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HIV/AIDS IN THE FAMILY; IMPACT AND CONTROL: A CASE FOR SPOUSAL NOTIFICATION.

BY: NJUGUNA CHARLES MBUGUA

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DEDICATION:

To my brother, Patrick Njuguna, without whose material and emotional help I would not be where I am today, Thanks so much.

To my Parents who have been there for me, anytime I needed their help and love. I hope I have fulfilled your hopes in me.

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1. Baxter v Baxter (1948) AC 274.
2. Doe v Estate of Frank W Sura. 2 Judicial District of Nevada.
3. F V Switzerland British Medical Association Journal. 1989, p. 51.
4. Gi...case. (1985) 1 WLR 830.
5. Mark Christian v Shelft. California Supreme Court. LA City.
6. R v Secretary of State Exparte Cuff.
7. Re McFrath (Infant)(1993) 1 Ch. 143.
8. Stewart v Stewart -.
9. Tarasoff case. 1976, 551 P2 d 334 California Supreme Court.
10. Thompson v Thompson. (1987) FLR 89.
11. Walker v Walker Harrison (1981) NZ Recent Law 257
12. White v Stone Limited (1939) 2KB 829.

ABBREVIATIONS

A.C Appeal Cases.
WLR Weekly Law Reports.
Ch Chancery Division.
FLR Family Law Reports.
NZ New Zealand.
K.B Kings Bench Division

TABLE OF STATUTES

Constitution of Kenya 1992 ed.
The Penal Code (cap 63)
The Matrimonial causes Act. (Cap 152)
The Mohammedan Marriage and Divorce Act. (Cap 157)
The Public Health Act (cap 242)
The Adoption Act (cap 143)

ABSTRACT

In this work, we aim to discuss the impact of HIV/AIDS in the family and in matrimonial jurisprudence. Further we aim to discuss the measures necessary to control transmission of HIV/AIDS and their legal implications. Lastly we hope from the discussion to develop the necessary legal framework for dealing with legal issues raised by the impact of HIV/AIDS in the family institution. To do this we have divided this work in four chapters.

In chapter One, HIV/AIDS as a disease is discussed. Further the impact of it in the family institution and attending legal issues are discussed. In chapter two specific issues are analysed. These includes AIDS and Parenting, separation and divorce and custody of children. Further modes of controlling HIV transmission are mooted and ways of enforcing them. Chapter three, gives the recommendations necessary in search for a legal framework. Chapter four is the concluding chapter analysing the effectiveness of the works in fulfilling the above aims.

CHAPTER ONE

TOPIC: AIDS AND FAMILY LAW.

1.0 INTRODUCTION:

In the recent past, the slogan "make love not war' had found favour with many people as a personal reaction to the politics of destruction and aggression especially in the era of cold war. It is an irony then, comparable to the twists in Greek myths that without firing a shot, the world should now be on the brink of a catastrophe of equivalent proportion if not greater, with the last, world war[1].

Responsible authorities speak of millions of anticipated deaths from Acquired Immune Deficiency Sydrome[2], herein referred to as AIDS).

However, proportionate figures are possibly of more significance in relation to this disease; there are reports that in the main towns especially in East and Central Africa, a quarter of the population may be infected with Human Immunodeficiency virus (HIV) the cause of AIDS. The situation is more extensive in USA especially in the State of New York, and to a lesser extent in Europe and Asia[3]. It is not difficult therefore to forecast that once the virus is extensively distributed in human populations, as the figures suggest, control of further spread will pose a problem of enormous dimensions.

It is not therefore surprising that AIDS could have become, as it has, a major political issue on both national and international scale. This has both a good and bad aspect. It is good because action at national and international level is needed to combat the disease; it is bad however because politics tends to divide when it is necessary to be united, to produce an adversarial response when what is needed is fellow feeling and common sense of human vulnerability. In addition there is incipient tendency of the third world and wealthier nations to confront each other in a spirit of mutual recrimination.

Parallel to this disharmony., there is a tendany within countries to identify current transmission with particular groups in a spirit of scape goating or to polarise the issue on a left-right axis with the protection of civil rights being set against the taking of strong measures to control the spread of the virus. It would be absurd if people generally were to associate attempts to prevent or control the spread of the virus with the political right and indifference to this issue with the political left; for the right is also concerned with civil liberties and the left is also concerned with survival[4].

A remarkable feature in any discussion on AIDS, is that the talk will be distinctly on individual and personal terms. The threat in AIDS is to the individual in the most personal and intimate area of life, and action to guard against that threat can also to some extent immediately and directly be taken by the individual. At the same time certain kinds of legislative action as well governmental in action may have direct and immediate effect on the personal life of the individual[5]. But there has been epidemics and even pandemics before; why should AIDS be seen as such a special case, a problem with so many dimensions even to invite legislative action?

To understand this, it is necessary to recognise the special features of this disease which can only be appreciated by an understanding of the basic facts about HIV and AIDS; that is, its causes, mode of transmission and basic facts about the virus, HIV, as many current preceptions about AIDS have arisen from misunderstandings of the facts. Misunderstandings that have resulted in part, from distortions in the media or ignorance[6].

1.1 AIDS; THE MEDICAL BACKGROUND:

AIDS is cause by Human Immunodeficiency Virus, HIV. HIV consists of two Elements:[7]

(a) An outer membrane.

(b) An inner core.

The outer membrane is taken from the cell, of the persons it infects and it determines the physical properties of the virus and in turn determining how it is transmitted and inactivated.. This membrane is extremely fragile, being readily disrupted by a variety of environmental influences. The virus however cannot repair its membrane as the membrane is not a virus product, as such disruptions leads, to enactivation. As a result, the virus survives extremely poorly outside the body. Further, although HIV may be found in the body fluids and secretions of the infected person, including blood, semen, female genital secretions, these is only in small quantities[8]. HIV is very easily inactivated by a variety of things including heat, drying, detergents and most standard disinfectants.

The inner core contains the nucleic acid which contains the genetic code of HIV. This genetic code gives HIV its three most important biological properties. First, is its ability to persist when it invades the cell. It genes are capable of incorporating their genetic codes into the genetic code of the cell it infects. This is the property of latency. Secondly, the infection caused by HIV is productive infection, in which new virus particles are being produced for all or most of the duration of the infection. This means that a person is infectious for life, whether they are well or ill, to some degree at any stage of the infection.

Thirdly, HIV specifically attacks certain cells of the body. HIV attacks the T helper cells and macrophage of the immune system; this leads to its capacity to cause disease(s). Diseases broadly speaking are of two types:

(1) Progressive Immune deficiency as seen in AIDS related complex (ARC) and AIDS itself, due mainly to the loss of T-helper cell, and their functions in which a person become susceptible to certain infections and tumors.

(2) Progressive damage to nervous system leading to dementia or loss of motor or sensory function, due to direct and indirect effects of HIV infection in nervous system macrophages.

1.2 TRANSMISION[9]

As a result of its physical properties, HIV is transmitted only in settings of very close and direct human contact. HIV is only transmitted by four basic means:

(i) Sexual intercourse through penetrative intercourse by exchange of blood, semen and vaginal secretions.

(ii) Transmission by blood, either by receipt of blood or blood products, organs and other human tissue.

(iii) Sharing of unsterilized syringes used in intravenous drug injections due to the exchange of infected blood on the needles.

(iv) Transmission from infected mother to her unborn child across the placenta, childbirth or possibly through breast milk[10].

Casual transmission besides the above modes of transmission has not been demonstrated despite observations on very large numbers of HIV infected persons living in family or social settings with close casual contact and on those providing for HIV infected persons in hospital and in the community[11]. However, it is important to appreciate that the routes of transmission above, have been proved by documenting spread in individual cases and through the study of populations through epidemiology.

1.3 CONSEQUENCES OF INFECTION:[12]

Exposure to HIV, as incase of other organisms does not mean automatic infection. Some people may be infected incase of an exposure to HIV through any of the above means. Others the minority do not get infected and may be exposed for a longer time to be infected. Differing susceptibility to HIV infection appears to be relative being effected by virus inoculum and the route of exposure and could be determined by genetic or enviromental co-factors.

For those who get infected, they develop antibodies to HIV within a few months that can reliably identify a person as being infected. Infact HIV antibody testing is used as a surrogate for the infection[13]. Following the infection, those infected are initially asymptomatic for several years and may remain so indefinitely. It may seem that some people who remain asymptomatic for long periods have some sort of protective immunity or innate resistance against HIV.

In other cases, HIV causes progressive damage to immune system or nervous system leading to symptomatic disease. In AIDS Related Complex there is evidence of moderate immune-deficiency from increased susceptibility to certain minor opportunistic infections. Such group is at high risk of progressing to AIDS.

In AIDS itself, more severe damage to cell mediated immunity cause susceptibility to more serious opportunist infections or turmous that take advantage of the weakened immune system. However the virus on its own may cause progressive damage to the central and peripheral nervous systems, which in turn causes gradual development of dementia and disorders of sensation of motor control. In all these case, gradual development to AIDS, leads ultimately to death.

Procession to AIDS has been seen in about 15-20% after 3 years, 30% after 5 years and 50% after 10 years, with still a small number who remain healthy and well after 10 years[14].

It has also been shown that co-factors may enhance the risk of progression. These include other sexually transmitted infections acquired after HIV, more than one pregnancy and infancy which act by activating latent HIV infection. Additionally immunosuppressive influences such as malnutrition, other infections and immune-suppressive drugs can also probably increase the risk of progression[15].

Where did HIV or AIDS come from? This question has not been answered convincingly. A number of theories have been brought forward on the origins of HIV. Such theories include, Patient Zero theory[15]. Gods retribution theory[16], Biological welfare theory[17], Co-factor theory,[18] Poppers Theory[19] and lastly Mutation theory[20]. However none of these theories has been successful in answering the question of where HIV came from. A number of them have been given credence up to a point[21]. However others have been ignored as being based upon ignorance, hysteria and prejudice.[22].

