

SOUTH AFRICAN LAW COMMISSION

Project 85

**FIFTH INTERIM REPORT ON
ASPECTS OF THE LAW RELATING TO AIDS**

**THE NEED FOR A STATUTORY OFFENCE AIMED AT HARMFUL
HIV-RELATED BEHAVIOUR**

APRIL 2001

**TO DR PM MADUNA, M P, MINISTER FOR JUSTICE AND CONSTITUTIONAL
DEVELOPMENT**

I am honoured to submit to you in terms of section 7(1) of the South African Law Commission Act, 1973 (Act 19 of 1973), for consideration the Commission's fifth interim report on **Aspects of the law relating to AIDS.**

JUSTICE Y MOKGORO

CHAIRPERSON: SOUTH AFRICAN LAW COMMISSION

April 2001

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INTRODUCTION

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

The members of the Commission are -

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The project leader responsible for the investigation is Mr Justice E Cameron. The researcher is Ms A-M Havenga.

SUMMARY

Background

- 1 This Report is the last in a series of Interim Reports¹ under the Commission's broad investigation into aspects of the law relating to AIDS. The preceding Reports dealt with certain health-related issues (First Interim Report); pre-employment HIV testing (Second Interim Report); HIV and discrimination in schools (Third Interim Report); and compulsory HIV testing of persons arrested in sexual offence cases (Fourth Interim Report).²

Scope of this Report

- 2 This Report deals with harmful (i.e. unacceptable) sexual behaviour by persons with HIV or AIDS that could transmit HIV or expose others to HIV, current measures available to address such behaviour, and whether there is a need for statutory intervention. The recommendations cover only *consensual* sexual activity. Transmission of or exposure to HIV can also occur during *non-consensual* sexual acts such as rape. The need for further measures in the latter regard will be dealt with under the Commission's investigation into sexual offences.³

Source of enquiry

- 3 The enquiry was undertaken at the request of the Parliamentary Justice Portfolio Committee. The request was made against the background of public concern and pressure for appropriate action regarding deliberate or knowing transmission of HIV infection. This came about largely in response to a number of widely publicised incidents of deliberate transmission of HIV, accompanied by the very real concern that

1 "Interim" refers to the Commission's working method of dealing with issues incrementally under its broad investigation into aspects of the law relating to AIDS. This Report, as well as its predecessors, contain final recommendations.

2 Chapter 1 contains information on these Reports and their outcome.

3 Chapter 4 sets out the parameters of this Report.

mostly women and young girls are being exposed to HIV infection in this manner.⁴

Three possible options for dealing with the issue

4 During the course of the investigation the Commission identified the following three possible options for responding to the Justice Portfolio Committee's request:

! Codification of common law crimes⁵

Deliberate conduct in the form of deliberate transmission of or exposure to HIV would already be liable to prosecution under the existing common law crimes of murder, assault, assault with the intent to do grievous bodily harm, rape or indecent assault. *Negligent* conduct would be liable to prosecution under existing law if HIV is transmitted and the victim died as a result of this. It may however be that HIV-related behaviour is difficult to prosecute successfully under these crimes. 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. Some believe that it may be necessary to codify the common law to eliminate these difficulties or some of them. This approach would not entail creating any *additional, new* offence, but would put into statutory form what is already illegal. Such codified HIV-specific offences would then be a clear confirmation of the existing common law position. Codification might also provide an opportunity for the creation of presumptions to deal with current perceived difficulties in the application of the common law.

! Criminalising behaviour not hitherto criminal⁶

The second option stems from the fact that our common law contains three distinct omissions: There are no crimes of negligent injury; of deliberately exposing another to danger short of assault; or of negligent endangerment (exposure). In this regard the following possibilities arose:

P The creation of HIV-specific measures requiring the *disclosure of their HIV status* by all persons with HIV before engaging in certain sexual activities. Whether disclosure would always be required - even if

4 Chapter 2 contains information on the Portfolio Committee's request and an overview of the research and consultation undertaken.

5 An exposition of the common law crimes applicable to harmful HIV-related behaviour is given in Chapter 6.

6 The presentations of experts set out in Chapter 11 contain arguments pertaining to the possibility of criminalising behaviour not hitherto criminal.

preventive measures (eg a condom) were used - is a controversial point.

P The creation of an HIV-specific offence/s targeting *negligent transmission of HIV*; or *negligent transmission of and negligent exposure to HIV*. This could be limited to cases where the perpetrator had actual knowledge of his or her HIV infection.

! ***Maintaining the present position***

Maintaining the present position would mean that persons with HIV who transmit HIV to others or expose others to HIV may under certain circumstances be prosecuted under the existing common law crimes.

Public consultation and deliberation

5 The Commission in January 1999 published a discussion document (Discussion Paper 80) for public comment. At that stage the Commission was not sufficiently convinced to make preliminary recommendations for legislative intervention and the question was left open for debate. Strong comments were received both opposing and supporting legislative intervention and it became necessary to discuss further with a wide range of experts the dilemmas faced by the Commission. Again consensus was not reached. However the strong momentum of opinion amongst a wide range of experts, representing diverse interests, was against legislative intervention.⁷

Position in comparable legal systems

6 In none of the comparable legal systems referred to in the Report (Canada, the United States of America, the United Kingdom, Australia, Zimbabwe and Namibia) have HIV-specific criminal offences relating to consensual sexual acts recently been created on a national level. In systems where there have been such attempts (Canada, the United States and Namibia) they were controversial and met with public opposition which led to their abandonment. In Zimbabwe, where draft legislation introducing HIV-specific criminal offences has apparently been under consideration since 1994, no enactment has as yet been passed.

7 The issues submitted for comment in Discussion Paper 80 are set out in Chapter 9. Comments are analysed in Chapter 10. The views of experts presented at a consultative meeting on 3 February 2000 and the subsequent debate and outcome of the meeting are set out in Chapter 11.

Guiding principles

- 7 The background material in this Report and the divergent responses and perspectives from commentators and experts bear evidence to the complexity of the issues. In seeking a solution the Commission was guided by the following principles:
- ! Respect for the human rights and interests of all concerned.
 - ! The primary objective of the creation of an HIV-specific statutory offence/s should be HIV prevention and the protection of the uninfected.
 - ! Legislative intervention should be rationally and scientifically based and not emotionally motivated.

Conclusion

- 8 The Commission concluded that statutory intervention is neither necessary nor desirable. It is of the view that arguments against intervention override arguments supporting such step. Moreover, the Commission believes that strong indications from the entire process of research and deliberation weigh against statutory intervention and that recommending new legislation under these circumstances would not be principled.⁸
- 9 Major reasons for this conclusion are the following:

! ***Lack of evidence that offences are occurring in regard to which statutory intervention along the lines envisaged is necessary***

There is no scientific, empirical or even informal evidence that the behaviour to be targeted is occurring to such an extent that the creation of an HIV-specific statutory offence/s is necessary. This may indicate that in practice there is no need for additional punitive measures, and that a change to the law would therefore probably be based (without denying that real instances of dangerous conduct occur) on general fears, anxieties and "urban legends" about alleged wilful or negligent behaviour by persons with HIV.

8 Arguments for and against intervention are set out in Chapter 7. A full discussion of the reasons for the Commission's conclusion, its response to arguments supporting legislative intervention and its final recommendation are contained in Chapter 12.

! *An HIV-specific statutory offence/s will have no or little practical utility*

The Commission believes this to be the case in view of the following:

- P An array of common law crimes exists which could be utilised against harmful HIV-related behaviour.
- P It is doubted whether the creation of an HIV-specific statutory offence/s could minimise the difficulties associated with the application of the common law crimes. Such an offence will indeed bring its own problems - not the least of which will relate to the burden of proof and constitutional issues. The common law crimes would first have to be more extensively applied in practice and shown to be inadequate before a need for a statutory offence/s can be determined.
- P A statutory offence/s could add to the problems an overburdened criminal justice system is currently experiencing.
- P There are few or no prosecutions under existing criminal measures. Will complainants come forward to utilise an HIV-specific statutory offence? This seems doubtful. The enactment of such offence/s might thus be largely of symbolic value.
- P The codification of existing common law crimes may, in addition, have the effect of promoting "exceptionalism"⁹ in dealing with HIV and AIDS.

! *The social costs entailed in creating an HIV-specific statutory offence/s are not justified*

The decision to criminalise implies a cost to society and the individual involved. The benefits and social gains to be obtained from the successful prevention or reduction of the conduct in question have to be commensurate with this cost. Otherwise a decision to criminalise cannot be constitutionally justified. The Commission is of the opinion that the social costs inherent in the creation of an HIV-specific offence are not justified:

- P This would be the case especially as regards the creation of a new additional offence targeting *negligent* behaviour. Negligence in the HIV/AIDS context would involve an individual who is not aware that he or she has HIV and in this state of ignorance unknowingly transmits HIV or exposes another to HIV. The Commission is convinced that where the

9 "AIDS exceptionalism" refers to the phenomenon of singling out HIV/AIDS for special treatment which, it is argued, may draw undue attention to the issue and in turn promote more subtle discriminatory practices against persons with HIV/AIDS.

majority of persons in South Africa with HIV are unaware of their HIV status and where there are insufficient resources for the widespread HIV testing that would be required to enable a change of behaviour, it is not just and right that persons who are ignorant of their health status (but ought perhaps ideally to know that they are infected), should be punished. In effect such individuals would be punished for their failure to know their HIV status - which may lie outside their control.

- P Additional important factors related to the social costs of creating an HIV-specific statutory offence include the following: It is generally believed that such offence/s would be counter productive to public health efforts to curb the spread of the disease; would entrench further discrimination and stigmatisation of persons with HIV; and would drain away scarce resources from the most effective HIV prevention programmes such as targeted education campaigns, condom distribution initiatives, and the provision of voluntary, accessible testing, counselling and medical treatment.

! *An HIV-specific statutory offence/s will infringe the right to privacy to an extent that is not justified*

The transmission of or exposure to HIV in the context of *consensual* sexual relationships involves the most intimate aspects of human interaction. The enforcement of an HIV-specific offence will call for inquiry into the medical histories and sexual affairs of both the accused and his or her sexual partner/s. The Commission is of the opinion that such infringement of privacy is not justified in circumstances where the creation of an HIV-specific offence is not based on evidence establishing a need for such offence/s; where such offence/s may serve no purpose additional to the existing common law offences; and would have no impact on diminishing or preventing the spread of HIV.

Recommendation

- 10 The Commission recommends that the present legal position be maintained.
- 11 In concert with this recommendation, the Commission identifies a pivotal need for the development of practical mechanisms by government departments to utilise effectively the existing common law crimes in cases of harmful HIV-related behaviour; and to encourage a culture of responsibility regarding HIV status. These mechanisms may include:
- ! Making the public aware of applicable common law crimes coupled with the assurance that our existing law will indeed be used in respect of harmful HIV-related behaviour.
 - ! Introducing practical measures to establish a standard of policing, investigation and prosecution that would ensure successful prosecutions of harmful HIV-related behaviour under the existing law.
 - ! Maintaining and improving public health measures relating to awareness about HIV and its prevention, and public access to HIV testing and counselling. Such activities should be aimed at encouraging a culture of responsibility.

SOURCES WITH MODE OF CITATION

A "mode of citation" as well as the full particulars of sources referred to in the Report, are recorded in the list below.

Abdool Karim 1998 Agenda - Empowering Women for Gender Equity

Quarraisha Abdool Karim "Women and AIDS - The Importance for a Gendered Prognosis and Prevention Policy" 1998 **Agenda - Empowering Women for Gender Equity** No 39 15-25

ACLU News 1 August 1996 (Internet)

"HIV 'Prevention' Bill Would Violate Rights and Do More Harm than Good" **American Civil Liberties Union News** 1 August 1996
(Internet <http://www.aclu.org/news/n080196c.html>)

ACLU News 29 September 1998 (Internet)

"Congressional Panel Considers HIV Name Reporting, Partner Notification" **American Civil Liberties Union News** 29 September 1998
(Internet <http://www.aclu.org/news/n092998a.html>)

ACTUP Report 23 March 2000 (Internet)

"What is the Coburn Bill?" AIDS Coalition to Unleash Power: Report, 23 March 2000
(Internet <http://www.actupny.org/reports/coburn.html>)

AFAIDS 30 April 1999 (Internet)

"Preventing Victims of Rape from Contracting AIDS Virus"
(Extract from the **New York Times** 2 April 1999 "AIDS Activists Urge South Africans" [Associated Press]
as reproduced in **AFAIDS HIVNET** at <http://www.hivnet.ch:800/af-aids/tm>)

AIDS 2000 - XIIIth International AIDS Conference 12 July 2000 (Internet)

"Violence against Women and the Spread of HIV/AIDS" and "Gender and Sexuality" Programme Session Reports 12 July 2000 at AIDS 2000 - XIIIth International AIDS Conference Durban, South Africa 9-14 July 2000
(Internet <http://www.aids2000.com/>)

AIDSScan March/April 1996

"Editorial - SA Actuarial Society Report Back on AIDS in South Africa" **AIDSScan** March/April 1996 3-7

AIDSScan March 1997

"Medical Schools and Teaching Hospitals at Risk for Civil Suits by HIV-infected Students" **AIDSScan** March 1997 9

AIDSScan September/October 1998

"A Telephone Survey of Condom Usage in a Developing Country - Brazil" **AIDSScan** September/October 1998 12

AIDSScan October/November 2000

"AIDS Vaccine Trials in Africa" **AIDSScan** October/November 2000 11-12

AIDS Action January -March 1998

"Drugs for Dealing with HIV" **AIDS Action** January-March 1998 11

AIDS Action Analysis 21 April 1997 (Internet)

"The Coburn HIV Prevention Act of 1997" **AIDS Action Analysis** 21 April 1997
(Internet <http://www.thebody.com/aac/apr2197.html>)

AIDS Practice Manual

AIDS Practice Manual edited by Paul Albert, Ruth Eisenberg, David A Hansell and Jody Kathleen Marcus
USA: National Lawyers Guild Network 1991

AIDS The Legal Issues

Discussion Draft of the American Bar Association AIDS Co-ordinating Committee USA: American Bar Association 1988

Albertyn (Unpublished [Internet])

Cathi Albertyn "Using Rights and the Law to Reduce Women's Vulnerability to HIV/AIDS" Discussion Paper for the Satellite Symposium "Putting Third First - Critical Legal Issues and HIV/AIDS" AIDS 2000 - XIIIth International AIDS Conference Durban, South Africa 9 - 14 July 2000
(Internet <http://www.aidslaw.ca/durban2000/e-durban-women.htm>)

AMA Sexual Assault Guideline Resources (Internet)

American Medical Association **Sexual Assault Guideline Resources** "Strategies for the Treatment and Prevention of Sexual Assault" 1995
(Internet <http://www.ama-assn.org/public/releases/assault/sa-guide.htm>)

AMFAR AIDS/HIV Treatment Directory June 1996

American Foundation for AIDS Research (AMFAR) 1996 **AIDS/HIV Treatment Directory** June 1996 94-137

Andrias 1993 **Fordham Urban Law Journal**

Richard T Andrias "Urban Criminal Justice: Has the Response to the HIV Epidemic been 'Fair'" 1993 **Fordham Urban Law Journal** Vol XX 497-512

Announcements, Tablings and Committee Reports, Parliament of the Republic of South Africa 4 October 2000
Parliament of the Republic of South Africa **Announcements, Tablings and Committee Reports** 4 October
2000 (Tablings No 123 - 2000 Second Session, Second Parliament)

Australia Discussion Paper Public Health

The Legal Working Party of the Intergovernmental Committee on AIDS **Discussion Paper Legislative Approaches to Public Health Control of HIV-infection** Canberra: Department of Health, Housing and Community Services 1992

Australia Final Report on AIDS

The Legal Working Party of the Intergovernmental Committee on AIDS **The Final Report** Canberra: Department of Health, Housing and Community Services 1992

Bayer 1994 **Hospital Practice**

Ronald Bayer "AIDS: Human Rights and Responsibilities" **Hospital Practice** 15 February 1994 155-164

Bayer in **Encyclopaedia of AIDS** (Internet)

Ronald Bayer "Public Ethics" excerpt from **Encyclopaedia of AIDS** edited by Raymond A Smith, Fitzroy Dearborn Publishers Chicago and London: 1999
(Internet <http://www.aids-encyc.com/ehthics.html>)

Beeld 14 May 1998

"IVP Vra Wet wat Mense met VIGS Dwing om Hul Seksmats te Sê" **Beeld** 14 May 1998

Beeld 27 May 1998

"Verkragting is Vermaak vir die Bende Vigslyers" **Beeld** 27 May 1998

Beeld 27 June 1998

"Groot Onkunde Heers Steeds oor VIGS" **Beeld** 27 June 1998

Beeld 15 August 1998

"Verkragting: Kruis van die Townships" **Beeld** 15 August 1998

Beeld 26 August 1998

"Ondersoek Gedoen na Amerikaanse Kits-HIV/Vigs Toets" **Beeld** 26 Augustus 1998

Beeld 10 March 1999

"Burgemeester 'Ontsteld' oor Verkragting" **Beeld** 10 March 1999

Beeld 10 March 1999

"Verkragte Student Kry Vigsmiddel" **Beeld** 10 March 1999

Beeld 12 March 1999

" 'Ons Lewe in Hoop - en Erge Spanning', Sê Ma van Verkragte" **Beeld** 12 March 1999

Beeld 12 March 1999

"Verkragte Vrou 'in Ekstase' oor Middel" **Beeld** 12 March 1999

Beeld 19 April 1999

"Kritiek teen Ministers se Vigsplanne" **Beeld** 19 April 1999

Beeld 23 April 1999

"Debat oor AZT Vlam Weer op" **Beeld** 23 April 1999

Beeld 23 April 1999

" 'Staat Word Laksman as Hy Verkragtes Terapie Weier' " **Beeld** 23 April 1999

Beeld 24 April 1999

"Verkragte Joernalis se Aanklag teen Polisie, Hospitale, Regering - en Samelewing: My Lewe Is nie R400 Werd nie" **Beeld** 24 April 1999

Beeld 21 May 1999

"Nuwe Hoop vir Vroue in SA wat Verkrag is" **Beeld** 21 May 1999

Beeld 12 July 2000

" 'Gedwonge Seks die Monster in Vigs krisis' "

Beeld 17 November 2000

"Verkragte 14-jarige het Res van Lewe Berading Nodig" **Beeld** 17 November 2000

Beeld 12 January 2001

"Vigs-Aanmeldingsplan Laat Vaar" **Beeld** 12 January 2001

Berge 1992 **Florida Law Review**

Peter H Berge "Setting Limits on Involuntary HIV Antibody Testing under Rule 35 and State Independent Medical Examination Statutes" 1992 **Florida Law Review** Vol 44 767-805

Birmingham 1999 **Nature Medicine**

Karen Birmingham "SAAVI Awards First AIDS Vaccine Grants" 1999 **Nature Medicine** Vol 5 No 2 November 1999 1220

BMJ (SA Ed) August 1997

"HIV May Be Eliminated from Reservoirs of Infection in the Body" **British Medical Journal** (South African edition) August 1997 487

Boland et al in **HIV/AIDS A Guide to Primary Care Management**

Mary Boland, Pamela Rothpleitz-Puglia and James Oleske "Infants and Children - HIV Disease Care Management" in **HIV/AIDS A Guide to Primary Care Management** edited by Peter J Ungvarski and Jacquelyn Haak Flaskerud Fourth Edition Philadelphia: WB Saunders Company 1999 65-97

Bowers 1996 **Bulletin of Experimental Treatments for AIDS** (Internet)

Mark Bowers "HIV Vaccines" **Bulletin of Experimental Treatments for AIDS** June 1996
(Internet <http://www.aegis.com/pubs/beta/1996/be963008.html>)

Bronitt 1992 **Criminal Law Journal**

Simon H Bronitt "Criminal Liability for the Transmission of HIV/AIDS" 1992 **Criminal Law Journal** Vol 16 85-93

Buchanan in **African Network on Ethics, Law and HIV**

David Buchanan "Public Health, Criminal Law and the Rights of the Individual" in **African Network on Ethics, Law and HIV - Proceedings of the Intercountry Consultation (Dakar, Senegal 27 June-1 July, 1994)** Senegal: United Nations Development Programme 1995 93-110

Burchell

Jonathan Burchell **Principles of Delict** Cape Town: Juta 1993

Burchell and Hunt

EM Burchell and PMA Hunt **South African Criminal Law and Procedure (Volume 1: General Principles of Criminal Law)** Third Edition by JM Burchell Kenwyn: Juta and Co Ltd 1997

Burchell and Milton

Jonathan Burchell and John Milton **Principles of Criminal Law** Second Edition Kenwyn: Juta and Co Ltd 1997

Burr 1997 **The Atlantic Monthly**

Chandler Burr "The AIDS Exception: Privacy vs Public Health" in **The Atlantic Monthly** June 1997 57-67

Business Day 23 October 1997

"Kahn Wants New HIV Testing Law in Rape Cases" **Business Day** 23 October 1997

Cameron (Unpublished)

Mr Justice E Cameron "Human Rights: Consequences for the HIV Epidemic: Beyond Policy Consensus to Effective Activism" (Unpublished Paper delivered at the 12th World AIDS Conference Geneva 28 June-3 July 1998)

Cameron and Swanson 1992 **SAJHR**

Edwin Cameron and Edward Swanson "Public Health and Human Rights - The AIDS Crisis in South Africa" 1992 **South African Journal on Human Rights** 200-233

Canadian HIV/AIDS Policy and Law Newsletter Spring 1999

"Criminal Law and HIV/AIDS: New Developments" **Canadian HIV/AIDS Policy and Law Newsletter** Spring 1999 45-51

Canadian HIV/AIDS Policy and Law Newsletter Summer 1999

"After Cuerrier: Legal Network Paper on Supreme Court Decision Released" **Canadian HIV/AIDS Policy and Law Newsletter** Summer 1999 44-47

Canadian HIV/AIDS Policy and Law Newsletter Spring/Summer 2000

"Criminal Law and HIV/AIDS: Update III" **Canadian HIV/AIDS Policy and Law Newsletter** Spring/Summer 2000 33-37

Canadian HIV/AIDS Legal Network **Info Sheet 1 on Criminal Law and HIV/AIDS**

"The Cuerrier Case" Info Sheet 1 on Criminal Law and HIV/AIDS published by the Canadian HIV/AIDS Legal Network 1999

Canadian HIV/AIDS Legal Network **Info Sheet 4 on Criminal Law and HIV/AIDS**

"Criminalization - Does it Make Sense?" Info Sheet 4 on Criminal Law and HIV/AIDS published by the Canadian HIV/AIDS Legal Network 1999

Canadian HIV/AIDS Legal Network **Info Sheet 7 on Criminal Law and HIV/AIDS**

"The Cuerrier Case: Issues for People with HIV/AIDS" Info Sheet 7 on Criminal Law and HIV/AIDS published by the Canadian HIV/AIDS Legal Network 1999

Canadian HIV/AIDS Legal Network **HIV Testing Info Sheet 9**

"Advances in HIV Testing Technologies" Canadian HIV/AIDS Legal Network **HIV Testing Info Sheet 9** 2000

CDC Drug Use and HIV/AIDS: The Body (Internet)

"Drug Use and HIV/AIDS" Centers for Disease Control **The Body**
(Internet <http://www.thebody.com.cdc/factdrug.html>)

CDC Facts About Recent HIV/AIDS Treatment July 1997 (Internet)

"Facts about Recent HIV/AIDS Treatment Advances and the Implications for Prevention" Centers for Disease Control July 1997
(Internet <http://thebody.com/cdc/treatment.html>)

CDC Frequently Asked Questions May 2000 (Internet)

"Does HIV Cause AIDS?" Centers for Disease Control Frequently Asked Questions May 2000
(Internet <http://www.aegis.com/topics/faq.html>)

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

"Facts about Recent HIV/AIDS Treatment Advances and the Implications for Prevention" Centers for Disease Control July 1997
(Internet <http://thebody.com/dcd/treatmetn.html>)

CDC Morbidity and Mortality Weekly Reports 18 December 1992 (Internet)

"1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS among Adolescents and Adults" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 18 December 1992
(Internet <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00018871.htm>)

CDC Morbidity and Mortality Weekly Reports 2 May 1997

"Contraceptive Practices before and after an Intervention Promoting Condom Use to Prevent HIV Infection and Other Sexually Transmitted Diseases among Women - Selected US Sites, 1993-1995" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 2 May 1997 373-377

CDC Morbidity and Mortality Weekly Reports 11 July 1997

"Transmission of HIV Possibly Associated with Exposure of Mucous Membrane to Contaminated Blood" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 11 July 1997 620-623

CDC Morbidity and Mortality Weekly Reports 27 March 1998

"Update: HIV Counselling and Testing Using Rapid Tests - United States, 1995" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 27 March 1998

CDC Morbidity and Mortality Weekly Reports 15 May 1998 (Internet)

"Public Health Service Guidelines for the Management of Health-care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 15 May 1998
(Internet http://www.cdc.gov/nchstp/hiv_aids/pubs/mmwr.htm)

CDC Morbidity and Mortality Weekly Reports 25 September 1998 (Internet)

"Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, including Considerations related to Antiretroviral Therapy" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 25 September 1998

(Internet http://hivinsite.ucsf.edu/medical/tx_guidelines/2098.3e58.html)

CDC PATHFINDER May 1997 (Internet)

"Guide to Information and Resources on HIV Testing" Centers for Disease Control **PATHFINDER** May 1997

(Internet <ftp://ftp.cdcnpin.org/Pathfinders/testing.txt>)

CDC Update March 1998 (Internet)

"Rapid HIV Tests - Questions/Answers" Centers for Disease Control **Update** March 1998

(Internet <http://www.thebody.com/cdc/rapidfaq.htm>)

CDC Update June 1998 (Internet)

"Facts about Recent HIV/AIDS Treatment Advances and the Implications for Prevention" Centers for Disease Control **Update** June 1998

(Internet <http://www.thebody.com/cdc/treatment.html>)

CDC Update September 1998

"PHS Report Summarises Current Scientific Knowledge on the Use of Post-Exposure Antiretroviral Therapy for Non-Occupational Exposures - Therapy Remains Unproven: Should Not be Used Routinely" Centers for Disease Control **Update** September 1998

CDC Update October 1998 (Internet)

"Human Immunodeficiency Virus Type 2" Centers for Disease Control **Update** October 1998

(Internet <http://www.cdc.gov/hiv/pubs/facts/hiv2.htm>)

Chaskalson et al

Matthew Chaskalson et al **Constitutional Law of South Africa** Kenwyn: Juta 1996 (Including Revision Service 2 1998)

Cohen (Unpublished)

Benjamin Gershon Cohen "Criminalizing the Sexual Transmission of HIV" (Unpublished paper prepared for the AIDS Law Project, Centre for Applied Legal Studies, University of the Witwatersrand, March 1997)

Cohn 1997 **BMJ**

Jonathan Allen Cohn "Recent Advances - HIV Infection-1" **British Medical Journal** February 1997 487-491

Colella 1995 **The Journal of Legal Medicine**

Ugo Colella "HIV-related Information and the Tension between Confidentiality and Liberal Discovery"
The Journal of Legal Medicine March 1995 33-100

Crichton (Unpublished)

Andrew Crichton "Condom Programming in Free State Health Care Clinics" (Dissertation submitted in accordance with the requirements for the degree of M Soc Sci) Bloemfontein: University of the Free State 1997

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

Mubarak S Dahir "Hard to Swallow" **The Body: POZ Gazette**
(Internet http://www.thebody.com/poz/survival/3_98/swallow.html)

Daily Dispatch 23 October 1997

"A-G's Office Knew Rape Suspect had AIDS, but Couldn't Tell" **Daily Dispatch** 23 October 1997

Dalton in **AIDS Law Today**

Harlon L Dalton "Criminal Law" in **AIDS Law Today - A New Guide for the Public** edited by Scott Burris, Harlon L Dalton Judith Leonie Miller and the Yale AIDS Law Project, New Haven and London: Yale University Press 1993 242-262

De Carlo **JAMA HIV/AIDS Information Centre** February 1995 (Internet)

Pamela De Carlo "Do Condoms Work?" **The Journal of the American Medical Association HIV/AIDS Information Centre**
(Internet <http://www.ama-assn.org/special/hiv/preventn/prevent2.htm>)

De Carlo **VAAIN** April 1995 (Internet)

Pamela De Carlo "Three Fact Sheets on Condoms" **Veterans Administration AIDS Information Newsletter** April 1995
(Internet <http://www.hsph.harvard.edu/Organizations/hai/researchtemp/vaain/110.html>)

De Jager 1991 **Journal of South African Law**

FJ De Jager "Vigs: Die Rol van die Strafreg" 1991 **Journal of South African Law** 212-223

De Jager 1991 **Journal of South African Law**

FJ De Jager "VIGS: Moontlike Grondslae vir Straftregtelike Aanspreeklikheid van HIV-draers" 1991 **Journal of South African Law** 547-560

Denenberg **The Body: GMHC Treatment Issues** (Internet)

Risa Denenberg Commentary: "Postexposure Antiretroviral Treatment for Rape Survivors?" **The Body: Gay Men's Health Crisis Treatment Issues** July 1997
(Internet [http:// www.thebody.com/gmhc/issues/julaug97/abuse.html](http://www.thebody.com/gmhc/issues/julaug97/abuse.html))

Deniaud 1997 **Sante** (Internet)

F Deniaud "Reseau IEC-Population, Abidjan, Cote d'Avoir" [Current Status of the Female Condom in Africa] 1997 **Sante** 405-415
(Internet <http://www.aegis.com.pubs/aidslines/1998/jun/m9861199.html>)

Department of Health Discussion Document on Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations August 1998

"Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations" Discussion Document issued by the Department of Health August 1999

Department of Health Policy Guideline on Management of Occupational Exposure to HIV March 1999

"Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV)" Policy Guideline issued by the HIV/AIDS and STD Directorate Department of Health March 1999

Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999

"Rapid HIV Tests and Testing" Policy Guidelines prepared by Dr Clive Evian (Policy Consultant, HIV/AIDS and STD Directorate: Department of Health) April 1999

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

Janet Dine and Bob Watt "The Transmission of Disease during Consensual Sexual Activity and the Concept of Associative Autonomy" 1998 **Web Journal of Current Legal Issues**
(Internet <http://webjcli.ncl.ac.uk/1998/issue4/watt4.html>)

Dorrington 2000 **SAMJ** 452-453

"HIV Surveillance Results - Little Grounds for Optimism yet" 2000 **South African Medical Journal** Vol 90 No 5 452-453

Elliot

Richard Elliot **Criminal Law and HIV/AIDS: Final Report** Montreal: The Canadian HIV/AIDS Legal Network and the Canadian AIDS Society April 1997

Elliot (After Cuerrier)

Richard Elliot **After Cuerrier** Montreal: The Canadian HIV/AIDS Legal Network and the Canadian AIDS Society 1999

Elliot (Discussion Paper)

Richard Elliot **Criminal Law and HIV/AIDS: Discussion Paper** Montreal: The Canadian HIV/AIDS Legal Network and the Canadian AIDS Society April 1996

Elliot (Unpublished)

Richard Elliot "Criminal Law and HIV/AIDS: Strategic Considerations - A Discussion Paper" (Unpublished paper delivered at a Plenary Session "Putting Third First: Critical Legal Issues" AIDS 2000 XIIIth International Conference on HIV/AIDS Durban 7 July 2000)

Emmons 1997 **The American Journal of Medicine**

Wesley Emmons "Accuracy of Oral Specimen Testing for Human Immunodeficiency Virus" **The American Journal of Medicine** April 1997 (Suppl 4A) 15-20

Epi Comments October 1995

"AIDS in South Africa - Reported AIDS Cases as on 30 November 1995" **Epidemiological Comments** October 1995 234

Evian

Dr Clive Evian **Primary AIDS Care** Third Edition Johannesburg: Jacana Education 2000

Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management**

Jacquelyn Haak Flaskerud and Peter J Ungvarski "Overview and Update of HIV Disease" in **HIV/AIDS A Guide to Primary Care Management** edited by Peter J Ungvarski and Jacquelyn Haak Flaskerud Fourth Edition Philadelphia: WB Saunders Company 1999 1-25

Fleming and Martin 1993 **SAMJ**

AF Fleming and DJ Martin "National Strategy for Serological Diagnosis of HIV Infection" **South African Medical Journal** September 1993 685-687

Flexner in **The Hopkins HIV Report** (Internet)

Charles Flexner "Post Exposure Prophylaxis Revisited: New CDC Guidelines" in **The Hopkins HIV Report** January 1998
(Internet http://www.hopkins-aids.edu/publications/report/jan98_2.html)

Forbes **WORLD** September 1998 (Internet)

Anna Forbes "What's up with Microbicides" **WORLD** (Women Organised to Respond to Life-Threatening Diseases) Issue No 89 September 1998
(Internet <http://hivinsite.ucsf.edu/topics/women/2098.3f3f.html>)

Gerberding in **The Medical Management of AIDS**

Julie Louise Gerberding "Limiting the Risks of Health Care Workers" in **The Medical Management of AIDS** edited by Merle A Sande and Paul A Volberding Fifth Edition London: WB Saunders Company 1997 75-88

Gibson 1997 **HIV/AIDS Legal Link**

Sally Gibson "Knowingly and Recklessly" 1997 **HIV/AIDS Legal Link** Vol 8 No 3 6-9

Gostin and Lazzarini

Lawrence O Gostin and Zita Lazzarini **Human Rights and Public Health in the AIDS Pandemic** New York: Oxford University Press 1997

Grimm 1997 **Human Rights Brief** (Internet)

Nicole Grimm "Combatting Discrimination against AIDS Patients in Tanzania" 1997 **Human Rights Brief** (Centre for Human Rights and Humanitarian Law, Washington College of Law, American University) (Internet <http://www.wcl.american.edu/pub/humright/brief/v4i3/aids43.htm>)

Groopman **The New Republic** 12 August 1996

Jerome Groopman "Chasing the Cure" **The New Republic** 12 August 1996

Guay et al 1999 **The Lancet**

Laura Guay, Philippa Musoke, Thomas Fleming, Danstan Bagenda, Melissa Allen, Clemensia Nakabiito, Joseph Sherman, Paul Bakaki, Constance Ducar, Martina Deseyve, Lynda Emel, Mark Mirochnick, Mary Glenn Fowler, Lynne Mofenson, Paolo Miotti, Kevin Dransfield, Dorothy Bray, Francis Mmiro and J Brooks Jackson "Intrapartum and Neonatal Single-dose Nevirapine Compared with Zidovudine for Prevention of Mother-to-Child Transmission of HIV-1 in Kampala, Uganda: HIVNET 012 Randomised Trial" 1999 **The Lancet** Vol 354 795-802

Guide to Clinical Preventive Services: US Preventive Services Task Force 1996 (Internet)

"Counselling to Prevent HIV Infection and Other Sexually Transmitted Diseases - Male Condoms" **Guide to Clinical Preventive Services: US Preventive Services Task Force** 1996 (Internet <http://www.ama-assn.org/special/HIV/treatmnt/guide/cps/couhiv/couhiv8.htm>)

Gunderson et al

Martin Gunderson, David J Mayo and Frank S Rhame **AIDS: Testing and Privacy (Volume 2 of Ethics in a Changing World)** Salt Lake City: University of Utah Press 1989

Gyldmark and Tolley in **The Economic Impact of AIDS in Europe**

Marlene Gyldmark and Keith Tolley "Towards a Standardized Framework for Costing HIV and AIDS Treatment and Care in Europe" in **The Economic Impact of AIDS in Europe** edited by FitzSimons, Hardy and Tolley London: Casell PLC 1995 30-37

Halkitis and Wilton 1999 **Focus** 1-4 (Internet)

PN Halkitis and L Wilton "Beyond Complacency: The Effects of Treatment of HIV Transmission" **Focus** April 1999 1-4
(Internet <http://www.aegis.com/pubs/aidslines/2000/aug/a0080206.html>)

Hamilton in **AIDS: A Guide to the Law**

Angus Hamilton "The Criminal Law and HIV Infection" in **AIDS: A Guide to the Law** Second edition edited by Richard Haigh and Dai Harris for the Terrence Higgins Trust London and New York: Routledge 1995 21-37

Harris 1993 **Arizona Law Review**

Kimberley Harris "Death at First Bite: A *Mens Rea* Approach in Determining Criminal Liability for Intentional HIV Transmission" 1993 **Arizona Law Review** Vol 35 237-264

Hassan (Unpublished)

Fatima Hassan "HIV Status in the Criminal Justice System - Case Review" (Unpublished presentation for the AIDS Legal Network 7-8 May 1998)

Henderson 1999 **JAMA** (Internet)

