SOUTH AFRICAN LAW COMMISSION

DISCUSSION PAPER 80

Project 85

ASPECTS OF THE LAW RELATING TO AIDS:

The Need for a Statutory Offence Aimed at Harmful HIV-Related Behaviour

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INTRODUCTION

The South African Law Commission was established by the South African Law Commission Act, 1973 (Act 19 of 1973).

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PREFACE

This discussion paper (which reflects information accumulated up to the end of October 1998), has been prepared to elicit responses from key parties and to serve as a basis for the Commission's deliberations. Following an evaluation of the responses and any final deliberations on the matter the Commission may issue a report on this subject which will be submitted to the Minister of Justice for Tabling in Parliament. The views, conclusions and recommendations in this paper are accordingly not to be regarded as the Commission's final views. The paper is published in full so as to provide persons and bodies wishing to comment or to make suggestions relating to the reform of this particular branch of the law with sufficient background information to enable them to place focussed submissions before the Commission.

For the convenience of the reader a summary of issues discussed and requests for comment appear on the next page.

The Commission will assume that respondents agree to the Commission quoting from or referring to comments and attributing comments to respondents, unless representations are marked confidential. Respondents should be aware that the Commission may in any event be required to release information contained in representations under the Constitution of the Republic of South Africa, Act 108 of 1996.

Respondents are requested to submit **written** comments, representations or requests to the Commission by **28 February 1999** at the address appearing on the previous page. The researcher will endeavour to assist you with particular difficulties you may have.

The researcher allocated to this project, who may be contacted for further information, is Mrs A-M Havenga. The project leader responsible for this project is the Honourable Mr Justice E Cameron.

SUMMARY

1 The Commission in 1995 in its Working Paper 58 *inter alia* considered the role of the State in respect of HIV/AIDS. In this context it investigated the desirability of the application of coercive administrative and criminal law measures against the spread of the disease.

1.1 Considering isolation and quarantining as existing administrative law measures that could be invoked in terms of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987,[1] the Commission at the time came to the preliminary conclusion that the extremely slight advantage which isolation may hold for public health is disproportionate to the infringement of individual rights which isolation, even if based on harmful behaviour, may entail. Commentators responding to Working Paper 58 between October 1995 and February 1996 were divided on this issue. Several of them (including the Department of Health), supported the preliminary recommendation. However, the medical profession and certain community health organisations indicated that grounds may exist for isolation based on behaviour where deliberate and repeated endeavours are made by an individual to spread infection. In this regard it was suggested that the mere fact that powers to isolate, exist, may succeed in acting as a deterrent.

1.2 As far as criminal law measures were concerned, the Commission at the time came to the preliminary conclusion that the criminal law is not pre-eminently the means by which to combat the spread of HIV, and was therefore not in favour of the creation of a statutory offence aimed specifically at HIV-related harmful behaviour. The main reason given for this was that conduct by persons with HIV which merits punishment remains punishable under the existing common law crimes. The majority of

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1 See Chapter 4 of the current Discussion Paper.

commentators responding to this, agreed with the Commission's preliminary conclusion.

2 Recently however, prominent reports of incidences of the deliberate transmission of HIV country wide resulted in public calls for the deliberate transmission of HIV to be made the subject of criminal sanction, and for some measures to alleviate the plight of women who fall prey to the deliberate spread of HIV. Various political parties since August 1997 submitted that deliberate transmission of HIV should be the subject of criminal sanction and in the beginning of 1998 the Commission was formally approached by the Justice Portfolio Committee (National Assembly) via the Department of Justice to investigate the need for legislation with regard to the "criminalisation"[2] of acts by persons with HIV/AIDS who deliberately or negligently infect others; and the compulsory HIV testing of sexual offenders.

2.1 The project committee assisting the Commission with its broad investigation into aspects of the law relating to AIDS, decided to deal incrementally with the issues in question. This entails that two discussion papers will be prepared as a basis for the Commission's consultative process. The first paper (i e the current paper) will address the issue of harmful behaviour[3] by persons with HIV/AIDS, the administrative and criminal law measures available to address such behaviour, and the need for statutory intervention. The second will deal with the question of HIV testing of sexual offenders and persons accused of having committed sexual offences.

3 After having examined the possible role of the criminal law in the prevention of the spread of HIV, the Commission on a preliminary basis confirms its 1995 premise that the criminal law is not pre-eminently the means by which to combat the spread of HIV. The AIDS epidemic is first and foremost a public health issue and it is internationally accepted that non-coercive measures are the most successful means

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2 See par 3.1 of the current Discussion Paper.

3 See par 5.2.1 of the current Discussion Paper.

through which public health authorities can reduce the spread of the disease.

3.1 However, it is accepted, and this Discussion Paper bears evidence to the effect, that there are individuals who, through their irresponsible and unacceptable behaviour, deliberately place others at risk of HIV infection. Where HIV-related behaviour results in harm to others (i e exposure to or transmission of HIV), public health measures in themselves are insufficient and the criminal law undoubtedly has a role to play in protecting the community and punishing those who transgress. The Commission is of the opinion that this limited role is not necessarily incompatible with any public health strategy against the disease. Just as other individuals in society are held responsible for behaviour outside the criminal law's established parameters of acceptable behaviour, persons with HIV who knowingly or recklessly conduct themselves in ways that harm others must be held accountable. In this sense the criminal law must obviously provide a measure of protection in the form of deterrence and can also reflect society's abhorrence of such behaviour.

4 On the premise that the criminal law has a role to play, albeit limited, in targeting behaviour harmful to others, the question arises what route should be taken in realising this role. Two possibilities exist: Applying the existing common law crimes or creating an HIV-specific statutory offence.

4.1 The State would indeed at present be able to institute criminal prosecutions for HIV-related behaviour under the existing common law crimes. In comment on the Commission's Working Paper 58 this was also emphasised as a reason why a new statutory offence should not be created. However, it could be that HIV-related behaviour does not fit easily under the common law crimes, and that securing a successful prosecution under one of these crimes may prove difficult. This would be due mainly to the specific characteristics of HIV as a disease: Its long incubation period and its

invisibility may present problems with regard to proof of causation and fault. Aspects regarding consent could further encumber prosecutions. On the other hand, the common law provides a variety of different crimes which could be utilised to meet a number of different forms of harmful HIV-related behaviour. The fact that applying the common law crimes has apparently not been tested in practice,[4] complicates the issue and contributes to the current lack of clarity as regards the viability of utilising the common law. As the Commission has currently no practical evidence on the application of the common law crimes to harmful HIV-related behaviour, it is not in a position at this stage to come to any conclusion on their possible efficacy.

4.2 If harmful HIV-related behaviour is to be targeted by the criminal law in any other way than utilising the common law crimes, an HIV-specific statutory provision would have to be created by the legislature. Such an approach would (except where negligent exposure to or transmission of HIV which does not result in death, and strict liability are concerned), in essence confirm the common law position, but could provide clarity on aspects such as causation and consent and the use of condoms to minimise the risk of infection. However, it could be argued that there are certain dangers to this approach.[5] These should be carefully weighed against the benefit to be derived from the enactment of a statutory offence. Finally, compulsory HIV testing of suspects may well be an unavoidable corollary of creating a statutory offence. Whether this would be constitutionally permissible is open to question and could constitute further reason for questioning the desirability of a special enactment.

4.3 The Commission is not in a position at this stage to come to any firm conclusion on the need for the creation of a statutory offence aimed at

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4 Cf par 2.1.5 of the current Discussion Paper where it is indicated that a man has recently been charged with attempted murder in the first case of its kind in South Africa. The case has not been finalised at the time of publication of this paper.

5 See the rationales against creating a statutory offence in par 5.50-5.65 below.

harmful HIV-related behaviour. Draft legislation has therefore not been included in this Discussion Paper for public comment. This Discussion Paper comprehensively sets out the issues regarding the application of the common law crimes to harmful HIV-related behaviour as well as arguments for and against the creation of a specific statutory offence. The Commission also includes, in an Annexure, six examples of different legislative approaches dealing with such behaviour derived from existing or proposed legislation of comparable foreign legal systems. The examples (which are also included at the end of this summary) cover the following possibilities for legislative reform:

* **Criminalising the conduct of any person who, with actual knowledge of HIV infection, "intentionally does or permits the doing of anything" which he or she knows or ought reasonably to know will infect another, or is likely to infect another with HIV. (Zimbabwe Criminal Law Amendment Bill 1996 - Example 1.)[6]**
* **Requiring a person infected with a "controlled notifiable disease"[7] (including HIV) "to take all reasonable measures to prevent transmission of the disease to others". (South Australia Public and Environmental Health Act 1987 - Example 2.)**
* **Providing that intentional infection of others with HIV is a felony.[8] (United States Draft HIV Prevention Bill 1997 - Example 3.)[9]**

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6 The current example is an extract form the Zimbabwean Criminal Law Amendment Bill 1996. As indicated in par 6.18.4 of this Discussion Paper, the proposed legislation has been withdrawn to enable the incorporation of further amendments. At the time of publication of this Paper it could not be ascertained whether these amendments would affect the provision with regard to HIV transmission. For more detail on the legislation, see par 6.18-6.18.4 below.

7 Examples 2 and 6 are examples of legislation aimed at harmful HIV-related behaviour which are not HIV-specific. Note that in South Africa neither AIDS nor HIV is currently notifiable medical conditions.

8 "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law.

9 See also par 6.10-6.11 of the current Discussion Paper.

* **Criminalising knowing exposure[10] to "a significant risk of HIV transmission". (Tennessee [United States] Annotated Code 1994 - Example 4.)**
* **Prohibiting "sexual intercourse" by a person with HIV "with any other person" unless such other person knows of the infection and has consented to the intercourse. (Florida [United States] Statutes 1997 - Example 5.)**
* **Prohibiting knowing exposure to a "sexually transmitted disease" (which will include HIV). (Montana [United States] Annotated Code 1995 - Example 6.)**

4.4 In order to facilitate a conclusion on the issues in question, the Commission invites comment particularly on the following principal issues:

(A) The role of the criminal law in the HIV/AIDS context (compare par 5.11-5.18).

(B) The definition of harmful conduct in the HIV/AIDS context (compare par 5.1-5.5).

(C) The suitability and possible efficacy of using existing common law crimes in respect of harmful HIV-related behaviour - with particular reference to possible difficulties in prosecuting such crimes (compare par 5.21-5.31.1).

(D) The need for the creation of an HIV-specific offence targeting harmful behaviour - with specific reference to the possible need for legal certainty, and to the counter-productive effect the creation of a new offence may have on public health efforts in curbing the spread of the disease (compare par 5.36-5.65).

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10 "Knowing" exposure could probably be equated to "intentional" exposure in South African criminal law.

(E) **The need for existing public health measures to be amended or new measures to be created to address the issue of harmful behaviour as an alternative to taking recourse to the criminal law, for example by adopting the Australian model of a graduated process, culminating in isolation or detention as a last resort** (compare par 4.9-4.15, 6.16).

(F) **The need for creating an offence of exposing another to HIV without transmission of HIV actually occurring** (compare par 5.15, 5.23, 5.30-5.31.1).

(G) **The need to inhibit negligent behaviour where negligence does not result in the death of the victim (i e where the relevant behaviour would not be prosecutable under a charge of culpable homicide)** (compare par 5.25.3-5.25.4 and 5.28-5.28.2).

(H) **The need to create offences of strict liability (i e requiring neither intention nor negligence as a form of fault) in addition to existing common law offences** (compare par 5.25-5.25.4, 5.33.2).

4.5 **Should the creation of a statutory offence be indicated, and with reference to the examples from other legal systems included below, comment is invited on the following issues:**

(A) **What behaviour should be targeted by a statutory offence? (Transmission of HIV; exposure to HIV; both transmission of and exposure to HIV; any other behaviour - such as the transmission of or exposure to sexually transmitted diseases?)**

(B) **What form of fault, if any, should be required? (Intention only; or should negligence be an alternative to intention; or should strict liability [i e liability without fault] be imposed?)** (Compare also par

5.33.2.)

(C) **What should be regarded as an appropriate defence to a criminal prosecution? (Legal consent to the relevant behaviour only; taking precautionary measures - i e using condoms - only; consent and taking precautionary measures jointly; consent or taking precautionary measures in the alternative.) What should "consent" mean?** (Compare also par 5.24-5.24.3.)

(D) **Where should the burden of proof with regard to consent lie? (Upon the accused to prove, on a balance of probabilities, that the person harmed or exposed consented to harm or the risk of harm; or upon the prosecution to prove, beyond reasonable doubt, that the person harmed did not so consent?)**

(E) **Would it be necessary or desirable to provide for statutory powers for the compulsory HIV testing of the accused (or suspects) for evidentiary purposes?**

(F) **Would it be necessary or desirable to create any presumptions with regard to the accused's HIV status?**

(G) **What would suitable punishment(s) be in the case of conviction on a statutory offence involving harmful HIV-related behaviour?**

EXAMPLES OF LEGISLATIVE APPROACHES DEALING WITH HARMFUL HIV-RELATED BEHAVIOUR DERIVED FROM EXISTING OR PROPOSED LEGISLATION OF COMPARABLE FOREIGN LEGAL SYSTEMS

EXAMPLE 1: CLAUSE 14 OF THE ZIMBABWE CRIMINAL LAW AMENDMENT BILL 1996

"**Deliberate Transmission of HIV**

14.(1) Any person who, having actual knowledge that he is infected with HIV, intentionally does anything or permits the doing of anything which he knows or ought reasonably to know -

(a) will infect another person with HIV; or

(b) is likely to lead to another person becoming infected with HIV;

shall be guilty of an offence and liable to imprisonment for a period not exceeding fifteen years.

(2) It shall be a defence to a charge of contravening subsection (1) for the person charged to prove that the other person concerned -

(a) knew that the person charged was infected with HIV; and

(b) consented to the act in question, appreciating the nature of HIV and the possibility of his becoming infected with it. ...

Presumptions regarding HIV infection

17.(1) For the purpose of [clause] 14, the presence in a person's body of HIV anti-bodies or antigens, detected through an appropriate test shall be prima facie proof that the person concerned was infected with HIV;".

Note:

The Bill is discussed more fully in paragraph 6.18-6.18.4. The Bill provides for a person who is alleged to have contravened clause 14, to be tested for HIV (clause 16(2)).

EXAMPLE 2: SECTION 37 OF THE SOUTH AUSTRALIA PUBLIC AND ENVIRONMENTAL HEALTH ACT 1987[11]

"**Persons infected with disease must prevent transmission to others**

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11 Internet **http://www.austlii.edu.au/** accessed 3/11/98.

37.(1) A person infected with a controlled notifiable disease shall take all reasonable measures to prevent transmission of the disease to others. Penalty: Division 3 fine".

Note:

The Australian position is discussed in paragraph 6.15-6.17. "AIDS" and "AIDS-Related Complex" (the severe symptomatic phase of HIV infection - referred to in paragraph 2.26-2.26.2) have been designated as controlled notifiable diseases for the purposes of the Act (HIV infection is not of itself notifiable). The penalty for contravening this provision is $10 000,00. Proceedings in terms of this section cannot be commenced except upon the complaint of an authorised officer; the chief executive officer of a local council; a member of the police force; or a person acting on the written authority of the relevant Minister.[12] *This is an example of legislation aimed at harmful HIV-related behaviour which is not HIV-specific. (Note that in South Africa neither AIDS nor HIV is currently notifiable medical conditions.)*

<u>EXAMPLE 3</u>: SECTIONS 2 and 4 OF THE UNITED STATES DRAFT HIV PREVENTION BILL 1997

"**Sec 2. Findings**

2. The Congress finds as follows: ...

(5) Individuals with HIV disease have an obligation to protect others from being exposed to HIV by avoiding behaviors that place others at risk of becoming infected. The States should have in effect laws providing that intentionally infecting others with HIV is a felony.

Sec 4. Sense of Congress regarding intentional transmission of HIV

It is the sense of the Congress that the states should have in effect laws providing that, in the case of an individual who knows, that he or she has HIV disease, it is a felony for the individual to infect another with HIV if the individual engages in the behaviours involved with the intent of so infecting the other individual".

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12 Sec 45(2) of the Public and Environmental Health Act 1987. See in general on these provisions also Godwin et al **Australian HIV/AIDS The Legal Issues** 37.

Note:

Background to the United States position is discussed in paragraph 6.6-6.11. "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law.

EXAMPLE 4: §39-13-109 OF THE TENNESSEE (UNITED STATES) ANNOTATED CODE 1994[13]

"**39-13-109. Criminal exposure to HIV - Defenses - Penalty**

(a) A person commits the offense of criminal exposure of another to HIV when, knowing that such person is infected with HIV, such person knowingly:

(1) Engages in intimate contact with another;

(2) Transfers, donates or provides blood, tissue, semen, organs, or other potentially infectious body fluids or parts for transfusion, transplantation, insemination, or other administration to another in any manner that presents a significant risk of HIV transmission; ...

(b) As used in this section: ...

(2) 'Intimate contact with another' means the exposure of the body of one person to a bodily fluid of another person in any manner that presents a significant risk of HIV transmission; ...

(c) It is an affirmative defense to prosecution under this section, which must be proven by a preponderance of the evidence, that the person exposed to HIV knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and gave advance consent to the action with that knowledge.

(d) Nothing in this section shall be construed to require the actual transmission of HIV in order for a person to have committed the offense of criminal exposure of another to HIV.

(e) Criminal exposure of another to HIV is a Class C felony".

Note:

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13 Internet **http://www.lexislawpublishing.com/** accessed 3/11/98.

Background to the United States position is discussed in paragraph 6.6-6.11. "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law.

EXAMPLE 5: §384.24 OF THE FLORIDA (UNITED STATES) STATUTES 1997[14]

"**384.24 Unlawful acts**

...

(2) It is unlawful for any person who has human immunodeficiency virus infection, when such person knows he or she is infected with this disease and when such person has been informed that he or she may communicate this disease to another person through sexual intercourse, to have sexual intercourse with any other person, unless such other person has been informed of the presence of the sexually transmissible disease and has consented to the sexual intercourse.

384.34 Penalties

...

(5) Any person who violates the provisions of s 384.24(2) commits a felony of the third degree ...".

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14 Internet **http://www.leg.state.fl.us/citizen/documents/statites/1997/** accessed 6/11/98.

Note:

Background to the United States position is discussed in paragraph 6.6-6.11. "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law. Under the above provisions a person convicted of a felony of the third degree may be punished by a term of imprisonment not exceeding 5 years. In addition, payment of a fine not exceeding $5 000 may be imposed.[15] *The court may also require a convicted offender to serve a term of criminal quarantine community control (i e intensive supervision, by officers with restricted caseloads, with a condition of 24-hour-per-day electronic monitoring, and a condition of confinement to a designated residence during designated hours).*[16]

EXAMPLE 6: §50-18-112 OF THE MONTANA (UNITED STATES) ANNOTATED CODE 1995[17]

"**50-18-112 Infected person not to expose another to sexually transmitted disease**

A person infected with a sexually transmitted disease may not knowingly expose another person to infection.

50-18-113 Violation a misdemeanor

A person who violates provisions of this chapter or rules adopted by the department of public health and human services concerning a sexually transmitted disease or who fails or refuses to obey any lawful order issued by a state or local health officer is guilty of a misdemeanor".

Note:

Background to the United States position is discussed in paragraph 6.6-6.11. "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences

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15 §775.082(3)(d) and 775.083(1)(c) of the Florida Statutes 1997.

16 Section 755.0877(7) and 948.001(3) of the Florida Statutes 1997.

17 Internet **http://statedocs/msl.state.mt/us/** accessed 6/11/98.

generally less heinous than felonies) in American criminal law. For the purposes of this provision "sexually transmitted disease" includes AIDS.[18] *This is an example of legislation aimed at harmful HIV-related behaviour which is not HIV-specific.*

18 Katner 1996 **Tulane Law Review** 2334.

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1 INTRODUCTION

1.1 The Commission has been investigating reform of the law relating to AIDS and HIV since 1993. An extensive discussion document (Working Paper 58) was published for general information and comment in September 1995. A reconstituted project committee - assisting the Commission in resolving differences of opinion between interest groups reflected in the comments on Working Paper 58, and in developing final recommendations - decided to adopt an incremental approach to this large and difficult task.

1.2 The Commission has already adopted the project committee's First, Second and Third Interim Reports on Aspects of the Law relating to AIDS.

1.2.1 The Commission's **First Interim Report**[1] (which was tabled in Parliament by the Minister of Justice on 30 August 1997) dealt with a limitation on the use of non-disposable syringes, needles, and other hazardous material in health care settings; the implementation, in relevant occupational legislation, of universal precautions in the work place; the statutory implementation of a national compulsory standard for condoms in accordance with international standards; the promulgation of a national policy on testing for HIV infection; and the amendment, finalisation and promulgation of the Draft Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1993 (which deschedule AIDS as a communicable disease in respect of which certain coercive measures apply mandatorily). The National Assembly resolved on 18 September 1997 that the recommendations in the First Interim Report should be implemented urgently by the government.[2]

1.2.2 The **Second Interim Report**[3] dealt with the question whether statutory

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1 **SALC First Interim Report on Aspects of the Law relating to AIDS**.

2 It was indicated on 14 March, 27 August and 8 October 1998 that the Department of Health is attending to the implementation of the recommendations (information supplied by Dr G Mtshali, Chief Director National Programmes and Ms Rose Smart, Director HIV/AIDS and STDs in the Department of Health; and Ms Ann Strode, consultant to the Department of Health and project committee member).

3 **SALC Second Interim Report on Aspects of the Law relating to AIDS.**

intervention to prohibit pre-employment testing for HIV is warranted. In this report the Commission offers comment on the Employment Equity Bill[4] which accommodates the Commission's recommendations in principle. The Commission also enunciates the principles accepted for legislative intervention in a proposed alternative Bill.

1.2.3 The **Third Interim Report**[5] covered the issue of HIV/AIDS and discrimination in schools and contained final recommendations with regard to the promulgation of a national policy on HIV/AIDS in public schools. The Second and Third Interim Reports were tabled in Parliament on 13 August 1998.

1.3 The current discussion paper covers the issue of harmful behaviour[6] by persons with HIV/AIDS; the administrative and criminal law measures available to address such behaviour; and the need for statutory intervention.

1.4 It is to be noted that this discussion paper contains preliminary proposals for public comment with a view to compiling an interim report. It does not contain the final views of the Commission on the issue under discussion.

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4 General Notice 1840 of 1997 in **GG** No 18481 of 1 December 1997.

5 **SALC Third Interim Report on Aspects of the Law relating to AIDS.**

6 Such behaviour would include exposure to and transmission of HIV and attempts thereto. See par 5.2.1 for a full discussion.

2 BACKGROUND

A) SOURCE OF PRESENT ENQUIRY

* Calls for government response

2.1 Recently, prominent reports of incidences of the deliberate transmission of HIV country wide resulted in calls for the deliberate transmission of HIV to be made the subject of criminal sanction, and for some measures to alleviate the plight of women who fall prey to the deliberate spread of HIV.[7] Public pressure comes from many different quarters. Some groups are calling merely for "revenge"; others for stricter measures in regard to specific serious offences such as rape; others are concerned about protecting women and children in what is regarded as a violent society; and yet others call for suitable measures to be taken in respect of exceptional cases of sexual violation such as gang rape. In all of these situations it appears that there is public concern and that there is pressure on the authorities to respond suitably.

2.1.1 Alarming research, reported on in 1996 and 1997, found that AIDS-stricken teenagers in KwaZulu/Natal are deliberately infecting others with HIV through sexual contact in order not to suffer and die alone.[8] Apparently being informed of a positive HIV test result tended to be accepted by these teenagers not only as a death sentence but also as a licence for unlimited sexual activity. According to the research, some teenage males are resorting to rape to spread the disease, while

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7 **Beeld** 30 August 1997.

8 The study records behavioural responses among educated Zulu-speaking youth (aged 18 to 25) to the HIV/AIDS epidemic during 1995, and evaluates to what extent these responses lend themselves to facilitating a decrease or increase in the continued transmission of HIV. Many of those teenagers polled during the research said they were convinced they were carrying the virus but did not want to be tested as it didn't really matter. Most felt that if they were not already infected it was only a matter of time before they would be (Leclerc-Madlala 1997 **Medical Anthropology** 367-370, 376; Leclerc-Madlala 1996 **Acta Criminologica** 31-34, 36; see also **Beeld** 27 August 1997; **Beeld** 30 August 1997; **The Citizen** 25 August 1997).

medical authorities cite their fear that men would respond to an HIV positive diagnosis by raping women, as a main factor for not determining the HIV status of patients.[9] (At the time of the research KwaZulu/Natal had more than two-thirds of the estimated 1,8 million persons with HIV/AIDS in South Africa.[10]) More or less similar findings were made in a study done in the Southern Substructure of the Johannesburg Metropolitan Area, reported on in May 1998. It was found that the scourge of rapes by gangs of young men with HIV deliberately infecting school going girls is not a unique phenomenon, but part of a culture of sexual violence and of regarding rape as a form of organised recreation.[11]

2.1.2 Political parties in August 1997 submitted that deliberate transmission of HIV should be the subject of criminal sanction.[12] Democratic Youth Leader Sipho Moganedi emphasised that persons with HIV/AIDS who deliberately spread the disease to others must be treated as criminals. He likened such behaviour to murder and serial killing and warned that South Africa would pay dearly if the country did not deal with the pandemic decisively.[13] Legal experts at the time

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9 Leclerc-Madlala 1997 **Medical Anthropology** 369-370, 372; Leclerc-Madlala 1996 **Acta Criminologica** 32-34). See also **The Citizen** 25 August 1997.

10 Leclerc-Madlala 1997 **Medical Anthropology** 363, 365-366.

11 The study was conducted by the Southern Substructure of the Johannesburg Metropolitan Area with the assistance of non-governmental organisations in the areas Soweto, Lenasia, Rosettenville, Ennerdale and the Johannesburg city centre and included interviews with 4 000 women, 2 100 men, 1 200 secondary school pupils, 90 members of the police force and 90 persons attached to service organisations including magistrates, social workers and medical practitioners (**Beeld** 27 May 1998). Experts believe that gang members could be unemployed with no education and are taking their anger out on girls who attend school; or they may associate their illness with women and reason that some woman gave it to them so they're going to pass it on; or act according to the myth that having sex with a virgin would "pass on" the disease, leaving the rapist "disinfected" (**Star** 19 May 1998). An example of this behaviour received wide press coverage when seven members of a gang were charged with rape and kidnapping in May 1998: The seven accused allegedly raped a 16 year old girl after having abducted her at gunpoint. According to the victim (who has since tested positive for HIV) the rapists told her that they had infected her, that they want her to wait for death just like them and to die a slow death from the disease. It is reported that the gang is made up of members with HIV who target schools, shebeens, parties, funerals or other social gatherings in Soweto in their efforts to deliberately spread the disease to girls between 15 and 17 years and that they are responsible for a scourge of abductions and rapes in Soweto (**Star** 19 May 1998; **Sunday Times** 24 May 1998; **Beeld** 27 May 1998; **Sowetan** 2 June 1998).

12 Ibid.

13 **The Citizen** 30 August 1997.

stated that although the common law would allow for prosecutions under existing crimes, evidentiary problems would arise. The response to this in a press editorial was that what is needed is a specific statute criminalising deliberate HIV transmission: "The courts have granted civil relief to victims of [such conduct] in this country, but the infected and even the dying with diabolical plans should know that further misery awaits them if they wittingly spread their disease".[14]

2.1.3 The Inkatha Freedom Party in May 1998, in a bid for HIV/AIDS legislation which "balances" the rights of persons with HIV and those without the disease, submitted that the limits of harmful behaviour of persons with HIV should be defined. The party requested the enactment of legislation making it a criminal offence if a person with HIV or AIDS does not inform his or her partner of his or her infection. Criticising the Commission's recent proposals for a prohibition on pre-employment HIV testing,[15] the Inkatha spokesperson said that the government is not taking sufficient steps to protect those members of society without HIV.[16]

2.1.4 Cries for the punishment of those who deliberately infect others with HIV also went up after damages were awarded in the civil case of **Venter v Nel**.[17] Three women, all former lovers of the defendant (who was ordered by the court to pay the plaintiff a substantial sum for having infected her with HIV), indicated that they were lobbying for criminal charges to be instituted against Nel who had intercourse with them without telling them he had HIV.[18] In their comment on this issue, Lawyers for Human Rights and the AIDS Legal Network, although not coming out in support of prosecution or creating statutory offences, stated that

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14 **Pretoria News** 26 August 1997.

15 See **SALC Second Interim Report on Aspects of the Law Relating to AIDS**.

16 **Beeld** 14 May 1998; see also **The Star** 2 October 1997.

17 1997 4 SA 1014(D). See also par 3.3.1 below.

18 **Sunday Tribune** 9 March 1997. (The claimant in **Venter v Nel** was not associated with efforts for Nel to be criminally charged - Cf par 3.3.1 below.)

they recognised the situation as a burning issue which required deliberation by all stakeholders. They warned however against the possible implications of such legislation where pregnant women with HIV could become the subject of prosecution for having passed the virus to their unborn children.[19]

2.1.5 In the latest publicised incident of allegedly deliberate HIV transmission by a person with HIV, a man is reported to have had sex with two women, knowing that he had HIV and failing to inform them about it. According to press reports the man has been charged with attempted murder in the Newcastle (KwaZulu/Natal) magistrate's court on 29 September 1998. As far as could be ascertained, this is the first criminal prosecution of its kind in South Africa. At the time of publication of this Discussion Paper, the case has not been finalised. Public comment recorded on the incident referred to widespread refusal among men to wear condoms since they believe that only women can become infected with HIV; and likened the behaviour of the accused to shooting at someone with a loaded gun.[20]

* Request by Justice Portfolio Committee, January1998

2.2 During debate on the Criminal Law Amendment Bill (B46-97)[21] (Minimum Sentencing Act) in October 1997, Justice Portfolio Committee (National Assembly) members raised public concerns about actions other than rape by persons with HIV/AIDS who endangered the public.[22] Adv Johnny De Lange (Chairperson of the Portfolio Committee) later advised the Minister of Justice in a letter dated 20 December 1997 that the African National Congress (ANC) proposed that the Department of Justice should consider the research, initiation or drafting of:

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19 **Sunday Tribune** 9 March 1997.

20 **Natal Witness** 29 September 1998.

21 Enacted as the Criminal Law Amendment Act 105 of 1997 (Minimum Sentencing Act).

22 **Business Day** 23 October 1998.

> Legislation to regulate matters relating to AIDS perpetrators, for example, compulsory testing for sexual offence perpetrators; the right of a victim to know whether a sexual offender has been diagnosed as HIV/AIDS positive; criminalisation of sexual activity when persons know they have AIDS and have not informed their partner; or sanctions when persons commit a sexual offence knowing they have AIDS; and so forth (see England and Zimbabwe).[23]

2.3 In response, the Department of Justice on 26 January 1998 formally informed the Commission of the discussions within the Portfolio Committee with respect to the Minimum Sentencing Act:

> During its deliberations on the Bill, ... some members of the (Portfolio)Committee raised concerns regarding persons, who, knowing that they have the acquired immune deficiency syndrome or the human immuno-deficiency virus, deliberately perform certain acts in order to infect others with the said syndrome or virus.
> The Committee recommends that the Minister of Justice be requested to direct that -
> (a) the criminalising of acts by persons with the acquired immune deficiency syndrome or the human immuno-deficiency virus who deliberately or negligently infect others with the said virus; and
> (b) in view of the fact that persons who may have been infected with the human immuno-deficiency virus, may only show symptoms of such infection after a protracted period of time, and in order to give victims of offences committed by persons who have the said syndrome or virus peace of mind, the possibility that persons who may have infected others, especially in the case of those who have been charged with committing sexual offences, be subjected to an obligatory test in order to determine whether or not they have the acquired immune deficiency syndrome or the human immuno-deficiency virus,
> be investigated with a view to the submission to Parliament of legislation, if any, at the earliest opportunity...

2.4 In view of the fact that the issue raised by the Portfolio Committee already forms part of the Commission's current broad investigation into Aspects of the Law relating to AIDS, the project committee at its first subsequent meeting resolved to turn its urgent attention

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23 The Justice Portfolio Committee's request follows on resolutions taken at the ANC's 50th National Conference in Mafikeng on 16-20 December 1997. The resolutions included the following: Shifting emphasis in the criminal justice system to a more victim orientated approach to ensure and restore a more equitable balance between the rights of accused or convicted persons and those of victims; humanising victims' interaction with the criminal justice system - especially in the instance of violence against women and children; further concretising the declaration by government of violence against women and children as a priority crime through the allocation of appropriate resources and practical mechanisms; supporting and endorsing the approach adopted in recent bail and sentencing legislation passed by Parliament (Acts 85 and 105 of 1997) (cf par 3.3 below) but also continuously maintaining and improving the implementation of such mechanisms (Internet www.anc.org.za/ancdocs/history/conf/coference50/resolutions6.html#Justice accessed 19/6/98).

to this matter. The Justice Portfolio Committee was informed accordingly.[24]

*** The Commission's approach in dealing with the Portfolio Committee's request**

2.5 The project committee, in determining the most appropriate way of dealing with the above request, decided to deal incrementally with the issues in question. This entails that two discussion papers will be prepared as a basis for the Commission's consultative process. The first paper (i e the current paper) will address the issue of harmful behaviour[25] by persons with HIV/AIDS, the administrative and criminal law measures available to address such behaviour, and the need for statutory intervention. The second will deal with the question of HIV testing of sexual offenders and persons accused of having committed sexual offences.

2.6 The reason for the incremental approach is primarily the following: First, the portfolio committee indicated that the possibility of testing of sexual offenders should be investigated from the point of view of obtaining and disclosing HIV test results for victims' peace of mind - not for evidentiary purposes. A common link as regards the role of the criminal law could therefore not be found. Second, positive comment on the need for a specially enacted criminal offence would influence any discussion on the need for HIV testing of sexual offenders or persons accused of committing such offences since it may well be a corollary of creating a statutory offence that compulsory HIV testing of suspects would have to be advocated. It therefore seemed to be more meaningful to deal with the issue of harmful behaviour first, though it may well prove to be possible to deal with the two issues together in a report with final recommendations. Finally, to ensure

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24 The Project committee met on 14 March 1998 and resolved that the Portfolio Committee's request should receive urgent attention, including a re-evaluation of the conclusion reached by the then Commission in 1995, focussing on recent developments regarding HIV transmission offences in Zimbabwe, Australia and the United Kingdom. In a letter dated 30 March 1998 Adv De Lange was accordingly informed that the Project committee was at the time still engaged in the finalisation of its Second and Third Interim Reports for submission to the Commission in April 1998. (In 1995 the then Commission in its Working Paper 58 came to the preliminary conclusion that the criminal law is not pre-eminently the means by which to combat the spread of HIV [**SALC Working Paper 58** par 4.43; for more detail see par 2.7 et seq below]).

25 See par 5.2.1below.

that both issues are thoroughly dealt with, and to ensure that the public is provided with an opportunity of commenting independently on two complex issues, it was decided to produce two different discussion papers.

B) PREVIOUS WORK DONE BY THE COMMISSION WITH REGARD TO COERCIVE MEASURES AGAINST HIV/AIDS: WORKING PAPER 58, 1995

2.7 The Commission in its Working Paper 58 (published for comment in 1995) *inter alia* considered the role of the State in respect of HIV/AIDS. In this context it investigated the desirability of the application of coercive administrative and criminal law measures against the spread of the disease.[26]

* Administrative law measures

2.8 The Commission stated that isolation and quarantining[27] are existing administrative law measures that could be invoked in terms of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 (the 1987 Regulations) promulgated in terms of the Health Act 63 of 1977.[28] The Commission (in considering isolation and quarantine as generally applicable measures), noted that the isolation of a few recalcitrant individuals will not substantially combat the spread of HIV and will have little influence if other individuals continue to pursue high risk sexual behaviour in private; that the , should, in an event not interfere in voluntary sexual acts

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26 **SALC Working Paper 58** par 4.1-4.46.

27 Isolation and quarantine are methods that were traditionally used to combat the spread of communicable diseases. Isolation is a measure applied to isolate ill persons in order to treat them, and to prevent them from spreading the disease concerned; while quarantining is used to restrict the freedom of movement of healthy persons who have been exposed to a disease, but who do not yet show signs of infection in order to prevent the spread of the disease (Van Wyk 444-445; cf also Jarvis et al 285-289). These measures are rarely used nowadays to combat disease, not only because of improved social circumstances and medicines, but also because of their enormous infringement of individual rights (Van Wyk 444-445; cf also Cameron and Swanson 1992 **SAJHR** 215-216).