1.4 TESTING FOR HIV/AIDS

Currently, a valid, reliable and sensitive test for the detection of HIV antigen is not commercially available. As such serologic tests for antibodies directed against HIV have been widely used in screening for exposure to the virus. One of such test is Enzyme linked Immunosorbent Assay-ELISA whose sensitivity in antibody screening is 99% or greater[23]. The specificity of the currently licenced tests is about 99% when repeatedly reactive tests are considered.

Thus, where ELISA screening, in duplicate, is performed in combination with Western blot testing, the false-positive rates are estimated to be between 1-5 per 100,000[24][25]

The presence of antibodies to HIV is not diagnostic of AIDS nor does a negative Elisa antibody test absolutely rule out exposure to HIV: as it takes a minimum of six weeks from time of infection with the virus to develop a measurable antibody response. Further as ELISA test is very sensitive, cases of false positive have been recorded. Also the presence of antibodies only show that one has HIV virus butt he might take same time to develop AIDS or AIDS related complications.[26].

1.5 **EXTENT:**

In considering the global situation, it is illuminating to see the world as divided into three areas:

(i) Developed Western liberal nations.

(ii) Countries of Eastern Europe.

(iii) Third World Countries.

The liberal democracies have taken the individual freedom in the sexual sphere as part of their ethos and way of life. They have also embraced the freedom of travel for their citizens. In their case then, sexual liberation combined with geographical mobility has provided the conditions for the rapid spread of the virus. The countries of Eastern Europe have an the whole endorsed a sterner personal morality. They have tended to reject what they see as the permissiveness of Western society and have not attached value to individual freedom in sexual sphere, other than state approved and regulated ways. Neither have their citizens been free to travel between countries with ease and frequency.

These countries it appears are at present time less affected by the desease as compared with western liberal Nations[27].

Third World Countries have borne the brunt of the disease,[28] where the low budget available for medical care, education and the spread of information about the mode of transmission of the virus has added difficulties. Parts of Africa are therefore recognised as having the highest rate of transmission and hence the most serious AIDS problems in the world[29]. Particularly affected regions are around the great lakes and East and Central Africa[30]. Kenya, being in this region is not immune to the AIDS epidemic. After diagnosing its first patient of AIDS in 1983, Kenya's AIDS population has increased to about 40,000 people with full blown AIDS and estimated to 1,000,000 (one million) infected with AIDS virus in 1995, merely 12 years later[31].

> The virus in Kenya as in other African countries is primarily transmitted through sexual intercourse. Other modes of transmission like mother to infant, blood transfusion and intravenous drugs use play a role in that order[32]. The problem here (third world countries) is compounded by the inadequacy of the resources available to cope with the scale of current AIDS cases. In the light of these economic and political limitations, statistics from parts of African continent are dounting[34].

From the above discussion, it is now possible to appreciate and recognise the special features of AIDS. The first ground of its uniqueness is that it combines two features, not previously found together in quite stark and absolute terms. These are:

(1) AIDS is prominently a sexually transmitted infection.

(2) Secondly, AIDS is a deadly disease lacking at present any medical means of prevention or cure.

As such, a person once infected is infected for life: Further, such person once infected is infectious for life; that this condition is without visible effects for a number of years during which a person becomes increasing more infectious to others. Infectious however is to be understood not in the sense of more modest illnesses in which a disease may be easily passed from one person to another in ordinary social contact but in the sense that it is likely to be transmitted only in highly specific ways:- mainly sexual intercourse and blood contamination.

As far as absence of cure is concerned, it is important to stress that this is a virus infection, and that modern advances in medicine have not produced cures for virus infection. Medical treatment of many other virus infections to which people are subject, consists in alleviating the symptoms of the illness until the patients immune system itself overcomes the infection[33]. But AIDS virus destroys the natural immune system so creating a problem that has never before been encountered thus diminishing the hope for cure in the near future.

Another salient feature of the disease is that it attacks mostly the middle aged group whose members are usually sexually active. However this age bracket is also the most economically productive group. Further unlike other diseases like cancer which man has learned to live with, AIDS involves an early death so far that Center for Disease Control in America estimate that AIDS is the second largest cause of lost years of expected life in America[34]. In Africa where the situation is more serious especially due to inadequate medical facilities, AIDS might have already reached this point.

From the above discussion, we can try to understand the cause of legal aspects which attend the infection with AIDS and the relationships of these legal aspects and Family law and family institution which are discussed hereunder.

1.6. THE LEGAL ASPECTS OF HIV INFECTION AND THEIR RELATIONSHIP ~~TO~~ WITH FAMILY LAW.

A question may be asked; How does family law, or any law governing the family institution come into this gloom of AIDS?

In order to answer such a question, it requires one to discuss what is Family Law. Further, it behoves one to analyse the legal aspects which attend this infection and their relationship with family law or the family institution.

In this discourse, the writer only intends to discuss generally how AIDS as disease and AIDS as a legal problem has had an impact on family institution and therefore family law. A deeper study of impact of AIDS on family jurisprudence will be discussed in chapter two.

> The word 'family' has been defined to mean either:- All persons related by blood or marriage or all members of a household including parents, children and perhaps with other relations, lodgers and even servants.

However for our purposes, a family will be regarded as the basic social unit constituted by at least two people. Whose relationship falls into any of these categories[36].

(a) The relationship may be one of husband and wife or of two persons living together. in a manner similar to spouses - cohabiting.

(b) Relationship may be one of one parent living with one or more children.

(c) Lastly a family may be constituted by the relationship existing between persons related by blood or marriage.

The classical legal meaning of family is restricted to that relationship which exist between persons of opposite sex who are living together as man and wife[37].

What then is Family Law? Family Law is the law which governs the rights and duties of parties in a family unit. It is the law which governs the legal antecedents of family relationships. Family law hence covers the creation and growth of a family thorough marriage, birth, adoption, guardianship and other service agreements. It also covers the legal mechanisms of a family, like domestic relations between the spouses and their issues. Further family law covers disintegration of the family through Divorce, separation or death, and devolution of property thereof. Lastly family law covers the rights of and obligations which arise out of other relationships recognised to constitute a family like cohabitation[38].

How has AIDS as a disease and as a social legal problem affect the family institution?

AIDS affect the family institution in two levels. The first level is that of AIDS as a disease. Taking into account that the primary avenues of HIV exposure occur in a family context[39], the family institution is very important in all considerations of HIV/AIDS. The main mode of infection especially in Kenya is through sexual intercourse. Other include mother to child, at birth, through the placenta or breast milk. The question to be asked is whether HIV positive couples should be allowed to get children, or even marry or solemnize their relationship. Other questions is whether infection of a spouse with HIV could be a ground for divorce or possibility of such infection. Another issue is whether, a spouse who is HIV positive has a duty to inform the other spouse.

Other areas including the medical and nursing care of the sick spouse and the financial burden attending it which will actually put a stress in the family relationship. Other issues include succession upon death and whether one who is liable for transmission of HIV to the deceased is entitled in succession.

The second level which AIDS effect the family institution, is by the legal and social problems which attend it. Such problems like discrimination against people with HIV, government policies and actions and legislation on the area in one way or the other affect the family institution.

Times of epidemic are also times of social tension, fears exacerbate already extant divisions revealing deepening social fault lines. In this context, discrimination against persons with HIV infection has become a world phenomenon. The AIDS virus has divided nations, ethnic, cultural and sexual groups. Individuals in or out of family units have not been spared. Noting the absence of cure, the potential for greater division is ever present. The process of blaming others have started and is going on[40]. This process is not new, as William McNeill showed in Plagues and People, his social history of epidemics[41]. A natural reaction, and an echo of international quarantines dating form fifteenth Century has been creation of trade barriers. Currently, there is an over-growing lists of nations demanding of long term visitors the proof that they are free from HIV infection[42].

HIV infection has also been used as rationale for exclusion from a range of critical social activities.[43] Fuelling these discriminatory actions, is often a visceral hostility to those groups popularly linked with AIDS and people suspected to be closely related to those infected with the virus. All these is bound to place alot of stress in the family units of those people who have the AIDS virus.

An example of such stress may be seen where the father in a family relationship gets the virus, transmits it to the wife, get sacked from his place of employment, and the children are expelled form school form unfounded fear of transmission. the effect of such to a family unit might be to break it up.

Government policies and special legislation have also had an effect on family institution and family law. Some nations like Cuba, has made testing for HIV antibodies mandatory, especially on all pregnant women, prisoners, patients being treated for venereal diseases and their sexual contacts. The consequences of being infected are grave as all those found to be HIV positive are put into quarantine centre. Parents who are infected are separated from their children who are not infected, spouses where one is infected and the other is not are separated, although they may visit each other and after full warning to each other about the risks of transmission have sexual relations[44].

However, unmarried residents of the quarantine centre are prohibited form having sexual relations.[44]. Other government policies and legislation criminalising exposure to transmission of AIDS virus and providing a imprisonment term as a penalty[45] will have a negative effect on the family unit as one is removed form a relationship where one is loved and may be cared for and taken to prison. Further issues whether a woman who is pregnant and she is HIV positive should be allowed to give birth through natural method or forced to caesarean operation in order to protect the infant are bound to arise.

All of these instances are a challenge to family law as they have a direct impact on family unit. Suffice is to say that AIDS has brought with it some legal and social problems which affect the family unit and which should be addressed by law.

Specific issues and mode of addressing them forms the matter of discussion in the next chapter.