David K Henderson "Post Exposure Chemoprophylaxis for Occupational Exposures to the Human Immunodeficiency Virus" **The Journal of the American Medical Association** 10 March 1999
(Internet http://www.ama-assn.org/special/HIV/library/readroom/vol_281/jgn80003.htm)

Hermann 1990 **St Louis University Public Law Review**

Donald Hermann "Criminalizing Conduct related to HIV Transmission" 1990 **St Louis University Public Law Review** 351-378

Hess **The Body: POZ Gazette** (Internet)

Scott Hess "Spitt Tune - the FYI on TSP" **The Body: POZ Gazette**
(Internet http://www.thebody.com/poz/gazette/5_98/spit.html)

Heyns (Unpublished)

A du P Heyns "HIV and the Safety of the Blood Supply" (Unpublished article prepared for the Department of Health June 1999)

Highleyman 1999 **Bulletin of Experimental Treatments for AIDS** (Internet)

Liz Highleyman "Sexual Transmission in the Era of New Treatments" **Bulletin of Experimental Treatments for AIDS** (BETA) Summer 1999

(Internet <http://www.aegis.com/pubs/pubs/beta/1999/be990703.html>)

HIV/AIDS & STD Strategic Plan for South Africa 2000-2005

Department of Health **HIV/AIDS & STD Strategic Plan for South Africa 2000-2005** Pretoria: Government Printer 2000

HIV-Infogram 20 September 1996 (Internet)

"Viral Load Testing" **HIV-Infogram** Seattle-King County Department of Public Health

(Internet <http://www.metrokc.gov/health/apu/infograms/vltest.htm>)

HIV Insite "Accuracy of Tests" (Internet)

"Accuracy of Tests" **HIV Insite** Information provided by CDC NAC, 1997

(Internet <http://hivinsite.ucsf.edu/topics/testing/2098.e075.html>)

HIV Insite "My Partner's HIV Test was Inconclusive - What Does This Mean?" (Internet)

"My Partner's HIV Test was Inconclusive - What Does This Mean?" **HIV Insite** Question answered by Nicolas Sheon, HIV Insite Prevention Editor October 1998

(Internet <http://hivinsite.ucsf.edu/prevention/ask/2098.3e63.html>)

HIV Insite "Vaccines - The Overall Picture" (Internet)

"Vaccines - The Overall Picture" **HIV Insite** Key Topics

(Internet http://hivinsite.ucsf.edu/topics/vaccines/the_overall_picture/)

Hirschowitz et al

Ros Hirschowitz, Seble Worku and Mark Orkin **Rape in South Africa - Quantitative Research Findings on Rape in South Africa** Pretoria: Statistics South Africa 2000

Holland 1994 **Criminal Law Quarterly**

Winifred Holland "HIV/AIDS and the Criminal Law" 1994 **Criminal Law Quarterly** 279-316

Hoskins 1998 **Body Positive** (Internet)

Valerie Michelle Hoskins "Dangerous Liaisons: Rape and HIV" 1998 **Body Positive** Vol XI No 11 November 1998

(Internet <http://www.thebody.com/bp/nov98/rape.html>)

Human Rights Watch **World Report 1999** (Internet)

"Women's Human Rights" Human Rights Watch **World Report 1999**

(Internet <http://www.hrw.org/wr2k/Wrd.htm>)

IAS Satellite Symposium at the XIIIth International AIDS Conference 2000 (Internet)

"Our Commitment to the Next Generation: Vaccine Development" IAS Satellite Symposium at AIDS 2000 - XIIIth International AIDS Conference Durban, South Africa 7-11 July 2000

(Internet http://www.webcast.aids.com/dailysummaries/ias_symposium.cfm)

IAVI Information Sheet (Internet)

"End AIDS for All Times (Phases in Testing of Vaccines)" International AIDS Vaccine Initiative Information Sheet

(Internet http://www.iavi.org/science_z_phases.html)

Inter Press Service 3 March 1999 (Internet)

"Health: UN Sees Link between AIDS and Gender Violence" **Inter Press Service** 3 March 1999

(Internet <http://ww2aegis.com/news/ips/1999/ip990301.html>)

IRIN 17 January 2000 (Internet)

"AFRICA-AIDS: How Reliable are the Figures?" **Integrated Regional Information Network** 17 January 2000

(Internet <http://www.aegis.com/news/irin/2000/ir000101.htm>)

Jackson in **AIDS Agenda**

Mark H Jackson "The Criminalization of HIV" in **AIDS Agenda - Emerging Issues in Civil Rights** edited by Nan D Hunter and William B Rubenstein New York: The New Press 1992 239-270

JAMA HIV/AIDS Information Center July 1997 (Internet)

"Effectiveness of Condoms" (Information from the Centers for Disease Control and Prevention July 1997)

The Journal of the American Medical Association HIV/AIDS Information Center

(Internet <http://www.ama-assn.org/special/hiv/support/transmis/transf.htm>)

Jarvis et al

Robert M Jarvis, Michael L Closten, Donald HR Hermann and Arthur S Leonard **AIDS Law in a Nutshell** USA: West Publishing 1991

Jürgens

Ralf Jürgens **HIV Testing and Confidentiality - Final Report** Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society 1998

Katner 1996 Tulane Law Review

David R Katner "The Ethical Dilemma Awaiting Counsel who Represent Adolescents with HIV/AIDS: Criminal Law and Tort Suits Pressure Counsel to Breach the Confidentiality of the Clients' Medical Status" 1996 **Tulane Law Review** 2311-2344

Katz AIDS Readings on a Global Crisis

Sandor Katz "HIV Testing - A Phony Cure" in **AIDS Readings on a Global Crisis** edited by Susan Rabinowitz and Karen Hanson Boston: Allyn and Bacon 1995 275-281

Katz and Gerberding 1998 Annals of Internal Medicine

Mitchell H Katz and Julie L Gerberding "The Care of Persons with Recent Sexual Exposure to HIV" 1998 **Annals of Internal Medicine** Vol 28 306-312

King AIDS Treatment Update August 1996 (Internet)

Edward King "Update on Viral Load" **AIDS Treatment Update** Issue 44 August 1996
(Internet <http://library.jri.org/library/news/atu/atu044c.html>)

Kirby 1994 AIDS Care

Michael Kirby "Colloquium: AIDS, Health and Human Rights, Foundation Marcel Merieux, Institute des Sciences du Vivant, Annece, France 18-20 June 1993" 1994 **AIDS Care** Vol 6 No 2 247-252

Kleinman et al 1997 Transfusion Medicine Reviews

Steven Kleinman, Michael P Busch, James J Korelitz and George B Schreiber "The Incidence/Window Period Model and its Use to Assess the Risk of Transfusion-Transmitted Human Immunodeficiency Virus and Hepatitis C Virus Infection" 1997 **Transfusion Medicine Reviews** Vol 11 No 3, July 1997 155-171

Labuschagne 1993 De Jure

JMT Labuschagne "Oningeligte Geslagsomgang met 'n VIGS-lyer en die Vraagstuk van Toestemming by Verkragting" 1993 **De Jure** 417-421

Lachman

Sydney J Lachman **Heterosexual HIV/AIDS as a Global Problem** Fifth edition South Africa: TPS Drug Information Center Inc 1995

Lansdown and Campbell

Alfred V Lansdown and Jean Campbell **South African Criminal Law and Procedure Vol 5 Criminal Procedure** Cape Town: Juta 1982

Laurie 1991 **Journal of the Law Society of Scotland**

Graeme T Laurie "AIDS and Criminal Liability under Scots Law" **Journal of the Law Society of Scotland**
August 1991 312-317

LAWSA Vol 5 Part 2

WA Joubert et al **The Law of South Africa** Vol 5 Part 2 (Criminal Procedure) First Reissue Durban:
Butterworths 1994 (References in footnotes refer to pages)

LAWSA Vol 6

WA Joubert et al **The Law of South Africa** Vol 6 (Criminal Law) First Reissue Durban: Butterworths 1996
(References in footnotes refer to pages)

Law Commission Consultation Paper No 139 1995

The Law Commission "Criminal Law: Consent in the Criminal Law" **Consultation Paper No 139** London:
HMSO 1995

Law Commission Report No 218 1993

The Law Commission "Criminal Law: Legislating the Criminal Code: Offences against the Person and
General Principles" **Report No 218** London: HMSO 1993

Leary and Schreindorfer in **HIV & Social Interaction**

Mark R Leary and Lisa S Schreindorfer "The Stigmatization of HIV and AIDS: Rubbing Salt in the Wound"
in **HIV & Social Interaction** edited by Valerian J Derlega and Anita P Barbee California: SAGE
Publications: 1998 12- 29

Leclerc-Madlala 1996 **Acta Criminologica**

S Leclerc-Madlala "Crime in an Epidemic: The Case of Rape and AIDS" 1996 **Acta Criminologica** Vol
9 No 2 31-37

Leclerc-Madlala 1997 **Medical Anthropology**

Suzanne Leclerc-Madlala "Infect One, Infect All: Zulu Youth Response to the AIDS Epidemic in South
Africa 1997 **Medical Anthropology** Vol 17 363-380

LoveLife 2000

"The Impending Catastrophe: A Resource Book on the Emerging HIV/AIDS Epidemic in South Africa"
LoveLife 2000 Parklands: LoveLife and the Henry J Kaiser Family Foundation 2000

Lurie et al 1998 **JAMA** (Internet)

Peter Lurie, Suellen Miller, Frederick Hecht, Margaret Chesney and Bernard Lo "Post Exposure Prophylaxis after Nonoccupational HIV Exposure" 1998 **The Journal of the American Medical Association** 25 November 1998 1769-1773

(Internet <http://www.ama-assn.org/special/HIV/library/readroom/jama98/jsc7065.htm>)

Maartens 1999 **SAMJ**

G Maartens "Clinical Progression of HIV Infection in Adults" 1999 **South African Medical Journal** Vol 89 (12) 1255-1258

Mail and Guardian 21-27 May 1999

"Zuma Resists Rape/HIV Studies" **Mail and Guardian** 21-27 May 1999

Mann et al 1994 **Health and Human Rights**

Jonathan Mann, Lawrence Gostin, Sofia Gruskin, Troyen Brennan, Zita Lazzarini and Harvey Fineberg "Health and Human Rights" 1994 **Health and Human Rights** Vol 1 No 1 7-79

Marseille et al 1999 **The Lancet**

Elliot Marseille, James G Kahn, Francis Mmiro, Laura Guay, Philippa Musoke, Mary Glenn Fowler and J Brooks Jackson "Cost Effectiveness of Single-Dose Nevirapine Regimen for Mothers and Babies to Decrease Vertical HIV-1 Transmission in Sub-Saharan Africa" 1999 **The Lancet** Vol 354 803-809

Martin (Unpublished)

Dr Des Martin, Deputy Director National Institute of Virology "Post Exposure Prophylaxis: Is it an Option?" (Unpublished paper delivered at a Seminar on "HIV/AIDS and Violence Against Women" 12 August 1998 by Tshwaranang Legal Advocacy Centre to End Violence against Women; and The Aids Law Project: Centre of Applied Legal Studies, University of the Witwatersrand)

McCutchan and Birx (Unpublished)

Francine E McCutchan and DL Birx "The Global Spread of Subtypes and Intersubtype Recombinant HIV-1" (Unpublished paper delivered at the 12th World AIDS Conference, Geneva 28 June-3 July 1998)

Milton

JRL Milton **South African Criminal Law and Procedure Vol II Common-law Crimes** Third edition by JRL Milton Kenwyn: Juta 1996

Milton and Fuller

JRL Milton assisted by NM Fuller **South African Criminal Law and Procedure Vol III Statutory Offences** Second edition by JRL Milton and MG Cowling Cape Town: Juta 1988 (incorporating Revision Service 10 1998)

Mirken 1998 **Bulletin of Experimental Treatments for AIDS** (Internet)

Bruce Mirken "Post Exposure Prophylaxis: Still More Questions than Answers" **Bulletin of Experimental Treatments for AIDS** October 1998

(Internet <http://ww2.aegis.com/pubs/beta/1998/be981009.html>)

MRC News September 1999 (Internet)

"SAAVI - New Hope for Millions?" **Medical Research Council News** September 1999

(Internet <http://www.mrc.ac.za/mrcnews/september99/saavi.htm>)

NACOSA National AIDS Plan 1994-1995

The National AIDS Convention of South Africa - A National AIDS Plan for South Africa 1994-1995

Sunnyside: NACOSA National Secretariat July 1994

Namibia Report on the Law Pertaining to Rape

Namibia Law Reform and Development Commission **Report on the Law Pertaining to Rape** (LRDC 4)

Windhoek, Namibia: July 1997

NIAID Fact Sheet March 2000 (Internet)

"Developing New Tools to Protect Women from HIV/AIDS and Other STDs" **National Institute of Allergy and Infectious Diseases Fact Sheet** March 2000

(Internet <http://www.thebody.com/niaid/topmicro/htm>)

Natal Witness 27 May 1997

"'Shocking' Stats for Crime Convictions" **Natal Witness** 27 May 1998

Natal Witness 29 September 1998

"HIV-positive Man up for Attempted Murder" **Natal Witness** 29 September 1998

National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 2000

Department of Health **National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa** 2000, March 2001

Neethling et al

J Neethling, JM Potgieter and PJ Visser **Neethling's Law of Personality** Durban: Butterworths 1996

Ontario Report

Ontario Law Reform Commission **Report on Testing for AIDS** Toronto: Ontario Government Bookstore 1992

Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet)

DC Ormerod and MJ Gunn "Criminal Liability for the Transmission of HIV" 1996 **Web Journal of Current Legal Issues**

(Internet <http://www.ncl.ac.uk/~nlawwww/1996/issue1/ormerod1.html>)

PACSA Factsheet June 1998

"Rape in South Africa" Pietermaritzburg Agency for Christian Social Awareness (PACSA) **Factsheet** No 44 June 1998

Palmer 1999 **Infectious Disease News** 28

Heather Palmer "Japanese Study Confirms Efficacy of the Female Condom" 1999 **Infectious Disease News** Vol 12 No 1 28

Perumal et al 1999 **The Southern African Journal of Epidemiology and Infection**

BG Perumal, J Moodley, B Singh, A Smith and D York "An Assessment of Saliva and Urine as Alternate Body Fluids to Blood for the Diagnosis of HIV in Pregnancy" 1999 **The Southern African Journal of Epidemiology and Infection** Vol 14(3) 73-76

PEP: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS July 2000

"HIV Post Exposure Prophylaxis: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS" UK Health Departments July 2000

Pienaar 1996 **In Focus Forum**

Anneke Pienaar "Protecting and Serving the Abused Child - The Child Protection Unit (CPU) of the South African Police Service" **In Focus Forum** (published by the Human Science Research Council) November 1996 15-20

Pithey et al (Unpublished)

Bronwyn Pithey, Lillian Artz and Helene Combrinck **Legal Aspects of Rape in South Africa** (Unpublished discussion document prepared by the authors for Rape Crisis Cape Town; the Women and Human Rights Project: Community Law Centre University of the Western Cape; and the Institute of Criminology: University of Cape Town April 1999)

Pretoria News 26 August 1997

"AIDS: A Chilling New Factor" **Pretoria News** 26 August 1997

Pretoria News 29 May 1998

"Man to Be Tried after Son Gets AIDS" **Pretoria News** 29 May 1998

Pretoria News 22 April 1999

"AIDS Activists Lashed Mbeki's Stand" **Pretoria News** 22 April 1999

Pretoria News 23 April 1999

" 'Give Rape Victims Free AIDS Drugs' " **Pretoria News** 23 April 1999

Pretoria News 17 November 2000

"Gang-rape Victim (14) out of Hospital" **Pretoria News** 17 November 2000

PRNewswire 9 July 2000 (Internet)

"IAVI Issues Blueprint to Assure Global Access to AIDS Vaccines" **PRNewswire** 9 July 2000
(Internet <http://www.aegis.com/news/pr/2000/pr000715.html>)

Quin **The Hopkins HIV Report** 2 September 1996 (Internet)

Thomas Quin "HIV Viral Load" **The Hopkins HIV Report** 2 September 1996
(Internet <http://www.thebody.com/jh/hiv rept/sep96/viral.html>)

Rape Statistics Rape Crisis Cape Town (Internet)

"Statistics" **Rape Crisis** (About Rape Crisis Cape Town)
(Internet <http://www.rapecrisis.org.za/statistics.htm>)

Rapport 15 November 1998

"Vroue Vrees na Prikke met Naalde" **Rapport** 15 November 1998

Re-engineer the Criminal Justice System Pre-scoping Draft Report

"Re-engineer the Criminal Justice System Pre-scoping Draft Report" (Report prepared for discussion purposes by the National Crime Prevention Strategy, July 1996)

Rees (Unpublished)

Dr Helen Rees "Women, Violence and HIV/AIDS" (Unpublished paper delivered at a Seminar on HIV/AIDS and Violence Against Women, 12 August 1998 hosted by Tshwaranang Legal Advocacy Centre to End Violence against Women; and The Aids Law Project: Centre of Applied Legal Studies, University of the Witwatersrand)

Report on Genetic Diversity Conference New York June 1999 (Internet)

Report on Genetic Diversity Conference New York 30 June 1999 coverage by Jay Dobkin MD
(Internet <http://www.thebody.com/confs/gene99/report.html>)

Reuters NewMedia 4 October 2000 (Internet)

"S Africa Prepares Clinical Trials of AIDS Vaccine" **Reuters NewMedia** 4 October 2000
(Internet <http://www.aegis.com/news/re/2000/re001003.html>)

Robinson in **AIDS and the Law**

David Robinson Jr "Criminal Sanctions and Quarantine" in **AIDS and the Law** edited by Wiley Law Publications Second Edition New York Wiley Law Publications: 1992

Robling 1995 **Cleveland State Law Review**

Kenneth C Robling "Negligent HIV Testing and False-Positive Plaintiffs: Pardoning the Traditional Prerequisites for Emotional Distress Recovery" 1995 **Cleveland State Law Review** Vol 43 655-692

SALC Discussion Paper 68

South African Law Commission **Aspects of the Law relating to AIDS (Project 85) Discussion Paper 68 (Health Related Aspects)** Pretoria: August 1996

SALC Discussion Paper 72

South African Law Commission **Aspects of the Law relating to AIDS (Project 85) Discussion Paper 72 (Pre-employment HIV Testing)** Pretoria: July 1997

SALC Discussion Paper 73

South African Law Commission **Aspects of the Law relating to AIDS (Project 85) Discussion Paper 73 (HIV/AIDS and Discrimination in Schools)** Pretoria: August 1997

SALC Discussion Paper 80

South African Law Commission **Aspects of the Law relating to AIDS (Project 85) Discussion Paper 80 (The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour)** Pretoria: January 1999

SALC Discussion Paper 84

South African Law Commission **Aspects of the Law relating to AIDS (Project 85) Discussion Paper 84 (Compulsory HIV Testing of Persons Arrested in Sexual Offence Cases)** Pretoria: September 1999

SALC Discussion Paper 85

South African Law Commission **Sexual Offences: The Substantive Law (Project 107) Discussion Paper 85** Pretoria: August 1999

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

South African Law Commission **First Interim Report on Aspects of the Law relating to AIDS (Project 85)** Pretoria: Government Printer 1997

SALC Fourth Interim Report on Aspects of the Law relating to AIDS

South African Law Commission **Fourth Interim Report on Aspects of the Law relating to AIDS** (Project 85) Pretoria: Government Printer 2001

SALC Interim Report on the Simplification of Criminal Procedure

South African Law Commission Interim Report on the Simplification of Criminal Procedure (Project 73) Pretoria: Government Printer 1996

SALC Report on Sentencing

South African Law Commission **Report on Sentencing** (Project 82) Pretoria: Government Printer 2000

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

South African Law Commission **Second Interim Report on Aspects of the Law relating to AIDS** (Project 85) Pretoria: Government Printer 1998

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

South African Law Commission **Third Interim Report on Aspects of the Law relating to AIDS** (Project 85) Pretoria: Government Printer 1998

SALC Working Paper 58

South African Law Commission **Aspects of the Law relating to AIDS** (Project 85) **Working Paper 58** Pretoria: 1995

Salminen et al (Unpublished)

Mika Oliva Salminen et al "Full-length Sequences of HIV-1 Subtypes A-J: Inter-subtype Recombination Plays a Significant Role on Global HIV-1 Evolution" (Unpublished paper delivered at the 12th World AIDS Conference, Geneva 28 June-3 July 1998)

SAPS Monthly Bulletin on Reported Crime in South Africa May 2000 (Internet)

South African Police Service Monthly Bulletin on Reported Crime in South Africa May 2000 (Internet [http://www.saps.co.za/8-crimeinfo/bulletin/2000\(5\).htm](http://www.saps.co.za/8-crimeinfo/bulletin/2000(5).htm))

SAPS National Instruction 22/1998

South African Police Service National Instruction 22/1998 (November 1998) "Sexual Offences: Support to Victims and Crucial Aspects of the Investigation" (Issued by the National Commissioner in terms of section 25 of the South African Police Service Act 68 of 1995)

SAPS Semester Report 1/2000 (Internet)

South African Police Service "Semester Report 1/2000 - The Incidence of Serious Crime in South Africa Between January and December 1999"

(Internet <http://www.saps.co.za/8-crimeinfo/1200/Semester01-2000.htm>)

Sawyer **The Body: Lambda Legal Defence and Education Fund** (Internet)

Heather C Sawyer "When Will They Learn? Spit Does not Transmit" **The Body: Legal Defence and Education Fund**

(Internet <http://www.thebody.com.lambda/saliva.html>)

Schoub

Barry D Schoub **AIDS & HIV in Perspective** Second Edition Cambridge: Cambridge University Press 1999

Snyman

CR Snyman **Strafreg** Third Edition Durban: Butterworths 1992

Sorgdrager 1988 **De Rebus**

AM Sorgdrager "Vigs: 'n Juridiese Seekat" 1988 **De Rebus** 792-794

South African STD/HIV/AIDS Review: Comprehensive Report July 1997

Department of Health **South African STD/HIV/AIDS Review: Comprehensive Report** Pretoria: July 1997

Sowadsky "A Few Questions from a Student" **The Body** (Internet)

Rick Sowadsky "A Few Questions from a Student" **The Body: Answers to Safe Sex and Prevention Questions**

(Internet <http://www.thebody.com/sowadsky/answers/quest580/html>)

Sowadsky "Approximate Timeline of Testing and Symptoms for HIV/AIDS" **The Body** (Internet)

Rick Sowadsky "Approximate Timeline of Testing and Symptoms for HIV/AIDS" **The Body: Answers to Safe Sex and Prevention Questions**

(Internet <http://www.thebody.com/sowadsky/faqs/faq2.htm#timeline>)

Sowadsky "CDC Standards for Needlesticks? Etc" **The Body** (Internet)

Rick Sowadsky "(1) CDC Standards for Needlesticks? (2) Regarding Needlesticks, how Can you Get the Needle Apparatus Fluid Residue Tested for HIV, Hepatitis and Any other Suspected Ids?" **The Body: Answers to Safe Sex and Prevention Questions**

(Internet <http://www.thebody.com.sowadsky/answers/quest332.html>)

Sowadsky "David Imagawa, MD Studied Window Period for CDC. What Results Were Misinterpreted by Public Health Officials and Media?" **The Body** (Internet)

Rick Sowadsky "David Imagawa, MD Studied Window Period for CDC. What Results Were Misinterpreted by Public Health Officials and Media?" **The Body: Answers to Safe Sex and Prevention Questions** (Internet <http://www.thebody.com.sowadsky/answers/quest333.html>)

Sowadsky "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet)

Rick Sowadsky "HIV Antibody Tests - Now You Have Several Choices" (Internet <http://www.thebody.com.sowadsky/tests2.html>)

Sowadsky "HIV Transmission from Patient with Nondetectable Viral Load" **The Body** (Internet)

Rick Sowadsky "HIV Transmission from Patient with Nondetectable Viral Load" **The Body** (Internet <http://www.thebody.com/sowadsky/answers/quest541.html>)

Sowadsky "How Long Does HIV Survive Outside the Body?" **The Body** (Internet)

Rick Sowadsky "How Long Does HIV Survive Outside the Body" **The Body** (Internet <http://www.thebody.com/sowadsky/answers/quest439.html>)

Sowadsky "How Safe are Condoms?" **The Body** (Internet)

Rick Sowadsky "How Safe are Condoms?" **The Body** (Internet <http://www.thebody.com/sowadsky/answers/quest113.html>)

Sowadsky "Kissing and Infection with HIV" **The Body** (Internet)

Rick Sowadsky "Kissing and Infection with HIV" **The Body: Answers to Safe Sex and Prevention Questions** (Internet <http://www.thebody.com.sowadsky.answers/quest407/html>)

Sowadsky "Let's Clear Something up ..." **The Body** (Internet)

Rick Sowadsky "Let's Clear Something up ..." **The Body: Answers to Safe Sex and Prevention Questions** (Internet <http://www.thebody.com/sowadsky/answers/quest526.html>)

Sowadsky "Minimum Viral Load for Transmission" **The Body** (Internet)

Rick Sowadsky "Minimum Viral Load for Transmission" **The Body** (Internet http://www.thebody.com/cgi/safe_ans/2382_MI.html)

Sowadsky "Postexposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet)

Rick Sowadsky "Postexposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet <http://www.thebody.com/sowadsky/pep/html>)

Sowadsky "Rapid HIV Tests" **The Body** (Internet)

Rick Sowadsky "Rapid HIV Tests" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet [http:// www.thebody.com/cdc/rapidfaq.htm](http://www.thebody.com/cdc/rapidfaq.htm))

Sowadsky "Risk from Fighting?" **The Body** (Internet)

Rick Sowadsky "Risk from Fighting" **The Body: Answers to Safe Sex and Prevention Questions** (Internet
http://www.thebody.com/cgi/safe_ans/17185Ris.html)

Sowadsky "Risk of Transmission Statistics" **The Body** (Internet)

Rick Sowadsky "Risk of Transmission Statistics" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet [http://www.the body.com.sowadsky/answers/quest628.html](http://www.thebody.com.sowadsky/answers/quest628.html))

Sowadsky "Spreading HIV Intentionally" **The Body** (Internet)

Rick Sowadsky "Spreading HIV Intentionally" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet [http://www.the body.com.sowadsky/answers/quest223.html](http://www.thebody.com.sowadsky/answers/quest223.html))

Sowadsky "Taking Unnecessary Tests: A Waste of Valuable Resources" **The Body** (Internet)

Rick Sowadsky "Taking Unnecessary Tests: A Waste of Valuable Resources" **The Body**
(Internet <http://www.thebody.com/sowadsky/tests.html>)

Sowadsky "The New Saliva HIV Tests" **The Body** (Internet)

Rick Sowadsky "The New Saliva HIV Tests" **The Body**
(Internet <http://www.thebody.com/sowadsky/saliva.html>)

Sowadsky "Urine HIV Antibody Tests" **The Body** (Internet)

Rick Sowadsky "Urine HIV Antibody Tests" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet http://www.thebody.com/cgi/safe_ans/17878Uri.html)

Sowadsky "Viral Load and Infectiousness" **The Body** (Internet)

Rick Sowadsky "Viral Load and Infectiousness" **The Body**
(Internet <http://www.thebody.com/sowadsky/answers/quest582.html>)

Sowadsky "15 Minute Test" **The Body** (Internet)

Rick Sowadsky "15 Minute Test" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet <http://www.thebody.com/sowadsky/answers/qest427.htm>)

Sowetan 23 October 1997

"Victims Should Have Right to Know if Attacker has AIDS or is HIV-positive" **Sowetan** 23 October 1997

Sowetan 9 March 1999

"Violence against Women Linked to Spread of AIDS" **Sowetan** 9 March 1999

Spadea and Puro 1999 **Epidemiol Prev** 77-83 (Internet)

T Spadea and V Puro "The Probability of Transmission of the Human Immunodeficiency Virus"

Epidemiological Preview April-June 1999 77-83

(Internet <http://www.aegis.com/pubs/aidsline/1999/dec/a99c0224.html>)

Stine

Gerald Stine **AIDS Update 1997** London: Prentice-Hall International 1997

Strauss

SA Strauss **Doctor, Patient and The Law** Third edition Pretoria: Van Schaik 1991

Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 1999

Department of Health **Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa** 1999, March 2000

Sunday Independent 2 March 1997

"AIDS Victim Set out to Infect Women" **Sunday Independent** 2 March 1997

Sunday Times 23 February 1997

"AIDS Romeo Says he's Sorry" **Sunday Times** 23 February 1997

Sunday Times 14 February 1999

"When Victims Get the Death Sentence" **Sunday Times** 14 February 1999

Sunday Times 4 April 1999

"Child Rape: A Taboo within the AIDS Taboo" **Sunday Times** 4 April 1999

Sunday Tribune 9 March 1997

"Coterie of Women to Put AIDS Man in Jail" **Sunday Tribune** 9 March 1997

TAGline August/September 1996 (Internet)

"Viral Load Comes of Age: Propelled by Results from Multiple Studies, Viral Load Monitoring Lunges to the Forefront of HIV Medicine" **TAGline** Vol 3 Issue 6 August/September 1996

(Internet <http://www.thebody.com/tag/aug96b.html>)

The AIDS Knowledge Base (Internet)

"Tests to Detect HIV Antigen" **The AIDS Knowledge Base** 1999 Edition, HIV Insite Version
(Internet <http://hivinsite.ucsf.edu/akb/1997/02agtest/index.html>)

The Citizen 30 August 1997

"Deliberate AIDS Spreaders 'Criminals' " **The Citizen** 30 August 1997

The Citizen 19 February 1999

"Dr Injected Girlfriend with AIDS" **The Citizen** 19 February 1999

The Citizen 13 October 1999

"Government May Drop Notifying AIDS" **The Citizen** 13 October 1999

The Eastern Province Herald 23 October 1997

"Victims Cannot Be Told Rapists Have AIDS" **The Eastern Province Herald** 20 October 1997

The Herald 20 May 1997

" 'Spreading STD, HIV May Become Criminal Offence' " **The Herald** 20 May 1997

The Nedcor Project

The Nedcor Project on Crime, Violence and Investment (Executive Summary of the Main Report) Nedcor:
June 1996

The Star 2 October 1997

"AIDS Battle: It's Rights v Reason" **The Star** 2 October 1997

The Star 20 March 1998

"AIDS Sufferers who Infect Others Could Be Prosecuted in Future" **The Star** 20 March 1998

The Star 19 May 1998

" 'AIDS-Infected' Gang Targeting Schoolgirls" **The Star** 19 May 1998

Tierney 1992 **Hastings International and Comparative Law Review**

Thomas Tierney "Criminalizing the Sexual Transmission of HIV: An International Analysis" 1992 **Hastings International and Comparative Law Review** Vol 15 475-513

Toronto Hospital Immunodeficiency Clinic Newsletter September 1996 (Internet)

Viral Load Testing: A Valuable Tool - XI International Conference on AIDS" **Toronto Hospital Immunodeficiency Clinic Newsletter** September 1996
(Internet <http://www.tthhivclinic.com/loadtesting.htm>)

Torres 1998 **GMHC Treatment Issues** (Internet)

Gabriel Torres "PEPping up Your HIV Defences" **Gay Men's Health Crisis Treatment Issues** May 1998:

The Body

(Internet <http://www.thebody.com/gmhc/issues/may98/pep.html>)

UNAIDS AIDS Epidemic Update December 2000

Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organisation (WHO) **AIDS**

Epidemic Update December 2000 Geneva: UNAIDS

UNAIDS Briefing Paper - Children and HIV/AIDS February 1999

"Children and HIV/AIDS" Joint United Nations Programme on HIV/AIDS (UNAIDS) Briefing Paper February 1999

UNAIDS Fact Sheet - HIV/AIDS in Africa June 2000 (Internet)

"HIV/AIDS in Africa" Joint United Nations Programme on HIV/AIDS (UNAIDS) Fact Sheet June 2000

(Internet <http://www.unaids.org/fact-sheets/files/Africa-Eng.html>)

UNAIDS Press Release 13 July 2000 (Internet)

"African Scientists Launch Vaccine Strategy for the Continent" **UNAIDS Press Release** 13 July 2000

(Internet http://www.thebody.com/unaids/african_vaccine.html)

Ungvarski in **HIV/AIDS A Guide to Primary Care Management**

Peter J Ungvarski "Post Exposure Prophylaxis" in **HIV/AIDS A Guide to Primary Care Management** edited

by Peter J Ungvarski and Jacquelyn Haak Flaskerud Fourth edition Philadelphia: WB Saunders

Company 1999 519-524

Van Dyk

Alta C Van Dyk **AIDS Care and Counselling** First edition Cape Town: Maskew Miller Longman 1999

Van Wyk

Christa Wilhelmina Van Wyk **Aspekte van die Regsproblematiek rakende VIGS** (Thesis submitted in

accordance with the requirements for the degree of Doctor Legum) Pretoria: University of South Africa

1991

Van Wyk 2000 **Codicillus**

Christa Van Wyk "The Need for a New Statutory Offence Aimed at Harmful HIV-Related Behaviour: The

General Public Interest Perspective" 2000 **Codicillus** Vol 41 No 1, May 2000 2-10

Viljoen 1993 **SALJ**

Frans Viljoen "Verligting of Verlostiging: Regshervorming in 'n Tyd van VIGS" 1993 **South African Law Journal** 100-114

Viljoen 2000 **Codicillus**

Frans Viljoen "Stigmatising HIV/AIDS, Stigmatising Sex? A Reply to Professor Van Wyk" 2000 **Codicillus** Vol 41 No 1 May 2000 11-16

Visser and Vorster

PJ Visser and JP Vorster **General Principles of Criminal Law through the Cases** Second edition Durban: Butterworths 1987

Voelker 1997 **JAMA** 460

Rebecca Voelker "Effective Female Condom" **The Journal of the American Medical Association** 13 August 1997 460

Volberding **AIDS Care** February 1998 (Internet)

Paul A Volberding "Better Safe Than Sorry - Does Reducing Viral Load Reduce the Risk of Transmitting HIV?" Editorial in **AIDS Care** February 1998
(Internet <http://www.thebody.com/hivnews/aidscafe/feb98/editor/html>)

Volberding 1996 **The Lancet**

Paul A Volberding "HIV Quantification: Clinical Applications" **The Lancet** 13 January 1996 71-73

Volberding in **The Medical Management of AIDS**

Paul Volberding "Antiretroviral Therapy" in **The Medical Management of AIDS** edited by Merle A Sande and Paul A Volberding Fifth edition London: WB Saunders Company 1997 113-123

Weiss **HIV-Law Digest** 3 June 1998 (Internet)

Stanley J Weiss, Associate Professor, Preventative Medicine, New Jersey Medical School, USA
(Internet owner-HIV-law@web-depot.com)

Whiteside and Wood (Unpublished)

Alan Whiteside and Greg Wood "Socio-economic Impact of HIV/AIDS in Swaziland" (Unpublished study prepared for the Swaziland Government, Ministry of Economic Planning and Development April 1994)

WHO Fact Sheet June 2000 (Internet)

"Violence Against Women" **World Health Organisation Fact Sheet** No 239 June 2000
(Internet <http://www.who.int/inf-fs/en/fact239.html>)

WHO Weekly Epidemiological Record 16 September 1994

"WHO Case Definitions for AIDS Surveillance in Adults and Adolescents" **World Health Organization Weekly Epidemiological Record** 16 September 1994 273-275

WHO Weekly Epidemiological Record 21 March 1997

"Joint United Nations Programme on HIV/AIDS (UNAIDS) - Revised Recommendations for the Selection and Use of HIV Antibody Tests" **World Health Organization Weekly Epidemiological Record** 21 March 1997

Women and AIDS

"Women and AIDS" UNAIDS Point of View (UNAIDS Best Practice Collection) Geneva: UNAIDS October 1997

World African Network 28 October 1999 (Internet)

"South Africa's Rape Statistics Are Inaccurate, Says Mbeki" **World African Network** 28 October 1999 (Internet <http://www.wanonline.com/news/news8182.html>)

TABLE OF CASES

South Africa

Where cases referred to were reported in more than one set of law reports, references of such law reports are supplied in the table below.

