle a given situation; they also regard it as their duty to ensure, as far as possible, the safety of other prisoners and of the public"<sup>130</sup>*

The British Medical Association's Handbook for the guidance of practitioners lays down a code of conduct for members of the medical profession. It is stated therein that a doctor should not voluntarily disclose to a third party information, which he has learnt directly or indirectly in his

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<sup>125</sup> Orr, p.117

<sup>126</sup> Hancock, G. & Carim, E. *AIDS: The deadly epidemic*, London:Victor Gollancz, 1986, p.25

<sup>127</sup> *Statutory Instrument 74/29*

<sup>128</sup> Aitken, p.

<sup>129</sup> Mason, JK. Recording HIV status on police computers. *British Medical Journal*, 1992, 304:995-6

<sup>130</sup> *ibid.*, p. 995

professional relationship with a patient subject to these, among other exceptions:

1. The patient gives his consent to that disclosure, and
2. The information is required by law.

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In *Hunter v Mann*<sup>131</sup>, the defendant, a doctor, had information, which might have led to identification of the driver of a stolen car that was alleged to be guilty of dangerous driving. He had treated the man at his evening clinic, and a girl, who said she had been involved in a road traffic accident. He did not seek their consent to disclose their identities to the police. When the police sought the identification of the persons from him, he declined on the ground that he considered such information confidential because it had been obtained through the relationship of doctor and patient. It was held that a doctor cannot refuse to disclose information required of him by the court. This therefore indicates that, in Britain, medical practitioners are not, unlike lawyers, legally protected by an absolute professional privilege, only capable of being waived by the client.

In *Lion Laboratories Ltd v Evans*<sup>132</sup>, the Court of Appeal said:

*"if the court decided that the defence of public interest could be raised, it had to go on to weigh the competing interests of, on the one hand, the public interest in preserving the rights of organisations and of individuals to maintain the secrecy of confidential information against, on the other, the interest of the public to be informed of matters which were of real public concern".*

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<sup>131</sup> [1974] 1 QB 767

<sup>132</sup> [1984] 2 All ER 417 at 418 (c)

In *AG v Guardian Newspapers*<sup>133</sup>, the AG sought an injunction to restrain the publication of information based on confidentiality. In dismissing his appeal, the House of Lords observed that:

*"... a duty of confidence could arise in contract or in equity and a confidant who acquired information in circumstances importing such a duty should be precluded from disclosing it to others; that a third party in possession of information known to be confidential was bound by a duty of confidence unless the duty was extinguished by the information becoming available to the general public or the duty outweighed by a countervailing public interest requiring disclosure of the information; that in seeking to restrain the disclosure of government secrets the Crown must demonstrate that disclosure was likely to damage or had damaged the public interest before relief could be granted;..."* (Emphasis by the author)

In *W. v Egdeell*<sup>134</sup>, the plaintiff was a patient and the defendant a consultant psychiatrist. The plaintiff had shot and killed five people and injured two others in 1974. He was suffering from paranoid schizophrenia. The court ordered that he be detained without limit of time in a secure hospital. In 1986, his medical officer recommended that he be transferred to a regional hospital with a view to releasing him back to the community. The Secretary of State declined. The plaintiff thereupon applied to the mental review tribunal and sought a report from the defendant to support his application. The defendant's report was unfavourable to the plaintiff's application, as he did not think that the plaintiff was no longer a danger to the public. The plaintiff withdrew his application to the mental review tribunal and denied the defendant permission to disclose the report to the medical officer at the secure hospital. The defendant considered that those

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<sup>133</sup> [1990] 1 AC. 109 at 110 (F - G)

<sup>134</sup> [1990] 1 Ch. 359 at 359-360

attending to him needed to know. So he disclosed the report to the medical officer at the plaintiff's hospital and sent copies to the Secretary of State and the Department of Health and Social Security. The plaintiff later learnt that the report had been disclosed and sought injunctions restraining the defendant from communicating the contents of his report and requiring him to surrender all copies. The trial court, in dismissing the application held that:

*"... the duty of confidence owed by the defendant to the plaintiff not to divulge the contents of the report was overridden by the public interest in protecting the public by placing the report before the proper authorities".*

The plaintiff appealed. In dismissing the appeal, the Court of Appeal held that:

*"... although the plaintiff had a personal interest to ensure that the confidence that he had reposed in the defendant was not breached, the maintenance of the duty of confidence by a doctor to his patient was not a matter of private but of public interest; that the private interest in maintaining that confidence had to be balanced against the public interest in protecting others against possible violence; that the nature of the crimes committed by the plaintiff made it a matter of public interest that those responsible for treating and managing him had all the relevant information concerning his mental state before considering his release from hospital; that the information in the defendant's report was relevant information and the public interest in its restricted disclosure to the proper authorities outweighed the public interest that the plaintiff's confidences should be respected; and that, since the defendant's disclosure had been properly made both in the public interest and in accordance with rule 81(g) of the General Medical Council's guidelines on professional conduct, the plaintiff's claims had been properly dismissed".*

The UK position on confidentiality can be summarised as follows:

Whereas generally a medical practitioner should not disclose his/her patients' information to third parties (true to the Hippocratic tradition), such disclosure is allowed where:

1. It is in the public interest so to do,
2. Such disclosure would facilitate treatment or prevention ( i. e informing the spouse),
3. Such disclosure is permitted by the patient (in the case of HIV/AIDS such permission is irrelevant), and
4. The disclosure is required by law.

The UK situation, just like that of the US, corresponds to the *Period of Crisis* in the metamorphosis of the Hippocratic corpus, i.e. medical confidentiality is not absolute. This has been modified largely by the need to preserve public health.

In South Africa, the South African Medical and Dental Council formulated a guideline in 1989 in connection with HIV which can be presented as follows<sup>135</sup>:

1. The general rules governing confidentiality shall apply,
2. The doctor has a duty to divulge information regarding the HIV positive status of his patient to other health care providers concerned with the patient, after informing the patient, and regardless of whether the patient consents or not, and
3. The Council would consider disciplinary action against a practitioner, whose act or omission led to unnecessary exposure to HIV infection of another health care worker.

The first South African case involving confidentiality and AIDS is *Jansen van Vuuren & Another NNO v Kruger*. The claim was based on the plaintiff's right to privacy as a patient. The plaintiff was a homosexual. He applied for life cover from Liberty Life insurance company, which asked for a medical report, including his HIV status. The plaintiff went to see the

respondent for the report. The plaintiff was sero-positive. He discussed the results with the respondent and agreed to keep them secret. While playing golf the following day, the respondent disclosed to a general practitioner and a dentist. The plaintiff, the respondent and the other doctors to whom disclosure was made lived in the same area and moved in the same circles. In fact, the plaintiff had business connections with the wives of the last two doctors. The news spread around and reached the plaintiff. The respondent relied on the defences of privilege, justification, public interest, and objectively reasonable. This was accepted by the trial court but overturned on appeal on the ground that the defendant did not pass on the information to the right authorities (see *W. v Egdell* above). The Court of Appeal recognised the need for upholding the Hippocratic ethic of "silence" and said:

*"There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others, which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS" (at 854 I-J).*

The court, in the above case also recognised that:

*"...a physician's legal duty to respect confidentiality of his patient the legal nature of which was today accepted as axiomatic was not absolute, but relative: a doctor could be justified in disclosing his knowledge where his obligations to society were of greater weight than his obligations to the individual" (at 843 J - 844 A).*

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<sup>135</sup> *Jansen van Vuuren and Anor NNO v Kruger* at 854 C - F

Similar rulings are to be found in the South African cases of *S v Bailey*<sup>136</sup>, *Sasfin (Pty) Ltd v Beukes*<sup>137</sup>, and in *Sage Holdings Ltd v Financial Mail (Pty) Ltd*<sup>138</sup>. In overturning the decision of the lower court therefore, the Court of Appeal relied on the fact that the people to whom disclosure was made and the manner in which it was made amounted to a violation of the privacy of the patient. Noteworthy here is that, just like the case in the US and UK, the confidentiality as envisaged in the Hippocratic corpus is not accepted in South Africa as absolute.

Sections 134-135 of the Evidence Act<sup>139</sup> offer privilege to the lawyer-client relationship. There is no such provision for the doctor-patient relationship. Section 152 of the Criminal Procedure Code<sup>140</sup> is to the effect that anyone refusing to answer a question may be imprisoned for up to 8 days and the process repeated until the person conforms. This means that the doctor/patient relationship, though recognised by common law, does not enjoy absolute protection of the law either in the UK or in Kenya. The Kenya Medical Association has decided to breach the doctor/patient confidentiality by disclosing the HIV status of patients who fail to inform their sexual partner(s) of their infection<sup>141</sup>. Cases touching on confidentiality are likely to be decided along the same lines as in the US, UK or even South Africa.

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<sup>136</sup> [1981] (4) SA 187 (N) at 189 F - G

<sup>137</sup> [1989] (1) SA 1 (A) at 31 F - 33 G

<sup>138</sup> [1991] (2) SA 117 (W) at 129 H - 131 F

<sup>139</sup> Cap 80 of the Laws of Kenya

<sup>140</sup> Cap of the Laws of Kenya

<sup>141</sup> Mwaniki, M. Doctors free to reveal spouses' status of HIV. *Daily nation*, November 30, 2001



consent of the tested person, unless otherwise provided for under the Act. Section 6(1) requires HIV testing to be done confidentially. Section 42 provides that court proceedings relating to HIV/AIDS are to be held in camera. Section 43 prohibits the use in court of information provided during an HIV testing session. Section 20(7) and (8) require a medical practitioner to inform a sexual contact of an HIV positive result.

The protection of confidentiality is considered both a legal and ethical duty<sup>145</sup>. However, in the case of an infectious condition, the consequence of an absolute duty of confidence is that sexual or needle sharing partners who are not informed of their risk are imminently in danger. The object of the modern AIDS statutes should be to protect confidentiality up to the point where disclosure is necessary to prevent a clear and imminent danger of HIV transmission<sup>146</sup>. It is admitted that confidentiality must be respected if the doctor is to maintain the trust of his patient, but that there is a limit to this confidentiality when it is putting others at severe risk<sup>147</sup>.

To effectively combat the spread of HIV/AIDS in relation to confidentiality, it is hereby submitted that:

1. There is need to lift the veil off the doctor patient relationship with regard to HIV/AIDS. This could be done through making it possible for health care providers to inform sexual partners, family and the employer or school.

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<sup>145</sup> Dickens, B.M.: Legal limits of AIDS confidentiality. *Journal of American Medical Association* 1988, 259:3449-3551

<sup>146</sup> Gostin 1989, 1627-8

<sup>147</sup> Orr, p.118

2. In case of blood transfusions - there is need to mark the donated blood in such a way that follow-up of the donor, in case of seropositivity, is possible.

### **2.1.3. HIV/AIDS on Death Certificates**

For many centuries, births, deaths and marriages have been recorded in a central registry in the UK<sup>148</sup>. However, the indication of the cause of death on the death register started in the nineteenth century, thanks to Edwin Chadwick, who had a special interest in child mortality. This practice entrenched itself as part of constitutional law on registration in 1836. Indicating the cause of death has been hailed as useful for medico-legal purposes<sup>149</sup>. Certain causes of death, such as alcoholism<sup>150</sup> and suicide<sup>151</sup> are considered as a stigma. As a result, medical personnel may be unwilling to certify any of the above two as causes of death to save the family some embarrassment. AIDS is a condition associated with stigma. It has been postulated that in the case of AIDS, people at risk may also be feared or stigmatised leading to serious medical<sup>152</sup>, psychological<sup>153</sup> and ethical<sup>154</sup> difficulties for the patients, relatives and their doctors. In the UK, AIDS is indicated on the death certificates either as an underlying condition that started the process or as another condition not directly causing death.

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<sup>148</sup> Office of Population Censuses and Surveys. *Population and health statistics in England and Wales*. London: OPCS, 1980

<sup>149</sup> Joint Report of the Royal College of Physicians and the Royal College of Pathologists. Medical aspects of death certification. *Journal of the Royal College of Physicians* 1982, 16:206-218

<sup>150</sup> Maxwell, JD. Accuracy of death certification for alcoholic liver disease. *British Journal of Addiction* 1986, 81:168-9

<sup>151</sup> Zilboorg, G. Suicide among civilized and primitive races. *American Journal of Psychiatry* 1936, 92:1347-9

<sup>152</sup> Ward, MW & Papadakis, MA. Untrapping the metaphor of AIDS. *American Journal of Medicine* 1987, 83:1135-7

<sup>153</sup> Kelly, JA, St. Lawrence, JS, Smith, S., Hood, HV & Cook, DJ. Stigmatization of AIDS patients by physicians. *American Journal of Public Health* 1987, 77:789-91

The problem with this practice is best illustrated by the case of a 37 year old homosexual who knew that he was positive for HIV antibodies, having been tested three years earlier. He did not inform his parents either of his homosexual orientation or of his HIV status. After his death, AIDS was indicated on his death certificate, which his parents were legally obliged to present to the Registrar of Births and Deaths. The Registrar's office was located in an area close to their residence and where they were well known. The death certificate had to be produced for their son's former employer, Insurance Corporation, mortgage company, solicitor, and others. There was no hope of privacy. The Register of Deaths in the UK is a public record. This makes the information accessible to many people, including journalists, who may further publicise it. A clear and unquestionable use to which such certificates can be put is to serve as an easy and quick means of evaluating AIDS surveillance<sup>155</sup>.

\* In Kenya, AIDS is not indicated on death certificates as the cause of death. The major argument is that AIDS is not a disease per se. It only creates favourable conditions for other diseases to set in and cause death. Besides, the question of confidentiality has hitherto been handled in a very confusing manner. Since AIDS is never publicised as a cause of death, this scenario has hampered not only awareness efforts, but it has also, in a way contributed to the spread of the virus. Many people in the villages still

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<sup>154</sup> Murphy, TF. Is AIDS a just punishment? *Journal of Medical Ethics* 1988, 14:154-60

<sup>155</sup> Hardy, AM, Starcher, ET, Morgan WM. Review of death certificate to assess completeness of AIDS case reporting. *Public Health Report* 1987, 102:386-91

attribute death to either witchcraft or to those causes shown on the death certificates. It is submitted that it may not be easy for a tradition like "wife inheritance" to persist, in cases where mourners are clearly told that the husband of a given widow succumbed to an AIDS-related illness. In addition, such a disclosure could enhance the awareness campaigns on HIV/AIDS currently in place.

It is therefore hereby recommended that a law should be put in place to facilitate the inclusion of AIDS as the cause of death on the death certificates.

#### **2.1.4. Public Health Statutes and the Hippocratic Ethic**

Public Health statutes<sup>156</sup> have further eroded the spirit of the Hippocratic ethic. All countries use such statutes. These statutes represent the "police powers" of the state in the control of certain diseases. In general, Public Health statutes provide for:

1. A doctor to pass on information about his/her patient to other relevant parties (i.e. partner/sexual contacts, other health facilities etc)
2. Detention of an infected person in certain circumstances, and
3. Punishment of those who either infect others or flout the rules laid down for them in connection with the statutes.

In short, whenever there is an outbreak of disease that falls within the purview of the Public Health Act, emphasis is placed more on its control, rather than on confidentiality.

The control of sexually transmitted diseases differs from that of most infectious diseases in that there is a strong moral factor, and combined with this, a stigma and sense of shame, which seriously interferes with control of the disease.

Advanced countries have required for many years the reporting to public health authorities of a number of communicable diseases. However, such reporting is deemed grossly incomplete. The reasons hereof include<sup>157</sup>:

- (i) diagnostic inexactitude
- (ii) desire of patients and doctors to conceal the occurrence of certain diseases i.e. sexually transmitted diseases
- (iii) reluctance of some countries to admit the occurrence of certain diseases which may interfere with tourism e.g. cholera
- (iv) indifference of physicians to usefulness of such information about some diseases like influenza, hepatitis and measles

In Scandinavian countries, sexually transmitted diseases are compulsorily notifiable. In Sweden, there is compulsory notification under a number, the name is not disclosed but is kept by the medical practitioner in case of the patient's default. It is compulsory for patients suffering from sexually transmitted diseases to accept treatment which is free. The scheme also provides for investigation into the source of infection and the supervision of contacts, and there are legal powers to deal with defaulters.

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<sup>156</sup> For example, s. 13 of the Public Health Act, Cap 242 of the Laws of Kenya empowers the Director of Medical Services to use any reasonable measures to prevent the spread of an infectious or notifiable disease. Such measures may include forced treatment, quarantine and detention of those infected!

The rates of sexually transmitted diseases in Sweden and Denmark fell from 10.2/100,000 in 1919 to 0.67/100,000 in 1935 and from 14.2/100,000 in 1919 to 2.1/100,000 in 1935 respectively<sup>158</sup>.

Compulsory notification of sexually transmitted diseases is also required in Turkey, South Africa, Australia, New Zealand, Czechoslovakia and Rumania. Compulsory treatment after the disease has been diagnosed is a must in the former Soviet Union, Scandinavian countries, USA, Canada, Italy and parts of Switzerland<sup>159</sup>. However, opponents of compulsory reporting say it may drive the disease underground.