END NOTES

1. Brenda, Almond, "War of the World"in Brenda Almond (ed), AIDS A moral issue, London, Macmillan 1990. pg. 1
2. Ibid.
3. Ibid.
4. Ibid P.2
5. Ibid p.3
6. Anthony, Pinching, "AIDS Clinical and Scientific Background" in Brenda Almond (ed) AIDS A moral issue London Macmillian 1990. p.26.
7. Ibid.
8. Ibid p.27
9. Ibid pg 28
10. Ibid pg.29
11. Ibid
12. Ibid pg.30
13. Ibid
14. Ibid pg. 31
15. Jarvis R, AIDS Law, in a Nutshell, New York, West Pub.Co 1991 pg. 10.

    (Patient Zero theory traces the source or origin of AIDS) to a flight attendant in AIR CANADA. However the theory does not identify where the patient zero got the AIDS virus)
16. Supra pg.11

    (Gods Retribution theory holds that AIDS is God's punishment against gay men and ~~intravenpis~~ intravenous drug users for their alleged violations of the law of nature and of man.

This theory does not explain why blood transfusion recipients, children and others, should be punished for contracting AIDS. Critics of this theory holds that such a theory is a fallacy and only helps to make a tragic situation worse by contributing to ignorance and hysterical that have impended the progress of coping with AIDS)

17. Surpa, pg.11

(Advocates of this theory see AIDS, as a racist plot against the lesser races as they argue that AIDS virus was manufactured by Americans in a laboratory.)

18. Supra pg.11.

(This theory is quite popular among medical researchers. It holds that AIDS is a result of some combinations of factors which causes the suppression of the body's immune system).

19. Supra, pg.12.

(This theory was proved to be incorrect. However it is important in that it helped identify and emphasizes on lifestyle as a factor in predicting who is at risk of contracting AIDS).

20. Surpa pg.13.

This theory holds that HIV originated as a mutation from some virus that affected monkeys. The theory is given more credence by the fact that HIV is not a simple virus but a number of variations in a virus that seems to be subject to occasional mutation thus complicating the efforts of medical science intreating or preventing the infection.

21. see note 18 and note 20.

22. See note 16 and 17.

23. Harold M.G, "Legal Aspects of Human Immunodeficiency virus (HIV) infection" in Vevaina, JR, et al (ed) Legal Aspects of Medicine, New York, Springer-velag 1989 pg 253.

24. Ibid pg.253.

25. Weiss, Sh, et al, "Screening Test for HTLU-11 (AID) Agent Antibodies, specificity, sensitivity and application" J Amer Med Assoc (1985); 253: 221-225.

26. Ibid.

27. Jonathan, MM, AIDS: "A worldwide Pandemic" in Gotthiebs et al (ed) Current Topics in AIDS ed .2 New York, John Wiley and Sons "1989 pg.6

28. Ibid

29. Peter P, et al "Epidemiology of Heterosexual spread of HIV" in Gottiebs et al (ed) Current Topics on AIDS, New York, John Wiley and Sons 1989 pg 19.

30. Ibid.

31. "AIDS: Developing Appropriate Strategies" Sunday standard Newspaper, April 27, 1997 pg 14.

32. Peter P, supra.

33. Peter P, Supra page 4.

34. Ibid page 5.

35. Infra page 3

36. Bromley, P.M and Lowe N.O, Bromley on Family Law, London, Butterworth 1992 pg.3.

37. Ibid.

38. Ibid pg.4

39. Supra note 9.

40. Gottlieb Supra, note 27 pg 264.

41. MCNeil, Plagues and People, Garden city, Anchor Press 1976.

42. Supra, note 40.

43. Ibid.

44. Curram WJ, and Gostin L, International Survey of Legislation Relating to the AIDS Epidemic, Geneva, World Health Organization 1988.

45. Ibid.

CHAPTER TWO

DEALING WITH HIV/AIDS IN THE FAMILY AN ANALYSIS OF SOME OF THE LEGAL ISSUES INVOLVED.

PART ONE: IMPACT.

21. AIDS AND PARENTING:

(a) Natural method 20

(b) Adoption. 23

2.2 AIDS AND BREAK-UP OF RELATIONSHIP. ... 29.

(a) Separation and Divorce: ... 30

(c) Child custody and visitation. ... 34

PART TWO; CONTROLLING HIV TRANSMISSION

2.3 DUTY TO DISCLOSE HIV STATUS. ... 36

(a) Who has the Duty. ... 37

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(a) Testing before marriage. ... 41

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PART ONE: IMPACT OF HIV/AID IN THE FAMILY:

2.1 AIDS AND PARENTING:

There are two ways of starting a family:

(a) Through natural conception, and

(b) Through adoption.

The incidence of HIV/AIDS epidemic has had a grave effect on both of these methods. Consequently any attempt at controlling HIV transmission in the family institution must have an impact on both of these modes of starting a family.

(a) Natural Conception:

Relating to natural conception, HIV/AIDS has complicated the already important and difficult decision of whether or not to have children. The conscious decision of a couple to engage in sexual relations or to utilize artificial insemination for the purpose of conceiving a child can result in transmission of HIV if one of the partners, or the semen donor is infected[1] to the other partner. Additionally children conceived in either fashion are at risk of being born infected with HIV.

Medical evidence has established that about 5o% to 60% of all children born of HIV infected mothers will contract the virus. It is not certain however, whether transmission occurs during pregnancy or upon birth or can be through breast feeding.

In Kenya, it was estimated that there was over 300,000 children under the age of 15 years left orphaned due to HIV/AIDS by 1996[2]. Among this group, a big number of those below three years of age are HIV positive. Further, HIV/AIDS is projected to raise child mortality by 75% over the next ten years[3].

To counter such a development, prenatal transmission of HIV must be controlled. Such a control will necessitate imposing restrictions on procreation by those identified as HIV positive, both men and women. However such a stand will obviously infringe on the right to found a family[4] of the affected people. The question which arises is whether such an infringement is justifiable.

The right to found a family is as old as mankind. This right has been held to be a fundamental right[5]. As such the role of the state should be limited to governing its exercise but it should not interfere with it substance. National laws may therefore lay down formal rules on its exercise. However, the state must not restrict or reduce the right in such a way or to such an extent that the very essence of the right is impaired. In such a case, any infringement of this right must be justifiable, the test being that; "the measure which does affect the very essence of the right must be proportionate to the legitimate aim being persued[6].

Does such a policy fulfill this test? according, to the accepted medical knowledge on HIV/AIDS seeking to restrict procreation by HIV positive individuals would presumably have two aims:

* Seeking to protect the health of the mother,
* Seeking to protect the health or well being of the unborn child.

On health of the prospective mother, medical evidence shows that the immune system of the mother weakens during pregnancy. Physicians are therefore concerned that pregnancy may increase the risk that the person already infected with HIV will develop full blown AIDS. Infact, pregnancy has been held to be one of the precipitating factors as far as HIV/AIDS is concerned.

To counter this, one can argue that the need to protect a person from herself cannot be considered to be of sufficient weight to justify such a measure especially incase of an individual of 'full' age and sane. However such a stand is wanting in that it fails to appreciate that the health of the prospective mother is of importance to the public at large. By her poor health due to pregnancy, and possibly death, she will have failed in providing for the child who she has brought forth and who is still in his infancy or below the age of majority. If such a woman has other children, she will not be in a position to adequately provide for them. Incase of her death the children will be left to provide for themselves or be provided for by other members of the society. This is an added burden to those members and to society at large. It should be noted further, that in Kenya, as incase of other countries facing HIV/AIDS epidemic, the number of children who have lost their parents, due to AIDS is high, and continues to grow[7]. In addition, neither orphanages nor foster homes are too keen to accept children orphaned by AIDS whether or not they are HIV positive[8] due to the social stigma attending the disease.

As for the unborn child, transmission of HIV has been found to occur during pregnancy, delivery and perhaps soon after birth. The extent of the risk of transmission by this means though high is not yet known with any certainty.

In respect of the above, an argument may be developed, that the fear of prenatal HIV transmission from mother to infant does not justify such gross violations of fundamental human right to raise a family. Infact such a stand was compared to Hitlers policy of compulsory abortions and sterilizations in concentration camps in an attempt to bring forth an ideal nation[9].

Such a stand would fail to appreciate the fact that a child born with HIV will possibly die within its infancy period. If it pre-diseases the mother, it will cause her psychological pain and suffering and she will not enjoy the satisfaction of being a mother which is the essence of the right to raise a family. Her health already bad due to pregnancy is bound to worsen at a faster rate.

Incase the mother pre deceases the child, another problem of taking car of the child arises. A foster family must be got to take care of the child. As has be noted earlier, adoption organizaitons foster institutions and orphanages are not so keen in taking in children who are HIV positive[10]. This also applies to people intending to adopt children.

The above notwithstanding, the unborn child has a right to be born healthy[11].

This right should be protected and enforced by the state by offering medical facilities and counselling to the pregnant woman, and incase where there is high risk of bearing unhealthy child, counselling on the need not to get pregnant. In respect of HIV/AIDS the danger of bearing unhealthy child is too real to be ignored. One way of enforcing this right is by restricting the HIV positive individuals right to procreate, because if they are allowed they shall undermine the rights of their issues to be born healthy by bearing them forth with very little chance of survival. However the moderaties of such restrictions may raise other legal issues of fundamental importance.

These will be discussed later in the chapter.

(b) **Adoption:**

Another way of starting a family is through adoption of children. The prospective parents who are desirous of having a child but cannot have one through

natural parenting may consider adoption as an alternative. However for individuals who are HIV positive, they might have a problem in getting their application for adoption approved.

In Kenya, adoption of children is governed by Adoption Act (cap 143 L.K). Section 5(6) of the said Act provides inter-alia that the court in making an order in respect of custody or adoption of a child should regard the interests of the child as paramount and subject thereto, shall consider firstly the interests of the parents and relatives of the infant and secondly the interests of the applicant.