28 Reg 2(1)(d), 3(1) and (2), 4(1) and (2), 14(3) and 17 of GN R 2438 in **GG** 11014 of 30 October 1987. The specific measures are discussed in more detail in par 4.9-4.15 below.

between consenting adults; that insolation could discourage voluntary testing; that it may create the potential for arbitrary and discriminatory separation; and that it drastically infringes certain fundamental rights.[29] The Commission however acknowledged that some countries allow for isolation and quarantine based on behaviour,[30] but came to the preliminary conclusion that the extremely slight advantage which isolation may hold for public health, is disproportionate to the infringement of individual rights which isolation, even if based on behaviour, may entail.[31]

2.9 Commentators responding to Working Paper 58 between October 1995 and February 1996 were divided on this issue. Several of them (including the Department of Health), supported the preliminary recommendation. However, the medical profession and certain community health organisations indicated that grounds may exist for isolation based on behaviour where deliberate and repeated endeavours are made by an individual to spread infection. In this regard it was suggested that the mere fact that powers to isolate, exist, may succeed in acting as a deterrent.[32]

*** Criminal law measures**

2.10 The Commission stated that the would be able to institute criminal prosecutions under existing (common law) offences against persons who have HIV in order to prevent them (and to punish them if they did not restrain themselves) from deliberately or negligently transmitting HIV that may eventually cause (or did cause) the death of other persons. Murder, attempted murder, culpable homicide, assault and *crimen iniuria* are the relevant

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29 **SALC Working Paper 58** par 4.6-4.9.

30 Eg several s in the United States adopted legislation to provide for the quarantining or isolation of persons with HIV who persist in behaviour which would probably lead to HIV transmission (**SALC Working Paper 58** par 4.8).

31 Ibid par 4.9 of **Working Paper 58**. Isolation and quarantine are measures aimed at the prevention of the spread of disease (HIV/AIDS in this instance) and not primarily at the punishment or deterrence of harmful behaviour (cf also par5.1-5.5 below on the objects of the criminal law).

32 See eg the comments of the Medical Association of South Africa and the Durban Medical Officer of Health.

offences mentioned in this regard.[33] It was noted at the time that, as far as could be ascertained, no criminal prosecution for transmitting HIV had as yet been instituted in South Africa for transmitting HIV.[34] The Commission however emphasised that the application of these offences may, for reasons inherent to HIV/AIDS, be problematic: Persons with HIV are often oblivious of their infection because of the long "latent" phase; HIV may well be transmitted to healthy persons during this phase; and there is seldom any direct manifestation of infection after transmission of HIV. It may therefore be difficult to establish who was responsible for transmitting the infection. Consequently it would be difficult to establish a causal connection between conduct and its consequence in order to identify a specific guilty party and to prove a completed common law offence; and furthermore in the case of a prosecution based on attempt,[35] to prove intent, be it in the form of *dolus eventualis, dolus directus* or *dolus indirectus.*[36]

2.11 The Commission at the time acknowledged that a solution may lie in creating a new criminal law sanction or public health offence for transmitting HIV.[37] It referred to the fact that several States in the United States of America (United States) introduced legislation along these lines, but emphasised that there seemed to be no consensus on its effectiveness.[38]

2.11.1 Arguments listed in favour of creating a statutory offence concentrated on the community danger created by HIV/AIDS; on the fact that such an offence could be construed as a no-fault statutory offence in regard to which liability could be excluded or reduced in cases where protective measures were taken during sexual intercourse, or where the sexual partner was aware of the infection; and on the possibility of a statutory offence being narrowly drafted to address only specific

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33 Ibid par 4.41.

34 Ibid par 4.40.

35 Ibid.

36 Ibid par 4.42.

37 Ibid.

38 Ibid.

conduct and to have maximum deterrent value.

2.11.2 On the other hand, it was pointed out that there may be substantive disadvantages in creating a statutory offence: Specific offences aimed at HIV-related behaviour in practice apparently do not contribute significantly to reducing the spread of HIV/AIDS; criminalisation of private, consensual sexual acts between adults has traditionally not been effective; a statutory offence would give rise to privacy infringements; the same problems of proof existing in respect of common law offences would also apply to a statutory offence; and there was concern that a statutory offence would be selectively applied to groups in respect of which perceptions exist that they spread HIV.

2.12 Although the Commission noted that the criminal law clearly has a role to play in protecting the community in instances where HIV is deliberately transmitted or its transmission is attempted,[39] it at the time came to the preliminary conclusion that the criminal law is not pre-eminently the means by which to combat the spread of HIV. The Commission was therefore not in favour of the creation of a statutory offence aimed specifically at HIV-related behaviour. The main reason given for this conclusion was expressed as follows:

> (C)onduct by persons with HIV which merits punishment remains punishable under the existing offences. Prosecutions under a new offence would ... once again amount to the 'prosecuting of bedroom offences' with all its known disadvantages. The creation of a special offence would probably further stigmatise persons with HIV and possibly also lead to the epidemic being driven underground with an eventual negative effect on the preventive programmes of the health authorities.[40]

2.13 Fifteen of the 47 commentators responding to Working Paper 58 commented on this preliminary recommendation. Of these, the majority agreed with the Commission's preliminary conclusion referred to in the previous paragraph.[41]

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39 Ibid par 4.43-4.44.

40 Ibid par 4.45.

41 *Comment favouring the Commission's conclusion:*
The City of Cape Town Medical Officer of Health, the Chamber of Mines of South Africa, and the Dutch Reformed Church without more supported the preliminary recommendation.

Business South Africa supported the view that no specific offences aimed at HIV-related behaviour should be created, while SAPPI observed that South African law is sufficiently extensive not to require specified HIV-related offences to be created. NACOSA (Western Sub-province of Eastern Province) was of the opinion that the creation of a special offence would further stigmatise persons with HIV, with possible detrimental consequences to preventive health programmes.

Comment favouring coercive criminal or other measures:

The Ministry of Caring, Dutch Reformed Church Orange Free State expressed itself in favour of creating a specific offence for deliberate transmission where the perpetrator withheld the fact that he or she has HIV from sexual partners. The Ministry felt that the Commission's recommendation prioritised the rights of persons with HIV. AM Bluhm (private citizen) was of the view that legislation should unequivocally provide for criminal liability in the case of deliberate or negligent transmission of HIV - also for appropriate penalties in such cases. The City Medical Officer of Durban believed that grounds exist for isolation based on behaviour where deliberate and repeated endeavours are made by an individual to spread HIV. The Medical Officer believed that the mere fact that such power exists may succeed in acting as a deterrent.

Other relevant comment:

The South African Medical and Dental Council, although not expressly addressing the question of criminalisation of HIV transmission, in general expressed the opinion that little recognition was given to the fact that persons with HIV also had specific responsibilities to prevent the spread of infection to others. The ALN and the Department of Health, although agreeing with the sentiments expressed by the Commission, stated that the Commission should have referred to the other criminal law issues which the respondents believed to be of particular importance. These include HIV/AIDS as a mitigating and aggravating factor in sentencing; HIV testing of a person charged with rape; and confidentiality within the criminal justice system. The City Medical Officer of Bloemfontein also requested that clear guidelines be issued regarding HIV testing of rape victims and rapists - emphasising that this was not dealt with in the Working Paper.

C) WHAT IS HIV/AIDS?[42]

2.14 AIDS is the acronym for "acquired immune deficiency syndrome". It is the clinical definition given to the onset of certain life-threatening infections in persons whose immune systems have ceased to function properly as a result of infection with HIV.[43] The condition is *acquired* in the sense that it is not hereditary - it is generally accepted that it is caused by the human immunodeficiency virus (HIV) which invades the body from outside. The genetic material of HIV becomes a permanent part of the DNA[44] (the genetic material of all living cells and certain viruses) of the infected individual with the result that this person becomes a carrier of HIV for the rest of his or her life (and can therefore infect other individuals). Moreover, HIV is unique in the sense that it attacks and may ultimately destroy the body's *immune* system. Due to this *deficient* immune system the body's natural defence mechanism cannot offer any resistance against illnesses, even those that normally do not involve an extraordinary danger to healthy people. *Syndrome* implies a group of specific symptoms that occur together and that are characteristic of a particular pathological condition. AIDS is described as a syndrome precisely because it does not manifest itself as one disease. It is rather a collection of several conditions that occur as a result of damage which the virus causes to the immune system. Persons thus do not die of AIDS as such. They die of one or more diseases or infections (such as pneumonia, tuberculosis or certain cancers) that are described as "opportunistic" because they attack the body when immunity is low. AIDS can therefore

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42 Virtually every source consulted for the purposes of this investigation presents the medical and empirical facts (as known at the time) with regard to AIDS - some more comprehensively than others. For purposes of this document a relatively simple and synoptic description of HIV/AIDS is presented. South African sources consulted in this regard include the following: Arendse 1991 **ILJ** 218-219; De Jager 1991 **TSAR** 212-216; FitzSimons **Facing up to AIDS** 13-33; Swanevelder **Epi Comments** May 1992 80-92; Van Dyk 1-22; Van Wyk 1-80; Whiteside **Facing up to AIDS** 3-12; Evian 5-7, 11-17, 23-29, 35-37, 66, 81-83, 92-94; Lachman 131-132, 156-157, 173-175, 181-183, 187-188, 190-191, 194-199, 313. Foreign sources consulted on the medical background of AIDS include: **Australia Report on Privacy and HIV/AIDS** 9-12; Brett-Smith and Friedland in **AIDS Law Today** 18-45; Jarvis et al 5-26; Krim **AIDS an Epidemic of Ethical Puzzles** 15-20; Carr **AIDS in Australia** 2-23; Crofts **AIDS in Australia** 24-32; **AMFAR AIDS/HIV Treatment Directory** June 1996 94-137.

43 For a complete discussion of medical aspects of HIV and AIDS, see **AMFAR AIDS/HIV Treatment Directory** June 1996 94-137.

44 DNA is the abbreviation for "deoxyribonucleic acid". It refers to the molecular chain found in genes within the nucleus of each cell, which carries the genetic information that enables cells to reproduce (**CDC PATHFINDER** May 1997 [CDC Clearinghouse]).

be defined as a syndrome of opportunistic diseases, infections and certain cancers that eventually cause a person's death.

2.15 Infection of a person with HIV does not necessarily entail that a person is sick. However, such person is infectious and may transfer the virus to other people. A person with HIV infection can remain otherwise healthy and without symptoms for a number of years. He or she can live without notice of infection. HIV infection during this period is called asymptomatic infection.[45] During asymptomatic infection a person is capable of performing all of his or her daily activities, and can thus lead a full and productive life.[46] At this stage the person does not have AIDS. A person has AIDS only when he or she becomes ill as a result of one or more opportunistic illnesses. AIDS is the final clinical stage of HIV infection.[47]

* **Transmission of HIV**[48]

2.16 As soon as a person is infected with HIV he or she is able to transmit the infection to other people irrespective of whether he or she shows any symptoms of the disease. However, HIV is not easily transmitted (in contrast with many other serious diseases such as certain sexually transmitted diseases and certain other viral infections[49]).

2.17 HIV has been identified in blood, semen, vaginal and cervical discharge, breast milk, the brain, bone-marrow, cerebrospinal fluid, urine, tears, foetal material and saliva. However, current scientific knowledge indicates that only blood, semen, vaginal and cervical

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45 Ibid.

46 See also par 2.24 and 2.27 below.

47 Although some scientists apparently no longer wish to differentiate between persons with HIV and those with AIDS (Cf Van Wyk 25), this differentiation is nevertheless maintained in the majority of sources consulted and is explicitly accepted in Canada and Australia where recommendations for law reform were made in 1992 (**Ontario Report** 6-7; **Australia Report on Privacy and HIV/AIDS** 9).

48 See the sources referred to in fn 42 above.

49 Eg hepatitis B (Van Dyk 22).

discharge and breast milk contain a sufficient concentration of the virus to be able to transmit HIV. Transmission can occur only through specific and limited routes.

2.18 At present no scientific evidence exists that HIV can be transmitted in any other mode than the following:[50]

- By hetero- or homosexual intercourse.
- By receipt of or exposure to the blood, blood products,[51] semen, tissues or organs of a person who is infected with HIV. This can occur *inter alia* by the use of dirty or used syringes and/or needles for intravenous drugs.[52]
- By a mother with HIV to her foetus before or during birth, or to her baby after birth by means of breast-feeding (also called perinatal transmission).

2.19 To infect a person, HIV must reach the blood stream or lymphatic system. HIV may possibly be transmitted via mucous membranes.[53] The virus cannot be spread by other forms of personal contact than those described above. Outside the human body and especially outside body fluids, HIV has an extremely limited life span of a few seconds only.[54] The virus is also destroyed by disinfectant.[55]

2.20 There is thus no risk of HIV transmission from casual contact. HIV cannot be transmitted by daily social contact such as breathing, coughing, shaking hands or hugging. It cannot

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50 See also par 2.39 et seq below where the risk of HIV transmission in the criminal context is discussed.

51 In comment on **SALC Discussion Paper 73**, the Department of Health pointed out that this mode of transmission is extremely rare and that "blood transfusion in South Africa is as safe as it could possibly be". The Department also pointed out that Factor XII (a blood product supplied to people with bleeding disorders) is sterilised through heat treatment.

52 Intravenous drug users inject drugs directly into their blood stream. To ensure that the needle has struck a vein, they usually draw blood into the syringe before the drug is injected (without removing the needle). Thus a small amount of blood always remains in the needle and/or syringe and is consequently injected directly into the bloodstream of the next injector (Van Dyk 18). See also par 2.45 below.

53 Recently a case was reported in the US of HIV transmission as a possible result of deep kissing. Both the man and the woman involved however had mouth lesions and blood stained saliva (CDC **Morbidity and Mortality Weekly Report** 11 July 1997 620 et seq).

54 Researchers say HIV can stay alive only from 20 to 60 seconds outside body fluids (Van Dyk 19); CDC **Morbidity and Mortality Weekly Report** 12 July 1991 5, 7.

55 Van Dyk 29-30; **Transvaler** 21 July 1992; **The Star** 22 July 1992.

be transmitted through food preparation, by toilet seats, or by sharing food, water or utensils. Even if blood contact did take place, the chances of being infected are small. (The incidence of infection, for instance, among health care workers who received injuries from needle sticks and other sharp objects contaminated with blood known to be HIV infected, is calculated to be approximately 3 in 1 000.[56] Where the status of the blood was not established, but surgical procedures were prone to expose a person to blood, the risk of infection was considered to be at most 1 in 42 000.[57])

2.21 Not every person exposed to HIV becomes infected. Similarly, it is possible that not every person who is infected with HIV eventually develops AIDS. Scientists are as yet uncertain of the precise position.[58] There is apparently reasonable consensus that 45-50% of infected persons will develop AIDS after 10 years, but it has also been estimated that between 65-100% of infected persons are likely to develop the disease within 16 years.[59]

* Course of AIDS[60]

2.22 The course of HIV infection is generally divided into four different stages: the initial phase; the asymptomatic phase; the symptomatic phase (during which less serious opportunistic diseases occur); and the severe symptomatic phase, during which the

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56 Tereskerz et al 1996 **New England Journal of Medicine** 1150-1153 (as quoted in **AIDSScan** March 1997 9). In a similar study the risk of HIV infection after percutaneous exposure in the work place (i e exposure resulting from needle stick injury) to HIV-infected blood was concluded to be 0,36% (**AIDSScan** March 1994 6).

57 **Doe v University of Maryland Medical System Corporation** 50 F 3d 1261 (1995).

58 One study went as far as to suggest that 20% of infected individuals could remain symptom-free for at least 25 years. Only observation over time will provide meaningful percentages (**AIDSScan** March/April 1996 6).

59 Keir **AIDS Analysis Africa** December 1990/January 1991 9; Krim **AIDS an Epidemic of Ethical Puzzles** 19; Carr **AIDS in Australia** 7. Cf also par 2.27 below where it is indicated that the average period of time in Africa from infection with HIV until the development of full-blown AIDS is generally accepted to be less than 10 years.

60 See the sources referred to in fn 42 above.

patient has full-blown or clinical AIDS.[61]

+ ***Initial phase: Preceding seroconversion***

2.23 The initial phase begins very shortly after a person has been infected with HIV. Symptoms that present are similar to those of influenza (fever, night sweats, headaches, muscular pain, skin rashes and swollen glands). This phase continues until seroconversion occurs (when antibodies develop in the person's blood in an ineffective attempt to protect the body against HIV). Seroconversion takes place on average six to twelve weeks after exposure (in exceptional cases even later). This period between infection and seroconversion is known as the "window period". Blood tests[62] in general use to determine whether a person has been infected with HIV do not trace HIV itself, but react to the presence of antibodies. The fact that antibodies are formed only after a lapse of time entails that blood tests conducted during the window period may deliver false negative (seronegative) results. Where antibodies have not yet developed, the blood test for antibodies will be negative in spite of infection. During the window period an infected person can transmit HIV but will not test positive for the virus.

+ ***Asymptomatic phase: Latent or "silent" infection***

2.24 During this phase the person is infected with HIV; antibodies have already developed and will be indicated by antibody tests from this stage onwards; but he or she shows no symptoms of illness. However, the body's resistance and immune response are slowly being impaired. This second phase can continue for many years while the infected person remains otherwise healthy. In this phase infected persons are often not aware that they have HIV; they can therefore unknowingly transmit the virus to others.

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61 Evian 25-29; cf also the WHO Staging System for HIV Infection and Disease, and the CDC (USA) case definition of AIDS (**Morbidity and Mortality Weekly Report** 1997 46 5-6; Evian 92-94; Lachman 173-175).

62 For more detail see par 2.29 et seq below.

+ ***Symptomatic phase: HIV-related disease***

2.25 This phase also can continue for several years. As the immune system continues to deteriorate and the person with HIV becomes more immune-deficient, symptoms of the opportunistic diseases that cause death in the next (severe symptomatic) phase now occur. These include swelling of the lymph glands in the neck, groin and armpits as well as drastic loss of body weight, skin rashes and bacterial skin infections, and persistent diarrhoea.

+ ***Severe symptomatic phase: Clinical AIDS***

2.26 Only during the severe symptomatic phase can a person be said to have AIDS. As a result of the compromised immunological response because of the HIV infection, a person during this stage is prone to infections by organisms that normally are present but do not cause disease in otherwise healthy and uninfected persons. This type of infection is referred to as opportunistic infection. In this phase such a person's body is no longer capable of withstanding opportunistic diseases, the symptoms of which were observed in the preceding phase. Unless effectively treated the person may no longer be able to work productively. He or she usually dies within two years as a result of these diseases.

2.26.1 Diseases that generally occur are pneumonia, tuberculosis and Kaposi's sarcoma (a rare type of skin cancer). Neurological and psychiatric disorders (known as AIDS dementia) may also occur in this final phase (and in rare cases may occur also earlier).[63] Symptomatic presentation differs from continent to continent. The most important opportunistic diseases in Africa are tuberculosis and chronic diarrhoea. A form of pneumonia (caused by Pneumocystis carinii [PCP]) is responsible for the majority of deaths among persons with AIDS in Europe and

63 **AMFAR AIDS/HIV Treatment Directory** June 1996 135-138.

North America.[64] The disease conditions from which people with AIDS suffer are generally not transmissible. Persons with AIDS usually pose no threat of infecting others with opportunistic diseases (as opposed to the transmission of HIV itself). A notable exception is untreated tuberculosis. Tuberculosis is transmissible in itself.[65] It is thus important that patients with pulmonary tuberculosis be on treatment so as not to expose others to active disease.[66]

2.27 The course of HIV infection varies from person to person. The period before seroconversion can last on average from six to twelve weeks. The average duration in Africa of the asymptomatic phase is estimated to be seven years, and it is generally accepted that the average period of time from infection with HIV until full-blown AIDS develops is less than 10 years. The final phase lasts on average from one to two years. However, the life expectancy of persons with HIV differs according to their general state of health, their living conditions, available health services and treatment, and the opportunistic disease in question. Although the course of the disease follows the same overall pattern in developed and developing countries, the period between becoming infected and death is much shorter in the latter. This can probably be ascribed to the prevalence of endemic diseases (for instance tuberculosis) and to a lack of adequate medical treatment.[67] In South Africa, severe poverty and malnutrition could possibly be included as reasons why patients with HIV have a shortened life expectancy.[68]

2.28 Not all persons with HIV go through all four phases. Some do not even show symptoms before they develop clinical AIDS (the final phase). During periods of symptomatic infection, a person with HIV may be able to live and work actively, but may experience fatigue or brief periods of illness.[69]

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64 Hawkes and McAdam 1993 **Medicine International** 70-71.

65 Lachman 202. Cf **AMFAR AIDS/HIV Treatment Directory** June 1996 97-134.

66 Comment on **SALC Discussion Paper 72** by the City of Cape Town Health Department.

67 Ibid; Carr **AIDS in Australia** 8.

68 Comment on **SALC Discussion Paper 72** by the City of Cape Town Health Department.

69 Evian 1991 16.

* Testing for HIV[70]

2.29 The most general manner in which it can currently be determined whether a person is infected with HIV is by blood tests for the presence of antibodies to HIV. Although available, blood tests to detect HIV itself (in contradistinction to the test for antibodies) are not at present generally used in the public sector.[71]

2.30 The blood tests that have been used throughout the world since 1985 to detect the presence of HIV antibodies are the enzyme-linked immunosorbent assay (ELISA) and the Western Blot (WB) tests.[72] The ELISA test for HIV antibodies is very sensitive and reacts beyond the window period positively to nearly any infection. Because of its high sensitivity, a single test can deliver a false positive result. For this reason it is necessary to carry out a second, more specific, test to confirm HIV positivity. It is also advisable to perform the tests on a second, different, blood specimen. The WB test, which is such a more specific test, is traditionally used to confirm an initial positive test. However, the WB is expensive[73] and can therefore not always be used in practice. Different types of ELISA tests with a higher degree of specificity have consequently been developed and the World Health Organisation (WHO) has compiled guidelines which indicate the circumstances under which multiple (different types of) ELISA tests will suffice in order to establish HIV infection.[74] South Africa has accepted the WHO recommendations to

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70 See the sources referred to in fn 42 above. See also Levine and Bayer in **AIDS an Epidemic of Ethical Puzzles** 21-22.

71 See par 2.31 below.

72 Chavey et al 1994 **Journal of Family Practice** 249 et seq.

73 The cost of a WB test is approximately R276 to R751; the cost of an ELISA test carried out by a private body varies from R74 to R203 (information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997).

74 According to the WHO guidelines the prevalence of HIV in the population to which the person belongs on whom the blood test is performed, is decisive. The scientific premise is that the higher the prevalence of HIV infection, the greater the probability that a person who in the first instance tests positive, is truly infected (cf Fleming and Martin 1993 **SAMJ** 685-687). UNAIDS and the WHO recently indicated that studies have shown that combinations of ELISA and rapid assays (such as dot immuno assays and

diagnose HIV infection with at least two positive ELISA test results.[75]

2.30.1 The result of a blood test to detect HIV antibodies is potentially available to the patient within approximately 24 to 48 hours after the blood sample is taken.[76]

2.30.2 Currently a positive HIV antibody test generally means that the person concerned is infected with HIV, will remain infected for life, and can infect other persons. The ELISA and WB tests do not indicate the stage of infection which the person tested has reached.[77] A negative HIV antibody test means that no antibodies to HIV have been traced in the blood of the person concerned. This could mean that the person is not infected. But it could mean merely that antibodies to the virus have not yet developed[78] and thus he or she is infected but is in the window period. To obtain a reliable result such a person will after a period of time have to be tested for HIV again.[79]

2.30.3 It is alleged that where the standard test procedure (an ELISA test followed by one or more confirmatory tests) is followed, a correct result will be obtained in more than 99% of HIV infections.[80]

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agglutination tests) can provide results as reliable as, and in some instances more reliable than, the ELISA/Western Blot combination, and at a much lower cost. UNAIDS and the WHO therefore recommended that countries consider testing strategies utilising the ELISA/rapid assay combination (**WHO Weekly Epidemiological Record** 21 March 1997[Internet]). See par 2.32 below for more information on rapid testing.

75 Fleming and Martin 1993 **SAMJ** 685-687.

76 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997. See also Gostin 1991 **AMJLM** 110.

77 Viral load testing has become a marker for disease progression in persons with HIV/AIDS (see par 2.31 and fn 91 below). The administration of certain vaccines may trigger the development of HIV antibodies without the person becoming infectious (cf fn 131 below).

78 Banta 5.

79 A very small percentage of infected people never develop antibodies to HIV and will therefore repeatedly show false negative tests (Van Dyk 13).

80 **Australia Report on Privacy and HIV/AIDS** 11; Van Dyk 12; **CDC PATHFINDER** May 1997 (CDC Clearinghouse).

2.30.4 Although the standard ELISA and WB tests demonstrate sufficient reliability for diagnostic purposes, utilising blood and handling specimens carry significant risk of HIV transmission.[81] This risk has recently led to the investigation of other fluids, including oral fluid (saliva[82]) and urine, for HIV antibody tests.[83] The saliva and urine tests use the same technique as the standard ELISA and Western Blot tests, are subject to the same window period as the standard tests, and are similar in accuracy to the standard tests.[84]

2.30.5 The same blood tests to detect the antibodies to HIV in adults, are generally used in respect of children.[85]

2.31 New tests are available that test for HIV itself, rather than antibodies to the virus.[86] These may shorten the period of uncertainty about actual infection to about 16 days.[87] The polimerase chain reaction technique (internationally known as the PCR), which detects the virus itself in the blood, is also available. It is however, complicated and difficult to execute and is thus performed only in specialised or reference laboratories.[88] PCR may

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81 Risks inherent in specimen collecting and handling (needle-stick injury and test tube breakage) exist for health care workers. Tests not using blood as specimen would also be more suitable for haemophiliacs or people on medications that affect bleeding (Emmons 1997 **The American Journal of Medicine** 15-16; Sowadksy "HIV Antibody Tests - Now You Have Several Choices" **The Body** [Internet]).

82 Although "saliva" is the general term used for oral fluid, the oral sample being collected for the HIV antibody test is known as "mucosal transudate" which comes from the cheeks and gums (**CDC PATHFINDER** May 1997 [CDC Clearinghouse]; Emmons 1997 **The American Journal of Medicine** 15-16).

83 Emmons 1997 **The American Journal of Medicine** 15 et seq.

84 Sowadsky "Urine HIV Antibody Tests" **The Body** (Internet); Sowadsky "The New Saliva HIV Tests" **The Body** (Internet); **CDC PATHFINDER** May 1997 (CDC Clearinghouse); Emmons 1997 **The American Journal of Medicine** 17.

85 It has been pointed out that the new saliva antibody test could also carry advantages in respect of HIV testing of children since oral fluid should be much easier to collect than venous blood (Emmons 1997 **The American Journal of Medicine** 16).

86 Orthmann **Law and Policy Reporter** April 1996 55.

87 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997.

88 Information supplied by Prof A Heyns of the S A Blood Transfusion Service on 27 October 1997; see also van Dyk 12; Crofts **AIDS in Australia** 26-27. The cost of a PCR test ranges from R150-R200 (information supplied by Prof A Smith, Department of Virology, Medical School, University of

further reduce the period of uncertainty about actual infection to 11 days.[89] In addition, some of these tests (for instance viral load tests[90]) may more accurately predict future health status by measuring the amount of virus in the blood of people with HIV.[91] However, because of their cost they are not yet recommended for general use.[92]

2.32 Research on the effectivity of a "rapid" HIV test, which would cost only R50, is currently being done in South Africa.[93] Rapid testing in general refers to HIV antibody testing, using blood as specimen,[94] and which usually can be performed more quickly (within five to 30 minutes) than the standard ELISA test.[95] Rapid testing do not shorten the window period.[96] Many of the rapid tests can be done without the need for a formal laboratory; are relatively easy to use; are cheaper than standard laboratory tests; can usually be operated and read by non-laboratory personnel; and some are even being marketed to the

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Natal/Durban on 27 July 1998).

89 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997.

90 Viral load testing is the direct measurement of the amount of HIV in the blood of people with HIV infection. It is currently regarded as the best marker for the progression of HIV disease and is becoming a standard of HIV treatment monitoring. Studies have eg determined that patients who have higher virus loads will progress more quickly to AIDS than persons with lower virus loads. Viral load testing is not used for initial diagnosis of HIV infection. The City of Cape Town Health Department in its comment on **SALC Discussion Paper 72** pointed out that viral load testing is extensively used for private patient management and for monitoring of patients in drug treatment trials. On the above, see **CDC PATHFINDER** May 1997 (CDC Clearinghouse); **Toronto Hospital Immunodeficiency Clinic Newsletter** September 1996 (Internet); **HIV-Infogram** 20 September 1996 (Internet); and par 2.35-2.35.1 and fn 113 below on the significance of viral load testing in administering new combination drug treatments for HIV infection.

91 Saag et al 1996 **National Medicine** 625-629.

92 Colebunders and Ndumbe 1993 **The Lancet** 601; Chavey et al 1994 **Journal of Family Practice** 249. But see also Volberding 1996 **The Lancet** 71-73.

93 **Beeld** 26 August 1998; see also Department of Health Discussion Document "Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations" August 1998 1-3.

94 Several rapid tests are however currently being developed, including one for use with oral fluids (**CDC Update** March 1998 [Internet]). (See fn 85 above.)

95 Department of Health Discussion Document "Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations" August 1998 2; **CDC Update** March 1998 (Internet); CDC **Morbidity and Mortality Weekly Report** 27 March 1998 (JAMA NEWSLINE).

96 Sowadksy "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet); Sowadsky "15 Minute Test" **The Body** (Internet). Cf also Department of Health Discussion Document "Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations" August 1998 4.

lay public for "self-testing" purposes.[97] The rapid test under research in South Africa is a simple test which provides the result within minutes of the user pricking his or her finger and mixing the blood with the chemical solutions supplied.[98] Research has already shown that the test results are reliable.[99] South African experts and the Department of Health however strongly discourage indiscriminate use of any rapid HIV test and marketing such tests as "self testing kits". They emphasise that a second confirmatory test (in the form of a laboratory test), should be done in respect of all positive test results.[100] Furthermore, they emphasise that rapid testing should be executed under the supervision of a health care worker to ensure proper counselling.[101] In a recent Discussion Document on regulating rapid HIV testing, the Department recognises that there may be a need for the use of rapid testing in cases of sexual abuse in order to assess the risk of HIV transmission.[102] It is envisaged that the test currently under research will be available by the beginning of 1999 and that it will be of specific value in regions lacking laboratory facilities.[103]

2.33 Another promising area of research is the new tests (commonly referred to as DNA[104]

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97 Ibid; see also CDC **Morbidity and Mortality Weekly Report** 27 March 1998 (JAMA NEWSLINE).

98 **Beeld** 26 August 1998.

99 Ibid. According to the press report the test has been shown to be correct in 99% of cases utilised. In studies conducted outside the United States, specific combinations of two or more different rapid HIV tests have provided results as reliable as those from the ELISA/Western Blot combination. However, only one rapid test, approved by the Food and Drug Administration, is currently commercially available in the United States (CDC **Morbidity and Mortality Weekly Report** 27 March 1998 [JAMA NEWSLINE]; **CDC Update** March 1998 [Internet]).

100 The negative predictive value of rapid tests is such that infection can often be confidently excluded if the test it negative. However they are more likely to miss sero-conversion or late stage HIV infection because they are often less able to detect low levels of antibody. A confirmatory test must therefore be done on all reactive test results (Department of Health Discussion Document "Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations" August 1998 1-3). See also **Beeld** 26 August 1998; CDC **Morbidity and Mortality Weekly Report** 27 March 1998 (Internet).

101 Department of Health Discussion Document "Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations" August 1998 1-3.

102 Ibid 3.

103 **Beeld** 26 August 1998.

104 See fn 44 above.

tests) that aim at determining the full genome sequence of the HIV-1. Through these tests molecular biologists are able to distinguish the different subtypes of HIV as well as to match those that have identical genome sequences. This level of precision will not only help epidemiologists to trace the spread of infections, it will also enable them to state with some degree of certainty the source of infection.[105]

2.33.1 The DNA technique was used in the early 1990s to verify that a Florida, United States dentist with HIV infected six of his patients.[106] To date however, the test is too costly for general use and, depending on the circumstances surrounding transmission, not necessarily conclusive. (A sexual offender could, for instance, after having infected a victim, engaged in high risk activities with other infected persons and as a result of those activities be infected with a different strand of the virus.) However, if scientists eventually develop a DNA matching test that is highly effective, the problem of proving causation in cases involving multiple probable sources of infection will disappear.[107]

* Treatment

2.34 There is at present no cure for HIV infection or AIDS. The best-known drug for the treatment of persons with HIV infection and AIDS, until recently has been zidovudine (AZT).[108] This drug does not cure AIDS, but brings temporary relief for persons with symptomatic HIV infection: AZT delays the increase of HIV in the body, decreases the

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105 Information supplied by Dr J Matjila (Department Community Health) and Prof G Lecatsas (Department of Virology) at the Medical University of South Africa on 21/10/98. See also Salminen et al (Unpublished); McCutchan and Birx (Unpublished); Colella 1995 **The Journal of Legal Medicine** fn 34 on 41.

106 Colella 1995 **The Journal of Legal Medicine** fn 34 on 41, and 97-98.

107 Ibid.

108 Havlir and Richman 1993 **Medicine International** 62; Plummer in **AIDS in Australia** 82; Van Wyk 60-61; Van Dyk 15.

number of opportunistic infections and increases the number of healthy cells.[109]

2.35 Significant progress has however been made in recent years with regard to the successful treatment of HIV infection and associated opportunistic infections. Wider use of medications for preventing tuberculosis and pneumocystis carinii can, for instance, assist in reducing the number of people with HIV who develop these serious illnesses and die prematurely from AIDS.[110] Also, several new compounds in a new class of drugs, called protease inhibitors, have been developed and approved during 1996/97 to treat HIV infection. These drugs, when taken in combination with previously approved drugs for the treatment of HIV infection (such as AZT), may reduce the viral load (i e the level of HIV particles circulant in the blood) of persons with HIV to undetectable levels, thus providing the means of maintaining or restoring immunological function and substantially postponing disease progression and death.[111] Application of these combination treatments may also improve results of prophylaxis for HIV transmission, reducing perinatal transmission and the risk of HIV infection for health care workers or persons exposed to HIV during sexual intercourse or rape.[112]

2.35.1 Studies found that people with the highest viral load had a 13 times greater risk of developing AIDS, and an 18,5 times greater risk of death than people with the lowest viral load.[113] Recent reports indicate that some combination treatments may

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109 Tindall et al in **AIDS in Australia** 218; Van Wyk 60-61; Havlir and Richman 1993 **Medicine International** 63; Penslar in **AIDS an Epidemic of Ethical Puzzles** 174.

110 CDC **Update** June 1998 (CDC Clearinghouse).

111 Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487; Groopman **The New Republic** 12 August 1996; Gyldmark and Tolley in **The Economic and Social Impact of AIDS in Europe** 30-37; CDC **Update** June 1998 (CDC Clearinghouse). Persons with undetectable viral load nevertheless remains positive for HIV antibodies in their blood (cf fn 131 below).

112 Ibid. CDC **Morbidity and Mortality Weekly Report** 15 May 1998. There are however to date no conclusive data on the effectiveness of antiretroviral therapy in preventing HIV transmission after non-occupational exposures (**CDC Update** September 1998).

113 As indicated in par 2.31 above, viral load tests are used to measure the amount of HIV in the blood. Viral load is frequently reported as an absolute number - i e the number of virus copies/ml blood. A result below 5 000-10 000 copies/ml is generally considered a low result, while a result over 5 000-10 000copies/ml is generally considered a high result (King **AIDS Treatment Update** August 1996 (Internet); see also Quinn **The Hopkins HIV Report** 2 September 1996 (Internet); **Toronto Hospital Immunodeficiency Clinic Newsletter** September 1996 (Internet); **HIV-Infogram** 20 September 1996

be so effective that people living with HIV/AIDS may be able to refrain from drug therapy for periods of up to one year without experiencing any rise in viral load.[114]

2.35.2 Although the new combination drug therapies have proved to be more effective than any previously available, their long-term effectiveness and safety are still unknown because they are so new:[115] They reduce the concentration of HIV circulating in the blood of most individuals, but there is no conclusive evidence that the therapies completely eradicate the virus from all parts of the body, nor for how long they will be effective in maintaining reduced levels of HIV in the bloodstream.[116] The drugs do not work for all people with HIV; they require patients to follow complex treatment regimens taking multiple medications several rimes each day; and many people develop serious side effects which prevent them from continuing the prescribed drug regimen.[117] Furthermore, the drugs are extremely expensive and are thus not widely available in developing countries.[118] There is however some hope that HIV and AIDS may eventually, for those who can afford treatment, become manageable in ways similar to diabetes, epilepsy, and heart disease.[119]

(Internet).

114 Dine and Watt 1998 **Web Journal of Current Legal Issues** (Internet).

115 CDC **Update** June 1998 (CDC Clearinghouse). Cf also Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487; Papaevangelou et al in **The Economic and Social Impact of AIDS in Europe** 70.