Bernstein and others v Bester NO and others

1996 (4) BCLR 449 (CC)

1996 (2) SA 751 (CC)

C v Minister of Correctional Services

1996 (4) SA 292 (T)

Case and another v Minister of Safety and Security and others; Curtis v Minister of Safety and Security and others

1996 (5) BCLR 609 (CC)

1996 (3) SA 617 (CC)

1996 (1) SACR 587 (CC)

S v C

1996 (2) SACR 503 (T)

Director of Public Prosecutions: Cape of Good Hope v Bathgate

2000 (2) BCLR 151 (C)

1999 (2) SACR 272 (C)

2000 (2) SA 535 (C)

Du Plessis and others v De Klerk and another

1996 (3) SA 850 (CC)

1996 (5) BCLR 658 (CC)

Ferreira v Levin NO and others and Vryenhoek and others v Powell NO and others

1996 (1) BCLR 1 (CC)

1996 (1) SA 984 (CC)

Hoffmann v South African Airways

2000 (11) BCLR 1211 (CC)

2000 (2) SA 628 (W)

Holomisa v Argus Newspapers Ltd

1996 (6) BCLR 836 (W)

1996 (2) SA 588 (W)

1996 (1) All SA 478 (W)

Jansen van Vuuren and another NNO v Kruger

1993 (4) SA 842 (A)

Mandela v Falati

1994 (4) BCLR 1(W)

1995 (1) SA 251 (W)

Minister van Polisie v Ewels

1975 (3) SA 590 (A)

National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others

1999 (1) SA 6 (CC)

1998 (2) SACR 556 (CC)

1998 (1) BCLR 1517 (CC)

R v Blom

1939 AD 188

R v Robinson

1911 CPD 319

S v Bernardus

1965 (3) SA 287 (A)

S v Cloete

1995 (1) SACR 367 (W)

S v Coetzee and others

1997 (1) SACR 379 (CC)

1997 (3) SA 527 (CC)

1997 (4) BCLR 437

S v Johnson

1969 (1) SA 201 (A)

S v Kampher

1997 (4) SA 460 (C)

1997 (2) SACR 418 (C)

1997 (9) BCLR 1283 (C)

1997 (4) All SA 129 (C)

S v Makwanyane and another

1995 (3) SA 391 (CC)

1995 (2) SACR 1 (CC)

1995 (6) BCLR 665 (CC)

S v Manamela and another

2000 (5) BCLR 491 (CC)

S v Mbatha; S v Prinsloo

1996 (3) BCLR 293 (CC)

1996 (1) SACR 371 (CC)

S v Mnisi and another

1996 (1) SACR 496 (T)

1997 (1) All SA 248 (T)

S v Nel

1989 (4) SA 845 (A)

S v Ngubane

1985 (3) SA 677 (A)

S v Sibonyane

(Unreported Pretoria Regional Court case 14/2865/967)

S v Solomon

1973 (4) SA 644 (C)

S v Van As

1976 (2) SA 921 (A)

S v Van der Mescht

1962 (1) SA 521 (A)

S v Zuma and others

1995 (2) SA 642 (CC)

1995 (1) SACR 568 (CC)

1995 (4) BCLR 401

Venter v Nel

1997 (4) SA 1014 (D)

Canada

R v Cuerrier

(1998), 127 CCC (3d) 1

R v Williams

[2000] NJ No 138 (SC-TD)

Germany

BGH v O

4.11.1988 - StR 262/88

United Kingdom

Her Majesty's Advocate v Stephen Kelly

(Unreported trial reference no 1126/2000, High Court Glasgow)

R v Clarence

(1888), 22 QBD 23

United States

Doe v University of Maryland Medical System Corporation

50 F 3d 1261 (1995)

US v Joseph

33 MJ 960 (1991)

US v Womack

29 MJ 88 (1989)

US v Woods

28 MJ 318 (1989)

Zimbabwe

S v Collett

1978 (3) SA 206 (RA)

S v Mahachi

1993 (2) SACR 36 (Z)

SELECTED LEGISLATION

International instruments

International Partnership Against AIDS in Africa 1999

United Nations Convention on the Rights of the Child 1989

United Nations International Guidelines on HIV/AIDS and Human Rights 1996

South African legislation

Arms and Ammunitions Act 75 of 1969

Births and Deaths Registration Act 51 of 1992

Child Care Act 74 of 1983

Constitution of the Republic of South Africa Act 108 of 1996

Criminal Law Amendment Act 105 of 1997

Criminal Law Amendment Bill 1997

Criminal Procedure Act 51 of 1977

Criminal Procedure Second Amendment Act 85 of 1997

Domestic Violence Act 116 of 1998

Draft Amendment to the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1999

Government Notice R 485 Regulation Gazette 6496 in **Government Gazette** 19946 of 23 April 1999

Draft National Policy on Testing for HIV 1999

Government Notice R 1479 in **Government Gazette** 20710 of 10 December 1999

Draft Regulations for Hazardous Biological Agents 1999

Government Notice R 1248 in **Government Gazette** 20555 of 1 November 1999

Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1993

Government Notice 703 in **Government Gazette** 15011 of 30 July 1993

Drugs and Drug Trafficking Act 140 of 1992

Employment Equity Act 55 of 1998

Employment Equity Bill 1997

General Notice 1840 in **Government Gazette** 18481 of 1 December 1997

Firearms Control Bill 1999

Health Act 63 of 1977

Human Tissue Act 65 of 1983

Medical Schemes Act 131 of 1998

National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions 1999

General Notice 1926 in **Government Gazette** 20372 of 10 August 1999

Prevention of Family Violence Act 133 of 1993

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

Regulations on the Registration of Births and Deaths 1992

Government Notice 2139 in **Government Gazette** 14182 of 9 September 1992

Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987

Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987

Road Traffic Act 29 of 1989

Third Amendment of the Regulations on the Registration of Births and Deaths 1992
Government Notice R 879 in **Government Gazette** 19006 of 3 July 1998

Foreign legislation

Australia

Public and Environmental Health Act 1987 (South Australia)

Austria

Penal Act

Botswana

Penal Code (Amendment) Act 1998

Canada

Bill C-290 (A Bill to amend the Criminal Code [Exposure to Human Immuno-deficiency Virus] Second Session, Thirty-third Parliament, 35-36-37 Elizabeth II, 1986-87-88)

Bill C-354 (A Bill to amend the Criminal Code [Transmission of HIV] First Session, Thirty-fifth Parliament, 42-43-44 Elizabeth II, 1994-95)

Criminal Code 1985

Germany

Penal Code

Namibia

Combatting of Rape Act 8 of 2000

Combatting of Rape Bill 1999

United Kingdom

Offences Against the Person Act 1861

United States of America

Arkansas Code Ann §5-14-123(b) (1993)

Uniform Code of Military Justice (Chapter 47 of United States Code Title 10 [USC 10] Armed Forces)

United States Constitution

Florida Stat Ann §14-384.24 (1997)

HIV Prevention Bill (105th Congress 1997 HR 1062)

Idaho Code §39-608 (1993)

Illinois Ann Stat Ch 38 par 12-16.2

Indiana Code Ann §35-38-1-7 (b)(8), (b)(9), (g) (1994)

Louisiana Rev Stat Ann §14.43.5 (1996)

Maryland Health-Gen Code Ann §18-601.1 (1994))

Michigan Stat Ann §14.15 (5210) (1995)

Missouri Stat Ann §191.677 (1996)

Model Penal Code §210.1 and 2.02 (1985)

Montana Code Ann §50-18-112 (1995)

North Dakota Cent Code §12.1-20-17(3) (Supp 1989)

Ohio House Bill 100 (1999)

Oklahoma Stat Ann tit 21, §1192.1 (West Supp 1996)

Pennsylvania Senate Bill 847 (1999)

Ryan White Comprehensive AIDS Resources Emergency Act 1990 (Pub L No 101-381, §2647, 104 Stat 576 [1990])

South Dakota Senate Bill 48 (2000)

South Carolina Codified Laws Ann §44-29-145 (Law Co-op Supp 1995)

Tennessee Code Ann §39-13-109m (1994)

Zimbabwe

Criminal Law Amendment Bill 1996

Sexual Offences Bill 2000

1 Introduction

Brief overview of the Commission's work on HIV/AIDS

- 1.1 The Commission has been investigating law reform relating to AIDS and HIV since 1993.

Working Paper 58

- 1.2 An extensive discussion document, Working Paper 58,¹ was published for general information and comment in September 1995. Comments received on the Paper reflected differences of opinion among various interest groups. In the light of this, the Project Committee assisting the Commission in developing final recommendations decided to adopt an incremental approach in resolving these differences by publishing a number of different Discussion Papers and Interim Reports² on critical issues.

First, Second, Third and Fourth Interim Reports

- 1.3 The Commission has already adopted the Project Committee's First, Second, Third and Fourth Interim Reports on Aspects of the Law relating to AIDS. Each of these reports was preceded by the publication of discussion documents affording the public the opportunity to provide input in the development of final recommendations.³

1 **SALC Working Paper 58.**

2 "Interim" refers to the Commission's approach in dealing with the issues at hand incrementally. All the Interim Reports published contain final recommendations for law reform.

3 **SALC Discussion Papers 68** (preceding the First Interim Report), **72** (preceding the Second Interim Report), **73** (preceding the Third Interim Report), and **84** (preceding the Fourth Interim Report).

1.4 The **First Interim Report** (tabled in Parliament by the then Minister of Justice on 30 August 1997) dealt with the following:

- ! A limitation on the use of nondisposable 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.
- ! The amendment, finalisation and promulgation of the Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1993⁴ (which deschedule AIDS as a communicable disease in respect of which certain coercive measures apply mandatorily).

1.5 The National Assembly resolved on 18 September 1997 that the recommendations in the First Interim Report should be implemented urgently by the government. The Department of Health is in the final stages of implementing the recommendations relating to an international standard for condoms⁵ and a national policy for HIV testing.⁶ No action has been taken by the Department to realise the recommendation relating to the promulgation of the 1993 Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions.⁷ The Department of Labour is attending to

4 Government Notice 703 of 1993 in **Government Gazette** 15011 of 30 July 1993.

5 Information supplied by Ms Ann Strode, consultant to the Department of Health on 17 August 2000.

6 The Department published a draft policy, based on the Commission's recommendations, for public comment on 10 December 1999 (Government Notice R 1479 in **Government Gazette** 20710 of 10 December 1999). The published draft adopted the Commission's proposed policy in principle but placed more emphasis on the need for pre- and post test counselling. Comments have been processed and the policy was expected to be promulgated by the end of 2000 (information supplied by Ms Ann Strode, consultant to the Department of Health on 17 August 2000).

7 The Commission 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 Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987) and whether they may be used in respect of persons with HIV infection or AIDS, particularly as the 1987 Regulations have never been applied to HIV/AIDS and as the 1993 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). Note that the Commission's recommendations did not deal with the *notification* of HIV and/or AIDS. As regards notification, the Department of Health (without input by the Commission) in April 1999 proposed amendments to the 1987 Regulations in order to make AIDS a notifiable medical condition (Government Notice R 485 Regulation Gazette 6496 in **Government Gazette** 19946 of 23 April 1999). The government however since dropped its intention to make AIDS notifiable as a result of public

the implementation of the recommendations relating to the use of nondisposable syringes and the utilisation of universal precautions in the work place.⁸

- 1.6 Then prevailing legal practice regarding medical certificates in respect of HIV/AIDS-related deaths was also identified as a matter to be included in the First Interim Report. In Discussion Paper 68, which preceded the First Interim Report, the Commission identified a need for amending the Regulations on the Registration of Births and Deaths 1992⁹ published under the Births and Deaths Registration Act 51 of 1992 so as to protect privacy in relation to HIV/AIDS while at the same time establishing a reliable mechanism for the collation of essential epidemiological information. Comments on Discussion Paper 68 alerted the Commission to the fact that the Departments of Health and Home Affairs had already initiated the formulation of alternatives. This issue was debated at a workshop hosted by the Commission's HIV/AIDS Project Committee on 7 February 1997 where consensus was reached that the registration of death process should incorporate two separate events. Firstly, a public notification of death containing the deceased's full particulars but otherwise specifying only whether the death was from natural causes or not; and secondly, a further confidential itemisation fully specifying the direct and underlying cause/s of death which would be available for medical research, health care modelling and private contractual purposes. The Department of Home Affairs subsequently amended the Regulations in accordance with this consensus.¹⁰
- 1.7 The **Second Interim Report** dealt with the question whether statutory intervention to prohibit pre-employment testing for HIV was warranted. In this Report the Commission

pressure and lack of support for such a step. According to press reports a spokesperson for the Department recently indicated that the Department will not go forward with notification from fear that persons with AIDS may be rejected and violated if their HIV status becomes known - especially in those communities where the disease is still stigmatised and where it has previously lead to violence against persons with HIV/AIDS (**Beeld** 12 January 2001. See also **Beeld** 12 August 1999; **The Citizen** 13 October 1999).

- 8 In November 1999 the Department of Labour published Draft Regulations for Hazardous Biological Agents (Government Notice R 1248 in **Government Gazette** 20555 of 1 November 1999) for public comment. The Draft Regulations incorporate the Commission's recommendations. Representatives of the HIV/AIDS Project Committee were on two occasions requested by the Department to comment on its drafts before they were published for comment (meetings with Mr T Curtis, Director Occupational Health and Hygiene, Department of Labour and representatives of the Infection Control Association of South Africa on 16 November 1998 and 21 April 1999). Public comments on the Draft Regulations have been processed and it is expected that the Regulations will be promulgated in the first half of 2001 (information supplied by Mr Curtis on 16 February 2001).
- 9 Government Notice R 2139 in **Government Gazette** 14182 of 9 September 1992.
- 10 See the Third Amendment of the Regulations on the Registration of Births and Deaths 1992 Government Notice R 879 in **Government Gazette** 19006 of 3 July 1998.

enunciated the principles it accepted for legislative intervention; offered comment on the Employment Equity Bill 1997¹¹ which accommodated many of the Commission's recommendations in principle; and also proposed an alternative Bill dealing directly with pre-employment HIV testing, should the provisions of the Employment Equity Bill not be enacted. The Report was tabled in Parliament on 13 August 1998.

- 1.8 The principles of the Commission's recommendations against pre-employment HIV testing for HIV were embodied in the Employment Equity Act 55 of 1998.¹²
- 1.9 The **Third Interim Report** 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 Report was tabled in Parliament on 13 August 1998.
- 1.10 The Department of Education adopted the Commission's recommendations in promulgating a National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions in August 1999.¹³ The Commission's recommendations led to Universities also starting to address the position of students with HIV/AIDS in tertiary education institutions. A policy in this regard is currently being drafted.
- 1.11 The **Fourth Interim Report**, which contains proposals for legislative intervention, deals with compulsory HIV testing of persons arrested in sexual offence cases. The primary purpose of the proposed intervention is to provide a speedy and uncomplicated mechanism whereby the victim of an alleged sexual offence can apply to have an arrested person tested for HIV and to have information regarding the test result disclosed to the victim in order to provide him or her with peace of mind regarding whether or not he or she has been exposed to HIV during the attack.

11 General Notice 1840 in **Government Gazette** 18481 of 1 December 1997.

12 See sec 7 and 50 (cf also sec 6) of the Act.

13 General Notice 1926 in **Government Gazette** 20372 of 10 August 1999. The Department adopted the Commission's proposed policy almost exactly. The main difference between the two policies is that the promulgated policy will also be applicable to *educators* in public schools, and to *students and educators in further education and training institutions*. For reasons set out in the Third Interim Report the Commission's proposed policy was intended primarily for *learners* in public schools (see fn 210, par 6.25 and 6.70 of **SALC Third Interim Report on Aspects of the Law relating to AIDS**).

- 1.12 The Report was submitted to the Minister for Justice and Constitutional Development on 7 December 2000.

This Interim Report

- 1.13 This Interim Report (the **Fifth Interim Report**) deals with the need for a statutory offence aimed at harmful HIV-related behaviour.

Conclusion of the Commission's work on aspects of the law relating to AIDS

- 1.14 The current Report represents the conclusion of the Commission's work on aspects of the law relating to AIDS. As indicated in paragraph 1.2 above, the Commission's work on HIV/AIDS commenced with the publication for public comment of Discussion Paper 58 in 1995. Discussion Paper 58 dealt with a range of issues not all of which have been finally addressed by the Commission by way of Interim Reports. The Commission however considers all of the issues raised in Working Paper 58 to be resolved or to be receiving attention - either through its own work or through other developments. In particular, many of the issues raised were resolved by the Constitution of the Republic of South Africa Act 108 of 1996 (the 1996 Constitution) and the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 which have since come into operation. Thus, although there is still widespread discrimination against persons with AIDS in practice, an adequate legislative framework for dealing with unfair discrimination has been created. The Commission accepts however that further legislative interventions may become desirable or appropriate as circumstances dictate. For the sake of completeness and because the Commission still receives enquiries as to the outcome of some of the issues raised in Working Paper 58, brief information on the current state of affairs regarding the issues *not* addressed in the Commission's five interim reports is supplied below:

! ***The need for HIV specific antidiscrimination legislation***¹⁴

Working Paper 58 recommended the adoption of antidiscrimination legislation addressing a range of aspects concerning HIV/AIDS (***including HIV testing without consent; disclosure of HIV-related information; discriminatory practices in the work place, the school environment, prisons, and the health care setting; and a general prohibition against unfair discrimination on the ground of HIV infection***). The Commission considers that unfair discrimination on the ground of HIV/AIDS in general is now comprehensively addressed by the 1996 Constitution,¹⁵ the Employment Equity Act referred to in paragraph 1.8 above,¹⁶ and the Promotion of Equality and Prevention of Unfair Discrimination Act referred to at the beginning of this paragraph.¹⁷ The Medical Schemes Act 131 of 1998 moreover provides specific protection to persons with HIV/AIDS from exclusion from benefits.¹⁸ Since the publication of Working Paper 58 our courts have also enunciated clear principles on HIV-related discrimination.¹⁹

14 See Summary of Preliminary Recommendations in **SALC Working Paper 58** par 1.1-1.4.

15 See secs 9 (the right to equality), 10 (the right to human dignity), 11 (the right to life), 14 (the right to privacy), 24 (the right to an environment that is not harmful), 27 (the right to health care), 28 (children's rights), 29 (the right to education), 32 (the right to access to information), and 36 (limitation of rights).

16 See secs 5, 6 and 7. Sec 5 expressly prohibits unfair discrimination against an employee in any employment policy or practice on the ground of HIV status. Sec 7 prohibits testing an employee (including a job applicant) for HIV unless testing is determined justifiable by the Labour Court. See also par 1.8 above.

17 See secs 5, 6, 9, 24, 25, 28, 34 and the Schedule. Sec 9 contains an express prohibition of unfair discrimination on ground of disability (which may include HIV and AIDS), while sec 34(1) provides specific directive principles on HIV/AIDS.

18 Sec 30(1)(h) provides that a medical scheme may not exclude or offer differential benefits to a person on the basis of past or present state of health.

19 **C v Minister of Correctional Services** 1996 (4) SA 292 (T); **Venter v Nel** 1997 (4) SA 1014 (D); and **Hoffmann v South African Airways** 2000 (11) BCLR 1211 (CC). See also **Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A) which preceded this Report.

! ***HIV/AIDS and sex workers***

The Commission, under its current investigation into Sexual Offences (Project 107), is addressing possible law reform regarding prostitution. Health issues related to prostitution, including HIV/AIDS, are specifically addressed.

! ***Children and HIV/AIDS***

As indicated in paragraph 1.10 above, the Department of Education adopted the Commission's recommendations in its Third Interim Report by promulgating a "National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions" in August 1999. Under its investigation on the Review of the Child Care Act 1973 (Project 110) the Commission is currently also attending to the need for measures to protect children in especially difficult circumstances, including children infected and affected by HIV/AIDS. In the latter regard the HIV/AIDS Project Committee in January 1999 supplied input for a draft consultative paper on Children Living with HIV/AIDS (prepared for the Commission by outside researchers), and a representative of the Project Committee subsequently attended a focus group discussion on the issue hosted by the Commission.²⁰

! ***HIV/AIDS in prisons***

The Commission is of the view that policy issues relating to prisoners which may have been problematic seem to have been addressed in the Department of Correctional Services' latest Management Strategy on HIV/AIDS in Prisons which is based on the principle of nondiscrimination.²¹ The National Council on Correctional Services moreover identified issues concerning HIV/AIDS in prisons as one of the aspects which may need its attention.²² The Council was alerted to the Commission's 1995 preliminary recommendations contained in Working Paper 58.²³

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- 20 Project Committee member Prof Christa Van Wyk attended the discussion on Children Living with HIV/AIDS in Durban on 26 March 1999.
- 21 "Management Strategy on HIV/AIDS in Prisons" Second Draft, August 2000 (Department of Correctional Services).
- 22 Information supplied by Ms Julia Sloth-Nielsen, member of the National Council on Correctional Services, on 16 February 2000.
- 23 Letter from the Project Committee to the National Council on Correctional Services dated 16 February 2000.

! ***Insurance issues***

HIV-related discriminatory practices in the insurance industry would in general be covered by the 1996 Constitution and the Promotion of Equality and Prevention of Unfair Discrimination Act referred to above.²⁴ Since the publication of Working Paper 58 the insurance industry has also attempted to create alternative financial products for persons with HIV in the form of limited insurance and savings products.²⁵ The Commission is not aware of any direct law reform questions which arise at this stage.

! ***Measures to combat HIV transmission: Compulsory notification of HIV/AIDS***

The Department of Health in April 1999 addressed a possible need for the notification of AIDS to caregivers and health authorities.²⁶ Proposed legislative intervention in this regard was not proceeded with.²⁷

24 Cf specifically item 5 of the Schedule to the Equality and Prevention of Unfair Discrimination Act containing an illustrative list of unfair practices in insurance services including "(U)nfairly disadvantaging a person or persons, including unfairly and unreasonably refusing to grant services, to persons solely on the basis of HIV/AIDS status".

25 See Life Offices' Association Code of Conduct HIV Testing Protocol 24 June 1999 Chapter 8.18.

26 Government Notice R485 Regulation Gazette 6496 in **Government Gazette** 19946 of 23 April 1999. See fn 7 above for more information.

27 See fn 7 above for particulars.

2 Background

Source of enquiry; the Commission's approach; brief overview of research and consultation undertaken; and previous relevant work by the Commission

- 2.1 In the course of its debates on violence against women, the Parliamentary Justice Portfolio Committee requested the Commission to investigate the possible criminalisation of deliberate and negligent behaviour by persons with HIV who infect others; and the possible enactment of legislation for the compulsory HIV testing of sexual offenders. As background to this request, information is provided below on the mounting public concern regarding the high rate of rape and other sexual offences, the high prevalence of HIV infection in our country, and calls for suitable government response.
- 2.2 Detail is provided on the Portfolio Committee's request, the Commission's approach in dealing with this request and the research and consultation undertaken.
- 2.3 To place the recommendations in this Report in the context of the Commission's broad investigation into aspects of the law relating to AIDS, information regarding previous relevant work by the Commission is also given below.

Source of enquiry

Mounting public concern

- 2.4 The high incidence of rape and other sexual offences coupled with the growing prevalence of HIV in South Africa has led to increasing public calls for the criminalisation of harmful HIV-related behaviour; compulsory HIV testing of sexual offenders; supplying

victims with information regarding their assailants' HIV status; providing prophylaxis (medication to reduce the possibility of infection with HIV²⁸) after possible exposure to HIV during rape and sexual assault; clear policy on victims' rights including HIV counselling, testing and treatment; and state funding for such interventions.²⁹

2.5 The public concern has been fuelled by a number of prominent incidents during the past two years of rape and gang rape, reported in the national press, where the victim has either been infected with HIV or has had to face the possibility of this occurring.

2.5.1 A young woman, who was allegedly raped by five assailants on a farm near Balfour, Mpumalanga in September 1998, was informed a week after the gang rape that one of her attackers had HIV and she has since tested positive for HIV.³⁰ In March 1999 a young Pretoria University student was allegedly raped 15 times by more than nine street vendors who dragged her from outside a student club near the University to a nearby railway station where they repeatedly raped her. She reportedly underwent medical care at her own cost while it was unclear whether her assailants had HIV.³¹ In a third incident a Johannesburg journalist, Ms Charlene Smith, who was attacked and raped in her home in April 1999, spoke publicly about her ordeal emphasising the lack of available information on prophylaxis for rape victims and the exorbitant cost of obtaining prophylaxis from private sources.³² In November 2000 a 14-year-old schoolgirl was allegedly gang raped by five men in her Pretoria family home during a robbery. She received prophylaxis while it was unknown whether her assailants were infected with HIV.³³

2.6 Public concern has also been expressed about persons who in consensual sexual relationships deliberately or negligently place others at risk of HIV infection by not disclosing their HIV positive status and/or refusing or neglecting to use precautionary

28 See par 3.33 et seq for more information on post exposure prophylaxis (PEP).

29 See Chapter 2 of **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** for information regarding the public outcry for compulsory HIV testing of sexual offenders and the provision of prophylaxis to victims of sexual offences.

30 **Sunday Times** 14 February 1999.

31 **Beeld** 10 and 12 March 1999.

32 **Beeld** 23 and 24 April 1999; **Pretoria News** 23 April 1999.

33 **Beeld** 17 November 2000; **Pretoria News** 17 November 2000.

measures to prevent possible transmission of HIV.

2.6.1 In the civil case of **Venter v Nel**³⁴ 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.³⁵ 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 a statutory offence/s, stated that they recognised the situation as a burning issue which required deliberation by all stakeholders. They warned however against the possible implications of creating statutory offences where pregnant women with HIV could become the subject of prosecution for having passed the virus to their unborn children.³⁶

2.6.2 In the latest publicised case of allegedly deliberate HIV transmission by a person with HIV during consensual sex, a man was alleged to have had sex with two women, knowing that he had HIV and failing to inform them about it. The accused was charged with attempted murder in the Pietermaritzburg High Court during 1999. The case (which would have been the first criminal prosecution of its kind in South Africa) was however withdrawn at the request of the complainant.³⁷ 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.³⁸

2.7 Internationally, concern has more recently been expressed about growing evidence of

34 **Venter v Nel** 1997 (4) SA 1014 (D). For more information see par 7.38 below

35 **Sunday Tribune** 9 March 1997. (The claimant in **Venter v Nel** was not associated with efforts for the defendant to be criminally charged - see par 7.38 below.)

36 **Sunday Tribune** 9 March 1997.

37 Information supplied by Adv Gert Nel, Office of the Director of Public Prosecutions Pietermaritzburg at a consultative meeting hosted by the Project Committee on 3 February 2000. For more information see par 11.31 et seq below. See also **Natal Witness** 29 September 1998.

38 **Natal Witness** 29 September 1998.

a link between the spread of HIV and rising violence against women.³⁹ Violence against women may contribute directly and indirectly to the spread of HIV. If women are raped or sexually assaulted by HIV positive men, this may directly increase the incidence of HIV. On the other hand, if women are faced with domestic violence and other forms of abuse, this may indirectly contribute to their vulnerability to HIV in that such women would find it difficult to control the sexual and other aspects of their lives.⁴⁰ Mr Peter Piot, Executive Director of UNAIDS⁴¹ stated on 3 March 1999 that violence against women is contributing to the merciless spread of AIDS.⁴² He regarded this as "one of the most insidious aspects of the AIDS epidemic which is only now beginning to receive the international recognition it deserves" and pointed out that domestic violence, rape and other forms of sexual abuse were gross violations of human rights and were closely linked to the spread of HIV.⁴³ "Violence against women is not just a cause of the AIDS

- 39 **Inter Press Service** 3 March 1999 (Internet); **Sowetan** 9 March 1999; Human Rights Watch **World Report 1999** (Internet); **WHO Fact Sheet** June 2000 (Internet); **Beeld** 12 July 2000; **AIDS 2000 - XIIIth International AIDS Conference** 12 July 2000 (Internet). Nationally, alarming research underscored this concern: Anthropological research, undertaken in 1995, found that teenagers with HIV in KwaZulu-Natal displayed an attitude of wanting to spread HIV in what seemed to be a type of emotional coping strategy for dealing with the reality of a deadly and growing epidemic in their province. Whether or not such attitudes are translated into actual behaviour is still questionable, at this time. However, the results of the study suggest that behaviour such as sexual violence against women and children and the recent increases in these types of crimes may be linked to the ongoing AIDS epidemic in South Africa. More empirical studies are needed to test the relationship between violence and HIV (Leclerc-Madlala 1996 **Acta Criminologica** 36). (At the time of Leclerc-Madlala's research KwaZulu-Natal had more than two-thirds of the then estimated 1,8 million persons with HIV in South Africa.) 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 (**Beeld** 27 May 1998; **Star** 19 May 1998). A case study conducted in Khayelitsha, Cape Town (which looked at the experiences of pregnant and nonpregnant teenagers) revealed the high prevalence of coercive sex and violent practices among youth in their sexual relationships. Of the study population interviewed, 71% of pregnant and 60% of nonpregnant teenagers reported being forced to have sex against their will, while 75% of pregnant and 69% of nonpregnant teenagers reported that they would be beaten if they refused sex (for reference to this study see Rees [Unpublished] 2 and the sources quoted by the author).
- 40 That the status of women is a crucial issue in HIV/AIDS spread and prevention in Southern Africa, has been recognised as early as 1994 when it was indicated that women are particularly vulnerable to HIV infection for physiological reasons and because they are, amongst others, relatively powerless when negotiating sexual relationships (Whiteside and Wood [Unpublished] 31; **Women and AIDS** par12; Abdool Karim 1998 **Agenda - Empowering Women for Gender Equity** 24; see also more recently Albertyn [Unpublished] 33 [Internet]).
- 41 The Geneva-based Joint United Nations Programme on HIV/AIDS which coordinates the global fight against the disease.
- 42 **Inter Press Service** 3 March 1999 (Internet); **Sowetan** 9 March 1999.
- 43 Ibid.

epidemic, it can also be a consequence of it" Mr Piot said.⁴⁴ He specifically singled out South Africa "where roving gangs of young men, many infected with HIV, engaged in what was called 'catch and rape' ".⁴⁵

Incidence of rape and other sexual offences in South Africa

2.8 Rape and indecent assault are ways in which HIV is transmitted.⁴⁶ Statistics on rape are available from a number of different sources. The latest available official statistics⁴⁷ show that a total of 39 262 cases of rape (including attempted rape) were reported to the South African Police Service (SAPS) during 1999.⁴⁸ According to estimates this amounts to a ratio of 119 rapes per 100 000 of the population - more than double the murder rate of 51,25 per 100 000.⁴⁹ Because of under-reporting it is impossible to determine with any certainty what the real position is.⁵⁰

44 Ibid. See also Mr Piot's statement at the Fourth International Conference on Women (Beijing + 5) that gender inequality is a fundamental driving force of the AIDS epidemic (Albertyn Unpublished 33).

45 Ibid. See also Leclerc-Madlala 1996 *Acta Criminologica* 31 et seq; Leclerc-Madlala 1997 *Medical Anthropology* 363; **AIDS 2000 - XIIIth International AIDS Conference** 12 July 2000 (Internet).

46 See par 3.47 et seq for information on sexual transmission of HIV.

47 Information provided by the South African Police Service (SAPS) Crime Information Management Centre on 22 August 2000. SAPS confirmed that a moratorium has been placed on the release of crime statistics by the Minister of Safety and Security during July 2000. Because of this no statistics for the year 2000 and up to date have been released (information supplied by Inspector Annatjie Wolmarans, Crime Information Management Centre on 6 March 2001).

48 The total for adults was 23 142 and for persons under the age of 17 years 16 552 (information provided by SAPS Crime Information Management Centre on 22 August 2000). In its Semester Report 1/2000 the SAPS indicated that the crime trend as regards rape showed a stabilisation during 1999. According to the Report the majority of rape cases occur within the family and/or friendship circles. Internationally, victims find it extremely difficult to report these crimes to the police - precisely because they may involve spouses, parents, children, boyfriends or girlfriends. The South African government have since 1994 launched various initiatives aimed at increasing the reporting of rape, including user-friendly specialised units created or expanded to make it easier for women and children to report rape. The Semester Report suggests that these initiatives are delivering positive results (**SAPS Semester Report 1/2000** [Internet]).

49 **SAPS Monthly Bulletin on Reported Crime in South Africa** May 2000 (Internet).

50 According to press reports on average only one in every 36 rapes was reported (**World African Network** 28 October 1999 [Internet]; see also **PACSA Factsheet** June 1998 1 [**PACSA Factsheet** cites Human Rights Watch 1995 51 "Violence Against Women in SA" New York, for similar information]; see also Rees [Unpublished] 1). In response to this Rape Crisis Cape Town indicated that the organisation takes a more conservative view on the issue and estimates that 1 in 20 rapes are reported to the SAPS. They stated that according to statistics for the last three years around 50% of their client group have reported the matter to the police (Rape Statistics Rape Crisis Cape Town [Internet]; and information supplied by Ms Kathleen Dey, Counselling Coordinator, Rape Crisis Cape Town on 2 August 2000). This estimate is also supported by other studies (see Hirschowitz et al 1). Rape Crisis Cape Town however

- 2.9 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.⁵¹ As far back as 1995, it was found that the most common crime against children was rape.⁵² According to the latest available official statistics released by the Crime Information Management Centre of the SAPS, figures regarding sexual abuse of children are alarmingly high: 221 072 cases of rape, attempted rape, statutory rape, indecent assault and incest with persons under the age of 17 years were recorded for the period January to December 1999.⁵³ Other 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.⁵⁴

Prevalence of HIV/AIDS in South Africa

- 2.10 Although no reliable statistics on the incidence of AIDS itself, or of AIDS-related deaths, appear to be available in South Africa, the prevalence of HIV can be projected from annual studies conducted at antenatal clinics of the public health services. Statistics

emphasised that while rape is under-reported in metropolitan areas (where their estimate of 1 in 20 originated), studies have shown that there is even greater under-reporting in rural areas because of the lack of permanent police stations; that rape within relationships is very high and are mostly not reported; and that there is both a high incidence of sexual violence and a high level of under-reporting among young people starting their sexually active lives. Whatever the real position, it seems to be clear that South Africa has the highest per capita rate of *reported* rapes in the world (Rape Statistics Rape Crisis Cape Town [Internet]; information supplied by Ms Kathleen Dey, Counselling Coordinator, Rape Crisis Cape Town on 2 August 2000; see also the recently published study by Statistics South Africa which supports this [Hirschowitz et al 3]). Several sources confirm that it can be safely argued that there is substantial and significant discrepancy between the number of rapes that are reported to the police, the number of rapes that are revealed as a result of research and the actual number of rapes that occur in South Africa (see eg Pithey et al [Unpublished] 2-3; Hirschowitz et al 1-2, 34).

- 51 Pienaar 1996 **In Focus Forum** 17-18; Leclerc-Madlala 1996 **Acta Criminologica** 35-36; **Beeld** 27 June 1998 and 15 August 1998; **AIDS 2000 - XIIIth International AIDS Conference** 12 July 2000 (Internet). Government legal personnel from the KwaZulu/Natal towns of Camperdown and Stanger confirmed this phenomenon: Ashen Singh, magistrate at Camperdown stated that at least five child rape victim cases are being dealt with daily, while a Stanger Court prosecutor Ayesha Bissessar, said that they deal with between 50 and 80 cases of child rape a month. Both indicated that the alleged rapists in many instances refer to sex with a virgin in order to rid them of HIV infection as a reason for their crimes (**Sunday Times** 4 April 1999).
- 52 **The Nedcor Project** 3. See also **Beeld** 15 August 1998.
- 53 Information supplied by SAPS Crime Information Management Centre on 22 August 2000.
- 54 Boland et al in **HIV/AIDS A Guide to Primary Care Management** 68; Lachman 477; **UNAIDS Briefing Paper - Children and HIV/AIDS** February 1999 12-14.

indicate that South Africa has one of the fastest growing epidemics in the world.⁵⁵ The results for the antenatal sero-prevalence surveys for the past three years (1998, 1999 and 2000) however suggest that infection rates may have reached a plateau after the alarming progression of the epidemic during the preceding years.⁵⁶

- 2.11 Estimates based on the latest survey are that 24,5% of women attending antenatal clinics of the public health services nationally were infected with HIV by the end of 2000.⁵⁷ When this figure is extrapolated, it is estimated that roughly 11% of the total population (compared to 10% of the total in 1999⁵⁸) is infected.⁵⁹ It is further estimated that approximately 4,7 million people were infected with HIV at the end of 2000.⁶⁰ This comprises an estimated 2,5 million women and 2,2 million men in the 15-49 year age group, and 106,109 babies.⁶¹
- 2.12 Between 1999 and 2000, HIV prevalence increased significantly among women in their twenties only.⁶² Pregnant women in their late twenties show the highest infection rate at 30,6% whereas those aged 20-24 yielded a prevalence of 29,1%.⁶³ Over the years, women in their twenties have consistently shown the highest levels of HIV infection, making up on average, not less than half of the adult HIV positive population.⁶⁴ The latest survey also suggests an upward shift in HIV prevalence in relation to age: In 2000 the age group 45-49 was found to have a significantly higher HIV prevalence rate (13,1%)

55 **UNAIDS Fact Sheet - HIV/AIDS in Africa** June 2000 (Internet). This has also been observed by various experts at AIDS 2000 - XIIIth International AIDS Conference (see eg Cameron [Unpublished]).