Section 7(1) (b)[12] provides that the court before making an adoption order, it all satisfy itself that the order will be in the best interests of the infant, due consideration being for this purpose given to the wishes of the infant having due regard to the age and understanding of the infant and the ability of the applicant to maintain and educate him.

These two sections provides what in English jurisprudence is called child welfare principle. This principle holds that the child best interests should always be supreme incase of any orders relating to infants and children. The welfare of the child includes its religion, moral and physical well being nor can the ties of attention be disregarded[13].

An application by a HI positive woman or couple to adopt a child may fail on the grounds of her/their inability to maintain the child and educate him. The question to be asked is whether the health of the applicant relevant a relevant issue in deciding the application, further, should the applicant disclose her HIV status.

The Adoption Act (cap 143) does not expressly provide that the poor health of the applicant amounts to disability for purposes of adoption. Further, it does not provide that the health of the applicant be revealed. However, the child's welfare principle requires that any information which will substantially affect the child's best interests, or which if known would affect to court's ruling on whether to grant the orders...requested for or not should be provided[13].

To buttress this argument is the position in England , where the relevant Act does not require information on the health of the applicant to be revealed. However adoption agencies in England are required in their regulations to obtain a report on the prospective adopters health[14]. A similar requirement is to be found in respect to Kenyan adoption agencies. This requirement has been held to cover the personal and family health history, the personal current state of health and the consumption of alcohol and tobacco among others[15].

The health of the applicant has been made a ground for refusing to grant adoption orders. In R v Secretary for State ex parte luff[16] the court refused to quash a Department of Health's recommendation to the Home Office that the adoptive applicants in respect of two children were unsuitable because of the male's applicant health following a heart by-pass operation.

Though that ruling is not binding in Kenyan courts it can be cited to give more force through that case was not dealing with HIV/AIDS it is logical that essence of that ruling may be expanded to include HIV/AIDS. In such a case, an application for adoption by HIV positive applicants may fail.

Another ground for such a refusal worth considering, is whether taking into account the social stigma and discrimination which is visited on individuals known or thought to be HIV positive, it is in the child best interests to allow such an application. Hardy Boys J, in his definition of child welfare in Walker v Walker Harrison[17] held

> *"Welfare is an all encompassing word. It includes material welfare, both in the sense of adequacy of resource to provide a pleasant home and a comfortable standard, of living, and in the sense of adequacy of core to ensure that good health and due personal pride are maintained.*

However, while material considerations have their place, they are secondary matters. More, important are the stability and the security, the loving and understanding care and guidance the warm and compassionate relationship, that are essential for the full development of the child's own character, personality and talents" (emphasis mine)

Taking into account the effect of HIV/AIDS both social and financial, would a seropositive couple provide adequately for the emotional needs of the child. Further, in the long term, would such a couple provide adequately for the financial needs of the child when at the same they are fighting HIV/AIDS. Lastly can such a child be brought up in a loving and caring relationship taking into account the social stigma attending or visited on people considered to be HIV positive or suffering form HIV/AIDS. The child welfare principle requires the court to take into account the child's long term future unless perhaps where the short term disadvantages are so overwhelming as to rule out the long term option[18].

From the above, we can now appreciate the serious problem posed by the health of the prospective parent or parents of children who might be adopted. An appropriate consideration in the context of any adoption of a minor is the health of both present and long-term of the prospective parent or parents. assurances are needed that they will be healthy enough to be able to support and care for the child until he or she reaches the age of majority and can be felt supporting. This requirement may not be fulfilled by persons who are sero-positive, and as such refusal of their application for adoption is a possibility.

Another relevant issue is that of children with HIV/AIDS. The number of infants with AIDS is growing dramatically. There is a serious problem in Kenya of new born babies being infected with HIV[19] the primary route of infection being from infected mother. These children tend to face short, lonely and painful lives. Many of them are abandoned[20] in hospital where they were born. Few ever get discharged[20]a as their immune systems are not fully developed and because their health is generally unsatisfactory due to the lack of appropriate maternal and prentatal care. For those who are discharged from hospital, another problem arises after abandonment death or inability of the mother to take care of the child. An appropriate placement for such a child must be found. This is an uphill task, as few foster care institutions or prospective adoptive parents are willing to take in a child, where it is known that the child will become progressively debilitated, suffer pain and suffering, experience costly medical care needs and die prematurely in a few months time.

However, for those who are adopted, a legal question which arises is whether the prospective applicant for adoption is entitled to information on the health of the child. Attending this issue is another on whether testing of children for HIV for purposes of adoption or foster care is tantamount to violation of the rights of the child.

Section 25 of Adoption Act (Cap 143) provides for the functions of adoption society. It provides that such a society should make inquiries and cause such reports to be obtained as the society may think fit or as the court may direct for the purposes of ensuring as far as may be possible the suitability of the infant and the person proposing to adopt him respectively and in particular to obtain a report on the health of the infant signed by a medical practitioner (emphasis nine)

This section 25, in principle allows the applicant access to the health reports of the infant to be adopted for purposes of ensuring his or her suitability.

The Act however does not make the poor health of the child a disabling factor for purposes of adoption. However the applicant is entitled to such information in order to make an informed decision on whether or not to adopt the child. This position is in conformity with the child welfare principle, as when the adoptive parent is aware of the poor health of the child and decides to adopt him the parent is in a better position to provide for the child's medical needs.

As relates to the second issue on HIV testing of children for purposes of adoption or foster care, such a position is felt to be unjustifiable infringement of childrens rights. Such children are entitled to love and care regardless of their HIV status. It has been recommended that HIV testing should not be carried out on children for purposes of providing social services but for medical purposes only and

after informed consent has been obtained from the parent or guardian of the child.[21]

Nevertheless, and in the interests of the child HIV status of the child should be made known to the prospective adoptive parents as it will affect their decision in respect of the child. Further if they decide to adopt the child, they will be in a better position to provided for its health.

Finally, it should be noted that lawsuits may be filed against the adoption agencies by adoptive parents where there has been concealment of serious health or emotional problem of the child.[22] Given the critical nature of HIV/AIDS, it can be expected that the failure of Natural Parents or the adoption agency to disclose that the child is HIV positive may result in lawsuits against them.

2.2. AIDS AND BREAK UP OF FAMILY RELATIONSHIPS:

HIV/AIDS epidemic has contributed to couples getting together either in marriage or cohabitation. Although some people may be opting for sexual abstinence HIV/AIDS has more often than not contributed to people remaining together in monogamous sexual unions. Marriage has been held as one way of escaping this menace. Programmes endorsing monogamous relationships are regarded as the best way of dealing with transmission of HIV[23]. However this is true only where neither of the parties are already infected, and they remain so, uninfected.

On the other hand, this epidemic has led to break down of family relationships. Even in best of circumstances personal relationships are difficult to maintain, and the presence of AIDS as well as the fear of AIDS can make matters more difficult. If one of the parties to a relationship is infected, both parties will encounter concerns on how and when the virus was transmitted. The infected

individual may feel quilt, depressed and angry. The other individual may feel betrayed uncertain, fearful and hostile. All this is because people tend to associate HIV/AIDS with promiscuity and unfaithfulness in sexual relationship. Though, especially in Africa, HIV/AIDS is mostly transmitted through sexual contacts, other ways like blood transfusion plays a significant role.

Further the party with AIDS has the prospect of needing substantial medical care, of becoming progressively less able to care for himself or herself, and of dying an early and agonizing death. Even where either party has AIDS, an individual may fear or suspect the other especially in non-monogamous families. If one party believes that the other is guilty of infidelity, serious obstacles to a harmonious relationship can arise.

(a) **Separation and Divorce:**

In respect of separation or Divorce the legal issue which arise is whether seropositivity of a spouse should found a ground for divorce or separation.

Where the HIV infection was prior to the celebration of the marriage and the spouse did not know of that fact when entering into the marriage it is possible for such a spouse to file for annulment of the marriage.

Among the accepted grounds for annulment[24] of a marriage is the inability of the respondent to consummate the marriage through sexual intercourse. Also wilful refusal to consummate the marriage may be a ground for seeking annulment. In respect to HIV/AIDS, the inability of the respondent to consumarate the marriage without using a condom or without injuring the petitioner may be a ground for annulment of the marriage.

However, it is doubtful if such an application would succeed especially if the respondent decides to defend it. The respondent may argue that he/she is willing and capable of consumating the marriage. The proposition of the petitioner that there cannot be consumation with a condom cannot stand in the face of the ruling in Baxter V Baxter[25]. in this case the court (House of Lords) held that a marriage has been consummated not withstanding the husband use of the sheath. In respect to HIV/AIDS, this argument may be developed to state that there is no reason why such a couple cannot consummate the marriage by use of condoms. Another proposition is that the uninfected spouse may refuse to consummate the marriage and leave it on the infected spouse to seek annulment orders. However, the chance of the infected spouse seeking annulment is very low and the chance of success lower if the respondent raises the defence of justification.

On refusal to consummate the marriage the respondent may raise the ground of fear of transmission of HIV which would amount to a good defence to the Action. However the petitioner, if she/he is the one refusing to consummate the marriage cannot rely on his or her own marital misconduct as a ground for the orders. He, must show that the respondent has willfully refused to consummate the marriage. Wilful refusal connotes a settled and definate decision come to without a just excuse[26]. In respect to HIV/AIDS such a ground cannot succeed. Further, as earlier pointed, there will not be a wilful refusal to consummate if one spouse insists upon the use of contraceptives. This effectively rules out incapacity to and wilful refusal to

consummate as possible grounds for seeking annulment orders where the spouse is HIV positive.