In the US, courts have developed a legal doctrine that a person must disclose sexually transmitted diseases to their partners<sup>160</sup>. This doctrine was first developed for syphilis (*State v Lankford*<sup>161</sup>) and herpes simplex (*Kathleen K v Robert B*<sup>162</sup>) and this has now been extended to HIV (*Christian v Sheft*<sup>163</sup>).

All US states require reporting of AIDS as defined by the Centre for Diseases Control, to the public health department without jeopardizing the confidentiality of individuals. State public health departments have an increased interest in mandatory reporting of HIV test results because such requirements are prerequisites to programs of partner notification or contact

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<sup>157</sup> Last, JM. Epidemiology and Health Information. In: Last, JM (ed.): *Maxcy-Rosenau Public Health and Preventive Medicine*, 12<sup>th</sup> ed. Appleton-Century-Crofts, Norwalk, Connecticut, 1973, pp.9-74

<sup>158</sup> Paul, *ibid.*

<sup>159</sup> *ibid.*

<sup>160</sup> Gostin, 1966

<sup>161</sup> 102 A 63 [1917]

tracing<sup>164</sup>. Contact tracing is a traditional form of medical surveillance in which public health officials actively seek to discover the sexual partners of an index case (an infected person), and without revealing the identity of the index case, inform those contacts that they may have been exposed to a sexually transmitted disease<sup>165</sup>.

In some states, HIV infection or AIDS has been reclassified as a sexually transmitted disease, while others have specifically authorised or require contact tracing for HIV infection<sup>166</sup>.

In a study conducted to determine the acceptability of Health Department notification of sex and needle-sharing partners of persons infected with HIV, a survey of 202 partners notified of their exposure to HIV in South Carolina was done. Ninety two percent thought the Department did the right thing<sup>167</sup>. In a similar study in Colorado, involving 239 partners of HIV infected persons, only 25% of index cases (those actually infected) wished to notify their partners<sup>168</sup>.

Sexually transmitted diseases are not notifiable in Britain<sup>169</sup>. In the UK, the Public Health (infectious Diseases) Regulations 1985 did not make

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<sup>162</sup> 150 Cal App 3d 992 [1984]

<sup>163</sup> *Executor of the Estate of Rock Hudson, Super Ct, LA Cty, AIDS Lit Rptr 24-02-1989*

<sup>164</sup> Gostin 1987, 1626

<sup>165</sup> *ibid.*

<sup>166</sup> Association of State & Territorial Health Officials, National Association of County Health Officials, US Conference of Local Health Officers. *Guide to Public Health Practice: HIV Partner Notification Strategies*. Washington, D.C.:Public Health Foundation, 1988

<sup>167</sup> Jones et al. Partner acceptance of Health Department notification of HIV exposure. *Journal of the American Medical Association* 1990, 264:1284-1286

<sup>168</sup> *ibid.*

<sup>169</sup> Paul, H. *The control of diseases*. 2<sup>nd</sup> ed. E. & S. Livingstone ltd, Edinburgh 1964, p.264

AIDS a notifiable disease, largely because the disease is not particularly infectious and to do so would have put unnecessary restrictions on sufferers<sup>170</sup>. However, the Public Health (Control of Diseases) Act 1984 allows in exceptional circumstances, for orders to be made so that persons believed to have AIDS may be compulsorily examined and for AIDS patients to be removed to hospital and detained. By 1990, only one case of compulsory removal to hospital had been reported<sup>171</sup>.

In the UK, the surveillance of AIDS is based on a voluntary confidential reporting system where the name of the patient is concealed. The problem with this system is incompleteness of reporting<sup>172</sup>. This surveillance relies on two national voluntary reporting systems run by the Public Health Laboratory Service Communicable Disease Surveillance Centre: one for cases of AIDS, and the other for positive HIV antibody tests<sup>173</sup>.

In Kenya, HIV/AIDS was made a notifiable disease in 1987<sup>174</sup>. Ten years later, HIV/AIDS was brought under the Public Health Act. However, this measure was not accompanied by an attempt to provide treatment. Needless to mention that it has not been possible to enforce the provisions of the said Act with regard to HIV/AIDS.

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<sup>170</sup> Aitken, R.G.S. 'AIDS: Some myths and realities' 1987, *84 Law Society's Gazette*, p. 239

<sup>171</sup> Aitken, *ibid*.

<sup>172</sup> Gevans et al. Completeness of reporting of AIDS cases. *British Medical Journal* 1991, 302:1351

<sup>173</sup> Hickman et al. HIV Surveillance: The value of audit. *British Medical Journal* 1991, 302:1376

<sup>174</sup> Rachier, A.D.O.: HIV/AIDS and the Law, *The Lawyer*, 2001, No. 39, pp. 10-13; notifiable here means information on those detected to be HIV positive can be passed on to other health care centres and especially the Ministry of health headquarters for statistical purposes.



The use of Public Health statutes represents a form of modification of the Hippocratic ethic, especially, the part that touches on confidentiality. In summary, it can be said that the Hippocratic corpus has been modified throughout the ages based on the necessities of the times. And now, may be, the challenge of HIV/AIDS presents yet another opportunity to amend or make such laws that would serve the public interest, even if it means chipping away a bit on the Hippocratic ethic that touches on confidentiality. This was the spirit in the holding in *Jacobson v Massachusetts*<sup>175</sup>, when the Supreme Court stated that:

*"... the legislature has the right to pass laws which, according to the common belief of the people, are adapted to prevent the spread of contagious diseases. A common belief, like common knowledge, does not require evidence to establish its existence, but may be acted upon without proof by the legislature and the courts."*

A major limitation of Public Health Statutes is that whereas they put an obligation on the infected person to seek treatment, failing which the Director of Medical Services may take measures to forcefully effect such a treatment, the government cannot guarantee nor does it provide free treatment for HIV/AIDS. Besides, the cost of drugs puts such treatment out of reach of the majority of would be interested persons. In short, the government cannot use a law to force people to get treatment, which is unavailable! This therefore calls for a special regime of laws on HIV/AIDS, quite apart from the Public Health Act. Such a regime could also provide an opportunity to have a fresh and realistic look at confidentiality. Currently,

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<sup>175</sup> 197 US 11 (1905)

the government is funding HIV/AIDS prevention measures with the aid of donor funds through the National AIDS Control Council.

Considering the state of the epidemic in terms of numbers of persons living with HIV/AIDS, e.g. Australia and New Zealand (15,000), North America (940,000), Central Europe (560,000), Africa south of the Sahara (28 million), and Kenya (2.5 million)<sup>176</sup>; it becomes apparent that there is need for disclosure and more openness across the board to help combat the spread of HIV/AIDS. Uganda used this route of openness with a lot of success<sup>177</sup>.

## **2.1.5. HIV TESTS**

### **2.1.5.1. HIV antibody tests**

The most commonly used tests for testing whether a person has an HIV-infection or not are the antibody tests. Such tests only establish whether the body of a given person is reacting to the presence of the virus or not. Such tests have accompanying difficulties. For example, HIV antibody tests do not<sup>178</sup>:

- (i) determine the level of infection with the virus;
- (ii) show that a person has AIDS;
- (iii) nor even that a person will have AIDS.

Owing either to a manufacturer's error or to human error, the results from these tests, just like from all other laboratory tests under similar

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<sup>176</sup> UNAIDS Programme, 2001

<sup>177</sup> Dr. Joseph Konde-Lule, Mulago Hospital, Uganda: Personal communication.

conditions, may be "false positive" (declaring someone to be sero-positive when they are not) or "false negative" (declaring someone not to be sero-positive when they are)<sup>179</sup>. There is a certain latency period (about three months) between acquiring the virus and testing positive<sup>180</sup>. The legal consequences that flow from the above include:

1. a positive HIV antibody test will require confirmation from a different and independent laboratory, and
2. Claims for damages arising out of an HIV infection may be difficult to prove and/or determine.

In order to capture the uncertainties aforementioned, it is recommended that a law touching on HIV infection should contemplate a "worst case scenario", i.e. that the person infected with HIV will eventually develop full blown AIDS and will die from an AIDS related disease and possibly leave offsprings that will require a certain standard of care.

### **2.1.5.2. Mandatory tests**

Various countries have taken varying positions on the question of mandatory testing. **India, China** and **Russia** have limited policies of screening foreign students, workers and business visitors<sup>181</sup>. **Belgium** insists on tests for students from third world countries that receive grants. **Russia** has deported over 30 people with AIDS. **India** has ordered it's over 5000 African students to be tested or leave.

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<sup>178</sup> Orr, p.119

<sup>179</sup> For example, it is not uncommon to certify a patient as not having malaria (false negative) only for the test to turn positive at a later date. The same applies to other laboratory tests. Hence, the need for another test to confirm a negative result!

<sup>180</sup> Orr, p.119

<sup>181</sup> Almond, p.7

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In the **UK**, the Royal College of Surgeons of England (RCS (E)) recently made a statement recommending that patients in high risk categories should be offered an HIV antibody test before surgery. Consent for such tests should still be sought in the case of an emergency, and counselling should be offered before and after the test. Both the RCS (E) and the British Medical Association (BMA) agree that in exceptional circumstances it may be necessary to test a patient without consent, but a doctor would have to justify that action to the General Medical Council (GMC). The general position in the UK therefore is that parties should be told if they are to be tested for HIV and that they should agree to the testing. If they do not, they should be treated as if they were infected<sup>182</sup>.

In **Germany**, the use of blood samples for HIV testing behind the patient's back is unlawful under s. 223 of the German Penal Code. HIV testing is only allowable if it is in the interest of the patient, i.e. in cases where clinical signs point towards HIV infection. However, where a patient demands a general check-up from a doctor, this can be considered implied consent for HIV testing. Where patients object to HIV testing, doctors are advised to be very careful.

In **Japan**<sup>183</sup>, testing for HIV is only with the patient's permission. Nonetheless, patients are tested for HIV antibodies without their permission. In 1989, a new law was passed that requires doctors to report

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<sup>182</sup> Sherrad, M. & Gatt, I. 'Human Immunodeficiency virus (HIV) Antibody testing', *British Medical Journal* 1987, 295:911

<sup>183</sup> Anonymous, p.196

to the government any patients infected with the HIV. Similarly, in the **Netherlands**<sup>184</sup>, a patient's permission is sought before testing. A patient who refuses is considered to be sero-positive. In **Australia**<sup>185</sup>, the consensus is that testing should only be performed if it is clinically relevant. Nevertheless, in some hospitals, all new admissions are screened for HIV. In **France**<sup>186</sup>, it is settled procedure that no doctor can perform a medical act without the consent of the patient.

In the **US**<sup>187</sup>, there have been reported cases of health workers infecting their patients with HIV. This development has led to calls for mandatory screening of all health care workers. However, no decision has yet been taken. Generally, however, the doctrine of informed consent does apply to the taking of blood for the purposes of an HIV test<sup>188</sup>. The American Medical Association has rejected mandatory testing of those groups at high risk of infection with HIV.<sup>189</sup> Numerous statutes in the US authorise compulsory screening of persons charged with or convicted of crimes during which the transmission of HIV is possible, such as sexual assault or rape, prostitution, or the sale or use of illegal drugs. The possible rationale for such testing include<sup>190</sup>:

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<sup>184</sup> *ibid.*

<sup>185</sup> *ibid.*

<sup>186</sup> Anonymous, p. 197

<sup>187</sup> *ibid.*

<sup>188</sup> Gostin, L.O. The AIDS litigation project part I: The social impact of AIDS. *Journal of the American Medical Association* 1990, 263:1962; *Doe v Equifax Serv*, 1989 WL 57348 (Ed Pa)

<sup>189</sup> AIDS Monitor, *New Scientist*, 23 July 1987, p.23

<sup>190</sup> *ibid.*

- lightening the burden of worry on those who fear exposure to HIV
- facilitating prosecution and conviction in these cases, and
- preventing future behaviour that could transmit the virus

Courts in the US require HIV testing of criminal defendants in cases of rape (*Cmwlth v Winkelspecht*<sup>191</sup>, *Cmwlth v Mason*<sup>192</sup>) and in other sexual assaults (*Shelvin v Lykos*<sup>193</sup>, *State v Bullock*<sup>194</sup>). This is on the basis that the victim's right to know outweighs the defendant's right to privacy (*People v Cook*<sup>195</sup>).

At the Federal level, the Defence department screens all new recruits and active duty personnel. Whereas those already serving and who test HIV positive may not be discharged from the military, new recruits testing positive are not absorbed in the military<sup>196</sup>. The State department, Peace Corps and Job Corps screen Foreign Service personnel. Persons applying to immigrate to the US are screened and those who test positive for HIV may not immigrate<sup>197</sup>. In *Batten v Lehman*<sup>198</sup> and in *American Federation of Government Employers v Department of State*<sup>199</sup>, the courts have upheld the Defence and state screening programs respectively.

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<sup>191</sup> 538 A2d 498

<sup>192</sup> *Ct of Common Pleas, Luzerne Cty, Pa, AIDS Lit Rptr 01/29/88*

<sup>193</sup> 741 SW2d 178 (*Tex App Hous 1<sup>st</sup> Dist 1987*)

<sup>194</sup> *Sup Ct, Wis, AIDS Lit Rptr 11/11/88*

<sup>195</sup> 533 NE2d 676 (1988)

<sup>196</sup> Herbold, M.R. AIDS policy development in the department of Defence. *Military Medicine* 1986, 1:5-10

<sup>197</sup> US Department of Health & Human Services, Medical Examination of Aliens (AIDS), 14 CFR par

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<sup>198</sup> *No. CA 85-4108 (USDC Jan 8, 1986)*

<sup>199</sup> 662 F Supr 50 (*DDC 1987*)

US state legislatures have enacted legislation mandating compulsory screening in a wide variety of special populations including marriage applicants, pregnant women, new-borns, hospital patients, mentally ill or mentally retarded patients, prisoners, prostitutes, intravenous drug users and sex offenders. This has been done despite public health consensus against compulsory screening<sup>200</sup>.

Prisoners have been obvious targets for public health measures to control AIDS because of the perceived high incidence of homosexual activity, including forced sexual contact and intravenous drug use. As at November 1988, 14 US states and the Federal Bureau of Prisons had mass screening programs for new and current inmates or releases. This is done at an administrative (non-legislative) level<sup>201</sup>. These measures go against the WHO recommendations<sup>202</sup>.

Nevada<sup>203</sup>, which is the only state to regulate prostitution, requires all prostitutes to submit to HIV testing. It is a felony for a prostitute to work after being informed that she or he had a positive test. Under Nevada statute, an owner of a house of prostitution who knows or reasonably should know that an employee is sero-positive is liable for damages to third parties as a result of the employment.

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<sup>200</sup> Centre for Diseases Control: Public Health Service Guidelines for counselling and antibody testing to prevent HIV infection and AIDS. *Morbidity and Mortality Weekly Report* 1987, 36:509-515; Report of the WHO Meeting on Criteria for HIV screening programmes. Geneva, Switzerland, WHO 1987; Gostin, L., Curran, W., and Clark, M. The case against compulsory casefinding in controlling AIDS: testing, screening and reporting. *American Journal of Law and Medicine* 1987, 12:7-53

<sup>201</sup> Gostin 1989, 1625

<sup>202</sup> Consultation on Prevention and Control of AIDS in Prison. Geneva, Switzerland, WHO 1987

The difficulties with mandatory testing include:

1. cost
2. need for regular testing,
3. possible high number of false positives
4. Testing without consent presents a vital challenge to individual liberty. Such measures could be justified where either therapeutic intervention is available or others were put at risk by social contact<sup>204</sup>.
5. The vastness of such an enterprise makes it doubtful whether it could succeed in combating AIDS.

Mandatory testing may be justified in certain situations such as patients in dialysis units (because of the risk of transmission) and in those in prison or the disciplined forces<sup>205</sup>. In Tasmania, the law provides for mandatory testing of a person charged with a sexual offence<sup>206</sup>. Under section 12 of the said law, a person may be required to undergo an HIV test pending a medical or dental procedure.

In the case of *Baugh v Delta Ltd*<sup>207</sup>, Lawson, J (as he then was) observed as follows:

*"A requirement under compulsion to submit to a medical exam or medical tests is an invasion of personal liberty - which can only be justified where parliament has imposed or authorized the imposition of such a requirement and as a rule has provided an appropriate sanction for non-compliance"*

Essentially, mandatory testing ought to be looked at in the following ways:

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<sup>203</sup> Gostin, 1626

<sup>204</sup> Bayer, R., Lavine, C. & Wolf, S.M. 'HIV Antibody screening: An ethical framework for evaluating proposed programs' *Journal of American Medical Association* 1986, 256:1768

<sup>205</sup> Orr, p. 120

<sup>206</sup> Ss. 10 & 11 of HIV/AIDS Preventive Measures Act 1993.

<sup>207</sup> (1971) 1 WLR 1295



1. Mass screening in the form of a "census" to get accurate figures of the extent of the problem and therefore be able to plan more realistically;
2. In addition to the above, this should be combined with the lifting the veil off confidentiality as a way of protecting the uninfected; and
3. Mandatory screening of special populations i.e. prostitutes and prison inmates.