56 **National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa** 2000 8, 15. Address by the Minister of Health in Parliament 18 April 2000 on the release of data regarding the 1999 National Antenatal HIV Survey; official comment by Metropolitan Life on the 1999 Antenatal HIV Survey (made available to the researcher by Metropolitan AIDS Research on 31 July 2000); cf also Dorrington 2000 **SAMJ** 452-453.

57 **National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa** 2000 8.

58 **Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa** 1999.

59 **National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa** 2000 12.

60 Ibid.

61 Ibid.

62 Ibid 10.

63 Ibid.

64 Ibid.

than the same group in the previous two years (10,2% in 1998 and 7,5% in 1999).⁶⁵ The Department of Health further noted that HIV prevalence amongst teenagers has not increased for the third consecutive year (21% in 1998, 16,5% in 1999 and 16,1% in 2000).⁶⁶

- 2.13 Statistics are not available on the risk of HIV transmission during rape and other sexual offences. It is therefore difficult to determine whether HIV-related criminal behaviour is increasing the prevalence of HIV although this is most likely.⁶⁷ Statistics however show that sexual transmission accounts for 80% of HIV transmissions in South Africa.⁶⁸

Calls for government response

- 2.14 Following public concern expressed in the national media, political parties have called on the legislature to respond to the growing AIDS epidemic. 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.

2.14.1 Political parties in August 1997 submitted that deliberate transmission of HIV should be subjected to criminal sanction.⁶⁹ 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

65 Ibid 11.

66 Ibid.

67 See also par 3.47.1 where the risk of HIV transmission during sexual exposure (including rape) is discussed. Transmission of HIV through sexual assault has been less studied, partly because rape and AIDS are not as widespread in Europe and the United States, where most research is carried out (**AFAIDS** 30 April 1999 [Internet]). South African research however lately noted that the AIDS epidemic is creating conditions of fear, hopelessness and resignation which may be driving a desire to spread the virus. In the light of this it was suggested that the growing South African rape crisis demands closer inspection (Leclerc-Madlala 1996 **Acta Criminologica** 34-35).

68 See comment by Tshwaranang Legal Advocacy Centre to End Violence Against Women on **SALC Discussion Paper 80** 3.

69 **Pretoria News** 26 August 1997; **The Citizen** 30 August 1997.

country did not deal with the pandemic decisively.⁷⁰ Legal experts at the time 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".⁷¹

2.14.2 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 proposals for a prohibition on pre-employment HIV testing,⁷² the Inkatha spokesperson said that the government is not taking sufficient steps to protect those members of society without HIV.⁷³

Request by Parliamentary Justice Portfolio Committee, January 1998

2.15 During parliamentary debate on the Criminal Law Amendment Bill (B46-97)⁷⁴ in October 1997, Justice Portfolio Committee (National Assembly) members raised public concerns about actions other than rape by persons with HIV/AIDS which endanger the public.⁷⁵ Adv Johnny De Lange (Chairperson of the Portfolio Committee) later advised the then Minister of Justice in a letter dated 20 December 1997 that the African National Congress proposed that the Department of Justice should consider the research, initiation or

70 **The Citizen** 30 August 1997.

71 **Pretoria News** 26 August 1997.

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

73 **Beeld** 14 May 1998; **The Star** 2 October 1997. See also par 10.33 below for the Inkatha Freedom Party's suggestions for legislation.

74 Enacted as the Criminal Law Amendment Act 105 of 1997. See fn 360 in Chapter 4 below for more detail.

75 **Daily Dispatch** 23 October 1997; **The Eastern Province Herald** 23 October 1997; **Sowetan** 23 October 1997; **Business Day** 23 October 1997.

drafting of -

(L)egislation 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).

- 2.16 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 Criminal Law Amendment Bill:

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 immunodeficiency 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 immunodeficiency syndrome or the human immunodeficiency 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 immunodeficiency 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 immunodeficiency virus,

be investigated with a view to the submission to Parliament of legislation, if any, at the earliest opportunity ...

- 2.17 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 to this matter. The Justice Portfolio Committee was informed accordingly.⁷⁶ Since then

76 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 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]). In a letter dated 30 March 1998 Adv De Lange was accordingly informed but it was indicated 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

the Portfolio Committee has been kept up to date on a regular basis of the progress made with the investigation.

The Commission's approach in dealing with the Parliamentary Portfolio Committee's request and a brief overview of research and consultation undertaken

- 2.18 The Project Committee, in determining the most appropriate way of dealing with the above request, decided to deal simultaneously but separately with the two issues in question primarily to ensure that both issues are thoroughly dealt with and that the public is provided with an opportunity of commenting independently on two complex issues.⁷⁷
- 2.19 Two Interim Reports (which were preceded by two Discussion Papers published for public comment)⁷⁸ containing the Commission's recommendations were thus prepared: The current Report (the Fifth Interim Report) dealing with the issue of harmful behaviour by persons with HIV/AIDS, the administrative and criminal law measures available to address such behaviour and the need - if any - for statutory intervention; and the Fourth Interim Report dealing with compulsory HIV testing of persons arrested in sexual offence cases and the right of alleged victims of such offences to be informed of the test results. The Fourth Interim Report is published under separate cover. Chapter 2 of that Report contains a brief overview of the research and consultation undertaken on the HIV testing issue.⁷⁹
- 2.20 Discussion Paper 80, which preceded the current Report (the Fifth Interim Report), was

in April 1998.

77 See also par 4.12 et seq below on the parameters of this investigation.

78 See SALC **Discussion Papers 80** (The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour) and **84** (Compulsory HIV Testing of Persons Arrested in Sexual Offence Cases).

79 See par 1.11 above for more detail on the Fourth Interim Report.

published by the Commission for public comment at the beginning of January 1999. The return date for comment was 28 February which was extended to 31 March 1999.

- 2.21 Comments on the Discussion Paper did not supply the Project Committee with clear-cut solutions. The Committee considered the comments on 22 September 1999 and subsequently. The majority of respondents were of the opinion that the criminal law does have a role to play in the AIDS epidemic in protecting members of society from harmful behaviour by persons with HIV/AIDS. However, which route to follow in realising this (i.e. dealing with it through the existing common law crimes, or through legislative intervention by creating an HIV-specific statutory offence/s) was a point of difference. This difference of opinion also manifested itself within the Committee. On 18 October 1999 the Committee considered undertaking additional research in an effort to resolve the difference. This proved to be impractical. In acknowledging the divergence of the comments and of the views within the Committee, it was decided to discuss the dilemmas facing the Committee with experts from different interest groups. A consultative meeting with a range of experts was held on 3 February 2000.⁸⁰ The Project Committee considered the outcome of the consultative meeting on 6 April 2000. It was then resolved that the prevailing range of opinion within the Committee would be accommodated within the current Report.

80 A list of persons who attended the consultative meeting is attached as ANNEXURE B. Detailed information on the meeting and its outcome is provided in Chapter 11 below.

Previous work by the Commission with regard to coercive measures against HIV/AIDS

- 2.22 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.⁸¹
- 2.23 The Commission stated that isolation and quarantining⁸² are existing **administrative law measures** that can 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 1977.⁸³ The Commission 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 state should in any event not interfere in voluntary sexual acts between consenting adults; that isolation could discourage voluntary testing; that it may create the potential for arbitrary and discriminatory separation; and that it may drastically infringe certain fundamental rights.⁸⁴ The Commission however acknowledged that some countries allow for isolation and quarantining based on *behaviour*,⁸⁵ 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.⁸⁶
- 2.24 Commentators responding to Working Paper 58 between October 1995 and February

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

82 See fn 341 in Chapter 4 below for definitions of isolation and quarantining. See also the discussion in **SALC Working Paper 58** par 4.3-4.10.

83 See regs 2, 4, 14 and 17 of Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987. The specific measures are discussed in more detail in par 5.8 et seq below.

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

85 Eg several states in the United States of America 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).

86 **SALC Working Paper 58** par 4.9. Isolation and quarantining 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 par 7.2 et seq below on the objects of the criminal law).

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.⁸⁷

2.25 As regards ***criminal law measures***, the Commission indicated that the state would be able to institute criminal prosecutions under existing (common law) crimes against persons who have HIV and who deliberately or negligently transmit 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 offences mentioned in this regard.⁸⁸ It was noted at the time that, as far as could be ascertained, no criminal prosecution for transmitting HIV has been instituted successfully in South Africa.⁸⁹ The Commission however emphasised that the application of these crimes 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,⁹⁰ to prove intent, be it in the form of *dolus eventualis*, *dolus directus* or *dolus indirectus*.⁹¹ 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.⁹² It referred to the fact that several states in the United States of America introduced legislation along these lines, but emphasised that there seemed to

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

88 **SALC Working Paper 58** par 4.41.

89 Ibid par 4.40. See par 2.6.2 above and par 11.31-11.33 below.

90 **SALC Working Paper 58** par 4.40.

91 Ibid par 4.42.

92 Ibid.

be no consensus on its effectiveness.⁹³

- 2.26 Arguments listed in favour of creating a new 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 new offence being narrowly drafted to address only specific conduct and to have maximum deterrent value. On the other hand, it was pointed out that there may be substantive disadvantages in creating a new 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 new statutory offence would give rise to privacy infringements; the same problems of proof existing in respect of existing common law offences would also apply to a new statutory offence; and there was concern that a new offence would be selectively applied to groups in respect of which perceptions exist that they spread HIV.
- 2.27 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,⁹⁴ 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 new statutory offence aimed specifically at HIV-related behaviour. The main reason given for this conclusion was expressed as follows:

93 Ibid.

94 Ibid par 4.43-4.44.

(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.⁹⁵

2.28 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.⁹⁶

95 Ibid par 4.45.

96 *Comments 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 Southern Africa observed that South African law is sufficiently extensive not to require specified HIV-related offences to be created. The National AIDS Coalition of South Africa (NACOSA) 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.

Comments favouring further coercive criminal or other measures:

The Ministry of Caring of the 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. He believed that the mere fact that such power exists may succeed in acting as a deterrent.

Other relevant comments:

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 AIDS Legal Network (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.

3 Medico-legal information

What is HIV/AIDS?⁹⁷

- 3.1 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. The condition is *acquired* and it is generally accepted that it is caused by the human immunodeficiency virus (HIV) which invades the body from outside.⁹⁸ The genetic material of HIV becomes a permanent part of the DNA⁹⁹ (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. 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 to 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

97 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 relatively simple and synoptic medical information on the disease is presented. Sources consulted in general include the following: Van Dyk 9-47, 77-92; Evian 1-54; Lachman 131-132, 156-157, 173-175, 181-183, 187-188, 190-191, 194-199, 313; Schoub 20-202; Stine 9-40, 59-103, 129-151, 154-203, 214-227, 238-251, 292-295, 310-347; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 1-25; and **AMFAR AIDS/HIV Treatment Directory** June 1996 94-137.

98 At present there are two major strains of HIV which causes AIDS, namely HIV-1 and HIV-2. HIV-1 is associated with infections in Central, East and Southern Africa, North and South America, Europe and the rest of the world. HIV-2 was discovered in West Africa. Both strains have the same modes of transmission, the development of antibodies is similar, and both are associated with similar opportunistic infections. However, in persons with HIV-2 immunodeficiency seems to develop more slowly and to be milder. Among all people with HIV, the prevalence of HIV-2 is very low compared with HIV-1 (Van Dyk¹⁰; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 15; **CDC Update** October 1998 [Internet]).

99 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 [Internet]).

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

- 3.2 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.¹⁰⁰ 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.¹⁰¹ 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.¹⁰²

Course of AIDS¹⁰³

- 3.3 The course of HIV infection is generally divided into four different stages: the ***initial phase*** (preceding seroconversion); the ***asymptomatic phase***; the ***symptomatic phase*** (during which less serious opportunistic diseases occur); and the ***severe symptomatic phase***, during which the patient has full-blown or clinical AIDS.¹⁰⁴

100 Evian 29; Van Dyk 18; Schoub 34; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 13-14.

101 See also par 3.5 below.

102 Van Dyk 19; Evian 31; Schoub 35; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 14-15.

103 See in general the sources referred to in fn 97 above.

104 Evian 28-34; Schoub 31-35; Maartens 1999 **SAMJ** 1255-125; cf also the World Health Organisation (WHO) staging system for HIV infection and the Centers for Disease Control (CDC), United States and WHO case definition of AIDS surveillance (**WHO Weekly Epidemiological Record** 16 September 1994 273-275; **CDC Morbidity and Mortality Weekly Reports** 18 December 1992 [Internet]).

- 3.4 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 infection - in exceptional cases much earlier¹⁰⁵ or even much later. This period between infection and seroconversion is known as the "**window period**".¹⁰⁶ Blood tests 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.¹⁰⁷ The fact that antibodies are formed only after a lapse of time means 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 antibodies to the virus.¹⁰⁸
- 3.5 During the **asymptomatic phase (latent or "silent" infection)** 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

- 105 Current antibody tests can detect antibodies to HIV which sometimes appear as soon as three weeks after infection (see par 3.18.2).
- 106 A distinction should be made between the "infectious window period" and the "conventional window period". The former can be defined as the interval between the time a person becomes infectious and the time that a particular laboratory test becomes positive. The latter can be defined as the interval between the time a person acquired the infection and the development of a positive laboratory test. The infectious window period will differ from the conventional window period if there is a lag between the acquisition time of infection and the person's ability to transmit the infection to others. Theoretically such a lag would exist if, on initial exposure to HIV the person were able to sequester the virus in the organs of the immune system before becoming viremic. Experimental animal evidence suggests that the difference between the conventional and infectious windows may range from 2 to 14 days (Kleinman et al 1997 **Transfusion Medicine Reviews** 158).
- 107 More recently tests which detect HIV itself in the blood have become available. These tests are known as viral load tests. They are however not normally used to diagnose HIV. For more detail on HIV testing see par 3.16 et seq below
- 108 When standard HIV antibody tests are used, the window period may be as short as 22 days in some instances. However, the usual length of the window period is 12 weeks (meaning that most, but not all people, will show positive on the test by this time), while the maximum length of the window period has been shown to be six months (meaning that more than 99% of infected persons will test positive for HIV by this time) (Sowadsky "David Imagawa, MD Studied Window Period for CDC. What Results Were Misinterpreted By Public Health Officials and Media?" **The Body** [Internet]).

phase infected persons are often not aware that they have HIV; they can therefore unknowingly transmit the virus to others.

- 3.6 The ***symptomatic phase (HIV-related disease)*** 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.
- 3.7 Only during the ***severe symptomatic phase (clinical AIDS)*** 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. Without recourse to appropriate medication¹⁰⁹ he or she usually dies within two years as a result of these diseases.
- 3.7.1 Diseases that generally occur are pneumonia, tuberculosis and Kaposi's sarcoma (a rare type of skin cancer). Not infrequently the nervous system is affected and there may be a meningitis (inflammation of the covering of the brain) or an encephalitis (inflammation of brain tissue itself) with a spectrum of neurological and psychiatric disorders (previously known as AIDS dementia). This can occur in the final phase (and in rare cases may occur also earlier).¹¹⁰ Symptomatic presentation differs from continent to continent. The most important opportunistic diseases in Africa are tuberculosis and chronic diarrhoea; whilst a form of pneumonia (caused by pneumocystis carinii [PCP]) is responsible for the majority of deaths among persons with AIDS in Europe and North America.¹¹¹ Many of the disease conditions from which people with AIDS

109 See par 3.21 et seq for recent developments with regard to treatment for AIDS.

110 **AMFAR AIDS/HIV Treatment Directory** June 1996 135-138; Schoub 33; Stine 148-149.

111 Stine 102-103; cf also Van Dyk 20-26.

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).

- 3.8 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 severe symptomatic phase (clinical AIDS) 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.¹¹² In South Africa, severe poverty and malnutrition could possibly be included as reasons why most patients with HIV have a shortened life expectancy.¹¹³
- 3.9 Not all persons with HIV go through all four phases. Some do not even show symptoms before they develop clinical AIDS. 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.¹¹⁴

Transmission of HIV¹¹⁵

- 3.10 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.

112 Stine 103.

113 Comment on **SALC Discussion Paper 72** by the City of Cape Town Health Department (1997); see also Stine 103.

114 Evian 125-28; Schoub 41-43; Van Dyk 18.

115 See in general the sources referred to in fn 97 above.

However, HIV is not easily transmitted (in contrast with many other serious diseases such as certain sexually transmissible diseases and certain other viral infections¹¹⁶).

- 3.11 HIV has been identified in varying concentrations in blood, semen, vaginal and cervical discharge, breast milk, the brain, bone-marrow, cerebrospinal fluid, urine, tears, foetal material and saliva. Current scientific knowledge indicates that only blood, semen, vaginal and cervical discharge and breast milk contain a sufficient concentration of the virus to be able to transmit HIV.¹¹⁷
- 3.12 At present no scientific evidence exists that HIV can be transmitted in any other mode than the following:¹¹⁸
- ! By hetero- or homosexual intercourse.
 - ! By receipt of or exposure to the blood, blood products,¹¹⁹ 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 drugs¹²⁰ or by injecting infected blood into a victim.¹²¹
 - ! 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).
- 3.13 To infect a person, HIV must reach the blood stream or lymphatic system.¹²² HIV does not survive well outside the specific environment of the human body, making

116 Eg hepatitis B (Van Dyk 43-44).

117 Schoub 91 et seq; Van Dyk 37 et seq; Evian 13 et seq.

118 See also par 3.47-3.55 below where the risk of HIV transmission in the criminal context is discussed.

119 In comment on **SALC Discussion Paper 73** (1997), 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. See also Van Dyk who emphasised that blood is currently far safer than it was in the past (at 38).

120 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 39; Schoub 112).

121 Cf reports in the media of a case in the United States where a father injected his young son with HIV infected blood from the medical laboratory where he was employed. The child was subsequently found to be infected with HIV (**Pretoria News** 29 May 1998). See also par 3.55 below.

122 This could also include transmission via mucous membranes in the mouth, nose and eyes (cf par 3.50 and 3.52 below).

environmental transmission remote.¹²³ Once outside the human body the virus rapidly weakens and dies. The longer it is outside the body the less the chance is for transmission to occur.¹²⁴ There are many variables that determine how long the virus will live outside the body, including whether the conditions surrounding the virus are wet or dry. The virus cannot survive in a dry environment (eg in dried blood or dried semen).¹²⁵ How long it will survive in wet conditions (eg in body fluid spills) is uncertain and depends on the specific conditions.¹²⁶ Generally speaking, under most circumstances, the virus can survive only for a few minutes outside the body.¹²⁷ Blood spills (which would carry a large concentration of virus) should however always be handled with extreme care.¹²⁸ The virus is destroyed by disinfectant.¹²⁹

- 3.14 The virus cannot be spread by other forms of personal contact than those described above. 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.¹³⁰ Casual contact through closed-mouth or "social" kissing is not a risk for transmission. Open-mouth kissing may however carry some risk because of the potential for contact with blood during such kissing.¹³¹ HIV can also not be transmitted

- 123 **CDC Frequently Asked Questions** May 2000 (Internet); Sowadsky "Let's Clear Something Up ..." **The Body** (Internet); Evian 18.
- 124 Ibid.
- 125 Ibid. In order to obtain data on the survival of HIV, laboratory studies have required the use of artificially high unnatural concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the number of infectious viruses by 90-99% within several hours. The CDC cautioned that these results should not be used to assess specific personal risk of infection because the high concentrations of virus used in laboratory studies are not found in human specimens or elsewhere in nature; and because no one has been identified as infected with HIV through contact with an environmental surface. The CDC concluded that extrapolated to personal circumstances, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to essentially zero (**CDC Frequently Asked Questions** May 2000; see also Sowadsky "How Long Does HIV Survive Outside the Body?" **The Body** [Internet]).
- 126 Sowadsky "Lets Clear Something Up ..." **The Body** (Internet).
- 127 Ibid.
- 128 Van Dyk 40.
- 129 Ibid 69.
- 130 **CDC Frequently Asked Questions** May 2000; Van Dyk 42-43; Schoub 101, 120-125.
- 131 A case was reported in the United States of HIV transmission as a possible result of open-mouth kissing. Both the man and the woman involved however had mouth lesions and blood stained saliva (**CDC Morbidity and Mortality Weekly Reports** 11 July 1997 620 et seq; **CDC Frequently Asked Questions** May 2000 [Internet]; Schoub 101). The CDC regards the risk of HIV transmission through open-mouth kissing as low (**CDC Frequently Asked Questions** May 2000 [Internet]).

through food preparation, by toilet seats, or by sharing food, water or utensils. Even if blood contact did take place in these circumstances the chances of being infected are small.¹³² (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 three to four in 1 000.¹³³ 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 one in 42 000.¹³⁴)

- 3.15 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.¹³⁵ 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.¹³⁶

Testing for HIV¹³⁷

- 3.16 The most general manner in which it can currently be determined whether a person is infected with HIV is through 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

132 **CDC Frequently Asked Questions** May 2000; Van Dyk 42-43; Schoub 101, 120-125.

133 Van Dyk 48; Tereskerz et al 1996 **New England Journal of Medicine** 1150-1153 as quoted in **AIDSScan** March 1997 9; Gerberding in **The Medical Management of AIDS** 75. See also par 3.47 below.

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

135 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). Cf also Schoub 41-42; Flaskerund and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 17-18.

136 Van Dyk 20; Schoub 42; Stine 137-139. Cf also par 3.8 above 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.

137 See in general the sources referred to in fn 97 above.

not at present generally used in the public sector.¹³⁸

3.17 The same blood tests to detect antibodies to HIV in adults, are generally used in respect of children.¹³⁹ However, the result of any HIV antibody test performed on an infant less than 15 months of age may reflect the mother's HIV status, because HIV antibodies are transferred from mother to baby.¹⁴⁰ Until these antibodies disappear, only specific virus detection tests can determine the infection status of an infant.¹⁴¹

3.18 The following types of tests are in current use:

! ELISA and Western Blot antibody tests

3.18.1 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.¹⁴² These tests involve a blood sample being taken from a person in a clinical setting with the blood subsequently being tested for HIV antibodies in a clinical laboratory. The ELISA test for HIV antibodies is very sensitive and reacts 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 second test on a 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 expensive¹⁴³ and can therefore not always be used in

138 Van Dyk 29-30; Schoub 126-130. See par 3.18.7 et seq below. The public sector would exclude the South African Blood Transfusion Services which utilises other tests, such as the P24 antigen test, on a routine basis (cf Heyns [Unpublished] 5).

139 Boland et al in **HIV/AIDS A Guide to Primary Care Management** 70. 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).

140 **CDC Update** March 1998 (Internet).

141 Ibid.

142 Schoub 126-130; Van Dyk 29-30; Evian 42 et seq.

143 The cost of a WB test is approximately R276,00-R751,00; the cost of an ELISA test carried out by a private body varies from R74,00-R203,00 (information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997). The cost of an ELISA test when used in a public facility would probably be around R80,00 (information supplied by Dr Clive Evian, consultant to the Department Health on 18 May 1999. According to Dr Evian, Western Blot tests are not used very often in public facilities as

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.¹⁴⁴ South Africa has accepted the WHO recommendations to diagnose HIV infection by using at least two positive ELISA test results.¹⁴⁵

3.18.2 Current antibody tests can detect antibodies to HIV from 22 days after infection.¹⁴⁶ 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.¹⁴⁷

3.18.3 A positive HIV antibody test at present 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.¹⁴⁸ 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 also mean that

they are too expensive.)

144 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 more recently indicated that studies have shown that combinations of ELISA and rapid assays (such as DOT immuno assays [referring to "directly observed therapy" i.e. tests carried out under the supervision of a health care worker or other designated person] and agglutination tests) can provide results as reliable as, and in some instances more reliable than, the ELISA/WB 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). See also Evian 42. See par 3.18.11 below for more information on rapid testing.

145 Fleming and Martin 1993 **SAMJ** 685-687. This was confirmed by the comment of Prof A Heyns at a consultative meeting hosted by the Project Committee on 4 February 2000 (see **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 3.28).

146 Information supplied by Prof A Heyns at a consultative meeting hosted by the Project Committee on 4 February 2000 (see **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 3.29).

147 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997. Van Dyk indicates that in practice it would be four to 10 days: Although the actual testing does not require much time, blood samples are generally tested in groups to decrease testing costs, and confirmatory testing also takes time (Van Dyk 29; cf also Canadian HIV/AIDS Legal Network **HIV Testing Info Sheet 9**).

148 Viral load testing has become a marker for disease progression in persons with HIV/AIDS (see par 3.18.8 and 3.57 below).

antibodies to the virus have not yet developed and that the person is infected but is in the window period.¹⁴⁹ To obtain a reliable result such a person will after a period of time have to be tested for HIV again.¹⁵⁰ Sometimes an indeterminate result is given. This means the test is not clear either way.¹⁵¹ To establish whether the person tested is infected, testing could be repeated after three months; alternative antibody tests could be performed; or tests which identify the virus itself (eg PCR or HIV antigen tests) could be performed.¹⁵²

- 3.18.4 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.¹⁵³

! *Saliva and urine tests*

- 3.18.5 Although the standard ELISA and WB tests demonstrate sufficient reliability for diagnostic purposes, utilising blood and handling specimens carry risk of HIV transmission for health care workers (eg through needle-stick injury and test tube breakage - risks inherent in specimen collecting and handling). Tests not using blood as specimen would also be more suitable for haemophiliacs or people on medications that affect bleeding.¹⁵⁴ These risks have recently led

149 Van Dyk 29-32; Evian 43-44.

150 A very small percentage of infected people never develop antibodies to HIV and will therefore repeatedly show false negative tests (Kleinman et al 1997 **Transfusion Medicine Reviews** 162).

151 An "indeterminate" result usually refers to the result of the WB test (i.e. the confirmatory test - see par 3.28 above). An indeterminate result may mean that the person tested is in the process of developing antibodies to HIV (i.e. still in, or just coming out of the window period). However some people may have an indeterminate result for reasons unrelated to HIV infection, including: prior blood transfusions - even with non-HIV infected blood; prior or current infection with syphilis or malaria parasites; auto-immune disease (eg diabetes); infection with other human retroviruses; or association with large animals (animal trainers and veterinarians are sometimes exposed to viruses which do not cause human disease but may interfere with HIV antibody tests (**HIV Insite** "My Partner's HIV Test was Inconclusive - What Does This Mean?" [Internet]; **HIV Insite** "Accuracy of Tests"[Internet]; see also Evian 44).

152 See par 3.18.9-3.18.10 for information on PCR and HIV antigen tests.

153 Evian 42-43; Schoub 129; **CDC PATHFINDER** May 1997 (Internet).

154 Emmons 1997 **The American Journal of Medicine** 15-16; Sowadsky "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet). See also Perumal et al 1999 **Southern African Journal of Epidemiology and Infection** who emphasised that using alternate body fluids for HIV testing may also have other advantages: It may be much more acceptable to persons being tested in that it is less traumatic, painless, noninvasive and acceptable to those who have cultural and religious objections to venipuncture (Ibid 75).

to the development of HIV antibody tests using other fluids, including oral fluid (saliva¹⁵⁵) and urine.¹⁵⁶ Both saliva and urine contain extremely low concentrations of HIV, and are therefore low risk body fluids. However, both would have sufficient detectable antibodies to HIV.¹⁵⁷

- 3.18.6 Saliva and urine tests use the same technique (i.e. testing for antibodies to HIV) as the standard ELISA and WB tests, are subject to the same window period as the standard tests, and are similar in accuracy to the standard tests.¹⁵⁸ They are however more expensive to perform.¹⁵⁹

! *Viral load, HIV PCR and HIV antigen testing*

- 3.18.7 More recently tests became available that test for HIV itself, rather than antibodies to the virus.¹⁶⁰ These may shorten the period of uncertainty about actual infection to about 16 days.¹⁶¹ In addition, some of these tests (eg viral load tests) may more accurately predict future health status by measuring the amount of virus in the blood of people with HIV.¹⁶² However, because of their cost they are not yet recommended for general use.¹⁶³

- 3.18.8 *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

155 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 [Internet]; Emmons 1997 **The American Journal of Medicine** 15-16).

156 Emmons 1997 **The American Journal of Medicine** 15 et seq; Van Dyk 31; Schoub 130.

157 Sowadsky "Urine HIV Antibody Tests" **The Body** (Internet).

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

159 Sowadsky "The New Saliva HIV Tests" **The Body** (Internet). Cf however Perumal et al 1999 **Southern African Journal of Epidemiology and Infection** 75 where they indicate that the GACELISA test (IgG antibody capture enzyme-linked immunosorbent assay) carried out on saliva and urine are more cost effective than the ELISA and WB tests (Ibid 75).

160 Van Dyk 30-31; Schoub 132.

161 Information supplied by Prof A Heyns at a consultative meeting hosted by the Project Committee on 4 February 2000 (see **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 11.10-11.11)

162 Evian 74-75; Van Dyk 34; Schoub 142.

163 Evian 46. But see also Volberding 1996 **The Lancet** 71-73.

progression of HIV disease and is becoming a standard of HIV treatment monitoring. Studies have for instance determined that patients who have higher virus loads will progress more quickly to AIDS than persons with lower virus loads.¹⁶⁴ Viral load tests are not normally used to diagnose HIV.¹⁶⁵ Viral load testing is also irrelevant in terms of immediate post exposure treatment.¹⁶⁶

3.18.9 The *polimerase chain reaction* technique (internationally known as PCR tests), which detects the virus itself in the blood, and which may reduce the period of uncertainty about actual infection to 16 days¹⁶⁷ is also available. PCR tests can probably be regarded as more accurate than the standard antibody tests since a PCR test result could be positive even if insufficient antibodies are present for detection by the standard tests.¹⁶⁸ However, PCR tests are more prone to false-positive and false-negative readings as compared to antibody tests.¹⁶⁹ In addition, they are expensive (more so than, eg ELISA antibody tests).¹⁷⁰ Generally speaking they have limited diagnostic value and are not

164 **CDC PATHFINDER** May 1997 (Internet); **Toronto Hospital Immunodeficiency Clinic Newsletter** September 1996 (Internet); **HIV-Infogram** 20 September 1996 (Internet); Evian 102-103; and par 3.23.1 et seq below on the significance of viral load testing in administering new combination drug treatments for HIV infection.

165 This is because a person may have a viral load below detectable limits (because of the use of protease inhibitors) yet still have the virus (i e it is possible to have HIV while viral load testing may not be able to detect the infection). In addition, viral load tests can give "positive" readings (most often when the viral load count is very low) resulting in the belief that a person is infected when this is actually not the case (Sowadsky "Taking Unnecessary Tests: A Waste of Valuable Resources" **The Body** [Internet]; Evian 102-103; Schoub 132-133).

166 First, since it is impossible to get viral load results of the arrested person who exposed the victim to risk of infection within the limited time span required for initiation of post exposure treatment; and second, since a person's blood may be infectious regardless of viral load, post exposure treatment would still be necessary to prevent infection, whether the viral load is high or low (Sowadsky "CDC Standards for Needle Sticks? Etc" **The Body** [Internet]).

167 Van Dyk 30; Evian 46. It has however been pointed out that PCR tests are not usually considered reliable until about one month after exposure to HIV (information supplied by Dr Rick Sowadsky, Communicable Disease Specialist, Nevada US AIDS Hotline Coordinator on 3 May 1999); see also Sowadsky "Approximate Timeline of Testing and Symptoms for HIV/AIDS" **The Body** (Internet).

168 **CDC PATHFINDER** May 1997 (Internet).

169 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist, Nevada US AIDS Hotline Coordinator on 3 May 1999. (See also Heyns [Unpublished] 2 where he indicates that even the most sensitive PCR test will not detect all early HIV infections.)

170 Ibid.

designed for routine testing.¹⁷¹

- 3.18.10 P24 antigen is a protein fragment of HIV which characteristically appears early and late during infection.¹⁷² It can be measured by the *P24 antigen test*. A positive test result suggests active HIV replication. HIV is detected within a similar period as is the case with the PCR test i e 16 days after infection.¹⁷³ This test is less expensive than the PCR.¹⁷⁴ The P24 antigen test has a higher false positive rate in the very early stage of HIV infection and is not recommended for HIV diagnosis under normal circumstances.¹⁷⁵

! Rapid testing

- 3.18.11 Rapid testing in general refers to HIV *antibody testing*, using blood as specimen,¹⁷⁶ which is easier to use (usually requiring no equipment other than what is provided in the test kit) and which produces results more quickly (within 10 to 30 minutes) than the standard ELISA test.¹⁷⁷ The sensitivity and specificity of rapid tests are however just as good as those of the ELISA test, and the negative predictive value (i e accuracy of a negative test result) is

- 171 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist, Nevada US AIDS Hotline Coordinator on 3 May 1999; see also Evian 46.
- 172 Following HIV infection, the sequence of markers to identify infection in chronological order of appearance in blood are: viral RNA (detected by the PCR test), p24 antigen (detected by the P24 antigen test) and HIV antibody (detected by HIV antibody tests such as the ELISA and Western Blot). P24 antigen appears during *acute* infection (i e early after infection due to the initial burst of virus replication; it then decreases and is often no longer demonstrable when antibodies to HIV become detectable - most likely due to antigen-antibody complexing in the blood; and appears again late in the course of infection) (**The AIDS Knowledge Base** [Internet]).
- 173 Information supplied by Prof A Heyns at a consultative meeting hosted by the Project Committee on 4 February 2000 (see **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 3.39). See also Evian 46.
- 174 Information supplied by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000 (see **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 3.39).
- 175 Experts suggest that its use be limited to cases where it is necessary to know HIV status very early (eg for establishing infection in victims post rape); screening blood; diagnosing infection in the newborn; and monitoring antiviral therapy (Evian 46; **The AIDS Knowledge Base** [Internet]).
- 176 Several rapid tests are however currently being developed, including one for use with oral fluids (**CDC Update** March 1998 [Internet]).
- 177 **Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 1. See also **CDC Update** March 1998 (Internet); **CDC Morbidity and Mortality Weekly Reports** 27 March 1998 211; Jürgens 86-87; Evian 46-47; Schoub 131; Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 9.

accurate enough to exclude HIV infection if the test is negative.¹⁷⁸ Rapid testing does not shorten the window period.¹⁷⁹ 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;¹⁸⁰ can usually be operated and read by nonlaboratory personnel; and some are even being marketed to the lay public for "self-testing" purposes.¹⁸¹

- 3.18.12 A rapid test under research in South Africa during 1999 was reported to be 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.¹⁸² Research has already shown that the test results are reliable if the test is performed properly and read accurately.¹⁸³ 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

- 178 **Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 1. See also Sowadsky "Rapid HIV Tests" **The Body** (Internet); **WHO Weekly Epidemiological Record** 21 March 1997; **CDC Update** March 1998 (Internet); Evian 46-47; Schoub 131; Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 9.
- 179 **CDC Update** March 1998 (Internet); Sowadsky "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet); Sowadsky "15 Minute Test" **The Body** (Internet).
- 180 Prices may however differ and some rapid test kits are actually more expensive than an ELISA test. (Prof A Heyns at a consultive meeting with the Project Committee on 4 February 2000 indicated that the price of some rapid tests used in the private sector are currently between R150,00-R180,00 [see **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 3.40]). Information received from the Department of Health indicated that rapid tests may be as inexpensive as between R7,00- R12,00 [Departmental letter N6/4/3/1 of 26 October 2000]). However, performance of an ELISA test requires expensive laboratory equipment and the time and expertise of laboratory technicians which should be taken into account (**CDC Update** March 1998 [Internet]).
- 181 **CDC Update** March 1998 (Internet); **CDC Morbidity and Mortality Weekly Reports** 27 March 1998 (212-214); Sowadsky "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet); Sowadsky "15 Minute Test" **The Body** (Internet). Cf also **Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 1 and 3.
- 182 **Beeld** 26 August 1998.
- 183 Ibid. See also **Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 1. According to the press report referred to in the previous footnote, 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/WB 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 Reports** 27 March 1998 [Internet]; **CDC Update** March 1998 [Internet]). As regards the position in South Africa, the Department of Health indicated that only rapid tests approved and validated by the National Institute of Virology or other specified institutions will be recommended for use. It is also envisaged that the Department will make recommendations to the Pharmaceutical Association before the marketing of rapid tests to the public (**Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 6).

that a second confirmatory test (in the form of a laboratory test), should be done in respect of all positive test results.¹⁸⁴ Furthermore, they emphasise that rapid testing should be executed under the supervision of a health care worker to ensure proper counselling.¹⁸⁵ In a 1998 discussion document preceding its April 1999 Policy Guidelines on Rapid HIV Tests and Testing, the Department of Health 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.¹⁸⁶ It is envisaged that the test will be of specific value in regions lacking laboratory facilities.¹⁸⁷

! DNA tests

3.18.13 Another promising area of research is the more recent tests (commonly referred to as DNA¹⁸⁸ tests) that aim at determining the full genome sequence of the HIV-1.¹⁸⁹ 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 criminal investigators to state with some degree of certainty the source of infection.¹⁹⁰ To date however, the test is too costly for general use and, depending on the circumstances surrounding transmission, not necessarily conclusive.¹⁹¹

184 The negative predictive value of rapid tests is such that infection can often be confidently excluded if the test is negative. However they are more likely to miss recent seroconversion or late stage HIV infection because they are often less able to detect low levels of antibody. A confirmatory test must be done on all reactive (i.e. positive) test results (**Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 1 and 4.4; **CDC Morbidity and Mortality Weekly Reports** 27 March 1998 213; **CDC Update** March 1998 [Internet]).