116 Volberding **AIDS Care** February 1998 (Internet); **TAGline** August/September 1996; **CDC HIV/AIDS Prevention: Facts About Treatment** July 1997. See further par 2.47.1 below.

117 **CDC HIV/AIDS Prevention: Facts About Recent HIV/AIDS Treatment** July 1997 (Internet).

118 **AIDS Action** January-March 1998 11. The current South African cost of a basic retroviral course of a minimum of two drugs, and possibly three, may be between R1 500-R4 000 per month depending on the drugs and how the drugs are acquired - eg by government tender, direct pharmaceutical supply or private sector outlet (information supplied on 27/7/98 by Dr Clive Evian, Consultant to the Directorate HIV/AIDS and STDs in the Department of Health).

119 Cf Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487; Farnham 1994 **Public Health Reports** 312.

D) MEDICO-LEGAL FACTORS REGARDING HIV/AIDS OF SPECIAL RELEVANCE TO THE PRESENT ENQUIRY

2.36 There are specific factors related to the nature of HIV as a disease, its transmission, prevention and treatment which impact on the issue investigated in this paper. These are discussed below.

* Factors relating to the nature of HIV/AIDS

+ *The invisibility of the disease*

2.37 One of the key characteristics of HIV/AIDS of significance in the criminal context, is the invisibility of the disease during the window period and the symptom-free second phase.[120] Although a person with HIV shows no signs of HIV infection during the six to twelve week window period and the symptom-free phase which may last up to seven years, the virus is active in the body of such a person and he or she is able to spread the virus.[121] Considering that a person may not have actual knowledge of or suspect his or her infection (especially during the asymptomatic phase), there may not be any reason for such a person to adapt his or her sexual behaviour. However, this person could pose a source of serious potential harm to the community.

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120 See for detail par 2.23-2.24 above.

121 Ibid. See also Evian 7.

+ ***Being infected with HIV has grave consequences***

2.38 Being infected with HIV may impact on several aspects of a person's life including the ability to find employment,[122] to join a medical aid and insurance fund,[123] and to relate with family, friends and sexual partners.[124] Furthermore, the disease brings with it great psychological and social stress which includes the inevitable fear of the unknown and feelings of helplessness and hopelessness.[125] The most pessimistic view is that without a cure all people with HIV will eventually develop AIDS and die prematurely.

2.38.1 As indicated above,[126] discoveries made during 1996/97 regarding new combination drug treatments, may provide the means of extending the symptom-free second phase and substantially postponing death for persons with HV.[127] These therapies are, however, extremely expensive[128] and may simply not be available in developing countries where over 90% of new HIV infections are

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122 It is expected that the Employment Equity Bill [N60-98] recently passed by Parliament, and the envisaged equality legislation currently being drafted by the Department of Justice and the Human Rights Commission in terms of the Constitution of the Republic of South Africa (Act 108 of 1996) (the 1996 Constitution), will bring relief to persons with HIV in the work place.

123 South African medical aid schemes are however starting to recognise that sound HIVand AIDS management strategies will be more cost-effective in the long run than continuing to ignore the disease. It has recently been suggested by Metropolitan Life that AIDS should be viewed by medical schemes as a chronic disease and that it be approached proactively by using managed-care principles (**The Sunday Independent** 25 October 1998 7).

124 Cf discussion of the leading German case on deliberate HIV infection in fn 343 where it is indicated that the court ruled that an infected victim would be faced with, amongst others, the stress of knowing for the rest of his or her life that he or she now risks infecting someone else with HIV.

125 Cf the reference to **Venter v Nel** in par 2.1.4 below.

126 See par 2.35 above.

127 Cohn 1997 **BMJ** 487-491; **BMJ** [SA Ed] August 1997 487. Cf also Groopman **The New Republic** 12 August 1996; Gyldmark and Tolley **The Economic and Social Impact of AIDS in Europe** 30-37.

128 A basic retroviral course of a minimum of two drugs, and possibly three, may cost between R1 500-R4 000 per month depending on the drugs and how the drugs are acquired (eg by government tender, direct pharmaceutical supply or private sector outlet) (Information supplied on 27/7/98 by Dr Clive Evian, Consultant to the Directorate HIV/AIDS and STDs in the Department of Health).

occurring.[129] Moreover, the long-term effectiveness and safety of these drugs are still unproven.[130] Although treatments for HIV infection have dramatically improved over the past few years, scientists are unsure as to when or whether a cure for HIV/AIDS will be found. Realistically, the chances of finding a cure or vaccine in the near future are small, and the benefits of finding a vaccine to those already infected with HIV are unknown.[131]

* Factors relating to the transmission of HIV

+ *Possible transmission of HIV through sexual intercourse (including rape and sexual assault)*

2.39 The probability of HIV infection from a single unprotected sexual exposure to HIV through a mucosal surface (vagina, rectum, or mouth) may be similar to that from a single occupational percutaneous exposure (i e needle- stick injury).[132] *Theoretically*, experts say that on average the chances of infection from a single exposure are "minimal", whether through unprotected intercourse (1 in 1 000) or occupational percutaneous

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129 Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487.

130 See par 2.35.2 above.

131 Sowadsky "A Few Questions From a Student" **The Body: Answers to Safe Sex and Prevention Questions** (Internet). Ongoing research towards the development of an HIV vaccine has been in progress since the late 1980s. Trials for a safe and effective vaccine on a number of different types of vaccines (more than 20 different types of vaccines have been tested at a Phase I trail level), have taken place in the USA, France, England, Switzerland, Israel, Brazil, Thailand, China and Japan. To date these trials have indicated that most of the candidate vaccines are safe to use in humans and there seems to be a preliminary conclusion that they create a variety of immune responses which may include protection against HIV disease (Mann [unpublished]; information supplied by Dr Margaret Johnston, International AIDS Vaccine Initiative on 2/9/98). In the light of the encouraging developments internationally, South Africa is considering embarking on its own HIV vaccine trials. To date several potential HIV vaccine sites have been identified and preparatory laboratory and field work is being undertaken (Minutes of Department of Health National Meeting on HIV Vaccines 30 July 1998).

132 Denenberg **The Body: GMHC Treatment Issues** Internet 18/6/98.

exposure (3 in 1 000).[133] However, it is apparent that assessing *actual* risk and exposure outside of a health care setting is extremely difficult. It is especially difficult to quantitate the risk of infection with HIV during a single sexual act. This is because the statistical risk would vary from situation to situation and from sex act to sex act depending on the following factors:

° *The nature of the exposure*. Experts hold the view that anal intercourse carries more risk than vaginal intercourse or oral sex since there is a greater likelihood of cuts and abrasions which allow the virus to enter the body more easily.[134] Statistics furthermore show that a woman having unprotected sex with an infected male runs a risk more than double that of an uninfected male having unprotected sex with an infected female.[135] A woman's risk of becoming infected is further increased if she is menstruating or bleeding, or by any pre-existing gynaepathology.

° *The duration of the act*. During prolonged sexual intercourse the victim may be exposed to more of the perpetrator's body fluids, which may result in increasing the average risk of transmission.[136]

° *Whether intercourse was accompanied by physical violence*. Physical violence frequently results in cuts and abrasions. This create risk of exposure to the perpetrator's blood, and provide entry points in the victim's body for the

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133 Dahir **The Body: POZ Gazette** (Internet).

134 Sowadsky "Risk of Transmission Statistics" **The Body** Internet 18/6/98; see also Evian 12; Van Wyk 11. Although few studies have assessed the per-episode risk for HIV infection with specific sexual practices, it is estimated that the probability is highest with unprotected receptive anal intercourse (between 8 and 32 in 1 000). The risk with receptive vaginal intercourse is estimated to be between .5 and 1.5 in 1 000 (cf Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq). Women run a similar risk than men from unprotected receptive anal intercourse - sometimes preferred because it preserves virginity and avoids the risk of pregnancy, this form of sex often tears delicate tissues and affords easy entry to the virus (**Women and AIDS** 3). It follows that anal rape (sexual assault) carries a greater risk of infection than vaginal rape.

135 Kirby 1994 **AIDS Care** 248. Kirby adds that this demonstrates that AIDS is another issue in the contemporary struggle concerning women's rights (Ibid). See also Evian 147. As compared to men, women have a bigger surface area of mucosa exposed during intercourse to their partner's sexual secretions. And semen infected with HIV typically contains a higher concentration of virus than a woman's sexual secretions. Younger women are at even greater biological risk: the physiologically immature cervix and scant vaginal secretions put up less of a barrier to HIV (**Women and AIDS** 3).

136 Evian 147.

perpetrator's body fluids.[137]

° *The presence or absence of other sexually transmitted diseases in both the perpetrator and the victim.* The presence of conditions associated with STDs (eg genital ulcers, sores or inflammatory responses in the genital tract) provide opportunities for HIV to enter the body.[138]

° *The kind of body fluid, and how much of it, the victim was exposed to*. Semen carries a greater concentration of HIV than vaginal fluid, while blood carries a greater concentration of HIV than semen.[139] Studies showed that exposure involving larger volumes of blood exceeds the average risk of HIV transmission.[140]

2.40 *Prima facie*, the risk of infection through a single unprotected sexual exposure appears to be small. However, every single act of unprotected sex presents a risk. Furthermore, although the risk may be small, the consequences of infection are grave. If sexual intercourse is non-consensual, violent or abusive, there may also be an increased risk of transmission due to the inability of the victim to control the perpetrator's behaviour in any way.[141] Gang rape and instances where a woman is repeatedly raped by one assailant pose a statistically higher risk of infection.[142] The risk of infection through sexual intercourse can indeed be diminished (albeit not completely excluded) by condom use -

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137 **Women and AIDS** 3.

138 Numerous studies on risk factors for HIV transmission have found an association with a history of other STDs - some of which indicated that the presence of an untreated STD could multiply the risk of HIV transmission by up to 10-fold (**Women and AIDS** 3. See also Lachman 8; Evian 12; Rees [Unpublished] 4). It is said that 50%-80% of STD cases in women go unrecognised because the sores or other signs are absent or hard to see and because women, if they are monogamous, do not suspect they are at risk (**Women and AIDS** 3).

139 **Women and AIDS** 3.

140 With regard to occupational exposure due to needle-stick injuries, it has been found that exposures involving a larger volume of blood, particularly when the source patient's viral load is probably high, exceeds the average transmission risk of 3 in 1 000 (**Morbidity and Mortality Weekly Report** 15 May 1998 4). See also Sowadsky "Risk of Transmission Statistics" **The Body** Internet 18/6/98; Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq.

141 Cf the increased risk factors outlined in the par 2.39 above.

142 Rees (Unpublished) 4; Martin (Unpublished).

however it is unlikely that a condom would be utilised during a non-consensual sexual act such as rape or other sexual assault.[143]

+ *Possible transmission of HIV through behaviour other than sexual intercourse*

2.41 Although this paper primarily focusses on the sexual transmission of HIV in a criminal context, it does recognise that such activity may be accompanied by other HIV-related risk behaviour such as biting, spitting, fighting and drug abuse. In addressing the issue whether HIV may be transmitted through such behaviour, experts emphasise the following:

- The victim must have been exposed to semen, vaginal secretions, blood, or breast milk of a person with HIV;
- the virus must get directly into the bloodstream of the victim (which, apart from intercourse could be through some fresh cut, open sore, abrasion, or the victim's eyes, nose or mouth); *and*
- transmission of blood or body fluids from the perpetrator with HIV to the victim must take place within minutes of leaving the perpetrator's body since HIV does not survive more than a few minutes outside the body.

If all three these factors are present, the victim could be at risk of contracting HIV.[144]

2.42 Where there have been reports in the medical literature in which HIV appeared to have been transmitted by a *bite*, severe trauma with extensive tissue tearing, damage and the presence of blood has in each instance occurred.[145] There has never been a case of HIV transmission through biting where only saliva was involved.[146]

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143 Lachman 133-134. See also par 2.46 below.

144 Sowadsky "Risk from Fighting?" **The Body: Answers to Safe Sex and Prevention Questions** (Internet). See also par 2.17-2.20 above.

145 CDC **Facts About the Human Immuno-deficiency Virus and Its Transmission** (Internet); **Morbidity and Mortality Weekly Report** 11 July 1997 620-623.

146 Sowadsky "Kissing and Infection with HIV" **The Body: Answers to Safe Sex and Prevention Questions** (Internet 18/6/98). See also par 2.43 below.

2.43 The risk of infection through *spitting*, although theoretically possible (since the virus is found in saliva - albeit in extremely small concentrations), is in realistic terms very small. Saliva would pose a significant risk of transmission only if there were visible blood in the saliva and the blood has direct access to the other person's bloodstream.[147]

2.44 In *physical fighting*, the victim would be at risk only if the perpetrator was infected with HIV, the victim was directly exposed to the perpetrator's blood during the fight, and the blood got directly into the victim's bloodstream within minutes of leaving the perpetrator's body.[148] The possibility of direct access to the bloodstream will for instance exist if the blood of a perpetrator with HIV got directly into a fresh open cut sustained during the fight, or into the eyes, nose or mouth of the victim.[149]

2.45 HIV can be transmitted through *intravenous drug use* when the blood of a drug user with HIV is transferred to one without HIV. This occurs almost exclusively through multi-person use, or sharing, of drug injection equipment (needles and syringes).[150] Persons who inject drugs and share drug injection equipment are at high risk of acquiring HIV because HIV is transmitted very efficiently through such sharing.[151]

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147 Ibid. See also CDC **Morbidity and Mortality Weekly Report** 15 May 1998 3; Sawyer **The Body: Lambda Legal Defense and Education Fund** (Internet). Researchers at the Laboratory for AIDS Virus Research at New York Hospital found that a natural sugar protein in human saliva (thrombospondin) may block HIV from entering the body (Hess **The Body: POZ Gazette** [Internet]).

148 Sowadsky "Risk from Fighting?" **The Body: Answers to Safe Sex and Prevention Questions** (Internet 18/6/98).

149 Ibid.

150 There are two drug injection activities that involve introducing blood into the needle and syringe: The first activity is to draw blood into the syringe to verify that the needle is inside a vein (so the drug can be injected intravenously). The second, following drug injection, is to refill the syringe several times with blood from the vein to "wash out" any heroin, cocaine, or other drug left in the syringe after the initial injection. If even a tiny amount of HIV infected blood is left in the syringe, the virus can be transmitted to the next user (CDC **Drug Use and HIV/AIDS: The Body** [Internet]).

151 CDC **Drug Use and HIV/AIDS: The Body** (Internet). It has been pointed out that HIV transmission may also occur among people (and their partners) who trade sex for non-injected drugs as trading sex for drugs is often associated with unprotected sex and having multiple sexual partners. Further, the use of non-injected drugs or alcohol can place a person at risk for HIV transmission in part because these substances lessen inhibitions and reduce reluctance to engage in unsafe sex (ibid).

* Factors relating to prevention and treatment of HIV transmission

+ *Effectiveness of condoms in reducing the risk of HIV transmission*

2.46 Recent studies provide compelling evidence that latex male condoms are highly effective against (but not totally excluding the risk of) HIV infection when used correctly and consistently.[152] In a European study reported on in 1994 following 256 discordant heterosexual couples (i e one member HIV positive), over an average of 20 months between 0%-2% of the uninfected partners became infected in couples who *consistently* used latex condoms; while 10%-12% of the uninfected partners became infected in couples who used condoms *inconsistently*.[153] However, in another study of HIV transmission within heterosexual couples it was calculated that "regular" condom use reduced transmission from an HIV-infected partner by 69% compared to infrequent users.[154] Female condoms have recently also become available. Although laboratory studies indicate that the female condom serves as a mechanical barrier to viruses, further

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152 Lachman 133; **CDC HIV/AIDS Prevention: Facts About Condoms** February 1996; **CDC HIV/AIDS Prevention: Facts About HIV and its Transmission** July 1997; De Carlo **JAMA HIV/AIDS Information Centre** February 1995 (Internet); **Morbidity and Mortality Weekly Report** 2 May 1997;Crichton (Unpublished). The *correct* use of condoms refers *inter alia* to using a new condom for each act of intercourse, with adequate water-based lubrication to prevent condom breakage. Several studies of correct and consistent condom use clearly show that condom breakage rates in the United States are less than 2%. *Consistent* use means using a condom with each act of intercourse (ibid).

153 **CDC HIV/AIDS Prevention: Facts About Condoms** February 1996; De Carlo **VAAIN** April 1995; Guide to Clinical Preventive Services: US Preventive Sevices Task Force 1996 in **JAMA HIV/AIDS Information Centre** (Internet); cf also Lachman 135. It has however been said that findings from European studies of stable heterosexual couples may not necessarily reflect the risks of HIV transmission for African heterosexual couples since promiscuous African heterosexual males are reluctant to use condoms (Lachman 135). In the latter regard a survey on condom usage in a developing country (Brazil) reported on in 1997, may be more indicative. According to the survey 500 persons between the ages 18-49 indicated that only 19% of sexual encounters in the 4 weeks prior to the survey included condoms (**AIDSScan** September-October 1998 12).

154 Weller SC "A Meta-analysis of Condom Effectiveness in Reducing Sexually Transmitted HIV" **Soc Sci Med** 1993 Vol 36 1635-1644 quoted in Guide to Clinical Preventive Services: US Preventive Services Task Force 1996 in **JAMA HIV/AIDS Information Centre** (Internet).

clinical research is necessary to determine its effectiveness in preventing transmission of HIV.[155] It is however advised that the female condom can be used as alternative when use of a male condom is not possible.[156]

+ ***The influence of combination drug therapies and a resultant lower viral load on the risk of HIV transmission***

2.47 As regards the question whether a lower or "undetectable" viral load in a person with HIV reduces or eliminates the risk of HIV transmission, conclusive findings are not yet available.[157]

2.47.1 Experts however emphasise that viral load at "undetectable levels" does not imply that a person with HIV is cured, or that he or she cannot transmit the disease.[158] "Undetectable" does not mean that there are no viral particles in the blood - it means only that the current viral load tests are not sufficiently sensitive to detect viral particles in the blood once they fall below a certain level.[159] Even with a very low viral load, transmission can still occur, although its likelihood is

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155 **CDC Facts About** February 1996. Cf however another source which claims that the typical failure rate of the female condom is 21% (much higher than the male latex condom) (Sowadsky "How Safe are Condoms?" **The Body** [Internet]).

156 Ibid.

157 Volberding **AIDS Care** February 1998 (Internet); **TAGline** August/September 1996; **CDC HIV/AIDS Prevention: Facts About Treatment** July 1997. See also par 2.31 and 2.34-2.34.2 above for information on viral load testing and combination drug therapies for HIV infection respectively.

158 Volberding **AIDS Care February** 1998 (Internet); **TAGline** August/September 1996; **CDC HIV/AIDS Prevention: Facts About Treatment** July 1997; Sowadsky "Viral Loads and Infectiousness" **The Body** (Internet); Sowadsky "HIV Transmission From Patient with Nondetectable Viral Load" **The Body** (Internet); Sowadsky "Minimum Viral Load for Transmission" **The Body** (Internet).

159 Ibid. It may however mean that a person has as few as 20 virus copies/ml of blood (Dine and Watt 1998 **Web Journal of Current Legal Issues** [Internet]). See also fn 113 above on what is regarded as high and low viral load.

reduced.[160] Viral load can thus affect the *risk* of HIV infection - the higher the viral load, the greater the risk of transmission.[161] Currently however, no "threshold" exists which indicates the lowest viral load likely to transmit HIV.[162] It is further emphasised that even when HIV has been eradicated from the bloodstream it can be present in lymph tissue and other reservoirs of HIV infection in the body, waiting to re-enter the bloodstream.[163] Moreover, viral load in blood can be highly variable throughout the disease, depending on the individual, the stage of the disease, and how well the person is responding to therapy.[164]

E) PREVALENCE OF HIV/AIDS IN SOUTH AFRICA

2.48 No reliable statistics on the incidence of AIDS itself, or of AIDS-related deaths, appear to be available in South Africa. However, the prevalence of HIV can be projected from annual studies conducted at antenatal clinics of the public health services. The results of the latest (1997) antenatal seroprevalence survey confirm the alarming progression of the HIV epidemic. Nationally the epidemic appears to be maturing, with a slowdown in the increase of HIV prevalence.[165] But in severely affected areas levels of HIV infections are reaching heights that were considered to be pessimistic scenarios in early projections.[166]

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160 Volberding **AIDS Care February** 1998 (Internet); Sowadsky "Viral Loads and Infectiousness" **The Body** (Internet); Sowadsky "HIV Transmission From Patient with Nondetectable Viral Load" **The Body** (Internet); Sowadsky "Minimum Viral Load for Transmission" **The Body** (Internet).

161 Ibid. Cf also Dine and Watt **Web Journal of Current Legal Issues** 9.

162 Sowadsky "Viral Loads and Infectiousness" **The Body** (Internet); Sowadsky "HIV Transmission From Patient with Nondetectable Viral Load" **The Body** (Internet); Sowadsky "Minimum Viral Load for Transmission" **The Body** (Internet).

163 Volberding **AIDS Care** February 1998 (Internet); **TAGline** August/September 1996; **CDC HIV/AIDS Prevention: Facts About Treatment** July 1997.

164 Volberding **AIDS Care** February 1998 (Internet); **TAGline** August/September 1996.

165 Kinghorn and Muhr (Unpublished) 1.

166 The worst hit regions include KwaZulu/Natal and Mpumalanga, each having increased by 7 percentage points during 1997. Prevalence in KwaZulu/Natal for the last three years is estimated at 18% (1995), 20% (1996), and 27% (1997) while that in Mpumalanga is 16% (1995), 16% (1996) and 23% (1997)

Estimates based on the latest survey are that 16,01% of women attending antenatal clinics of the public health services nationally were infected with HIV by the end of 1997.[167] Compared to the infection rate of 14,17% of 1996, the prevalence level of HIV infection increased by 12,99% during the past year.[168] When these figures are extrapolated, estimates are that roughly 7% of the total population or 12% of the adult (i e sexually active) population (compared to 6% of the total or 11% of the adult population in 1996[169]) is infected.[170] It is estimated that approximately 2,7 million adults were infected with HIV at the end of 1997.[171] The latest survey shows women in their twenties becoming infected at the highest rate (between 18% and 19%).[172] By the end of 1997 it was estimated that 1,6 million women were infected with HIV, and that almost 50 000 HIV-infected babies were born in 1997.[173] The number of babies with HIV born between 1990 and end 1997 could be 207 000.[174]

(Kinghorn and Muhr [Unpublished 1]).

167 "Summary Results of the Eighth National HIV Survey of Women Attending Antenatal Clinics of the Public Health Services in South Africa in 1997" released by the Department of Health on 10 March 1998.

168 Ibid. For the 1996 infection rate see **Epi Comments** December 1996/January 1997 6.

169 Doyle and Muhr (Unpublished) 1.

170 Information supplied by Dr Thomas Muhr (Metropolitan Life) on 30/6/98. Dr Muhr emphasised that the reliability of these projections (based on the 1997 antenatal results referred to in fn 71 above) will obviously be influenced by factors such as the uncertainty regarding the total RSA population, general fertility rates, and fertility changes with regard to HIV positive women.

171 Ibid. Deputy President Thabo Mbeki, in addressing the South African people on HIV/AIDS on 9 October 1998, indicated that to date, more than 3 million people in our country have HIV; that every day a further 1 500 people get infected; and that the rate at which HIV spreads in South Africa is one of the fastest in the world (Internet **http://www.anc.org.za/ancdocs/history/mbeki/1998/tm1009.htm** accessed 19 October 1998).

172 The eighth national HIV survey carried out in South Africa at the end of 1997 indicated that the 20-24 year group was the group most infected (19,67%), closely followed by the 25-29 year old group (18,18%) ("Summary Results of the Eighth National HIV Survey of Women Attending Antenatal Clinics of the Public Health Services in South Africa in 1997" released by the Department of Health on 10 March 1998).

173 See fn 174 below.

174 The number of babies with HIV born between 1990 and end 1996 is estimated to be 157 000 (**Epi Comments** December 1996/January 1997 6). According to projections supplied by Dr Thomas Muhr (Metropolitan Life) on 30/6/98 it is estimated that almost 50 000 HIV-infected babies were born during 1997 (see also fn 74 above). Official figures including babies born during 1997 were not available at the time of compiling the current Discussion Paper.

2.49 The epidemic of AIDS sickness and AIDS deaths (which lags several years behind the infections with HIV) is, according to experts, now emerging in all parts of the country with a rapid raise in the number of cases being expected.[175] Already many hospitals report that over 50% of admissions to medical wards are HIV/AIDS related.[176]

2.50 Rape and sexual abuse are ways in which HIV may be transmitted. High levels of these crimes could lead to an increase in the general prevalence of HIV. Statistics on possible HIV-related criminal behaviour are set out in par 5.48.1 below. However, statistics on whether HIV-related criminal behaviour is increasing the incidence of HIV do not exist.[177]

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175 Kinghorn and Muhr (Unpublished) 2.

176 Ibid.

177 Recent research noted that the relationship between the AIDS epidemic, the fear, hopelessness and resignation which may be driving a desire to spread te virus and the growing South African rape crisis demands closer inspection (Leclerc-Madlala 1996 **Acta Criminologica** 34-35; cf also par 2.1.1 above).

3 DEFINING THE PROBLEM

A) "CRIMINALISATION" OF CERTAIN BEHAVIOUR

3.1 The Commission's mandate from the Justice Portfolio Committee is to investigate the "criminalisation" of sexual activity of persons with HIV who deliberately or negligently infect others with HIV in the context of creating stricter measures in respect of serious sexual offences and violence against women.[178] Practical examples of such behaviour include rape by a person who knows or suspects that he has HIV; sexual intercourse by a person with HIV who deliberately withholds information from the other partner with a desire to infect that other; and deceiving a person into the belief, or exploiting a mistaken belief, that a potential partner does not have HIV.[179] The term "criminalistion" refers to the decision to proscribe conduct as a crime.[180]

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178 Par 2.2-2.4 above.

179 Cf also **Law Commission Consultation Paper No 139** 1995 par 6.24-6.30; Dine and Watt 1998 **Web Journal of Current Legal Issues** (Internet).

180 Burchell and Milton 28. Crimes are created to protect certain values and interests. As society develops, its values and interests may change resulting in a need to criminalise different forms of conduct. The principal interests that motivate criminalisation are maintaining or retaining human and civil rights; maintaining a common community morality; the advancement of collective welfare; and protecting the government of the State. The decision to criminalise is a government decision which has important implications: It implies a social cost for those who undergo punishment, namely the stigma attached to a conviction for a crime and the resultant "criminal record" that follows the offender everywhere; and it carries the economic cost of maintaining and expanding a criminal justice system. If the benefits to society are not commensurate to the social or economic costs of having the particular crime, then the decision to criminalise cannot be justified (Burchell and Milton 25, 31-32; cf also Dine and Watt 1998 **Web Journal of Current Legal Issues** [Internet]). In general, it has been said that there has been an over-utilisation of the criminal sanction in modern westernised societies which resulted in an adverse effect upon the administration of criminal justice including *inter alia* lessening the authority of the criminal law; stigmatising individuals as criminals; and overloading the criminal justice system (Burchell and Milton 25, 31-33; **LAWSA** Vol 6 9-10). In view of the fact that criminalisation would thus not always be desirable, certain criteria indicating when it would be appropriate to criminalise conduct and when not, have been developed. These ultimately turn on balancing the social gains that will accrue from the successful prevention or reduction of the conduct in question, against the social, human and financial costs of invoking the criminal sanction (Burchell and Milton 32-33). The Canadian Committee on Corrections for instance suggested the following criteria for criminalisation: No act should be criminally proscribed unless its incidence, actual or potential, is substantially damaging to society; no act should be criminally prohibited where its incidence may be adequately controlled by forces other than the criminal process; and no law should give rise to social or personal damage greater than it was designed to prevent (**Toward Unity: Criminal Justice and Corrections** [1969] 11-12 as referred to in

Since the behaviour described above could already fit within the parameters of certain common law crimes (including murder, rape, culpable homicide and assault with intent to do grievous bodily harm),[181] the creation of a statutory offence in this instance will mostly serve as confirmation and a clear exposition of the existing common law position rather than amount to the creation of a "new" offence. However, if a new enactment renders criminal no fault or negligent exposure to the virus, or negligent transmission of the virus where death does not ensue, this will entail the creation of a new offence where the term "criminalisation" would be appropriate.[182]

B) DIFFERENT OPTIONS FOR ADDRESSING HARMFUL BEHAVIOUR?

3.2 Before exploring the possibility of creating a statutory offence to deal with harmful HIV-related behaviour,[183] the question arises whether the South African law currently has available measures to deal with such behaviour - be it criminal law measures or other measures.

3.2.1 Some argue that since HIV/AIDS is first and foremost a public health issue, a solution for dealing suitably with harmful HIV-related behaviour should first be sought in *public health measures.* The Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 (the 1987 Regulations)[184] issued by the Minister of Health (and proposed Draft Regulations of 1993 to replace these) contain measures which may be suitable in this regard. Whether these measures

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Burchell and Milton 33).

181 See par 5.19 et seq below.

182 Cf fn 180 above. See also par 5.33.2 below regarding no fault or strict liability.

183 See also par 5.2.1 below for a discussion of harm in the criminal context.

184 G N R 2438 in **Government Gazette** 11014 of 30 October 1987.

are adequate to deal with the issue in question, is examined in Chapter 4 below.

3.3 The *criminal law* has not had to deal with HIV/AIDS issues until very recently.[185] There is no specific statutory provision for the prosecution of persons who deliberately or negligently transmit HIV to others. Persons who deliberately or negligently infect others with HIV could however currently be prosecuted under existing common law crimes. As far as could be ascertained, there have not been any successful prosecutions for the deliberate or negligent transmission of HIV to date.[186] The core question which should be explored with regard to the common law crimes is whether they supply sufficient protection to persons without HIV/AIDS; and in any

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185 Parliament has recently passed two amendments to criminal law and procedure relevant to the present enquiry. Both *inter alia* attempt to deal with the consequences of sexual violence by a perpetrator who has HIV.

The *Criminal Procedure Second Amendment Act* 85 of 1997 (*Bail Act)* provides for stricter bail measures to be taken in respect of an accused who is charged with or convicted of rape. If such an accused knew that he had AIDS or HIV, the following applies: The accused's bail application must be considered by the Regional Court; the accused is not entitled to bail unless he or she can satisfy the court "that exceptional circumstances exist which in the interests of justice permit his or her release"; and if the accused is convicted, the court is obliged to consider the possible sentence it will impose before granting an extension of bail (sec 1(b), 4(f) and 2).

The *Criminal Law Amendment Act* 105 of 1997 (*Minimum Sentencing Act*) provides for compulsory minimum sentences to be applied where a person is convicted of certain serious offences. In particular it provides that if a person has been convicted of rape which "caused psychological harm" to the victim, a court is obliged to impose a minimum sentence of imprisonment of not less than 15 years for a first offender, and not less than 25 years for a third offender (sec 52(1)(a) read with Part 1 of Schedule 2). Provision is however made for imposition of a lighter sentence provided the presiding officer lists the reasons for not imposing the prescribed sentence. These compulsory minimum sentences shall cease to exist after the expiry of a two year period. However, the President, with the concurrence of Parliament, may extend this period for one year at a time (sec 52(1) and 53(1) and (2)). It is significant to note that the legislator has expressly recognised in these provisions that psychological harm (in contradistinction to physical harm) is cause to apply the severe mechanisms of the criminal law and procedure. It is submitted that in view of the fact that exposure to and possible infection with HIV is a real fear of many rape survivors, it will in fact cause psychological harm as envisaged by the legislator. Furthermore, HIV is incurable, has grave social, psychological and economic implications and will invariably lead to death (cf **Venter v Nel** referred to in par 3.3.1 below).

How these provisions will be applied in practice is still unclear, particularly on the question whether they imply that the court will be able to direct an accused to be tested for HIV and to reveal his HIV status as part of the trial or pre-trial proceedings.

186 The first criminal prosecution for HIV-related behaviour has recently been brought in a South African magistrate's court. At the time of compiling this Discussion Paper, the prosecution has not been finalised (see par 2.1.5 above).

event whether the common law should or would be strengthened by the creation of a statutory offence. This is discussed in Chapter 5 below.

3.3.1 In delict, a person could be held liable for causing damage to another person.[187] A person with HIV could thus also be held *civilly* liable as a result of exposing others to or infecting them with HIV. Damages were awarded in a recent South African case against a man with HIV who infected a women during sexual intercourse.[188] The civil law is however a measure which is available in the context of a personal duty to compensate the victim for harm done. It is not a public law measure available for the sexual, to invoke against individuals who endanger the lives of fellow citizens.

3.4 Both the criminal law and public health measures aimed at restraining recalcitrant individuals are, by their very nature, *coercive legal measures.* It has been suggested that utilising such measures in the HIV/AIDS epidemic may be counterproductive in that this could contradict and undermine public health strategies to curb the spread of the disease.[189] It is necessary to examine briefly this issue by way of background

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187 A delict is an unlawful, blameworthy (i e intentional or negligent) act or omission which causes another person damage to person or property or injury to personality and for which a civil remedy for recovery of damages is available (Burchell 10).

188 In **Venter v Nel** 1997 4 SA 1014(D) the court recently granted a plaintiff damages in the amount of R344 399, 06 on the ground that the defendant had infected her with HIV during sexual intercourse. (The claim was undefended. The defendant allegedly discovered that he had HIV after he had applied for an insurance policy in 1990 - several years before he met the plaintiff.) Damages were granted for future medical expenses as well as for the possibility of a reduction in life expectancy, psychological stress, contumely and pain and suffering . It was held that the plaintiff's condition was one which called for "extremely high damages" (at 1016J - 1017 D-E). Factors taken into account by the court in assessing the damages were *inter alia* the stress and inevitable fear of the unknown, the feelings of helplessness and hopelessness, the adverse effects that the condition had on her general relationship with all others, the adverse effects on her sex life and psychological and social suffering. According to press reports the plaintiff commented that laying a criminal charge against the defendant would not have helped her - she took recourse to the available civil measures "to get money to pay for her medical expenses - not revenge" (**Sunday Times** 23 February 1997; see on the law, in general, van Wyk 497; Burchell 149-151; Neethling et al 43-44 [on remedies for personality infringement]).

189 Holland 1994 **Criminal Law Quarterly** 280, 284; Jackson in **AIDS Agenda** 260; Cameron and Swanson 1992 **SAJHR** 203-232; Hermann 1990 **St Louis University Public Law Review** 377-378; Tierney 1992 **Hastings International and Comparative Law Review** 512; Elliot 9-14, 67; Andrias 1993 **Fordham**

to the discussions on public health and criminal law measures which follow below.

C) THE ROLE OF COERCIVE LEGAL MEASURES IN REDUCING THE SPREAD OF HIV/AIDS

3.5 Throughout history, public health issues - and in particular epidemics of disease - have raised questions on the extent to which the community is entitled to protect itself at the expense of the rights of the individual. The questions become acute in the case of diseases where the source of contagion and mode of transmission involve human behaviour. Abstract logic appears to dictate that in circumstances of a threatening epidemic of disease transmitted by human activity, the risk to the community is best dealt with by reducing the risk posed by the source (eg identifying and isolating or removing individuals whose infection poses a risk to others). The latter has been the traditional public health approach to disease prevention.[190]

3.6 Leaving aside questions of prejudice and stereotype, the incurable nature of HIV/AIDS and early confusion about the nature of its transmission led many governments to follow the traditional approach of infectious disease control - consisting of various punitive efforts to deter infected persons from transmitting the virus to others.[191] In invoking the coercive force of the law, indirect and direct coercive measures were called upon. Indirect measures involved oblique efforts to

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Urban Law Journal 505-506; see also par 5.54-5.55 below for more detail on the counter-productive effect of criminal law on public health initiatives.

190 Buchanan in **African Network on Ethics, Law and HIV** 93-96, 105; **Ontario Report** 27-29; Andrias 1993 **Fordham Urban Law Journal** 503.