In order to make mandatory testing justifiable, it is necessary to:

- ◆ Establish HIV/AIDS clinics at the community level,
- ◆ Provide free drugs,
- ◆ Empower the community to carry out counselling, and
- ◆ Set up resources to mitigate the effects of HIV/AIDS.

The major drawback of mandatory testing is that it would drive the disease underground so that those infected avoid testing. This, coupled with a huge financial and human resource outlay that would be necessary to carry out mandatory testing strongly militates against such an approach. However, mandatory testing would appear to have a place with regard to special populations, i.e. prostitutes, sex offenders, health care workers, prison inmates etc.

It is recommended that a relevant law on mandatory testing targeting such groups be enacted.

### **2.1.5.3. Voluntary Counselling and Testing (VCT)**

Some people argue for voluntary testing saying it provides a non-legal impetus to be tested and it could be effective in limiting the spread of the

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disease<sup>208</sup>. In Kenya, voluntary counselling and testing centres have been set up. An UK study investigated two hundred respondents (100 males and 100 females) on the reasons for reluctance to VCT<sup>209</sup>. Sixty four percent of the men were concerned with confidentiality of the test results while the majority of the women (40%) said their inability to cope with a positive result was the reason.

In *Planned Parenthood v Danforth*<sup>210</sup>, Blackmun J (as he then was) defined informed consent as follows:

*"[W]e are content to accept, as the meaning, the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession."*

The doctrine of informed consent is basic in law<sup>211</sup>. In practice, consent is usually implied from the patient's appearance before the physician in all but the more drastic or dangerous medical procedures. The main aim of obtaining formal consent to riskier interventions is to protect the doctor against intentional tort suits, i.e. to avoid a possible action for battery. The doctrine of informed consent requires that a doctor gives his or her patient information about certain risks of the proposed procedure as

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<sup>208</sup> Peto, J. 'AIDS: The next step to stop it', Sunday Times, 15 Feb., 1987

<sup>209</sup> Kell et al. Testing for HIV antibodies. *British Medical Journal* 1991, 302:660-661

<sup>210</sup> 428 US 52, 67 n.8 (1976)

<sup>211</sup> Wadlington, W. Breaking the silence of doctor and patient. A review of "The silent world of Doctor and patient" by J Katz, NY: The Free Press 1984 In *Yale Law J* 1640 (1984) at 1645

well as alternatives to it. In Tasmania<sup>212</sup>, no testing for HIV may be undertaken without the consent of the person concerned.

The rationale for the requirement of informed consent in HIV antibody testing is grounded on the fact that an HIV test is unlike any other "routine" blood test because of the profound psychological and social risk of a positive result, including the risk of suicide<sup>213</sup>. Further, pre-test counselling, which together with post-test counselling are considered vital preparation for test results, cannot occur without the patient's consent. Several states in the US have put in place statutes that specifically require written consent for HIV testing.

Testing for HIV without consent has been argued by doctors in respect of certain patients, based on the perceived danger of infection, which such patients pose to them. However, patients also have an interest. If a person's body is invaded by being intentionally touched by another without that person's consent then a battery has been committed. In general, courts are reluctant to hold a doctor liable in tort for battery where a general consent to the touching has been given<sup>214</sup>. However, where the touching is different from that to which consent was given, the courts have been willing

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<sup>212</sup> S. 7 of the HIV/AIDS Preventive Measures Act 1993, exceptions: are in cases of a sexual offence (ss. 10 & 11), and in case of an emergency dental or medical procedure (s.12).

<sup>213</sup> Marzuk et al. Increased risk of suicide in persons with AIDS. *Journal of American Medical Association* 1988, 259:1333-7

<sup>214</sup> *Chatterton v Gerson* [1980] 3 WLR 1003.

to classify this as battery, even where the treatment resulting from such illegal touching is to the benefit of the patient<sup>215</sup>.

In warning doctors against testing without consent, one court observed as follows<sup>216</sup>:

- (i) there is no vaccine, no primary treatment and no cure for the condition (AIDS)
- (ii) the diagnosis of any condition carries trauma which is increased by the unique stigma attached to AIDS and HIV
- (iii) public authorities currently assure the public that no testing will be performed without full consent
- (iv) testing for the virus can affect insurance policies applications whether or not the result is positive

Based on the American experience, some authors are of the opinion that:

*"It is time we admit that voluntary testing and AIDS education are not stopping the spread of the lethal virus. We must dedicate our attention to the asymptomatic carrier of HIV who, once identified, can be educated to not spread the virus and to identify contacts that can be tested. Obviously, HIV testing must be mandatory for identified contacts<sup>217</sup>."*

It would appear that VCT is useful in collecting certain information, respecting privacy and "not driving the disease underground". However, it is submitted that a mixture of both VCT and mandatory tests may go a long way in preventing the spread of this scourge.

#### 2.1.5.4.

#### **Anonymous tests**

<sup>215</sup> *Devi v West Midlands Area Health Authority* [1980] 7 CL 44

<sup>216</sup> Medical Defence Union, *AIDS - Medico-Legal Advice*, 1988

<sup>217</sup> Harris, CJ. Mandatory testing for HIV. *Journal of American Medical Association*, 1993, 269:115 (letter)

Anonymous testing in which the patient does not know the results and the doctor does not know the patient except the age, sex, and location helps to build up a picture of the spread of the disease. Such testing is generally allowed in the US and the UK<sup>218</sup>. Whereas such a form of testing is considered to be in the public interest, the prevalence rate of HIV sero-positivity based on those consenting to the test does not accurately reflect the true rate of sero-positivity, but seriously underestimates it. Nevertheless, such form of testing also serves a scientific purpose. It is necessary that our laws should make provision for this form of testing.

## **2.2. Criminalization of deliberate HIV infection of others**

The general debate on criminalization of HIV infection is argued on two opposing ends. On the one hand, the proponents of criminalization say that those who knowingly infect others without their permission ought to be punished. Some say those people who expose others to the AIDS virus with the intent to infect are committing a crime and should be punished. They contend that such laws are necessary because they deter HIV positive people from engaging in high-risk behaviour in the future and punish those who have endangered others in the past<sup>219</sup>. On the other hand, opponents of criminalisation argue that criminal laws may cause loss of trust and confidence by vulnerable populations who will not co-operate with public health programs. They say that such laws may spread a hysteria in the population, thereby making people frightened of punitive solutions to their

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<sup>218</sup> Cook, S. 'Go-ahead for mass AIDS tests', *Guardian*, 24 Nov 1988

health problems. In addition, they argue that having special laws on HIV/AIDS sends the message that the current criminal law is inadequate and that individuals who are HIV-positive are more irresponsible and reckless than others<sup>220</sup>. The challenge is to discuss state practice obtaining in various countries with a view to coming up with recommendations based on best practices.

Two methods of criminalizing the risk of HIV transmission have been recognised: (1) traditional criminal law and (2) public health or AIDS-specific offences<sup>221</sup>.

The transmission of a potentially lethal virus is just as dangerous as other behaviour criminal law proscribes. The advantage of criminal law is that it clearly specifies in advance the prohibited behaviour, requires proof beyond a reasonable shadow of doubt, and imposes a period of confinement proportionate to the gravity of the harm. Such a transmission could be through:

1. Sexual contact,
2. Transfusion of infected blood,
3. Supply of sub-standard condoms, and
4. Other means, e.g. splashing infected blood on uninfected persons.

### **2.2.1. Sexual contact**

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<sup>219</sup> Lisa Speissegger, Stephanie Wilson, and Amanda Watson: HIV/AIDS: Criminal Transmission and Exposure. *Issue Brief - Health Policy Tracking Service 2001*, <http://www.stateserv.hpts.org>

<sup>220</sup> *ibid*

<sup>221</sup> Gostin 1987 1627

Sanctions may be applied against those who knowingly transfer the virus to others, or who knowingly put others at risk through having sexual intercourse with them. In the US, it may be argued that passing on the virus might be homicide, or attempted murder, or criminal assault<sup>222</sup>. In the UK, the leading authority of *R v Clarence*<sup>223</sup> held that a man who passed on gonorrhoea to his wife was not guilty of assault. This decision has been highly criticised. It was based on s.20 or s.47 of the Offences Against the Person Act 1861. However, such a prosecution would be more successful if brought under s.23 of the Act, which prohibits maliciously administering any poison or other destructive and noxious thing<sup>224</sup>.

In Scotland, the 1861 Act does not apply. However, it has long been recognised that all intentional infliction of physical injury is criminal<sup>225</sup>. In *Khaliq v HMA*<sup>226</sup>, it was held that the sale of "glue sniffing kits" to children is criminal.

A more recent development is the use of criminal law as a preventive weapon in Tasmania. Section 20<sup>227</sup> makes wilful transmission of HIV a crime punishable by either a fine or a term not exceeding 2 years. Where a person persists in risky behaviour with respect to HIV, such a person may be isolated for 28 days. In the absence of case law, it is not clear how successful the implementation of this Act is. The government of Zimbabwe

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<sup>222</sup> Orr, p.124

<sup>223</sup> [1888] 22 QBD 23

<sup>224</sup> Farlin, G. & Wauchope, P. 'AIDS & the criminal law' *Law Society's Gazette*, 25 March 1987, p.884

<sup>225</sup> Gordon, G.H. *The Criminal Law of Scotland*, Edinburgh:W.Green & Son, 2<sup>nd</sup> ed., 1978, pp.29-48

<sup>226</sup> [1984] SLT 137

drafted a bill in 1996<sup>228</sup>, which aimed at criminalising deliberate HIV transmission. For a person to be convicted of deliberate transmission of HIV, the accused person must know that they are HIV positive, they must intentionally perform an act that transmits HIV infection, and they must know that their act will or is likely to result in the infection of another person. Opposition to this provision is based on the fact that the requirement of actual knowledge of one's status for one to be convicted would discourage people from going for voluntary testing. The other side of that argument is that it was feared there would be calls for mandatory testing so that people can know their status. In addition, it is argued that it would be difficult for the courts to decide whether the accused has "actual knowledge" they are HIV positive<sup>229</sup>. Also, it was argued that it would be difficult to establish whether a person "intended" to engage in an act that would transmit HIV or is likely to lead to infection. Another provision of the said bill is that a person accused of deliberate HIV transmission of HIV could use as their defence the fact that they disclosed their HIV status to the complainant. Criticism against this provision is levelled at three levels: firstly, it is said that the provision assumes that those to whom disclosure of an HIV positive test is made will be able to understand all the consequences that go with it. Such an assumption is an overshot in developing countries with limited resources for HIV/AIDS campaigns. Secondly, it is assumed

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<sup>227</sup> HIV/AIDS Preventive Measures Act 1993

<sup>228</sup> This bill has not been enacted into law due to great opposition to it.

<sup>229</sup> Sheillah Kanyangarara: Propose use of the criminal law to deal with HIV transmission in Zimbabwe. *Canadian HIV/AIDS Policy & Law Newsletter* 1998:98



that one can give permission to be harmed contrary to the existing common law position (see *King v Donovan* discussed below). Thirdly, this provision would put pressure on HIV-positive persons to disclose their status before engaging in sexual intercourse but there are no protections against breach of confidentiality<sup>230</sup>. In other words, if they do not disclose, they may be convicted of a criminal offence, but if they disclose, they risk being shunned by the larger society. The other provision that raised a lot of concern was the threat of prison term of 15 - 20 years. The main problem with such a provision is that prison is basically a reform institution, but HIV/AIDS is a permanent infection from which one cannot reform. Furthermore, the care provided under prison conditions may lead to the deterioration of the health of the convict. In short, there is not much to be achieved through long prison terms.

It has been noted that many women are not able to prevent a partner from putting them at risk of HIV infection even if they know that he has other partners or use drugs "like the Friday night guy and the Andy Cappy, who comes home drunk from the pub wanting sex and not taking no, or a condom, for an answer"<sup>231</sup>. Cases have also been reported of the male stereotype, who has multiple partners himself but when asked to use a condom accuses his girlfriend of infidelity<sup>232</sup>. It has also been noted that male clients of a prostitute may agree to wear a condom but slip it off before

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<sup>230</sup> Sheillah Kanyangarara, *ibid*

<sup>231</sup> Bradbeer, C. Safer Sex for women. *British Medical Journal* 1990, 301:1223

<sup>232</sup> *ibid*.

penetration without her knowledge, especially if it is dark and she has taken drugs<sup>233</sup>.

Generally, it is considered dangerous to have sex with anyone who continues to engage in high-risk activities even if he or she tests negative for HIV<sup>234</sup>. In *King v Donovan*<sup>235</sup>, the appellant was charged with indecent assault and common assault upon a 17-year-old girl. The prosecution alleged that he induced her to accompany him to his garage at Morden in Surrey, and that while there he beat her with a cane. The case for the defence was that she consented to everything, which the appellant had done, and that the onus was on the prosecution to prove absence of consent. The prosecution argued that the assault was of a kind prohibited as being contrary to public morality, and no consent on the part of the individual can nullify the criminal charge. The Court of Appeal held *that "no person can license another to commit a crime"*.

About 100 prosecutions for HIV transmission have been brought against HIV-infected persons in the US for sexual intercourse, spitting, biting, splattering of blood or donating blood<sup>236</sup>. Violation of a "safe sex" order within the Defence department led to courts-martial for offences ranging from disobeying a military order to assault with a deadly weapon

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<sup>233</sup> *ibid.*

<sup>234</sup> Hearst & Hulley, 2431

<sup>235</sup> [1934] 2 KB 498

<sup>236</sup> Gostin, L.: The politics of AIDS: compulsory state powers, public health & civil liberties. *Ohio St L J* 1989, 49:1017-58

and attempted murder<sup>237</sup>. Many of the civilian cases were however hampered by the difficulty of proving intent. It is difficult, for example, to know what went on in the privacy of a sexual relationship, such as whether the partner was informed of the risk or if barrier protection was used<sup>238</sup>.

However, one can here lean on the words of Sir James FitzJames

Stephen<sup>239</sup> when he says:

*It is uncertain to what extent any person has a right to consent to his being put in danger of death or bodily harm by the act of another."*

In a recent Finnish case<sup>240</sup>, Steven Thomas, a 35 year old HIV positive American, resident in Helsinki was charged with attempted manslaughter for allegedly having sex with over 100 women. He was aware of his HIV status, but not the women, who had sex with him. In 1995, the Finnish parliament modified the penal code related to crimes against health. It was provided that anyone convicted of endangering the health of others, even without violence, is guilty of "aggravated assault", whose sentence is lighter than that of manslaughter. Counsel for 6 of the affected women argued that the accused was guilty of manslaughter, that due to the low rates of HIV infection in Finland, parliament did not have HIV/AIDS in their amendment of 1995, and that the right charge for the accused was that of manslaughter, which implies an intention to kill. Defence counsel said his client was guilty, but not of manslaughter. He said people living with

HIV/AIDS try to go on living as they were before. The decision on this case is not yet known.

One may try to prosecute someone by alleging that they had wilfully and recklessly infected others with the virus by sexual intercourse. The difficulties for this line of argument are presented by impossibility to show that a particular person transferred the virus to another due to<sup>241</sup>:

- (i) latency period of the disease; and
- (ii) possibility of other contacts

The problem with criminalizing deliberate infection of partners lies in the difficulty to establish *mens rea*. It is reported that people enter sexual relationships with many different intentions, desires and fears. It is difficult to prove that a person intended to transmit HIV (*People v Markowitz*<sup>242</sup>, *State v Sherouse*<sup>243</sup>). However, such a difficulty did not arise in a case of an AIDS patient who splattered his blood on health workers. The Court of Appeal of Indiana, in upholding a conviction of attempted murder said:

*"The defendant was aware of the infection, believed it to be fatal, and intended to infect others with the disease."*<sup>244</sup>.

In the case of *Maraham v Maraham* (1986)<sup>245</sup>, it was held that a spouse who knows he or she has a sexually transmitted disease, lies to

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<sup>241</sup> Orr, p. 125

<sup>242</sup> *Super Ct, LA, Cal., AIDS Lit Rptr 03-11-1988*

<sup>243</sup> *536 So2d 1194 (Fla App Ct 5<sup>th</sup> Dist), (1989)*

<sup>244</sup> *Indiana v Haines 545 NE2d 834 (Ind App 2d Dist), (1981)*

<sup>245</sup> *123 AD 2d 165*

his/her spouse, and actually transmits the infection can be liable to punishment.

An HIV carrier who is aware of the fact and yet does not take any precaution to ensure he does not transmit it to others, or deliberately continues to involve himself in high risk behaviour obviously knows that he will injure others and can be taken to intend to do so<sup>246</sup>.

The Kenyan Penal Code (Cap. 63) makes it an offence for one to infect another person. This provides:

*"S.186: 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, is guilty of a **misdemeanour**"* (emphasis mine)

The key words in this provision are "unlawfully", "negligently" and "misdemeanour." "**Unlawfully**" would require proof of *mens rea*. This provision would probably cover unlawful acts involving transmission of HIV infection such as rape, defilement, transfusing infected blood, and maybe, sharing a needle (for intravenous drug users). Does this provision cover a sexual relationship in which the parties thereto are consenting adults? What about in a marital situation? Can one "licence" another to infect him or her? Can there be a lawful way of infecting another person with HIV? "**Negligently**": does this cover a situation where parties may attempt to play safe by using a condom, but the condom breaks? Where would acts of transmission through "wet" or "deep" or "French" kissing fall?