185 **Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 2 and 5.

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

187 **Beeld** 26 August 1998. **Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999** par 3.1.

188 See fn 99 above.

189 See fn 98 above for information on the different strains of HIV (HIV-1 and HIV-2).

190 Information supplied by Dr MJ Matjila (Department Community Health) and Prof G Lecatsas (Department of Virology) at MEDUNSA on 21 October 1998. See also Salminen et al (Unpublished); McCutchan and Birk (Unpublished); Colella 1995 **The Journal of Legal Medicine** fn 34 on 41.

191 A person with HIV could, for instance, after having infected his or her sex partner (or victim in the case of rape or sexual assault), 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 which means that the sex partner (or victim)

However, if scientists eventually developed a DNA matching test that is highly effective also in such instances, the problem of proving causation in cases involving multiple probable sources of infection would disappear.¹⁹² The South African Police Service (SAPS) currently already uses the DNA technique for evidentiary purposes in sexual offence cases where necessary.¹⁹³

- 3.19 HIV testing is available at private and public facilities. In the public sector any person may approach a primary health care clinic or AIDS Training, Information and Counselling Centre (ATICC)¹⁹⁴ for free HIV testing.¹⁹⁵ HIV testing is also offered in all state hospitals where such facilities may charge for their services. Although most clinics provide this service, those who do not have trained counsellors or facilities to take the blood to a laboratory, will have to refer patients to another service.¹⁹⁶
- 3.20 In terms of section 14(f) of the Health Act 63 of 1977 one of the functions of the Department of Health is to provide services in connection with the procurement or evaluation of evidence of a medical nature with a view to legal proceedings.¹⁹⁷ Full-time and part-time District Medical Officers (formerly known as "District Surgeons" and currently employed by the Provincial Departments of Health) fulfil this function.¹⁹⁸

Treatment

and the person with HIV would no longer have matching DNA.

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

193 **SAPS National Instruction 22/1998** Annexure A 2.

194 ATICCS are established at the health departments of certain local authorities.

195 Information supplied by Dr Nono Simelela, Director: HIV/AIDS and STDs, National Department of Health on 21 May 1999.

196 Information supplied by Ms Rose Smart, then Director: HIV/AIDS and STDs, Department of Health on 24 July 1998.

197 This may change in future as Draft 9 (as far as could be ascertained the latest public version dated November 1996) of the envisaged National Health Bill provides that Provincial Departments of Health will be responsible for "ensuring the rendering of medico-legal services" (sec 3, read with item 16 of part 2 of Schedule 2 of Draft 9 of the National Health Bill).

198 Information supplied to the researcher by Prof PWW Coetzer, Head Department of Community Health, MEDUNSA on 7 April 2000.

- 3.21 There is at present no cure for HIV infection or AIDS.
- 3.22 The most widely-used drug for the treatment of persons with HIV infection and AIDS is zidovudine (AZT).¹⁹⁹ 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 number of opportunistic infections and increases the number of healthy cells.²⁰⁰ Since significant progress has been made during the past few years with the development of new drugs for the more successful treatment of HIV infection and associated opportunistic diseases, monotherapy (the use of one drug at a time) is no longer recommended for HIV therapy.²⁰¹ Monotherapy, with AZT alone, is however still an option in the following two instances: As a short-term limited course treatment of HIV in pregnant mothers to prevent vertical transmission to babies,²⁰² and as post exposure prophylaxis (PEP) in noninfected individuals exposed to infection.²⁰³
- 3.23 Current emphasis in treatment is on antiretroviral therapy to inhibit disease progression by keeping the viral count as low as possible; treating opportunistic diseases; and attempting to restore the immune system.²⁰⁴
- 3.23.1 There are currently three main categories of antiretroviral drugs.²⁰⁵ Until 1995 antiretroviral therapy concentrated on the development of drugs (known as nucleoside analogs) which prevented the spread of HIV to new cells - they however did not interfere with viral replication in cells that are already infected. These were the first anti-HIV drugs developed and included AZT. In 1995 a

199 Schoub 171; Van Dyk 15.

200 Cf Schoub 178; Volberding in **The Medical Management of AIDS** 113.

201 Van Dyk 84; Schoub 178. The reduction of viral load (see fn 206 below) on monotherapy is transient and resistance develops within weeks to months (Van Dyk 84).

202 More recently studies showed that a single dose of the anti-AIDS drug, Nevirapine, to both mother and infant was cheaper and more effective than treatment with AZT to prevent vertical transmission (Guay et al 1999 **The Lancet** 795-802; Marseille et al 1999 **The Lancet** 803-809).

203 Van Dyk 84-85; Evian 215-217; Schoub 181-183; Volberding in **The Medical Management of AIDS** 113.

204 Van Dyk 35; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19; Schoub 163 et seq.

205 Evian 81; Van Dyk 82; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19; Schoub 163 et seq. The number of categories and the number of drugs in each category have been undergoing rapid change in the past few years and it is expected that this will continue in future (Evian 81).

second group (commonly known as protease inhibitors) were approved. They disturb the life cycle of HIV by interfering with viral replication and included drugs such as indinavir and nelfinavir. A third type of drug (known as nonnucleoside reverse transcriptase inhibitors) was introduced in 1996. These also prevent the spread of HIV to new cells (like the first group of drugs) but have a different mode of action and include drugs such as nevirapine. Over the past few years scientists have learned that a major factor decreasing the durability and efficacy of antiretroviral therapy is the use of monotherapy. Combination drug therapy produces a more sustained effect. It reduces viral load below detectable levels²⁰⁶ thus substantially postponing disease progression and death and dramatically improving the overall health and well-being of persons with HIV.²⁰⁷ Combination drug therapy goes hand in hand with the regular monitoring of viral load in the blood of persons with HIV to assess the response to therapy.²⁰⁸ Application of these combination treatments may also improve results of prophylaxis for HIV transmission to babies, health care workers and persons exposed to HIV during sexual intercourse or rape.²⁰⁹

3.23.2 The treatment of opportunistic infections in AIDS is particularly difficult as the organisms which cause the infections are often unusual organisms which do not respond to the more commonly used treatments. The severe suppression of their immune systems also hinders recovery in persons with HIV/AIDS.

206 It is however uncertain whether replication is ever totally suppressed (Evian 81). As indicated in par 3.18.7 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 of blood. A result below 5 000-10 000 copies/ml is generally considered a low level, while a result over 5 000-10 000 copies/ml is generally considered a high level. 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. Recent reports indicate that some combination treatments may 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 (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 [Internet]).

207 Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19; Schoub 163 et seq.

208 Schoub 179-180; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19; See par 3.18.7 for more on viral load testing.

209 Schoub 179-180; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19; **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet). There are however to date no conclusive data on the effectiveness of antiretroviral therapy in preventing HIV transmission after nonoccupational exposures (**CDC Update** September 1998).

New and highly effective treatments for the prevention and treatment of certain opportunistic infections have significantly contributed to an improvement in the prognosis of AIDS in recent times. Important examples of this have been the treatment of pneumocystis carinii, tuberculosis, and candida.²¹⁰

- 3.23.3 The development of drugs for immune reconstitution therapy has until now been hampered by a limited knowledge of the interaction between HIV, immune cells and various cytokines.²¹¹ At present attempts to reconstitute the immune system still plays little role in the treatment of persons with HIV.²¹²
- 3.24 Although the new combination drug therapies have proved to be more effective than any previously available treatment, their long-term effectiveness and safety are still unknown because they are so new.²¹³ Although these therapies have been shown to be effective in reducing HIV in the blood stream, it is not known whether they will in the long-term be effective in maintaining the low levels of HIV in the bloodstream.²¹⁴ It is also recognised that they do not eradicate the virus from all parts of the body.²¹⁵ The drugs do not work for all people with HIV and they require patients to follow complex treatment regimens which involve taking multiple medications several times each day. Many people develop serious side effects which lead to discontinuation or change of treatment regimens.²¹⁶ Furthermore, the drugs are extremely expensive and not widely available in developing countries. They are thus unaffordable to most people with HIV.²¹⁷ There is however some hope that HIV and AIDS may eventually, for those who can afford treatment,

210 Schoub 163-165; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19;

211 Cytokines are powerful chemical substances secreted by cells (Stine 392).

212 Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19; Schoub 163 et seq.

213 **CDC Update** June 1998 (Internet). Cf also Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487.

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

215 **CDC Facts About Recent HIV/AIDS Treatment** July 1997 (Internet).

216 Ibid.

217 **AIDS Action** January-March 1998 11; Schoub 181; Evian 79; Van Dyk 35. The current South African cost of a basic retroviral course of a minimum of two drugs, and possibly three, may be between R1 500,00-R4 000,00 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 by Dr Clive Evian Consultant to the Department of Health on 17 July 1998). Cf also information supplied more recently by the Department of Health according to which the cost of treatment with two drugs could be in the region of R1 000,00 (information supplied by Ms L Coetzer of Department of Health: Directorate HIV/AIDS/STDs on 17 October 2000).

become manageable in ways similar to diabetes, epilepsy, and heart disease.²¹⁸

Prevention of HIV transmission

Development of a vaccine to prevent HIV infection

- 3.25 Developing an effective and safe HIV vaccine²¹⁹ has become a global public health priority. These efforts have focussed on creating either a vaccine that will protect people from HIV infection (a preventive vaccine) or a vaccine that will protect people from becoming ill after they have already acquired the virus (a therapeutic vaccine). In both approaches, the effectiveness of the vaccine depends on its ability to elicit a protective immune response.²²⁰
- 3.26 Vaccine research is a lengthy process and ongoing efforts have been in progress throughout the world since 1987.²²¹ Human trials for safe and effective preventive and therapeutic vaccines on some 30 different types of candidate vaccines have taken place in the United States, France, England, Switzerland, Israel, Brazil, Thailand, China and Japan.²²² To date no one candidate vaccine has been proven effective and currently

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

219 "Vaccine" has been broadly defined as "a material which is administered to an individual to stimulate their immune system to give protection from infection with a specific micro-organism" (Schoub 186).

220 **HIV Insite** "Vaccines - The Overall Picture" (Internet).

221 A candidate vaccine undergoes stringent testing in animals and human volunteers. Human trials consist of three distinct phases which can take six or more years to complete: *Phase I* trials are generally conducted on small numbers (10-30) of healthy adult volunteers who are not at risk of HIV infection. The main goal of such trials is evaluating safety. Phase I trials usually take 8-12 months to complete. *Phase II* trials involve larger numbers of human volunteers (50-5000) - usually a combination of low-risk and higher-risk individuals. Phase II trials generate additional safety data as well as information for refining the dosage and immunisation schedule. These trials generally take 18-24 months. *Phase III* trials are large scale trials on thousands of human volunteers from high-risk populations in geographic regions where HIV is prevalent to verify whether a candidate vaccine is effective in protecting against HIV or AIDS. Successful demonstration of efficacy can lead to an application for licensure of the vaccine. Phase III trials of candidate AIDS vaccines are generally expected to require a minimum of three years for enrollment, immunisations, and assessments of efficacy (**IAVI Information Sheet** [Internet]; **UNAIDS Press Release** 13 July 2000 [Internet]).

222 Van Dyk 35-36; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 19; **UNAIDS Press Release** 13 July 2000 (Internet).

many vaccines are undergoing clinical trials.²²³

- 3.27 AIDS vaccine trials have up to very recently not been conducted in Africa mainly for ethical and practical reasons. Moreover, most vaccine efforts have focussed on HIV subtypes that are prevalent in the United States and Europe, despite the fact that two-thirds of the estimated number of people infected world-wide live in Sub-Saharan Africa.²²⁴ The first vaccine trial conducted in Africa (i.e. on an African population) was a small scale Phase I trial initiated in Uganda during 1999. This preventive vaccine had already been tested on populations in Europe and the United States and targets the HIV subtype (clade B) predominantly found in those countries. The Uganda trial however focusses on looking for cross-reactive immune responses (i.e. immune responses not only to clade B, but also to clades A and D which cause most HIV infections in Uganda).²²⁵
- 3.28 At the XIIIth International Conference on AIDS in Durban, July 2000, the International AIDS Vaccine Initiative²²⁶ in its Scientific Blueprint 2000 called for a greater focus on vaccines targeting the specific HIV subtypes prevalent in developing countries.²²⁷ Primary requirements for such vaccines are: low cost and ease of administration.²²⁸ Trials for the first preventive HIV vaccine designed specifically for use in Africa were expected to commence in Nairobi (Kenya) and Oxford at the end of 2000.²²⁹

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- 223 Virological difficulties (the rapid mutation of the virus which seems to make an effective HIV vaccine impossible to design), ethical difficulties (eg the choice of volunteers, and the evaluation of the efficacy of candidate volunteers) and economic difficulties have been major obstacles in the development of an HIV vaccine (Schoub 192 et seq; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 19; **IAS Satellite Symposium at the XIIIth International AIDS Conference 2000** [Internet]).
- 224 **AIDSScan** October/November 2000 11-12; **UNAIDS Press Release** 13 July 2000 (Internet); **NIAID News Release** 8 February 1999 (Internet).
- 225 Ibid.
- 226 An international organisation founded in 1996 to ensure the development of safe, effective and accessible preventive HIV vaccines for use throughout the world.
- 227 **PRNewswire** 9 July 2000 (Internet).
- 228 Ibid; Bowers 1996 **Bulletin of Experimental Treatments for AIDS** (Internet).
- 229 The rationale for the specific approach in developing this vaccine comes from extensive studies of sex workers in Nairobi. Despite frequent exposure to HIV a small minority of these women has resisted infection over many years. The vaccine aims at creating the same immune response to HIV that has been seen in these women. This vaccine is targeted at developing immunity against the HIV viral subtype specifically found in East Africa (clade A) (**HIV Insite** "Announcement of Human Testing of HIV Vaccine for Africa" [Internet]).

- 3.29 South Africa joined the international search for a vaccine through the establishment of the South African AIDS Vaccine Initiative (SAAVI) under the management of the South African Medical Research Council in 1999. SAAVI is a public-private initiative aimed at developing an effective, affordable vaccine for use in South Africa and Southern African Development Community countries by 2005.²³⁰ Eight candidate vaccines specifically targeting the HIV subtype prevalent in South Africa (clade C) are currently at various stages of development in South Africa and human trials on one or more of these are expected to commence in 2001.²³¹

230 **MRC News** September 1999 (Internet); Birmingham 1999 **Nature Medicine** 1220.

231 The vaccines under development are first and foremost intended to be preventive. However, it is possible in the clinical trial process that they (or some of them) may also prove to have therapeutic value (information supplied by Ms Michelle Galloway, Medical Research Council) on 5 February 2001; see also **Reuters NewMedia** 4 October 2000 (Internet); **AIDSScan** October/November 2000 12.

Effectiveness of condoms in reducing the risk of HIV transmission

- 3.30 Recent studies provide compelling evidence that latex male condoms are highly effective in preventing (but not totally excluding the risk of) HIV transmission when used correctly and consistently.²³² The Department of Health in South Africa has consistently promoted condom use as part of its HIV/AIDS strategy. In a 1994 European study on 256 discordant heterosexual couples (i.e. one partner HIV positive and the other HIV negative), who *consistently* used latex condoms over an average of 20 months, only 0%-2% of the uninfected partners became infected; while in those couples who *did not consistently* use condoms, 10%-12% of the uninfected partners became infected.²³³ 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.²³⁴
- 3.31 Female condoms have more recently also become available. Although laboratory studies indicate that the female condom serves as a mechanical barrier to viruses, and are as effective as the male condom in reducing the average incidence of sexually transmissible diseases, further clinical research is necessary to determine its effectiveness in preventing transmission of HIV.²³⁵ As the female condom is the only

232 Stine 215; **CDC Frequently Asked Questions** May 2000 (Internet); **JAMA HIV/AIDS Information Center** July 1997; De Carlo **VAAIN** April 1995 (Internet); **CDC Morbidity and Mortality Weekly Reports** 2 May 1997 373; 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 (**CDC Frequently Asked Questions** May 2000 [Internet]; **JAMA HIV/AIDS Information Center** July 1997).

233 **CDC Frequently Asked Questions** May 2000 (Internet); De Carlo **VAAIN** April 1995 (Internet); cf also Lachman 135. It has however been said that findings from European studies may not necessarily reflect the risks of HIV transmission in the African context because of different sexual attitudes (cf 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 latter survey 500 persons between the ages 18-49 indicated that only 19% of sexual encounters in the four weeks prior to the survey included condoms (**AIDSScan** September/October 1998 12).

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

235 **CDC Frequently Asked Questions** May 2000 (Internet); Voelker 1997 **JAMA** 460; Palmer 1999 **Infectious Disease News** 28; Stine 222-223. 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

device other than the male condom that could prevent HIV transmission, it is advised that the female condom can be used as alternative when use of a male condom is not possible.²³⁶

Development of microbicides as an alternative or in addition to condoms

3.32 Avoiding infection with sexually transmissible diseases, including HIV, is often more problematic for women than for men. Although condoms, if used correctly and consistently during sexual intercourse, provide a good physical barrier against infection, condom use ultimately requires the consent and cooperation of the male partner. To address the need for effective female-controlled strategies to avoid infection, researchers have recently increasingly focussed on the development of chemical barriers which destroy HIV in the vagina.²³⁷ Microbicides (in the form of foam, gel, cream or suppository products) are chemical barriers currently being researched and developed for this purpose.²³⁸

Post exposure prophylaxis (PEP) after recent sexual exposure to HIV

3.33 Although information on PEP is not of pivotal relevance to the current Report, it bears on the impact of HIV transmission and is thus briefly discussed below.

3.34 PEP is an antiviral therapy designed to reduce the possibility of an individual becoming

Safe are Condoms?" **The Body** [Internet]).

236 Ibid. By 1997 the female condom had been marketed in 13 countries, including South Africa. It has been said that the female condom may provide protection to women who are more vulnerable to sexually transmissible diseases and HIV because of their political, educational, social and sexually subordinate position to men (Deniaud 1997 **Sante** 405-415 [Internet]).

237 Although microbicides are intended for use by women, effective products will prevent infection in female and male partners (**NIAID Fact Sheet** March 2000 [Internet]).

238 **NIAID Fact Sheet** March 2000 (Internet); Forbes **WORLD** September 1998 (Internet).

infected with HIV after a known exposure to the virus. The treatment usually involves administration of a group of drugs (or AZT alone) which act against HIV.²³⁹

- 3.35 For HIV successfully to enter and establish itself in the body it needs to be taken up by, and presented to certain immune cells in the body. This process takes anything from several hours to several days providing a brief window of opportunity between exposure and infection. During this time lag antiviral treatment may abort infection by inhibiting HIV replication and allowing the host's immune defences to eradicate the virus.²⁴⁰ The sooner the treatment is started, the better the chance of reducing viral replication and enabling the body to eliminate viable virus.²⁴¹ In recent years evidence has become available to demonstrate the efficacy of certain antiviral drugs (preferably used in combination) in reducing the risk of HIV infection from occupational percutaneous exposure (skin perforating needle-stick injury).²⁴² Although failures of PEP with antiviral drugs have occurred, PEP with AZT alone was reportedly associated with an approximate 81% reduction in risk for HIV seroconversion after occupational percutaneous exposure. AZT has also proved to have a 67% reduction in the risk of mother to child perinatal transmission when administered to women with HIV during pregnancy and labour and to their infants for six weeks postpartum.²⁴³
- 3.36 The biggest advantage of PEP is that it could drastically reduce the chances of

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- 239 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); Sowadsky "Post Exposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet).
- 240 Katz and Gerberding 1998 **Annals of Internal Medicine** 306; Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 519; **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to the HIV** March 1999 4.
- 241 HIV replication is rapid and continues unless controlled by the immune system or other mechanisms. Theoretically, initiation of antiretroviral PEP soon after exposure may prevent or inhibit systemic infection by limiting the proliferation of virus in the initial target cells or lymph nodes (**CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet)). In order for the drugs to be protective, they must be inside the target cell. There is therefore a need to initiate PEP as soon as possible. In most instances however, there is a several hour delay between the time of initial exposure and initiation of antiretroviral therapy (**Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 5).
- 242 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 4.
- 243 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); Flexner in **The Hopkins HIV Report** (Internet); Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 519; Lurie et al 1998 **JAMA** (Internet); Henderson 1999 **JAMA** (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 4. In a Thailand drug trial, perinatal HIV transmission was reduced by 51% for women treated from 36 weeks' gestation until delivery. However, perinatal transmission despite the use of AZT prophylaxis in pregnancy also has been reported (**CDC Morbidity and Mortality Weekly Reports** 25 September 1998 [Internet]).

becoming infected after known exposure to HIV. However, protection with prophylaxis is not absolute and there have been reports of failure to prevent HIV transmission, especially with single AZT therapy.²⁴⁴

- 3.37 PEP however also carries serious possible disadvantages and limitations, including the following: treatment should be initiated promptly, preferably immediately, within one to two hours after exposure;²⁴⁵ the standard combination drug regimen is onerous to follow and carries a long list of potential side effects;²⁴⁶ administration of prophylaxis carries the remote risk of multidrug-resistant virus developing;²⁴⁷ all the treatments recommended may have potentially serious drug interactions when used with certain other drugs because of their toxicity;²⁴⁸ there is little or no data available on the safety and tolerability of these drugs in pregnant women and the developing fetus (except of course if used towards the end of pregnancy to limit transmission of HIV to newly-born infants);²⁴⁹ the use of PEP in children has not been studied, and therefore the safety and effectiveness of PEP administered to children would be completely uncertain;²⁵⁰ and

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- 244 Failure may be due to exposure to HIV viral strains which are resistant to the drug regime; high HIV viral loads in the source person; or if treatment was initiated too late or for insufficient duration (**CDC Morbidity and Mortality Weekly Reports** 15 May 1998 [Internet]; **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 5).
- 245 Although the interval after which there is no benefit from using PEP is not yet defined, animal studies suggest that it is probably not effective when started later than 24-36 hours after exposure; PEP initiated at 72 hours after exposure had no effect; while PEP initiated within 8 hours of exposure was most potent. The interval after which there is no benefit from PEP for humans is presently not known - however, it is assumed that such therapy is no longer effective after 24-36 hours (Sowadsky "CDC Standards for Needle Sticks? Etc" **The Body** [Internet]; **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 6-7; Denenberg **The Body: GMHC Treatment Issues**[Internet]; Sowadsky "A Few Questions From a Student" **The Body**[Internet]; see also **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 5).
- 246 It involves taking a number of pills daily for four weeks, and submitting to a battery of blood tests in the course of monitoring the impact of the treatment. The potential side effects include anaemia, malaise, insomnia, debility, fatigue, headache, liver inflammation, kidney stones and gastro-intestinal symptoms (abdominal pain, nausea, vomiting, diarrhea and indigestion). Among health care workers receiving combination drugs as PEP, 50%-90% reported side effects that caused 24%-36% to discontinue treatment (**CDC Morbidity and Mortality Weekly Reports** 15 May 1998 [internet]; Mirken 1998 **Bulletin of Experimental Treatments for AIDS** [Internet]; Dahir **The Body: Poz Gazette** [Internet]).
- 247 I.e. if a person becomes infected with HIV despite taking retroviral medication, there is a theoretical risk that the viral strain will become resistant to the medications (**CDC Morbidity and Mortality Weekly Reports** 15 May 1998 [Internet]; Dahir **The Body: POZ Gazette** [Internet]).
- 248 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet).
- 249 Henderson 1999 **JAMA** (Internet).
- 250 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist, Nevada US AIDS Hotline Coordinator on 11 June 1999.

finally, the regimen is extremely expensive to complete.²⁵¹

- 3.38 Certain experts submit that although there is no direct evidence to show that PEP prevents infection after *sexual exposure* to HIV, this is biologically plausible given the efficacy of treatment after occupational percutaneous exposure and the similarities between the immune responses to percutaneous and transmucosal exposures (exposure through a mucosal surface such as the vagina, rectum, or mouth).²⁵² In the United States, for instance, certain researchers recommend routine PEP after unprotected receptive and insertive anal and vaginal intercourse with a partner who is, or is likely to be, HIV infected. They advise that the treatment regimen for sexual exposures should be modelled on that used for occupational exposures, with similar baseline HIV testing, follow-up care and surveillance for HIV infection.²⁵³ Taking into account the estimated medical costs of HIV disease versus the cost of PEP per seroconversion averted, proponents submit that PEP after (consensual) sexual exposure would be cost-effective even if its efficacy was only 40%.²⁵⁴ Although these researchers concede that the public health implications for routine PEP after (consensual) sexual exposure may pose some risks for the community as a whole (in that HIV prevention efforts could be undermined if persons initiate or resume unsafe sexual practices because they expect PEP treatment to be protective) they maintain that post sexual exposure prophylaxis should be seen as a backup in case of failure of primary prevention

251 According to Dr Clive Evian, drafter of the **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 and information received from the Department of Health, the cost of a two-drug combination regime taken for 30 or 31 days is varies between R1 077,00 (including a starter pack at R194,00) and R1 493,00 depending on whether the drugs are purchased by way of government tender and distributed through state institutions or obtained from a pharmaceutical wholesaler (information supplied by Dr Evian on 13 August 1998; and Ms L Coetzer of the Department of Health: Directorate HIV/AIDS/STDs on 26 October 2000). Similar prices were quoted in the press: The total price of a starter pack (R171,00) and a 28 day (i.e. the 31 day regimen minus the three day starter pack) supply of a two drug regimen (AZT at R619,38 plus 3TC at R851,20) would be R1 641,58 (**Mail and Guardian** 21-27 May 1999). However, if a third drug is added (eg crixivan at R2 049,00 for 28 days) this would considerably raise the total price of the treatment therapy.

In the United States the cost would be in the region of \$900 for a standard three drug regime taken for four weeks (Denenberg **The Body: GMHC Treatment Issues** [Internet]).

252 Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; Dahir **The Body: POZ Gazette** (Internet); Lurie et al 1998 **JAMA** (Internet); Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 519.

253 Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq. See **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 3.61 et seq for comprehensive information on PEP after occupational percutaneous exposure to HIV.

254 Ibid.

methods.²⁵⁵

- 3.39 Opponents of PEP after sexual exposure contend that there are too many factors differentiating transmission after occupational needle-stick exposure from transmission during sexual intercourse to recommend treatment in instances of sexual exposure on the basis of studies in respect of occupational exposure: These include host factors (genetics, the type of membrane exposed to HIV, the presence of other sexually transmissible diseases, and the frequency of exposure); viral factors (phenotype, quantity of infectious material that the infected person has been exposed to, and the presence of resistant mutations); and environmental factors (timing of prevention therapy and choice of drugs).²⁵⁶ Moreover, as indicated above, PEP has serious implications for an individual's short and long term health.²⁵⁷
- 3.40 The United States Centers for Disease Control (CDC)²⁵⁸ in September 1998 published a Report on management of possible sexual or other nonoccupational exposure to HIV to address concerns in this regard.²⁵⁹ The Report emphasised that as no conclusive data exist regarding the efficacy of drug therapies to prevent HIV infection in persons following nonoccupational HIV exposure, it should be considered an unproven clinical intervention. Under these circumstances the CDC was not prepared to make definitive

255 Katz and Gerberding 1998 **Annals of Internal Medicine** 306-312; Dahir **The Body: POZ Gazette** (Internet).

256 Torres 1998 **GMHC Treatment Issues** (Internet); Sowadsky "Post Exposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet). International experts, for instance, advised the AIDS Law Project (a specialist HIV/AIDS law and human rights programme run by the Centre for Applied Legal Studies based at the University of the Witwatersrand) that the toxicities involved in the recommended standard post exposure drug regimes may pose far greater risks than an informed person would want to take, given the low risk of transmission attached to exposure during rape. In addition, the experts referred to very new data which show a growing concern about the potential for teratogenicity (malformation in a fetus), stating that beyond the issue of possible pregnancy associated with rape, women must be concerned with subsequent (or existing) pregnancies as well. It was emphasised that post-rape prophylaxis is still considered experimental and therefore of unknown benefit in the criminal setting (Weiss **HIV-Law Digest** 3 June 1998).

257 These would include the various immediate side-effects (such as insomnia, debility, fatigue and headache) as well as the toxic effects associated with the long-term administration of the drugs - see par 3.37 above.

258 The CDC (in Atlanta, Georgia) is the government institution charged with disease monitoring and surveillance in the United States but also performs the lion's share of international disease monitoring (Schoub 17).

259 **CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet).

recommendations for or against the use of PEP for sexual exposure.²⁶⁰ The Report suggested that the possible risks and benefits of each individual case should be carefully weighed before a decision is taken. It advised that benefits from antiretroviral treatment would most likely be restricted to situations in which the risk of infection is high, where the intervention can be initiated promptly, and where adherence to the regimen is likely. In such instances the physician and patient should weigh the low per-act probability of HIV transmission associated with the reported exposure (especially taking into account the probability of transmission from a single sexual exposure)²⁶¹ against the uncertain effectiveness, potential toxicities and cost of drugs, as well as the patient's anticipated adherence to the therapy.²⁶² It was firmly stated that PEP should never be administered routinely or solely at the request of a patient - it is a complicated medical therapy, not a form of primary HIV prevention.²⁶³

- 3.41 In some countries, on the basis that PEP provides a significant decrease in risk for occupational infection with HIV, health care providers have nevertheless started providing prophylaxis to the victims of sexual assault where there has been an established risk of HIV transmission. It is for instance apparently "generally accepted as advisable" by health care centres to offer PEP in cases of sexual assault throughout the United States and Canada.²⁶⁴ In these instances the treatment regimen is usually modelled on that used for occupational exposures which basically consists of a two-drug regime with the addition of a protease inhibitor if the source patient has advanced HIV disease or is known to have a high HIV viral load.²⁶⁵

260 Ibid. Relying on the CDC Report, President Thabo Mbeki (in an exchange with Mr Tony Leon, Leader of the Opposition, between June and September 2000) challenged the efficacy of AZT in preventing HIV infection in cases of rape. Mr Leon expressed himself in favour of the government supplying rape victims with AZT on the basis that administration of the drug will increase victims' chances of not becoming infected (**Announcements, Tablings and Committee Reports, Parliament of the Republic of South Africa** 4 October 2000 816, 819).

261 See par 3.47 et seq for information on the risk of becoming infected with HIV through sexual exposure.

262 **CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet).

263 Ibid.

264 The Rape Crisis Centre at the British Columbia Women's Hospital in Vancouver is believed to be the first to establish such an official post exposure protocol (consisting of handing out a five-day prophylaxis starter pack) at the end of 1996 (Dahir **The Body: POZ Gazette** [Internet]). St Vincent's Hospital AIDS Center in New York City has been offering PEP for survivors of sexual assault since June 1997 (Dahir **The Body: POZ Gazette** [Internet]).

265 Although some experts routinely prescribe triple drug therapy for PEP after sexual exposure, others do not favour this as a routine approach because use of a third drug increases the risk for side effects, complicates the regimen (which may decrease adherence), and increases the cost of treatment. Some

- 3.42 As regards the cost-effectiveness of PEP after sexual exposure, the CDC in its 1998 Report (referred to in paragraph 3.40 above), stated that uncertainties about key factors make it difficult to estimate the cost-effectiveness of treating nonoccupational HIV exposure with antiretroviral drugs. According to the CDC recent studies demonstrated that these drugs could be cost-effective for persons who engage in activities with high per-act infectivity (eg receptive anal intercourse) with persons known or likely to be HIV positive.²⁶⁶ However, the drugs might not be cost-effective for treating exposures with low per-act infectivity or involving partners at low risk of HIV infection.²⁶⁷
- 3.43 South Africa has no official guidelines on PEP after (consensual or nonconsensual) sexual exposure; and victims of sexual crimes are not supplied with PEP at government cost.²⁶⁸

Medico-legal factors of special relevance to the present enquiry

experts are also of the opinion that a third drug would be unnecessary since the viral inoculum immediately after sexual exposure is very small and a single drug may therefore be effective. However, patients who have had multiple exposures and do not seek care until close to the 72 hour cut-off will probably have higher viral loads(Katz and Gerberding 1998 **Annals of Internal Medicine** [Internet]).

- 266 **CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet). See par 3.47 below for information on the risk of becoming infected with HIV through sexual exposure.
- 267 Ibid. See also Katz and Gerberding 1998 **Annals of Internal Medicine** (Internet) stating that post exposure treatment has been shown to be cost effective.
- 268 Our research however revealed a single instance where AZT is administered to rape victims free of charge by a state hospital (Groote Schuur, Cape Town) as part of a pilot project aimed at research on prophylaxis after rape. The project is funded from the hospital's pharmaceutical budget(**Beeld** 21 May 1999; **Mail and Guardian** 21-27 May 1999). Tshwaranang in their comment on **SALC Discussion Paper 84** stated that in terms of the pilot project the following services are included in the support offered to victims of sexual offences at Groote Schuur:
- * Informing victims of the risk of HIV infection and offering them an HIV test.
 - * Having victims assessed individually by a gynaecologist with a view to discussing the possibility of administering PEP with a resident hospital HIV expert, who authorizes the provision of AZT.
 - * Providing AZT to women who have been raped, provided they present for treatment within 48-72 hours of being raped.
 - * Providing AZT for a period of one month after the alleged incident. In cases where a woman cannot afford PEP, the hospital carry the costs of PEP.
 - * Making AZT available 24 hours a day to ensure that the treatment starts immediately.
 - * Routinely treating victims for other STDs (eg syphilis, chlamydia, and gonorrhoea).
 - * Routinely giving the "morning after" pill to prevent the possibility of pregnancy.
 - * Follow-up treatment in the outpatient division and monitoring the side effects of PEP.

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

Factors relating to the nature of HIV/AIDS

The invisibility of the disease

- 3.45 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.²⁶⁹ 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.²⁷⁰ Considering that such persons may not have actual knowledge of or suspect their infection, there may not be any reason for them to adapt their sexual behaviour. However, they could pose a serious potential harm to the community.

Becoming infected with HIV has grave consequences

- 3.46 Becoming infected with HIV has grave consequences. It has an impact (although on an increasingly limited scale due to legal developments²⁷¹) on different aspects of a person's life including the ability to obtain life insurance,²⁷² and to relate with family,

269 See par 3.4-3.5 above.

270 Ibid. See also Evian 7.

271 See the Employment Equity Act 55 of 1998; the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000; and the Medical Schemes Act 131 of 1998 as referred to in par 1.14 and the accompanying footnotes above. See also the recent decision of the Constitutional Court in **Hoffmann v South African Airways** 2000 (11) BCLR 1211 (CC).

272 As indicated in par 1.14 above, the insurance industry has more recently attempted to create alternative financial products for persons with HIV in the form of limited insurance and savings products.

friends and sexual partners.²⁷³ 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.²⁷⁴ In addition to this, the social ramifications of having HIV may be devastating as AIDS carries with it social stigmatisation and can lead to intense discrimination.²⁷⁵ Discoveries regarding new combination drug treatments may provide the means of extending the symptom-free second phase and substantially postponing death for persons with HIV.²⁷⁶ These therapies are however extremely expensive and may simply not be available to persons who have been exposed to HIV in developing countries where over 90% of new HIV infections are occurring.²⁷⁷ Moreover, the long-term effectiveness and safety of these drugs are still unproven.²⁷⁸ 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.²⁷⁹ The most pessimistic view is that without a cure persons who have contracted HIV through the deliberate or negligent actions of persons with HIV will eventually develop AIDS and die prematurely.