191 The core functions and responsibilities of public health measures are threefold: collection of data on important health problems in a population; developing policies to prevent and control priority health problems; and assuring services capable of realising policy goals. In the past, restrictions on human rights were however often simply justified on the basis that they were necessary to protect public health. This resulted in governments applying coercive measures in the context of disease control (Mann et al 1994 **Health and Human Rights** 15-17). See also Andrias 1993 **Fordham Urban Law Journal** 502-503; Cameron and Swanson 1992 **SAJHR** 201-202; Van Wyk 96-98; Jackson in AIDS Agenda 239-240; Mann et al 1994 **Health and Human Rights** 15-17. See also **SALC Second Interim Report on Aspects of the Law relating to AIDS** 21-22.

stop the spread of HIV through criminalising or discouraging conduct which may lead to transmission (eg laws which restrict or criminalise activities such as prostitution, sodomy, extra-marital sexual intercourse and intravenous drug use). Direct measures, on the other hand, were designed to slow the spread of HIV by targeting the movements or conduct or affecting the civic status of known or presumed HIV "carriers" (eg quarantining or isolation of individuals known to carry the virus, criminal punishment of persons who negligently or knowingly infect others, and mandatory screening of specified segments of the population for HIV).[192]

3.7 There are however facets of the AIDS epidemic which sharply distinguish it from other diseases:[193] HIV cannot be transmitted through casual contact. It is an epidemic where the major mode of transmission is human sexual behaviour (possibly the most private of human activities). Furthermore, HIV infection cannot be treated so as to reduce or eliminate the infectivity of an individual. Additionally, considerable social stigma still attaches to infection with HIV resulting in risky behaviour often being denied as there are no incentives to disclose HIV status.

3.8 The above features of HIV/AIDS challenged the traditional approach to disease control involving coercive legal measures: It is argued that HIV prevention and care programmes that were based on coercive measures resulted in reduced public participation and an increased alienation of those at risk of infection.[194] Moreover,

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192 Cameron and Swanson 1992 **SAJHR** 201-202; Buchanan in **African Network on Ethics, Law and HIV** 94; Cuba, for instance, in the 1980s embarked on a programme of mass screening for HIV and isolating the infected (Buchanan in **African Network on Ethics, Law and HIV** 97; Van Wyk 167).

193 Jackson in **AIDS Agenda** 240-242; Buchanan in **African Network on Ethics, Law and HIV** 94-95.

194 A now-classic University of South Carolina (United States) study, presented at the Fourth International Conference on AIDS in Stockholm in 1988, charted changes in HIV testing patterns after South Carolina repealed anonymous HIV testing in 1986 and established mandatory name reporting. The number of gay men tested dropped by 51%. While the total number of people tested increased slightly, the overall rate of seropositivity among those being tested decreased by 43%. The study demonstrates that ending anonymous testing and requiring the reporting of names, serve to scare away from diagnostic information and health care those people at greatest risk (Katz **AIDS Readings on a Global Crisis** 276).

In January 1988 Illinois and Louisiana adopted mandatory premarital screening for HIV. During the first months of statutorily mandated premarital testing in Illinois only eight of 70 846 applicants for marriage licences were found to be seropositive. In the same period the number of marriage licences

that since HIV infection is mostly spread through voluntary activities, both infected and uninfected individuals are themselves in the best position to slow the spread of the disease. It was accepted that where confidentiality, informed consent and non-discrimination were not guaranteed, individuals did not come forward for early education, counselling, testing and treatment. Instead they remained outside of the public health services thus posing a greater risk to the community at large.[195] This led to acceptance of the view that coercive measures not only infringe upon people's civil rights, but do nothing to advance understanding of the HIV epidemic or to slow its spread.[196] Measures taken to deal with the HIV/AIDS epidemic have been influenced by contemporary thinking about optimal strategies for disease control which has more recently evolved significantly. Efforts to confront the most serious global health threats, including cancer, cardiovascular disease and other chronic diseases, injuries, reproductive health and infectious disease increasingly emphasise the role of personal behaviour within a broad social context.[197]

3.9 Following general public health trends, in the first decade of the AIDS epidemic policymakers therefore broke with the traditional model of disease control by adopting a non-coercive approach to public health - a phenomenon that has on occasion been called "HIV exceptionalism".[198] As a result, public health officials

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issued in Illinois decreased by 22,5%. But during this time the number of licences issued to Illinois residents in surrounding sexuals increased significantly. Evaluation suggests that applicants for marriage licences with a history of previous or present risk behaviour may have left the sexual to avoid the test (Lachman 128; see also Gunderson et al 213 and Jarvis et al 266-267). A documented study on compulsory pre-marital testing claimed that national mandatory premarital testing would not be a cost-effective way to slow HIV transmission and should not be implemented (Paul Cleary et al "Compulsory Premarital Screening for the Human Immuno-deficiency Virus: Technical and Public Health Considerations" **Journal of the American Medical Association** 258[1987] 1757-1762 as referred to in Gunderson et al 214). In this regard the claim that cost-effectiveness alone should warrant the rejection of mandatory testing was questioned, and the role of intrusion into privacy emphasised (Gunderson et al 214). Both Illinois and Louisiana subsequently repealed their mandatory premarital testing laws (Jarvis et al 266).

195 Berge 1992 **Florida Law Review** 805; **Australia Final Report on AIDS** 31. This approach has more recently also been endorsed by the Supreme Court of Appeals in **Jansen van Vuuren v Kruger** 1993 4 SA 842 (A) at 854B-D.

196 Mann et al 1994 **Health and Human Rights** 16-17.

197 Ibid.

198 Bayer 1994 **Hospital Practice** 155.

committed themselves to encouraging programmes of voluntary behavioural change, protection of confidentiality, and HIV testing only with informed consent. This strategy excluded contract tracing and quarantine, even when the behaviour of an infected individual was believed to pose a threat to others, and stressed education rather that coercion.[199] The new approach has also been confirmed through recent studies in countries such as Thailand, Uganda and Tanzania. These show a decreasing HIV prevalence rate following the introduction of prevention strategies based upon non-coercive, voluntary principles in which persons with HIV participate fully.[200]

3.10 As shown in Chapter 6 below, some Governments have however recently initiated legislative changes to return to the more traditional public health approach to curb the epidemic. These changes have included coercive measures such as criminal law sanctions as part of public health HIV/AIDS interventions.[201] Attempts to return to the more traditional approach have, however, not been without controversy.[202]

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199 Ibid.

200 W Poolcharoen and S Phonghpit "HIV Prevention Works: The Experience of Thailand" and Dr E Madraa "HIV Prevention Works: The Uganda Case Study" (Unpublished papers presented at the XI International Conference on AIDS Vancouver, July 1996) as quoted in the **United Nations Guidelines on HIV/AIDS and Human Rights 1996**; Grimm 1997 **Human Rights Brief** (Internet accessed 10/11/1997).

201 See par 6.10 below where the United States' HIV Prevention Act, 1997 is discussed.

202 Cf par 6.11 below.

D) PARAMETERS OF THE CURRENT ENQUIRY

3.11 In accordance with the request by the Justice Portfolio Committee and its background, the current paper deals mainly with the question whether there is a need to create a separate statutory offence aimed at harmful behaviour related to the *sexual transmission* of HIV. (However it is recognised that other forms of criminal behaviour such as biting, spitting and fighting may result in the transmission of HIV. The latter is briefly referred to in par 2.42-2.45 above.)

3.12 The current paper does not separately address the question of applying the criminal law to other modes of exposure or transmission of HIV (for instance mother to child transmission, needle sharing by intravenous drug users, and donation of body fluids or organs). Mother to child transmission raises a host of issues that significantly distinguish it from transmission through sexual exposure and has never in South Africa been the subject of demands for criminalisation.[203] Needle-sharing by intravenous drug users is a mode of HIV transmission which has received scant attention in South Africa[204] and which has likewise never been targeted for criminalisation. Furthermore, this paper does not separately address application of the criminal law to the donation of body fluids or organs infected with HIV. The latter activity is uncommon in the criminal context and does not raise the same complex psycho-social factors as those related to sexual transmission. All the additional issues referred to in this paragraph in any case fall outside of the project committee's mandate as outlined by the Justice Portfolio Committee.

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203 There has been no suggestion in South Africa that pregnancy by a woman with HIV, or a mother nursing her child, should constitute a criminal offence. Even in the United States, where criminalising HIV-related behaviour has received much attention during the past decade, no legislation specifically criminalising perinatal transfer of the infection has been enacted - although it has been suggested that some sexuals have passed statutes sufficiently ambiguous for such prosecutions to be possible (Cf Elliot 29-31).

204 Of the 8 784 cases of clinical AIDS reported as on 30 November 1995, only three were the result of intravenous drug use (**Epi Comments** October 1995 234 - these are apparently the last available statistics issued by the Department of Health on drug abuse as a mode of HIV transmission).

4 DEALING WITH HARMFUL HIV-RELATED BEHAVIOUR THROUGH EXISTING PUBLIC HEALTH MEASURES

4.1 As indicated in the previous Chapter, some argue that since HIV/AIDS is first and foremost a public health issue, a solution for dealing suitably with harmful HIV-related behaviour should first be sought in public health measures.

4.2 What is the Government's current public health response to the epidemic, and are there any existing public health measures which could be invoked in respect of harmful HIV-related behaviour? These questions are discussed below.

A) THE GOVERNMENT'S CURRENT PUBLIC HEALTH RESPONSE TO THE HIV/AIDS EPIDEMIC[205]

4.3 The Government has a strong National AIDS Programme which aims at co-ordinating and facilitating a united response to the HIV/AIDS epidemic from all sectors of society and government.[206] The National Programme is assisted by nine Provincial AIDS Programmes (based within the provinces' respective health departments) which are primarily responsible for the implementation of the national HIV/AIDS policy. In addition, the National Programme works closely with 15 ATICCs (AIDS Training, Information and Counselling Centres, located within local

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205 Information for this section was supplied by Ms Ann Strode (project committee member) with the assistance of Ms Rose Smart, Director: HIV/AIDS and STDs, Department of Health on 7/9/98.

206 The Programme's mission statement is "to reduce the transmission of STDs (including HIV infection) and provide appropriate support for those infected and affected, through collaborative efforts within all levels of government, using the NACOSA National AIDS Plan as the terms of reference. The Programme is committed to challenging prejudice and discrimination wherever it occurs" (Department of Health Directorate HIV/AIDS and STDs Operational Plan 1 April 1998-31 March 1999). In order to concretise the Government's commitment to HIV/AIDS issues, the National Programme, although situated within the Department of Health, was in 1995 elevated to the level of a RDP (Reconstruction and Development Programme) presidential lead project. Furthermore, the existing HIV/AIDS budget has been supplemented with both additional departmental and donor funds.

government AIDS programmes) and with numerous non-governmental organisations and community based organisations.

4.4 As far back as 1992, the National AIDS Convention of South Africa (NACOSA) was established outside government to afford persons and bodies from the private as well as the public sector the opportunity to develop a national AIDS strategy together.[207] The NACOSA National AIDS Plan was developed through a consultative process and was adopted by the Government on 21 July 1994 as the basis of the Government's HIV/AIDS intervention policy and programme.[208]

4.5 The Department of Health has adopted four major goals to guide the National AIDS Programme until the year 2 000. These include reducing HIV and STD prevalence; monitoring the HIV/AIDS epidemic; reducing the impact of HIV/AIDS at the personal, family and community level; and protecting the rights of persons living with HIV/AIDS. Currently these goals have led to the following implementation programmes:

- Mobilising every sector of the community to respond to the epidemic;[209]
- Initiating the full involvement of all sectors of society in the development and implementation of the National AIDS Programme;
- Involving persons living with HIV/AIDS in every aspect of the Government's HIV/AIDS response;
- Developing a life skills programme targeted at youth;
- Using mass media to popularise key HIV/AIDS prevention messages;
- implementing the appropriate management of STDs at a primary health care level;

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207 **NACOSA National AIDS Plan 1994-1995** ix-x.

208 Ibid 10. The following major principles are enshrined in the Plan: People with HIV and AIDS shall be involved in all prevention, intervention and care strategies; People with HIV and AIDS, their partners, families and friends shall not suffer any form of discrimination; the vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection; confidentiality and informed consent with regard to testing and results shall be adhered to at all times; and the government has a crucial responsibility with regard to the provision of education, care and welfare to all people of South Africa.

209 Eg motivating the business community to respond in tandem with the Government to the epidemic.

- Facilitating the national distribution of condoms at both a primary health care and community level;
- Providing care, counselling and support services for persons living with HIV/AIDS and their families;
- Ensuring that all tuberculosis (TB) control programs adequately address HIV/AIDS issues;
- Researching ways in which HIV transmission from mother to child can be reduced;
- Educating and empowering women so as to enable them to exercise sexual autonomy;
- Ensuring that the rights of PWAs are protected.

4.6 In 1997 the Department of Health undertook a National Review of all its HIV/AIDS activities in an attempt to determine the impact its AIDS Programme was having on the spread of the epidemic. The Review established that the Department needed to focus on six key issues when addressing the epidemic: the need for political and public leadership; the importance of strengthening inter-departmental and inter-sectoral responses to the epidemic; developing the capacity of communities to respond; strengthening collaboration between HIV and TB programmes; involving persons living with HIV/AIDS meaningfully in all interventions and protecting their human rights; and countering discrimination and reducing stigmatisation associated with HIV/AIDS.[210] In response to the Review findings, an Inter-Departmental Committee on HIV/AIDS was set up by the Department in 1997. The Committee is representative of all government departments and it aims at ensuring that the responsibility for combatting the epidemic does not fall on the shoulders of the Department of Health alone. Furthermore, an Inter-Ministerial Committee on

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210 Relevant to the current investigation the Report notes :

> Clients also reported instances of negative or discriminatory attitudes from health care workers. Experiences of counselling services are that they were not uniformly available and some client reported the damaging experience of being tested without consent or counselling. Breaches of confidentiality were frequently reported and caused enormous pain and stress given the generally hostile and unsupportive social climate. (The South African STD/HIV/AIDS Review : Comprehensive Report [July 1997] at 22.)

HIV/AIDS has been set up which is chaired by the Deputy President. This committee's object is to ensure that the Government's AIDS Programme receives political commitment at the highest level. One of its key achievements thus far has been the development of a national HIV/AIDS awareness campaign.

4.7 With regard to the Law Commission's current investigation, the NACOSA Plan expressly states the following as a human rights and law reform priority: "To ensure that punitive measures aimed at those alleged to be spreading HIV are not introduced."[211] Furthermore, the Minister of Health has on occasion warned against the criminalisation of HIV-related behaviour.[212]

4.8 In summary the Government's response to the AIDS epidemic is based upon public health principles which rely on voluntary participation and behaviour change.[213] Coercive measures are not part of the National AIDS Programme's current response and it is not envisaged that a policy change in this direction will be made by the Programme in the future.[214]

B) EXISTING PUBLIC HEALTH REGULATIONS

4.9 Measures relevant to harmful HIV-related behaviour are public health regulations allowing for isolation and quarantine. These measures are rarely used nowadays to combat disease, not only because of improved social circumstances and medicines, but also because of their enormous infringement of individual rights.[215] However, the

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211 **NACOSA National AIDS Plan** 1994-1995 49.

212 See par 5.60 below.

213 Cf the Department's goals and implementation programmes referred to in par 4.5 above.

214 Comment by Ms Rose Smart, Director HIV/AIDS and STDs, Department of Health on 7 September 1998.

215 Isolation was traditionally a measure applied to isolate ill persons in order to treat them, and to prevent them from spreading disease. Quarantine was traditionally used to restrict the freedom of movement of healthy persons who have been exposed to a disease, but who do not yet show signs of infection, in order to prevent the spread of disease (Cf **SALC Working Paper 58** par 4.3 et seq).

Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 (the 1987 Regulations)[216] issued by the Minister of Health in terms of sections 32, 33 and 34 of the Health Act 63 of 1977 (the Health Act) contain measures for the isolation and quarantining of persons with HIV/AIDS[217] under certain circumstances:

- A local authority may, if it is satisfied that the spread of HIV/AIDS constitutes or will constitute a real danger to health, place under quarantine any person with AIDS or suspected to have AIDS[218] for a maximum period of 14 days (which period may be extended by the Director-General of Health to 28 days or by the Minister of Health for a longer period) in order to prevent the spread of AIDS or in order to control or restrict the disease.[219] (Regulations 2 and 4.)[220]
- A medical officer of health may, upon being satisfied on medical scientific grounds that the danger exists of a person with HIV transmitting the disease to other people, order that the person concerned be removed to a hospital or place of isolation so as to remain there under medical supervision for a determined

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216 G N R 2438 in **Government Gazette** 11014 of 30 October 1987.

217 The1987 Regulations are applicable to persons with "communicable diseases". The wide definition of "communicable disease" in sec 1 of the Health Act (a disease that "can be communicated directly or indirectly ... through any agent to any person or from any person suffering therefrom or who is a carrier thereof to any other person") clearly encompasses HIV infection and AIDS. However, the Regulations also provide for certain specific measures in respect of communicable diseases referred to in Annexure I to the Regulations. The Annexure expressly lists "AIDS" (but not HIV).

218 Reg 2 and 4 refer to a person "suffering" from a communicable disease (by implication a person with AIDS) in contradistinction to a person who is a "carrier" of a communicable disease (cf reg 14). A "carrier" of a communicable disease is defined in reg 1 as a person who, although not exhibiting clinical symptoms of a communicable disease, is for well-founded reasons and after medical tests suspected of being thus infected and who could therefore spread such a communicable disease. It is presumed that the drafters of the 1987 Regulations intended to distinguish between the terms "carrier" and "sufferer". It is submitted that in an HIV/AIDS context this means that "carrier" refers to a person with HIV; and "sufferer" to a person with AIDS.

219 Since a medical officer may, "at his discretion, in order to prevent the spread of a communicable disease referred to in Annexure I (i e AIDS) or in order to control or restrict such disease ... medically examine any person" or have such person medically examined (i e tested for HIV), he would be able to ascertain whether a person is infected (cf reg 6(1)(b)).

220 The 1987 Regulations, reg 2(1)(d) and 4(1) and (2).

period.[221] (Regulation 14.)[222]

° Finally, provision is also made for compulsory medical examination, hospitalisation or isolation, or treatment of persons with AIDS, *if* so instructed by a medical officer of health, until they are "free of infection" or may be discharged (from hospital or isolation)without in any way endangering public health. The decision to give such an instruction is in the discretion of the medical officer of health. (Regulation 17.)[223]

4.10 The 1987 Regulations have apparently never been applied to people living with HIV or AIDS.[224] It is in any case argued that many of the provisions contained in the Regulations are inappropriate to HIV infection or AIDS.[225] Having regard to the long asymptomatic phase, fit and healthy persons may be at risk of being kept in isolation for long periods of time on account of their HIV positive status. In view of the fact that there is as yet no cure for HIV/AIDS, persons with AIDS may find themselves isolated for the rest of their lives since they may never be "free from infection".[226] In addition, the express inclusion of AIDS within an Annexure to the Regulations (which effectively includes AIDS in the ambit of *inter alia* regulation 17 - the provision referred to in the previous paragraph) has been widely criticised.[227] Neither HIV infection nor AIDS corresponds with the highly contagious diseases likewise listed in

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221 Any person suspected to have HIV and who as such constitutes a danger to the public health, could be instructed by a medical officer of health to subject him or herself to a medical examination (i e HIV testing) to establish whether this is indeed the case (reg 14(1)).

222 Ibid reg 14(1) and (3). This regulation refers to a person who is a "carrier" of a communicable disease (by implication a person with HIV). The medical officer may also order that such a person not prepare or handle any food intended for other persons (reg 14(3)(c)).

223 Ibid reg 17 read with Annexure I to the Regulations. This regulation refers to a person "suffering" from a communicable disease referred to in Annexure I to the Regulations (i e a person with AIDS).

224 **SALC Working Paper 58** par 4.5.

225 Cf Van Wyk 259, 448-452; Cameron and Swanson 1992 **SAJHR** 212-213.

226 Cf reg 17 of the 1987 Regulations which allows for the discretionary isolation of persons "suffering" from a communicable disease referred to in Annexure I to the Regulations "... till they are free from infection".

227 Cf **SALC First Interim Report on Aspects of the Law relating to AIDS** par 5.1-5.16.

the Annexure.[228]

4.11 Draft Regulations, intended to replace the 1987 Regulations, were published for comment under Notice 703 of 1993 in Government Gazette No 15011 of 30 July 1993 (the 1993 Draft Regulations). In the 1993 Draft Regulations "AIDS" was removed from the Annexure to the Regulations. This seems to imply that the measure noted in paragraph 4.9 under reference of regulation 17 will no longer be applicable in respect of AIDS.[229] Although this may seem to lessen the current coercive administrative powers in respect of AIDS, the application of this provision was in any event left in the discretion of the medical officer of health under the 1987 Regulations and there was, even before the intended amendments, no efficient enforcement mechanism. The fact that the 1987 Regulations have apparently never been applied to persons with HIV/AIDS confirms this. The provisions referred to above under regulations 2, 4 and 14 have been replaced with more or less similar provisions which will remain applicable to HIV infection and AIDS in terms of it being a "communicable disease" as defined in the Health Act.[230]

4.12 The Draft Regulations published in 1993 have however not been finalised and promulgated in the Government Gazette. Since the existing 1987 Regulations have

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228 The other diseases listed include chicken pox, cholera, German measles, leprosy, louse infestation, measles, hepatitis A, mumps, plague, poliomyelitis, tuberculosis of the lungs, typhoid fever and whooping cough (see Annexure I to the 1987 Regulations). Because of the particular but limited way by which HIV is transmitted, casual contact between infected and healthy persons presents no threat to public health (see also **SALC First Interim Report on Aspects of the Law relating to AIDS** par 5.5).

229 The major differences between the 1993 Draft Regulations and those of 1987 with regard to HIV/AIDS is that AIDS is removed from Annexure I to the Regulations, listing highly contagious diseases in respect of which certain measures apply additionally; regulation 7(4) was added in the 1993 Draft to explicitly prohibit discrimination against pupils with HIV infection; and regulation 15(1) added provisions for measures to be taken when conveying and burying bodies of people known to have died with HIV infection. Regulations 6(1), 7(1) and 11(1) of the 1993 Draft Regulations corresponds with regulations 6(1), 7(1) and 17 of the 1987 Regulations.

230 Compare the 1993 Draft Regulations reg 2, 4 and 11(3) respectively. (The 1993 Draft Regulations added in reg 2 that a quarantining order should be directed to the owner, occupier or person in control of premises (reg 2(1)). It seems as if a quarantining order in terms of the 1993 Draft Regulations would thus only be possible in relation to persons present on premises in the district of a local authority. Cf however, draft regulation 8 which distinguishes between "any person placed under quarantine in terms of ... reg 2(1)" and "any person who is present on premises or in an area that is placed under quarantine in terms of reg 2(1)".

never been applied to persons with HIV or AIDS, and since the Draft Regulations have not been finalised in the past five years, a situation of uncertainty prevails. The Commission recommended urgently in 1997 that this should be resolved by promulgating the Draft Regulations.[231] Measures relating to isolation and quarantine (i e those referred to under regulations 2, 4 and 14 above, which were of a discretionary nature) are retained in the 1993 Draft Regulations, as indicated above.[232] However, as already indicated, similar provisions in the 1987 Regulations have never been applied in practice to HIV/AIDS. Moreover, these provisions, as is the case in the 1987 Regulations, retain the condition that their application is subject to the communicable disease in question creating a real danger to public health, or to the danger that a carrier or sufferer of a communicable disease may transmit such disease to other people. And finally, their application is not mandatory but left in the discretion of local authorities and public health officials.[233]

4.13 Applied to harmful HIV-related behaviour, the current position as regards relevant public health regulations could be summarised as follows: The1987 Regulations are currently still in force and could theoretically be applied to recalcitrant individuals with HIV/AIDS. The Regulations currently allow for the following:

- When the spread of HIV constitutes a danger to public health, a person with AIDS may be quarantined for a maximum period of 14 days (which period may be extended by the Director-General of Health to 28 days or by the Minister of Health to a longer period).[234]
- When the danger exists of a person with HIV transmitting the virus to other

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231 The Commission in its First Interim Report on Aspects of the Law Relating to AIDS recommended that the 1993 Draft Regulations be finalised and promulgated. The motivation for this was that uncertainty exists in the public mind about the status of the 1987 Regulations and whether they may be used in respect of persons with HIV infection or AIDS, particularly as the Draft Regulations removed AIDS from the Annexure listing certain communicable diseases. (**SALC First Interim Report on Aspects of the Law relating to AIDS** par 5.1-5.16). Parliament on 19 September 1997 indicated that the Commission's recommendations be implemented urgently.

232 Compare regulations 2, 4 and 11(3)of the 1993 Draft Regulations, but cf fn 230 above.

233 Ibid.

234 The 1987 Regulations reg 2 and 4.

people, such person may be removed to a hospital or other place of isolation for a period determined in the isolation order.[235]

° A person with AIDS may, in the discretion of a medical officer of health, be removed to a hospital or other place of isolation in order to remain there under medical supervision and receive treatment until such person is free of infection, or until he or she may be discharged without in any way endangering public health.[236]

With the exception of the last mentioned measure, the above measures would also be available should the 1993 Draft Regulations replace the 1987 Regulations.[237]

4.14 Apart from the fact that the application of those 1987 Regulations providing for isolation and quarantining of persons with HIV/AIDS is discretionary, the position regarding their status is presently unclear.[238]

4.14.1 In some other countries a case has also been made out for isolation based on behaviour. It is regarded as appropriate in exceptional cases where other persons are deliberately and repeatedly exposed to infection by persons with HIV.[239] Consequently, legislation aimed at the quarantine or isolation of infected persons who persist in behaviour which could lead to HIV transmission, has been adopted in the United States and Australia.[240] It is argued in this regard that where recalcitrant infected persons create, through their behaviour, a significant danger to the community, the limitation of individual freedom that isolation entails, is justified in the

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235 Ibid reg 14(3). (It seems that in terms of the 1993 Regulations this would be the only remaining measure that could be effectively applied to persons with HIV [cf par 4.11 and fn 230 above].)

236 Ibid reg 17.

237 Cf the 1993 Draft Regulations reg 2, 4 and 11(3).

238 See **SALC Working Paper 58** par 4.6-4.9.

239 Legislation to this effect has been introduced in several Statess in the United States (Jarvis et al 288; Cameron and Swanson 1992 **SAJHR** 214).

240 **AIDS The Legal Issues** 57-58; Jarvis et al 287-288; **Australia Discussion Paper Public Health** 34-35; **Australia Final Report on AIDS** 21.

public interest. In the United States sanctions in terms of this legislation have been imposed only in a few rare instances where infected persons have been unwilling to forego their activities,[241] while in Australia it was recommended that such legislation is acceptable only if it complies with certain requirements creating, for instance, a graded process with isolation as last resort.[242]

4.14.2 However, even if such measures are limited to specific harmful HIV-related behaviour, isolation may entail the infringement of several fundamental rights in South African terms: the right to equality;[243] the right to freedom and security of the person;[244] the right to privacy:[245] the right to freedom of association;[246] the right to freedom of movement;[247] the right freely to reside anywhere in the Republic;[248] the right as a citizen of the Republic to leave the country;[249] the right to administrative justice;[250] and the right freely to engage in economic activity and to pursue a livelihood anywhere in the national territory.[251] As indicated above, the limitation of these rights is permissible only to the extent that it is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking

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241 **AIDS The Legal Issues** 22.

242 The Legal Working Party of the Intergovernmental Committee on AIDS expressed the opinion in 1992 that legislation aimed at limiting the freedom of movement of infected persons based on their behaviour, should create a graded process consisting of confrontation , counselling of the recalcitrant individual and as a last resort confirmation of isolation by an order of court (**Australia Discussion Paper Public Health** 34-35 and **Australia Final Report on AIDS** 121; cf also par 6.16 below).

243 The 1996 Constitution sec 9.

244 Ibid sec 12.

245 Ibid sec 14.

246 Ibid sec 18.

247 Ibid sec 21.

248 Ibid.

249 Ibid.

250 Ibid sec 33.

251 Ibid sec 22.

into account, inter alia the purpose of the limitation and less restrictive means to achieve the purpose.

4.14.3 Public health measures have as their aim the promotion of public health, while criminal law measures have as their aim protecting society from harm and also retribution. Therefore the latter may be a more suitable way of dealing with recalcitrant individuals. The spread of HIV is surely not primarily the result of deliberate conduct by individuals who know they are infected, but of unwitting transmission of HIV by those who do not know of their infection. The isolation of recalcitrant individuals might thus not have more than a minimal effect on any attempt by the authorities to combat the spread of HIV and the promotion of public health. The small advantage which isolation may hold for public health in general is thus disproportionate to the infringement of individual rights which isolation, even if based on harmful behaviour, may entail. Furthermore, the costs and administration involved in the isolation of recalcitrant individuals would make such measures impracticable.[252] Isolation also creates the potential for arbitrary and discriminatory separation - how will it be determined that a danger to public health in fact exists? Coercive measures that provide for the isolation and detention of persons with HIV infection or AIDS are not a successful means of curbing the epidemic. As pointed out above and in previous documents of the Commission, quarantine, isolation and detention create a climate of fear and denial which encourages the spread of the epidemic rather the curbing it.[253] This has been repeatedly confirmed during the last decade in public pronouncements by the World Health Assembly, the WHO and the United Nations.[254]

4.15 In view of the above it is argued that the current available public health measures (including those providing for isolation and quarantining of persons in order to prevent or restrain recalcitrant HIV-related behaviour), would not have more than a

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252 See **SALC Working Paper 58** par 4.6-4.9.

253 See par 5.4 et seq above. See also **SALC Working Paper 58** par 2.10 et seq; **SALC Second Interim Report on Aspects of the Law relating to AIDS** par2.35-2.42.

254 Gostin and Lazzarini 103.

minimal effect on public health attempts to curb the spread of the disease. It is also argued that such measures would not constitute a viable alternative to the criminal law objects of retribution and deterrence: The limited duration of quarantine on the one hand, and the uncertainty surrounding the duration and nature of isolation on the other, militate against the successful application of such public health measures to punish or deter people from reckless or intentional behaviour.[255]

255 Cf par 5.1-5.5 and par 5.44.2 below.

5 DEALING WITH HARMFUL HIV-RELATED BEHAVIOUR THROUGH THE CRIMINAL LAW

A) A ROLE FOR THE CRIMINAL LAW

* Fundamental values, functions and objects of the criminal law

5.1 *Criminal law* is that branch of national law that indicates what actions expose a person to punishment by the state, and what that punishment will be.[256] Criminal law has its origin in the human instinct for vengeance, and the history of criminal law systems mostly consists of a process of replacing private vengeance with state punishment i e with acceptable alternative methods of penalising those who inflict harm or damage on fellow citizens.[257] Its object is to promote the welfare of society and its members by establishing and maintaining peace and order.[258] *Crime* refers to conduct which society intuitively believes to be wrong, disapproves of and which is believed to deserve some form of retaliation or punishment.[259] Such conduct is then declared by the law (either common law or statutory law) to be criminal.[260] *Punishment* is the sanction that is inflicted by the state upon a person who has committed a crime. It involves deprivation or the infliction of suffering and may take

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256 **LAWSA** Vol 6 3. See also Burchell and Milton 1.

257 Burchell and Milton 5. Cf also par 5.2.1 and fn 266 below.

258 Burchell and Milton 1-2. For comparative purposes it is useful to examine the American Law Institute's Model Penal Code (Article II,02(1)) regarding the general objectives of the criminal law in a modern legal system. They describe the purposes of criminal law as: a) to forbid and prevent conduct that unjustifiably and inexcusably inflicts or threatens substantial harm to individual or public interests; b) to subject to public control persons whose conduct indicates that they are disposed to commit crimes; c) to safeguard conduct that is without fault from condemnation as criminal; d) to give fair warning of the nature of the nature of the conduct to be an offence; e) to differentiate on reasonable grounds between serious and minor offences (as quoted in Visser and Vorster 7-8.)

259 Burchell and Milton 1-2; **LAWSA** Vol 6 4.

260 **LAWSA** Vol 6 4.

the form of the loss of life, liberty or property or the infliction of physical pain.[261] Punishment is justified on the grounds that it prevents crime either directly or indirectly through the threat of harm (*deterrence*); it reforms or *rehabilitates* criminals; and it effects *retribution* upon the criminal for contravening the law.[262] The criminal law is thus a social mechanism that is used to coerce members of society, through the threat of pain and suffering (punishment) to abstain from conduct which is harmful to various interests of society.

5.2 Interests of society can refer to human life, physical integrity, dignity, property, security of the state and public morality. In the case of the creation of statutory offences, it is the task of the legislature to decide what interests require protection through criminal law. There is little guidance on how this is determined.[263]

5.2.1 However, criminal law obviously does not serve to protect every societal interest. It has been contended that the interest in question should be so valuable that peaceful and orderly societal coexistence cannot be guaranteed without its protection through the criminal law, even though it may also be protected through other branches of the law.[264] The criminal law is also not a device whereby all social wrongs in society should, or even can, be corrected. Nor is it, according to the prevailing view, a device through which standards of morality can or should be endorsed. There are other less costly devices and institutions through which moral wrongdoing can be, and is, censured and treated, and whereby values are inculcated. These include the family, the peer group, schools, churches and welfare institutions. It has been remarked that not every standard of conduct that is fit to be observed is also fit to be enforced through the law, more particularly the criminal law. This does not mean that society condones the deviant conduct in question. It means only that society should not be

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261 **LAWSA** Vol 6 3; Burchell and Milton 1-2.

262 Burchell and Milton 1-2; Snyman 8; **LAWSA** Vol 6 5. See also par 5.16.1 below.

263 Cf also par 5.16.1 below for the respective punishment theories as justification for punishment.

264 **LAWSA** Vol 6 14; Van Wyk 463 et seq.

willing to utilise its most drastic weapon to attempt to correct every type of deviant or antisocial conduct.[265] Yet, there is a strongly supported view that moral wrongdoing may be criminalised if there is evidence of harm to society resulting from the incidence of such conduct.[266]

5.3 The concepts of "crime", "punishment" and "criminal" are closely interrelated in that

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265 **LAWSA** Vol 6 11.

266 **LAWSA** Vol 6 11. A long and controversial debate, which impacts also on HIV/AIDS, is whether it is proper to enforce morality (sexual or religious) through the medium of the law. In their debate on morality at the end of the previous century, John Stuart Mill and Sir James Fitzjames Stephen held opposing views in this regard: Mill's conception of liberty included the notion that power should not be used against a member of society for any purpose other than "to prevent harm to others". Stephen, on the other hand considered the enforcement of morality to be justified as a value in itself (Burchell and Milton 34-35). In the 1950s the Wolfenden Committee on Homosexual Offences and Prostitution in England defined the function of the criminal law (so far as it concerned the subject under its investigation) as "not to intervene in the private lives of citizens, or to seek to enforce any particular pattern of behaviour" further than is necessary (Burchell and Milton 35). The Report was however challenged shortly afterwards by Lord Devlin, who in *The Enforcement of Morals* contended that society disintegrates when no common morality is observed. However, Professor HLA Hart in the early 1960s responded to Devlin's "danger to society" argument by pointing out that there is no empirical evidence to support the assumption that immorality threatens the existence of society (ibid). It has been submitted that though there are further reasons for regarding them as "harmful", there are traces of the enforcement of morality "as such" in each of the crimes of bigamy, incest, public indecency, blasphemy, and violating a grave(Burchell and Milton 37). Recently the Constitutional Court declared the common law offence of sodomy, and of commission of an unnatural sexual act committed by a man or between men, to be inconsistent with the 1996 Constitution's notions of privacy, individual freedom and autonomy (**S v Kampher** 1997 4 SA 460 (C); **The National Coalition for Gay and Lesbian Equality v The Minister of Justice** unreported case No 97/023677 in the High Court of SA, Witwatersrand Local Division; and unreported Constitutional Court judgment CCT 11/98 of 9 October 1998). In the latter decision the court remarked as follows:

> "The censure [against homosexuality] arose mainly from moral objections rooted in religious interpretation; it was believed society needed to be protected against invasions of morality which the State regarded as subversive of the State religion and the fabric which bonds society together; thus if licence were granted to commit acts against the course of nature, the building blocks of human association, the propagation of the species, the family relationship and the integrity and dignity of right-thinking subjects of the State would be threatened or undermined. Criminalisation of homosexual conduct reflected the seriousness with which the State viewed deviations from sexual rectitude. The consequence was ... persecution, stigmatisation, exclusion of sexual non-conformists and punishment ... Although the suppression of sodomy may in times past have been regarded as a necessary prop of morality both public and private, that is today too tenuous a thread upon which to support its continued criminalisation ... (T)he protection of the morals of the people does not carry great weight where the law adequately protects the vulnerable as it does in the case of possible homosexual ... exploitation ... Attitudes emanating from religious belief (a personal and not a State concern in South Africa) and popular opinion cannot constitute a justification for the continued operation of the crime of sodomy in a face of the explicit constitutional guarantees" (p13, 33 and 34 of the unreported High Court case record).