In passing, it is important to note that Baxter v Baxter, (supra), has raised a difficult issue which cannot be easily resolved and which is bound to arise in context of HIV/AIDS. Suppose the marriage is never consummated because the husband H refuses to use a condom and the wife W, refuses to let him have intercourse unless he dos. It is difficult to see how either of them can be said to have refused to consummate for W, has been prepared to does so within the meaning given to the term by Barter v. Baxter and H has expressed his willingness to have intercourse in natural way.

Another ground for nullification of a marriage worth considering in respect of HIV/AIDS, is the allegation by the petitioner that the respondent is suffering from a venereal disease in a communicable form. A marriage is voidable if at the time of the ceremony the respondent was suffering from a venereal disease in a communicable form[27]. Venereal disease is not defined in the Act. The question here is whether it includes HIV/AIDS. Which though it may be sexually transmitted, it can also be transmitted in other ways.

But the petitioner has to prove that the respondent had acquired it as a result of sexual intercourse; a heavy duty to discharge.

It is clearly socially desirable to release a person from marriage to an infected spouse and it would be unreasonable to limit the relief to a petitioner who would show that the respondent had acquired it as a result of sexual intercourse a burden which many would be unable to discharge. It is

submitted that to regard AIDS as a venereal disease for this purpose would suppress the mischief and advance the remedy that parliament had provided, but it is by no means/certain that a court would adopt this construction. However it should be noted that such a petition bound to fail if it is shown that the petitioner was aware of the fact of venereal disease at the time of the marriage. Further, the petitioner will fail if the respondent can show that he got HIV/AIDS otherwise than by sexual intercourse.

If the transmission has occurred after the celebration of the marriage the only option the uninfected spouse has is to file for divorce. Among the accepted grounds for a divorce in Kenya family law system which is of importance in respect of HIV/AIDS is adultery of the respondent. It has been argued[30] that HIV/AIDS may be evidence of adultery and therefore it can found a good ground for divorce. However, this stance fails to appreciate the strict proof needed for adultery. One has to prove that the spouse committed adultery beyond reasonable doubt. The fact of HIV infection on its own as in case of any venereal disease does not amount to such proof[31]. Further, HIV/AIDS can be transmitted through other means except sexual intercourse.

The only way one can succeed under this ground is by proving that the spouse has HIV, such infection was through sexual intercourse and the act of intercourse amounted to adultery. Whether one can discharge that heavy burden of proof remains to be seen.

In respect to Kenyan family legal systems, it should be appreciated that the above discussion relates to statutory and Hindu marriages. African customary and Islamic marriages are not so covered. In respect to the latter

two, one has to show that the named ground he is relying on is recognized under the specific customary law,or incase of Islamic marriage the Mohammedan Law, as a ground for annulment or divorce. Those two legal systems, having never before experienced such a problem as that attending HIV/AIDS such a claim is unlikely to succeed.

The question whether HIV/AIDS should be a ground for divorce still remains unanswered. We submit that where it is proved that the spouse got the infected through sexual relations the other spouse should have a relief. However if such transmission was due to no fault of the respondent such a relief on grounds of HIV/AIDS should be denied.

(b) **Child Custody and Visitation.**

Attending issue to separation and divorce is child custody and visitation. In divorce cases, where minor children are involved, the parents battle to win custody of and visitation with the children can be quite fierce and can result in severe emotional problem on the children. AIDS impacts on this aspect of the law because the health of both the child and the parents must be considered. As always the law takes the position that the best interests of the child should guide decisions relating to child custody and visitation. The legal issue which arises is whether a parent who is HIV positive should be allowed to have custody or have visitation rights with the child Though such issues have not been decided on by the Kenyan courts, other jurisdictions have had a chance of ruling on them.

In Doe v Roe[31]a, a New York state court refused to require a gay father suspected of having AIDS to submit to a HIV test as a precondition to

continued custody of his children. The court emphasized the lack of medical evidence that the father would present any health risk to his children, the unreliability of HIV test results in some cases and the severe emotional stress that would be placed upon the father if he was required to be tested and if he was found to be HIV positive, in denying the application.

In Stewart v Stewart[32] an Indiana state trial court ruling terminating the visitation rights of the father who had tested HIV positive was reversed by the appellate court. The appellate court relied on the medical evidence that HIV/AIDS is not transmitted through everyday household contacts in reversing the ruling.

However both the trial judge, and the dissenting judge on appeal, accepted the view that even if there was only slight possibility that the child might be exposed to HIV/AIDS, the father should not be entitled to visitation with the infant. These two cases should put to rest the notion that the HIV status of a parent should bar custody or visitation with minor children.

An issue which still remains a moot question is whether the social stigma and discrimination which is visited on persons known to be HIV positive should be a ground for denying custody or visitation, would social stigma jeorpadize the welfare of the child? In any ruling on that point, though it has to be subjective, the interests of the child should also be balanced against the public interest to disapprove this social stigma and discrimination.

On the other hand, custody of a child to a HIV positive parent may be denied in certain circumstances. For example:- it is possible that the parent with HIV/AIDS will become physically incapable of properly caring for the

child. Similarly the parent may suffer AIDS related dimension and emotional distress and fail to properly care for the child. Financial inability may also arise. In all this instances, a balance should be got which is in the best interest of the child by balancing the available options. Suffice to say that HIV/AIDS will likely have relevant impact on decisions about custody and visitation.

PART TWO: CONTROLLING HIV TRANSMISSION:

2.3 Duty To Disclose:

Under common law, it is well settled that an individual owes a duty of reasonable care to avoid contact with others if the individual is affected with an infectious disease that can be transmitted by such contact. Alternatively the individual owes a duty to warn others before engaging in contact that involves the risk of transmission of the infectious condition. Infact this position has been borrowed into the Kenyan legal system. Section 193 of the Kenyan Penal code[33], provides that any person who unlawfully or regugently does an act which he knows or has reason to believe is likely to spread the infection of a disease is guilty of a misdemeanor.

Such a position may be developed to cover HIV/AIDS. The duty to disclose may require that a person who is HIV positive and knows of his/her seropositivity should inform the sexual partner of that fact before he goes on to have sexual intercourse. In the family context, the spouse who is seropositive should have a duty to inform the other spouse. failure to discharge this duty should open one to criminal sanctions under the Penal Code or to a civil action. Infact, in some countries with special AIDS legislations, failure to disclose to the sexual partner will open one to prosecution for negligent transmission of HIV especially if such a person did not use

any safe sex method[34].

(a) **Who has the Duty:**

As already discussed, the person who has HI has the duty to inform his/her sexual partner. In a family context the effected spouse has a duty to inform the other spouse. The question which arises is whether a doctor has a duty to disclose the HIV status of his patient in face of express refusal by the patient to inform his spouse. This may be refereed as the need for spousal notification.

A doctor has a duty to keep in confidence all information regarding a patient which he has known in his professional capacity[35]. The rule of confidentiality in medical practice is governed by hippocratic Oath. Further in Kenya, this position is buttressed by statutory law, international declarations which Kenya is signatory and rules of professional bodies[36]. The essence of this duty is that a health care worker should not disclose to a third party any information which he has obtained in confidence in his professional capacity. On the other hand, the patient has an enforceable right against the doctor to insist that such information be kept in confidence. However, there are some exceptions to this rule vis:-

(i) Where a valid consent has been obtained

(ii) Where information is required by law[37].

(iii) Information is vital for purposes of Bio-medical research[38].

(iv) When the public interest so diclares[39].

Incase of HIV/AIDS the only ground which the doctor can rely on in breaching this duty in the face of express refusal to consent, it that of public interest.

Similar position may be found in England where the General Medical council has outlined a number of guidelines concerning the disclosure of confidential information[40] by Doctors. On of the grounds is where public interest demands that the doctors' duty to maintain confidentiality be overridden. Public interest in face of medical records and confidentiality has been defined to include prevention of further transmission of the disease or to enable the person to be treated.[41]

Though confidentiality must be respected if the doctor is to maintain the trust of his patients, there is a limit to this when putting others at a severe risk especially the spouse of the patient. In respect of this, the California Supreme Court in the Tarasoff Case[42] held health practioners civily liable for ".....not giving appropriate warning to an identified person at risk of grave danger they correctly anticipated would be caused by a patient...." The court held that the protective privilege (of confidentiality) ends where public Peril begins and hence prioritized duty to warn of anticipated grave peril as limiting the scope of confidentiality. In this light, a doctor has a duty to inform the spouse of the patient. However he should first discuss with the patient the need for such disclosure to the other spouse and only when such a patient refuses to disclose that the doctor should disclose.

(b) **To Whom is the Duty to Disclose Owed.**

Generally as regards the infected individual the duty is owed to his or her sexual partner. In family context the duty is owed to the spouse of such an individual. As regards the doctor, the duty is owed to anyone he reasonably foresees that non-disclosure poses a real risk. This covers in the family situation the spouse of the patient.

In American, they have developed the doctrine of right to know and the duty to warn. Under these doctrine, sexual partners and especially spouses have claimed that they have a right to be informed of a potential exposure to HIV. Damages have been awarded against persons liable for not disclosing the fact of HIV infection.[43]

As regards spouses, the major contention is whether a doctor has a duty to disclose which can be enforced by the spouse or he has a privilege either to divulge or not in which case he cannot be sued for failure to divulge. This contention has yet to be resolved. It is felt that the doctor should be free to divulge or not without incurring any legaliability. He should have a privilege.

The rationale for spousal notification is to enable the spouse to take the necessary precautions against HIV infection. It has been argued that HIV negative spouse would benefit form an early opportunity to practice safe sex where the other spouse has tested HIV positive. Following this argument the jury in Doe v Estate of Frank W Silva[44] awarded the ex-wife of Frank 2.1 million US dollars on the grounds that Frank, who died of AIDS failed to inform her of his seropositivity.