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- 273 Cf the leading German case on deliberate HIV infection (**BGH v O** 4.11.1988 - StR 262/88) referred to in **SALC Discussion Paper 80** fn 353 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.
- 274 **Venter v Nel** 1997 4 SA 1014 (D); Robling 1995 **Cleveland State Law Review** 678-681; Leary and Schreindorfer in **HIV & Social Interaction** 12-25.
- 275 This is so because sexual intercourse - for many still a taboo subject - is the major form of HIV transmission; and because HIV infection is traditionally associated with marginalised groups (in North America and Western Europe the disease initially manifested amongst gay men against whom social stigma already operated (Cameron [Unpublished] par 15 and 17; Gostin and Lazzarinni 51-52; Leary and Schreindorfer in **HIV & Social Interaction** 12 et seq).
- 276 See par 3.21 et seq.
- 277 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. It is indicated above that a basic retroviral course of a minimum of two drugs, and possibly three, may cost between R1 500,00 and R4 000,00 (par 3.24).
- 278 See par 3.24.
- 279 Sowadsky "A Few Questions From a Student" **The Body** (Internet).

Factors relating to the transmission of HIV

Possible transmission of HIV through sexual exposure (including rape and other sexual offences)

- 3.47 HIV may be transmitted through sexual exposure²⁸⁰ (including rape²⁸¹ or other sexual offences²⁸²),²⁸³ The probability of HIV infection from a single unprotected sexual exposure to HIV through a mucosal surface (vagina, rectum, or mouth) may be theoretically similar to that from a single occupational percutaneous exposure (i.e. skin perforating needle-stick injury, injection, piercing or cut with a sharp object²⁸⁴).²⁸⁵ However, the theoretical and actual risk in the case of sexual exposure would differ since it is apparent that assessing *actual* risk and exposure outside of a health care setting is extremely difficult.²⁸⁶ This is so because the probability of HIV transmission is a function of three factors: the frequency of exposure (while repeated exposures are infrequent in the occupational setting, they are common with sexual contact); the probability that the source person is HIV positive (in the occupational setting, the HIV status of the source

- 280 A *sexual exposure* that can place a person at risk for HIV infection has been defined by the CDC as "a discrete penetrative sex act (eg acts involving the insertion of the penis into the vagina, anus, or mouth) involving vaginal, anal, penile, or oral contact with the sex partner's potentially infectious body fluids, including substances that have been implicated in the transmission of HIV infection (i.e. blood, semen, vaginal secretions, or other body fluids when contaminated with visible blood) (**CDC Morbidity and Mortality Weekly Reports** 25 September 1998 [Internet]).
- 281 Rape consists of unlawful intentional sexual intercourse with a woman without her consent (Milton 439). See also **SALC Discussion Paper 80** par 5.29-5.29.1.
- 282 This may currently include statutory rape, indecent assault and incest. It should be noted that the Commission is also engaged in an investigation into sexual offences which, inter alia, aims to codify the current range of sexual offences. At the time of compilation of this Report the new legislation - which will include a definition of "sexual offence" - has not been finalised. See also par 2.24 of **SALC Fourth Interim Report on Aspects of the Law relating to AIDS**.
- 283 Van Dyk 87; Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; **AMA Sexual Assault Guideline Resources** (Internet).
- 284 **CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet).
- 285 **CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet); Denenberg **The Body: GMHC Treatment Issues** (Internet); Lurie et al 1998 **JAMA** (Internet); Katz and Gerberding 1998 **Annals of Internal Medicine** 306-312; **PEP: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS** July 2000 20. Experts estimate that on average the theoretical risk of HIV transmission from a single incident of occupational percutaneous exposure is small: They estimate that it could be .4% (4 in 1 000) on average (**CDC Morbidity and Mortality Weekly Reports** 25 September 1998 [Internet]).
- 286 Schoub 121; Lurie et al 1998 **JAMA** (Internet); cf also Van Dyk 87.

person is often known or can be determined - in contrast, the source person may not be available or his or her HIV status may be unclear in the case of sexual exposures); and the probability of transmission if the source person is infected (the risks of occupational HIV transmission have been fairly well delineated while the risk after nonoccupational exposures is less clear).²⁸⁷

3.47.1 From the above it is clear that it is especially difficult to quantify the risk of infection with HIV during a single sexual exposure or a single act of indecent assault or rape. The risk of HIV transmission is highly variable - with some individuals infected after the first encounter, while others remain uninfected after several unprotected sexual contacts.²⁸⁸ Moreover, the statistical risk would vary from situation to situation and from sex act to sex act depending on the following factors:

! **The type of sexual 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.²⁸⁹ 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.²⁹⁰ A woman's risk of becoming infected is further increased if she is menstruating or bleeding, and by her own physiology (eg the presence of any pre-existing disease of the female reproductive

287 Ibid.

288 Schoub 121; Van Dyk 87.

289 Sowadsky "Risk of Transmission Statistics" **The Body** (Internet); see also Evian 14; Schoub 96-97. 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 penile-anal intercourse. The risk with receptive vaginal intercourse is estimated to be lower (**CDC Morbidity and Mortality Weekly Reports** 25 September 1998 [Internet]); cf also Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; Lurie et al 1998 **JAMA** [Internet]). 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 carries a greater risk of infection than vaginal rape.

290 Schoub 100; Evian 193-194; Van Dyk 37-38; Kirby 1994 **AIDS Care** 248 adds that this demonstrates that AIDS is another issue in the contemporary struggle concerning women's rights. 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).

organs).²⁹¹

- ! ***The duration of the act.*** During prolonged sexual intercourse a sexual partner (or victim) may be exposed to more of the body fluids of the partner (or assailant) with HIV - which may result in increasing the average risk of transmission.²⁹²
- ! ***Whether intercourse was accompanied by physical violence.*** Physical violence (such as accompanies rape and indecent assault) frequently results in cuts and abrasions. These create risk of exposure to the assailant's blood, and provide entry points in the victim's body for the assailant's body fluids.²⁹³
- ! ***The presence or absence of other sexually transmissible diseases in either party.*** The presence of conditions associated with sexually transmissible diseases (eg genital ulcers, sores or inflammatory responses in the genital tract) in either sexual partner provide opportunities for HIV to enter the body.²⁹⁴
- ! ***The kind of body fluid, and how much of it a sex partner (or victim) was exposed to.*** Semen carries a greater concentration of HIV than vaginal fluid, while blood carries a greater concentration of HIV than semen.²⁹⁵ Studies show that exposure involving larger volumes of blood exceeds the average risk of HIV transmission.²⁹⁶ Larger amounts of body

291 Evian 193-194; Van Dyk 37-38.

292 Ibid.

293 **Women and AIDS 3**; Van Dyk 87.

294 Numerous studies on risk factors for HIV transmission have found an association with a history of other sexually transmissible disease - some of which indicated that the presence of an untreated sexually transmissible disease could multiply the risk of HIV transmission by up to 10-fold (**Women and AIDS 3**; Evian 14; Rees [Unpublished] 4; Lurie et al 1998 **JAMA** [Internet]). It is said that 50%-80% of sexually transmissible disease 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**).

295 **Women and AIDS 3**.

296 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, while an estimated 95% of recipients become infected with HIV from transfusion of a single unit of infected whole blood (**CDC Morbidity and Mortality Weekly Reports 15 May 1998** [Internet]; **CDC Morbidity and Mortality Weekly Reports 25 September 1998** [Internet]). See also Sowadsky "Risk of Transmission Statistics" **The Body** (Internet); Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; Lurie et al 1998 **JAMA** (Internet).

fluid transferred during a gang rape would thus increase the risk of HIV transmission.

- ! ***The serological and clinical status of the sexual partner with HIV (or the assailant in the case of rape or a sexual offence).*** Factors that may affect the infectiousness of the partner with HIV include the clinical stage of HIV infection, with recently infected individuals and those at late stages (with associated high viral loads) being the most infectious.²⁹⁷ Another variable is the virulence of the viral strain in the partner with HIV.²⁹⁸
- ! ***The prevalence of HIV infection in the sexually active population.*** The higher the prevalence of HIV infection in the sexually active population, the greater the chances would be for a person to become infected with HIV through consensual or nonconsensual sexual exposure.
- ! ***Whether the person exposed to HIV was a child.*** The risk of becoming infected through sexual exposure (including rape or sexual assault) is greater with children for anatomical and physical reasons including the greater risk of trauma.²⁹⁹ It is however not certain how much greater the risk is. Because of the increased risk, early intervention with PEP is even more important than in the case of adults.³⁰⁰

3.48 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 nonconsensual, violent or abusive, there may also be an increased risk of transmission due to abrasions which facilitate entry of the virus, and the inability of the victim to control the assailant's behaviour in any way.³⁰¹ Gang rape and instances where a woman is repeatedly raped by one assailant pose a statistically higher risk of

297 Evian 17; Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq.

298 Ibid. There are different strains and subtypes of HIV - some more virulent than others, which may make them more infectious (**Report on Genetic Diversity Conference**, New York June 1999 [Internet]).

299 Comment by Dr Neil McKerrow attending a consultative meeting hosted by the Project Committee on 4 February 2000 (see **SALC Fourth Interim Report on Aspects of the Law relating to AIDS** par 3.16.1).

300 Ibid.

301 Cf the increased risk factors outlined in par 3.47.1 above. See also Lurie et al 1998 **JAMA** (Internet); Van Dyk 87.

infection.³⁰² The risk of infection through sexual intercourse can indeed be diminished (albeit not completely excluded) by condom use - however it is unlikely that a condom would be utilised during a nonconsensual sexual act such as rape or indecent assault.³⁰³

Possible transmission of HIV through behaviour other than sexual intercourse

3.49 Although this paper primarily focusses on the sexual transmission of HIV, it does recognise that HIV may be transmitted in rare circumstances through other risk behaviour such as biting and spitting (if blood is present in sputum), fighting, drug abuse and injecting HIV-infected blood.

3.50 In addressing the issue whether HIV may be transmitted through the behaviour referred to, experts emphasise the following:

- ! The receptive party must have been exposed to semen, vaginal secretions, blood, or breast milk of a person with HIV; *and*
- ! the virus must get directly into the bloodstream of the receptive party (which, apart from intercourse could be through some fresh cut, open sore, abrasion, or mucous membranes in the victim's eyes, nose or mouth); *and*
- ! transmission of blood or body fluids from the person with HIV to the receptive party must take place soon after leaving such person's body since HIV does not survive well outside the specific environment of the human body. As indicated above, once the virus is outside the body it is in an environment in which it cannot survive unless it gets into another person's body within minutes.³⁰⁴

If all three these factors are present, the receptive party could be at risk of contracting HIV.³⁰⁵

302 Rees (Unpublished) 4; Martin (Unpublished); Lurie et al 1998 **JAMA** (Internet). According to press reports 75% of all rape cases dealt with by the rape trauma unit at the Groote Schuur Hospital, Cape Town are gang rapes (**Mail and Guardian** 21-27 May 1999).

303 Lachman 133-134. See also par 3.30-3.31 and 3.56.

304 See par 3.13 above.

305 Sowadsky "Risk from Fighting?" (Internet); Schoub 120-122. See also par 3.10-3.15 above.

- 3.51 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.³⁰⁶ There has never been a case of HIV transmission through biting where only saliva (untinged by blood), was involved.³⁰⁷
- 3.52 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 blood in the saliva of the person with HIV and the blood had direct access to the other person's bloodstream or mucous membranes (eg eyes).³⁰⁸
- 3.53 In *physical fighting*, the victim would be at risk only if the assailant was infected with HIV, the victim was directly exposed to the assailant's blood during the fight, and the blood got directly into the victim's bloodstream within minutes of leaving the assailant's body.³⁰⁹ The possibility of direct access to the bloodstream will for instance exist if the blood of an assailant with HIV got directly into a fresh open cut sustained during the fight, or into the eyes, nose or mouth of the victim.³¹⁰
- 3.54 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).³¹¹ Persons who inject drugs and share drug injection equipment are at high risk of acquiring HIV

306 **CDC Morbidity and Mortality Weekly Reports** 11 July 1997 620-623; **CDC Frequently Asked Questions** May 2000 (Internet); Schoub 120-125.

307 Ibid. See also Sowadsky "Kissing and Infection with HIV" **The Body** (Internet).

308 **CDC Morbidity and Mortality Weekly Reports** 11 July 1997 620-623; **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); **CDC Frequently Asked Questions** May 2000 (Internet); Sawyer **The Body: Lambda Legal Defense and Education Fund** (Internet); Schoub 120-125. 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]).

309 Sowadsky "Risk from Fighting?" **The Body** (Internet). See also Schoub 121-122.

310 Ibid.

311 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** [Internet]). See also Van Dyk 59; Schoub 112-113.

because HIV is transmitted very efficiently through such sharing.³¹²

3.55 Rare incidents of persons intentionally *injecting HIV-infected blood* have been reported.³¹³ In the United States a medical technician was in 1998 convicted and jailed for life for injecting his son with blood infected with HIV, while a medical doctor was in 1999 convicted of attempted murder and sentenced to 50 years' imprisonment for injecting his former mistress with HIV-infected blood.³¹⁴ In South Africa there were reports in November 1998 of the SAPS investigating two alleged incidents in Welkom, Free State of women having been stabbed in the back with injecting needles, presumably with the intention to infect them with HIV. Both women tested negative for HIV soon after the alleged incidents but further tests would have been necessary to establish whether they were in fact infected with HIV.³¹⁵ There have been reports of twenty primary school learners in Chatsworth, Durban allegedly being injected with HIV by three fellow learners during May 1999. The victims were treated with AZT although it was not established whether they had been injected with HIV. As regards transmission risk in this regard medical experts emphasise the same factors as mentioned in paragraph 3.50 above: In order to spread HIV to others through needles, the blood of a person with HIV would have to be directly injected into another person's bloodstream soon after withdrawal of the blood;³¹⁶ HIV in body fluids does not live long outside the body and the longer the body fluids are outside the body, the less the chance for transmission to occur,³¹⁷ the greater the volume of blood that the victim of this crime is exposed to, the greater the chance for transmission to occur,³¹⁸ however, once the blood is dry, the virus is dead, and transmission will not occur.³¹⁹

312 **CDC Drug Use and HIV/AIDS** (Internet). It has been pointed out that HIV transmission may also occur among people (and their partners) who trade sex for noninjected drugs as trading sex for drugs is often associated with unprotected sex and having multiple sexual partners. Further, the use of noninjected 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). See also Schoub 112-113.

313 Sowadsky "Spreading HIV Intentionally" **The Body** (Internet).

314 **Pretoria News** 29 May 1998; **The Citizen** 19 February 1999.

315 **Rapport** 15 November 1998.

316 See also Sowadsky "Spreading HIV Intentionally" **The Body** (Internet) and par 3.13 above.

317 See par 3.13 and 3.50 above.

318 Cf par 3.47.1 above where this issue is discussed with regard to sexual exposure to HIV.

319 See par 3.13 and fn 125 above.

Factors relating to prevention and treatment of HIV transmission

Effectiveness of condoms in reducing the risk of HIV transmission

- 3.56 It is indicated in par 3.30-3.31 above that latex male condoms are highly effective in preventing (but not totally excluding the risk of) HIV transmission when used correctly and consistently. It is however unlikely that condoms will be used in the case of a nonconsensual sexual act such as rape or indecent assault.³²⁰

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

- 3.57 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.³²¹
- 3.57.1 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.³²² "Undetectable" does not mean that there are no viral particles in

320 Interestingly, in the United States it has been noted that increasing numbers of sexual assault and rape survivors report rapists complying when they were asked to wear condoms. This has been ascribed to assailants' fear of contracting HIV and not to protect victims. Apparently such requests by victims have often been used by an assailant as evidence of the victim's complicity with the sexual act (Hoskins 1998 **Body Positive** [Internet]).

321 Volberding **AIDS Care** February 1998 (Internet); **CDC Facts About Recent HIV/AIDS Treatment** July 1997 (Internet); Spadea and Puro 1999 **Epidemiol Prev** 77-83 (Internet); Halkitis and Wilton 1999 **Focus** 1-4 (Internet); Highleyman 1999 **Bulletin of Experimental Treatments for AIDS** (Internet). See also par 3.18.7-3.18.8 and 3.23 above for information on viral load testing and combination drug therapies for HIV infection respectively.

322 Volberding **AIDS Care February** 1998 (Internet); **CDC Facts About Recent HIV/AIDS Treatment** July 1997 (Internet); Highleyman 1999 **Bulletin of Experimental Treatments for AIDS** (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**

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.³²³ Even with a very low viral load, transmission can still occur, although its likelihood is reduced.³²⁴ Viral load can thus affect the *risk* of HIV infection - the higher the viral load, the greater the risk of transmission.³²⁵ Currently however, no "threshold" exists which indicates the lowest viral load likely to transmit HIV.³²⁶ 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.³²⁷ 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.³²⁸

Body (Internet).

- 323 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 206 above on what is regarded as high and low viral load.
- 324 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).
- 325 Ibid. Cf also Dine and Watt **Web Journal of Current Legal Issues** 9.
- 326 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).
- 327 Volberding **AIDS Care** February 1998 (Internet); **TAGline** August/September 1996; **CDC Facts About Recent HIV/AIDS Treatment** July 1997 (Internet).
- 328 Volberding **AIDS Care** February 1998 (Internet); **TAGline** August/September 1996.

4 Defining the problem

Interpretation of the Commission's mandate

- 4.1 The Commission's mandate from the Parliamentary Justice Portfolio Committee via the Department of Justice was to investigate the "*criminalising* of acts by persons with the acquired immunodeficiency syndrome or the human immunodeficiency virus who deliberately or negligently infect others with the said virus" in the context of creating stricter measures in respect of serious sexual offences and violence against women.³²⁹
- 4.2 In this Report the term "***harmful HIV-related behaviour***" (i.e. unacceptable behaviour by persons with HIV) is used as a wide term to refer to any *sexual* activity which could transmit HIV or expose another to HIV.³³⁰ (The reasons for limiting the current investigation to *sexual* activity are set out in par 4.12 below.) Scenarios of such activity or behaviour would include a range of possible factual situations from where a person, unaware of his or her HIV status, exposes another to or transmits HIV without taking precautions (although the reasonable person in the circumstances would have foreseen the possibility and would have gone for HIV testing); to where a person who knows about his or her HIV positive status deliberately withholds this information and has unprotected sex with his or her partner. Harmful HIV-related behaviour could for instance include rape (i.e. *nonconsensual sexual intercourse*) by a person who knows or suspects that he or she has HIV. It could also include *consensual sexual intercourse* by a person with HIV who deliberately withholds information from his or her partner with a desire to infect that partner; or who deceives that partner into the belief, or exploits a mistaken belief, that he or she does not have HIV.³³¹ (The reasons for limiting the current investigation to transmission of or exposure to HIV through *consensual* sexual activity are set out in

329 Par 2.14-2.16 above.

330 See also par 7.3 et seq below for a discussion of "harm" in the criminal context.

331 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).

par 4.13 below.)

- 4.3 The term "**criminalisation**" refers to the decision to proscribe conduct as a crime.³³² Since certain of the harmful activities 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),³³³ the creation of a statutory offence in these instances 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.³³⁴
- 4.4 The Project Committee has thus interpreted its mandate as a task to consider the creation of a *new*, additional statutory offence/s explicitly criminalising conduct not hitherto criminal.³³⁵ As indicated below, the possibility of codifying the existing common

332 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 Burchell and Milton 33).

333 See par 6.11 et seq below.

334 Cf fn 332 above. See also par 7.18.2 below regarding no fault or strict liability.

335 This was confirmed in discussions with the Commission's Sexual Offences Project Committee ("Response to Submission of Possible Overlap Between Project 107 [Sexual Offences] and Project 85 [Aspects of the Law relating to AIDS]" 31 May 1999; and in a submission to the Law Commission

law crimes (i.e. transforming the existing common law crimes into HIV-specific statutory offences to restate them) was also raised by the Project Committee in its Discussion Paper 80,³³⁶ it was submitted for discussion at a consultative meeting with experts hosted by the Project Committee, and some experts suggested that it could be a solution to the issue under discussion.³³⁷ This possibility would also amount to legislative intervention, although not criminalisation as such, and will be referred to throughout where relevant.

The role of coercive legal measures in reducing the spread of HIV/AIDS

- 4.5 Criminal law measures aimed at restraining recalcitrant individuals are, by their very nature, *coercive legal measures*. It has been suggested that utilising criminal law 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.³³⁸
- 4.6 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

("Overlap Between the Investigations into The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour/HIV Testing of Persons Arrested in Sexual Offence Cases and the Investigation into Sexual Offences" [Commission Paper 575 22 October 1999]).

336 **SALC Discussion Paper 80** par 7.5 and item (D) of par 7.7.

337 See Chapter 9 below for the issues submitted for comment in Discussion Paper 80; par 11.3 below for the issues submitted for discussion with experts at the consultative meeting; and par 11.13 et seq for Prof Christa Van Wyk's presentation.

338 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 Urban Law Journal** 505-506; see also par 7.30 et seq below for more detail on the counter-productive effect of criminal law on public health initiatives.

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.³³⁹

- 4.7 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.³⁴⁰ In invoking the coercive force of the law, indirect and direct coercive measures were called upon. *Indirect measures* involved oblique efforts to 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, extramarital 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 isolation or quarantining³⁴¹ 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).³⁴²
- 4.8 There are however facets of the AIDS epidemic which sharply distinguish it from other diseases:³⁴³
- ! HIV cannot be transmitted through casual contact. It is an epidemic where

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

340 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; Elliot (Unpublished) 1.

341 *Isolation* was traditionally a measure applied to isolate ill persons in order to treat them, and to prevent them from spreading disease (Van Wyk 444-445; cf also Jarvis et al 285-289). *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 (Van Wyk 444-445; cf also Jarvis et al 285-289).

342 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).

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

the major mode of transmission is human sexual behaviour (possibly the most private of human activities).

- ! HIV infection cannot at present be treated so as to reduce or eliminate the infectivity of an individual.
- ! 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.

These features of the disease challenged the traditional approach to disease control involving coercive legal measures: It was 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,³⁴⁴ and that since HIV infection was mostly spread through voluntary activities, both infected and uninfected individuals were themselves in the best position to slow the spread of the disease.³⁴⁵ It was further argued that where confidentiality, informed consent and nondiscrimination 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.³⁴⁶ This led to acceptance of the view that coercive measures not only infringe upon people's

344 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 issued in Illinois decreased by 22,5%. But during this time the number of licences issued to Illinois residents in surrounding states increased significantly. Evaluation suggests that applicants for marriage licences with a history of previous or present risk behaviour may have left the state 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 Immunodeficiency 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).

345 Berge 1992 **Florida Law Review** 805; **Australia Final Report on AIDS** 31.

346 Ibid. This approach was also endorsed by the Supreme Court of Appeals in **Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A) at 854B-D.

civil rights, but do nothing to advance understanding of the HIV epidemic or to slow its spread.³⁴⁷ Measures taken to deal with the HIV/AIDS epidemic have also 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.³⁴⁸

- 4.9 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 noncoercive approach to public health - a phenomenon that has on occasion been called "AIDS exceptionalism".³⁴⁹ As a result, public health officials committed themselves to encouraging programmes of voluntary behavioural change, protection of confidentiality, and HIV testing only with informed consent. This strategy excluded contact tracing, isolation and quarantine, even when the behaviour of an infected individual was believed to pose a threat to others, and stressed education rather than coercion.³⁵⁰ The new approach has also been confirmed through more 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 noncoercive, voluntary principles in which persons with HIV participate fully.³⁵¹ Moreover, it has been repeatedly confirmed by the World Health Organisation and the United Nations that no public health rationale justifies discriminatory and coercive measures based solely on HIV infection.³⁵²

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

348 Ibid.

349 Bayer 1994 **Hospital Practice** 155. "AIDS exceptionalism" refers to the phenomenon of singling out HIV/AIDS for special treatment as opposed to other infectious diseases (Bayer in **Encyclopaedia of AIDS** [Internet]).

350 Ibid.

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

352 Gostin and Lazzarini 102-104; Elliot 55 and the sources quoted by the author. See especially the **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** Guideline 3, and Annex I (supplying a history of the recognition of the importance of human rights in the context of HIV/AIDS).

- 4.10 As shown in Chapter 8 below, some governments have lately initiated legislative changes to return to the more traditional public health approach to curb the epidemic. These changes and attempted changes included coercive measures such as criminal law sanctions as part of public health interventions.³⁵³ Attempts to return to the more traditional approach have, however, not been without controversy.³⁵⁴

Different options for addressing harmful behaviour?

- 4.11 Before exploring the possibility of creating a statutory offence/s to deal with harmful HIV-related behaviour, 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.

4.11.1 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 1987³⁵⁵ issued by the Minister of Health (and proposed Draft Regulations of 1993 to replace these³⁵⁶) contain measures which may be suitable in this regard. Whether these measures are adequate to deal with the issue in question, is examined in Chapter 5.³⁵⁷

4.11.2 In delict, a person could be held liable for causing damage to another person.³⁵⁸ A person with HIV could thus also be held **civilly** liable as a result of exposing others to or infecting them with HIV. This possibility is briefly

353 See par 8.10 below where the United States' HIV Prevention Bill (1997) is discussed.

354 Cf par 8.8.2 below.

355 Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987.

356 Government Notice 703 in **Government Gazette** 15011 of 30 July 1993.

357 See also Chapter 7 below where the availability of alternatives are raised as an argument in the debate for and against legislative intervention (par 7.36 et seq).

358 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).

discussed in Chapter 7.³⁵⁹

4.11.3 The legislature has until recently not had to deal with HIV/AIDS issues in the field of the criminal law.³⁶⁰ There is no specific statutory provision for the

359 See par 7.38.

360 Parliament 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.

Amendments to the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act) by the *Criminal Procedure Second Amendment Act 85 of 1997* (the Criminal Procedure Second Amendment Act) provide for stricter bail measures to be taken inter alia 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 can satisfy the court "that exceptional circumstances exist which in the interests of justice permit his ... 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 (see secs 50(6)(c), 58 and 60(11)(a) of the Criminal Procedure Act as introduced by secs 1(b), 2, 4(f) and 10 of the Criminal Procedure Second Amendment Act).

The *Criminal Law Amendment Act 105 of 1997* 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* knowing that he has AIDS or HIV, a High Court is obliged to impose a minimum sentence of life imprisonment (sec 51(1) and Part 1 of Schedule 2). Provision is made for imposition of a lesser sentence if the court is satisfied that "substantial and compelling circumstances exist" justifying such lesser sentence. In such instance the presiding officer must enter those circumstances on the record of the proceedings (sec 51(3)). The operation of the sentence imposed may not be suspended (sec 51(5)). These provisions shall cease to have effect after the expiry of a two year period from its commencement (the Act commenced on 1 May 1998). However the President, with the concurrence of Parliament, may extend this period for one year at a time (sec 53(1) and (2)). The period of operation has since been extended until 1 May 2001 (Proclamation R 23 in **Government Gazette** 21122 of 28 April 2000).

Cf also the similar provisions in the Zimbabwe *Sexual Offences Bill 2000* and the Botswana *Penal Code (Amendment) Act 1998*. According to the Zimbabwe Bill a maximum sentence of 20 years' imprisonment may be imposed after conviction of rape as well as certain other sexual offences irrespective of whether the convicted person was aware of his HIV infection at the time of the offence (clause 15). (At the time of compilation of this Report the Zimbabwe draft legislation has not yet been approved by the Zimbabwe government - see also par 8.24 et seq below. The Botswana legislation contains a similar provision providing for a minimum sentence of 15 years' imprisonment and a maximum of life imprisonment with corporal punishment where it is proved that a person convicted of rape was *unaware* of being infected with HIV. If it is proved that on a balance of probabilities the perpetrator was *aware* of his or her infection, the prescribed minimum sentence rises to 20 years (section 3 of the Act).

Cf also the very recent recommendations of the SALC relating to a new sentencing framework. It is recommended that comprehensive new legislation replace the current common law and statutory position regarding sentencing. Although the recommended effect of this is that the provisions relating to compulsory minimum sentences in the *Criminal Law Amendment Act* will be repealed, life imprisonment will be retained as a sentencing option through the following proposed legislative provision: "Imprisonment for life is the most severe sentence and may be imposed only where the offence is extremely serious" (**SALC Report on Sentencing** xxii and clause 14 of the proposed draft Sentencing Framework Bill).

(It was indicated in the Commission's Fourth Interim Report on Aspects of the Law relating to AIDS - dealing with compulsory HIV testing of persons arrested in sexual offence cases - that in implementing

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 been few prosecutions for the deliberate or negligent transmission of HIV to date and none has been successful.³⁶¹ 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; whether they satisfy the objects of the criminal law as discussed in Chapter 7 below;³⁶² and in any event whether the common law should or would be strengthened by the creation of an HIV-specific offence/s (be they additional offences criminalising conduct not hitherto criminal or offences restating the common law).³⁶³ The applicable common law crimes are discussed in Chapter 6 below and the need for legislative intervention is debated in Chapter 7. Chapters 10 and 11 contain public comments on the Commission's preliminary recommendations and the views of experts as enunciated and debated at a subsequent consultative meeting. In Chapter 12 the Commission sets out its conclusion.

Parameters of the current enquiry

- 4.12 In accordance with the context of the request by the Parliamentary Justice Portfolio Committee, this Report 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. (It is nevertheless recognised that other forms of criminal

the current provisions of the *Criminal Law Amendment Act* relating to compulsory minimum sentences, a procedure taking recourse to the provisions of section 37 of the Criminal Procedure Act would have to be resorted to in order to establish the convicted person's HIV status [see par 7.14 of the Fourth Interim Report].)

361 See par 2.6.2 above and par 11. 31 et seq below for more detail.

362 See the discussion in par 7.15 below which indicates that criminal punishment is justified either because it is deserved (i.e. punishment is justified in the context of retribution); or because it is socially beneficial (in the sense that it will be preventive or deterrent).

363 See par 4.4 above.

behaviour such as biting, spitting and fighting where blood is involved may result in the transmission of HIV in rare circumstances. The latter instances are briefly referred to in par 3.49 et seq above.)

- 4.13 Recommendations in this Report are further confined to the need for statutory intervention with regard to HIV transmission or exposure caused by **consensual** sexual acts. The Commission is currently investigating the need for codification of the law pertaining to sexual offences (Project 107). Transmission of or exposure to HIV can also occur during commission of a sexual offence (i.e. during acts of nonconsensual sex such as rape). Subsequent to the publication of Discussion Paper 80 it has been agreed that the need for additional offences in the instance of HIV transmission or exposure during nonconsensual sexual acts will be addressed by the Sexual Offences Project Committee under the above-mentioned investigation.³⁶⁴
- 4.14 The current Report does not address the question of applying the criminal law to other modes of exposure to 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.³⁶⁵ Needle-sharing by intravenous drug users is a mode of potential HIV transmission which has received scant attention in South Africa³⁶⁶ and which has likewise never been targeted for

364 Minutes of HIV/AIDS Project Committee Meeting 18 October 1999 (Committee Paper 828 of 6 December 1999) ; "Overlap Between the Investigations into The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour/HIV Testing of Persons Arrested in Sexual Offence Cases and the Investigation into Sexual Offences" (Commission Paper 575 of 22 October 1999). Discussion Paper 85 (Sexual Offences: The Substantive Law) was published for public comment in August 1999. Pending the outcome of the current Report, no preliminary recommendations relating to the creation of HIV-related offences have been made in this Discussion Paper.

365 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 and a half, no legislation specifically criminalising perinatal transfer of the infection has been enacted - although it has been suggested that some states have passed statutes sufficiently ambiguous for such prosecutions to be possible (Cf Elliot 29-31).

366 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 intravenous drug use as a mode of HIV transmission.)

criminalisation.³⁶⁷ Furthermore, this Report does not separately address application of the criminal law to the donation of body fluids or organs infected with HIV.³⁶⁸ 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. The additional issues referred to above in any case fall outside of the Project Committee's mandate as outlined by the Parliamentary Justice Portfolio Committee.³⁶⁹

367 Drug abuse and drug trafficking are targeted by the Drugs and Drug Trafficking Act 140 of 1992. This Act does not deal with HIV/AIDS-related issues.

368 Criminal activities related to the donation of body fluids and organs are targeted by the Human Tissue Act 65 of 1983. This Act does not deal with HIV/AIDS-related issues.

369 See par 2.15 et seq above.

5 Dealing with harmful HIV-related behaviour through existing public health measures

- 5.1 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.
- 5.2 The government's current public health response to the epidemic, and the existence - if any - of public health measures which could be successfully invoked in respect of harmful HIV-related behaviour are discussed below.

The government's current public health response to the HIV/AIDS epidemic³⁷⁰

- 5.3 The government has a 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.³⁷¹ The National Programme is assisted by the Government AIDS

370 Information for this section was supplied by Project Committee member Ms Ann Strode (consultant to the Department of Health at the time of preparation of this Report).

371 The Programme's mission statement is "to reduce the transmission of sexually transmissible diseases (including HIV infection) and provide appropriate support for those infected and affected, through collaborative efforts within all levels of government, using the National AIDS Convention of South Africa (NACOSA) National AIDS Plan as the terms of reference. The Programme is committed to challenging prejudice and discrimination wherever it occurs" (cf Department of Health: Directorate HIV/AIDS/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 Reconstruction and Development Programme (RDP) presidential lead project. Furthermore, the existing HIV/AIDS budget has been supplemented with both additional departmental and donor funds.

Action Programme (GAAP)³⁷² and 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 AIDS Training, Information and Counselling Centres (ATICCs) located within local government AIDS programmes, and with numerous nongovernmental and community-based organisations.

5.4 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.³⁷³ 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.³⁷⁴ With regard to the 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."³⁷⁵

5.5 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.³⁷⁶

- ! 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.

372 GAAP is aimed at expanding the Department of Health's National AIDS Programme beyond the Department of Health to other government departments and all sectors of society.

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

374 Ibid 10. The following major principles are enshrined in the Plan:

- * People with HIV/AIDS shall be involved in all prevention, intervention and care strategies.
- * People with HIV/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.
- * The government has a crucial responsibility with regard to the provision of education, care and welfare to all people of South Africa.

375 Ibid 49.

376 **South African STD/HIV/AIDS Review: Comprehensive Report** July 1997.

- ! Strengthening collaboration between HIV and TB programmes.
- ! Involving persons living with HIV/AIDS meaningfully in all interventions and protecting their human rights.
- ! Countering discrimination and reducing stigmatisation associated with HIV/AIDS.

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. In addition, an Inter-Ministerial Committee on HIV/AIDS, chaired by the Deputy President, was established. This Committee's object was to ensure that the government's AIDS Programme receives political commitment at the highest level. One of its key achievements was the development of a national HIV/AIDS awareness campaign. The Inter-Ministerial Committee was disbanded during 2000 and replaced with the South African National AIDS Council which is also chaired by the Deputy President. The latter is a multi-sectoral body (including representatives from human rights organisations, nongovernmental organisations, organised sport, business and trade unions) that oversees the national response to the epidemic and the implementation of the strategic plan referred to in the following paragraph.³⁷⁷

- 5.6 In January 2000 the Department of Health issued its HIV/AIDS and STD National Strategic Plan for the years 2000-2005. The Plan is intended as a guide for the national response to the epidemic by government and other stakeholders in order that all initiatives can be harmonised for maximum efficiency.³⁷⁸ According to the Plan the Department of Health has adopted four priority intervention areas with regard to which it will direct its response to the epidemic. These include:³⁷⁹
- ! Prevention.
 - ! Treatment, care and support.
 - ! Research, monitoring and surveillance.
 - ! Human rights issues.