**"Misdemeanour"**: Infection with HIV/AIDS amounts to a death sentence on the part of the victim (in the face of absence of a cure). Should such an act be classified as a misdemeanour? The provision talks of a disease, but neither HIV infection nor AIDS is a disease! Based on the definition of disease, this provision cannot be used in connection with HIV/AIDS. From the foregoing, one can say that the provision in the Penal Code does not deal with HIV/AIDS. It is submitted that this provision does not adequately address HIV/AIDS.

The difficulty in prosecuting cases related to AIDS has led state legislatures in the US to enact public health or AIDS-specific offences<sup>247</sup>. These statutes are modelled after the old sexually transmitted disease offences. These offences are not concerned with "nice" jurisprudential questions of intention or culpability. They make it an offence only if the person knows he or she is infected and has sexual intercourse without informing the partner of the risk. Later statutes are broader and apply also to needle sharing, blood donation and assault with intent to transmit HIV, such as biting. Whilst the old standard offences tended to be minor misdemeanours, the newer statutes often attach draconian penalties. For example, Louisiana and South Carolina have a maximum sentence of \$5000 and 10 years imprisonment with or without hard labour.

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<sup>246</sup> Forlin, G & Walichope, P.: AIDS & the criminal law. *The law society's Guardian Magazine* 1987

<sup>247</sup> Gostin 1989, 1627

The Public Health Act Cap 242 of the Laws of Kenya prohibits deliberate infection of others. Under s.44 it provides:

*"S.44 (3): Any person who fails to comply with the provisions of this section shall be guilty of an offence"*

The provisions in this Act have not been rigorously enforced due largely to the absence of the relevant machinery. In addition, even if it were to be rigorously enforced, the provisions therein do not adequately address the uniqueness of HIV infection and the subsequent disease pattern. The Act itself is a little archaic and is in dire need of revision to bring the legislation therein in line with the current advances in public health. At the risk of repetition in certain instances, there is need for special laws specifically targeting HIV, which would provide among others, for deliberate infection to be *Malum in se*, i.e. a crime in which consent is not a defence.

### **2.2.2. Transfusion of contaminated blood**

This may happen during a surgical procedure or as part of the *standard treatment for haemophiliacs, or also during dialysis*. Between 1987-88, haemophiliacs in France successfully sued the Ministry of Health for giving them contaminated blood. Not only were they compensated but also the then Minister for Health resigned from his job. There is need to put laws in place that would enable persons being infected in health facilities and in other institutional settings, i.e. prisons, to seek legal redress. A notable case on negligence is one involving haemophiliacs in France already referred to above. A similar one is that of *Robb v Canadian Red Cross*

*Society*<sup>248</sup>. Here, three haemophiliacs contracted HIV infection from blood supplied by the Canadian Red Cross Society. The blood had not been handled with due care, i.e. it was not heat-treated. The court held that Canada owed the plaintiffs a duty of care. A problem that remains unresolved is that criminal law aims mainly at punishing the offender. The most common forms of punishment are a fine or a custodial sentence or both. However, can a statutory body that has committed an offence be punished by way of a custodial sentence?

### **2.2.3. Supply of sub-standard condoms**

The German case of Thalidomide is very informative<sup>249</sup>. In this case, expectant mothers were treated with thalidomide, a painkiller, between 1956 - 1963. All mothers who had used this drug gave birth to babies with either missing arms (amelia) or deformed arms (dysmelia). When it became clear that the above drug was the cause of this unique occurrence, parents brought a representative suit against the manufacturers of the drug seeking a permanent injunction to prohibit the sale and marketing of the drug as well as compensation. They were compensated handsomely and the drug banned in Germany. We therefore need laws that would enable Kenyans to sue manufacturers of HIV drugs and condoms that are defective. To succeed in a suit touching on defective condoms, one may have to:

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<sup>248</sup> [2000] OJ No. 2396

<sup>249</sup> Prof. K.-A. Jochheim, Personal communication, Cologne, 1985.



1. establish a nexus between the defective condom and the individual suing to establish *locus standi* (i.e. proof that the seminal fluid in the condom belongs to the complainant),
2. produce remnants, probably from the same packet or lot, which is/are also defective,
3. prove regularity of condom use (to show that one knows how to use the condom),
4. offer proof of purchase of the condoms ( a receipt would do!), and most difficult of all,
5. prove that one followed the instructions for condom use on this material occasion.

#### **2.2.4. Other means of deliberate infection**

In *R v Clarence*<sup>250</sup>, the court said:

*"The cases put of a person suffering from smallpox, diphtheria or any other infectious disorder, thoughtlessly giving a wife or a child a mere affectionate kiss or shake of the hand from which serious consequences never contemplated, ensure, seem, cases impossible to suppose any criminal prosecution should be tolerated, or should, if tolerated, result in conviction but I can picture to myself a state of things in which a kiss or shake of hand given by a diseased person, maliciously with a view to communicating his disorder might well form the subject of criminal proceedings".*

In *Indiana*<sup>251</sup>, an AIDS patient who splattered his blood on health workers was convicted of murder as his act was considered to have been intended to infect others. Acts of spitting and biting by HIV sero-positive persons<sup>252</sup> have been considered criminal in the US. HIV/AIDS laws therefore need to be broad enough to cover all forms of possible transmission of HIV infection.

#### **2.2.5. Compensation**

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<sup>250</sup> [1897] 22 QB 23

<sup>251</sup> *Indiana v Haines*, *ibid.*

<sup>252</sup> *Gostin*, 1989, *ibid.*

Whereas criminalization of HIV infection can be achieved by the amendments suggested above, two questions that remain unanswered are: (a) what would happen if either an accused person or a complainant died in the course of the proceedings? (b) How would punishment alone help the long-suffering visited upon a complainant and his/her family? It must be appreciated that infection with HIV implies:

- ◆ infection for life,
- ◆ dependency on medication for life (these are costly),
- ◆ fear of imminent death,
- ◆ the need for re-allocation of resources to maintain the health of the infected, etc.

In order to ensure justice, there is need to have laws in place that not only punish risky HIV conduct but also provide for a form of "restitution." Those found guilty of such conduct should be made to compensate those they have infected. This means, in the case of individuals, the laws should provide for the suing of the Estate of the individual where a criminal suit has established guilt and the accused dies while a civil suit is still pending. Likewise, institutions and corporations adjudged guilty of HIV transmission should be made to pay up. Laws touching on restitution would serve the purpose of:

- medical care of the infected/complainant,
- providing for the widow/widower and any children,
- providing for the orphans, and
- any other needs.

## **2.3. Discrimination against Persons living with HIV/AIDS**

### **2.3.1. Discrimination and Human Rights issues**

The greatest challenge the law faces with regard to AIDS is the reconciliation between the private right of the individual to conduct his/her own life with the public right to health<sup>253</sup>. As a way of tackling AIDS, those with the virus and those at risk must be able to seek whatever treatment is available and provide health services with information about the spread and nature of the disease. This contrasts with the public need to restrict conduct which is likely to spread the disease. Many find this conduct offensive, yet some argue it is their right to enjoy. There is therefore need to strike a balance so that those at risk are willing to come forward, otherwise the disease will be driven underground.

The debate on the ethical constraints to a growing body of law on AIDS is frequently presented in terms of a conflict between public health (utility for many) and civil liberties (for the few infected)<sup>254</sup>. For the affected individual there is the possibility of discrimination such as loss of employment, or of residence, risk of being publicly shunned, a possibility of a strong enough psychological distress to lead to suicide. All these would be against a background of a person posing little or no threat to others in relation to ordinary social living and may personally remain in good health for years. For the majority, there is the fear of the spread of a virus so far

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√ <sup>253</sup> Orr, A.: The legal implications of AIDS & HIV infection in Britain and the US. In: Almond, B. (ed.): *AIDS - A moral issue. The ethical, legal & social aspects*. MacMillan, London, 1990, p.113

<sup>254</sup> Almond, p.8

invulnerable to medical control, and likely to remain so for a number of years.

Two issues arise out of this apparent discrimination<sup>255</sup>:

- (i) the public are apprehensive of AIDS and they wish to be given some sort of legal protection against it
- (ii) Those infected or at risk must not be unduly imposed upon and any restrictions must be equitable.

The threat of AIDS is to the individual. Certain kinds of legislative action and government inaction may have a direct and immediate effect on the individual. People of liberal or "leftist" leanings respond by construing the ethical and legal issues generated as essentially matters of civil liberties: the marginal groups must be protected against discrimination that comes from their assumed connection with a lethal and incurable infectious disease. In answer to the question of responsibility to guard against the spread of infection, they argue that this is a concern of everybody else. It is the other people (uninfected majority) who must take precautions in relation to their sex lives, "on a kind of sexual *caveat emptor* principle."<sup>256</sup>

On the general question of rights, it may be observed that:

*"It is obvious that rights cannot be guaranteed on absolute terms if for no other reasons. To guarantee rights without qualifications is to guarantee licence and anarchy. The freedom of the just man is worth little to him if the murderer or thief can prey him upon. It is not only in the interest of the public order and the protection of rights of others that qualification upon individual rights is necessary, the demands of security of state itself, of morality, public*

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<sup>255</sup> Pinching, p.139

<sup>256</sup> Almond, B.: Introduction: War of the world. In: Almond, B. (ed.): *AIDS - A moral issue. The ethical, legal & social aspects.* MacMillan, London, 1990, pp.2-3

health and the provision of social economic services are no less worthy of recognition"<sup>257</sup>.

As far as the "leftist" argument goes, this may be easily countered by the writings of leading constitutional lawyers such as Nwabueze, when the latter says:

*"Although society is not founded on contract, and though no good purpose is served by inventing a contract in order to deduce social obligation from it, everyone who receives the protection of society owes a return for the benefits and the fact of living in society renders it indispensable that each should observe a certain conduct towards the rest. This conduct consists of, first, in not injuring one another or rather certain interests, which either by express legal provision or by tacit understanding ought to be considered rights. As soon as any part of a person's conduct affects prejudicially the interest of others, society has jurisdiction over it"<sup>258</sup>.*

Those found with the virus have suffered discrimination in education<sup>259</sup>, employment<sup>260</sup>, housing<sup>261</sup>, and insurance<sup>262</sup>.

In *New York State Association for Retarded Children v Carey*<sup>263</sup>, the court held that mentally retarded pupils who were carriers of Hepatitis B should not be put in separate classrooms, because the 'relevant inquiry' here was whether on a balance the proposed segregation, with its resultant educational disadvantages, could be justified to protect health and welfare

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<sup>257</sup> Mill, J.S. *On the liberty and considerations on representative government*, Basil Blackwell, Oxford 1948, 66

<sup>258</sup> Nwabueze, B.O. *Constitutionalism in the emergent states*, Hurst and Co. Ltd, 1973, 43-4

<sup>259</sup> Freeman, D.M. *Wrong without a remedy*. *Amer Bar Assoc J* 1986, p.36. Ryan White was initially excluded from school but later allowed back to the disagreement of many parents.

<sup>260</sup> 'Lawyers fear of AIDS led to sack'. *Guardian*, 9 Dec. 1986

<sup>261</sup> *People of New York v 49 West 12 Tenants Corp. No. 436004/83* (NY Supreme Ct, 20 Dec 1983). It was held that it was a violation of a NY Human rights law to refuse to renew a physician's lease because he treated AIDS patients on the premises.

<sup>262</sup> *National Gay Rights Advocates v Great Rep Insurance Co No. 857323* (San Francisco Super Ct filed 5 May, 1986) In this case, Gay Rights activists filed a US\$11m lawsuit contending that the practice of requiring unmarried male applicants to answer special questions is in contravention of the state insurance regulations that prohibit discrimination against homosexuals.

<sup>263</sup> 466 F. Supp. 487 (1978)

of the non-carrier children. In the circumstances, the health risk was not sufficient to outweigh the burden of individual rights.

All 50 states and the District of Columbia have handicap statutes similar to the Federal Relations Act. These prohibit discrimination against private as well as public employees. These laws have been declared to apply to AIDS or HIV infection in the majority of states. Many states and municipalities have also put in place AIDS-specific statutes, which prohibit discrimination in areas such as hiring, employment and insurance<sup>264</sup>.

The state of Los Angeles passed an AIDS Discrimination Ordinance<sup>265</sup> which prohibits discrimination against those with AIDS or HIV infection, and those perceived to be at risk of AIDS in employment, rental housing, business establishments, city facilities and services, and educational institutions. This legislation provides for remedies both at law and in equity. In addition to protecting against discrimination, this statute also tries to educate the public about the AIDS virus.

✱ Discrimination in certain cases has been done by way of pre-employment medical exams; i.e. some employers have used an HIV positive test to deny certain applicants jobs. In a Namibian case of *N v Minister of Defence*<sup>266</sup>, the defence force's action of declining to enlist an applicant, N, on account of his HIV positive test was described as unfair and discriminatory, and, therefore, null and void. This position contrasts with

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<sup>264</sup> Gostin 1989, 1628

that prevailing in the US referred to above<sup>267</sup>. In *Hoffmann v South African Airways*<sup>268</sup>, the defendant, refused to employ the plaintiff as a cabin attendant based on the latter's HIV positive test. The Supreme Court, in overturning the decision of the High Court, held this action of the defendant to be a violation of the plaintiff's constitutional rights. Tasmania has expressly outlawed the use of pre-testing for purposes of employment or provision of services<sup>269</sup>. In Kenya, it has been postulated that Legislative measures that restrict the liberty of AIDS victims who endanger other members of society are not inconsistent with the personal liberty of the victims guaranteed in our constitution<sup>270</sup>. To alleviate possible discrimination at the workplace, the Federation of Kenya Employers (FKE) has revised its Code of Conduct 2001 in which it urges employers not to take actions that would be discriminatory to persons with HIV/AIDS<sup>271</sup>. These measures point to the need for comprehensive legislation on the question of HIV/AIDS.

The guidelines on HIV infection and AIDS in prisons issued by the WHO do not support discriminatory treatment of inmates<sup>272</sup>. Guideline 10 says: Compulsory testing of prisoners for HIV is unethical and ineffective and should be prohibited. Guideline 27 is to the effect that segregation,

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<sup>265</sup> Los Angeles, Cal. Code Ch. 4, art. 5.8 (1985)

<sup>266</sup> *Case No. L.C. 24/98 Labour Court of Namibia*

<sup>267</sup> Herbold, *ibid*; *Batten v Lehman*, *ibid*

<sup>268</sup> (*Constitutional Court of South Africa No. CCT 17/00*) Sept. 2000

<sup>269</sup> HIV/AIDS Preventive Measures Act 1993 (Tasmania), S. 6(2):

<sup>270</sup> Kibara, 88

<sup>271</sup> Nzioka, M. Conquering AIDS stigma at work. *East African Standard*, Wed. 30 May, 2001

<sup>272</sup> *WHO Guidelines on HIV Infection and AIDS in Prisons*, Geneva, March, 1993

isolation and restrictions on occupational activities, sport and recreation are not considered useful and relevant. According to Guideline 21, prison authorities are responsible for combating aggressive sexual behaviour such as rape, exploitation of vulnerable prisoners and all forms of prisoner victimisation by providing adequate staffing, effective surveillance, disciplinary sanctions, education, work and leisure programmes.

In Canada<sup>273</sup>, a report on HIV/AIDS in prisons says:

*"The most important response to the problem of HIV infection and AIDS in Canada penitentiaries is to increase efforts to protect inmates and staff, promote their health, and prevent transmission of HIV and other infectious agents within these institutions. These efforts should include, among other things, increased and more effective education about HIV/AIDS and drug abuse for both inmates and staff, better inmate access to condoms, access to bleach, and improved initiatives to provide staff with the ability to protect themselves from HIV transmission. Without exception, they need to be undertaken regardless of the degree of sero-prevalence in correctional facilities."*

In *Farmer v Brennan*<sup>274</sup>, the US Supreme Court vouched for the protection of all prisoners when it held that:

*"Prison officials may be held liable for failure to remedy a risk of harm so obvious and substantial [as prison rape] that the prison officials must have known about it."*

In *S v Mahachi*<sup>275</sup>, the accused had been convicted of theft. Evidence adduced showed he had tested HIV antibody positive two years previously and now had full-blown AIDS. Robinson, J observed:

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<sup>273</sup> Correctional Services of Canada, *HIV/AIDS Prison Policies: testing and segregation in Canada*, pp. 5-6

<sup>274</sup> Lexis, 6 June 1994

<sup>275</sup> [1993] 2 SACR 36 (Z)



*"...it is well for those responsible for the making of policy decisions in this regard, while they lie snugly and safely in their beds at night, to say that they find it offensive to allow discrimination against HIV positive and AIDS prisoners by isolating such infected prisoners from other prisoners at night in order to safeguard the latter from the lethal viral consequences of sexual assaults by the former - can the policy makers not begin to appreciate how a prisoner, particularly a young one, will feel if he should go to prison for a short term, only to emerge with an HIV positive death warrant hanging over his head because of his having been sexually assaulted in prison?"*

It should be noted that prisons in most African countries, Kenya included, are overcrowded. A policy of testing all inmates would divert scarce resources from education, care, counselling and other preventive efforts<sup>276</sup>. Such testing is, however, desirable as the first step in addressing a major question that arises from the above, namely: how can prisoners be effectively protected from infection? In agreement with the deliberations of the National AIDS Conference<sup>277</sup> it is submitted that:

1. There should be mandatory testing of all inmates, followed by segregation of those found sero-positive from those who test seronegative. In order to take care of the "latency period" of the infection, there will be need to repeat such tests on those who test seronegative after three months. Such a measure would mainly be directed at the new inmates
2. A duty to prevent the transmission of HIV infection among prison inmates should be imposed on prison authorities. This would make them liable in case of a breach.
3. Prisoners should have an opportunity to enjoy conjugal rights with their partners who are outside the prison. This requires that facilities be made available in prison for visitation.