See also a further interpretation on the meaning of "harm" in the HIV/AIDS context in fn 299 below.

crime is conduct in respect of which punishment is inflicted, while punishment is the sanction which is inflected by the state upon a person who has committed a crime. For our purposes this should be borne in mind, since subjecting certain conduct to punishment should not be inconsistent with the goals of punishment.[267]

5.4 Although the ultimate aim of the criminal law and of punishment may be the protection of society through the prevention of crimes, it must be realised that as long as the criminal law and punishment are employed to achieve this aim, one is not dealing with a neutral regulatory or correctional device, but with a tool - "society's most drastic legal sanction" - which has a retributive character, implying the imposition of reproach and censure for reprehensible conduct.[268]

5.5 Criminal law in its broadest sense also includes the *process* of detection, apprehension, trial and punishment according to which a person suspected of having committed an offence is brought before the court and which the court applies in determining whether or not he or she is to be found guilty.[269]

*** Factors tempering the application of the criminal law**

5.6 The criminal justice system (by resort to arrest, trial and punishment), proceeds mainly by way of interference with basic civil rights of life, liberty and property. In modern Western liberal democracies, these interferences, while permitted, are subject to the Rule of Law, and in countries like South Africa to the Bill of Rights as well. This implies that the nature and manner of the interference with civil rights is regulated by principles and laws designed to ensure that the criminal law is applied with respect for

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267 Cf par 5.16.1 below for the goals of punishment as expressed through the different punishment theories.

268 **LAWSA** Vol 6 5.

269 Cf Burchell and Milton 2-3; **LAWSA** Vol 5 Part 2 122.

human rights and according to agreed norms of justice and fairness.[270]

+ ***The principle of legality***

5.7 The principle of legality (the essence of the Rule of Law in the context of the criminal law), entails that punishment may be inflicted only for contravention of a designated crime created by a law (either common law or statute law) that was in force before the contravention.[271] As such the principle imposes certain demands and constraints upon both the legislature and the judiciary: the legislature is required to create crimes in a particular form and language and the courts are required to abstain from usurping the law making function of the legislature, and to interpret penal laws in a particular manner.[272] One of the practical effects of the principle of legality is that the courts have no power to create new crimes or extend the ambit of existing crimes on grounds of public morality.[273] Although this does not preclude the courts from adapting existing crimes to meet contemporary requirements, such a process may be controversial as there is a fine line between adaptation and extension so as to render criminal that which was not previously.[274]

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270 Burchell and Milton 57; Snyman 33.

271 Burchell and Milton 57 et seq. See also **LAWSA** Vol 6 21, 338-339; Snyman 33 et seq.

272 Burchell and Milton 59; **LAWSA** Vol 6 21-23; Snyman 34.

273 **R v Robinson** 1911 CPD 319; Cf also **S v Solomon** 1973 4 SA 644 (C). The principle of legality requires that there be a closed list of common law crimes and that no new crimes can be added to the list. Thus there can be no conviction of, or punishment for, an act not previously declared to be a crime at common law. In effect this means that the courts have no power to and are precluded from inventing or creating new common law crimes. Only the legislature possesses the power to create new crimes through a legislative act (Burchell and Milton 59); **LAWSA** Vol 6 21-22. Cf also Snyman 39-41. (Note that the themes of constitutional democracy and fairness and the derived values of certainty and fair notice contained in the broad principle of legality can be enunciated as several practical applications in the context of the criminal law. Only those of relevance to the present enquiry are referred to in this Discussion Paper.)

274 This effect of the principle of legality also bears relation to the ideology of modern liberal democracies which holds that the laws, and especially penal laws, should be made by the democratically chosen representatives of the people (Snyman 35-36; Burchell and Milton 59).

+ ***The influence of the 1996 Constitution***

5.8 The 1996 Constitution affirms the principle of legality in general in that its founding provisions refer to the "supremacy of the rule of law". Thus any aspects of the principle not expressly referred to in the Constitution could be embraced within "the rule of law".[275] More specifically, section 35(3)(l) expressly provides that everyone who is arrested for allegedly committing an offence has the right "not to be convicted for an act or omission that was not an offence either under national or international law at the time it was committed or omitted".

5.8.1 The result of this superimposition of the principle of legality upon the procedures for apprehending, trying and punishing offenders is that the modern criminal justice system is activated by two distinct ideologies: That of "crime control" (based on the proposition that the repression of criminal conduct is the most important function of criminal process); and "due process" (of which the central value is that innocent persons should not be convicted of a crime that did not exist at the time the act was committed; and that the criminal process should give due recognition and protection to the basic human and civil rights of and accused).[276] The blend must be right - too great an emphasis upon due process of law values will inhibit the efficacy of crime control and too great an emphasis of the values of crime control will lead to injustice.[277]

5.9 While crime involves an infringement of the State's or someone else's rights, the criminal justice system's response of arresting, bringing the wrongdoer to trial and invoking punishment interferes with individual rights. The Constitutional Court has acknowledged that the enforcement of the criminal law involves the State acting in its executive and administrative capacity and, therefore, that the rules of the criminal law would have to be compatible with the provisions of the Bill of Rights contained

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275 The 1996 Constitution sec 1(c).

276 Burchell and Milton 67-71.

277 Ibid.

in the 1996 Constitution.[278] The 1996 Constitution prescribes the bounds of permissible intrusion into the sphere of individual rights by the criminal justice system. Chapter 2 lays down certain fundamental rights. For instance, due process rights are protected,[279] as are the right to freedom and security of the person, [280] the right to dignity,[281] the right to privacy,[282] and the right to equality.[283] These rights are however not absolute and may be limited: Section 36 provides that the rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account the nature of the right; the importance of the purpose of the limitation; the nature and extent of the limitation, the relation between the limitation and its purpose, and less restrictive means to achieve the purpose. The Constitution does not provide for an express hierarchy of rights. The courts are therefore required to balance competing interests and values and determine the precedence of one right over another in the context in which the clash occurs by reference to the standard of *boni mores* of the community,[284] and by using an assessment based on proportionality.[285]

5.10 Any statutorily created crime will clearly have to pass the test of compatibility with the provisions of the Constitution: Since the modern democratically representative legislature expresses the will of the majority of the people, it follows that the

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278 **Du Plessis v De Klerk** 1996 3 SA 850 (CC) at 881D. See also Burchell and Hunt Vol 1 1-5.

279 The 1996 Constitution sec 35.

280 Ibid sec 12.

281 Ibid sec 10.

282 Ibid sec 14. Cf also **Case v Minister of Safety and Security; Curtis v Minister of Safety and Security** 1996 5 BCLR (CC) 609; **The National Coalition for Gay and Lesbian Equality v The Minister of Justice** unreported case No 97/023677 in the High Court of SA, Witwatersrand Local Division, and unreported Constitutional Court judgment CCT 11/98 of 9 October 1998.

283 Ibid sec 9.

284 **Mandela v Falati** 1994 4 BCLR 1(W) and 1995 1 SA 251 (W).

285 **Holomisa v Argus Newspapers** Ltd 1996 6 BCLR 836 (W) and 1996 2 SA 588 (W).

legislature in creating new crimes reflects the current values and attitudes of people in relation to the type of conduct that society considers to be harmful to itself and its members.[286]

* A role for the criminal law: Premise

5.11 As indicated above, an integrated public health and human rights approach has over the years been accepted as having the best results in reducing the spread of HIV.[287] It is recognised internationally that coercive legal measures, and the criminal law in particular, are to a great extent unacceptable as a public health tool and cannot reduce the unintentional spread of HIV. The most effective means of limiting the spread of HIV is behavioural modification. In the absence of a cure, public health authorities thus maintain that public education and counselling about the modes of transmission and methods of reducing risk are more effective in preventing the transmission and spread of HIV.[288]

5.12 However, although education and counselling about HIV, its modes of transmission and prevention will undoubtedly have a profound impact on behaviour, they have limitations. There will be exceptional situations where the lethal and devastating virus is inflicted upon a victim by negligent or intentional criminal act and where the victim is not able to protect him or herself against infection. Sexual assault and rape are examples of this. Even in the area of intimate relationships, education about risks has its limits where a person for instance abuses his or her position of trust by

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286 Burchell and Milton 29.

287 See par 3.8-3.9 above. See also Cameron (Unpublished) 2-3; **SALC Second Interim Report on Aspects of the Law Relating to AIDS** 25-27;

288 Tierney 1992 **Hastings International and Comparative Law Review** 475; Holland 1994 **Criminal Law Quarterly** 279-280; Jackson in **AIDS Agenda** 260-261; Hermann 1990 **St Louis University Public Law Review** 351; Harris 1993 **Arizona Law Review** 262. In Australia, Canada and the United States policy makers accepted this (Ibid). Also in South Africa, this premise is accepted as is evident from the principles underlined in the **NACOSA National AIDS Plan 1994-1995** and in the Department of Health's current response to the HIV epidemic (see par 4.3-4.8 above).

concealing high-risk behaviour, such as having had unprotected sex away from his or her partner.[289] The latter is of special significance as regards women's vulnerability to HIV: men often have the power to insist on unprotected intercourse notwithstanding their HIV status.[290]

5.13 The limitations of education and information campaigns are emphasised in the concern increasingly being expressed by public health authorities, legislators, politicians and victims' rights advocates that certain individuals, knowing that they are infected with HIV, may deliberately disregard the risk they pose to others.[291] When individuals threaten the health of others by their deliberate or reckless behaviour it has been urged that criminal prosecution should be considered an appropriate response by the state. Hence proponents strongly lobby for greater protection of persons who are unwittingly exposed to or infected with HIV, particularly in respect of those victims who become infected with HIV through sexual assault.[292] If it is accepted that the criminal law does *not* have a role in actually reducing or preventing the spread of HIV, could it nevertheless have a role in terms of its traditional values, functions and objects i e in outlawing and punishing behaviour which society regards as harmful? It could be argued that transmission of and exposure to HIV can be harmful to human life and to physical and psychological integrity - which are so valuable that orderly societal coexistence cannot be guaranteed without their protection by the criminal law.

5.14 It has been pointed out above that a country can have or create laws making it a crime

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289 Holland 1994 **Criminal Law Quarterly** 285-286; Harris 1993 **Arizona Law Review** 262.

290 Buchanan in **African Network on Ethics, Law and HIV** 106-107. Cf also par 2.2.1-2.1.5 above.

291 Hermann 1990 **St Louis University Public Law Review** 351; Harris 1993 **Arizona Law Review** 263. See, for instance the incidents of gang rape with the accompanying threats of transmission of HIV described in par 2.1.1 and fn 12 above. See also the judgement in the recent Supreme Court of Canada case **R v Cuerrier** (Unreported Case File No 25738 [Internet]) where the limitations of public health efforts were pointed out in the context of an accused with HIV having disregarded public health directions regarding safe sex and disclosure of his status to sex partners (see par 5.16.3 for more detail).

292 Hermann 1990 **St Louis University Public Law Review** 351.

to harm others.[293] Death constitutes a legally cognizable harm. So, too, does having to live with a debilitating disease. To deliberately or recklessly infect another person with a fatal disease would, in most legal systems, amount to the offence of attempted murder, murder, or infliction of grievous bodily harm. What court, faced with proof that a person with HIV deliberately had unprotected sex with another who in consequence sero-converted, would fail to convict the person of an offence involving infliction of serious harm?[294] In many systems, to infect another person negligently (for example where the perpetrator is aware that he or she has HIV, or has reason to believe he or she might have HIV but believes that infection will not occur), would also be a legal wrong and may amount to culpable homicide or a civil wrong. Experts who criticise the utilisation of coercive legal measures in the HIV/AIDS context acknowledge this.[295]

5.15 However, where unacceptable high risk behaviour does not result in the transmission of HIV, the harm question is more complex.[296] The criminal law applies most straightforwardly where physical injuries (including those resulting in death) have been sustained. Where exposure to HIV does not result in transmission, the injury inflicted is mostly psychological in the sense that the perpetrator's HIV status causes the victim mental anguish. Should a perpetrator escape criminal liability where he or she intends to cause physical injury or exhibits gross indifference to the probability that such injury will be sustained, but through fortuity no injury occurs? Although harm does not include only physical harm, it is not quite clear under what

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293 Cf par 5.2.1 and fn 266 above.

294 Dalton in **AIDS Law Today** 246; Buchanan in **African Network on Ethics, Law and HIV**105-106.

295 They concede that "the criminal law naturally has a role to play where a person's behaviour falls within the area of established common law crimes" (Viljoen 1993 **SALJ** 108-109 [our translation]) and " ... there is obviously a place for prosecuting flagrant offenders under the common law ..." (Cameron and Swanson 1992 **SAJHR** 220). Cf also the United States Report of the Presidential Commission on the Human Immuno-deficiency Virus Epidemic 1988 at 130 as quoted in Hermann 1990 **St Louis University Public Law Review** 352: "Just as other individuals in society are held responsible for their actions outside the criminal law's established parameters of acceptable behaviour, HIV-infected individuals who knowingly conduct themselves in ways that pose a significant risk of transmission to others must be held accountable for their actions".

296 Van Wyk 477; Dalton in **AIDS Law Today** 246.

circumstances such HIV related behaviour would fall within the parameters of the criminal law.[297] It has been said that criminal wrongfulness lies in behaviour which is regarded by society as "so wrong" that it should be punished as a crime.[298] Some argue that a person with HIV (knowing that he or she is infected) should both inform their partner of their HIV status and take precautionary measures to prevent infection as the possibility of harm ensuing cannot be totally excluded by using condoms.[299] Others submit that it is sufficient for a person with HIV to protect their partner by simply using precautionary measures or to inform their partner of their HIV status without taking precautions.[300]

5.16 Subjecting behaviour to punishment should not be inconsistent with the goals of punishment as expressed in the respective theories of punishment. These theories suggest that punishment is justified either because it is deserved (the retributive theories), or because it is socially beneficial in the sense that it will be preventative or deterrent (the utilitarian theories).[301]

5.16.1 *Retributive theories* are based on the elementary idea that persons who have caused harm should themselves suffer harm and punishment. Punishment is regarded as being

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297 Van Wyk 467. Cf also the Criminal Law Amendment Act 105 of 1997 which recognises that "psychological harm" caused may necessitate a harsh sentence.

298 Cf Van Wyk 462 where she refers to JV Van der Westhuizen's "Noodtoestand as regverdigingsgrond in die Strafreg" (LLD Thesis University of Pretoria 1979 at 480).

299 Cf Van Wyk 470. This would be in accordance with Hart's notion of harm (as expressed in the course of the Hart-Devlin debate on morality and the law), as applied to the scenario of HIV/AIDS (Van Wyk 470). Hart supported the notion that protection of an individual against harm could be the only justification for criminal sanction and emphasised that harmless sexual activities should not be the subject of criminal sanction (Van Wyk 467; see also par 5.2.1 above).

300 Cf also the discussion on consent in par 5.24.1 (and fn 339) below; and the recent decision of the Supreme Court of Canada **R v Cuerrier** referred to in fn 5.24.2.2 below. However it is not clear how this judgment will be interpreted and applied in practice.

301 Burchell and Milton 33, 38-49; Snyman 19-27; **LAWSA** Vol 6 6-7. See also van Wyk 474 et seq where the theories of punishment are discussed in the HIV/AIDS context.

justified by an event in the past, the commission of a crime.[302] *Utilitarian theories* contend that punishment has a social benefit for society, and is thus justified by the advantage it brings to the social order. In this case justification for punishment is found in the future, by the value of its consequences. This value is twofold and lies in the prevention of crimes (by removing the criminal from society and thus making it impossible for him or her to commit further crimes) and deterrence from committing crime.[303] Deterrence may either be individual (by teaching the individual offender a lesson so that he or she will be deterred from repeating the offence) or general (in that persons threatened with punishment will abstain from committing crimes).[304] Modern sentencing policy reflects a combination of several or all of the aims of punishment. However, retribution is regarded as the backbone of the South African approach to sentencing. The retributive theory is the only theory of punishment that explains the fundamental justification for resorting to punishment as a response to crime. It is also the only theory which actually associates punishment with a crime that has been committed. Moreover, it is also the only theory that requires that punishment should be proportionate to the crime.[305] This does not mean that the other theories have no relevance. While retribution provides the justification for punishment, in specific instances deterrence and rehabilitation may also be accessory.[306]

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302 This concept should not be confused with revenge, which is the mere infliction of harm in return for harm suffered without consideration of the nature or extent of the harm suffered. Retribution rests upon a principle of proportionality in terms of which the retribution visited upon the wrongdoer must bear some relationship to the harm done to society (Burchell and Milton 38-42; Snyman 19-22; **LAWSA** Vol 6 7. Cf also Elliot [Final Report] 38-43).

303 Burchell and Milton 42et seq; Snyman 19-20, 22. Cf also Elliot (Final Report) 41-43.

304 Burchell and Milton 42-44; Snyman 22-24; **LAWSA** Vol 6 7.

305 Snyman 21, 25-27; Burchell and Milton 48-49; **LAWSA** Vol 6 5-7. If deterrence is the purpose of punishment there is no logical reason why severe punishment should not be imposed on an innocent person, since the punishment will have a deterrent effect whether the person is guilty or innocent. Punishment of the innocent is contrary to the principle of legality and incompatible with our sense of justice (Burchell and Milton 48-49).

306 Snyman 26-27; Burchell and Milton 49. Cf however the reference in **LAWSA** Vol 6 7-8 to MA Rabie and SA Strauss **SA Punishment: An Introduction to Principles** third edition Lex Patria: Johannesburg 1981 22, 89-116 - where the authors, although emphasising the importance of retribution, notes that deterrence has been described as the essential, all-important and universally admitted object of punishment, the other objectives being regarded as accessory.

5.16.2 For a perpetrator to deliberately or recklessly expose another to, or infect another with HIV, without informing the victim of the perpetrator's HIV positive status and/or without taking the necessary precautions, would deserve condemnation. The strongest way to express this condemnation would be through the criminal law. The consequences of infection or exposure are so severe that there is a need for condemnation which would have a salutary denunciatory effect:

> If we do not use the criminal law then there will be public outrage at high-profile cases where individuals have recklessly infected others. Such outrage will be aimed indiscriminately at all individuals who are HIV infected. We need an outlet for expression of outrage at such wilful or reckless behaviour.[307]

Criminal sanction would thus be justified in terms of retribution. Criminal sanction under these circumstances would however also send out a clear message that engaging in deliberate or reckless behaviour with potentially fatal consequences for the unwitting victim is unacceptable.[308] In this sense applying the criminal law would also fulfil its preventative and deterrent functions.

5.16.3 As Cory J, delivering the majority judgement in the recent Supreme Court of Canada case, **R v Cuerrier**[309] stated in relation to the role of the criminal law in the HIV/AIDS context:

> (T)he criminal law does have a role to play both in deterring those infected with HIV from putting the lives of others at risk and in protecting the public from irresponsible individuals who refuse to ... abstain from high-risk activities ... Where public health endeavours fail to provide adequate protection to individuals .. the criminal law can be effective. It provides a needed measure of protection in the form of deterrence and reflects society's abhorrence of the self-centered recklessness and the callous insensitivity of the actions of the respondent and those who have acted in

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307 Holland 1994 **Criminal Law Quarterly** 288.

308 Ibid.

309 **R v Cuerrier** (Unreported case File No 25738 [Internet]). See par 5.24.2.2 below for more detail.

> a similar manner.[310] The risk of infection and death of partners of HIV-positive individuals is a cruel and ever present reality. Indeed the potentially fatal consequences are far more invidious and graver than many other actions prohibited by the Criminal Code. The risks of infection are so devastating that there is a real and urgent need to provide a measure of protection for those in the position of the complainants. If ever there was a place for the deterrence provided by criminal sanctions it is present in these circumstances. It may well have the desired effect of ensuring that there is disclosure of the risk and that appropriate precautions are taken.[311]

5.17 As regards the vulnerable position of women with respect to HIV transmission, it is further submitted that in denouncing and punishing HIV related activities outside the parameters of acceptable behaviour, the criminal law could at the same time enforce an agreed societal norm that the personal and physical integrity of women should be respected by men.[312]

5.18 In conclusion the Commission is of the preliminary view that HIV transmission, and conduct that brings with it risks of transmission are matters of public health first and foremost.[313] The criminal law has a *limited role* which consists in minimizing and dealing with harm rather than altering the realities of social behaviour and human desire. It is submitted that this role consists of denouncing and punishing unacceptable behaviour which causes harm or exposes others to harm.[314] What would be "unacceptable behaviour" and "harm" would depend on prevailing societal values. However, constitutional rights and specific factors inherent to HIV/AIDS as a disease will also play a role in this regard.

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310 The respondent in the case knew that he had HIV and had been instructed several times by health care workers to inform his sexual partners of the fact and to take precautionary measures when engaging in sexual intercourse - he however disregarded this.

311 At par 140-142 of the unreported majority judgement referred to in fn 309 above.

312 Cf Buchanan in **African Network on Ethics, Law and HIV** 107.

313 Refer to par 3.5-3.10 above. Cf also Elliot (Final Report) 8; Buchanan in **African Network on Ethics, Law and HIV** 107.

314 Van Wyk 479; Buchanan in **African Network on Ethics, Law and HIV** 98, 110.

B) UTILISING THE COMMON LAW TO ADDRESS HARMFUL HIV-RELATED BEHAVIOUR

5.19 It is stated above that the project committee's premise in defining the role of criminal law in the HIV/AIDS context is that the criminal law is not a public health tool to reduce the spread of the disease, but that it may have a limited role in minimising or dealing with harm caused by unacceptable behaviour. It is also stated that most legal systems already have laws making it a crime to harm others - these may be either common law or statutory crimes.

5.19.1 In South African law these include the common law crimes of murder, culpable homicide, rape, assault, and attempts to commit these crimes.[315] Our law does not at present have any HIV specific statutory provisions criminalising HIV-related behaviour.[316] What complicates the present inquiry is the fact that our relevant common law crimes have not been applied to HIV-related behaviour in practice: there have been no reported examples in South Africa of prosecutions under common law crimes for such behaviour.[317] (At the time this Paper was compiled, a man has been charged with attempted murder in a magistrate's court in wat is reportedly the first case of its kind in South Africa.[318]) The lack of prosecutions in our country stands in contrast to the position in certain other jurisdictions, for instance the United States, Canada, England and Australia.[319]

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315 The South African terminology are used here. Other systems have corresponding crimes, although they may sometimes be referred to in slightly different terms. See also par 7.47-7.57 below.

316 The only existing criminal law and procedure provisions relating to HIV/AIDS are those dealing with bail and minimum sentences described in par 3.21 above.

317 HIV has indeed indirectly received the attention of the criminal law in that our courts have taken infection with HIV into account in sentencing convicted persons. In all of these instances the accused's HIV infection was a factor independent of the offence in question. In all instances it was indicated that a life threatening condition such as AIDS could be (or was) a mitigating factor (**S v Mahachi** 1993 2 SACR 36 (Z); **S v Cloete** 1995 1 SACR 367 (W); **Chauke v S** 1996 2 SACR 507 (T); **S v Sibonyane** unreported Regional Court case (14/2865/967 Pretoria Regional Court). Naturally, where HIV is shown to be directly related to the offence committed - for instance in the case of a prosecution for rape - and where same should be used as an aggravating factor in sentencing, our courts will not be bound by these decisions (Hassan [Unpublished]) 4. In the latter regard see fn 185 above for information on the recently enacted Minimum Sentencing Act.

318 See par 2.1.5 above.

319 See par 6.6 et seq below for more detail.

5.20 If it is accepted that the criminal law indeed has a role to play in the HIV/AIDS context, the question arises as to whether using the existing common law crimes or creating a new statutory offence is the most appropriate way of giving effect to this role. The suitability of applying the common law crimes to HIV-related behaviour is examined below against the general requirements for criminal liability. Thereafter the need for the possible creation of a statutory offence is considered. The latter is done on the basis of considering rationales for and against creating HIV specific legislation. The experiences in other legal systems are set out in Chapter 6.

* General requirements for criminal liability under common law

5.21 For criminal liability to result the prosecution (i e the State) must prove, beyond a reasonable doubt, that the accused has committed a voluntary *act or omission* which is *unlawfu*l and that this conduct was accompanied by criminal capacity, and *fault*.[320] In the case of completed crimes the state must also prove that an *unlawful consequence* was caused by the act or omission.

+ *Unlawful conduct*

5.22 Criminal law essentially punishes the *conduct* of human beings. As a general rule conduct must consist in doing something (a positive act) or not doing something (an omission).[321] An omission, however, entails criminal liability only where a person was under a legal duty to act (i e where the legal convictions of the community require action) as opposed to a moral duty.[322] When a person, through prior conduct for instance creates an unlawful or dangerous state of affairs, an omission to act in order to prevent harm may result in criminal liability.[323]

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320 Burchell and Milton 95; **LAWSA** Vol 6 23 et seq.

321 **S v Johnson** 1969 1 SA 201 (A). Burchell and Milton 95-96; **LAWSA** Vol 6 23-26.

322 **Minister van Polisie v Ewels** 1975 3 SA 590 (A). See also **LAWSA** Vol 6 24-25.

323 Ibid.

5.22.1 In the HIV/AIDS context this could mean that where a person with HIV fails to inform a sex partner of his or her infection, and/or does not take other steps to prevent harm (by using a condom, for instance), such conduct may result in criminal liability.

5.23 Moreover, in crimes which involve bringing about an unlawful consequence, for instance the death of another person, there must be *causal link* between the initial act or omission and the ultimate unlawful consequence.[324] Crimes of this nature require proof of a causal relationship between the accused person's conduct and the legally prohibited harmful event, and in addition proof of fault in respect of the event.[325] The problem of causation almost invariably arises in cases of murder and culpable homicide, where the court must decide whether the act of the accused was the cause of death.

5.23.1 The greatest evidentiary hurdle in proving criminal charges in HIV transmission cases would be in substantiating the element of causation:[326] Proof of causation would require proof that the perpetrator was HIV positive at the time the act was committed; proof of an act by the perpetrator that could transmit the virus; and proof that the victim actually acquired the infection from the act of the perpetrator. Proving that the perpetrator had HIV at the time would be difficult without direct evidence that he or she was in fact infected.[327] The uncertainty in determining which particular act transmitted the virus makes it nearly impossible for the prosecution to prove that the perpetrator was the source of the infection. Because of the delay period between seroconversion and the onset of symptoms, definitive proof that the victim did not already have HIV before the alleged transmission took place will be necessary. If it is shown that the victim engaged in any high risk contact with others

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324 Burchell and Milton 96.

325 **LAWSA** Vol 6 29.

326 Harris1993 **Arizona Law Review** 240-241; Robinson in **AIDS and the Law** 245-246; Tierney 1992 **Hastings International and Comparative Law Review** 493; Laurie 1991 **Journal of the Law Society of Scotland** 315; see also Van Wyk 491.

327 The information could only be established by way of either an admission by the perpetrator or by relevant medical evidence. Medical practitioners may be required to give evidence in court even if the information they disclose would otherwise be confidential (Strauss 112).

within a reasonable period before or after the perpetrator's alleged transmission, it would be difficult, if not impossible (at least at present), to decide beyond a reasonable doubt that the victim acquired his or her infection from the perpetrator.[328]

5.24 The accused's conduct must further be *unlawful* in order to lead to criminal liability.[329] Public policy would be decisive in ascertaining what is unlawful and what not.[330] In the context of HIV/AIDS it has been submitted that rational considerations of society should be taken into account in this regard, and that only sexual behaviour which harms others should in principle be regarded as unlawful.[331]

5.24.1 The requirement of unlawfulness requires that there must be no defence available to the accused which could exclude unlawfulness. One of the relevant defences, in the context of HIV transmission or exposure would be *consent* by the victim. Consent does not as a rule justify a criminal act, because an individual decision by a victim cannot justify an act which constitutes a wrong against the community as a whole.[332] Thus murder is not justified by the consent of the victim to be killed. Where the victim dies of AIDS, consent is unlikely therefore to set aside unlawfulness.[333]

5.24.2 However, a person may legally consent to *risk* of serious bodily harm provided that it is not against public policy.[334] Consent to the risk of serious bodily harm would in most instances be against public policy except where the contrary is established.[335]

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328 Tierney 1992 **Hastings International and Comparative Law Review** 493; Robinson in **AIDS and the Law** 246. Research is being undertaken which aims at perfecting a test which will be able to identify the DNA structure of a particular strand of the AIDS virus. This will enable scientists to trace the exact source of HIV infection (see also par 3.24 above).

329 Burchell and Milton 96. **LAWSA** Vol 6 39 et seq.

330 Van Wyk 479.

331 Ibid.

332 The State has an interest in the preservation of life and thus in preventing the spread of HIV(Cf Burchell and Milton 97). See also Van Wyk 500-501; De Jager 1991 **Journal of South African Law** 558.

333 Sorgdrager 1988 **De Rebus** 793.

334 Considerations of public policy and reasonableness should be indicative of whether consent should be recognised as a defence in a particular case It should be noted that a court would apply an objective test to determine whether the consent was reasonably given in the specific circumstances (Burchell 68-72; Van Wyk 501).

335 The inviolability of bodily integrity and the sacrosanctity of human life is of public interest to such an

Consent to risk of serious bodily harm would probably not be against public policy where the harm is considered to be of a minor nature, or is known and appreciated and accepted, or is an inevitable part of life or human society.[336] In the case of consent to unprotected sexual intercourse knowing that the partner is HIV positive, it is uncertain what conclusion a court would reach on whether such consent was in fact valid. On the one hand it may be argued that a person who consents to intercourse knowing that the sex partner has HIV, accepts the risk of HIV transmission and that this acceptance will be legally recognised. On the other hand the courts may take the view that the extent of the possible supervening harm (i e infection with HIV) is so great that consent to it cannot be given.

5.24.2.1 Some writers are of the opinion that as the use of condoms is widely accepted as a means of protecting sexual partners against the risk of HIV infection, a victim could not legally consent to the risk of unprotected sexual intercourse even if he or she was aware of the perpetrator's positive HIV status.[337] Others, who confirm the latter view, state that consent under these circumstances would be *contra bonos mores* in view of the following: the high probability that the consenting party will die if HIV is indeed transmitted (consent in this sense would thus amount to consent to the risk of loss of life); the potential of the victim becoming infected; the wide-spread prevalence of the disease; and the expected debilitating influence of the disease on society.[338] Opponents express the view that consent to unprotected sexual intercourse by an informed victim would be sufficient to set aside unlawfulness as the risk of harm is proportionally very small.[339] Yet others submit that the use of protective measures may negate the need to disclose HIV positivity - in this instance, consent to

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extent that an individual does not have unlimited rights in respect thereof (Cf **S v Collett** 1978 3 SA 206 (RA); Van Wyk 500-501; De Jager 1991 **Journal of South African Law** 558). Examples of cases where the courts for policy reasons refused to recognise consent as a defence are murder, assault by inflicting strokes as punishment on an adult woman, and assault by heaping coals on the body of another to drive out evil spirits (**LAWSA** Vol 6 51-52).

336 Cf Van Wyk 501; Neethling 108.

337 Cf Van Wyk 501; Neethling 108 (on consent to risk of harm in general).

338 De Jager 1991 **Journal of South African Law** 559.

339 Labuschagne 1993 **De Jure** 421. Cf also par 2.39 above where it is indicated that the risk of contracting HIV from a single instance of unprotected sexual intercourse is estimated to be less than 1 in 1 000.

behaviour which could transmit HIV could still be valid.

5.24.2.2 The Canadian Supreme Court very recently found in **R v Cuerrier**[340] that consent to sexual intercourse which carried the risk of serious bodily harm, was vitiated by fraud and thus became sexual assault because of the non-disclosure of the known HIV status of the accused who had unprotected intercourse. The facts were that the accused had engaged in unprotected sex with two women without informing them of his seropositivity even though he had been explicitly instructed on three occasions by a public health worker to inform all prospective sex partners thereof and to use condoms every time he engaged in sexual intercourse. At the time of the trial neither of the complainants had tested positive for HIV. Both testified that they would never have engaged in unprotected intercourse with the accused had they known about his seropositivity. The majority decision held that in order to vitiate consent to sex, the fraud must carry with it a "significant risk of serious harm".[341] It was held that the risk of contracting AIDS as a result of engaging in unprotected intercourse meets that test. The judgement however also carried the qualification that the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant.[342] It is not yet clear however how the latter qualification will be interpreted and applied in Canadian law.[343]

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340 Unreported Case File No 25738 released on 3 September 1998 (Internet).

341 Until 1983, the indecent assault provisions in the Canadian Criminal Code provided that consent was vitiated where it was obtained "by false and fraudulent representations as to the nature and quality of the act". This requirement reflected the approach to consent in sexual assault cases which has existed at common law sine **R v Clarence** (1888), 22 QBD 23. There it was held that a husband's failure to disclose that he had gonorrhea did not vitiate his wife's consent to sexual intercourse - a decision "based on a harsh and antiquated view of marriage". Specifically, that a husband could not be guilty of raping his wife since the marital relationship implied, in law, the wife's consent to all sexual relations. Further, the very narrow interpretation of fraud was based on the view that it would be undesirable to treat fraud in a case of assault or sexual assault in the same way that it is treated in criminal or commercial contexts (see **R v Ceurrier** par 97 and 103 of the unreported judgment referred to in fn 309 above).

342 Par 124-129 of the unreported judgment referred to in fn 309 above.

343 Compare also the position in Germany and the United States: In the leading German case on deliberate exposure to HIV infection (i e no condom used) where it was ruled that engaging in sexual activity without informing a sex partner about one's HIV status qualifies as "a life endangering act"[fn 292]; In the *United States* several courts have used the public policy exception to prevent individuals from granting consent to engage in sexual intercourse with HIV positive individuals (i e without using protectionary measures). The majority of the American criminal exposure cases against HIV positive individuals were brought under sec 134 of the Uniform Code of Military Justice. In these cases the defendants usually knew that they were HIV positive and had been warned about the possibilities of

5.24.3 The consent must be given by a person fully aware of what he or she is consenting to.[344] In this respect knowledge and appreciation of the essential elements of the harm or potential harm will suffice to constitute consent even though the victim does not know and appreciate every detail.[345] Consent to harm would thus only be regarded as valid consent where the victim was fully aware of the perpetrator's HIV positive status and of the dangers to be associated therewith. It would not suffice for the perpetrator to argue that the victim should have a public knowledge about the risk of HIV transmission associated with unprotected sexual intercourse - the victim should be informed about the risk of the specific instance of contact with the perpetrator.[346]

+ ***Fault***

5.25 It is a general principle of South African criminal law that a guilty mind (the element referred to as fault or culpability) is required for criminal liability.[347] "Fault" indicates either intention or negligence. With the exception of culpable homicide, all common law crimes, including attempts to commit them, require intention for liability.

5.25.1 Different forms of intention have been distinguished. Of these, *dolus eventualis* ("constructive" or legal intent) is specifically relevant in respect of murder, and therefore also in respect of HIV transmission. This form of intention exists where the accused does not "mean" to bring about the unlawful circumstance or to cause the

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transmission. The military cases have suggested that there is no possible defence to unprotected sex because pubic policy prevents an individual from consenting to his or her death. Even when the complainant was aware of the defendant's infection, the court in certain cases found that consent was invalid due to the deadly nature of the act (Cohen [Unpublished 20-21; see also **US v Woods** 28 MJ 318 (1989); **US v Joseph** 33 MJ 960 (1991); **US v Womack** 29 MJ 88 (1989).

344 Burchell and Milton 97; **LAWSA** Vol 6 39 et seq.

345 Ibid.

346 Van Wyk 502.

347 Burchell and Milton 98 et seq; **LAWSA** Vol 6 73 et seq.

unlawful consequence which follows from his or her conduct, but foresees the possibility of the circumstance existing or the consequence ensuing and nevertheless proceeds with his of her conduct.[348] The multiple characteristics of *dolus eventualis* have been described as subjective foresight; the possibility of the occurrence of the consequences - however remote; a correlation between the foreseen and the actual manner of the consequence occurring; and recklessness in regard to it.[349] The subjective state of mind of the perpetrator is not ordinarily capable of direct proof - it may however be inferred from the perpetrator's conduct and from the circumstances in which the crime was committed. It could therefore be reasoned that in particular circumstances the accused "ought to have foreseen" the consequences, and thus "must have foreseen", and therefore, by inference "did foresee".[350] It is established law that what must be foreseen, is only *a* possibility, and not necessarily the probability or likelihood of the occurrence of the result in question. However, the degree of probability of its occurring may be relevant in drawing the inference that the accused did in fact foresee it: the greater the probability or the risk to life, in the instance of murder, for example, the stronger would be the inference that the accused in fact foresaw the victim's death.[351] "Reckless" means "not caring what the result might be".[352] However, reckless conduct as such is not sufficient to establish *dolus eventualis*: it is necessary that the accused also subjectively foresaw the possibility of the occurrence of the consequences.[353]

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348 Burchell and Milton 302 et seq; **LAWSA** Vol 6 74.

349 **LAWSA** Vol 6 74.

350 Ibid 76; Burchell and Milton 308.

351 **LAWSA** Vol 6 78.