However serious considerations should be had to the effect of such disclosure on the whole family. The doctor must balance against his patient interests and the risks to other individuals.

When he is foresees that nondisclosure poses a real risk, then he should be free to warn the third party. He must however be careful to counsel the patient and the spouse before and after such disclosure[46]. Disclosure might also be very necessary where the patient is taken for home based care. Does this duty to disclose apply to children in respect of their parents. Should the parents know the HIV status of their children?

The test here is that laid down in White v Stone Limited[40].

> *" The person who makes a communication has an interest or a duty either legal, social or moral to make it to the person to whom it is made, and the person to whom it is made has a corresponding interest or right to receive it"*

Under this test, the parents need not be informed of the HIV status of the child especially where there is no risk of HIV transmission to the parent, unless it is to the best interests the child

In Gillick Case[47] it was held that where the child is mature and has capacity to make up his own mind, the parent need not be informed of the child's medical information unless the child consents.

However, as noted earlier, confidentiality is not absolute and the parents are in a position of 'need to know' and should be informed where it is in the best interest of the child, for example, where the child is taken for home

care treatment.

2.4 ENFORCEMENT OF DUTY TO DISCLOSE:

Spouses are not always ready to disclose their HIV status to their partners. With the aim of controlling HIV transmission in the family between the spouses and the mother to infant transmission, a mechanism of enforcement of this duty need to be put into place.

(a) Testing Before Marriage:

HIV testing before marriage has been considered as a save way of enforcing the duty to disclose between would be spouses. Though different jurisdictions have had different policies this mode of enforcement of the duty to disclose has been held to infringe on the fundamental right to marry.

A policy of mandatory premarital HIV testing coupled with a denial of a marriage license if either person proved to be HIV positive would be a measure interfering with the substance of the right to marry indeed so, would any prohibition of marriage of persons known or suspected of being HIV positive. The aim of such policy though noble, reducing sexual and prenatal transmission of HIV by enforcing the duty to disclose, would be not be achieved by such a policy.

In the first place, for many people not being married is not a bar to sexual activity. Secondly even where there is ample opportunity for marriage, substantial proportion of sexual activity takes place outside it, nor is there

reason to suppose that prohibiting marriage would be effective means of preventing the HIV transmission to children as an increasing number of them today are born out a wedlock.

The state of Illinois and Indiana in the USA which had legislated on such a policy has already repealed their laws after appreciating the futility of enforcing them[48]. It was found that applicants for marriage licences often did not wish to submit to HIV testing for fear that the confidentiality of the test or its results might be breached. As a result of this legislation many couples cohabited or crossed state lines and obtained marriage licences in neighbouring jurisdictions that did not require HIV testing[49]. World Health Organisation, coming to similar conclusion held that.

> *"Routine screening as a prerequisite for marriage is of little use in controlling or slowing down the HIV/AIDS epidemic"*[50].

A policy or law requiring mandatory testing is not justifiable. However one requiring both parties to voluntary submit to pre marital AIDS tests, informing the prospective spouse of the result (even without the others consent) counselling them about risk reduction behaviour and then issuing them with a marriage license regardless of the test may be a better alternative. Though such a policy may be objectionable. as infringing on to right to privacy of each of the prospective spouse by requiring disclosure without their consent, it would be easier to defend and such infringement is justifiable.

However, the best alternative is a law requiring that each couple seeking a marriage license be informed about HIV infection and

transmission together. Further be taught and counselled on risk reduction behaviour and be offered antibody test and results be disclosed to both of them together. Such a law would achieve the aims of reducing HIV transmission between spouses and between mother to infant. At the same time it would not pose any human rights problems.

(b) **Testing of Pregnant Woman:**

Another way of controlling HIV transmission form mother to child is by requiring HIV testing of pregnant women. In some jurisdictions such a test is compulsory.[51]

Compulsory testing for HIV amounts to infringement of a person's privacy. Further the individual has a right to ignorance to his condition if he chooses to do so. When we require compulsory testing of pregnant women, a number of issue are bound to arise.

Does a pregnant woman have the right to ignorance of her seropositivity? It must be accepted that many people do not want to know if they are HIV positive or not as nothing can be done about it medically. When they are ignorant, they have a reasonable hope of some years of healthy and satisfying life, which would be blighted by knowledge of their seropositivity.

But this argument which is tenable when advanced in connection with testing proposals for other members of the populace, is inadequate when applied to the case of a pregnant woman or one who is contemplating pregnancy for a number of reasons.

Pregnancy and childbirth could well be precipitating factors as far as HIV/AIDS is development is concerned. Secondly, where HIV/AIDS is

already present, these factors may operate to accelerate the disease and most important it may lead to the birth of a child with poor medical prognosis. Such a child may proceed to AIDS and death. For these reasons, it is not true, that in case of pregnancy that knowledge of ones' sero-status can make no difference. In Britain, the fact that one is seropositive is considered sufficient medically to provide a therapeutic reason for abortion[52]. It may also deter other women from becoming pregnant.

What happens when a HIV positive woman is pregnant, should seropositivity be a justification for abortion? Without ruling on this point, it is important to note that recent studies suggest that a woman who is HIV positive but otherwise healthy may give birth to a healthy baby and remain healthy herself[53]. Further, the use of AZT has been held to block HIV transmission from mother to infant. The possibility of prenatal transmission can be further reduced by increased intake of Vitamin A. With this in mind, some women, will be prepared to accept the odds, especially for those who do not have other children. As such, the question whether or not to proceed with the pregnancy should be the woman's alone. However the government or state should allow abortion in such a case. The issues arising when the mother is HIV positive is not only her health risks buth also the question of who is to care for the child if either or both parents are unlike to or do not survive the infancy of the child. Another issue is that of disclosure to the woman's sexual partner. If such a partner is sero-negative then he is clearly at risk because pregnancy in itself is evidence of an active sexual relationship without protection. As far as the physician is concerned the situation could be regarded as one in which

breach of confidentiality could be justified where the woman is unwilling to take any kind of action herself.

Do we need compulsory testing to achieve these goals? As already discussed, there is a good reason for HIV status to be established early in pregnancy. However other means are available to achieve similar goals as those of compulsory testing. A requirement that HIV testing be a routine test as incase of other tests carried out on pregnant women would achieve these goals. Without infringing on the woman's rights. consent for other medical tests should be presumed to cover HIV test. In such a case, HIV testing should be a routine procedure except where special objections are expressed After test counselling should be provided to such a woman with her husband if she has one. Such a requirement or law should also give the physician impunity or immunity form any legal actions which might result after an uninformed HIV test.

It should be noted however, that prevention of prenatal transmission depends, on protection of women of child bearing age from HIV infection. In absence of medical means of doing this, it is important that those with responsibility for health and sexeducation should move this issue to the front of education about HIV and AIDS. Women should be made to understand the importance of knowing before hand about their HIV status before becoming pregnant. For those who are pregnant they should be made to appreciate the need to establish their HIV status at the earliest possible stage.

As far as counselling and medical practice is concerned, those working in this fields should recognise the importance of testing for HIV infection as another routine procedure except where the patient specifically objects.

END NOTES TO CHAPTER TWO

1. HIV is transmitted through exchange of body fluids or organs.
2. Paul, Saoke, et al, "Children Orphaned by AIDS" in AIDS Cap (ed) AIDS IN KENYA, New York, Family Health International, 1996 pg.45
3. Ibid.
4. Paul, Sighort, 'AIDS and Human Rights;" A UK Perspective'" in British Medical Association Journal, London, 1989, Pg.51.
5. This right is not expressly provided for in Kenyan Legal regime. However this right is acknowledged under common law and in Article 12 of European Convention. See Paul Sighart, Ibid.
6. F v Swis zerland (Applies Mutati Mutandis to the right to raise a family) as quoted in Paul Sighart, Supra.
7. Supra note 2.
8. Janet Odual, of the Society of Child Welfare of Kenya. UNICEF, AIDS and Orphans in Africa, Report on meting about AIDS and Orphans in ~~Afirea~~ Africa, Forence June 14-15 1991. Pg.60
9. Supra, note 4
10. Supra, note 8
11. Article 12 and 16, United Nations Convention on Elimination of all forms of Discrimination against women.
12. Lindley, LJ, in Re Mc Grath (infant) (1893) 1 Ch 143, 148.
13. Ibid.
14. British Adoption Agencies Regulations 1983 reg. 8 (2) (c)

15. Ibid.

16. (1992) 1FLR 59.

17. (1981) NZ recent LAW 257.

18. Thompson v Thompson (1987) FLR 89 (CA)

19. Supra note 8

20 Ibid.

20a Supra note 8

21. Solomy Balungi, et al, Uganda Country Paper to African Network on Ethics, Law and HIV, proceedings on the Inter country consultation, Dakar Senegal, 27 June - 1 July 1994 pg.6

22. Jarvis R, AIDS Law in a Nutshell, New York, West Pub. Co, 1991. Pg.114.

23. Judith Kasumba et al, " HIV/AIDS within the family:Women Responses and Needs" in AIDSCAP (ed) AIDS IN KENYA (Supra)

24. Bromley, P.M and Lowe N.O, Bromley on Family Law, London, Butterworths (1992) see note 27 supra

25. (1984) AC 274 (HL)

26. Bromley (Supra) Pg 92.

27. Matrimonial Causes Act Section 14(1)(g) Cap 152, 1962 (ed)

28. Ibid.

29. S.12(d) of Cap 157, Laws of Kenya.

30. R. Jarvis AIDS Law in a Nutshell (Supra) pg. 120

31. Bromley (Supra) pg. 98.

31a. As quoted in R. Jarvis, AIDS Law in Nutshell (Supra) pg.120.