From the foregoing, it becomes obvious that legal enforcement of preventive measures against HIV infection may entail "violation" of the

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<sup>276</sup> Achmat, Z. & Cameron, E. Judges and Policy on AIDS: Prisons and Medical Ethics, *SA Law J* 1995, pp. 1-9

rights of those persons living with AIDS. To mitigate the effects of such "violations," the National AIDS Conference recommended certain extra-legal strategies. These include:

1. Rigorous awareness campaigns to de-stigmatise the disease;
2. Empowering local communities to carry out counselling and set up counselling centres at the workplace and in institutions;
3. Setting up of HIV/AIDS clinics at community level
4. Provision of free medication for HIV/AIDS;
5. Abolition of discrimination of HIV sero-positive persons in recruitment, promotion and dismissal from employment;
6. Abolition of the use of HIV test results for insurance;
7. Inclusion of persons living with HIV/AIDS in the category of persons with disabilities so that they can also enjoy the legal protection provided to such persons;
8. Provision of a social network for material guarantees (food, clothing, school fees etc) for widows and orphans.

The question of human rights of persons living with HIV/AIDS can be seen as a balancing act between public health and civil liberties. In legislating on this subject, the AIDS Discrimination Ordinance of Los Angeles could serve as a useful guide. The guidelines issued by WHO regarding treatment of prisoners appear to overemphasise civil liberties at the expense of public health. Legislation here would make it a duty of prison authorities to put specific measures in place to combat the spread of HIV infection.

### **2.3.2. Quarantine**

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<sup>277</sup> National AIDS Conference organised by the Kenya AIDS Watch Institute (KAWI), Mbagathi, Nairobi, 11-12 Oct., 2001

The rationale for isolation is the undeniable danger that a person with HIV infection poses to the general public<sup>278</sup>. This way, it may be constitutional. Isolation is a serious form of deprivation of liberty without a criminal conviction, based on what he or she might do in future. Such isolation would have no time limit inasmuch as HIV positive persons are presumed to be chronically infectious, it (isolation) therefore amounts to a kind of civil life sentence. The danger of isolation is that it could drive the disease underground.

Some writers say that quarantine can only be imposed on the basis of the victims' unwillingness to co-operate with health authorities<sup>279</sup>. That is, quarantine should be imposed on those who, after detection of the infection and subsequent counselling show themselves by words or conduct unwilling to take precautions against the spread of their infection and those like lunatics and psychopaths who are mentally incompetent, those who are mentally incapable of appreciating the danger their conduct poses to others.

It is generally thought that an isolation policy could cause unimaginable hardship, dislocation, human as well as financial cost. No state in the US has seriously considered this option. Some states expressly authorise isolation of persons with AIDS or HIV infection who pose a serious threat to public health when less restrictive measures have failed to curtail their dangerous behaviour<sup>280</sup>. Other states authorise isolation for sexually

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<sup>278</sup> Gostin 1987, 1626

<sup>279</sup> Meritt, D.J. Communicable diseases and constitutional law:controlling AIDS, *NYU LR* 1986, 61:774

<sup>280</sup> Gostin 1987, 1626

transmitted or communicable diseases generally and AIDS or HIV infection is included therein.

In the US, the politics of AIDS appears to be moving in the direction of the use of compulsory powers of the state. Both politicians and public opinion seem to be united in their support for isolation and criminal confinement of recalcitrants<sup>281</sup>. Cuba has one of the lowest prevalence rates (at 0.02%) which can be traced to quarantine measures<sup>282</sup>. For many years, people living with HIV/AIDS were quarantined in Cuban sanatoriums. Now they are free to mix with the rest of society.

Numerous states prison systems segregate all prisoners with AIDS (20 states) or ARC (eight states) or who are sero-positive for HIV infection (6 states). Cases from the lower courts in the US indicate that courts are not likely to interfere with this administrative function<sup>283</sup>. Arguments against such a measure state that: firstly, such segregation may be harmful to prisoners as it may repeatedly expose infected persons to HIV and may hasten the development of AIDS, and secondly, segregation publicly signals which inmates are infected which would result in assaults in prison and discrimination when prisoners are discharged, and it provides a false sense of security for prisoners who are not segregated<sup>284</sup>.

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<sup>281</sup> Blendon, R.J. and Donelan, K.: Discrimination against people with AIDS: the public's perspective. *New England Journal of Medicine* 1988, 319:1022-6; Gostin, L.: The politics of AIDS: compulsory state powers, public health & civil liberties. *Ohio St L J* 1989, 49:1017-58

<sup>282</sup> Voelker, *ibid.*

<sup>283</sup> *Cordero v Coughlin*, 607 F Supp 9, 10 (SDNY 1984); *Johnson v Fair*, USDC Mass, Aug 10, 1987; *LaRocca v Dalsheim*, 120 Misc2d 697

<sup>284</sup> Gostin, *ibid.*

Cuba is one of the very few countries that resorted to quarantine measures with respect to HIV/AIDS<sup>285</sup>. At the moment, it has one of the lowest HIV prevalence rates in the world. However, this has now been relaxed. Tasmania's legislation on HIV/AIDS provides for isolation for 28 days in cases where a person persists in HIV risky behaviour<sup>286</sup>.

In Kenya, the Constitution provides for deprivation of freedom of movement in the interest of public health. Sections 48 and 50 of the Public Health Act<sup>287</sup> allude to measures touching on quarantine. These provisions have not been enforced. If the issue of AIDS is looked at in terms of guilt and innocence, of morality and immorality, then a solution should be sought in legislation directed against target groups, i.e. (re-) criminalization of homosexual behaviour or compulsory quarantine. Section 50 of the Public Health Act<sup>288</sup> provides for detention of infected persons. These methods become problematic where the major mode of transmission is heterosexual behaviour, resulting from extra-marital affairs<sup>289</sup>.

It is hereby submitted that quarantine measures are very effective and necessary in diseases that are of a contagious nature, i.e. Ebola, bubonic plague, typhoid fever, etc. Given the modes of transmission of HIV infection, quarantine per se is not an appropriate measure to contain its spread. However, quarantine, used in special circumstances such as

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<sup>285</sup> Voelker, *ibid.*

<sup>286</sup> HIV/AIDS Preventive Measures Act 1993 (Tasmania), s. 21(2)(c)

<sup>287</sup> Cap 242, Laws of Kenya

<sup>288</sup> Cap 242, Laws of Kenya

delinquent behaviour, and in combination with other measures, may be useful in checking the spread of the HIV scourge. It may therefore be necessary to make provisions for quarantine in the laws on HIV/AIDS.

### **2.3.3. HIV/AIDS persons as Disabled Persons**

The Rehabilitation Act of 1973 prohibits discrimination based on disability in employment and provision of services or benefits by any program or activity of an entity receiving federal financial assistance.

The Americans with Disabilities Act (ADA) was enacted in 1990 to protect individuals who had historically been victims of purposeful unequal treatment because they possess characteristics that are beyond their control and that are not truly indicative of each individual's ability to participate in, and contribute to society<sup>290</sup>. Unlike the Rehabilitation Act that was restricted to agencies receiving federal funding, ADA applies to all employers with at least 15 employees. Furthermore, ADA extends protection to persons without disabilities if they have a known relationship or association with a person with a disability. Title I of ADA provides<sup>291</sup>:

*"no covered entity shall discriminate against a qualified individual with a disability ... in regard to job application, procedures, the hiring, advancement, or discharge of employees, employee compensation, job training and other terms, conditions, and privileges of employment".*

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<sup>289</sup> Almond, B. Introduction: War of the world. In: Almond, B.: *AIDS - A moral issue. The ethical, legal & social aspects*, London-Macmillan, 1990, p.3

<sup>290</sup> Gridley, D. Genetic Testing under the ADA: A case for protection from Employment Discrimination. *The Georgetown Law J*, 2001, 89:981

<sup>291</sup> Gridley, p. 982

The ADA<sup>292</sup> defines a disability as (1) a physical or mental impairment that substantially limits one or more of the major life activities of the individual, (2) a record of such an impairment, or (3) being regarded as having such an impairment. Only one of these three must apply for a person to be covered under the Act. In *Piquard v City of East Peoria*<sup>293</sup>, two police officers with disabilities claimed that their exclusion from a pension plan violated the employment and public services provisions of ADA. The court found for the petitioners, saying, that like costing disabilities should be treated alike and rejected the defendants' argument that s. 501(c) exempts insurance decisions from ADA's non-discrimination requirement. The question as to whether a person living with HIV fits into the definition of a person with a disability was answered in *Bragdon v Abbot*<sup>294</sup>. In that case, the US Supreme Court held that a person infected with presymptomatic HIV has a physical impairment that "substantially limits" reproduction, which the court deemed a major life activity and therefore HIV constitutes a disability under the ADA. In *Samuel P. Givens, Jr. v South Carolina Health Insurance Pool & Ors*<sup>295</sup>, the defendants/respondents excluded the appellant from their insurance cover on the basis of an HIV/AIDS diagnosis. The trial court found for the respondents. On appeal, it was argued for the appellant that the statutory exclusion of people living with HIV/AIDS from the South Carolina insurance pool violated ADA, a

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<sup>292</sup> *ibid.*

<sup>293</sup> 887 F. Supp. 1106, 1121 (C.D. Ill. 1995)

<sup>294</sup> 524 US 624 (1998)

<sup>295</sup> In the US Court of Appeals for the Fourth Circuit No. 95-2791, <http://www.aclu.org/court/givens.html>

federal legislation; that the exclusion of the appellant was done without any actuarial justification; that the cost of treating patients with HIV/AIDS from infection to death was comparable to costs of treating other medical conditions not expressly excluded by the same statute such as end stage renal disease, multiple sclerosis, cancer of the digestive system, heart and liver transplants; and that the State of South Carolina legislation should therefore be declared a violation of ADA and therefore inapplicable in the present case.

Further, the Family Medical Leave Act (FMLA) came into effect on August 5, 1993 and applies to private employers. This Act requires covered employers to provide eligible employees with an unpaid leave of up to 12 weeks in any 12 month period for a variety of health reasons, including the care of a son, daughter, spouse or parent of the employee with a serious health condition. Employment benefits which would have accrued to the employee cannot be taken away.

In Germany, the Employment Act<sup>296</sup> as well as guidelines to employers<sup>297</sup> generally outlaw discrimination of persons with disabilities. In a subsequent legislation on the rehabilitation of persons with disabilities<sup>298</sup>, employers are obliged to either employ a certain proportion of persons with disabilities, or to contribute a certain amount of money equivalent to the salary and benefits they would have paid to such employees to compensate

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<sup>296</sup> Arbeitsfoerderungsgesetz (AFG) 1969

<sup>297</sup> Anordnung des Verwaltungsrates der Bundesanstalt fuer Arbeits- und Berufsfoerderung Behinderter 1975



those employers, who may employ more than their required quota of persons with disabilities.

Legislation therefore, that would include persons with HIV/AIDS under the category of persons with disabilities would go a long way in ensuring job security for persons living with HIV/AIDS and in further protecting them from undue discrimination.

### **CHAPTER THREE: METHODOLOGY**

The triangulation method was adopted in this study. This is a methodology that uses several approaches to arrive at a likely solution. In this particular research, the triangulation method involved a study of case law, statutory law, medical, other relevant literature, and an empirical component using a questionnaire to collect information.

The questionnaire was constructed based on the Likert scale, which allows respondents a wider choice of responses. In addition, the questionnaire was kept brief and precise to ensure better co-operation and a higher return quota. The instrument was pilot tested using 100 University students and it was corrected for inconsistencies in language level and clarity.

Overall, 1239 respondents of both genders were recruited randomly into the study. These included 399 from Nairobi, 412 from Bungoma and 428 from Kisumu. Attempts were made to balance the gender of the respondents across the age groups.

The major working hypotheses were:

- A legal regime on HIV/AIDS in Kenya is lacking.
- The current legal regime on communicable diseases is wanting as far as HIV/AIDS is concerned.
- The lack of a legal regime on HIV/AIDS is an obstacle in the prevention of the pandemic.
- Enactment of legislation on HIV/AIDS will result in a reduction of its spread

More specifically, this study considered the following hypotheses:

- The adherence to the Hippocratic rule on doctor-patient confidentiality with regard to the HIV sero-positive status of a patient is a hindrance to its prevention of its spread as this leaves close contacts very vulnerable.
- The lifting of the veil of confidentiality will reduce the spread of HIV infection.
- The lack of laws criminalising the deliberate spread of HIV/AIDS hampers efforts to reduce its spread.
- Enactment of laws criminalising such behaviour will result in a reduction of the spread of the pandemic.
- There is discrimination against persons living with HIV/AIDS which has resulted in stigmatisation and secrecy about the pandemic.
- Current trends in Kenya appear to favour openness.
- Laws prohibiting discrimination and advocating for openness will result in destigmatization and openness thereby facilitating voluntary counselling and testing and the provision of other services with a net result of reduction in the prevalence of HIV/AIDS.

Both qualitative and quantitative statistics were employed in the treatment of data<sup>299</sup> collected via the questionnaire. Qualitative measures included the sum, mean, standard deviation, bar charts, frequencies, and pie charts. The quantitative measures included the chi-square test and a one way analysis of variance (ANOVA) to test for differences across age, gender, profession, marital status and location (urban/rural). Significance was accepted at  $p < 0.01$ . Inferences were drawn based on the results from the questionnaire as well as from other methodologies employed in this study. The results of the empirical part of the study as well as their discussion are presented in the next chapter.

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<sup>299</sup> McClave, J.T. & Dietrich, II, F.H. *Statistics*, 4<sup>th</sup> ed., Dellen Publishing Co., San Francisco, 1988; Montgomery, D.C. *Design & Analysis of Experiments*, 3<sup>rd</sup> ed., John Wiley & Sons, NY, 1991; Sachs, L. *Angewandte Statistik. Anwendung statistischer Methoden*, 6. Aufl., Springer-Verlag, Berlin, 1982

## **CHAPTER FOUR: RESULTS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS**

This chapter presents the results of the empirical part of the study and tries to link these data to results of the library research already presented. From this fusion, conclusions and recommendations are drawn.