377 **HV/AIDS & STD Strategic HIV/AIDS Plan for South Africa 2000-2005 12-15.**

378 Ibid 5-6.

379 Ibid 19-25.

- 5.7 In summary the government's response to the AIDS epidemic is based upon public health principles which rely on voluntary participation and behaviour change.³⁸⁰ Coercive measures are not part of the National AIDS Programme's response to the epidemic. With the publication in April 1999 of draft regulations providing for the compulsory notification of AIDS,³⁸¹ it appeared that the government might be moving towards a more coercive approach and a national policy change.³⁸² However, at the time of compilation of this Report the proposed amendments have not been promulgated and according to media reports the Department abandoned its intention to make AIDS notifiable.³⁸³

Existing public health regulations

- 5.8 Traditional public health measures relevant to harmful HIV-related behaviour are those allowing for isolation or quarantining of persons with HIV or AIDS.³⁸⁴ The Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987³⁸⁵ 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 the following

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- 380 This has been confirmed by Dr N Simelela, Project Committee member (Dr Simelela is Director: HIV/AIDS/STDs in the Department of Health). Cf also the Department's goals and implementation programmes referred to in par 5.5-5.6 above.
- 381 Government Notice R 485 Regulation Gazette 6496 in **Government Gazette** 19946 of 23 April 1999. The proposed amendment is quoted in fn 404 below.
- 382 The Department of Health at the time indicated that the proposed step was necessitated by the severity of the AIDS epidemic in South Africa and that it would enable the government to more accurately plan resource allocation with regard to hospitalisation, and community or home care. The Department stressed that AIDS is a notifiable medical condition in many countries in Africa (eg Angola and Kenya) as well as in other parts of the world (eg Sweden, Israel, and certain states in Canada and Australia). According to a comprehensive nation-wide demographic and health survey done in 1998, 88% of those who responded agreed that AIDS should be reported to the health authorities. Moreover, the decision to declare AIDS disease and AIDS death notifiable was supported by Cabinet and by the Inter-Ministerial Committee on AIDS (which has since been replaced by the South African National AIDS Council) (Media release by the Department of Health 23 April 1999; see also **Beeld** 19 April 1999; **Pretoria News** 22 April 1999).
- 383 See fn 7 in Chapter 1 above.
- 384 As indicated in par 4.7 above, isolation and quarantining are methods that were traditionally used to combat the spread of communicable diseases. These measures are rarely used nowadays, 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; see fn 341 for definitions of "isolation" and "quarantine").
- 385 Government Notice 2438 in **Government Gazette** 11014 of 30 October 1987.

measures in this regard:

- ! A local authority may, if it is satisfied that the spread of a "communicable disease" (i e HIV or AIDS)³⁸⁶ constitutes or will constitute a real danger to health, place under **quarantine** "any person suffering or suspected to be suffering from such disease" (i e **a person with AIDS or suspected to have AIDS**)³⁸⁷ for a maximum period of 14 days in order to prevent the spread of the disease or in order to control or restrict the disease.³⁸⁸ The period of quarantine may be extended by the Director-General of Health to 28 days or by the Minister of Health for a longer period. (See regulations 2(1)(d) and 4(1) and (2)).
- ! A medical officer of health may, upon being satisfied on medical scientific grounds that the danger exists of "a carrier of a communicable disease" (i e **a person with HIV**)³⁸⁹ 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 period.³⁹⁰ (See regulations 14(1) and 14(3)(a).)

386 The Regulations are in general applicable to "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. Note however, that the Regulations in addition 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).

387 The Regulations refer to persons "suffering" from a communicable disease (eg reg 2) and persons who are "carriers" of a communicable disease (eg 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 submitted that in an HIV/AIDS context this means that "carrier" refers to a person with HIV, and "sufferer" to a person with AIDS.

388 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)).

389 See fn 386 and 387 above.

390 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 he or she indeed has HIV (reg 14(1)).

! Finally, provision is also made for compulsory medical examination, hospitalisation or *isolation*, or treatment of "any person who is or could be suffering from a communicable disease referred to in Annexure I to the Regulations" (i e *a person with AIDS or who could have AIDS*)³⁹¹ if so instructed by a medical officer of health, until he or she is "free of infection" or until he or she 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. (See regulation 17 read with Annexure I.)

It is clear that application of the above measures is subject to the communicable disease in question (i e HIV or AIDS) creating a danger to public health; or to the danger of a carrier or sufferer of such disease transmitting the disease to another. In addition, application of the above measures is not mandatory but in the discretion of local authorities and public health officials.

5.9 The 1987 Regulations have apparently never been applied to people living with HIV or AIDS³⁹² and have been criticised in that many of the provisions contained in the Regulations are inappropriate to HIV/AIDS.³⁹³

5.9.1 The criticism was, amongst others, in particular aimed at the provisions relating to the isolation and quarantining of persons with HIV or AIDS referred to in paragraph 5.8 above.³⁹⁴ It was submitted that having regard to the long asymptomatic phase, fit and healthy *persons with HIV* may be at risk of being kept under quarantine or in isolation for long periods of time on account of their HIV positive status.³⁹⁵ 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".³⁹⁶ In addition, it was submitted that the provisions would be inappropriate

391 See fn 386 and 387 above.

392 **SALC Working Paper 58** par 4.5. See also the comment on Discussion Paper 80 referred to in par 10.26.18-10.26.19 below.

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

394 Criticism was inter alia also aimed at provisions preventing persons with HIV to prepare food or handle food or water intended for other persons (see reg 14(3)(c)).

395 Cf reg 2, 4 and 14 referred to in par 5.8 above.

396 Cf reg 17 referred to in par 5.8 above.

to HIV/AIDS as neither HIV infection nor AIDS corresponds with the highly contagious diseases (listed in Annexure I to the Regulations) in respect of which additional restricting provisions in the Regulations apply.³⁹⁷

5.10 Draft Regulations, intended to replace the 1987 Regulations, were published for public comment in 1993.³⁹⁸

5.10.1 In the 1993 Draft the provisions referred to in par 5.8 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.³⁹⁹ The only change envisaged as regards isolation and quarantine of persons with HIV or AIDS is the following: As "AIDS" is not included in the Annexure to the 1993 Draft, isolation of persons with AIDS until they are "free from infection" will no longer be applicable.⁴⁰⁰ This may appear to be an intention to lessen the current coercive administrative powers in respect of AIDS. However, under the 1987 Regulations application of this measure is in the discretion of the medical officer of health and apparently it has never been applied in respect of persons with AIDS.⁴⁰¹

5.11 At the time of compilation of this Report the Draft Regulations published in 1993 have

397 Cf **SALC First Interim Report on Aspects of the Law relating to AIDS** par 5.1-5.16 and the sources quoted there. The other diseases listed in Annexure I include chicken pox, cholera, German measles, leprosy, louse infestation, measles, hepatitis A, mumps, plague, poliomyelitis, tuberculosis of the lungs, typhoid fever and whooping cough. 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.

398 Government Notice 703 in **Government Gazette** 15011 of 30 July 1993. The major differences between the 1993 Draft Regulations and those of 1987 with regard to HIV/AIDS in general are the following:

* AIDS was not included in the Annexure to the draft Regulations (listing highly contagious diseases in respect of which certain measures apply additionally).

* Discrimination against pupils with HIV infection was explicitly prohibited (draft reg 7(4)).

* Measures to be taken when conveying and burying bodies of people known to have died with HIV infection were added (reg 15(1)).

399 Cf regs 2, 4 and 11(3) respectively of the 1993 Draft. (The 1993 Draft added in reg 2(1) that a quarantining order should be directed to the owner, occupier or person in control of premises. It seems as if a quarantining order in terms of the 1993 Draft would thus only be possible in relation to persons present on premises in the district of a local authority. Cf however draft reg 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)").

400 See the measure under regulation 17 in paragraph 5.8 above.

401 See par 5.9 above.

not been finalised and promulgated in the Government Gazette. The position as set out in paragraph 5.8 above thus currently prevails.⁴⁰²

- 5.12 The Department of Health in April 1999 published proposed amendments to the 1987 Regulations in order to make AIDS disease and AIDS deaths notifiable.⁴⁰³ The proposed amendments contain no provisions relating to isolation or quarantine and therefore apparently do not propose to alter the position as set out in paragraph 5.8.⁴⁰⁴ As indicted above, according to media reports the Department has since abandoned its intention to make AIDS notifiable.⁴⁰⁵

Evaluation and conclusion

- 5.13 Although the public health measures discussed in the previous paragraphs could currently be utilised to address harmful HIV-related behaviour which creates a danger to public health or to other persons, the Commission believes that they are inadequate and unsuitable to address such behaviour.⁴⁰⁶ Apart from the fact that

402 The Commission submitted in its First Interim Report that the current situation (with the 1987 Regulations never having been applied to persons with HIV or AIDS and the 1993 draft Regulations not having been finalised and promulgated for many years) causes uncertainty. It was recommended that this should be addressed by promulgating the 1993 Draft Regulations (**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 (see par 1.4-1.5 above).

403 See fn 381-383 above.

404 The proposed amendment provides as follows:

"19 (1) When a medical practitioner ... or any other person legally competent to diagnose and treat a person ... diagnoses a notifiable medical condition in a person, he or she shall report his or her findings -

(a) ... without delay orally, and this must be confirmed in writing within 24 hours ...

(2) In cases where the medical condition diagnosed is ... AIDS disease, the person performing the diagnosis shall also inform the immediate family members and the persons who are giving care to the person in respect of whom the report is made and, in cases of ... AIDS death, the persons responsible for the preparation of the body of such person.

(3) On making a report ... the following shall be furnished: age, sex, population group, date of diagnosis, medical condition at the time of diagnosis, any available information concerning the probable place and source of infection and the name of the city, town or magistracy in which the person resides in respect of whom the report is made.

(4) The local authority concerned shall forward, weekly ... particulars of all reports ... to the Director-General ...".

405 See fn 7 in Chapter 1 above.

406 See also the comment supporting this view in par 10.15, 10.26.18 and 10.29.18 below.

their application is of a discretionary nature,⁴⁰⁷ there are strong legal and social arguments for not utilising them:

- ! As indicated in Chapter 4 above, the inappropriateness of applying coercive measures in respect of persons with HIV/AIDS solely on the basis of their HIV status is widely recognised.⁴⁰⁸ Measures entailing isolation and quarantining in particular have been rejected internationally.⁴⁰⁹ It was pointed out in previous documents of the Commission and also above that quarantine, isolation and detention create a climate of fear and denial which encourages the spread of the epidemic rather than curbing it.⁴¹⁰
- ! Even if application of these measures is restricted to exceptional cases of harmful HIV-related behaviour by recalcitrant individuals with HIV (as is done in some jurisdictions),⁴¹¹ they may entail the infringement of several fundamental rights in South African terms: the right to equality;⁴¹² the right to freedom and security of

407 See par 5.8 above.

408 See par 4.5-4.9 above.

409 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** Guideline 3, par 74, par 80, par 110-111, and Annex I. Guideline 3 in particular provides that "(S)tates should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations". The explanatory information under this Guideline states the following: "Public health legislation should ensure that people not be subjected to coercive measures such as isolation, detention or quarantine on the basis of their HIV status. Where the liberty of persons living with HIV is restricted, due process protection (eg notice, rights of review/appeal, fixed rather than indeterminate periods of orders and rights of representation) should be guaranteed" (par 28(d)).

410 **SALC Working Paper 58** par 2.10 et seq; **SALC Second Interim Report on Aspects of the Law relating to AIDS** par 2.35-2.42; and par 4.5-4.9 above.

411 In some countries a case has 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. This approach is based on the argument 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 public interest. Legislation aimed at the quarantining or isolation of infected persons who persist in behaviour which could lead to HIV transmission has for instance been adopted in the United States and Australia. In the United States sanctions in terms of such legislation have however been imposed only in a few rare instances where infected persons have been unwilling to forego their activities, 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 (**AIDS The Legal Issues** 57-58; Jarvis et al 287-288; Cameron and Swanson 1992 **SAJHR** 214; **Australia Discussion Paper Public Health** 34-35; **Australia Final Report on AIDS** 21. See also par 8.7 et seq and 8.20 et seq below on the position in the United States and Australia respectively).

412 The 1996 Constitution sec 9.

the person;⁴¹³ the right to privacy;⁴¹⁴ the right to freedom of association;⁴¹⁵ the right to freedom of movement;⁴¹⁶ the right freely to reside anywhere in the Republic;⁴¹⁷ the right as a citizen of the Republic to leave the country;⁴¹⁸ the right to administrative justice;⁴¹⁹ and the right freely to engage in economic activity and to pursue a livelihood anywhere in the national territory.⁴²⁰ As indicated in Chapter 7 below, 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 into account, inter alia the purpose of the limitation and less restrictive means to achieve the purpose.⁴²¹ Public health measures have as their aim the promotion of public health. The spread of HIV is 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 and quarantining 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 would thus be disproportionate to the infringement of individual rights which isolation, even if based on harmful behaviour, may entail.⁴²² Furthermore, isolation and quarantining create the potential for arbitrary and discriminatory intervention.⁴²³ The costs and administration involved in the isolation of recalcitrant individuals would also make

413 Ibid sec 12.

414 Ibid sec 14.

415 Ibid sec 18.

416 Ibid sec 21.

417 Ibid.

418 Ibid.

419 Ibid sec 33.

420 Ibid sec 22.

421 Ibid sec 36. See the discussion on limitation of rights in par 7.9 et seq below.

422 Cf the **United Nations International Guidelines on HIV/AIDS 1996** which state as follows: "There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status" (par 105); "The right to liberty and security of a person should ... never be arbitrarily interfered with, based merely on HIV status by using measures such as quarantine ... or isolation" (par 111). "In order for restrictions on human rights to be legitimate, the State must establish that the restrictions is ... proportional to that interest and constitutes the least intrusive and least restrictive measure available and actually achieving that interest in a democratic society" (par 82).

423 Ibid.

such measures impracticable.⁴²⁴

- ! Isolation and quarantining of recalcitrant individuals with HIV or AIDS under the provisions discussed in par 5.8 above would not constitute a viable alternative to the criminal law, which aims at retribution and deterrence.⁴²⁵ 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.⁴²⁶
- ! Finally, given the nature of transmission of HIV and the extent of the epidemic in the population, isolation and quarantine would not be effective in controlling the further spread of the epidemic.⁴²⁷

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

425 See par 7.2 et seq below on the objects of the criminal law.

426 Cf par 5.8 above. See also Elliot 57-59.

427 See par 3.10 et seq and 2.10 et seq for information on the transmission of HIV and the prevalence of HIV in South Africa respectively.

6 Dealing with harmful HIV-related behaviour through existing criminal law measures

- 6.1 Most legal systems have laws making it a crime to harm others - these may be either common law crimes or statutory offences.
- 6.2 In South African law there is at present no HIV-specific statutory provisions criminalising HIV-related behaviour.⁴²⁸ Common law offences which could be used to address harmful HIV-related behaviour include murder, culpable homicide, rape, assault, and attempts to commit these crimes.⁴²⁹
- 6.3 What complicates the present inquiry is the fact that the relevant common law crimes have not been applied to HIV-related behaviour in practice: there have been no reported examples in South Africa of successful prosecutions under common law crimes for such behaviour.⁴³⁰ (During the course of this investigation a man has been charged with attempted murder in the Pietermaritzburg High Court for allegedly exposing two women to HIV. The case was however withdrawn at the request of the complainant. This was the first case of its kind in South Africa.⁴³¹) The lack of

428 The only existing criminal law and procedure provisions relating to HIV/AIDS are those dealing with bail and minimum sentences described in par 4.11.3 and fn 360 above.

429 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 Chapter 8 below.

430 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 HIV infection could be (or was) a mitigating factor (see eg **S v Cloete** 1995 (1) SACR 367 (W); **S v C** 1996 (2) SACR 503 (T); **S v Sibonyane** unreported Pretoria Regional Court case 14/2865/967. Cf also the Zimbabwe case of **S v Mahachi** 1993 (2) SACR 36 (Z)). 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 77 above for information on the Criminal Law Amendment Act 105 of 1997 which provides for compulsory minimum sentences to be applied where a person is convicted of rape knowing that he has AIDS or HIV.

431 See par 2.6.2 above and 11.31 et seq below.

prosecutions in our country stands in contrast to the position in certain other jurisdictions, for instance the United States, Canada, the United Kingdom and Australia.⁴³²

- 6.4 The suitability of applying the common law crimes to HIV-related behaviour is examined below against the general requirements for criminal liability.

General requirements for criminal liability under common law

- 6.5 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 *unlawful* and that this conduct was accompanied by criminal capacity, and *fault*.⁴³³ In the case of completed crimes the state must also prove that an *unlawful consequence* was caused by the act or omission.⁴³⁴

Unlawful conduct

- 6.6 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).⁴³⁵ 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.⁴³⁶ 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.⁴³⁷

- 6.6.1 In the HIV/AIDS context this could mean that where a person with HIV fails to inform

432 See Chapter 8 below for more detail.

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

434 Ibid.

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

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

437 Ibid.

a sexual partner of his or her infection, and/or does not take other steps to prevent harm (eg by using a condom), such conduct may result in criminal liability.

6.7 Moreover, in crimes which involve bringing about an unlawful consequence, for instance the death of another person, there must be a *causal link* between the initial act or omission and the ultimate unlawful consequence.⁴³⁸ 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.⁴³⁹ 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.

6.7.1 The greatest evidentiary hurdle in proving criminal charges in HIV transmission cases would be in substantiating the element of causation.⁴⁴⁰ 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.⁴⁴¹ 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 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.⁴⁴²

438 Burchell and Milton 96.

439 **LAWSA** Vol 6 29.

440 Harris 1993 **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.

441 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).

442 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

- 6.8 The accused's conduct must further be *unlawful* in order to lead to criminal liability.⁴⁴³ Public policy would be decisive in ascertaining what is unlawful and what not.⁴⁴⁴ 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.⁴⁴⁵
- 6.8.1 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.⁴⁴⁶ 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.⁴⁴⁷
- 6.8.2 However, a person may legally consent to *risk* of serious bodily harm provided that it is not against public policy.⁴⁴⁸ Consent to the risk of serious bodily harm would in most instances be against public policy except where the contrary is established.⁴⁴⁹ 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.⁴⁵⁰ In the case of consent to unprotected sexual intercourse knowing that the partner is HIV positive, it is uncertain what conclusion

HIV infection (see also par 3.18.13 above).

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

444 Van Wyk 479.

445 Ibid.

446 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.

447 Sorgdrager 1988 **De Rebus** 793.

448 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).

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

450 Cf Van Wyk 501; Neethling et al 108.

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 sexual 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.

6.8.2.1 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.⁴⁵¹ 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.⁴⁵² 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.⁴⁵³ Yet others submit that the use of protective measures may negate the need to disclose HIV positivity - in this instance, consent to behaviour which could transmit HIV could still be valid.

6.8.2.2 The Canadian Supreme Court recently found in **R v Cuerrier**⁴⁵⁴ 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 nondisclosure 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 sexual partners thereof and to use condoms every time he engaged in sexual intercourse. At the time of the trial neither of the complainants had

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

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

453 Labuschagne 1993 **De Jure** 421. Cf also par 3.47 et seq above where it is indicated that the theoretical risk of contracting HIV from a single instance of unprotected sexual intercourse is estimated to be approximately 4 in 1 000.

454 (1998), 127 CCC (3d) 1. See also **Canadian HIV/AIDS Legal Network Info Sheet 1 on Criminal Law and HIV/AIDS**; Elliot (After Cuerrier) 10-16.

tested positive for HIV. Both testified that they would never have engaged in unprotected intercourse with the accused had they known about his seropositivity.⁴⁵⁵ The majority decision held that in order to vitiate consent to sex, the fraud must carry with it a "significant risk of serious harm".⁴⁵⁶ 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.⁴⁵⁷ It is not yet clear how the latter qualification will be interpreted and applied in Canadian law.⁴⁵⁸ It has however been suggested in Canadian legal literature that courts should expressly recognise a "safer sex" defence, meaning that persons with HIV who use condoms for penetrative sex or who otherwise modify their conduct so as to avoid "high risk" activities are not criminally liable if they do not disclose their serostatus.⁴⁵⁹ It has further been suggested that courts should adopt a contextual approach in interpreting and applying **Cuerrier**.⁴⁶⁰ Such an approach should include a recognition that, even if an activity poses a "significant risk" of transmitting HIV, an objective assessment of whether not disclosing is "dishonest" should be made only in light of all the circumstances of the case. Where

455 Ibid.

456 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 since **R v Clarence** (1888), 22 QBD 23. There it was held that a husband's failure to disclose that he had gonorrhoea 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 Cuerrier** par 97 and 103 of the judgment referred to in fn 454 above).

457 Par 124-129 of the judgment referred to in fn 454 above.

458 Elliot (After **Cuerrier**) 17-22; **Canadian HIV/AIDS Legal Network Info Sheet 7 on Criminal Law and HIV/AIDS**. Compare also the position in Germany and the United States: In the leading German case on deliberate exposure to HIV infection (i.e. where no condom was used) it was ruled that engaging in sexual activity without informing a sex partner about one's HIV status qualifies as "a life endangering act" (**BGH v O** 4.11.1988 - StR 262/88; see fn 471 below for more information on this case). 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 (Ch 47 USC 10). In these cases the defendants usually knew that they were HIV positive and had been warned about the possibilities of transmission. The military cases have suggested that there is no possible defence to unprotected sex because public 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)).

459 Elliot (After **Cuerrier**) 66.

460 Ibid 67.

persons with HIV for instance honestly believe there is a risk of physical violence to them if they disclose their status to a sexual partner, then it should not be considered "dishonesty" which attracts criminal liability, if they do not disclose their status. A contextual analysis should not necessarily be limited to the risk of physical violence; all the circumstances of the case should be assessed in determining whether or not failure to disclose was "objectively dishonest". Other adverse consequences of disclosure may suffice to relieve one from a duty to disclose.⁴⁶¹

- 6.8.3 The consent must be given by a person fully aware of what he or she is consenting to.⁴⁶² 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.⁴⁶³ 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.⁴⁶⁴

Fault

- 6.9 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.⁴⁶⁵ "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.
- 6.9.1 Different forms of intention have been distinguished. Of these, *dolus eventualis* ("constructive" or legal intent) is specifically relevant 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 unlawful consequence which follows from his or her

461 Ibid.

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

463 Ibid.

464 Van Wyk 502.

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

conduct, but foresees the possibility of the circumstance existing or the consequence ensuing and nevertheless proceeds with his or her conduct.⁴⁶⁶ 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.⁴⁶⁷ 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".⁴⁶⁸ It is established law that what must be foreseen, is only a *possibility*, and not necessarily a 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.⁴⁶⁹ "Reckless" means "not caring what the result might be".⁴⁷⁰ 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.⁴⁷¹

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

467 **LAWSA** Vol 6 74.

468 Ibid 76; Burchell and Milton 308.

469 **LAWSA** Vol 6 78.

470 Ibid 80.

471 Ibid. In the leading criminal case in Germany dealing with knowingly exposing another to HIV through unprotected consensual sexual intercourse (**BGH v O** 4.11.1988 - StR 262/88), 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 (sec 211 of the Penal Code) or attempted manslaughter (which is possible in German law under sec 212 of the 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

6.9.1.1 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.⁴⁷²

6.9.2 **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.⁴⁷³ The "reasonable person" is the fictitious person of ordinary intelligence, knowledge and prudence. Nevertheless, if the perpetrator had knowledge or experience beyond that which the reasonable person would have, he or she is 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.⁴⁷⁴ Finally, the degree of care (duty to guard against harm), which should be exercised in a given circumstance depends on the foreseeability of the

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 *nonconsensual* 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 August 1998; cf also Van Wyk 486-488; De Jager 1991 **Journal of South African Law** 547-555).

472 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 sexual partner. See however also par 3.57 et seq above on the influence of viral load on the risk of HIV transmission.

473 **LAWSA** Vol 6 92.

474 Ibid 99.

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 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, if it 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.⁴⁷⁵

6.9.3 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 6.9.2 above, conscious negligence may be present where the person with HIV subjectively *believes* that infection of his or her sexual partner will not occur and under those circumstances proceeds with unprotected intercourse⁴⁷⁶ (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.⁴⁷⁷

Proof beyond reasonable doubt

475 Ibid.

476 Cf the example in respect of *dolus eventualis* in par 6.9.1.1 above.

477 In **S v Ngubane** 1985 (3) SA 677 (A) 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 241-245 on *dolus eventualis*, and conscious and unconscious negligence.

6.10 The general principle in criminal cases is that the legal burden of proving the perpetrator's guilt rests upon the prosecution.⁴⁷⁸ Therefore, the state must prove every element of the perpetrator's guilt beyond a reasonable doubt: the commission of the act charged; its unlawfulness; the identity of the perpetrator; fault; and the causation of the unlawful consequences.⁴⁷⁹ 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 negated".⁴⁸⁰

Applicable common law crimes

Murder

6.11 Murder consists in the unlawful and intentional killing of another living person.⁴⁸¹ 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.⁴⁸²

6.11.1 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.⁴⁸³
- ! Second, the greatest obstacle would probably be at the moment to prove

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

479 Lansdown and Campbell 909.

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

481 Milton 310; Snyman 435.

482 Van Wyk 491.

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

causation i.e. that the victim died because of the acts of the perpetrator.⁴⁸⁴ Problems in this regard have been outlined in paragraph 6.7 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).⁴⁸⁵
- ! Fourth, the requisite intention in the form of *dolus directus*, *dolus indirectus* or *dolus eventualis* would have to be proved.⁴⁸⁶ *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 form of intent would probably be very difficult to establish.⁴⁸⁷ *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,⁴⁸⁸ 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.

Culpable homicide

484 As indicated in par 3.18.13 above, this may change if an effective DNA matching test in respect of HIV could be developed.

485 Tierney 1992 *Hastings International and Comparative Law Review* 492-493.

486 Van Wyk 492.

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

488 See par 6.9.1.

6.12 Culpable homicide consists in the unlawful, negligent killing of another person.⁴⁸⁹ 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.

6.12.1 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.⁴⁹⁰ 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 preventive steps which determines that he or she was negligent in bringing about the death of the victim.⁴⁹¹

6.12.2 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 rebut the perpetrator's defence. A further problem would be whether the use of condoms would amount to "reasonable preventive steps" which would exclude negligence.⁴⁹²

489 Milton 364; Snyman 441.

490 Milton 365. See also par 6.9.2-6.9.3.

491 Milton 365. See also van Wyk 495-496.

492 In the light of the then 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 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. See par 3.47 et seq above for a discussion of the risk related to sexual exposure to HIV; and par 3.56 on the effectiveness of condoms in reducing the risk.

Rape

- 6.13 Rape consists in unlawful, intentional sexual intercourse with a woman without her consent.⁴⁹³ 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 nonconsent beyond reasonable doubt on a rape charge, the victim's consent is assumed, the prosecution will fail and the accused will be acquitted.⁴⁹⁴
- 6.13.1 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 nondisclosure of the HIV status of the accused who had unprotected intercourse with two women.⁴⁹⁵ If such an approach is applied to South African law, it would imply that a person with HIV who does not inform his sexual partner of his infection and proceeds with unprotected intercourse, may be guilty of rape.

Assault

- 6.14 Assault consists in unlawfully and intentionally applying force to the person of 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.⁴⁹⁶ 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").⁴⁹⁷

493 Milton 439.

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

495 See the discussion of **R v Cuerrier** in par 6.8.2.2 above.

496 Milton 406, 431; Snyman 452.

497 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.

6.14.1 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.⁴⁹⁸ 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.⁴⁹⁹ An assault charge could also be instituted when HIV transmission has taken place because of violence associated with fighting or sexual activity.

Attempt

6.15 A prosecution for attempt to commit any of the crimes above (with the exclusion of culpable homicide, in respect of which attempt is not possible⁵⁰⁰), could be a way in which the problems presented by the requirement of causation in a prosecution for HIV transmission could be sidestepped in that it is not necessary to prove a completed crime.⁵⁰¹ 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.

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

499 Van Wyk 496;

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

501 Burchell and Hunt 342.

6.15.1 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.

7 An HIV-specific statutory offence/s for HIV transmission and exposure?

7.1 It is indicated in Chapter 4 that the use of coercive measures in dealing with the HIV/AIDS epidemic is controversial.⁵⁰² In comparable legal systems where the creation of criminal offences for HIV-related harmful behaviour was at issue, the suitability and desirability of the criminal law to deal with a health-related issue have invariably been part of the debate. This aspect as well as the general requirements for criminal liability under statutory offences are explored below as background to the debate on the need for legislative intervention. Thereafter the pivotal arguments for and against the creation of HIV-specific offences (be they additional offences criminalising conduct not hitherto criminal, or offences restating the common law crimes) are recorded.⁵⁰³

A role for the criminal law

Fundamental values, functions and objects of the criminal law

7.2 *Criminal law* is that branch of the law that indicates what actions expose a person to punishment by the state, and what that punishment will be.⁵⁰⁴ 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.⁵⁰⁵ Its object is to promote the welfare of society and its members by

502 See par 4.5 et seq.

503 See the Commission's interpretation of its mandate in par 4.4 above.

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

505 Burchell and Milton 5. Cf also par 7.3.1 and fn 514 below.

establishing and maintaining peace and order.⁵⁰⁶ *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.⁵⁰⁷ Such conduct is then declared by the law (either common law or statutory law) to be criminal.⁵⁰⁸ *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 the form of the loss of life, liberty or property or the infliction of physical pain.⁵⁰⁹ 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.⁵¹⁰ 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.

- 7.3 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.⁵¹¹

506 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:

- * To forbid and prevent conduct that unjustifiably and inexcusably inflicts or threatens substantial harm to individual or public interests.
 - * To subject to public control persons whose conduct indicates that they are disposed to commit crimes.
 - * To safeguard conduct that is without fault from condemnation as criminal.
 - * To give fair warning of the nature of the conduct to be an offence.
 - * To differentiate on reasonable grounds between serious and minor offences.
- (As quoted in Visser and Vorster 7-8.)

507 Burchell and Milton 1-2; **LAWSA** Vol 6 4. See also the discussion on conduct which society disapproves of in par 7.14 et seq below.

508 **LAWSA** Vol 6 4.

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

510 Burchell and Milton 1-2; Snyman 8; **LAWSA** Vol 6 5. See also par 7.15.1 below.

511 Cf also par 7.15 et seq below for the respective punishment theories as justification for punishment.

7.3.1 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.⁵¹² 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 would not be willing to utilise its most drastic weapon to attempt to correct every type of deviant or antisocial conduct.⁵¹³ 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.⁵¹⁴

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

513 **LAWSA** Vol 6 11.

514 Ibid. 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, Prof 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 (Burchell and Milton 35). 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); **National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others** 1999 (1) SA 6 (CC). 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

- 7.4 The concepts of "crime", "punishment" and "criminal" are closely inter-related in that crime is conduct in respect of which punishment is inflicted, while punishment is the sanction which is inflicted 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.⁵¹⁵
- 7.5 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.⁵¹⁶
- 7.6 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.⁵¹⁷

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 nonconformists 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 the face of the explicit constitutional guarantees" (at 13, 33 and 34).

See also a further interpretation of the meaning of "harm" in the HIV/AIDS context in par 7.14.3 and fn 550 below.

515 Cf par 7.15 et seq below for the goals of punishment as expressed through the different punishment theories.

516 **LAWSA** Vol 6 5.

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

Factors tempering the application of the criminal law

7.7 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 human rights and according to agreed norms of justice and fairness.⁵¹⁸

The principle of legality

7.8 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.⁵¹⁹ 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.⁵²⁰ 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.⁵²¹ 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

518 Burchell and Milton 57; Snyman 33.

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

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

521 **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 Report.)

was not previously.⁵²²

The influence of the 1996 Constitution

- 7.9 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".⁵²³ 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".
- 7.9.1 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 the 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 an accused).⁵²⁴ 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.⁵²⁵
- 7.10 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

522 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).

523 The 1996 Constitution sec 1(c).

524 Burchell and Milton 67-71.

525 Ibid.

compatible with the provisions of the Bill of Rights contained in the 1996 Constitution.⁵²⁶ 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,⁵²⁷ as are the right to freedom and security of the person,⁵²⁸ the right to dignity,⁵²⁹ the right to privacy,⁵³⁰ and the right to equality.⁵³¹ These rights are however not absolute and may be limited: Section 36 provides that the rights in the Bill of Rights may be limited -

- (1) ... 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 -
- (a) the nature of the right;
 - (b) the importance of the purpose of the limitation;
 - (c) the nature and extent of the limitation;
 - (d) the relation between the limitation and its purpose;
 - (e) 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,⁵³² and by using an assessment based on proportionality.⁵³³ In the latter regard the Constitutional Court's approach in ascertaining whether it is justified to limit an entrenched right is to determine the proportionality between the extent of the limitation of the right considering the nature and importance of the infringed right on the one hand; and the purpose, importance and effect of the infringement, taking into account the availability of less restrictive means available to achieve that purpose.⁵³⁴ O'Regan J and Cameron AJ in **S v Manamela and**

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- 526 **Du Plessis and others v De Klerk and another** 1996 (3) SA 850 (CC) at 881D. See also Burchell and Hunt 1-5.
- 527 The 1996 Constitution sec 35.
- 528 Ibid sec 12.
- 529 Ibid sec 10.
- 530 Ibid sec 14. Cf also **Case and another v Minister of Safety and Security and others and Curtis v Minister of Safety and Security and others** 1996 5 BCLR 609 (CC); **National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others** 1999 (1) SA 6 (CC).
- 531 The 1996 Constitution sec 9.
- 532 **Mandela v Falati** 1994 (4) BCLR 1(W).
- 533 **Holomisa v Argus Newspapers Ltd** 1996 (6) BCLR 836 (W).
- 534 **S v Manamela and another** 2000 (5) BCLR 491 (CC) at 519G-520A referring to **S v Makwanyane and another** 1995 (3) SA 391 (CC) and **National Coalition for Gay and Lesbian Equality v Minister of Justice and others** 1999 (1) SA 6 (CC). See also **Director of Public Prosecutions: Cape of Good Hope v Bathgate** 2000 (2) BCLR 151 (C). Note that constitutional analysis under sec 36 is a two-stage procedure which the Constitutional Court held requires first, an establishment that the activity for which

another formulated the above approach thus:

The level of justification required to warrant a limitation upon a right depends on the extent of the limitation. The more invasive the infringement, the more powerful the justification must be.⁵³⁵

In giving appropriate effect to the factor of "less restrictive means", the Constitutional Court further pointed out that it must be taken into consideration that legislative choices are not only made with regard to constitutional rights, but are also influenced by considerations of cost, practical implementation, the prioritisation of certain social demands and needs, and the need to reconcile conflicting interests.⁵³⁶

- 7.11 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 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.⁵³⁷

constitutional protection is sought falls within the sphere of activity protected by a particular constitutional right; and second, a determination whether the infringement is justified or not (**S v Zuma and others** 1995 (2) SA 642 (CC); see also Chaskalson et al 12-3).

- 535 **S v Manamela and another** supra at 521A. Cf also Cameron and Swanson who (before the constitutional dispensation) submitted that as regards the limitation of rights in the HIV/AIDS context, there must be some intellectual criterion of rationality and some acceptable consensus on ethical values against which every measure sought to combat AIDS must be tested. The following criteria were suggested:

- * Does a particular proposed measure actually achieve its objective in combatting the spread of HIV?
- * Does the measure proposed invade a 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 the particular objective? (1992 **SAJHR** 202-203).

- 536 **S v Manamela and another** supra at 508H and 529A-B, the court referring with concurrence to the minority judgment of O'Regan J and Cameron AJ.

- 537 Burchell and Milton 29.

A role for the criminal law: Premise

- 7.12 As indicated in Chapter 4 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.⁵³⁸ 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.⁵³⁹
- 7.13 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 acts 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 concealing high-risk behaviour, such as having had unprotected sex away from his or her partner.⁵⁴⁰ 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.⁵⁴¹

538 See par 4.5 et seq above. See also Cameron (Unpublished) 2-3; **SALC Second Interim Report on Aspects of the Law relating to AIDS** 25-27.

539 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 (Holland 1994 **Criminal Law Quarterly** 279-280). 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 5.3-5.7 above).

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

541 Buchanan in **African Network on Ethics, Law and HIV** 106-107. Cf also par 2.5-2.6.2 above and 7.21 et seq below.

7.13.1 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.⁵⁴² 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 against exposure to or infection with HIV, in particular against sexual assault which may result in HIV infection.⁵⁴³ 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 deterrence, and in outlawing and punishing behaviour which society regards as harmful? It could be argued that transmission of and exposure to HIV is 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.

7.14 It has been pointed out above that a country can have or create laws making it a crime to harm others.⁵⁴⁴ Death constitutes a legally cognizable harm. So, too, does having to live with a debilitating disease.

7.14.1 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 seroconverted, would fail to convict the former of an offence?⁵⁴⁵

7.14.2 In many systems, to infect another person *negligently* (for example where the

542 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 2.5.1 and fn 39 above; and the cases of deliberate HIV infection during consensual sex referred to in par 2.6.1 and 2.6.2 above. See also the judgement in the recent Supreme Court of Canada case **R v Cuerrier** (1998) 127 CCC (3d) 1 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 6.8.2.2 for more detail).

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

544 Cf par 7.3.1 and fn 514 above.

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

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. Experts who criticise the utilisation of coercive legal measures in the HIV/AIDS context acknowledge this.⁵⁴⁶

7.14.3 However, where unacceptable high risk behaviour does *not result in the transmission of HIV*, the "harm question" is more complex.⁵⁴⁷ 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 circumstances such HIV-related behaviour would fall within the parameters of the criminal law.⁵⁴⁸ 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.⁵⁴⁹ 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.⁵⁵⁰ 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

546 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 Immunodeficiency 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".