32. Ibid.

33. Cap 63 Laws of Kenya.

34. Mark Christian v Shelft, Executor of estate of Hudson, California Surpreme Court. LA city.

35. The Hippocratic Oath.

36.(i) The medical Practitioners and Dentist Act cap 253 (1983ed).

The Public Health Act cap 242 (1986ed)

The Penal code cap 63 Laws of Kenya (1985 ed)

International code of Medical Ethics (1949) which Kenya is signatory.

The Kenyan Constitution (1992 edition)

The Declaration of Helnski on Human experimentation which Kenya is signatory.

The code of Professional conduct and Discipline issued by the Medical Practitioners Board (among others)

37. Evidence Act cap 80. (1987 ed)

38. The Science And Technology Act Cap 250 (1980 ed)

39. Section 70 of Kenyan Constitution (1992 ed)

40. These are outlined and discussed by Margaret Brazier, in Medicine, Patients and the Law. Harmond worth, Penquin 1987 p.36.

41. Aitken, AIDS some Mythsl and Realities" 1987, 84 Law Society Gazette (Britain) P.239.

42. (1976) 551 P20 334 Calf sup t 43. Supra note 34.

44. 2nd Jud Dst of Nevada.

45. Supra note 41.

46. (1939) 2KB 827, 834.

47. (1985) 1 WLR 830.

48. R. Jarvis, AIDS Law in a Nutshell, (Supra) p.105.

49. Ibid.

50. World Health Organization Statement, June 1987 WHO Geneva, 1987.

51. Cuba & Utah, are some of the states.

52. Catterines, et al, " Obsteric and Perinatal consequences of HIV infection; a review," British Journal of Obsterics and Gynaecology, 94 (May 1987) p.403.

53. G.B Scott, et al, "Mothers of infants with AIDS" Journal of the American Medical Association 1985 p.253.

CHAPTER THREE:

A CASE FOR SPOUSAL NOTIFICATION:

From the previous two chapters, one can now appreciate the nature of HIV/AIDS, the impacts it has on the family institution and the challenges its control has raised. In Kenya, HIV transmission is mainly through heterosexual intercourse. This being the main mode of transmission, efforts at control must be specifically tailored at reducing HIV transmission through heretosexual intercourse. Aany mode of control will as a matter ofcourse have an impact on the family institution. Further a large percent of HIV transmission also takes place in the family unit, where one spouse gets infected outside the family unit, through sexual intercourse infects the child who is born.

In absence for a cure, in near future, the state must make headway in containing the spread of HIV/AIDS in the family and also protect the family institution. However, such an effort should be free of any challenge on basis of constitutionality or legality of the action. Further the effort should not be made in expense of those people already infected with HIV/AIDS. In this respect a legal framework is needed to facilitate effective control of HIV transmission in the family and also to offer solutions to the problems and legal issues raised by incidence HIV/AIDS in the family unit. The importance of the family as the basic social unit cannot be belabored. In this respect any control policy framework must also seek to protect and not to disintegrate family units. In search for an effective legal framework, it would be humirating to look at, the recommedations given in the international conference on HIV/aids/ by different countries facing similar problem.

In conference held in Senegal, on Ethics Law and HIV in June 1994, it was recommended by the host country that HIV positive individuals should enjoy the right to marry, that their sero status should not be raised as an obstacle to marriage. However the individuals have a duty to inform their prospective spouses of their sero status. it was further recommended that failure to disclose should be a ground for nullifying the marriage on the instance of the aggrieved spouse. Senegal was of the opinion that where the spouse has developed full blown AIDS the other spouse may be granted a divorce on grounds of temperamental incompatibility which is a ground for divorce in Senegal.

In regard to family law, promiscuous practices customs and traditions that enhance transmission of HIV must be condemned by law[2]. This was held to cover widow inheritance, polygamy and child marriages. Uganda held that it intended to pass laws limiting the number of wives a person could have. Further it was intending to revise its laws governing marriage and divorce to enable a spouse to separate or seek divorce where a partner indulges indulges in delinquent sexual relations or if either spouse refuse to practice safer sex or refuses to establish medically his or her sera-status.

In Zambia,[3] questions whether, HIV positive should enjoy the right to marry or raise a family are still being mooted. However it held that it intended to pass a law requiring mandatory HIV tests for those intending to marry[4] and a legislation on HIV/AIDS which among others would make spousal notification mandatory as one way to control and reduce HIV transmission[5].

From the foregoing we can see the trend of the policy and legislations being considered or put into effect in some African countries. A common issue in all these examples is that of spousal notification of HIV status of the other partner.

The paper describes the HIV/AIDS challenges which the government aims to address itself to. These includes the economic impact of HIV/AIDS morbidity and Mortality, its costs to the economy, social and cultural challenges, legal and ethical challenges. Youth and HIV/AIDS, children and HIV/AIDS, Health care and religion, culture and Gender challenges.

In the search for an appropriate legal framework of dealing with HIV/AIDS, in the family, it would be illuminating to look at the legal and ethical policies of the government. In this respect, the government through the sessional paper No.4 of 1997 proposes to[8].

* Ensure voluntary testing of individuals with informed consent except for authorized research where the protocol has been approved by the National AIDS Committee.
* Enhance enforcement of ethical codes as they pertain to confidentiality in relation to HIV/AIDS..
* Ensure legal provisions regulating circumstances in which a partner notification or those at risk of HIV infection may be made without consent to the infected person in the interests of public health.
* Develop codes of counseling that have the force of law taking into account the requirements of voluntary testing and confidentiality as they relate to home and community based care of HIV infected persons and people living with HIV/AIDS.
* Institute legislation to deal with isolation and discrimination of HIV infected persons.
* Ensure provisions for the protection of children orphaned by HIV/AIDS and people infected with HIV.
* Uphold criminal sanctions against those who deliberately infect others.
* Harmonize age of consent, marriage and maturity to 18 years.
* Encourage voluntary HIV testing to all women and men of reporductive age in order

to enhance their capacity for decision making regarding their fertility and sexuality.

* Advocate for care ofr HIV positive children and social support for orphans in institutions and in the community.

* Enforce the Liquor Licensing Act in order to stamp out the current practice where bars and lodges and other social amenities are located in residential areas thus giving young people negative experiences.

From the foregoing the trend of the policy framework and legislation put into effect or being considered can be seen. A common issue in all these examples is the requirement of spousal notification.

Spousal notification in respect of HIV/AIDS means that the spouse of the individual tested is entitled to the results of the test if they are positive. This will be an exception to the doctrine of strict confidentiality. As has been held that the principle of strict confidentiality should give way in the public interest. Infact it has been proposed that strict application of this doctrine goes against the very social and cultural fabric which our African society is based[9]. Prof. Kibwana, observes that:

> *"....strict confidentiality is a constraint because it contradicts the Kenyan cultural set up where all is shared by the community. Strict individual confidentiality could jeorpadize the community support required in the counselling and increase the myths sourrounding HIV/AIDS*[10]

However, this is true only when it is interpreated strictly to include members of the family directly affected. In the family context, the doctrine of stared confidentiality should replace, strict confidentiality. Shared confidentiality involves informing the sexual partner(s) or spouse(s) or caretaker of the individual's HIV status. This would be practical and

essential in those situations where sexual partners need to make fully informed decisions about their behaviours.

Another point for spousal notification is that it will reduce cases of HIV transmission between spouses and prenatal transmission. Infact, in a research carried out in Kenya[11] it was held that HIV/AIDS transmission in the family context has risen due to the ignorance of spouses in appreciating their sero status. Those interviewed stated that if they knew of the fact of their sero positivity they would have informed their sexual partners or reconsidered parenting through natural method. In this light we recommend that:

* Spousal notification be made mandatory by law.
* Such law to require that the infected spouse who has come to know of his/her seropositivity must inform the other spouse of that fact.
* That the spouse of tested individual is entitled to the results of the test.
* That, as far as possible disclosure of the results of a test to the patient shall be done in the presence of his/her spouse after due counselling of both of them.

However spousal notification though it may reduce HIV transmission between spouses, it will not solve other legal issue arising due to HIV/AIDS in the family. In this respect of other issues raised in the family we make the following recommendations.
In respect of HIV/AIDS and parenting: HIV positive individuals should enjoy the right to marry and raise a family subject to qualifications on spousal notification.

* After a test, proves to be positive, the patients should be counselled against raising a family through natural parentage. no use!
* Natural parentage for HIV positive/individuals should be discouraged though not prohibited by law.

* For the pregnant women, HIV testing should be made a routine test as incase of other tests carried out on pregnant women. Consent for such tests should be construed to include consent for HIV/AIDS test.

* The doctor who carries out HIV test without informing a pregnant woman should be granted immunity form any legal liability based on lack of consent for such a test.

In respect of adoption of children:- we recommend that;

* HIV positive individuals should not be allowed to adopt children in this respect, the position as it is in the Adoption Act is adequate.

* That adoption agencies are entitled to the health information of the applicant which should cover his/her HIV status.

* However, where the applicants are married and only one of the applicants is HIV positive, the sero positivity of the co-applicant should not be made a ground for refusing the application, and is such a case, the application should be approved subject to the fulfillment of other general requirements for adoption.

* Where the child to be adopted is sero-positive, the applicants for adoption are entitled to that information, or are entitled to health records of the child which should include his/her HIV status.

In respect of marriage, we have already seen that refusal of HIV positive right to marry would not be effective in controlling HIV transmission. Further such a policy in Kenya, where non-statutory marriages, and cohabitation are rampant and acknowledged would suffer no purpose. In such a case seropositivity should not be made a ground refusing a marriage license. However the need to know one sero status before marriage is important. In this respect pre-marital test should be encouraged.

It is therefore recommended that:-

* Sero positivity should not be a ground for refusing to celebrate a marriage or to grant a marriage license.