352 Ibid 80.

353 Ibid. In the leading criminal case in Germany **(BGH v O4.11.1988 - StR 262/88**; see also Van Wyk 486 et seq) dealing with knowingly exposing another to HIV through unprotected consensual sexual intercourse, the Federal Court in 1988 found that this type of behaviour is punishable under sec 223 ("Bodily Harm") and 223a ("Dangerous Bodily Harm") of the German Penal Code. The Court ruled that *infection of another person with HIV* would cause "impairment to the health" of the victim under sec 223 as it leads to a significant change of such person's health condition. In particular, the infected individual has to cope with a situation where he or she risks infecting someone else for the rest of his or her life. In addition the court ruled that *engaging in sexual activity without informing a partner about the other's positive HIV status* qualifies as a "life endangering act" under sec 223a since no suitable medical treatment is available that could lead to recovery. However, in the case concerned the perpetrator was found guilty only of an attempt to contravene the relevant provisions as it was not possible to ascertain whether the victim had indeed been infected. The perpetrator was sentenced to two years' imprisonment. The Federal Court indicated that the facts of the case would also fit a prosecution for attempted murder

5.25.2 Applied to HIV/AIDS, *dolus eventualis* as a form of intention may be present where a person, knowing that he or she is infected, has unprotected sexual intercourse with another without informing him or her of the infection and without taking any precautionary measures. As indicated above, the subjective state of mind of the perpetrator under these circumstances is decisive. Therefore, although the perpetrator may not mean to bring about the infection of his or her partner, if he or she does foresee the possibility that it may happen and nevertheless proceeds with sexual intercourse, the requisite intent is present. If the person with HIV has a low viral load and transmission could seem unlikely, transmission may indeed still be possible and if this is known to the perpetrator, even in such a case *dolus eventualis* may be found to be present.[354]

5.25.3 Negligence is established if a reasonable person in the position of the perpetrator would have foreseen the possible occurrence of the prohibited consequence or the possible existence of the circumstance in question; and a reasonable person would have taken steps to guard against that possibility; and the perpetrator failed to take these steps.[355] Although the "reasonable person" is the fictitious person of ordinary

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(sec 211 of the German Penal Code) or attempted manslaughter (which is possible in German law) (sec 212 of the German Penal Code). However, the court found that the required higher level of intent for a conviction on these offences was not present: With reference to the long period of incubation, the Court argued that the defendant may share the hope of virtually all persons with HIV, that an effective treatment may in the meantime be developed and that the victim will therefore not die. The court deduced the required intent for the lesser conviction under secs 223 and 223a from the facts that the defendant was engaged in behaviour likely to transmit HIV without using precautions; was fully aware of his HIV status; and of the risk of transmitting the disease i e that his behaviour was of such a nature that it could be inferred therefrom that he accepted the possible infection of his partner. In cases of non-consensual sexual intercourse (i e forced unprotected sex with a person with HIV) the perpetrator could, under German law, be charged with rape, however the German Federal Court has not yet dealt with such cases. Thus far, not many persons with HIV have been convicted for having unprotected sexual intercourse under German law because of evidentiary problems (information supplied by Johann Weusmann, Junior Lawyer attached to the High Regional Court of Celle, Germany on 19/8/98; Cf also Van Wyk 486-488; De Jager 1991 **Journal of South African Law** 547-555).

354 Cf Dine and Watt 1998 **Web Journal of Current Legal Issues** (Internet) who submit that (because it is by no means clear that transmission of HIV is a "virtual certainty" where the person with HIV has a low viral load) it may seem improbable that a person with HIV in such a case subjectively foresaw the possibility of HIV transmission to his or her sex partner. See however also par 2.47 et seq above on the influence of viral load on the risk of HIV transmission.

355 **LAWSA** Vol 6 92.

intelligence, knowledge and prudence, if the perpetrator had knowledge or experience beyond that which the reasonable person would have, he or she should be judged by a higher standard, being that of the reasonable person with such knowledge and experience. What a reasonable person would have foreseen depends *inter alia* on what he or she would have known - this is an objective test in which facts which a reasonable person would have had, are imputed to a perpetrator.[356] Finally, the degree of care (duty to guard against harm), which should be exercised in a given circumstance depends on the one hand upon the foreseeability of the potential harm which may ensue - a lesser degree of care is required if the potential harm which may be suffered is slight. On the other hand, a greater degree of care is required if the accused brought about a condition which is potentially highly dangerous. Where such a serious consequence as death is reasonably foreseeable, the conclusion will usually be reached that the reasonable person would have taken steps to guard against its occurrence. This will be the case even if the likelihood of death is small, since the harm, it if results, is very serious. However, the reasonable person will guard against the harm only if there is at least a reasonable possibility that the apprehended harmful consequence may ensue.[357]

5.25.4 As regards the relation between intention and negligence, a clear distinction should be drawn between unconscious and conscious negligence. In the case of unconscious negligence, the perpetrator does not foresee the unlawful consequences of his or her conduct; he or she is not even aware of the possibility of the consequences occurring (although objectively seen, the reasonable man would have foreseen it). In the case of conscious negligence the perpetrator indeed foresees the consequences but unreasonably believes that these would not occur. In the context of HIV/AIDS the difference between conscious negligence and *dolus eventualis* can in practice be problematic. In the example given in par 5.25.2 above, conscious negligence may be present where the person with HIV subjectively *believes* that infection of his or her sex partner will not occur and under those circumstances proceeds with unprotected

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356 Ibid 99.

357 Ibid.

intercourse[358] (while with *dolus eventualis* the perpetrator *accepts* the risk of infection occurring and nevertheless proceeds with unprotected intercourse). Unconscious negligence may be present where a person is not aware of any risk of HIV transmission (for instance where the person is not aware of his or her own infection), but should have been aware of it - and under these circumstances proceeds with unprotected intercourse.[359]

+ *Proof beyond reasonable doubt*

5.26 The general principle in criminal cases is that the legal burden of proving the perpetrator's guilt rests upon the prosecution.[360] Therefore the state must prove every element of the perpetrator's guilt beyond a reasonable doubt: the commission of the act charged; its unlawfulness; the identity of the perpetrator; and the causation of the unlawful consequences .[361] It is difficult to define what exactly amounts to proof beyond a reasonable doubt. The former Appellate Division (now Supreme Court of Appeal) has adopted a common-sense approach to this requirement quoting with approval the following statement: "before a man is convicted of a crime, every supposition not in itself improbable which is consistent with his innocence ought to be negatived".[362]

* Relevant common law crimes

+ *Murder*

358 Cf the example in respect of *dolus eventualis* in par 5.25.2 above.

359 In **S v Ngubane** 1985 3 SA 677 the then Appeal Court held that the distinguishing feature of *dolus eventualis* is the volitional component of the perpetrator reconciling him or herself with the unlawful consequences. Cf also the discussion in Van Wyk 494-495, Snyman 194-196 and Burchell and Hunt Vol I 241-245 on *dolus eventualis,* and conscious and unconscious negligence.

360 Burchell 40; cf **S v Coetzee** 1997 1 SACR 379 (CC).

361 Lansdown and Campbell 909.

362 Per Tindall JA in **R v Blom** 1939 AD 188. Cf also Lansdown and Campbell 909.

5.27 Murder consists in the unlawful and intentional killing of another living person.[363] If it is proved beyond a reasonable doubt that a perpetrator with HIV intentionally or recklessly transmitted the virus to a victim with the effect of causing that victim's death, and the victim dies in consequence, the perpetrator could be convicted of murder.[364]

5.27.1 Murder is the most serious criminal offence with which a person transmitting HIV can be charged. However, it is unlikely that a prosecution for murder would be successful: First, a prosecution for murder would require the death of the victim. Because death may not occur for a considerable time after transmission, the perpetrator may die before the victim and a charge of murder would be moot.[365] Second, the greatest obstacle would probably be to prove causation i e that the victim died because of the acts of the perpetrator. Problems in this regard have been outlined in paragraph 5.23 et seq above. Third, the state must prove that the perpetrator was infected and was actually aware of his or her infection at the time the unlawful behaviour occurred - testing the perpetrator after the event is irrelevant because he or she could have become infected after the incident in question. Testing also does not address the situation in which the accused may have been infected but tests negative for HIV antibodies (in which case tests for the virus itself may be necessary).[366] Fourth, the requisite intention in the form of *dolus directus*, *dolus indirectus* or *dolus eventualis* would have to be proved.[367] *Dolus directus* requires proof that the perpetrator had the actual intent to cause the death of the victim. *Dolus indirectus* would be present if the perpetrator knew that he or she was infected, and that his or her behaviour could infect and kill the victim, and proceeded even though causing the death of the victim was not his or her main purpose. Since having sex is "a highly indirect modus operandi for the persons whose purpose is to kill", this

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363 Milton 310; Snyman 435.

364 Van Wyk 491.

365 Robinson in **AIDS and the Law** 2245-246; Tierney 1992 **Hastings International and Comparative Law Review** 492-493.

366 Tierney 1992 **Hastings International and Comparative Law Review** 492-493;

367 Van Wyk 492.

form of intent would probably be very difficult to establish.[368] *Dolus eventualis* will be present when a perpetrator knows that he or she is infected, (or may be infected), and that his or her behaviour may transmit the virus and may cause the victim's death but nevertheless proceeds with the risky behaviour regardless of possible transmission. His or her behaviour would then be reckless. As indicated above,[369] the greater the probability or the risk to life, in the instance of murder, the stronger would be the inference that the accused in fact foresaw the victim's death.

368 Tierney 1992 **Hastings International and Comparative Law Review** 492-493; Harris 1993 **Arizona Law Review** 244; Van Wyk 492-493.

369 See par 5.25.1.

+ ***Culpable homicide***

5.28 Culpable homicide consists in the unlawful, negligent killing of another person.[370] The only difference between a prosecution for murder and culpable homicide as regards HIV -related behaviour is that the criminal culpability required in this instance is negligence instead of intent. The same problems of proof involved with the requirement of causation will apply to a prosecution for culpable homicide.

5.28.1 Negligence is in all likelihood the state of mind which will be applicable in the majority of cases of HIV related behaviour. The test of negligence is formulated in such a way as to require an investigation into whether in the circumstances the conduct of the perpetrator in bringing about the death of the victim complied with established social norms of care in undertaking an activity which carries a risk of harm to other persons. As indicated above, the test is formulated in terms of measuring the conduct of the perpetrator against the conduct of the "reasonable person" in the same circumstances.[371] In the case of the crime of culpable homicide, the concept of negligence has three significant components: first, from the objective perspective of the reasonable person foresight that death could be a consequence of the conduct in question; second, a determination of what steps should reasonably have been taken to prevent the death of the victim; and third, whether the perpetrator in fact took those steps. It is the perpetrator's failure to take those reasonable preventative steps which determines that he or she was negligent in bringing about the death of the victim[372].

5.28.2 The objective test of foreseeability could present insurmountable problems of proof in instances where the perpetrator alleges that he or she relied on the probability that the victim would not become infected with HIV. If it is taken into account that the risk of infection from a single sexual exposure is less than 1%, it will be difficult to

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370 See par 5.25.3. Cf also Milton 364; Snyman 441.

371 Milton 365.

372 Ibid. See also van Wyk 495-496.

rebut the perpetrator's defence.[373] A further problem would be whether the use of condoms would amount to "reasonable preventative steps" which would exclude negligence.

+ ***Rape***

5.29 Rape consists in unlawful intentional sexual intercourse with a woman without her consent.[374] The element of consent confers a unique quality to the crime of rape: In crimes such as theft, robbery or assault, consent is a defence which could be raised by the accused - it is not one of the essential elements of the crime charged. The crime of rape is however defined in terms of lack of consent. Therefore, if the State cannot prove non-consent beyond reasonable doubt on a rape charge, the prosecution will fail and the victim's consent is assumed, and the accused is acquited.[375]

5.29.1 The Canadian Supreme Court recently held that consent to sexual intercourse which carried the risk of serious bodily harm was vitiated by fraud because of the non-disclosure of the HIV status of the accused who had unprotected intercourse with two women. If such an approach is applied to South African law, it would imply that a person with HIV who does not inform his sex partner of his infection may be guilty of rape.

+ ***Assault***

5.30 Assault consists in unlawfully and intentionally applying force to the person of

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373 In the light of the Appellate Division decisions in **S v Van der Mescht** 1962 1 SA 521 (A), **S v Bernardus** 1965 3 SA 287 (A) and **S v Van As** 1976 2 SA 921 (A), it is clear that on a charge of culpable homicide the prosecution must prove, beyond reasonable doubt, that a reasonable person in position of the accused would have foreseen the possibility of death: reasonable foreseeability of bodily injury short of death will not suffice (Burchell and Hunt Vol I 276). See also Snyman 226 who emphasises that death should be a *reasonable* possibility - unlikely possibilities ("vergesogte moontlikhede") are not taken into account. Cf also van Wyk 494-495.

374 Milton 439.

375 Ibid 450; Robinson in **AIDS and the Law** 247-248.

another; or inspiring a belief in a person that force is imminently to be applied to him or her. Assault can be committed by the mere touching of the person of the victim that is not consensual, or a beating and battering that leaves the victim at death's door.[376] The South African law has created a version of the crime of assault which identifies serious assaults under the appellation of "assault with intent to do grievous bodily harm" ("assault GBH").[377]

5.30.1 Assault GBH may be the most appropriate charge for unacceptable HIV related behaviour because the victim need not die for the offence to be complete. No causal link between the perpetrator's behaviour and the resultant death of the victim need therefore be established or proved.[378] It would be possible to institute a prosecution for assault both in instances where the unacceptable behaviour of the perpetrator with HIV results in infection of the victim, and where there has merely been exposure to the virus - without infection having resulted.[379] An assault charge could also be instituted when HIV transmission has taken place because of violence associated with fighting or sexual activity.

+ ***Attempt***

5.31 A prosecution for attempt to commit any of the crimes above (with the exclusion of culpable homicide, in respect of which attempt is not possible[380]), could be a way in which the problems presented by the requirement of causation in a prosecution for HIV transmission could be side stepped in that it is not necessary to prove a

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376 Milton 406, 431; Snyman 452.

377 No special punishment is prescribed for this form of assault, which, as in the case of common assault, is left to the discretion of the court. In the result, a charge of assault GBH has only a symbolic significance (Milton 431), though assault GBH is invariably accorded a much harsher sentence than common assault.

378 Harris 1993 **Arizona Law Review** 247-248; Tierney 1992 **Hastings International and Comparative Law Review** 4489-499; Van Wyk 496-497.

379 Van Wyk 496;

380 Intent is always a requirement in respect of attempt - one cannot form intent in respect of negligence (Snyman 443).

completed crime.[381] In other words, a prosecution would be successful if it could be proved that a person with HIV committed an unlawful act with the intention of harming the victim.

5.31.1 In the context of HIV/AIDS this could mean that a person who, knowing his or her HIV positive status, has unprotected sexual intercourse without informing a partner and with the intention (in the form of *dolus directus*, *indirectus*, or *eventualis*) of infecting the partner with HIV, could be guilty of attempt to commit murder or assault. A charge of attempt could also be used where the victim is exposed to, but has not been infected with, HIV.

C) CREATING A STATUTORY OFFENCE FOR HIV TRANSMISSION AND EXPOSURE

5.32 A statutory offence can either re-inforce common law crimes that already exist or it may create new offences in respect of behaviour not previously covered by criminal sanction. As indicated in par 3.1 above, the term "criminalisation" applies only to the second category.[382] It should be clear from the discussion of certain common law crimes earlier in this Chapter,[383] that harmful HIV-related behaviour is already covered by the common law. Whether such behaviour is sufficiently addressed by the common law is a core issue which impacts on the need for a statutory offence. This issue will be considered below in the rationales for and against the creation of a statutory offence.

* General requirements for criminal liability under statutory offences

5.33 Statutory offences are created by commands or prohibitions issued by a competent

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381 Burchell and Hunt Vol I 342.

382 Cf Burchell and Milton 25-32.

383 See par 5.27-5.31.1.

legislature enjoining or prohibiting conduct under threat of punishment.[384] The general rule is that, just as in respect of common law crimes, criminal liability under statutory offences requires unlawful conduct, criminal capacity and the fault element.[385] In enacting, the legislature may however alter, exclude or add to the application of the general principles of liability.[386]

5.33.1 Statutory offences will include a definition of the specific unlawful conduct (which may be an act, or an omission to act) which the legislature has prohibited. It may also be required in the definition that the perpetrator possesses certain attributes before the conduct gives rise to liability.[387] To obtain a conviction the State will have to prove each of the requirements outlined by the legislature with regard to the act.[388] The various common law defences (for instance consent to the unlawful conduct by the victim[389]) which establish absence of unlawfulness are also applicable to statutory offences, and in appropriate circumstances can be relied upon by the perpetrator to escape conviction.[390]

5.33.2 While all common law crimes require proof of fault (which - except in the case of culpable homicide - invariably manifests itself as one of the forms of *dolus)*, proof of fault may not necessarily be required in statutory offences. Liability without fault (strict liability) is however the exception and traditionally applied only in respect of so-called "regulatory" or "public welfare" offences.[391] Liability without fault may also

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384 Milton and Fuller (Revision Service 1995 7,9).

385 Burchell 33.

386 Milton and Fuller (Revision Service 1997 1).

387 Ibid.

388 Ibid

389 See par 5.24.1 above for more detail about consent as a defence.

390 Milton and Fuller (Revision Service 1997 3).

391 Not requiring fault in respect of these types of offences is justified on the grounds that these offences involve a shift of emphasis from the protection of individual interests to the protection of public and social interests. The interests involved are those of the maintenance of minimum standards of public health, public safety and welfare. Strict liability contributes to the efficient administration of such legislation, encourages and stimulates compliance with the provisions of the legislation and enables more expeditious and efficient prosecution of what are prevalent yet minor offences. Furthermore, such offences are by nature not regarded as true crimes and attract only light or minimal penalties (Milton and Fuller Revision Service 1997 18). Cf also par 3.1 above.

in principle be unconstitutional since it does not require established culpability and denies an accused the substantive benefit of the presumption of innocence.[392] It has consequently been submitted that there will be few, if any, circumstances in which it can be said that it is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, to hold a person criminally liable without proof of fault on their part.[393] The fault element in statutory crimes can consist of intention (either *dolus directus, dolus indirectus* or *dolus eventualis)* or negligence, depending on how the legislature formulates the offence.[394] As a general rule intention, where required, must relate to all the elements of the offence, and, as such, imports as an element of liability, proof of knowledge of unlawfulness.[395]

5.34 Finally, section 256 of the Criminal Procedure Act 51 of 1977 provides that if the evidence in criminal proceedings does not prove the commission of the offence charged but proves an attempt to commit that offence, the accused may be found guilty of an attempt to commit that offence. The effect of this provision is thus that a person charged with a statutory offence may be convicted of an attempt to commit that offence.[396]

* Rationales for and against the creation of HIV-specific offences to deal with harmful HIV-related behaviour

5.35 Rationales bearing on societal values, constitutional rights and factors inherent to HIV/AIDS as a disease, are usually put forward in favour of and against punishment

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392 See sec 12(1)(a) of the 1996 Constitution where it provides that "Everyone has the right to freedom an security of the person which includes the right - (a) not to be deprived of freedom arbitrarily or without just cause"; and sec 25(3)(c) which include the right to be presumed innocent. See also **S v Coetzee** 1997 1 SACR 379 (CC) at 384d-e.

393 Milton and Fuller (Revision Service 21, 32).

394 Ibid. The word "intention" in a statute indicates the requirement of *dolus.* This does not necessarily entail that *dolus eventualis* is sufficient for liability (Cf **S v Nel** 1989 4 SA 845 (A); Burchell 252-253). See also Milton and Fuller (Revision Service No 4, 1994 2)

395 Milton and Fuller (Revision Service 1997) 21.

396 Ibid 42. See par 5.31 above for more information on attempt to commit a crime.

by way of HIV-specific offences - be they enforcement of common law offences or the creation of new offences.

+ ***Rationales for creating an HIV-specific statutory offence***

FIRST RATIONALE:

HIV-SPECIFIC STATUTORY OFFENCES WOULD MINIMISE AMBIGUITIES ASSOCIATED WITH THE APPLICATION OF COMMON LAW CRIMES AND WOULD THUS BE MORE EFFECTIVE THAN THE COMMON LAW IN TARGETING HARMFUL BEHAVIOUR

5.36 It is argued that specific statutory offences would minimise ambiguities associated with trying to fit harmful HIV-related behaviour into pre-existing, although not altogether relevant, common law crimes. Such statutes could in particular be defined so as to circumvent evidential problems attendant on the common law.[397] It is submitted that it would be possible to develop statutory provisions which focus on behaviour likely to transmit HIV rather than requiring proof of actual infection. This would deal with problems of proof due to the possibly long period between becoming infected and knowledge of the injury (i e HIV infection).[398]

5.37 Furthermore, such a specific offence would be effective to deter individuals from engaging in harmful HIV-related behaviour to the extent that statutory provisions specifically proscribe behaviour which is likely to spread HIV, to the extent that violations of such provisions will be reported and prosecuted and to the extent that such statutes have explicit penalties established for their contravention:

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397 Laurie 1991 **Journal of the Law Society of Scotland** 317. In the US for instance, a wide range of offences have been created including knowingly exposing another to HIV, engaging in a sexual act while knowing oneself to be infected, or committing an act of unprotected sexual penetration conscious of one's own HIV status. All these offences do away with the need for HIV to be transmitted, thereby eliminating the question of causation from such cases (Ibid).

398 Hermann 1990 **St Louis University Public Law Review** 356. Cf also par 2.37. The invisibility of HIV infection means in most instances that the victim will not have any reason to suspect that he or she has been exposed to HIV.

> It is not unreasonable for society to establish clear parameters as to the behaviours it will not tolerate. By drawing a bright line around the behaviours that pose serious public health risks, the law gives clear notice of the conduct which will be subject to criminal penalty.[399]

Even if specific coercive criminal measures do not prevent the spread of HIV in general, or are difficult to enforce, the law nevertheless has a moral role to play in preventing or punishing harm done to others. [400]

5.38 It could also be argued that creating a statutory offence would create clarity and certainty in the law thus providing ordinary citizens with clear guidelines on what is acceptable behaviour.[401] An offence which is formulated to achieve this objective would send a clear signal of what behaviour in the context of HIV/AIDS is unacceptable and will be punished. Common law crimes are generally not well publicised, not clearly circumscribed or well known among the general public. It is argued that the publicity inherent in a statutory offence will facilitate public knowledge of such offence and will thus have a greater deterrent impact than the mere existence and availability of common law crimes.

SECOND RATIONALE:

STATUTORY OFFENCES ARE LESS SUSCEPTIBLE TO MORAL OR SOCIETAL INFLUENCES WHICH MAY CAUSE THEM TO BE APPLIED SELECTIVELY

5.39 It is argued that as statutory offences specifically state the conduct which is prohibited, and the sanction for such conduct, they are less susceptible to moral or societal influences which could lead to their selective application and diminished

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399 Hermann 1990 **St Louis University Public Law Review** 353.

400 Cf Buchanan in **African Network on Ethics, Law and HIV**105.

401 Cf also the requirements of the principle of legality as referred to in par 5.7; and the **United Nations International Guidelines on Human Rights and HIV/AIDS 1996** which states that if the criminal law in its traditional sense (i e common law or codified common law) is to be used, such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a verdict of guilty (see par 6.2 et seq above).

effectiveness. Their existence serves to reflect the community's viewpoint on HIV/AIDS and yet they can be worded in narrow terms to reduce the potential for prosecutorial abuse.[402] Moreover, the danger of possible selective enforcement of criminal provisions aimed at HIV transmission can be avoided by public vigilance of policing and prosecutorial activity.[403]

THIRD RATIONALE:

ENACTING HIV SPECIFIC CRIMINAL PROVISIONS AND PENALTIES IS JUSTIFIED AS IT REALISES THE PURPOSES UNDERLYING THE CRIMINAL LAW

5.40 The criminal law should reflect the needs of the public. In view of the lack of an effective vaccine or curative therapy for HIV/AIDS, all reasonable means of encouraging restraint with respect to unacceptable HIV related behaviour should be explored. Conduct likely to harm others by exposing them to or infecting them with HIV (including serious illness and likely death) therefore warrants criminal sanctions.[404]

5.41 Those persons who purposely violate laws intended to prevent conduct transmitting HIV, deserve to be punished. Just as other individuals in society are held responsible for their actions when they violate the minimum standards of behaviour set by the criminal law, persons with HIV who engage in conduct which they know could harm others should be held accountable for their actions. Accountability is justified because of the severe consequences of infection with HIV.[405] The use of the criminal law would be fair to those who may be subject to criminal liability when forbidden behaviour is within their control and the law gives such persons clear notice of the

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402 Laurie 1991 **Journal of the Law Society of Scotland** 317.

403 Hermann 1990 **St Louis University Public Law Review** 357.

404 Ibid 353.

405 Tierney 1992 **Hastings International and Comparative Law Review** 486; Cf also Buchanan in **African Network on Ethics, Law and HIV**105; the decision in the leading German case referred to in fn 343 above; **Venter v Nel** referred to in par 3.3.1 above.

behaviour prohibited.[406]

5.42 Those opposing the creation of a statutory offence often submit that such an approach will undermine the educational message that all are responsible for protecting themselves against HIV infection; and that creating such offences would deter persons in high-risk groups or marginalised communities from seeking HIV testing because of possible subsequent criminal charges. The first argument has little weight: Persons who know or suspect that they are HIV positive have a fundamental responsibility to advise their partners of their condition or their suspicion of it and/or to ensure that their sex practices are as safe as possible. Although it is true that all members of society should be aware of the danger of HIV infection and take steps to avoid the risk, the primary responsibility for making sex as safe as possible (be it by disclosure of their HIV status to sex partners and/or taking precautionary measures) must rest upon persons with HIV. This responsibility cannot be lightly shifted to unknowing members of society.[407] The outcome foreseen in the second argument is likewise unlikely: Those who seek testing basically seek treatment; people want to know whether they are infected or not and whether any treatment is available. Fear of possible future prosecution for something which has not yet occurred (and may never occur) is most unlikely to deter anyone from being tested.[408] Furthermore, if a new offence is directed also at those merely suspecting (as opposed to knowing) that they are infected, the argument that they would be deterred from seeking testing, would not hold.

FOURTH RATIONALE:

A SPECIFIC STATUTORY PROVISION IS JUSTIFIED AS IT WOULD SERVE THE PURPOSES OF DETERRENCE

5.43 The effect of the criminal law is not merely to punish, but also to deter and prevent

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406 Hermann 1990 **St Louis University Public Law Review** 353.

407 **R v Ceurrier** (par 144 of the unreported majority judgement - see fn 309 above for the full reference).

408 Holland 1994 **Criminal Law Quarterly** 288; **R v Ceurrier** (majority judgement in unreported case record at par 143.)

criminal acts. Deterrence occurs at two levels. First, with the individual prosecuted and second, within the community. At an individual level, prosecuting and punishing recalcitrant individuals persuade such persons to change their behaviour. Moreover, the criminal law also provides a social means to educate and reinforce norms of social behaviour. There is a social objective to prevent conduct likely to spread HIV in order to prevent further transmission, to educate the public about such conduct and to reinforce social norms against such behaviour.[409] The publicity given to prosecutions for (for instance) deliberate HIV transmission or exposure is likely to have a deterrent effect on the conduct of the community.[410] Studies of other forms of sexual behaviour (eg incest) in fact suggest that statutory interventions which are used to detect, convict, and punish specified sexual behaviours can be effective in controlling such behaviour.[411]

FIFTH RATIONALE:

HIV-SPECIFIC CRIMINAL PROVISIONS ARE JUSTIFIED IN VIEW OF CONSTITUTIONAL CONSIDERATIONS[412]

5.44 This rationale encompasses two different considerations: First, that it is in general justified to target unacceptable HIV-related behaviour with a statutory provision in view of the need for protection of some of the most basic of human rights (i e the rights to life and bodily integrity); and second, that an HIV-specific statutory provision rather than public health measures is justified in view of constitutional considerations which have a bearing on the principle of legality.

5.44.1 One of the principal interests that motivates criminalisation is that of maintaining or

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409 Hermann 1990 **St Louis University Public Law Review** 352-353.

410 See eg the discussion in par 2.1 et seq of such instances in the press during the past year. Cf also Hermann 1990 **St Louis University Public Law Review** 356.

411 Ibid 355-356.

412 See also par 5.8-5.10 above where the influence of the 1996 Constitution on the criminal law is discussed.

retaining human and civil rights.[413] The right to life[414] and bodily integrity[415] count amongst the foremost of human rights which modern liberal democracies purport to recognise and uphold.[416] Conduct which is perceived to harm these interests is usually prohibited under threat of punishment. This is evident in, for instance, the common law crimes of culpable homicide, assault and rape. These crimes involve forms of conduct that in one way or another violates the victim's rights of person. It is this harm to the victim that provides the reason for punishing the conduct concerned.[417] HIV is a deadly virus and the infection probably invariably leads to death. Where a perpetrator through his or her unacceptable HIV-related behaviour endangers a victim's life by infecting the latter with or exposing him or her to the virus, it is argued that it would be fair and rational for the State to take steps to prevent such behaviour, or to punish it when it has taken place .[418] Section 7(2) of the 1996 Constitution requires that the State must respect, protect, promote and fulfil the rights in the Bill of Rights. It is thus further submitted that the State will have to take positive steps to protect persons against any behaviour that could jeopardise their right to life.

5.44.2 Proponents of HIV-specific statutory measures in general submit that public health alternatives would not be more appropriate than criminal measures in addressing recalcitrant HIV related behaviour for the following reason: A constitutionally valid criminal statute expressly describes the behaviour it proscribes while application of public health measures could be more expansive.[419] Criminal conviction requires proof of proscribed behaviour beyond a reasonable doubt while public health violations may be established by clear and convincing evidence.[420] Criminal law

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413 Burchell and Milton 25.

414 See the 1996 Constitution, sec 11 which provides that "(E)veryone has the right to life"; **S v Makwanyane** 1995 3 SA 391 (CC).

415 Ibid sec 12(2) which provides that "(E)veryone has the right to bodily integrity...".

416 The right to life has been held to be (with the exception of the right to human dignity), the most basic value protected by the 1996 Constitution. In the absence of the right to life no other rights may be meaningfully held (see Chaskalson P in **S v Makwanyane** 1995 3 SA 391 (CC) par 144). Cf also Chaskalson et al (Revision Service 2 1998) 15-1.

417 Burchell and Milton 25.

418 Cf the recent Canadian Supreme Court judgment in **R v Ceurrier** referred to in par 5.16.3 above.

419 Hermann 1990 **St Louis University Public Law Review** 354. Cf also par 5.29-5.30 above.

420 Ibid. See also the discussion of the 1987 Regulations in par 4.9-4.12 above where it was emphasised that

measures therefore provide significant civil liberties and due process protections to individuals which may not be available under the public health law.[421] Moreover, the period of imprisonment in respect of a criminal violation is for a fixed term and in proportion to the seriousness of the crime - while detention under public health regulations can be undetermined.[422] Finally, every person convicted of a criminal offence has demonstrated a disposition to violate a legal proscription. It is in general argued that if the need to protect others from possible infection will otherwise lead to implementation of the alternative use of the police power through the public health authority to quarantine or isolate infected individuals, the onus of personal responsibility placed on individuals by the criminal law seems preferable. The personal responsibility not to engage in behaviour likely to infect others imposed on persons with HIV is not disproportionate to the harm those behaviours would otherwise impose on others.[423]

SIXTH RATIONALE:

CURRENT ALTERNATIVES TO HIV SPECIFIC CRIMINAL MEASURES ARE NOT ADEQUATE

5.45 In South African law alternatives to utilising the criminal law in the sphere of HIV/AIDS may be available in existing civil and administrative law (pubic health) measures in a limited form.

5.45.1 A person with HIV could be held *civilly* liable as a result of exposing others to or infecting them with HIV.[424] In **Venter v Nel**[425] the court recently granted a plaintiff

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the application of several of the coercive measures provided for in these Regulations is left in the discretion of public health officials.

421 See the discussion of the influence of the legality principle in par 5.7 above. See also Hermann 1990 **St Louis University Public Law Review** 355.

422 See the discussion of the 1987 Regulations in par 4.13 above, where is has been indicated that a person with AIDS may be quarantined for 28 days - which period may be extended by the Minister of Health "to a longer period".

423 Ibid 356.

424 Van Wyk 497. Cf also Burchell 149-151; Neethling et al 43-44, 65-66 on remedies for personality

damages in the amount of R344 399, 06 on the ground that the defendant had infected her with HIV during sexual intercourse.[426] Damages were granted for future medical expenses as well as for the possibility of a reduction in life expectancy, psychological stress, contumely (deliberate injury) and pain and suffering. According to press reports the plaintiff commented that laying a criminal charge against the defendant would not have helped her - she took recourse to the available civil measures "to get money to pay for her medical expenses - not revenge".[427] It is however argued that apart from the fact that civil measures would not send the strong message of a criminal sanction that certain HIV-related behaviour is unacceptable, they are costly and time consuming. Moreover, not only are individual rights invaded by harmful HIV-related behaviour, but also the State's interest in protecting its citizens from harm.

5.45.2 Administrative measures relevant to recalcitrant HIV-related behaviour are currently contained in the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 (the 1987 Regulations)[428] issued by the Minister of Health in terms of sections 32, 33 and 34 of the Health Act 63 of 1977 (the Health Act). These measures (which have been set out in detail in Chapter 4 above), provide for the isolation and quarantining of persons with HIV/AIDS under certain circumstances. As indicated above, the application of the relevant provisions is discretionary and their status is unclear.[429] In addition, the inapplicability and impracticality of the relevant provisions with regard to HIV/AIDS prevail: For instance, where a person with HIV recklessly spreads HIV, he or she could be quarantined for a period of 28 days (which could be extended by the Minister of

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infringement in general. See also par 3.3.1 and fn 187 above.

425 1997 4 SA 1014 (D). See par 3.3.1 for more detail.

426 The claim was undefended. The defendant allegedly discovered that he had HIV after he had applied for an insurance policy in 1990, several years before he met the plaintiff (**Sunday Times** 23 February 1997).

427 According to press reports the defendant set out deliberately to sleep with women without protection and without making any attempt to inform his sex partners that he had HIV (**Sunday Times** 23 February 1997).

428 G N R 2438 in **Government Gazette** 11014 of 30 October 1987.

429 Par 4.10, 1.12 and 4.14.

Health to a longer period), or be isolated for a determined period.[430] It is unclear what a "place of isolation" would be or indeed how long the periods of quarantine or isolation would be in practice. Moreover, quarantine and isolation may in any event entail the infringement of several fundamental rights which, it is argued, would not be justified in terms of protecting public health, since the spread of HIV is probably not primarily the result of deliberate conduct by individuals who know they are infected.[431]

SEVENTH RATIONALE:

WOMEN'S VULNERABILITY TO HIV/AIDS JUSTIFIES THE INTRODUCTION OF HIV-SPECIFIC CRIMINAL MEASURES

5.46 From being almost absent from the AIDS epidemic in the 1980s, women at the end of 1997 accounted for 42% of the over 21 million adults now living with HIV worldwide, with HIV infection for women still rising.[432] In sub-Saharan Africa, there are already 6 women with HIV for every 5 men, and close to four-fifths of all infected women are African. Moreover, the infection rates among young women outnumber their male peers by a ratio of 2 to 1.[433] The latter is borne out by the latest available South African statistics which show that women in their twenties are becoming infected at the highest rate.[434]

5.46.1 Why is a virus that infects both men and women, increasingly affecting women in a disproportionate manner? It is argued that although women are biologically more vulnerable to HIV infection, most of the services relating to information and prevention messages (urging abstinence, fidelity or safer sex; promoting condom use; and encouraging and enabling people to get prompt care for STDs) are inaccessible to women:[435] Young girls are brought up with little understanding of their

430 Refer to par 4.13 and par 5.44.2 above.

431 See also par 4.14-4.15 above.

432 **Women and AIDS** 2.

433 Ibid.

434 See par 2.48 above.

435 **Women and AIDS** 3; Rees (Unpublished) 1, 2, 5.

reproductive system or the mechanics of HIV/STD transmission and prevention; girls are taught to leave the initiative and decision-making in sex to males, whose needs and demands are expected to dominate and whose predominance often comes with a tolerance for predatory, violent sexuality; and failure to respect the human rights of girls and women in terms of equal access to schooling, training and employment opportunities reinforces their economic dependence on men which leaves them with little or no control over how and when they have sex - and hence over their risk of becoming infected with HIV.

5.47 It is submitted that where a national consensus can be achieved, no matter how fragile, that men should respect the personal and physical integrity of women, the criminal law could reinforce such an agreed norm and be a useful weapon in enforcing it - both in the message learnt from the individual case and the message learnt from publicity about that.[436]

EIGHTH RATIONALE:

THE HIGH LEVEL OF CRIME AND PUBLIC PRESSURE REQUIRE THAT THE ISSUE BE DEALT WITH

5.48 Rape and sexual abuse are ways in which HIV may be transmitted and the statistics on these and other possible sources of HIV transmission are submitted by some as additional motivation for introducing HIV-specific criminal offences.