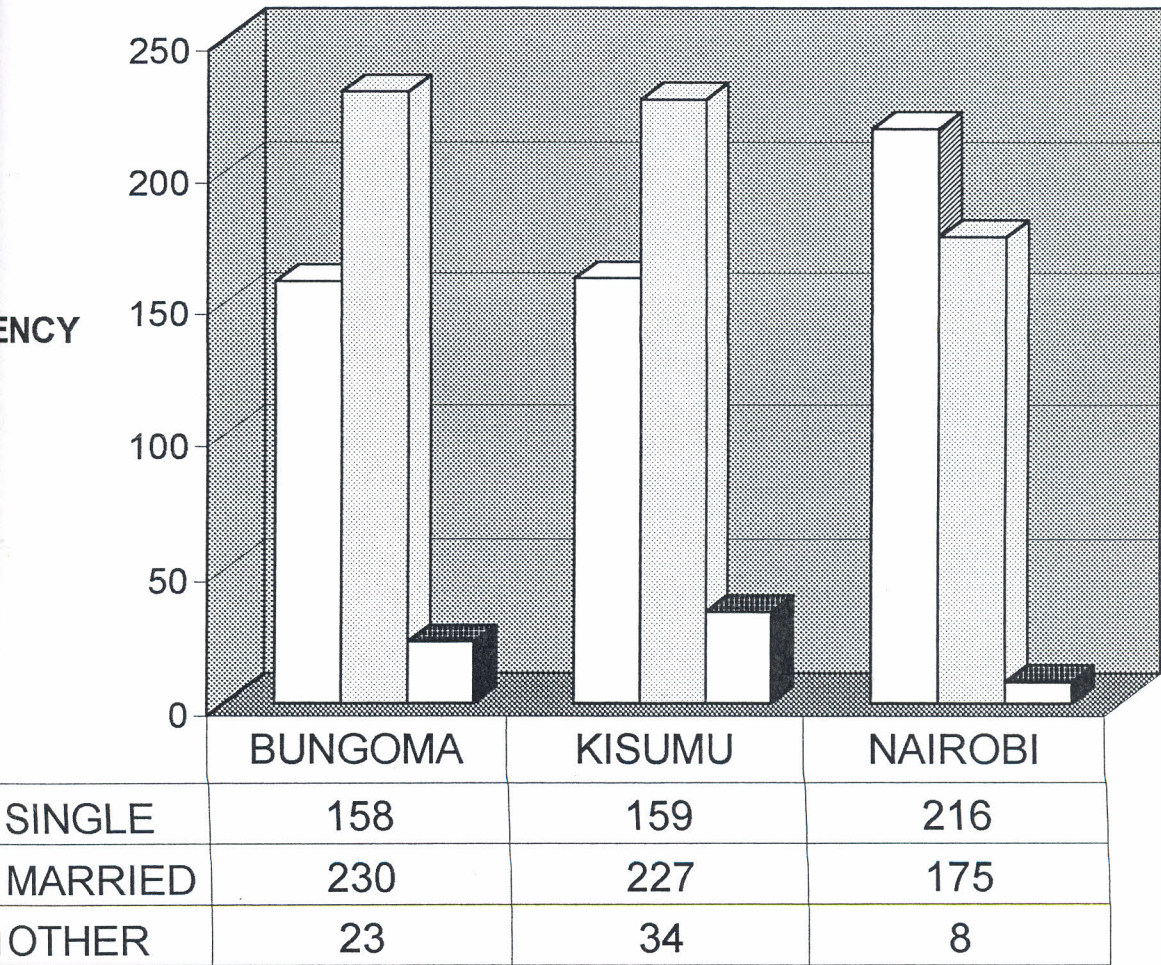
### **4.1. Results and Discussion**

#### **4.1.1. Biographical Data**

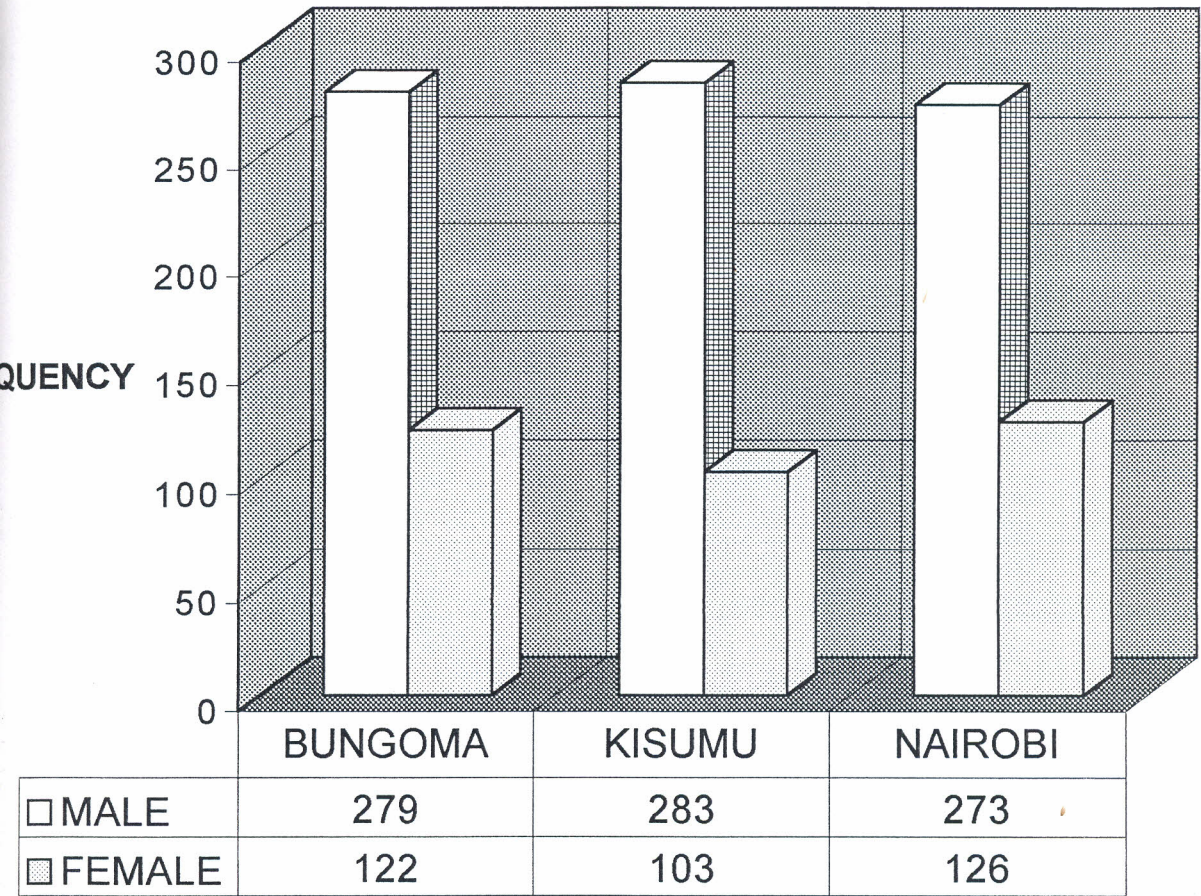
The age of the participants ranged from 14 years upwards. The majority lay in the 14-30 age group (68.5%). There was no difference in marital status between the respondents. There were as many single respondents (46%) as there were married ones (49.9%). There was a significant difference in the gender ( $p < 0.05$ ). The male respondents made up 68.2% as compared to 31.8% for the females. In terms of profession, there was no group that stood out. The respondents were overwhelmingly Christians (85.2%) and Moslems (8.6%). Overall, there was a balance in the selection of respondents.

Figure 1 shows respondents by marital status. Figure two shows the distribution of the respondents according to gender and figure 3, according to age. Figure 4 depicts the level of general awareness with regard to HIV/AIDS.

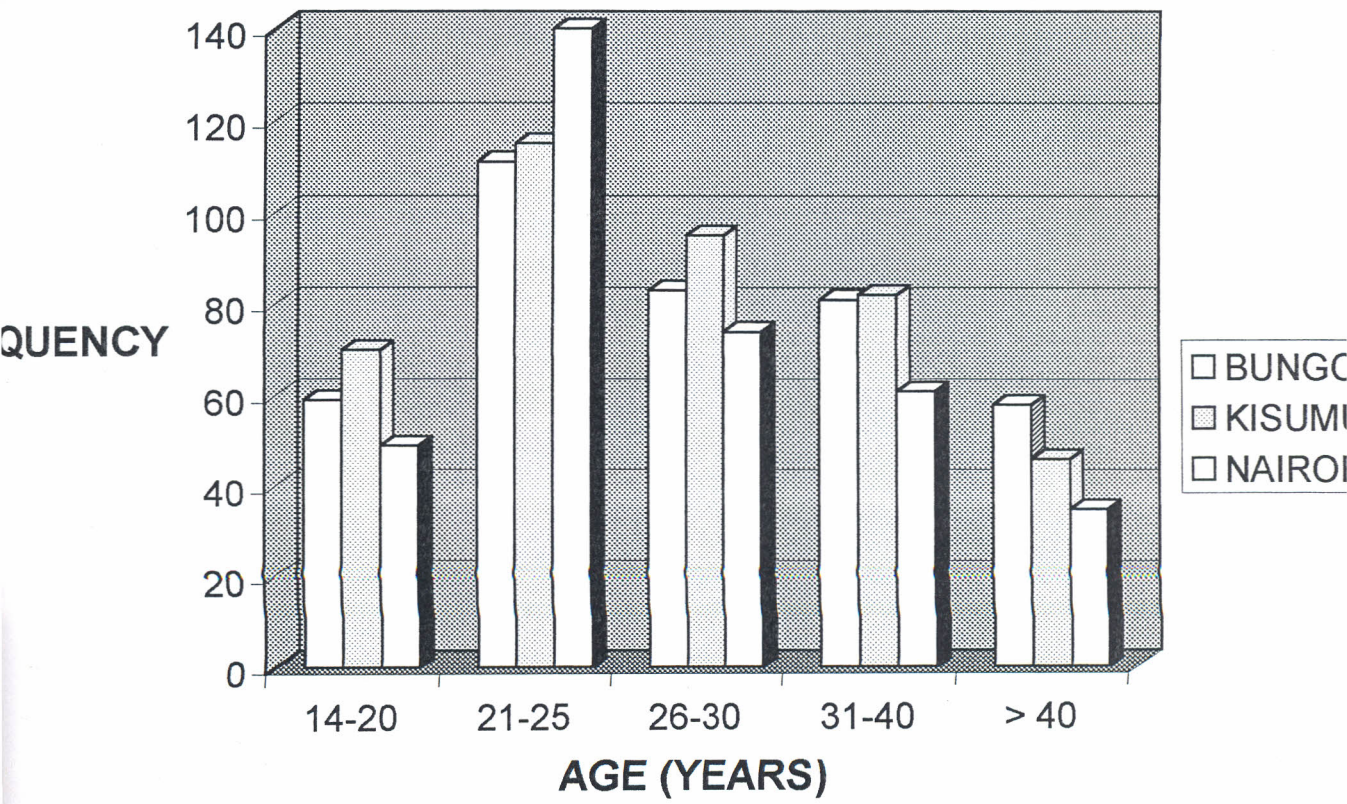
**Fig. 1: DISTRIBUTION OF RESPONDENTS ACCORDING TO MARITAL STATUS**



**Fig. 2: DISTRIBUTION OF RESPONDENTS ACCORDING TO GENDER**

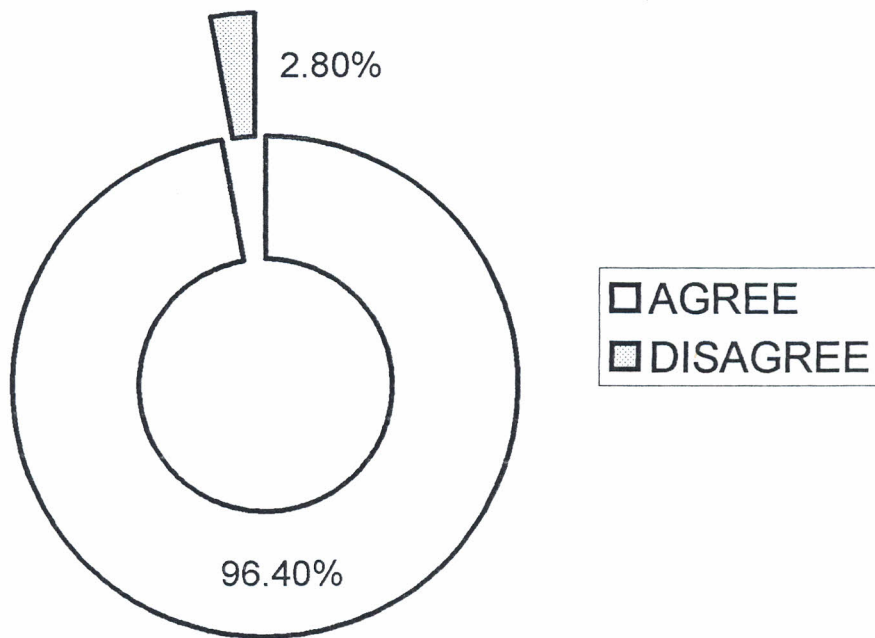


### 3: DISTRIBUTION OF RESPONDENTS BY AGE



About 96% of the respondents are aware that HIV/AIDS is "terrible" disease (Fig. 4). This figure is in line with the current national trends.

**Fig. 4: HIV/AIDS is a terrible "disease"**



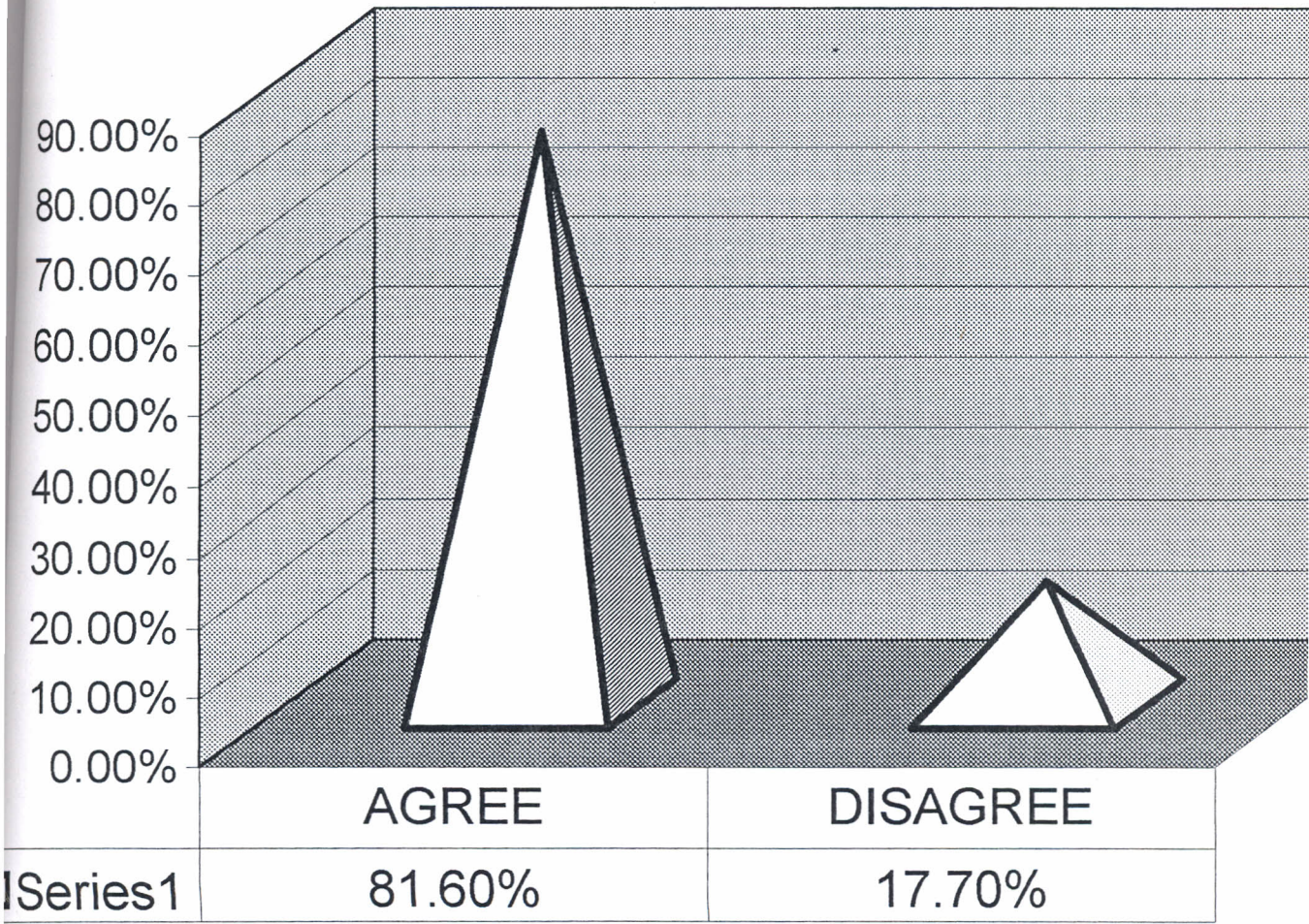
#### **4.1.2. Confidentiality**

Confidentiality was assessed by way of questions touching on disclosure of information from the doctor, information on death certificates and HIV antibody testing. Ninety percent of the respondents would like doctors to inform next of kin. Over 80% of the respondents would like persons living with HIV/AIDS to be known publicly, 83% want persons committed to prisons for the first time to be tested for HIV/AIDS, 87% say prostitutes must be tested, and 88% want information on AIDS-related deaths to be made public.

Figure 5 shows the opinions of the respondents on the question whether persons living with HIV/AIDS should be publicly known.