* Sero positive individuals should enjoy the right to marry and raise a family, and any infrigment of this right by requirement of mandatory testing should be prohibited.

* That couples intending to marry should be counselled on the need for HIV test. However when a couple submits voluntarily to a pre marital HIV test, they should be informed together of the results of such a test after due counselling; if they still wish to get married, they should be issued with a marriage license.

Such laws will to a large extent reduce HIV transmission between spouses and also have an impact on perinatal HIV transmission.

Another area which should be addressed by law in the family context is issues of separation and divorce. Though in our matrimonial laws there is no place for HIV/AIDS as a ground for divorce it is recommended that such a ground should be created. Incase of nullification of marriage, it is felt that failure to inform the prospective spouse of ones seropositivity should be a ground for seeking nullification orders. It is clearly socially desirable to release the innocent party from such a marriage to an infected spouse. It is further felt that it would be unreasonable to limit this relief to a petitioner who would show that the respondent had acquired HIV/AIDS through sexual intercourse. It is therefor recommended that:

* Failure to inform the prospective spouse of ones seropositivity before celebration of marriage should amount to a matrimonial offence. This will further strengthen the need for pre-marital HIV test.

* That such failure should form a ground for nullification of the marriage at the

instance of the aggrieved spouse.

* That the test for failure to inform be that the respondent, knowingly or being in a position to know, failed to inform the petitioner of his/her seropositivity before the celebration of the marriage.
* In this instance the knowledge of the petitioner, of the respondents seropositivity, or the agreement of the petitioner to marry the respondent in the face of refusal to go for HIV/AIDS test should be a defence to such an application.

Where the infection of a spouse has occurred after celebration of the marriage, though it is desirable to release the other spouse from such a marriage, public interest and human rights demand that HIV positive persons remain integrated in the society rather than be treated in degrading manner. In such a case, counselling, practice of safe sex, or abstention altogether seems to be a better alternative to divorce or separation. However, in this respect we recommend that:-

* Failure to inform the spouse of one seropositivity with the effect of transmitting the same to the spouse to amount to a marital offence, entitling the aggrieved party to divorce.
* It is lawful and justifiable denial of conjugal rights to abstain from sexual activities with an infected spouse. Such a refusal should not found a ground for divorce or for nullifying the marriage.
* That infection of a spouse with the virus constitutes a ground for divorce or separation if it can be shown that such infection was through sexual intercourse. The test being on balance of probabilities.

* That these provisions together with those relating to nullification orders be applied generally irrespective of ones personal laws. in the public interest to control HIV transmission.

Attending the divorce and separation is the question of custody of children. As already discussed, in any ruling affecting, a child welfare, the best interests of the child should be supreme. In respect to HIV/AIDS it is recommended that sero positivity should not be made a ground for refusing an application for custody of children, or visitation with the children. It has been shown that HIV/AIDS cannot be transmitted through the every day household casual contacts. As such any ruling on above issue should not make sero-positivity per se a ground for such refusal. However custody may be refused when the applicant for custody is already suffering from full blown bouts of AIDS, or when it is proven that he is unable to financially provide for the child.

Incase of visitation with the children we recommend that, seropositivity (of person should not be made a ground for refusing such an application. However, such an application may be refused when it is proven that the applicant is suffering from secondary infectious conditions or diseases or is unable to physically provide for the child visiting him or her. The negative stigma and discrimination attending HIV/AIDS individuals should not have a place in deciding the above issues. However it is appreciated that whatever decision a court will give will depend on the particular set of circumstances of the case.

In respect of cultural practises hindering control of HIV transmission a study should be made of ways of making them less popular. Incase of polygamy, it has been held to be a custom militating against AIDS control requirement of reducing number of sexual partners. However this should not be the case, because if the spouses in the family remain faithful,

they are as safe as those in monogamous unions. However thought must be given to ways of regulating the conduct of those in a polygamous union. Especially when one of the spouses is infected.

The best way is not through legislation but through counselling on the conduct of those in the union towards, the person with HIV/AIDS having regard to cultural and traditional values.

Same case applies to issues of wife sharing or 'age mating' among nomadic tribes, and widow inheritance among the Luo and Luhya communities. Such phenomenons should be studied and ways of discouraging them evolved. If they became less popular in Kenya, legislation may discourage it. However it is a fact that cultural practices die hard and education and awareness are best able to deal with them as opposed to law.

END NOTES TO CHAPTER 3

1. Senegal Country Paper, to African Network on Ethics, Law and HIV, Proceedings of inter country consultation. Dakar Senegal, 27 June - 1 July 1994.
2. Uganda Country Paper, Solomy Balungi et al to African Network on Ethics Law and HIV (Ibid).
3. Zambia Country Paper, David Chupaita, lan Sulu, to African Network on Ethics, Law and HIV (Supra)
4. Ibid in a Seminar of Permanent Secretaries at Misio-Tunga Inter Continetal Hotel, Livingstone September 1993.
5. Zambia Country Paper (Supra) in Regional Workshop on HIV/AIDS at Commonwealth Youth Programme African Centre, University of Zambia September 1993.
6. Sessional Paper NO. 4 of 1997, On AIDS in Kenya, 1997 Ministry of Health.
7. Ibid p.6.
8. Supra note6 p.24.
9. Kibwana, 'The conflict of confidentiality and Disclosure in relation to STD and HIV/AIDS" A Paper Presented at the first Kenya HIV/AIDS Conference 21-23 April 1993.
10. Ibid.
11. Raphael Tuju, AIDS Understanding the Challenge, Nairobi, English Press 1996.

CHAPTER FOUR

CONCLUSIONS:

In this work, we aimed to discuss the impact of HIV/AIDS in the family and in the matrimonial jurisprudence. Further, we aimed to discuss the control measures necessary and their impacts to the family, and the legal issues raised, with the aim of developing a legal framework for dealing with HIV/AIDS in the family.

In chapter one, we analysed HIV/AIDS as a disease. Under this we saw the extent of HIV/AIDS in Kenya, The two main modes of transmission in Kenya were held to be heterosexual contact and mother to infant transmission. Due to these modes of transmission, we concluded that the family unit was endangered. In this respect we analysed the impact of HIV/AIDS on the family institution and legal issues raised. Here, the need to control both heterosexual and mother to infant HIV transmission was underlined. We acknowledged that such a control will also raise some legal issues which need to be addressed.

In chapter two, we discussed the main areas where HIV/AIDS have had an impact in the family context. These areas include HIV/AIDS and parenting where issues like whether HIV positive individuals should enjoy they right of procreation were discussed. We felt that seropositive individuals should enjoy their right to marry and raise a family. However the need for counselling against natural parenting was held to be necessary and the medical help to bring up healthy children was emphasized. Impact of HIV/AIDS on break of relationships was discussed. It was felt that it is socially desirable to release the innocent spouse from a marriage where the other spouse has been infected with HIV through extra-marital sex or where he of she has failed to disclose medically his or her sero-status.

On controlling HIV transmission in the family context, the need for duty to disclose one's sero status to the spouse was advocated for, model of ensuring this disclosure were discussed discussed which included premarital HIV testing and testing of pregnant women. It was felt that HIV testing of pregnant women should be made a routine test just like other medical tests carried on pregnant women.

In chapter three, we gave the recommendations necessary in the search for legal framework for dealing with HIV/AIDS in the family context. Here we recommended among others that spouse communication be made mandatory by law. We further recommended a legal framework which covered HIV/AIDS and parenting, separation and divorce and child custody. These recommendations are necessary in solving the legal issues which have arisen due to the impact of HIV/AIDS in the family. Further it is hoped that with such a legal framework in place other policy framework of controlling HIV/AIDS or dealing with HIV/AIDS in the family context may be put into effect without their legality being challenged.

However and in respect of spousal notification, it is important to note that one problem remains. This is due to the possible deleterious effect on the detection and treatment of HIV/AIDS if confidentiality is seen as a relative principle in medical practice. Clearly if the attitude was ever to take root that the medical profession cannot be trusted to maintain confidentiality, then the feared effect would occur. However we believe where the people infected and the general public were told of the only ground on which confidentiality would be breached and the only people who would be informed then this effect would not occur. This underlines the need for counselling and education and information on HIV/AIDS. This is one area where the government should put much effort in while effecting its policy framework on HIV/AIDS as stipulated in sessional paper No.4 of 1997.

SELECTED BIBLIOGRAPHY

1. Brenda Almond (Ed.) AIDS A Moral Issue. London, MacMillan, 1990.

2. Jarvis, R., AIDS Law, In A Nutshell, New York, West Pub. Co. 1991.

3. Vevaina, J.R.,(Ed.) Legal Aspects of Medicine New York, Springer - Velag. 1989.

4. Gottliebs (Ed.) Current Topics On AIDS New York, John Wiley and Sons, 1989.

5. Bromley, P.M. and Lowe N.O., Bromley On Family Law. London, Buttersworth, 1992.

6. Curram, W.J. and Gostin L., International Survey of Legislations Relating to the AIDS Epidemic, Geneva WHO 198

7. AIDS Cap (Ed.) AIDS In Kenya, New York, Family Health International, 1996.

8. Report on the African Network On Ethics, Law and HIV. Proceedings on the Inter Country consultation, Dakar, Senegal 27 June- 1 July 1994.

9. Raphael Tuju, AIDS: Understanding the Challenge Nairobi, English Press 1996.

10. Kivutha Kibwana "The Conflict of Confidentiality and Disclosure in Relation to STD and HIV (AIDS)". A paper presented at the First Kenya HIV (AIDS) Conference, Safari Park, 21-23 April 1993.

11. Sessional Paper No.4 of 1997, AIDS in Kenya, Ministry of Health 1997.

12. Omollo P.O.M., LL.B Dissertation, Nairobi 1995.