5.48.1 Statistics on rape are available from a number of different sources. The latest available official statistics show that a total of 30 756 cases of rape (including attempted rape) involving adults, and 537 cases of statutory rape (intercourse with a girl under the prescribed age and/or female imbecile) were reported to the South African Police Service (SAPS) during 1997.[437] With under-reporting it is impossible to determine

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436 Cf Buchanan in **African Network on Ethics, Law and HIV** 105-107.

437 Statistics obtained from the South African Police Service Crime Information Management Centre (Departmental letter N269/98 of 29 June 1998).

with any certainty what the real position is. However, figures from the SAPS indicate that on average only one in every 35 rapes are reported.[438] Unofficial sources allege that in South Africa a woman is raped every 87 seconds.[439] It is further alleged that one in four South African women experiences rape each year, i e a total of 380 000 - of whom 95% are black.[440] Moreover, 1 484 cases of sodomy (all ages) were reported to the South African police.[441] The dangerous myth that sex with a virgin or a young girl will either cure or prevent AIDS has apparently stimulated an increase in child sexual exploitation.[442] As far back as 1995, it was found that the most common crime against children was rape.[443] According to the latest available official statistics released by the Crime Information Management Centre of the SAPS, statistics regarding sexual abuse of children are alarmingly high: 21 606 cases of rape and attempted rape, and incest with persons under the age of 17 years were recorded for the period January to December 1997.[444] Researchers found that children and adolescents who are subjected to sexual abuse are increasingly found to be infected with HIV. This is regarded as a disturbing feature of the whole scenario of HIV infection.[445]

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438 **PACSA Factsheet** June 1998 1 (PACSA Factsheet cites Human Rights Watch 1995 51 "Violence Against Women in SA" New York, for this information); see also Rees (Unpublished) 1.

439 Horton 1993 **The Lancet** 1340. More recently Rape Crisis reported in the **PACSA Factsheet** of June 1998 that a women is raped every 23 seconds in South Africa (ibid 1). This estimate seems to represent all rapes that take place in South Africa, including those that are not reported to the SAPS: The latest official SAPS total would rise to 1 076 460 per year if the current SAPS figures were multiplied by 35 - to deal with current under reporting. This total would amount to an average of 2 949 rapes being committed per day, 123 per hour and 2 per minute i e one every 30 seconds. Ms Catherine Day, Counselling Co-ordinator at Rape Crisis, Cape Town however reported that it would be more realistic to work on a ratio of 1 in every 10 rapes being reported (information supplied on 18/9/98).

440 Horton 1993 **The Lancet** 1340. According to a recent press report the Institute for Security Studies found that more than 75% of the victims of murder, rape and assault are black (**Beeld** 15 August 1998).

441 Information supplied by the South African Police Service Crime Information Centre (Departmental letter N269/98 of 29 June 1998).

442 Pienaar 1996 **In Focus Forum** 17-18; Leclerc-Madlala 1996 **Acta Criminologica** 35-36. See also **Beeld** 27 June 1998 and 15 August 1998.

443 **The Nedcor Project** 3. See also **Beeld** 15 August 1998.

444 Information supplied by the SAPS Crime Information Centre (Departmental letter N269/98 of 29 June 1998). The SAPS anticipated that the incidence of rape will only start decreasing once the suspected under-reporting is eliminated and a less violent and drug (alcohol) dependent culture has been established among new generations through a process of socialisation. It is expected that policing as such will probably not cause a noticeable decrease in the incidence of rape (**SAPS Quarterly Report 3/97** Internet 10/10/97).

445 Lachman 477. (Confirmation of sexual abuse was eg found in 14 of 96 HIV-positive children in a

5.49 The information supplied at the outset of this Paper reflects that public pressure on the issues in question comes from many different quarters. Some groups are merely calling for "revenge", others for measures to provide for victims' peace of mind, others for stricter measures for specific serious offences (eg rape), others are concerned about protecting women and children in what is regarded as a violent society, others call for suitable measures to be taken in respect of cases of sexual exploitation such as gang rape. In all of these situations it appears that the public is concerned about the implications of HIV/AIDS and is exorting pressure on the authorities to respond suitably.

+ ***Rationales against creating an HIV-specific statutory offence***

FIRST RATIONALE:

COMMON LAW MEASURES ARE AVAILABLE AND SHOULD BE UTILISED SINCE SIMILAR EVIDENTIARY PROBLEMS WILL BE ENCOUNTERED WITH A NEW STATUTORY OFFENCE

5.50 Opponents of creating a statutory offence argue that the available common law and civil remedies should be utilised: Our common law already provides for the situation where a person deliberately or recklessly infects another with or exposes him or her to a fatal disease in that such person could be prosecuted under several existing common law offences. (In addition, the 1997 Criminal Law Amendment Act already provides for a harsher sentence where rape causes psychological harm.)[446] Moreover, civil remedies would also be at the disposal of the aggrieved party.

5.51 They maintain that as far as application of the common law is concerned, evidentiary problems are to a great extent the result of the nature of HIV/AIDS and experience has shown that they will remain in the event of a statutory offence being created:

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paediatric AIDS unit at Duke University USA in a study reported on in 1991 (Ibid).)

446 Viljoen 1993 **SALJ** 110. See also par 3.3 and fn 185 above on the 1997Criminal Law Amendment Act.

Problems of proof resulting from the difference in time between proscribed behaviour and awareness of injury may reduce the likelihood of detection and conviction with a lessening of the intended deterrent effect of the criminal statute.[447] Laws (including the common law) criminalising sexual intercourse by those who know or believe or suspect they might have HIV have proved to be extremely difficult to enforce, and are, perhaps partly as a consequence, rarely enforced. A more successful approach would be to inculcate in every potential sex partner a sense of responsibility for him or herself through education and counselling rather than to rely on coercive measures.[448] Moreover, creating a statutory offence will not necessarily overcome evidentiary burdens with regard to proving fault. Statutory provisions relying on strict liability may be created only for exceptional circumstances and are in any event constitutionally questionable.[449] Unless strict liability is imposed, the State will still have to prove each of the elements of the offence to obtain a conviction - which will of necessity include at least unlawful conduct, fault and the fact that the perpetrator was infected with HIV.[450]

5.52 In the above regard opponents in general submit that if a statutory offence is created, it must attempt to deal with the current evidentiary problems posed by a prosecution under the common law crimes. If this is not done it could be argued that the creation of such offence serves no public interest purpose.

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447 Hermann 1990 **St Louis University Public Law Review** 356. In the United States for instance, formulations of traditional statutory crimes have significant problems of proof when directed at prosecution for conduct related to intended or likely transmission of HIV. Problems of intent and causation are particularly acute (Ibid 357). Likewise in Germany, where many prosecutions for HIV-related behaviour have been brought under the German Penal Code, but have failed due to evidentiary problems (information supplied by Johann Weusmann, Junior Lawyer attached to the High Regional Court of Celle, Germany on 19/8/98; Cf also Van Wyk 486-488 and De Jager 1991 **Journal of South African Law** 547-555).

448 Buchanan in **African Network on Ethics, Law and HIV** 109. Compared to legal regimes supportive of changing risky behaviour, anti-HIV laws on their own do not work. There is no country which has passed such laws which has avoided at the least a slow but steady increase in infection rates (Ibid 106).

449 Burchell and Hunt Vol I 251.

450 Cf par 5.33 above.

SECOND RATIONALE:

STATUTORY OFFENCES ARE IN DANGER OF BEING APPLIED SELECTIVELY

5.53 Opponents of statutory criminalisation of HIV-related behaviour hold that there is a possibility that laws specifically targeting HIV-related behaviour, will be selectively enforced against particular groups, for example, gay men, sex workers or other marginalised groups who already are discriminated against in our society. Rigorous application of the law to such groups might be motivated by bias and result in harassment of the targeted groups.[451] This could negate any possible effectiveness of a new statutory offence.

THIRD RATIONALE:

CRIMINAL LAW MEASURES MAY BE COUNTERPRODUCTIVE TO PUBLIC HEALTH EFFORTS TO ADDRESS HIV/AIDS

5.54 It is submitted that creating a new statutory offence would have serious public health implications. This submission is based on the following arguments:

5.54.1 Enacting laws specifically targeting those with HIV may suggest that the main risk of HIV infection is by way of acts of deliberate or reckless infection. This is epidemiologically wrong and dangerous. It also creates a false sense of security.[452] Laws targeting people with HIV contradict the more effective message that it is the behaviour of each individual, whether infected or not, that determines the course of the epidemic and whether individuals contract HIV. The moral force of anti-HIV laws cuts two ways: They tell people that it is wrong to do something that risks transmission of disease. But they may also suggest that there is no need for people to take responsibility for their own protection - a contradiction of the lesson that over

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451 Holland 1994 **Criminal Law Quarterly** 287; Viljoen 1993 **SALJ** 113; Cf also De Jager 1991 **Journal of South African Law** 217.

452 Cf also De Jager 1991 **Journal of South African Law** 216-217.

a decade of experience with HIV has taught us: that when every person takes responsibility for him- or herself the impact of the epidemic is drastically reduced.[453]

5.54.2 To the extent that statutory provisions directed to prevent HIV transmission require a person to know that he or she is infected before being subject to a criminal charge for engaging in activity likely to spread the virus, such provisions may well encourage individuals to refrain from HIV testing in order to avoid establishing a basis for subsequent criminal liability. Statutes going further and punishing those who merely suspect that they have HIV, may even inhibit persons from obtaining information about their own risk of HIV infection. Testing should provide a link to available medical treatment rather than providing a basis to protect others, and the criminal law should not discourage testing.[454] Moreover, the possibility of subsequent prosecution could discourage trust and openness between patients and health care providers and deter some individuals from seeking health care services.[455]

5.55 Coercive criminal measures do not contribute to an enabling environment which supports people with HIV and their families: Specially enacted "anti-HIV laws" tend to incite ill-feeling towards people with or perceived to be at risk of infection. Such laws lower the self esteem of people with or at risk of infection, stigmatise them and give them less reason to want to come forward for treatment, care, counselling or testing.[456] This makes it more difficult to encourage behaviour change, and more difficult to construct a society in which the disharmony and dislocation resulting from the epidemic are reduced.[457]

FOURTH RATIONALE:

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453 Buchanan in **African Network on Ethics, Law and HIV** 106.

454 Hermann 1990 **St Louis University Public Law Review** 357; Cf also Viljoen 1993 **SALJ** 111.

455 Gostin and Lazzarini 106.

456 Buchanan in **African Network on Ethics, Law and HIV** 106.

457 Ibid 105; Cf also Viljoen 1993 **SALJ** 111.

CRIMINALISATION IS UNLIKELY TO HAVE A BROAD DETERRENT EFFECT

5.56 Some argue that HIV specific criminal measures are in the main unnecessary since they will not have a broad deterrent effect (except perhaps for discouraging individuals at risk of HIV infection from seeking testing or health care services). Proponents of this argument base their view on the generally accepted fact that HIV/AIDS is not mainly spread by the activities of recalcitrant individuals but by consensual sexual intercourse in the ordinary course of events.[458] Therefore seeking to prevent aberrant individuals from infecting others will not have a significant impact on the course of the epidemic. Second, it is argued that it is unlikely that a special statutory provision will inhibit the conduct sought to be deterred. Violent and flagrant offenders may feel able to act with impunity, regardless of the creation of a special additional offence. More significantly, those who expose others to risk because of human weakness rather than from recklessness or design, are even less likely to have their conduct changed by the enactment of an additional offence.

FIFTH RATIONALE:

HIV-SPECIFIC CRIMINAL PROVISIONS IMPOSE CERTAIN HUMAN RIGHTS BURDENS[459]

5.57 In terms of section 36 of the 1996 Constitution rights contained within the Bill of Rights may be limited only to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors including less restrictive means to achieve the purpose.[460] As regards the limitation of rights in the HIV/AIDS context, Mr Justice I Mahomed (now Chief Justice of the Republic of South Africa) at the First National Conference on HIV/AIDS held in South Africa in 1992, stated that "there must be some intellectual criteria of rationality and some acceptable consensus on ethical

458 Buchanan in **African Network on Ethics, Law and HIV** 105; Gostin and Lazzarini 106.

459 See also the discussion of the 1996 Constitution in par 5.8-5.10 above.

460 Sec 36(1)(e) of the 1996 Constitution.

values against which every measure sought to combat the AIDS menace must be tested".[461] He suggested the following criteria:[462]

° Does a particular proposed measure actually achieve its objective in combatting the spread of HIV?

° Does the measure proposed invade a more crucial and fundamental human right?

° If so, is there a pressing social need for the infringement and is it the least restrictive way possible of attaining a particular objective?

It is argued that additional suggested statutory prohibitions fail to meet these criteria.

5.58 The Bill of Rights in the 1996 Constitution applies to all law, and binds the legislature.[463] The criminal law approach imposes potentially heavy human rights burdens - with individual liberty and the right to humane treatment specifically at stake.[464] As suggested earlier, the danger arises that in applying such laws they may be selectively enforced: Criminal penalties most often target already marginalised groups, including commercial sex workers, homosexuals, and prisoners. Punitive laws designed to control disease epidemics harbour an enormous potential for abuse because the police, prosecution and judicial officers exercise considerable discretion. The selective application of criminal statutes creates a more general concern - that the public, which does not identify with these groups, may mistakenly feel that the danger of HIV infection is contained.[465] It may also be inequitable to use criminal penalties to discourage behaviour related to HIV infection - in the sense that this is tantamount to requiring individuals to behave at the highest levels of moral development, and that (leaving aside violent and deliberate perpetrators) it may be

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461 Mahomed 1993 **SAJHR** viii. (The First National Conference on HIV/AIDS was hosted by the Centre for Applied Legal Studies, University of the Witwatersrand on 25-26 June 1992. Mr Justice Mahomed is currently Chief Justice of the Republic of South Africa and Chairperson of the South African Law Commission.)

462 Ibid. Similar criteria were suggested by Cameron and Swanson in a discussion on the purported dichotomy between human rights and public health (Cameron and Swanson 1992 **SAJHR** 202-203). See also Elliot (Discussion Paper) 36 where he suggests that any coercive legislative response must be guided by the principle of "most effective, least intrusive".

463 The 1996 Constitution sec 11. See also **LAWSA** Vol 6 39.

464 Cf also Elliot (Discussion Paper) 30-31.

465 Gostin and Lazzarini 106; Hermann 3 1990 **St Louis University Public Law Review**57.

unrealistic to expect vulnerable groups to do so.[466] Therefore using the criminal law in this fashion may fall foul of the equality clause in the Constitution as it may impact on an individual's right to be equal before the law.[467]

5.59 A more compelling reason for caution in creating a statutory criminal offence aimed at HIV-related behaviour is the potential of intrusion into sexual privacy.[468] Section 14 of the 1996 Constitution provides that "(E)veryone has the right to privacy".[469] It has been specifically pointed out that legislation which criminalises sexual conduct between consenting adults, could fall foul of the limitations set in section 36 of the 1996 Constitution.[470] Once an infected person is identified there would be a need to identify other sexual contacts in order to rule out sources of infection other than the perpetrator.[471] It has been said that the use of criminal law is a public procedure affording the perpetrator no confidentiality as to his or her HIV status.[472]

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466 Ibid.

467 Cf sec 9(1) of the 1996 Constitution. Refer also to Elliot (Discussion Paper) 31.

468 Holland 1994 **Criminal Law Quarterly** 287; Elliot (Final Report) 53; Cameron and Swanson 1992 **SAJHR** 220 et seq; Tierney 1992 **Hastings International and Comparative Law Review** 488. See also **Case v Minister of Safety and Security; Curtis v Minister of Safety and Security** 1996 5 BCLR (CC) 609.

469 The Constitutional Court in **Bernstein v Bester** 1996 4 BCLR 449 (CC) at 462F emphasised the connection between the common law and constitutional right to privacy stating that "... (a) breach of privacy can occur either by way of an unlawful intrusion upon the personal privacy of another, or by way of unlawful disclosure of private facts about a person".

470 See in general, **The National Coalition for Gay and Lesbian Equality v The Minister of Justice** (unreported case No 97/023677 in the High Court of SA, Witwatersrand Local Division, and unreported Constitutional Court judgment CCT 11/98 of 9 October 1998). It is accepted that the appropriate enquiry in terms of the limitations clause involves first an enquiry as to whether the right entrenched has been infringed; and second, if so, whether the infringing law is one of general application and the limitation is reasonable and justifiable in terms of the constitutional norms (Burchell and Hunt 22-23; see also **LAWSA** Vol 6 340-341). In **S v Makwanyane** 1995 6 BCLR 665 (CC) (also at 1995 2 SACR 1 (CC)) Chaskalson P indicated that the limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values and ultimately an assessment based on proportionality (see also **LAWSA** Vol 6 341).

471 Tierney 1992 **Hastings International and Comparative Law Review** 488; cf also Holland 1994 **Criminal Law Quarterly** 287.

472 Ontario Advisory Committee on HIV/AIDS **Reducing HIV Transmission by People Who Are Unwilling or Unable to Take Appropriate Precautions** Toronto: The Committee 1995 - as referred to in Elliot (Final Report) 53.

SIXTH RATIONALE:

ALTERNATIVES DO EXIST: THE GOVERNMENT CURRENTLY FOLLOWS AN HIV/AIDS STRATEGY RELYING UPON PUBLIC HEALTH MEASURES

5.60 It has been indicated above that the Government's current response to the AIDS epidemic is exclusively based upon public health principles which rely on voluntary participation and behaviour change. Coercive measures are not part of the National AIDS Programme's current response and it is not envisaged that a policy change in this direction will be made in the future.[473] Moreover, the Minister of Health, although supporting the Justice Portfolio Committee's request to the Law Commission for the current investigation, warned that the issue whether certain behaviour ought to be made a criminal offence, had complex social, ethical and moral implications.[474] Proponents of this position argue that the creation of a statutory offence sends the wrong message to the public about how the government intends responding to the HIV/AIDS epidemic as a public health issue.

SEVENTH RATIONALE:

HIV-SPECIFIC CRIMINAL MEASURES WILL NOT ASSIST IN ALLEVIATING THE POSITION OF WOMEN AS REGARDS THEIR VULNERABILITY TO HIV/AIDS

5.61 Opponents of HIV-specific statutory measures strongly argue that such measures will not change the subservient situation of women. They remain vulnerable in situations where a man insists on unprotected intercourse notwithstanding his HIV infection or risk of it. They argue that education and counselling would be more effective and cheaper than punitive measures which will only send others in similar situations underground, and further that a broader response is required which enhances the position and status of women which would ensure that protective legislation exists,

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473 See par 4.3 et seq above for more detail about the Government's current response to the HIV/AIDS epidemic.

474 **The Star** 20 March 1998.

and that women are enabled to take up an equal position in society.[475] This position, of advocating deepgoing change in social attitudes in order to protect women, is supported by a **UNAIDS Best Practice Collection on Women and AIDS** (October 1997) which states the following:

> Policies from community to national level must be reshaped if women's vulnerability to HIV is to be reduced. Among other things this means protecting their human rights and fundamental freedoms and improving their economic independence and legal status.[476]

5.62 An even more compelling consideration derives from the demographics of HV testing in South Africa. Most South Africans whose HIV status is ascertained are women (who undergo testing at antenatal clinics). To create a new statutory offence aimed at deliberate or negligent exposure to or transmission of HIV will disproportionately impact on women - that segment of our society which is already more vulnerable to infection, abuse and predatory conduct. Many women are infected by husbands or permanent partners who themselves have acquired the infection outside the relationship but who remain heedless of the risk of infection until the woman's HIV status is known. The result of a special statutory prohibition will be in all likelihood to further victimise women who are themselves already the disproportionate victims of the epidemic. A further aspect is that women are known to suffer abandonment, rejection and violence on disclosing their HIV status to the male partners who communicated the infection to them. A criminal provision enhancing this state of affairs can hardly be desirable.[477]

EIGHT RATIONALE:

OVER-CRIMINALISING WILL NOT REDUCE THE CRIME RATE

5.63 Opponents argue that despite alarming statistics of crimes which could spread HIV

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475 Buchanan in **African Network on Ethics, Law and HIV** 107.

476 **UNAIDS Best Practice Collection on Women and AIDS** Geneva: UNAIDS October 1997 5.

477 Information supplied by Ms Merci Makhalemele, SALC project committee member and counsellor at the Durban ATICC (AIDS Training, Information and Counselling Centre) on 9 November 1998.

and strong public pressure to act against persons who deliberately harm others by spreading HIV, the creation of HIV-specific criminal legislation may result only in an over utilisation of the criminal sanction with resultant negative effects of lessening the authority of the criminal law, unnecessarily stigmatising individuals as criminals, and overloading the criminal justice system.

5.63.1 South Africa is already a country with signally low rates of arrest, conviction, imprisonment and rehabilitation. It is estimated that in general, of 1 000 crimes committed, 450 are reported, 230 solved, 100 perpetrators prosecuted, 77 convicted, and 36 imprisoned of which only 8 are imprisoned for 2 years or more.[478] In terms of reported crimes and offences, the incidence of crime in South Africa is well above the world average. South Africa's recorded crime rate is 5 651 per 100 000 persons, while the international average is 2 662 per 100 000.[479] The government in May 1995 started addressing this situation by adopting a comprehensive National Crime Prevention Strategy (NCPS).[480] From a practical perspective the NCPS has identified vast problems, insufficiencies and lacunae on every level of the criminal justice system from reporting and investigating of offences, to awaiting trial, court procedure and sentencing - with insufficiencies relating to human resources management and available infrastructure playing a major role.[481] The Nedcor Project on Crime, Violence and Investment (the Nedcor Project) - a business response to the crime situation - to a great extent echoed the factors identified by the NCPS reflecting current insufficiencies of the criminal justice system.[482] It was moreover concluded

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478 **The Nedcor Project** 2.

479 Ibid 2.

480 The National Crime Prevention Strategy (NCPS) is a fundamentally new approach from government, representing a vision on how South Arica can tackle crime. The Strategy puts forward a comprehensive policy framework enabling government to address crime in a co-ordinated and focussed manner. One of the key factors of the NCPS will be an effective and efficient criminal justice system (**Re-engineer the Criminal Justice System Pre-scoping Draft Report** 3).

481 **Re-engineer the Criminal Justice System Pre-scoping Draft Report** 1-29.

482 The insufficiencies include: inadequate funding of law enforcement agencies; a need for improved law enforcement and policing; a need for improved rates of arrests and greater consistency in enforcing and restoring respect for the law; a lack of rapid and effective sentencing of offenders; a lack of visible, community-based policing; a need for improved crime information, available to the police for law-enforcement purposes and to the business community and the general public for purposes of raising awareness of crime patterns and thereby improving strategic responses; a need for more extensive networking between business, private security agencies and the police, both in terms of crime prevention

that the present criminal justice system is not functioning at a level where it constitutes a credible deterrent to criminals.[483]

5.63.2 Although the Government is attending to these problems and insufficiencies through the NCPS, it will take some time before the benefits of the new approach are realised in practice. This is borne out by recent crime statistics and comment on the state of the criminal justice system: what has been labelled as "shocking" crime statistics have been quoted lately to illustrate that the South African justice system is "still leaking like a sieve". (The statistics quoted indicate a conviction rate of only 6,7% for rape.[484]) In its Third Quarterly Report of 1997 the SAPS reported a stabilising or decreasing trend with regard to crime ratios[485] in South Africa. However, the Report itself imphasised that the incidence of crime in the country is still at a very high and unacceptable level, with crime frequencies in many instances still increasing. Furthermore, that severe impediments regarding crime prevention are still caused by shrinking human and logistic resources.[486]

5.64 Opponents of creating an HIV-specific criminal offence cite the problems and insufficiencies identified in the NCPS and the Nedcor Project as factors which may

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and to improve reaction times when crimes have been committed; a need for improvement in the rate of arrests and convictions; a need for improving prison conditions and space to made langer sentences possible, with offenders serving the full sentence; a need for increase in the retention of experienced staff (eg public prosecutors) in the service of the Department of Justice; a need for increased training, salaries, management and professionalisation of the South African Police Service; and a need for resources to be made available for proper logistical, administrative, technological and communication services to be rendered (**The Nedcor Project** 3-4, 9-10, 16-18).

483 **The Nedcor Project** 14. See also **SALC Interim Report on the Simplification of Criminal Procedure** which highlighted several problems relating to the lack of administrative control over the court process and delays in the completion of criminal trails(Ibid iii-xix).

484 Comment by Democratic Party Safety and Security spokesman Douglas Gibson in reply to information tabled in Parliament by the Minister of Safety and Security on 26 May 1997. The Minister disclosed that of 52 110 rapes and attempted rapes reported to the South African Police Service in 1996, there were 22 255 prosecutions and 3 532 convictions - a 6,7% conviction rate (**Natal Witness** 27 May 1997).

485 Crime ratios indicate the incidence of a specific crime per 100 000 of the population (in contradistinction to crime frequencies). Employing ratios allows for the growth in population figures over time to be neutralised. In this way provision is made to prevent the population growth from causing an artificial increase in crime tendencies not reflecting a real increase in the incidence of crime (**SAPS Quarterly Report** 3/97 Internet 10/10/97).

486 **SAPS Quarterly Report** 3/97 Internet 10/10/97. Limited resources were also emphasised by the Nedcor Project (see fn 481 above)in their assessment of how best to address the crime situation in South Africa (**The Nedcor Project** 7).

fundamentally impact on the ability of the criminal justice system to deal with any statutory offence. They further argue that the more actions that are considered as criminal, the more common place becomes the idea of crime. The effect of this may in fact be to diminish the stigma attached to a criminal conviction and thus to diminish the moral authority of the criminal law.[487] Moreover, conviction of a person involves a number of personal and social consequences that impose hardship and social degradation, the cumulative social effect of which may well outweigh the social harm involved in the prohibited conduct.[488] In an HIV/AIDS context this may well mean that utilising scarce resources to prosecute persons through the criminal justice system would not be as effective as using the same resources in public health programmes.

5.65 Opponents of creating an HIV-specific statutory offence also point to perhaps the most striking fact in the whole debate: the relative absence (until very recently, the apparently complete absence) of any prosecutions under existing (common law) offences. If there was a need for such prosecutions, they argue, why has the existing panoply of criminal mechanisms not been utilised? What, they ask, will a new specially created statutory offence add, other than a diversionary, and possibly counter-productive, rhetorical gesture from government? Far rather, they urge, direct resources and energy at governmental interventions which have been proved to be sound and effective. These, international experience has uniformly shown, lie well outside the field of the criminal law.

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487 Cf Burcell and Milton 32.

488 Ibid.

6 COMPARATIVE PERSPECTIVE

6.1 The position in other legal systems is set out below with reference to recent international guidelines; and the position in comparable legal systems - including reference to recent developments with regard to coercive legal measures aimed at harmful HIV-related behaviour in the United States, the United Kingdom, Australia and Zimbabwe.

A) RECENT INTERNATIONAL GUIDELINES

6.2 The United Nations in 1997 adopted **Guidelines on HIV/AIDS and Human Rights**[489] aimed at outlining how human rights standards apply in the area of HIV/AIDS and indicating specific legislative and practical measures to be undertaken by governments.[490] The essential conclusion underlying the Guidelines is that public health interests need not conflict with human rights of those at risk of infection.[491] They stress that the promotion and protection of human rights are essential components in preventing transmission of HIV and reducing the impact of HIV/AIDS. Furthermore, that the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation

489 Prepared by the Joint United Nations Programme on HIV/AIDS and the United Nations Centre for Human Rights at the Second International Consultation on HIV/AIDS and Human Rights, Geneva 22-25 September 1996.

490 The Guidelines are seen as the culmination of various international, regional and national activities, including prestigious international studies on HIV/AIDS and human rights, and an attempt to draw on the best features of these documents. These include studies from the British Medical Association Foundation for AIDS, Harvard School of Public Health, International Federation of Red Cross Societies, National Advisory Committee on AIDS in Canada, Pan-American Health Organisation, Swiss Institute of Comparative Law, Danish Centre of Human Rights, and the Johns Hopkins University Program on Law and Public Health. More than 20 documents, including charters and declarations which specifically or generally recognise the human rights of people living with HIV/AIDS, and which have been adopted at national and international conferences and meetings over the last decade, are cited. These include documents from Europe, Latin America, the United Kingdom, Australia, Eastern-Europe, the United Nations, Malaysia, Thailand, the Asia-Pacific region, India, and Canada (**United Nations International Guidelines on HIV/AIDS and Human Rights** 1-4, 60-61).

491 **United Nations International Guidelines on HIV/AIDS and Human Rights** 5.

of those at risk of infection.[492]

6.3 Of relevance to the present enquiry is that the Guidelines require that States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups. It is advised that criminal and or public health legislation should not include specific offences involving the deliberate and intentional transmission of HIV but rather should apply general criminal offences to such cases. Such application should furthermore ensure that the elements of foreseeability, intent, causality, and consent are clearly and legally established to support a finding of guilt and/ or harsher penalty.[493]

6.4 However, the Guidelines also provide that although certain rights are non-derogable and cannot be restricted under any circumstances,[494] international human rights law, under narrowly defined circumstances, allows Sates to impose restrictions on some rights if such restrictions are necessary to achieve overriding goods, such as public health, the rights of others, morality, public order, the general welfare in a democratic society and national security. For such restrictions to be legitimate, a State must establish that -[495]

° the restrictions are provided for and carried out in accordance with the law (i e according to specific legislation which is accessible, clear and precise, so that it is reasonably foreseeable that individuals will regulate their conduct accordingly);

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492 Ibid 39-40, 58-61.

493 Ibid 14 (Guideline 4).

494 The Guidelines list the right to life, freedom from torture, freedom from enslavement or servitude, protection from imprisonment for debt, freedom from retroactive penal laws, the right to recognition as a person before the law; and the right to freedom of thought, conscience and religion in this regard (**United Nations International Guidelines on HIV/AIDS and Human Rights** 42-43).

495 **United Nations International Guidelines on HIV/AIDS and Human Rights** 42-43. Cf sec 36 of the 1996 Constitution (the limitations clause) which provides that the rights in the South African Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose; and less restrictive means to achieve the purpose.

- they are based on a legitimate interest, as defined in the provisions guaranteeing the rights;
- they are proportional to such interest; and
- they constitute the least intrusive and least restrictive measures available and actually achieve such legitimate interest in a democratic society (i e established in a decision-making process consistent with the rule of law).

6.5 Governments are specifically urged to promote a supportive and enabling environment for women and children by addressing underlying prejudices and inequalities.[496] It is noted that sexual violence against children, among other things, increases their vulnerability to HIV/AIDS.[497] Moreover, it is noted that discrimination against women and girls renders them disproportionately vulnerable to HIV/AIDS and that even when information and support services are available, they are often unable to negotiate safer sex or to avoid HIV-related consequences of the sexual practices of their husband or partners as a result of social and sexual subordination, economic dependence on a relationship and cultural attitudes. The Guidelines indicate that measures for the elimination of sexual violence and coercion against women in the family and in public life should not only protect women from human rights violations but also from HIV infection that may result from such violations.[498]

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496 **United Nations International Guidelines on HIV/AIDS and Human Rights** 22-24 (Guideline 8).

497 Ibid 46-47. "Child" is internationally defined as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier (article 1 of the Convention on the Rights of the Child, 1989).

498 **United Nations International Guidelines on HIV/AIDS and Human Rights** 44-45.

B) EXPERIENCE IN OTHER LEGAL SYSTEMS - INCLUDING RECENT DEVELOPMENTS WITH REGARD TO COERCIVE MEASURES

* United States

6.6 In the United States both the traditional criminal law as well as older public health offences and more recently enacted HIV-specific offences are applied in respect of HIV-related behaviour.[499]

6.7 As regards the application of the traditional criminal law, criminal acts that supposedly create risk of HIV transmission have resulted in convictions ranging from assault to murder for behaviour ranging from sexual contact, splattering of blood to spitting.[500] It is however acknowledged that factors unique to HIV transmission present evidentiary obstacles in the application of the traditional criminal law.[501]

6.8 In the face of a threat to national public health catastrophe, public health offences presented an alternative to criminal prosecutions for HIV transmission in several States. These offences consist of older infectious disease and venereal disease

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499 Harris 1993 **Arizona Law Review** 239 et seq; Katner 1996 **Tulane Law Review** 2333 et seq; Andrias 1993 **Fordham Urban Law Journal** 504 et seq.

500 Harris 1993 **Arizona Law Review** 239 et seq; Katner 1996 **Tulane Law Review** 2333 et seq;. Andrias 1993 **Fordham Urban Law Journal** 504 et seq; Elliot 18-20.

501 American literature emphasises that the greatest evidentiary hurdle in proving criminal charges in HIV transmission cases is substantiating the element of causation. Proof of actual transmission attributable to a specific individual would generally be extremely difficult if not impossible. In addition, the requirement of *mens rea* (fault) is difficult to prove in the instance of HIV transmission: The Model Penal Code defines, in descending order of culpability, the states of mind required to establish a crime: Depending on the charge, a person with HIV can be accused of an act of transmission which is intentional, knowing, or reckless. Proving any of these states of mind are difficult in the context of HIV/AIDS transmission. Exerts have expressed the opinion that these two factors could make successful prosecution impossible in the great majority of situations, and suggested that a careful analysis of traditional homicide and assault offences shows that established criminal law is an inappropriate method for treating HIV transmission as a crime (Harris 1993 **Arizona Law Review** 239-243, 248; Andrias 1993 **Fordham Urban Law Journal** 504 et seq; Tierney 1992 **Hastings International and Comparative Law Review** 490-499).

statutes.[502] However, as they contain no language specific to HIV transmission they have come to be regarded as improper vehicles for prosecution of HIV transmission.[503] The conclusion has been reached by some that if the criminal law is to operate effectively in the area of HIV-related behaviour, a criminal statute specific to AIDS would be the most efficient and fair means of regulation.[504]

6.9 In 1988 President Reagan's Presidential Commission on the Human Immunodeficiency Virus Epidemic in its final report recommended that States adopt criminal statutes specific to HIV infection.[505] Its reasoning was based on the problems in applying traditional criminal law to HIV transmission. The Commission expressly appealed to State legislatures to adopt criminal statutes relating specifically to HIV infection that should provide "clear notice of socially unacceptable standards of behaviour specific to the HIV epidemic, and tailor punishment to the specific crime of HIV transmission".[506] In addition, in 1990, the federal Congress passed the Ryan White AIDS Funding Act, containing a requirement that before a State can receive grants under the Act, the State must certify that its criminal laws are adequate to prosecute any individual with HIV who knows that he or she is infected and who intends to

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502 Several States had long had statutes criminalising willfully or knowingly exposing another person to a communicable disease, or willfully or knowingly exposing another to sexually transmitted diseases eg venereal diseases (Harris 1993 **Arizona Law Review** 250 et seq).

503 Their unsuitability results from being either over-inclusive with respect to AIDS (in the case of communicable disease offences) because they construe exposure as casual contacts that pose no risk whatsoever of spreading HIV; or they are under-inclusive (in the case of venereal disease statutes) because HIV can be spread by means other than sex (i e needle-sharing and blood transfusions). Moreover, these offences fail to consider the deadly nature of HIV in that they may impose only misdemeanour liability because modern medicine can cure most if not all, of the (communicable and venereal) diseases covered by such statutes. These statutes preclude felony liability for the highly culpable cases of purposeful knowing, or reckless HIV transmission. On the other hand they are regarded as being too harsh since they impose sentences of temporary abstinence until the infected person is cured - an unrealistic and unfair situation in the context of HIV since society has never had success in enforcing outright bans on human behaviour in the past (Andrias 1993 **Fordham Urban Law Journal** 505-506).

504 Cf Harris 1993 **Arizona Law Review** 258.

505 Tierney 1992 **Hastings International and Comparative Law Review** 499; Elliot 18.

506 See reference to the **Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic** US Government Printing Office, 1988 130 in Tierney 1992 **Hastings International and Comparative Law Review** 499 and Elliot 18. The Report states that "HIV infected individuals who knowingly conduct themselves in ways that pose significant risk of transmission to others must be held accountable for their actions" (Reference to the Report in Elliot 18).

expose another to HIV by means of donating blood, semen or breast milk, or through sexual activity or sharing of hypodermic needles.[507]

6.9.1 In response, many States have enacted new legislation specifically criminalising certain behaviour by persons with HIV. Others have amended their existing criminal or quasi-criminal public health legislation penalising the transmission of communicable or venereal diseases.[508] Three general approaches have been identified which have been adopted by States in this regard:[509]

- The first is to require disclosure of HIV status before engaging in certain activities. Most statutes do not require proof that violation of this requirement resulted in transmission of HIV, or even posed a medically recognised risk of HIV transmission. Under most such statutes, taking precautionary measures (such as using condoms) is usually not sufficient to constitute a defence.[510]
- The second is to criminalise certain otherwise legal acts if performed by a person with HIV.[511]

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507 Andrias 1993 **Fordham Urban Law Journal** 505-506.