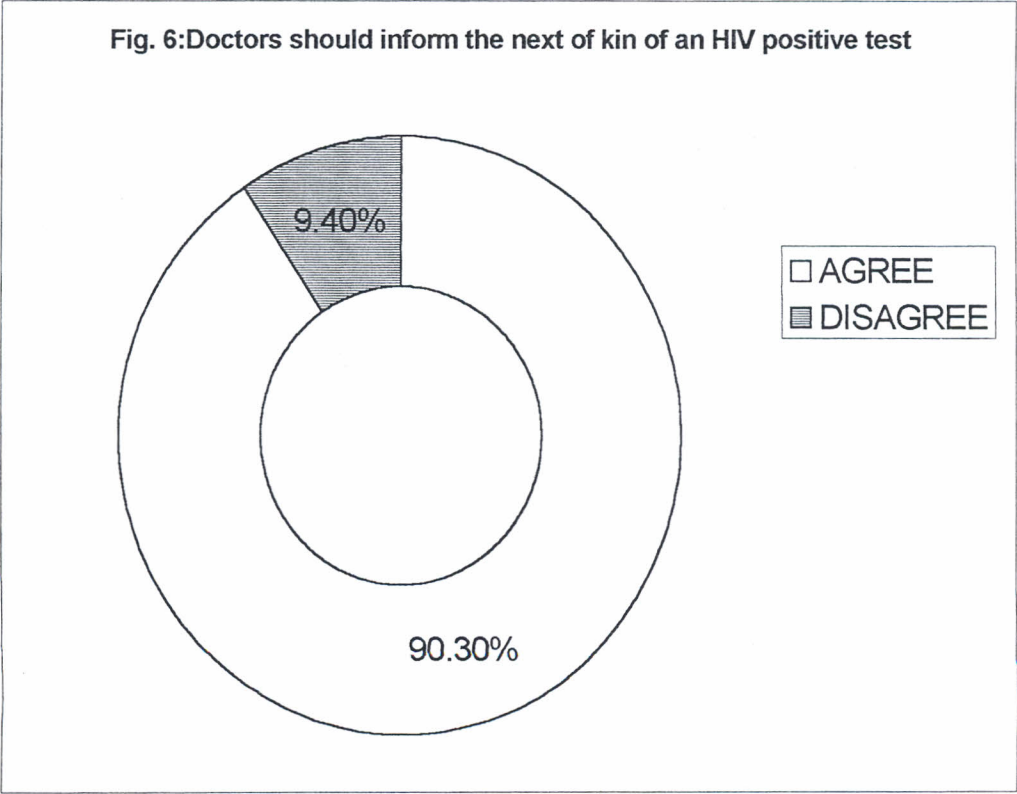
**Fig. 5: Persons living with HIV/AIDS should be known publicly**



Clearly, it is accepted that whereas the doctor-patient confidentiality is both a legal and ethical duty, such a duty is not absolute<sup>300</sup>. To date, no Nation-State has legislated so widely as to require public disclosure of HIV/AIDS to an amorphous public. Many legislatures are sensitive to the "public interest." In seeking to protect the public interest, it is those in imminent danger who should be informed. Disclosure of HIV information

<sup>300</sup> *Tarasoff, Hunter, Jansen van Vuuren and Egdell*

on the golf course<sup>301</sup>, on the laboratory bulletin<sup>302</sup> is not considered the proper way of making such a disclosure. The proper method of disclosure of such information can be found in *Tarasoff and in Egdell*. Such a method requires that the information be passed on using the correct and laid down procedures and to those with an interest in such information. In addition, the revised Hippocratic oath gives leeway to disclosure of confidential



information where the situation so warrants<sup>303</sup>.

Figure 6 shows the response on the involvement of the next of kin. Ninety percent favour this approach. This result is close to that found in

<sup>301</sup> *Van Vuuren*

<sup>302</sup> *In re Worcester Hospital*

<sup>303</sup> British Medical Association: Revised version of the Hippocratic Oath 2002

South Carolina (92%) on the question of partner notification<sup>304</sup>. In the US, Public Health statutes require such disclosure for purposes of contact tracing. Courts in the US require that infected with HIV disclose that information to their partners<sup>305</sup>. In the UK, a lot of reliance is put on Public Health Statutes. However, Police have been allowed to store people's HIV status in computers<sup>306</sup>, thereby widening the scope of disclosure. The Kenya Medical Association has decided to go ahead with the approach of informing the next of kin/spouse. However, such an approach does not go far enough to bring into the net, sexual liaisons between persons who are either unmarried or who are not spouses so properly called.

On whether AIDS-related deaths should be made public, the responses are shown in figure 7. About 88% of all respondents are in favour of this measure as a way of controlling the spread of HIV/AIDS. These result echoes the practice in the UK where AIDS is indicated on death certificates as an underlying condition in AIDS related deaths<sup>307</sup>.

On the question of voluntary counselling and testing (VCT), the responses are shown in figure 8. About 94% of the respondents would like VCT to be encouraged. Whether reasons reported in the UK for reluctance

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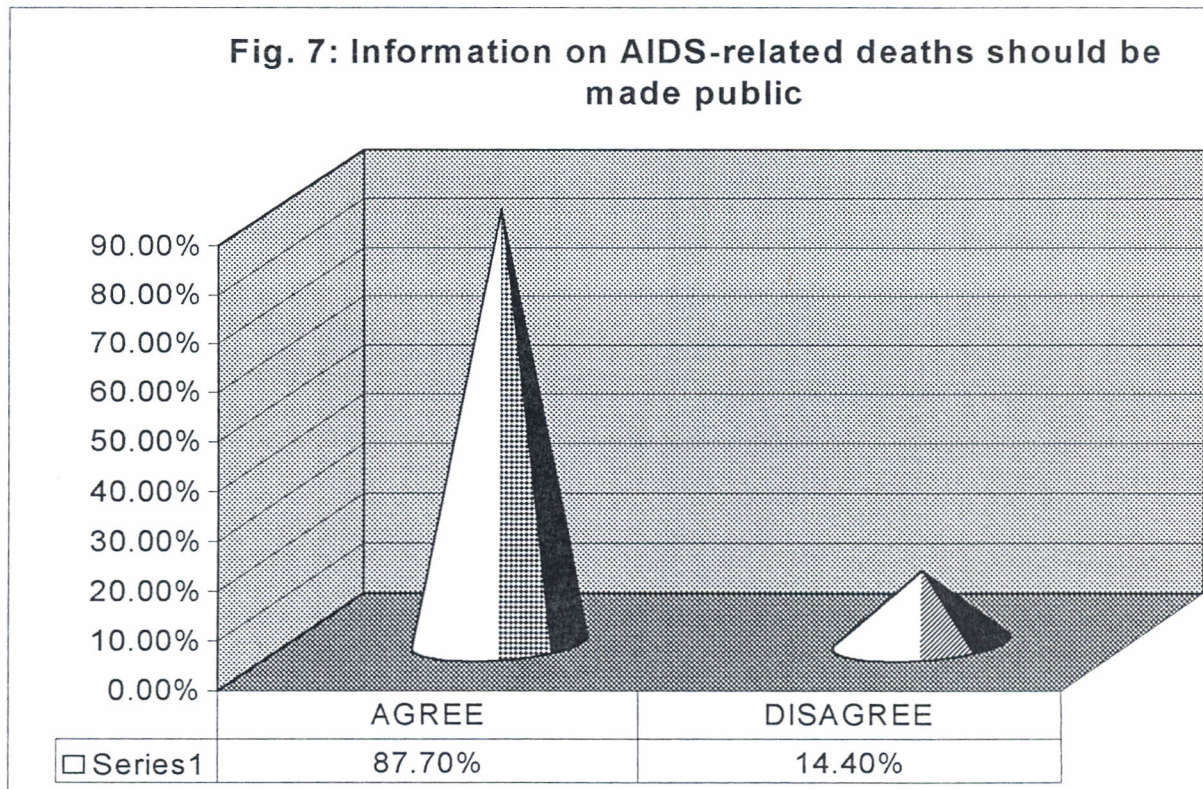
<sup>304</sup> Jones et al, 1990

<sup>305</sup> *Christian*

<sup>306</sup> Mason, 1992

<sup>307</sup> Hardy, 1987

to participate in VCT<sup>308</sup> are also applicable to Kenya requires further research.

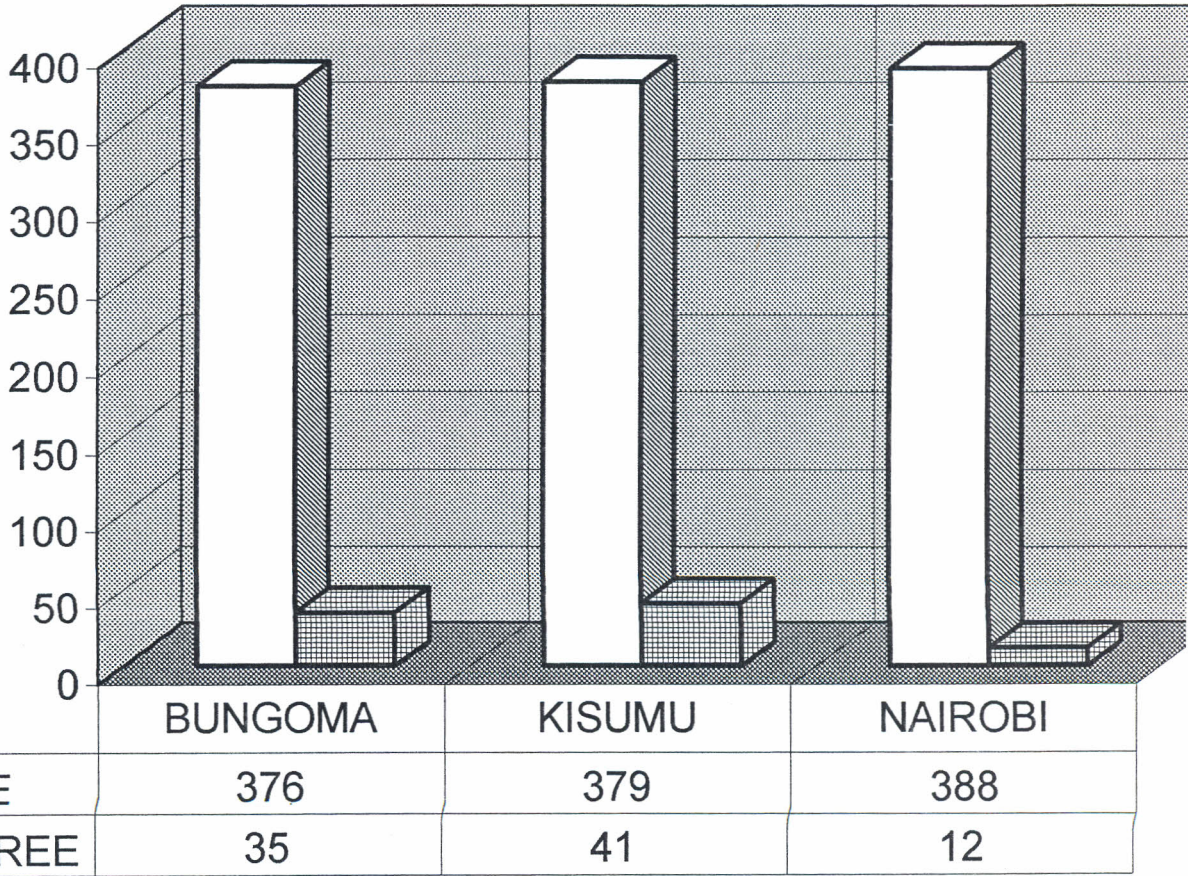


The frustration expressed by Harris, C.J<sup>309</sup>. regarding VCT should serve as a warning against considering VCT as the "all in all." In fact, it is submitted that whereas VCT should be left open, mandatory testing will be necessary for certain sub-populations such as that accused of rape, those committed to jail terms, prostitutes and those identified "contacts."

<sup>308</sup> Kell et al., 1991

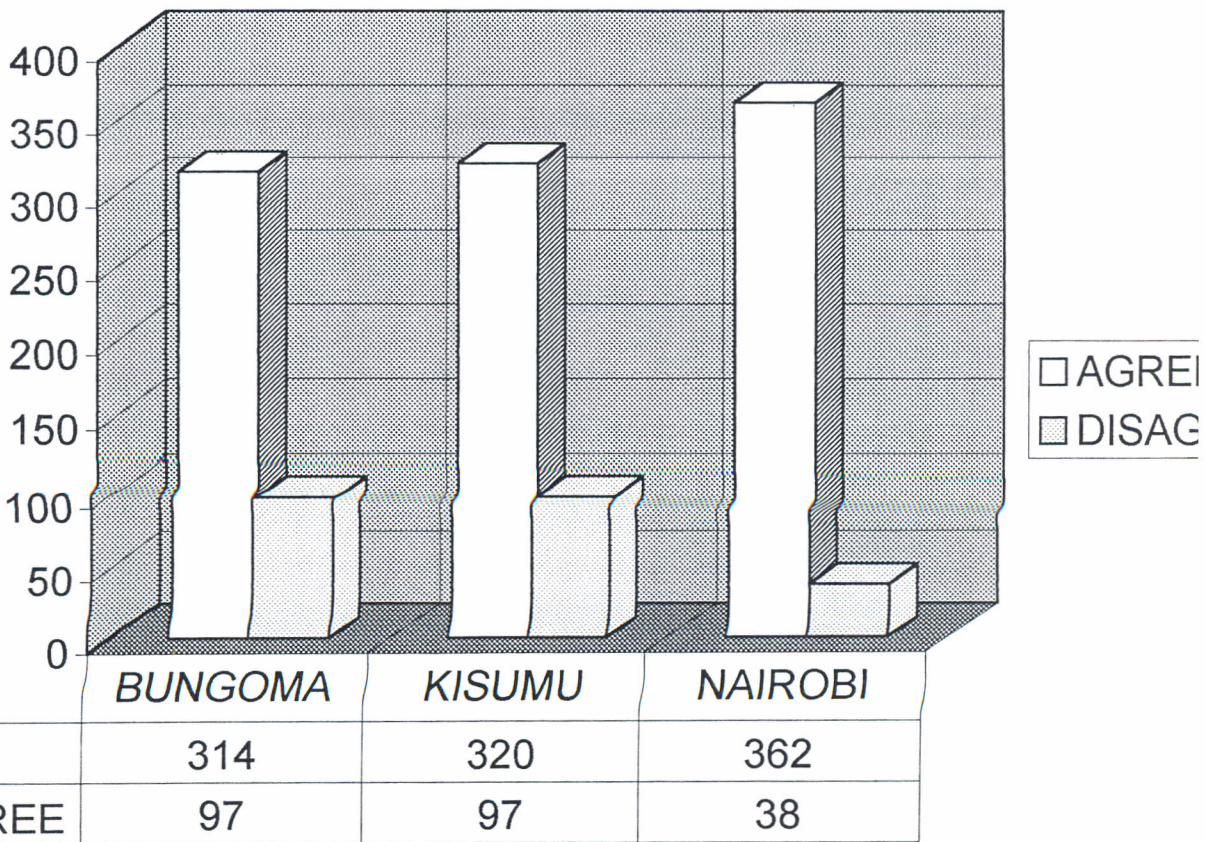
<sup>309</sup> JAMA 1993, 269:115

**Fig. 8: Voluntary Counselling and Testing (VCT) should be encouraged**



The question whether traditional practices that would appear to facilitate the spread of HIV infection should be outlawed, the majority of the respondents answered in the affirmative (fig. 9). In practice, however, banning alone, without adequate education and awareness may not be effective. This is one aspect of human behaviour that is even better left to awareness campaigns than to be handled by legislation.

**Fig. 9: Traditions like "wife-inheritance" and "traditional" circumcision should be banned**

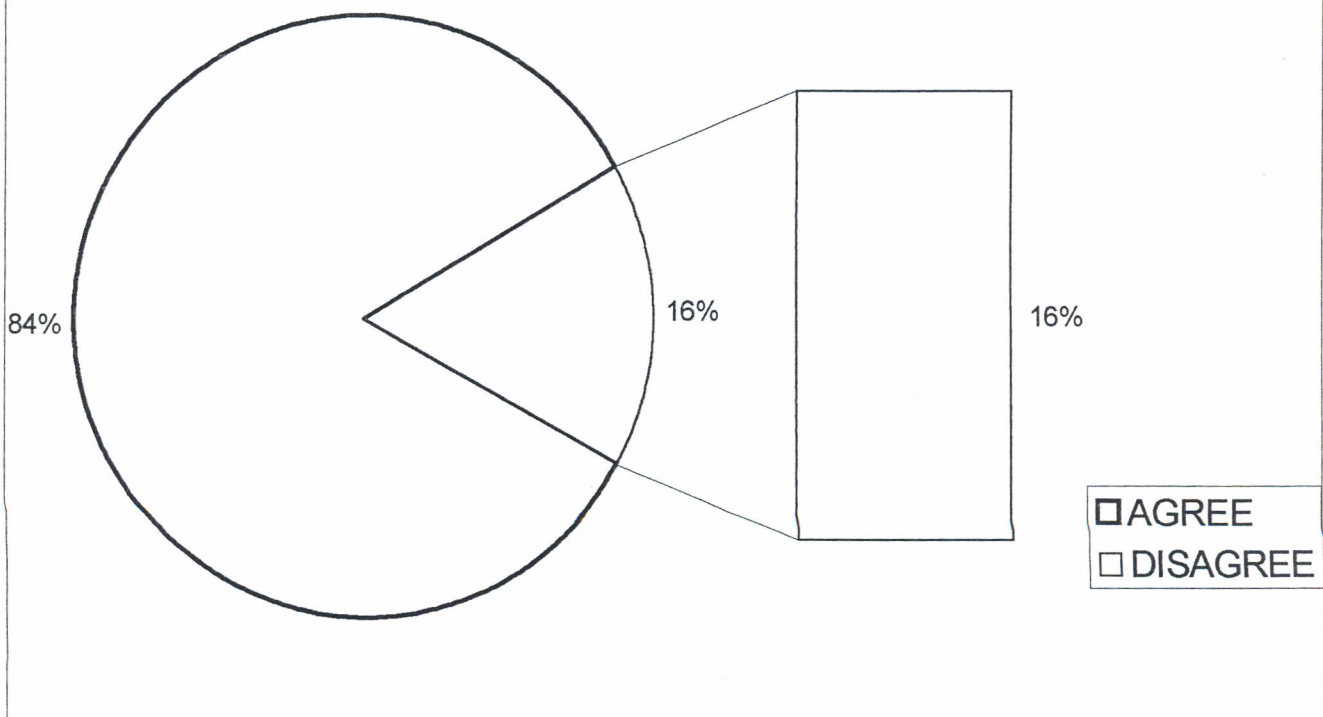


Overall, the tone is set for dealing that is more open with medical information relating to HIV/AIDS. Kenyans are very clear on the issue of confidentiality in the prevention of HIV/AIDS: no confidentiality. Results on confidentiality are in line with legal developments in other countries as presented above under confidentiality. The Hippocratic Oath in its Revised Version allows for disclosure where the life of others is in danger. What remains now is to reduce into law a provision that favours disclosure and openness in the fight against HIV/AIDS.