508 More than 25 States have legislation making it a misdemeanour or felony for a person with HIV intentionally to spread the virus through various methods ranging from sexual contact to the splattering of blood (Cf Cohen Unpublished 23; **AIDS Practice Manual** 13-21 - 13-24; Katner 1996 **Tulane Law Review** 2333 et seq). Examples of these statutes include the following : In Arkansas, Illinois and Maryland transmission of HIV is a felony (ARK CODE ANN § 5-14-123(b) (1993); ILL ANN STAT ch 38 para 12-16.2; MD Health-Gen CODE ANN §18-601.1 (1994)). In Idaho sharing needles or engaging in sexual activity after knowledge of HIV infection and without full disclosure to partner is a felony (IDAHO CODE § 39-608 (1993)); In Indiana knowledge of HIV positive status is an aggravating factor in determining sentence for sexual assault and prostitution offences (IND CODE ANN § 35-38-1-7 (b)(8), (b)(9), (g) (1994)). In Louisiana to expose another to HIV through sexual contact is a felony (LA REV STAT ANN § 14.43.5 (1996)). In Michigan sexual penetration after knowledge of seropositivity and without informing the partner is a felony (MICH STAT ANN § 14.15 (5210) (1995)). In Missouri creating grave and unjustifiable risk of infecting another with HIV through sexual or other contact is a felony (MO ANN STAT §191.677 (1996)). In Oklahoma it is a felony to engage in any activity with the intent to infect another person with HIV (OKLA STAT ANN tit 21, § 1192.1 (West Supp 1996)). In South Carolina it is a felony to knowingly expose another to HIV through exchange of bodily fluids without informing them of the risks (S C CODIFIED LAWS ANN § 44-29-145 (Law Co-op Supp 1995)) (**AIDS Practice Manual** 13-21 - 13-24; Katner 1996 **Tulane Law Review** 2333 et seq).

509 Elliot 19.

510 Ibid; **AIDS Practice Manual** 13-21 - 13-24.

511 See also **AIDS Practice Manual** 13-21 et seq; Katner 1996 **Tulane Law Review** 2333 et seq. In South Carolina for instance, a Bill was introduced to criminalise blood donations by "practising homosexuals"

° Thirdly, some statutes enhance penalties for already illegal acts (most commonly prostitution) when committed by a person with HIV.[512]

These approaches are not exclusive of one another - legalisation in many jurisdictions encompasses all three.[513] Most States have defined the relevant offence as a felony rather than simply a misdemeanour.[514] The majority of these statutes require only that the prosecution prove that the proscribed behaviour took place - there is no need to prove that the accused knew the conduct risked transmitting HIV - thus treating the prohibited acts as strict liability crimes.[515] Many States impose compulsory, involuntary HIV testing upon those convicted of prostitution and/or those charged with certain sexual offences.[516]

6.9.2 In a challenge to the State statutes it has been submitted that for the most part such prosecutions would present the same evidentiary problems and potential defences as charges brought under traditional criminal statutes, that they may also implicate constitutionally protected privacy rights, that they raise significant questions of fairness, and that less restrictive means are readily available to accomplish the goal of preventing the spread of HIV.[517] Concern has been expressed that many of these statutes are drafted so broadly that they clearly encompass conduct that poses no risk of transmitting HIV: By reaching beyond sex acts known to transmit HIV such statutes actually prohibit a person with HIV from engaging in many acts that are

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or intravenous drug users (Elliot 19); see also some of the examples referred to in fn 508.

512 Elliot 19; **AIDS Practice Manual** 13-23 - 13-24.

513 Elliot 19.

514 Ibid.

515 Ibid; **AIDS Practice Manual** 13-21 - 13-24.

516 Ibid.

517 When applied to consensual sexual activity, such prosecutions may result in unwarranted assaults upon the privacy rights of persons with HIV as well as their lovers and spouses. At worst, some statutes could be used to prosecute a person with HIV for engaging in forms of sexual intimacy that pose no risk of transmitting HIV, or even for refusing to use a condom because of a desire to have a child (North Dakota eg requires a person with HIV to use an "appropriate prophylactic device" when engaging in sexual intercourse [N D Cent Code §12.1-20-17(3) (Supp 1989)]). In such cases, it may be possible to challenge the statute as an unconstitutional invasion of the defendant's privacy, as it goes overboard and goes far beyond the asserted goal of preventing the spread of HIV (**AIDS Practice Manual** 13-24 - 13-25).

taught by AIDS educators as safe forms of sexual expression.[518]

6.9.3 Apparently there have been few prosecutions under these statutes: The criminal sanction approach has not worked in the two areas it was designed to affect - punishing persons who are transmitting the virus and deterring others.[519]

6.10 New federal legislation in the form of the HIV Prevention Bill was proposed in the House of Representatives in March 1997. The proposed Bill (which is currently still at committee discussion stage), covers a range of more traditional public health interventions such as improved HIV epidemic measurement (surveillance); partner notification; HIV testing of sexual offenders; protection for patients and health care providers; HIV notification of insurance applicants and adoptive parents; criminalisation of intentional HIV transmission; and strict confidentiality for implementation of the provisions of the Bill. As regards unacceptable HIV-related behaviour, the Bill states that individuals with HIV/AIDS have an obligation to protect others from being exposed to HIV by avoiding behaviour that places others at risk of becoming infected. It directs that States should have in opertion laws providing that intentionally infecting others with HIV is a felony.[520]

6.11 Attempts to return to the traditional, more coercive, public health approach with

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518 Among the worst examples of broad drafting are statutes which prohibit "sexual penetration that involves any part of a person's body or any object" - while HIV cannot be transmitted by the use of, eg sex toys (**AIDS Practice Manual** 13-22 - 13-23).

519 **AIDS Practice Manual** 13-24; Andrias 1993 **Fordham Urban Law Journal** 505-506. In the United States the infection rates, particularly among intravenous drug abusers and the female partners of infected drug abusers, continues to rise at alarming rates. There are literally too many potential offenders to prosecute. Penal statutes in the HIV/AIDS context have met with controversy. Opponents of this approach are of the view that the real danger lies in driving infected persons underground: There is broad agreement that the soundest public policy approach to stemming the epidemic is to stress education, voluntary testing and counselling, and that the criminal sanctions approach could have the opposite effect. The "knowing" or "intentional" transmission standard creates a clear incentive not to be tested so that the infected person could remain ignorant of his HIV status and thus presumably not be criminally responsible for infecting others (Ibid).

520 HIV Prevention Bill (105th Congress, 1st Session in the House of Representatives 1997 HR 1062; 105 HR 1062 clause 2(5). The Bill also directs States to require in legislation that defendants in cases of sexual activity where force or threats of force were involved, be tested for HIV for, amongst others, evidentiary purposes (clauses 3(a)(3)(A), (B), and (D)).

regard to HIV/AIDS have met with fierce opposition in the United States.[521] Opponents of the HIV Prevention Bill denounced these initiatives as an attempt to federalise policies that do nothing but stigmatise and punish people living with HIV/AIDS. They moreover submit that these measures replace education and personal responsibility with "Big Brother" intrusion and control, and view them as failed policies that do nothing to prevent persons from becoming infected with HIV. Although the traditional procedures as proposed may identify more infected people, it is alleged that no practical plan is offered in the new legislative proposals for helping those with HIV (such as providing them with drug treatments) after they have been identified. This is particularly the case as many of them have no access to health care, little education, and many are homeless. A return to the traditional approach will cost money and its critics submit that those who advocate such an approach should concede that it could not be implemented without additional funds. Opponents of the new legislation submit that ultimately it seems that there is no guarantee that traditional public health methods applied to HIV/AIDS would markedly bolster the success of public health efforts.[522]

* United Kingdom

6.12 In the United Kingdom there is currently no HIV-specific legislation to criminalise HIV transmission or exposure to HIV; existing common law and statutory offences are applied.[523] These however suffer from the same problems as their counterparts elsewhere: HIV-related behaviour does not clearly fit the behaviour described as

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521 Burr **The Atlantic Monthly** June 1997 65-67.

522 Ibid 67.

523 Elliot 24-25. For over a hundred years British statutory and common law have imposed criminal sanctions upon those individuals who knowingly transmit a contagious disease. The traditional common law crimes of murder, manslaughter and assault have been used as well as statutory provisions such as sec 23 of the Offences Against the Persons Act, 1861 (Tierney 1992 **Hastings International and Comparative Law Review** 502-504). The latter section prohibits "maliciously administering to another person any poison or other destructive or noxious thing so as thereby to endanger the other persons's life or to inflict upon him or her grievous bodily harm" (OAPA 24 &25 Vict ch 100 § 23 (1861) (Eng) as referred to in Tierney 1992 **Hastings International and Comparative Law Review** 504).

being unlawful, and problems of proving intent and causation are present.[524]

6.13 In 1992, in the wake of a case that received widespread media attention, there were calls from a variety of quarters for Parliament to enact a new offence to address wilful (intentional) transmission of HIV.[525] The Law Commission recognised this public concern and in a 1993 Report on the codification of English criminal law (including the Offences Against the Person Act, 1861) expressed the view that such behaviour should not be beyond the reach of the criminal law.[526] The Commission proposed legislation restating the position in the Offences Against the Person Act with regard to the offence of "inflicting serious injury to another" whilst removing certain technical obstacles which the Commission considered may be problematic in the case of the injury inflicted being illness or disease.[527] The Commission suggested that the amended restatement of the law would cover situations involving the intentional or reckless infection of others with HIV.[528] The proposed offence of causing intentional serious injury to others, carries a maximum sentence of life imprisonment.[529] In addition, the proposed legislation contains a provision making it an offence if a person "knowing that the other does not consent to what is done, ... intentionally or recklessly administers to or causes to be taken by another a substance which he knows

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524 Tierney 1992 **Hastings International and Comparative Law Review** 506; Hamilton in **AIDS: A Guide to the Law** 27-30;

525 Elliot 19. See also Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet).

526 **Law Commission Report No 218** 1993 par 15.17; see also Elliot 24-25.

527 **Law Commission Report No 218** 1993 par 5.10, 5.16 and 5.17; see also clauses 2-4 of the draft Criminal Law Bill (at p 90-93 of the Report). In **R v Clarence** (1888) 22 QBD 23 the accused had intercourse with his wive when he knew, but she did not, that he was suffering from gonorrhoea. He was charged under sec 20 and 47 of the Offences Against the Person Act,1861. These sections required the accused "unlawfully and maliciously *inflicting* grievous bodily harm" on his wife. His conviction was quashed by the Court for Crown Cases Reserve, the reason being *inter alia* that he had not *inflicted* harm. In the Law Commission's opinion this seems to suggest that the transmission of illness or disease might not amount to *inflicting* harm. The restatement of the law in clauses 2 to 4 of the draft Bill therefore refers to *causing* harm (**Law Commission Report No 218** 1993 par 5.10, 5.16-5.17; Tierney 1992 **Hastings International nd Comparative Law Review** 503-504; Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** [Internet]).

528 **Law Commission Report No 218** 1993 par 15.17; see also Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** [Internet].

529 Schedule 2 of the draft Criminal Law Bill (**Law Commission Report No 218** 1993 p121).

to be capable of interfering substantially with the others's bodily functions".[530] It is to be noted that this measure, while encompassing HIV, is not HIV-specific.

6.14 In 1995, the Law Commission, in addressing the issue of consent in the criminal law context in a Consultation Paper, contemplated the possibility of imposing an "express duty to communicate information" on a person who wishes to rely on consent to the causation of injury or to the risk of injury and of invalidating consent to "serious disabling injury" subject to some exceptions (eg medical treatment, medical research and recognised sports).[531] "Serious disabling injury" would include HIV infection according to some commentators. Many are critical of these proposals. Their main concerns include the following:[532] First, it is dangerous to encourage people who believe they do not have HIV to assume it is safe to have unprotected sex with someone who assures them that he or she is also not infected. Second, criminal law will be invading privacy if it seeks to dictate what must be disclosed between two people in the course of agreeing to engage in sexual activity. And finally, proposals to criminalise otherwise consensual activities leading to risk of HIV infection (by extending the law on assault and sexual offences), are contrary to the country's public health traditions and therefore contrary to public interest.

* Australia

6.15 The present law dealing with criminal liability for transmission can be found both in the general criminal law dealing with offences against the person and in specific

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530 **Law Commission Report No 218** 1993 par 24.4-24.7 and clause 5 of the proposed Criminal Law Bill (a copy of which is attached in Annexure A to this Discussion Paper); Elliot 24-25; Omerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet). This is also an amended restatement of the law - cf the reference to sec 23 of the Offences of the Person Act, 1861 in fn 523 above.

531 **Law Commission Consultation Paper** No 139 1995 par 4.47-4.52 and p 204; Elliot 25; Omerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet). The definition of "serious disabling injury" includes injury which causes serious distress, and involve permanent bodily impairment (**Law Commission Consultation Paper** No 139 1995 par 4.51).

532 Elliot 25. Cf also Dine and Watt 1998 **Web Journal of Current Legal Issues** (Internet); Omerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet);

offences contained in various public health Acts and Ordinances.[533] Public health and criminal law vary across States/territories in Australia. In some jurisdictions, public health legislation includes provisions specifically relating to HIV transmission, while others contain broader offences regarding infectious diseases that could be applied to HIV. In some jurisdictions, the criminal law is codified, in others it remains a mixture of statute and common law.[534] It has been suggested that, as far as the criminal law is concerned, the significant deficiencies and anomalies inherent in its application to HIV-related behaviour justify the creation of a new crime of culpable transmission.[535]

6.16 However, in most jurisdictions in Australia provision is made by way of public health legislation for offences aimed at the transmission of, or exposure to HIV.[536] The Legal Working Party of the Intergovernmental Committee on AIDS in 1992 approved the application of these offences - in preference to the criminal law - but with the following qualifications:[537]

- Insistence upon protective measures (eg a condom) by a person with HIV should be a complete defence in cases where the other person has been exposed only to the risk of infection, while in cases where infection actually resulted, the use of protective measures should lead to a lesser penalty.
- Prosecutions for these offences should be brought only with the approval of the public health authorities.
- Responses to harmful HIV-related behaviour ought to include stages such as

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533 Bronitt 1992 **Criminal Law Journal** 86-87.

534 Elliot 21-23.

535 Bronitt 1992 **Criminal Law Journal** 92-93.

536 **Australia Discussion Paper Public Health** 36. In New South Wales, for instance, an HIV infected person is prohibited from having sexual intercourse with another person unless that person has been informed of the risk of HIV transmission and has voluntarily consented to sexual intercourse. In Victoria and Queensland it is an offence knowingly, or recklessly to infect another person with a contagious disease, while in South Australia an infected person who does not take all reasonable precautions to prevent to transmission of HIV to another person, commits an offence. In respect of some of these offences provision is made for the defence of informed consent by the "healthy" person, while in other cases this defence is limited to the spouse of the infected person. Penalties for the contravention of these measures are generally heavy fines (Godwin et al 34 et seq).

537 **Australia Final Report on AIDS** 22-23; Elliot 22-23; Gibson 1997 **HIV/AIDS Legal Link** 6-7; cf also fn 242 above.

counselling and education, medical and psychological assessment, restriction of movement and activities and detention and isolation as a last resort.

6.17 In a 1997 survey (after the Working Party's proposals) on policy and practice of managing persons who place others at risk of infection, it was found that more than 100 people in Australia have been "case managed" in the period 1995-1996.[538] It seems that most people who have been managed experienced drug dependency, intellectual disability and/or mental illness.[539] Only in exceptional cases has the criminal law intervened.[540] The conclusion was drawn that States and territories exhibit an intention to use the least restrictive measures possible for people with HIV who are reported to be placing others at risk of infection. This was reflected in the fact that only six people were reported to be detained by public health authorities, while the rest received counselling.[541]

*** Zimbabwe**

6.18 Zimbabwe intended introducing legislation in the past two years utilising the criminal law as a response to HIV/AIDS.[542]

6.18.1 The proposed Criminal Law Amendment Bill, 1996 makes it a criminal offence for any person, having actual knowledge that he or she has HIV, intentionally to do anything or permit the doing of anything which he or she knows or ought reasonably to know will infect another person with HIV; or is likely to lead to another person

538 Gibson 1997 **HIV/AIDS Legal Link** 7.

539 Ibid.

540 In Victoria, for instance two persons had been prosecuted as at July 1996 under general criminal law (presumably the period is taken as from the time when the Intergovernmental Committee's proposals were made i e 1992); In Tasmania, one person was prosected under criminal law. In these instances the police (in contradistinction to the public health services presumably) were involved in receiving the allegations of the incidents that had taken place. In Victoria a man charged with endangering the lives of two women was acquitted (Gibson 1997 **HIV/AIDS Legal Link** 9).

541 Gibson 1997 **HIV/AIDS Legal Link** 9.

542 It is not clear whether the measures are proposed with the intention to curb the spread of HIV/AIDS or to punish harmful behaviour.

becoming infected with HIV.[543] The draft legislation indicates that it shall be a defence for the accused to prove that the other party knew that the accused was infected with HIV, *and* consented to the act in question, appreciating the nature of HIV and the possibility of his or her becoming infected.[544] According to press reports the proposed legislation initially excluded married men from its ambit and only after considerable public outcry by women's organisations were the proposals altered to make it possible for a married woman to lay charges against her husband for intentionally infecting her with HIV.[545] As regards punishment the proposed legislation provides that "a court of a regional magistrate shall have jurisdiction to impose any penalty prescribed".[546]

6.18.2 The legislative proposals also include a minimum sentence of 15 years imprisonment for rapists with HIV - regardless of whether the rapist knew that he had HIV at the time of committing the offence.[547]

6.18.3 The Zimbabwean Minister of Justice expressed the hope that the legislation will be passed by Parliament. Several women's organisations in Zimbabwe welcomed the proposals saying it was long overdue.[548] However, representatives from several NGOs concerned with human rights submitted that a blanket criminalising provision in the form suggested would not curb the spread of HIV/AIDS "as it would let off the hook those who think that they are (HIV) negative".[549] Their comment implies that

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543 Clause 14(1) of the Zimbabwean Criminal Law Amendment Bill, 1996. See also **The Citizen** 5 July 1997. The Bill also makes provision for a court to direct that the accused be tested for HIV for the purpose of ascertaining whether he (sic) is infected or not. Moreover, any person who unreasonably hinders or obstructs such testing shall be guilty of an offence and liable to a fine not exceeding five thousand dollars or imprisonment not exceeding two years or to both (clause 16(1),(2) and (6) of the Bill).

544 Ibid clause 14(2).

545 Ibid clause 14(3); **The Citizen** 5 July 1997.

546 Zimbabwean Criminal Law Amendment Bill, 1996 clause 18. (See fn 543 above for the prescribed penalties.)

547 Ibid clause 15.

548 **The Herald** 20 May 1997.

549 Comment on the Zimbabwean Criminal Law Amendment Bill, 1996 by Women and AIDS Support

recalcitrant behaviour would be the exception and would occur mostly in the context of sexual abuse. They submit that where persons with HIV commit sexual offences, their HIV positive status should be regarded as an aggravating factor in sentencing, rather than targeting intentional transmission of or exposure to HIV with a blanket criminal provision.[550] These NGOs submit that most people who know that they have HIV, take measures to ensure that they do not compromise their immunity further by having unsafe sex. They further argue that the proposed legislation places an unfair responsibility for prevention and protection on those who are already infected in the case of consensual sex.[551]

6.18.4 Following a process of public consultation, the proposed legislation has subsequently been withdrawn to enable the incorporation of further amendments. The new Bill has been renamed the Sexual Offences Bill (1998) and will be presented to Parliament shortly.[552]

Network; Women in Law and Development in Africa; Zimbabwe AIDS Network; The Center; Musasa Project; Zimbabwe National Network of People with AIDS; NG Development Agency; Zinatha; and SAFaids (Information supplied by Ms Lynde Francis of The Center on 14 March 1998) - refer to p4 of their Comment. (This was one of several points of criticism on the proposed legislation in general. Neither the proposed legislation nor the comments indicate whether the purpose of the legislation was to specifically curb the spread of the disease.)

550 Comment on the Zimbabwean Criminal Law Amendment Bill, 1996 as indicated in fn 549.

551 Ibid. This argument is however not clear since consent (which would imply full knowledge of the perpetrator's HIV status and appreciation of the risks involved) will be a lawful defence in terms of the proposed legislation (cf clause 14(2)(b)).

552 Information provided by Ms BT Chivizhe on behalf of the Secretary for Justice, Legal and Parliamentary Affairs, Zimbabwe on 7/7/98.

7 EVALUATION, PRELIMINARY CONCLUSION AND REQUEST FOR COMMENT

7.1 After having examined the possible role of the criminal law in the prevention of the spread of HIV, the Commission on a preliminary basis confirms its 1995 premise that the criminal law is not pre-eminently the means by which to combat the spread of HIV.[553] The AIDS epidemic is first and foremost a public health issue and it is internationally accepted that non-coercive measures are the most successful means through which public health authorities can reduce the spread of the disease.

7.2 However, it is accepted, and this Discussion Paper bears evidence to the effect, that there are individuals who, through their irresponsible and unacceptable behaviour, deliberately place others at risk of HIV infection. Where HIV-related behaviour results in harm to others (i e exposure to or transmission of HIV), public health measures in themselves are insufficient and the criminal law undoubtedly has a role to play in protecting the community and punishing those who transgress. The Commission is of the opinion that this limited role is not necessarily incompatible with any public health strategy against the disease. Just as other individuals in society are held responsible for behaviour outside the criminal law's established parameters of acceptable behaviour, persons with HIV who knowingly or recklessly conduct themselves in ways that harm others must be held accountable. In this sense the criminal law must obviously provide a measure of protection in the form of deterrence and can also reflect society's abhorrence of such behaviour.

7.3 On the premise that the criminal law has a role to play, albeit limited, in targeting behaviour harmful to others, the question arises what route should be taken in realising this role. Two possibilities exist: applying the existing common law crimes or creating an HIV-specific statutory offence.

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553 See par 2.12 above where the former Commission's view has been referred to.

7.4 The State would indeed at present be able to institute criminal prosecutions for HIV-related behaviour under the existing common law crimes. In comment on the Commission's Working Paper 58 this was also emphasised as a reason why a new statutory offence should not be created.[554] However, it could be that HIV-related behaviour does not fit easily under the common law crimes, and that securing a successful prosecution under one of these crimes may prove difficult.[555] This would be due mainly to the specific characteristics of HIV as a disease: Its long incubation period and its invisibility may present problems with regard to proof of causation and fault. Aspects regarding consent could further encumber prosecutions. On the other hand, the common law provides a variety of different crimes which could be utilised to meet a number of different forms of harmful HIV-related behaviour. The fact that applying the common law crimes has apparently not been tested in practice,[556] complicates the issue and contributes to the current lack of clarity as regards the viability of utilising the common law. As the Commission has currently no practical evidence on the application of the common law crimes to harmful HIV-related behaviour, it is not in a position at this stage to come to any conclusion on their possible efficacy.

7.5 If harmful HIV-related behaviour is to be targeted by the criminal law in any other way than utilising the common law crimes, an HIV-specific statutory provision would have to be created by the legislature. Such an approach would (except where negligent exposure to or transmission of HIV which does not result in death, and strict liability are concerned) in essence confirm the common law position, but could provide clarity on aspects such as causation and consent and the use of condoms to minimise the risk of infection. However, as argued above in the rationales against the creation of a statutory provision, there are certain dangers to this approach. These should be carefully weighed against the benefit to be derived from the enactment of

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554 See par 2.11.2 and 2.13 above.

555 See par 5.21-5.31 above.

556 Cf par 2.1.5 above where it is indicated that a man has recently been charged with attempted murder in the first case of its kind in South Africa. The case has not been finalised at the time of publication of this Paper.

a statutory offence. Finally, compulsory HIV testing of suspects may well be an unavoidable corollary of creating a statutory offence. Whether this would be constitutionally permissible is open to question and could constitute further reason for questioning the desirability of a special enactment.

7.6 It should be clear from the above that the Commission is not in a position at this stage to come to any firm conclusion on the need for the creation of a statutory offence aimed at harmful HIV-related behaviour. Draft legislation has therefore not been included in this Discussion Paper for public comment. The Commission however includes, in an ANNEXURE, six examples of different legislative approaches dealing with such behaviour derived from existing or proposed legislation of comparable foreign legal systems. The examples cover the following possibilities for legislative reform:

* **Criminalising the conduct of any person who, with actual knowledge of HIV infection, "intentionally does or permits the doing of anything" which he or she knows or ought reasonably to know will infect another, or is likely to infect another with HIV. (Zimbabwe Criminal Law Amendment Bill 1996 - Example 1.)[557]**
* **Requiring a person infected with a "controlled notifiable disease"[558] (including HIV) "to take all reasonable measures to prevent transmission of the disease to others". (South Australia Public and Environmental Health Act 1987 - Example 2.)**
* **Providing that intentional infection of others with HIV is a felony.[559] (United**

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557 The current example is an extract form the Zimbabwean Criminal Law Amendment Bill 1996. As indicated in par 6.18.4 above, the proposed legislation has been withdrawn to enable the incorporation of further amendments. At the time of publication of this Discussion Paper it could not be ascertained whether these amendments would affect the provision with regard to HIV transmission. For more detail on the legislation, see par 6.18-6.18.4 above.

558 Examples 2 and 6 are examples of legislation aimed at harmful HIV-related behaviour which are not HIV-specific. (Note that in South Africa neither AIDS nor HIV is currently notifiable medical conditions.)

559 "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanours" (offences generally less heinous than felonies) in American criminal law.

States Draft HIV Prevention Bill 1997 - Example 3.)[560]

* **Criminalising knowing exposure**[561] **to "a significant risk of HIV transmission". (Tennessee [United States] Annotated Code 1994 - Example 4.)**
* **Prohibiting "sexual intercourse" by a person with HIV "with any other person" unless such other person knows of the infection and has consented to the intercourse. (Florida [United States] Statutes 1997 - Example 5.)**
* **Prohibiting knowing exposure to a "sexually transmitted disease" (which will include HIV). (Montana [United States] Annotated Code 1995 - Example 6.)**

7.7 In order to facilitate a conclusion on the issues in question, the Commission invites comment particularly on the following principal issues:

(A) The role of the criminal law in the HIV/AIDS context (compare par 5.11-5.18).

(B) The definition of harmful conduct in the HIV/AIDS context (compare par 5.1-5.5).

(C) The suitability and possible efficacy of using existing common law crimes in respect of harmful HIV-related behaviour - with particular reference to possible difficulties in prosecuting such crimes (compare par 5.21-5.31.1).

(D) The need for the creation of an HIV-specific offence targeting harmful behaviour - with specific reference to the possible need for legal certainty, and to the counter-productive effect the creation of a new offence may have on public health efforts in curbing the spread of the disease (compare par 5.36-5.65).

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560 See also par 6.10-6.11 above.

561 "Knowing" exposure could probably be equated to "intentional" exposure in South African criminal law.

(E) **The need for existing public health measures to be amended or new measures to be created to address the issue of harmful behaviour as an alternative to taking recourse to the criminal law, for example by adopting the Australian model of a graduated process, culminating in isolation or detention as a last resort** (compare par 4.9-4.15, 6.16).

(F) **The need for creating an offence of exposing another to HIV without transmission of HIV actually occurring** (compare par 5.15, 5.23, 5.30-5.31.1).

(G) **The need to inhibit negligent behaviour where negligence does not result in the death of the victim (i e where the relevant behaviour would not be prosecutable under a charge of culpable homicide)** (compare par 5.25.3-5.25.4 and 5.28-5.28.2).

(H) **The need to create offences of strict liability (i e requiring neither intention nor negligence as a form of fault) in addition to existing common law offences** (compare par 5.25-5.25.4, 5.33.2).

7.8 **Should the creation of a statutory offence be indicated, and with reference to the examples from other legal systems attached in ANNEXURE A-F, comment is invited on the following issues:**

(A) **What behaviour should be targeted by a statutory offence? (Transmission of HIV; exposure to HIV; both transmission of and exposure to HIV; any other behaviour - such as the transmission of or exposure to sexually transmitted diseases?)**

(B) **What form of fault, if any, should be required? (Intention only; or should negligence be an alternative to intention; or should strict liability be imposed?)**

(C) **What should be regarded as an appropriate defence to a criminal prosecution? (Legal consent to the relevant behaviour only; taking precautionary measures - i e using condoms - only; consent and taking precautionary measures jointly; consent or taking precautionary measures in the alternative?) What should "consent" mean?** (Compare also par 5.24-5.24.3.)

(D) **Where should the burden of proof with regard to consent lie? (Upon the accused to prove, on a balance of probabilities, that the person harmed or exposed consented to harm or the risk of harm; or upon the prosecution to prove, beyond reasonable doubt, that the person harmed did not so consent?)**

(E) **Would it be necessary or desirable to provide for statutory powers for the compulsory HIV testing of the accused (or suspects) for evidentiary purposes?**

(F) **Would it be necessary or desirable to create any presumptions with regard to the accused's HIV status?**

(G) **What would suitable punishment(s) be in the case of conviction on a statutory offence involving harmful HIV-related behaviour?**

ANNEXURE

EXAMPLES OF LEGISLATIVE APPROACHES DEALING WITH HARMFUL HIV-RELATED BEHAVIOUR DERIVED FROM EXISTING OR PROPOSED LEGISLATION OF COMPARABLE FOREIGN LEGAL SYSTEMS

Example 1: Zimbabwe Criminal Law Amendment Bill 1996

Example 2: South Australia Public and Environmental Health Act 1987

Example 3: United States Draft HIV Prevention Bill 1997

Example 4: Tennessee (United States) Annotated Code 1994

Example 5: Florida (United States) Statutes 1997

Example 6: Montana (United States) Annotated Code 1995

EXAMPLE 1: CLAUSE 14 OF THE ZIMBABWE CRIMINAL LAW AMENDMENT BILL 1996

"**Deliberate Transmission of HIV**

14.(1) Any person who, having actual knowledge that he is infected with HIV, intentionally does anything or permits the doing of anything which he knows or ought reasonably to know -

(a) will infect another person with HIV; or

(b) is likely to lead to another person becoming infected with HIV;

shall be guilty of an offence and liable to imprisonment for a period not exceeding fifteen years.

(2) It shall be a defence to a charge of contravening subsection (1) for the person charged to prove that the other person concerned -

(a) knew that the person charged was infected with HIV; and

(b) consented to the act in question, appreciating the nature of HIV and the possibility of his becoming infected with it. ...

Presumptions regarding HIV infection

17.(1) For the purpose of [clause] 14, the presence in a person's body of HIV anti-bodies or antigens, detected through an appropriate test shall be prima facie proof that the person concerned was infected with HIV;".

Note:

The Bill is discussed more fully in paragraph 6.18-6.18.4 above. The Bill provides for a person who is alleged to have contravened clause 14, to be tested for HIV (clause 16(2)).

EXAMPLE 2: SECTION 37 OF THE SOUTH AUSTRALIA PUBLIC AND ENVIRONMENTAL HEALTH ACT 1987[562]

"**Persons infected with disease must prevent transmission to others**

37.(1) A person infected with a controlled notifiable disease shall take all reasonable measures to prevent transmission of the disease to others. Penalty: Division 3 fine".

Note:

The Australian position is discussed in paragraph 6.15-6.17 above. "AIDS" and "AIDS-Related Complex" (the severe symptomatic phase of HIV infection - referred to in paragraph 2.26-2.26.2 above) have been designated as controlled notifiable diseases for the purposes of the Act (HIV infection is not of itself notifiable). The penalty for contravening this provision is $10 000,00. Proceedings in terms of this section cannot be commenced except upon the complaint of an authorised officer; the chief executive officer of a local council; a member of the police force; or a person acting on the written authority of the relevant Minister.[563] *This is an example of legislation aimed at harmful HIV-related behaviour which is not HIV-specific. (Note that in South Africa neither AIDS nor HIV is currently notifiable medical conditions.)*

EXAMPLE 3: SECTIONS 2 and 4 OF THE UNITED STATES DRAFT HIV PREVENTION BILL 1997

"**Sec 2. Findings**

2. The Congress finds as follows: ...

(5) Individuals with HIV disease have an obligation to protect others from being exposed to HIV by avoiding behaviors that place others at risk of becoming infected. The States should have in effect laws providing that intentionally infecting others with HIV is a felony.

Sec 4. Sense of Congress regarding intentional transmission of HIV

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562 Internet **http://www.austlii.edu.au/** accessed 3/11/98.

563 Sec 45(2) of the Public and Environmental Health Act 1987. See in general on these provisions also Godwin et al **Australian HIV/AIDS The Legal Issues** 37.

It is the sense of the Congress that the states should have in effect laws providing that, in the case of an individual who knows, that he or she has HIV disease, it is a felony for the individual to infect another with HIV if the individual engages in the behaviours involved with the intent of so infecting the other individual".

Note:

Background to the United States position is discussed in paragraph 6.6-6.11 above. "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law.

EXAMPLE 4: §39-13-109 OF THE TENNESSEE (UNITED STATES) ANNOTATED CODE 1994[564]

"**39-13-109. Criminal exposure to HIV - Defenses - Penalty**

(a) A person commits the offense of criminal exposure of another to HIV when, knowing that such person is infected with HIV, such person knowingly:

(1) Engages in intimate contact with another;

(2) Transfers, donates or provides blood, tissue, semen, organs, or other potentially infectious body fluids or parts for transfusion, transplantation, insemination, or other administration to another in any manner that presents a significant risk of HIV transmission; ...

(b) As used in this section: ...

(2) 'Intimate contact with another' means the exposure of the body of one person to a bodily fluid of another person in any manner that presents a significant risk of HIV transmission; ...

(c) It is an affirmative defense to prosecution under this section, which must be proven by a preponderance of the evidence, that the person exposed to HIV knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and gave advance consent to the action with that knowledge.

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564 Internet **http://www.lexislawpublishing.com/** accessed 3/11/98.

(d) Nothing in this section shall be construed to require the actual transmission of HIV in order for a person to have committed the offense of criminal exposure of another to HIV.

(e) Criminal exposure of another to HIV is a Class C felony".

Note:

Background to the United States position is discussed in paragraph 6.6-6.11 above. "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law.

EXAMPLE 5: §384.24 OF THE FLORIDA (UNITED STATES) STATUTES 1997[565]

"**384.24 Unlawful acts**

...

(2) It is unlawful for any person who has human immunodeficiency virus infection, when such person knows he or she is infected with this disease and when such person has been informed that he or she may communicate this disease to another person through sexual intercourse, to have sexual intercourse with any other person, unless such other person has been informed of the presence of the sexually transmissible disease and has consented to the sexual intercourse.

384.34 Penalties

...

(5) Any person who violates the provisions of s 384.24(2) commits a felony of the third degree ...".

Note:

Background to the United States position is discussed in paragraph 6.6-6.11 above. "Felonies"

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565 Internet **http://www.leg.state.fl.us/citizen/documents/statites/1997/** accessed 6/11/98.

(serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law. Under the above provisions a person convicted of a felony of the third degree, may be punished by a term of imprisonment not exceeding 5 years. In addition, payment of a fine not exceeding $5 000 may be imposed.[566] *The court may also require a convicted offender to serve a term of criminal quarantine community control (i e intensive supervision, by officers with restricted caseloads, with a condition of 24-hour-per-day electronic monitoring, and a condition of confinement to a designated residence during designated hours).*[567]

EXAMPLE 6: §50-18-112 OF THE MONTANA (UNITED STATES) ANNOTATED CODE 1995[568]

"**50-18-112 Infected person not to expose another to sexually transmitted disease**

A person infected with a sexually transmitted disease may not knowingly expose another person to infection.

50-18-113 Violation a misdemeanor

A person who violates provisions of this chapter or rules adopted by the department of public health and human services concerning a sexually transmitted disease or who fails or refuses to obey any lawful order issued by a state or local health officer is guilty of a misdemeanor".

Note:

Background to the United States position is discussed in paragraph 6.6-6.11 above. "Felonies" (serious crimes such as murder and arson) are distinguished from "misdemeanors" (offences generally less heinous than felonies) in American criminal law. For the purposes of this provision "sexually transmitted disease" includes AIDS.[569] *This is an example of legislation*

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566 §775.082(3)(d) and 775.083(1)(c) of the Florida Statutes

567 Section 755.0877(7) and 948.001(3) of the Florida Statutes, 1997.

568 Internet **http://statedocs/msl.state.mt/us/** accessed 6/11/98.

569 Katner 1996 **Tulane Law Review** 2334.

aimed at harmful HIV-related behaviour which is not HIV-specific.