#### **4.1.3. Discrimination**

The question whether there should be discrimination against persons living with HIV/AIDS has been given a resounding no. Kenyans do not think that discrimination against such persons is a vehicle for prevention of the spread. This is shown in figure 10.

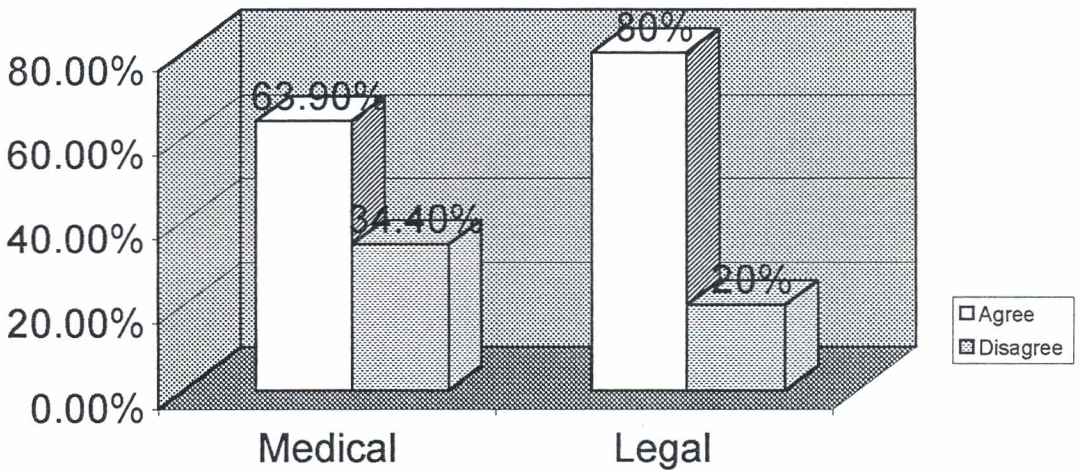
**Fig. 10: There should be no discrimination against persons living with HIV/AIDS**



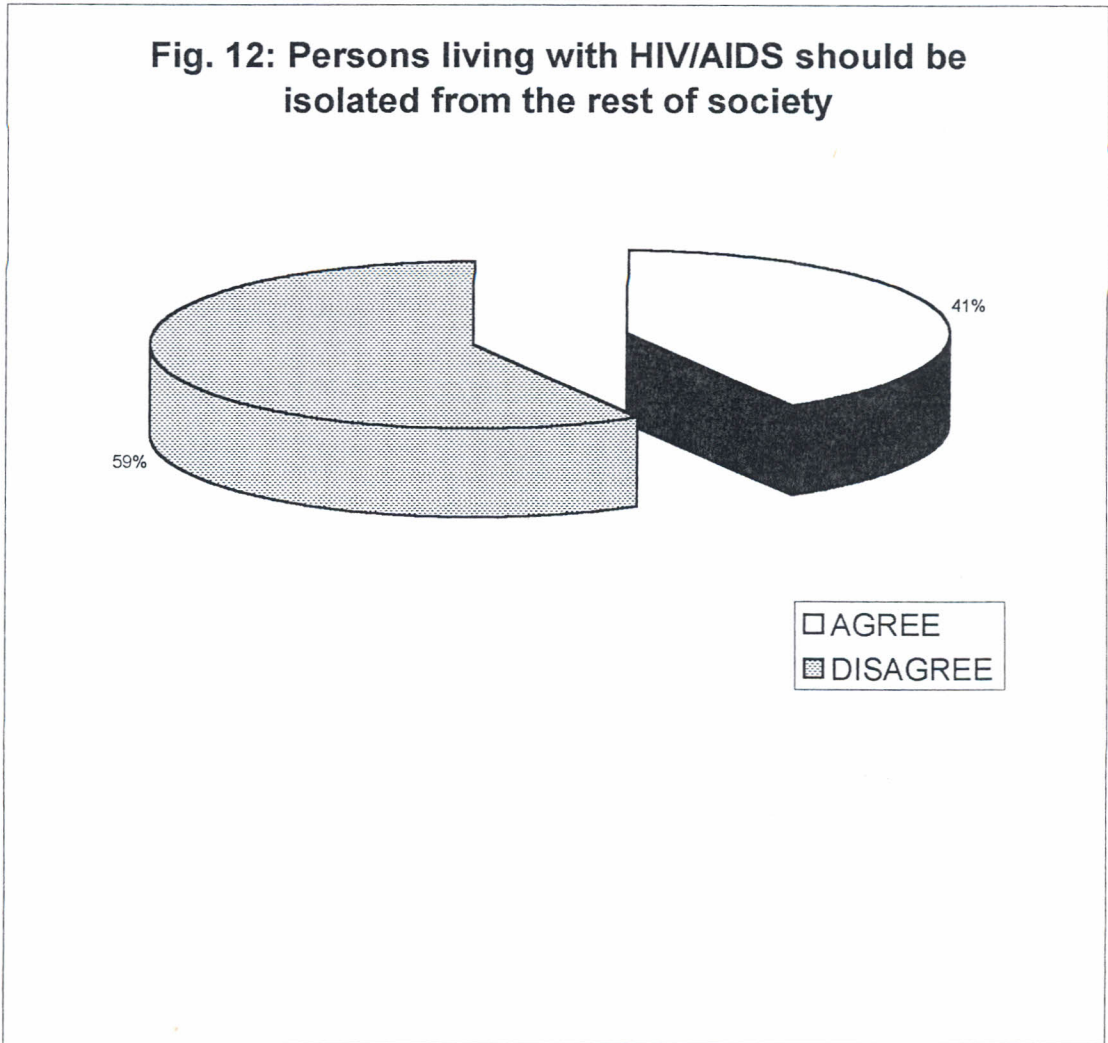


On the question of whether insurance companies should not require HIV sero-negative tests for their services, 63.9% and 80% of the medical and legal professionals respectively agreed, whereas 34.4% and 20% of the legal and medical professionals disagreed (fig. 11). Clearly, the practice of disqualifying would be clients on account of a positive HIV test does not appear to find favour with the respondents.

Fig. 11: INSURANCE COMPANIES SHOULD NOT REQUIRE HIV TESTS FOR THEIR SERVICES



The respondents are not in favour of isolation of persons living with HIV/AIDS as shown in figure 12. The slight differences in the responses are not significant.



Clearly, Kenyans do not favour the discrimination of persons living with HIV/AIDS in all facets of life, including insurance. This response conforms to the rulings of the courts<sup>310</sup> in certain countries against

<sup>310</sup> *Minister of Defence(Namibia), South African Airways*

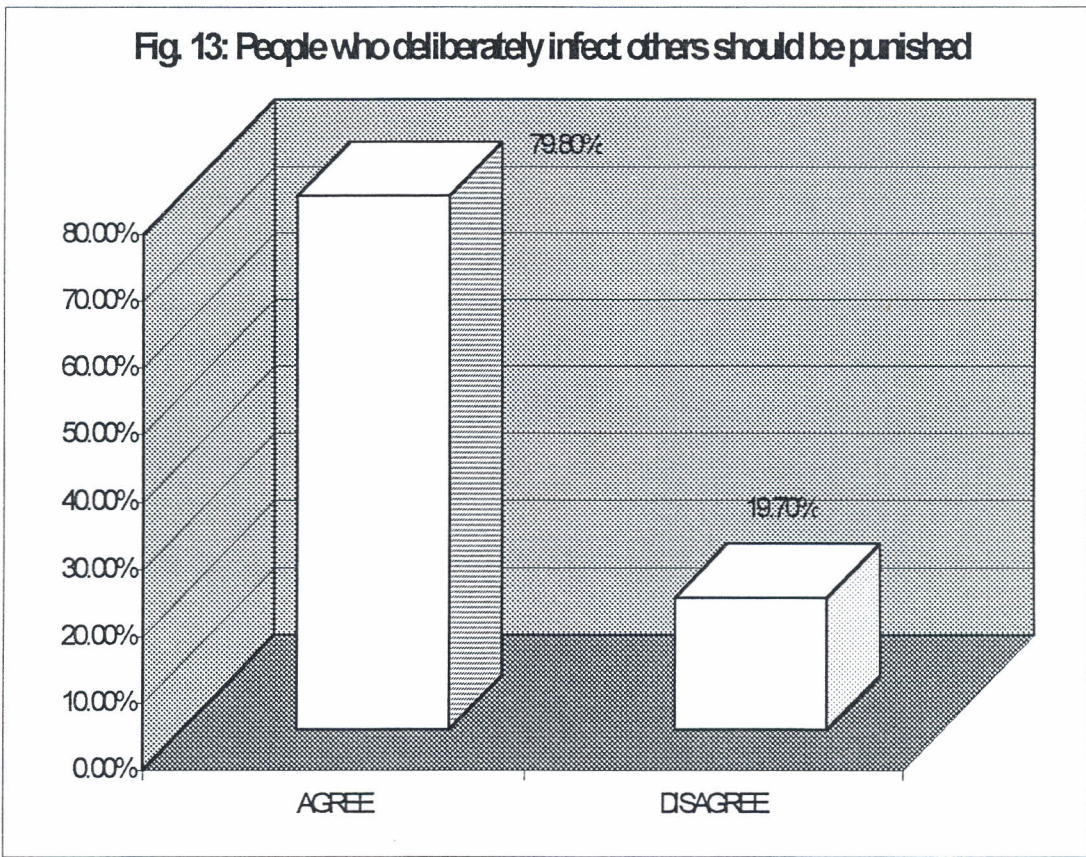
discrimination as well as some legislation<sup>311</sup> that have been put in place in certain other areas. We need airtight laws barring discrimination in schools, employment, and other areas of life. However, certain measures such as mandatory testing of new convicts, commercial sex workers and other sub-populations at greater risk of HIV infection should not be seen as discrimination. The practice of employers to require pre-employment HIV testing as well as the current practice by churches to insist on HIV sero-negative certificates before conducting weddings should be clearly outlawed. The acceptance of persons infected with presymptomatic HIV as persons with disabilities in the US<sup>312</sup>, ought to be considered in our legislation seriously so as to confer further protection to persons living with HIV/AIDS.

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<sup>311</sup> Los Angeles, Cal. Code Ch.4

<sup>312</sup> *Bragdon*

**Fig. 13: People who deliberately infect others should be punished**



#### **4.1.4. Punishment of Deliberate offenders**

Kenyans are overwhelmingly agreed that deliberate offenders in HIV/AIDS should be punished (figure 13). There was no significant difference on this variable between males and females, along marital status, age, religion or profession. Politicians and public opinion in the US is for punishment of recalcitrants<sup>313</sup>. In the UK<sup>314</sup> as in the US<sup>315</sup>, it is accepted

<sup>313</sup> Blendon & Donelan 1988; Gostin 1989

<sup>314</sup> King

<sup>315</sup> Maraham

that no one can license another to commit a crime. Those who deliberately infect others in those countries are liable to criminal sanctions.

There is the difficulty of proving *mens rea* alluded to earlier on. This is complicated by the anatomical structure of HIV, which consists of an outer and an inner membrane. The outer membrane changes and takes on the characteristics of the host. This makes proof of the source of the infection difficult. The second problem is presented by the latency characteristic of the inner membrane of the virus. This means that one becomes infected for life. The social implications for such an infection touch on dependency on medication for life, need to care for orphans where applicable, and sacrifice in terms of re-allocation of resources. In legal terms then, punishment of the offender alone would be insufficient to mitigate the harm caused and for which one is being punished. It is therefore submitted that there is need for restitution, alongside punishment.

Another difficulty presented by punishment is the ability of some people to produce cytotoxic T lymphocytes (CTLs) that keep an infection at abeyance. This means a rapist who is HIV sero-positive may not infect his victim with the virus, if the victim is capable of producing CTLs. Such a fact may not be possible to establish at the time of prosecution.

It is also not clear, how spouses can be protected against HIV infection. The case of *Maraham* makes it criminal for a spouse to withhold

information relating to a sexually transmitted disease. However, should a spouse run away from his/her marital home to escape re-infection?

Going back to the question of *mens rea*, this may be sorted out in two ways: (i) make HIV/AIDS offences relating to infection to be offences of strict liability; and (ii) where non-natural persons are involved, hold the officers liable, like in cases of transfusing contaminated blood.

A question that requires further consideration is one of how much punishment would be adequate. This question assumes a greater importance in view of the fact that a person infected with HIV/AIDS is a sick person, that such a person is not likely to receive proper medical attention in confinement, that the conditions under confinement are likely to worsen the "disease" state, and that there is a danger of the person either infecting others in confinement or being re-infected. These considerations ought to be balanced against the consideration that such a person has deliberately infected another person and that such infection cannot be undone - its an infection for life. In view of all the above considerations, a minimal jail sentence if any, is called for. Such a sentence, combined with the aspect of restitution in which such a person (the offender) loses part of his/her property should be punitive enough.

Due to the inadequacy of the current statutes, and in order to effect punishment of deliberate offenders in HIV/AIDS infection, it will be

necessary to either have a separate set of laws on HIV/AIDS or to amend the Penal Code to accommodate HIV/AIDS.

## **4.2. Conclusions**

The following conclusions were arrived at:

- ❖ The use of law in medical practice is an age old phenomenon
- ❖ Parliament has the mandate to make relevant laws whenever the health of the people is threatened
- ❖ Infection with HIV is an infection for life, and the use of anti-retrovirals is equally for life
- ❖ Infection with HIV is analogous to a "death sentence" in the absence of a cure or a vaccine
- ❖ Medical ethics based on the Hippocratic corpus have undergone many modifications as driven by necessity. It is now necessary to further modify the aspect on confidentiality as a way of preventing the spread of HIV
- ❖ It is wrong for a person (whether natural or legal) to endanger the life or lives of another or others respectively
- ❖ Discrimination of persons living with HIV/AIDS is uncalled for
- ❖ Mandatory testing of the whole population is both costly and cumbersome; VCT appears to be more affable although its relevance has not been scientifically documented

## **4.3. Recommendations for law-making**

The following recommendations were arrived at:

- There is need to (re-) define HIV infection and AIDS in such a way that there is a clear congruence between the medical and legal understanding of these terms.
- Confidentiality with respect to HIV/AIDS should be dispensed with, in situations where such confidentiality would put the wider public at risk of infection.
- Deliberate infection of others ought to be criminalized.

- Compensation for those infected against their will or those who are infected unknowingly should be provided for.
- Provide for prosecution of manufacturers of defective condoms and HIV/AIDS drugs that may prove more harmful than good.
- Provide for VCT for the general population and mandatory testing in specific situations, i.e. prisoners, commercial sex workers, and health care providers.
- Discrimination of persons living with HIV/AIDS should be expressly outlawed, and stiff criminal sanctions provided for in case of non-compliance.
- Persons living with HIV/AIDS should be included under the category of persons with disabilities so that they may benefit from the provisions of the Act on Disabilities.
- AIDS as a precondition to death should be indicated on death certificates.

#### **4.3. Recommendations for further Research**

Further research should attempt to answer the following questions:

- What are the medico-legal consequences of a mother who has tested HIV positive and who, nonetheless is desirous of being a mother?
- How can the law protect a married person against infection by the spouse?
- How best can the social factor of "orphans" due to HIV/AIDS be legally mitigated?



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**APPENDIX I: QUESTIONNAIRE**

*Please answer all questions*

Age (please tick): 14-20 [ ] 21-25 [ ] 26-30 [ ] 30-40 [ ] Over 40 [ ]

Gender (M/F) \_\_\_\_\_ Profession/Occupation \_\_\_\_\_

Married/Single/Divorced/Separated/Widowed \_\_\_\_\_

Religion (please tick) : Christian [ ], Hindu [ ], Moslem [ ], Other [ ]

*{The above information is captured under figs. 1-3 of chapter 3}*

=====

*Please tick one of the choices:*

1. HIV/AIDS is a terrible disease *{fig. 4}*

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

2. Doctors should inform the next of kin of an HIV positive test *{fig. 6}*

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

3. Information on deaths from HIV/AIDS related illnesses should be made public *{fig. 7}*

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

4. HIV positive persons should be known publicly in order to prevent the spread of the disease *{fig. 5}*

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

5. HIV positive persons should not be discriminated against in school, employment, insurance, etc. *{fig. 10}*

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

6. HIV positive persons who deliberately infect others should be punished (i.e. jailed, fined or hanged) *{fig. 13}*

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

7. HIV positive persons should be isolated and kept in special institutions away from other people *{fig.12}*

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

8. Parliament should make or amend existing laws to provide for punishment of HIV positive persons who persist in risky behaviour

1. Strongly agree [ ] 2. Agree [ ] 3. Strongly disagree [ ] 4. Disagree [ ]