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

548 Van Wyk 467.

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

550 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 7.3.1 and fn 514 above).

taking precautions.⁵⁵¹

7.15 As indicated in paragraph 7.4 above, crime and punishment are inter-related and subjecting behaviour to punishment should thus 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 preventive or deterrent (the utilitarian theories).⁵⁵²

7.15.1 *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 justified by an event in the past, the commission of a crime.⁵⁵³ *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.⁵⁵⁴ 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).⁵⁵⁵ 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.⁵⁵⁶ The retributive theory is the only theory of

551 Cf also the discussion on consent in par 6.8.1 et seq above; and the recent decision of the Supreme Court of Canada in **R v Cuerrier** referred to in par 6.8.2.2 above. However it is not clear how this judgment will be interpreted and applied in practice (see par 6.8.2.2 above).

552 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.

553 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 38-43).

554 Burchell and Milton 42 et seq; Snyman 19-20, 22. Cf also Elliot 41-43.

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

556 Cf however also the very recent proposals of the SALC relating to a new statutory sentencing framework to replace the current common law and statutory position. It is recommended that sentencing decisions should be informed by new initiatives from the legislative and administrative branches that will meet the need for consistency as well as sensitivity to the seriousness of offences, the needs of victims and the

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.⁵⁵⁷ 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.⁵⁵⁸

7.15.2 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.⁵⁵⁹

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.⁵⁶⁰ In this sense applying the criminal law would also fulfil its preventive and deterrent functions.

7.15.3 As Cory J, delivering the majority judgment in the recent Supreme Court of

capacity of the system to carry out the sentences that have been imposed (**SALC Report on Sentencing** xxi).

557 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).

558 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, note that deterrence has been described as the essential, all-important and universally admitted object of punishment, the other objectives being regarded as accessory.

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

560 Ibid.

Canada case, **R v Cuerrier**,⁵⁶¹ 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 a similar manner.^[562] 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.⁵⁶³

- 7.16 As regards the vulnerable position of women with respect to HIV transmission, it is further submitted that in denouncing and punishing HIV-related activities which transgress 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.⁵⁶⁴
- 7.17 In view of the above the Commission, for purposes of further deliberation on the matter, accepts that criminal law undoubtedly has a role to play in protecting the community and in punishing unacceptable HIV-related behaviour.⁵⁶⁵ 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 conduct themselves in ways that harm others must be held accountable. In this sense the criminal law must obviously provide a measure of

561 **R v Cuerrier** (1998), 127 CCC (3d) 1. See also par 6.8.2.2 above.

562 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.

563 At par 140-142 of the majority judgement referred to in fn 454 above.

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

565 See also the comment supporting this view in par 10.13-10.17 below.

protection in the form of deterrence and can also reflect society's abhorrence of such behaviour.⁵⁶⁶ 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.

General requirements for criminal liability under statutory offences

7.18 Statutory offences are created by commands or prohibitions issued by a competent legislature enjoining or prohibiting conduct under threat of punishment.⁵⁶⁷ 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.⁵⁶⁸ In enacting, the legislature may however alter, exclude or add to the application of the general principles of liability.⁵⁶⁹

7.18.1 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.⁵⁷⁰ To obtain a conviction the state will have to prove each of the requirements outlined by the legislature with regard to the act.⁵⁷¹ The various common law defences (for instance consent to the unlawful conduct by the victim⁵⁷²) which establish absence of unlawfulness are also applicable to statutory offences, and in appropriate circumstances can

566 Van Wyk 479; Buchanan in **African Network on Ethics, Law and HIV** 98, 110. See also **SALC Discussion Paper 80** par 7.2. This view was strongly supported by the majority of persons and bodies responding to Discussion Paper 80 (par 10.13-10.17 below). Even some of those who were in principle against utilising the criminal law and who believed that the criminal justice system is ill-suited to deal with HIV-related behaviour, conceded that in rare circumstances utilisation of the criminal law in the form of criminal prosecutions under the existing common law crimes may be warranted (see the comment in par 10.16).

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

568 Burchell 33.

569 Milton and Fuller (Revision Service 1997) 1.

570 Ibid.

571 Ibid

572 See par 6.8.1 et seq above for more detail about consent as a defence.

be relied upon by the perpetrator to escape conviction.⁵⁷³

7.18.2 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.⁵⁷⁴ Liability without fault may also in principle be unconstitutional since it does not require established culpability and denies an accused the substantive benefit of the presumption of innocence.⁵⁷⁵ 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.⁵⁷⁶ 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.⁵⁷⁷ 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.⁵⁷⁸

7.19 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

573 Milton and Fuller (Revision Service 1997) 3.

574 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).

575 See sec 12(1)(a) of the 1996 Constitution where it provides that "Everyone has the right to freedom and 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; **Ferreira v Levin NO and others and Vryenhoek and others v Powell NO and others** 1996 (1) BCLR 1 (CC) at § 246; and **S v Mbatha; S v Prinsloo** 1996 (3) BCLR 293 (CC).

576 Milton and Fuller (Revision Service 1997) 21, 32.

577 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 1994) 2.

578 Milton and Fuller (Revision Service 1997) 21.

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.⁵⁷⁹

The debate for and against the creation of an HIV-specific offence/s to deal with harmful HIV-related behaviour

7.20 The following pivotal arguments (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 by way of HIV-specific offences (be they additional offences criminalising conduct not hitherto criminal, or offences restating the common law crimes).

579 Ibid 42. See also par 6.15 et seq above for more information on attempt in terms of the common law.

The high prevalence of HIV coupled with women's vulnerability to HIV

7.21 The prevalence of HIV has recently increased markedly in our country.⁵⁸⁰ Proponents of HIV-specific offences emphasise that this, coupled with women's vulnerability to HIV, calls for legislative intervention. From being almost absent from the AIDS epidemic in the 1980s, women at the end of 2000 accounted for 48% of the 34,7 million adults now living with HIV world-wide, with HIV infection for women still rising. In sub-Saharan Africa 55% of adults currently living with HIV are women. Moreover, the infection rates among young women outnumber that of their male peers.⁵⁸¹ 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.⁵⁸²

7.22 Proponents of HIV-specific offences argue 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:⁵⁸³

- ! Young girls are brought up with little understanding of their 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.
- ! 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.

Proponents submit that men should respect the personal and physical integrity of women

580 See par 2.10 et seq above.

581 **UNAIDS AIDS Epidemic Update** December 2000 3, 5; **Women and AIDS** 2.

582 See par 2.12.

583 **Women and AIDS** 3; Rees (Unpublished) 1, 2, 5; Albertyn (Unpublished) 33 (Internet); see also the presentation by Ms Lebo Malepe at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.18 et seq below.

and that the criminal law could reinforce such a norm.⁵⁸⁴

- 7.23 Opponents of HIV-specific statutory measures strongly submit that such measures will not change the subservient situation of women: Women remain vulnerable in situations where men insist on unprotected intercourse notwithstanding their 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. Further, that a broader response is required which enhances the position and status of women and enables them to take up an equal position in society.⁵⁸⁵ This view, of advocating deep-going 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.⁵⁸⁶

- 7.24 According to opponents an even more compelling consideration against HIV-specific offences derives from the demographics of HIV testing in South Africa. They point out that most South Africans whose HIV status is ascertained are women (who undergo testing at antenatal clinics). To create statutory offences 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 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 special statutory prohibitions 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.⁵⁸⁷

584 Cf Buchanan in **African Network on Ethics, Law and HIV** 105-107. Cf also the behavioural and social facts cited by UNAIDS which emphasise women's particular vulnerability to HIV (**UNAIDS AIDS Epidemic Update** December 2000 8).

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

586 **Women and AIDS** 5.

587 Information supplied on 9 November 1998 by Ms Mercy Makhalemele, HIV/AIDS Project Committee

Difficulties with application of common law crimes

- 7.25 Proponents submit that 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.⁵⁸⁸ They believe that a situation currently prevails which attempts to fit harmful HIV-related behaviour into pre-existing, although not altogether relevant, common law crimes. Statutory offences could in particular be defined so as to circumvent evidential problems attendant on the common law.⁵⁸⁹ It is submitted that it would, for instance, 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).⁵⁹⁰
- 7.26 Proponents also argue that creating statutory offences would create clarity and certainty in the law - thus providing ordinary citizens with clear guidelines on what is acceptable behaviour.⁵⁹¹ 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:

It is not unreasonable for society to establish clear parameters as to the

member and counsellor at the Durban AIDS Training, Information and Counselling Centre (ATICC) at the time. See also par 11.21 and fn 969 below.

- 588 See Chapter 6 above for the perceived difficulties in applying the available common law crimes. See also the presentation by Prof Christa Van Wyk at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.15 below.
- 589 Laurie 1991 **Journal of the Law Society of Scotland** 317. In the United States 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 (Laurie 1991 **Journal of the Law Society of Scotland** 317).
- 590 Hermann 1990 **St Louis University Public Law Review** 356. See also the presentation by Prof Christa Van Wyk at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.16 below. (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 [see par 3.45 above]).
- 591 Cf also the requirements of the principle of legality as referred to in par 7.8; 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 8.2 et seq above).

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.⁵⁹²

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.⁵⁹³

7.27 Opponents on the other hand argue that the available common law and civil remedies should be utilised as is: They believe that the 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.⁵⁹⁴ In addition, the Criminal Law Amendment Act 105 of 1997 already provides for a harsher sentence where a person is convicted of rape knowing that he has AIDS or HIV.⁵⁹⁵ Moreover, civil remedies would also be at the disposal of the aggrieved party.⁵⁹⁶ Opponents question why, under these circumstances, one area of the common law should be singled out for supplementation or codification.⁵⁹⁷ They emphasise that thus far there has been a very limited number of complaints leading to prosecutions and submit that if there had been such a dire need for intervention one would at least have expected the common law to have been used and tried out on numerous occasions.⁵⁹⁸ While this has not happened, the argument that the common law is somehow lacking invites the suspicion that there is another motive for the creation of HIV-specific offences.⁵⁹⁹ They pose the question whether intervention will make any difference to the current situation (eg by leading to more complaints or deterring recalcitrant individuals) or whether it will not only stigmatise persons with HIV as persons

592 Hermann 1990 **St Louis University Public Law Review** 353. See also the presentation by Prof Christa Van Wyk at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.16 below.

593 Ibid. Cf also Buchanan in **African Network on Ethics, Law and HIV** 105.

594 Viljoen 1993 **SALJ** 110.

595 See fn 360 above.

596 See par 4.11.2 above and 7.38 below.

597 Viljoen 2000 **Codicillus** 13.

598 Cf par 2.6.2 and 11.31 et seq below on information on the lack of prosecutions for HIV-related behaviour in South Africa.

599 Viljoen 2000 **Codicillus** 13.

more likely to commit offences than uninfected individuals.⁶⁰⁰

7.28 Opponents maintain that as far as application of the common law is concerned, underlying problems associated with HIV prosecutions will persist even if HIV-specific offences are created. They believe that these problems are to a great extent the result of the nature of HIV/AIDS and emphasise that experience has shown that the problems will remain in the event of a statutory offence being created.⁶⁰¹

! Problems of proof resulting, for instance, from the difference in time between proscribed behaviour and awareness of injury will remain and may reduce the likelihood of detection and conviction with a lessening of the intended deterrent effect of HIV-specific offences.⁶⁰²

! Creating a statutory offence/s 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.⁶⁰³ 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.⁶⁰⁴ In addition, as far as conduct is concerned, there is usually only a single witness.⁶⁰⁵

! Another difficulty relates to the fact that human beings and human sexual intimacy are involved. The fear of being stigmatised by society and the legal system may deter victims from laying complaints.⁶⁰⁶ In this respect prosecutions under HIV-specific offences would be similar to rape prosecutions: the incidence of rape is believed, by most, to be under-reported.⁶⁰⁷ The reason is amongst others the treatment by the justice system, and the stigma society still attaches to the victim alleging rape. It is submitted that this prejudice will be even more pronounced in the case of HIV, where the sexual encounter took place voluntarily.

600 Ibid.

601 Hermann 1990 **St Louis University Public Law Review** 356. Problems of intent and causation are particularly acute (Hermann 1990 **St Louis University Public Law Review** 357). Cf also Van Wyk 486-488; De Jager 1991 **Journal of South African Law** 547-555.

602 Hermann 1990 **St Louis University Public Law Review** 356; see also Viljoen 2000 **Codicillus** 14.

603 Burchell and Hunt 251. See also par 7.18.2 above on strict liability.

604 Cf par 7.18 et seq above. See also Viljoen 2000 **Codicillus** 14.

605 Viljoen 2000 **Codicillus** 14.

606 Ibid.

607 See par 2.8 et seq above.

7.29 Opponents in general emphasise that laws (including the common law) targeting 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. They believe that 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.⁶⁰⁸

The possible influence of statutory intervention on public health initiatives

7.30 Opponents of HIV-specific criminal measures submit that creating such measures would have serious public health implications. This submission is based on the following arguments:

- ! 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.⁶⁰⁹ 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 a decade and a half 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.⁶¹⁰
- ! 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

608 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 (Buchanan in **African Network on Ethics, Law and HIV** 106).

609 Viljoen 2000 **Codicillus** 14; cf also De Jager 1991 **Journal of South African Law** 216-217.

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

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 provide information for the protection of others, and the criminal law should not discourage testing:⁶¹¹

(A)ny knowledge of HIV/AIDS is (thus) dangerous. People could consider it "safer" to avoid all knowledge, all information, all thinking of HIV/AIDS. The less you know of HIV/AIDS the less your chances are of "having reason to believe" that you are HIV positive. This will obviously work counter to the main thrust on which public health campaigns are based - information and education.⁶¹²

- ! 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 discourage trust and openness between patients and health care providers.⁶¹³ 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.⁶¹⁴

611 Hermann 1990 **St Louis University Public Law Review** 357; Viljoen 1993 **SALJ** 111 and 2000 **Codicillus** 15; see also the presentations by Mr Mark Heywood and Ms Nolwazi Gasa at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.24 et seq and 11.26 et seq below.

612 Viljoen 2000 **Codicillus** 15.

613 Gostin and Lazzarini 106; Buchanan in **African Network on Ethics, Law and HIV** 106; Viljoen 2000 **Codicillus** 14.

614 Buchanan in **African Network on Ethics, Law and HIV** 105; cf also Viljoen 1993 **SALJ** 111.

7.31 Proponents of HIV-specific offences submit that 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.⁶¹⁵

! They submit that the argument that such an approach will undermine the educational message that all are responsible for protecting themselves against HIV infection, 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.⁶¹⁶

! Proponents also submit that the outcome foreseen in the argument regarding the detrimental effect of a new offence on voluntary HIV testing, 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.⁶¹⁷ 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.

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

616 **R v Cuerrier** (1998), 127 CCC (3d) 1 (par 144 of the majority judgment).

617 Holland 1994 **Criminal Law Quarterly** 288; **R v Cuerrier** supra (majority judgement at par 143).

The danger of selective enforcement of HIV-specific offences

- 7.32 Opponents of statutory offences 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 such as black women 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.⁶¹⁸ This could negate any possible effectiveness of such statutory offences.
- 7.33 Proponents however believe that as statutory offences expressly and specifically state the conduct which is prohibited, and the sanction for such conduct, such offences are less susceptible to moral or societal influences which could lead to their selective application and diminished effectiveness. It is argued that their existence serves to reflect the community's viewpoint on HIV/AIDS and that they can be worded in narrow terms to reduce the potential for prosecutorial abuse.⁶¹⁹ Moreover, the danger of possible selective enforcement of HIV-specific criminal provisions can be avoided by public vigilance of policing and prosecutorial activity.⁶²⁰

Constitutional considerations⁶²¹

- 7.34 Proponents of HIV-specific offences submit that statutory intervention is justified in view of constitutional considerations. This rationale encompasses two different aspects: 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.

7.34.1 One of the principal interests that motivate criminalisation is that of maintaining

618 Holland 1994 **Criminal Law Quarterly** 287; Viljoen 1993 **SALJ** 113 and 2000 **Codicillus** 14-15; cf also De Jager 1991 **Journal of South African Law** 217. See also the presentations by Mr Mark Heywood and Ms Nolwazi Gasa at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.24 et seq and 11.26 et seq below.

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

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

621 See also the discussion of the 1996 Constitution in par 7.9 et seq above.

or retaining human and civil rights.⁶²² The right to life⁶²³ and bodily integrity⁶²⁴ count amongst the foremost of human rights which modern liberal democracies purport to recognise and uphold.⁶²⁵ 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.⁶²⁶ 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.⁶²⁷ 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.

7.34.2 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.⁶²⁸ Criminal conviction requires proof of proscribed behaviour beyond a reasonable doubt while public health violations may be established by clear and convincing evidence.⁶²⁹ Criminal law measures therefore provide significant civil

622 Burchell and Milton 25.

623 See sec 11 of the 1996 Constitution which provides that "(E)veryone has the right to life". See also **S v Makwanyane and another** 1995 (3) SA 391 (CC).

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

625 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 1998) 15-1.

626 Burchell and Milton 25.

627 Cf **R v Ceurrier** referred to in par 6.8.2.2 above. See also the presentations by Prof CR Snyman and Prof Christa Van Wyk at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.10-11.12 and 11.16 below.

628 Hermann 1990 **St Louis University Public Law Review** 354.

629 Ibid. See also the discussion of the Regulations relating to Communicable Diseases and the

liberties and due process protections to individuals which may not be available under the public health law.⁶³⁰ 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.⁶³¹ 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.⁶³²

- 7.35 Opponents in turn emphasise that HIV-specific criminal provisions would impose certain human rights burdens which they believe are not justified.⁶³³ 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.⁶³⁴ It is indicated in paragraphs 7.10-7.11 above that as regards the limitation of rights in the HIV/AIDS context in particular, it has been suggested that the following specific intellectual criteria of rationality and ethical values, against which every measure sought to combat the AIDS menace must be tested, must be applied:⁶³⁵

Notification of Notifiable Medical Conditions 1987 in par 5.8-5.12 above where it was emphasised that the application of these measures is in the discretion of public health officials.

- 630 See the discussion of the influence of the legality principle in par 7.8 et seq above. See also Hermann 1990 **St Louis University Public Law Review** 355.
- 631 See the discussion of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 in par 5.8 above, where it is indicated that a person with AIDS may be quarantined for 14 days - which period may be extended by the Minister of Health "to a longer period".
- 632 Hermann 1990 **St Louis University Public Law Review** 356.
- 633 Viljoen 2000 **Codicillus** 15. See also the presentation by Mr Mark Heywood at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.23 et seq below.
- 634 Sec 36(1)(e) of the 1996 Constitution. See also the discussion on the limitation of rights in par 7.9 et seq above.
- 635 Cameron and Swanson 1992 **SAJHR** 202-203. See also Elliot (Discussion Paper) 36; Viljoen 2000 **Codicillus** 15; and the **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** referred to in par 8.2 et seq below.

- ! Does a particular proposed measure actually achieve its objective in combatting the spread of HIV?
- ! Does the measure proposed protect a more crucial and fundamental human right than the one that is infringed?
- ! 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 HIV-specific statutory measures would fail to meet these criteria.

7.35.1 Opponents argue that individual liberty and the right to humane treatment are specifically at stake.⁶³⁶ As suggested earlier, the danger arises that in applying HIV-specific 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.⁶³⁷ 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 unrealistic to expect vulnerable groups to do so.⁶³⁸ 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.⁶³⁹

636 Cf also Elliot (Discussion Paper) 30-31; Viljoen 2000 **Codicillus** 14-15; and the presentation by Mr Mark Heywood at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.24 et seq below.

637 Gostin and Lazzarini 106; Hermann 1990 **St Louis University Public Law Review** 357.

638 Ibid.

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

7.35.2 A more compelling reason for caution in creating HIV-specific statutory offences is the potential of intrusion into sexual privacy.⁶⁴⁰ Section 14 of the 1996 Constitution provides that "(E)veryone has the right to privacy".⁶⁴¹ Opponents specifically point out that legislation which criminalises sexual conduct between consenting adults, could fall foul of the limitations set in section 36 of the 1996 Constitution.⁶⁴² 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.⁶⁴³ Opponents submit that the use of criminal law is a public procedure affording the perpetrator no confidentiality as to his or her HIV status.⁶⁴⁴

Currently available alternatives

7.36 In South African law alternatives to creating HIV-specific offences may be available in existing administrative (i.e. public health) and civil measures in a limited form.

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- 640 Holland 1994 **Criminal Law Quarterly** 287; Elliot 53; Cameron and Swanson 1992 **SAJHR** 220 et seq; Tierney 1992 **Hastings International and Comparative Law Review** 488; Viljoen 2000 **Codicillus** 14-15; and the presentation by Mr Mark Heywood at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.24 et seq below. See also **Case and another v Minister of Safety and Security and others; Curtis v Minister of Safety and Security and others** 1996 (5) BCLR (CC) 609.
- 641 The Constitutional Court in **Bernstein and others v Bester NO and others** 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".
- 642 See in general, **National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others** 1999 (1) SA 6 (CC) and **S v Makwanyane and another** 1995 (3) SA 391 (CC). See also the discussion on limitation of rights in par 7.10 et seq above.
- 643 Tierney 1992 **Hastings International and Comparative Law Review** 488; cf also Holland 1994 **Criminal Law Quarterly** 287; and the presentation by Mr Mark Heywood at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.24 below.
- 644 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 53.

7.37 As indicated in Chapter 5 above, public health 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. These measures provide for the isolation and quarantining of persons with HIV/AIDS under certain circumstances.

7.37.1 Proponents of HIV-specific offences however emphasise that the application of the relevant public health provisions is discretionary and that they would not be adequate to address recalcitrant behaviour.⁶⁴⁵ 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 14 days (which could be extended by the Minister of Health to a longer period), or be isolated for a determined period.⁶⁴⁶ 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.⁶⁴⁷

7.37.2 Opponents also do not support the application of the currently available public health measures. They emphasise that the government's current response to the AIDS epidemic is based exclusively upon public health principles which rely on voluntary participation and behaviour change. Coercive measures are in any event not part of this response: application of coercive public health measures would send the wrong message to the public about how the government responds to the HIV/AIDS epidemic as a public health issue.⁶⁴⁸

7.38 As indicated in paragraph 4.11.2 above, a person with HIV could be held *civilly* liable as

645 Par 5.9, 5.11 and 5.13 above.

646 Refer to par 5.13 above.

647 Ibid.

648 See par 5.7 above.

a result of exposing others to or infecting them with HIV.⁶⁴⁹ In **Venter v Nel**⁶⁵⁰ the court 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. According to press reports the defendant set out deliberately to sleep with women without protection and without making any attempt to inform his sexual partners that he had HIV.⁶⁵¹) Damages were granted for future medical expenses as well as for the possibility of a reduction in life expectancy, psychological stress, contumely (i.e. deliberate injury) and pain and suffering. It was held that the plaintiff's condition was one which called for "extremely high damages".⁶⁵² Factors taken into account by the court in assessing the damages were inter alia the stress and inevitable fear of the unknown suffered by the plaintiff, her feelings of helplessness and hopelessness, the adverse effects that infection with HIV had on her general relationship with all others, the adverse effects on her sex life and psychological and social suffering.⁶⁵³ 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".⁶⁵⁴

7.38.1 Proponents of HIV-specific offences argue 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, such measures 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: In this regard it is submitted that the civil law is 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 protection of citizens to invoke against individuals who endanger the lives of fellow citizens.

649 See, on the law regarding remedies for personality infringement in general, Van Wyk 497; Burchell 149-151; Neethling et al 43-44, 65-66.

650 1997 (4) SA 1014 (D).

651 **Sunday Times** 23 February 1997; **Sunday Independent** 2 March 1997.

652 **Venter v Nel** supra at 1016J-1017E.

653 Ibid.

654 **Sunday Times** 23 February 1997.

7.38.2 Opponents however see the civil law as a measure which could be utilised in conjunction with the currently available common law.⁶⁵⁵

The justice system's capacity to deal with an additional offence

7.39 Proponents cite the high incidence of violent sexual practices, the disregard for women's rights, sexual exploitation of women and children, the implications of HIV infection and the need for government protection as motivation for the creation of HIV-specific offences.⁶⁵⁶

7.40 Opponents however believe that despite 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.⁶⁵⁷

7.40.1 South Africa is already a country with signally low rates of arrest, conviction, imprisonment and rehabilitation.⁶⁵⁸ The National Crime Prevention Strategy (NCPS) adopted by the government in 1995 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.⁶⁵⁹ From a practical perspective the Nedcor Project on Crime, Violence and Investment - a business response to the

655 See par 7.27 above.

656 See information on the public outcry for legislative intervention in par 2.4 et seq and 2.14 et seq above.

657 See eg Viljoen 2000 **Codicillus** 13-15; and the presentation by Mr Mark Heywood at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.24 et seq below. Cf also the presentation by Prof John Milton at the meeting referred to, in par 11.5 below.

658 **The Nedcor Project 2.**

659 **Re-engineer the Criminal Justice System Pre-scoping Draft Report** 1-29. (The National Crime Prevention Strategy puts forward a comprehensive policy framework enabling government to address crime in a co-ordinated and focussed manner.)

crime situation - to a great extent echoed the factors identified by the NCPS.⁶⁶⁰ It was moreover concluded that the present criminal justice system is not functioning at a level where it constitutes a credible deterrent to criminals.⁶⁶¹ Opponents of new statutory criminal offences cite these problems and insufficiencies as factors which may fundamentally impact on the ability of the criminal justice system to deal with such new offence/s. 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.⁶⁶² 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.⁶⁶³ 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.

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- 660 The insufficiencies include the following:
- * 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 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 make longer 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 (SAPS).
 - * 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).
- 661 **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 trials (at iii-xix).
- 662 Cf Burchell and Milton 32.
- 663 Ibid. See also the presentation by Prof John Milton at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.5 below.

The absence of prosecutions under existing common law

- 7.41 Opponents to HIV-specific offences 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.⁶⁶⁴ 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?⁶⁶⁵ Far rather, they urge, direct resources and energy at governmental interventions which may have proved to be sound and effective. These, international experience has uniformly shown, lie well outside the field of the criminal law.
- 7.42 As is clear from paragraph 7.25 above, proponents of HIV-specific offences however argue that the difficulties associated with application of the common law crimes to HIV-related behaviour stand in the way of its successful application.

The possible deterrent effect of an HIV-specific offence/s

- 7.43 Proponents of HIV-specific offences observe that the effect of the criminal law is not merely to punish, but also to deter and prevent 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. They submit that there is

a social objective to prevent conduct likely to spread HIV in order to prevent further

664 As far as could be ascertained only a single prosecution has up till now been instituted in South Africa against a person who allegedly exposed another to HIV (see par 2.6.2 above). The prosecution was not proceeded with as the request of the complainant (see par 11.31-11.33 below).

665 See eg Viljoen 2000 *Codicillus* 13.

transmission, to educate the public about such conduct and to reinforce social norms against such behaviour.⁶⁶⁶ Proponents believe that 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.⁶⁶⁷

- 7.44 Opponents however submit that the creation of HIV-specific offences is unlikely to have a broad deterrent effect. They 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.⁶⁶⁸ 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/s 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.⁶⁶⁹

666 Hermann 1990 **St Louis University Public Law Review** 352-353. Cf also the presentation by Prof Christa Van Wyk at a consultative meeting held by the Project Committee on 3 February 2000 in par 11.16 below; and Van Wyk 2000 **Codicillus** 6, 8.

667 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 (Hermann 1990 **St Louis University Public Law Review** 355-56). See also par 7.25-7.26 where this argument was raised in the context of the difficulties with application of the current common law crimes.

668 Buchanan in **African Network on Ethics, Law and HIV** 105; Gostin and Lazzarini 106; Viljoen 2000 **Codicillus** 13, 15. See also the presentations by Mr Mark Heywood and Ms Nolwazi Gasa at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.24 et seq and 11.27 et seq below.

669 Cf the presentation by Ms Nolwazi Gasa at a consultative meeting hosted by the Project Committee on 3 February 2000 in par 11.27 below.

8 Comparative perspective

- 8.1 Information on relevant international instruments and the position in comparable legal systems (including the United States of America, Canada, United Kingdom, Australia, Zimbabwe and Namibia) is supplied below. The Project Committee also specifically looked at the position in Germany for guidance on the possibility of creating an offence of *negligent injury* - information sourced for this purpose is also referred to below.

Relevant international instruments

- 8.2 The United Nations in 1996 adopted **International Guidelines on HIV/AIDS and Human Rights**⁶⁷⁰ 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.⁶⁷¹ The essential conclusion underlying the Guidelines is that public health interests need not conflict with human rights of those at risk of infection.⁶⁷² It is stressed in the Guidelines 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 of those at risk of infection.⁶⁷³

670 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.

671 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 (**United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 1-4, 60-61).

672 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 5.

673 Ibid 39-40, 58-61.

- 8.2.1 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.⁶⁷⁴
- 8.2.2 The Guidelines also provide that although certain rights are nonderogable and cannot be restricted under any circumstances,⁶⁷⁵ international human rights law, under narrowly defined circumstances, allows states 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 -⁶⁷⁶
- ! 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);
 - ! 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

674 Ibid 14 (Guideline 4).

675 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 1996** 42-43).

676 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 42-43. Cf sec 36 of the 1996 Constitution 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.

established in a decision-making process consistent with the rule of law).

8.2.3 Governments are specifically urged to promote a supportive and enabling environment for women and children by addressing underlying prejudices and inequalities.⁶⁷⁷ It is noted that sexual violence against children, among other things, increases their vulnerability to HIV/AIDS.⁶⁷⁸ 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.⁶⁷⁹

8.2.4 The Guidelines are the product of the Second International Consultation on HIV/AIDS and Human Rights initiated by the United Nations Office of the High Commission for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS),⁶⁸⁰ 1996 in which South Africa was a participant.⁶⁸¹ They were issued in response to a call for guidelines that outline clearly how human rights standards apply in the area of HIV/AIDS. It was envisaged that one of the principal users of the Guidelines would be legislators and government policy makers.⁶⁸²

677 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 22-24 (Guideline 8).

678 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 **United Nations Convention on the Rights of the Child 1989**).

679 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 44-45.

680 See fn 41 for information on UNAIDS.

681 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** v, 62.

682 Ibid v-vi.

- 8.3 The **International Partnership against AIDS in Africa** was forged in July 1999 between 20 African countries (including South Africa) and certain UNAIDS cosponsors to intensify the response to AIDS in Africa. The vision of the Partnership is that within the next decade African nations will be implementing larger-scale, sustained and more effective national responses to HIV and AIDS. Through collaborative efforts and promotion and protection of human rights, countries will substantially reduce new HIV infections, provide a continuum of care for those infected and affected by HIV/AIDS, and mobilise communities, nongovernmental organisations, the private sector, and individuals to counteract the negative effects of the epidemic in Africa.⁶⁸³ Amongst others the Partnership in particular calls for the strengthening of the status of women through legal and other means to reduce their vulnerability to HIV/AIDS.⁶⁸⁴

Experience in other legal systems - including recent developments with regard to coercive measures

United States of America

- 8.4 In the United States the traditional criminal law, older public health offences and more recently enacted HIV-specific offences are applied in respect of HIV-related behaviour.⁶⁸⁵

683 **International Partnership Against AIDS in Africa 1999.**

684 Policy Area 10 as referred to in Albertyn (Unpublished [Internet] 38).

685 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.

- 8.5 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.⁶⁸⁶ It is however acknowledged that factors unique to HIV transmission present evidentiary obstacles in the application of the traditional criminal law.⁶⁸⁷
- 8.6 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 mainly consist of older infectious disease and venereal disease statutes.⁶⁸⁸ However, as they contain no language specific to HIV transmission they have come to be regarded as improper vehicles for prosecution of HIV transmission.⁶⁸⁹

686 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.

687 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 (Model Penal Code §210.1 and 2.02). Proving any of these states of mind are difficult in the context of HIV/AIDS transmission. Experts 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).

688 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 transmissible diseases eg venereal diseases (Harris 1993 **Arizona Law Review** 250 et seq).

689 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. (American criminal law distinguishes between *felonies* [serious crimes such as murder and arson] and *misdemeanours* [offences generally less heinous than felonies]). 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).

8.7 In 1988 President Reagan's Presidential Commission on the Human Immunodeficiency Virus Epidemic in its Final Report 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".⁶⁹⁰ The appeal was based on the problems in applying traditional criminal law to HIV transmission. In addition, the federal Congress in 1990 passed the Ryan White Comprehensive AIDS Resources Emergency Act, containing a requirement that to receive grants under the Act, a 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 expose another to HIV by means of donating blood, semen or breast milk, or through sexual activity or sharing of hypodermic needles.⁶⁹¹ In response, many states have enacted 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.⁶⁹² Three general approaches have been identified which have been

690 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).

691 Ryan White Comprehensive AIDS Resources Emergency Act 1990 (Pub L No 101-381, §2647, 104 Stat 576 [1990]); Andrias 1993 **Fordham Urban Law Journal** 505-506.

692 More than 25 states have legislation making it a felony (i.e. serious crime) or misdemeanour (i.e. less serious crime) 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 (Arkansas Code Ann §5-14-123(b) [1993]; Illinois Ann Stat Ch 38 para 12-16.2; Maryland 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 the 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 (Indiana 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 (Louisiana Rev Stat Ann §14.43.5 [1996]).

* In Michigan sexual penetration after knowledge of seropositivity and without informing the partner is a felony (Michigan 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 (Missouri Stat Ann §191.677 [1996]).

* In Oklahoma it is a felony to engage in any activity with the intent to infect another person with HIV (Oklahoma 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 (South Carolina 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).

During the past two years the following states have also introduced similar legislation:

* In Ohio it is a felony for a person who knows he or she has HIV to have sex without obtaining the

adopted by states in this regard:⁶⁹³

- ! 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.⁶⁹⁴
- ! To criminalise certain otherwise legal acts if performed by a person with HIV.⁶⁹⁵
- ! To enhance penalties for already illegal acts (most commonly prostitution) when committed by a person with HIV.⁶⁹⁶

These approaches are not exclusive of one another - legalisation in many jurisdictions encompasses all three.⁶⁹⁷ Most states have defined the relevant offence as a *felony* (i.e. serious crime) rather than simply a *misdemeanour* (i.e. less serious crime).⁶⁹⁸ 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.⁶⁹⁹ Many states impose compulsory, involuntary HIV testing upon those convicted of prostitution and/or those charged with certain sexual offences.⁷⁰⁰

8.7.1 In a challenge to these 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

partner's consent in advance (Ohio House Bill 100 [1999]).

* In Pennsylvania "criminal transmission of HIV/AIDS" is a felony and applies in respect of anyone who knows he or she has HIV and engages in sexual intercourse or shares a needle without disclosing his or her infection to their partner (Pennsylvania Senate Bill 847 [1999]).

* In South Dakota it is a felony for a person who knows that he or she has HIV to engage in intimate physical contact that presents a significant risk of HIV transmission (South Dakota Senate Bill 48 [2000]).

(**Canadian HIV/AIDS Policy & Law Newsletter Spring/Summer 2000** 36).

693 Elliot 19.

694 Ibid; **AIDS Practice Manual** 13-21 - 13-24.

695 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" or intravenous drug users (Elliot 19); see also some of the examples referred to in fn 508.

696 Elliot 19; **AIDS Practice Manual** 13-23 - 13-24.

697 Elliot 19.

698 Ibid. See fn 689 above for the distinction between felonies and misdemeanours.

699 Elliot 19; **AIDS Practice Manual** 13-21 - 13-24.

700 Ibid.

questions of fairness, and that less restrictive means are readily available to accomplish the goal of preventing the spread of HIV.⁷⁰¹ 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 taught by AIDS educators as safe forms of sexual expression.⁷⁰²

701 When applied to *consensual* sexual activity, such prosecutions may result in unwarranted invasions of the privacy rights of persons with HIV as well as their sexual partners 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 (North Dakota 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). In other instances the challenge that these provisions are unconstitutional referred to their violation of the "equal protection" clause of the United States Constitution in that they singled out people with HIV for unequal treatment (**Canadian HIV/AIDS Policy & Law Newsletter Spring/Summer 2000** 37).

However, Appellate courts in several states have upheld HIV-specific criminal exposure laws as constitutional. In September 1999, the Kentucky Supreme Court eg denied an HIV-positive man's application for a discretionary review of an Appellate Court decision that had upheld his conviction for having engaged in sexual intercourse without disclosing his HIV status. The Court of Appeals held that the accused's allegation that the complainant consented to sex knowing that he was HIV-positive, was irrelevant to the issue of whether he could be legally charged with the offence (**Canadian HIV/AIDS Policy & Law Newsletter Spring/Summer 2000** 36). In November 1999 the Washington Court of Appeals upheld a conviction and sentence of a man with HIV charged under the state's "criminal exposure law" for having unprotected sex with a woman. The accused did not hide his HIV status from his numerous sexual partners, but was inconsistent in his use of condoms and was not particularly concerned if some of his partners became infected. The Court held that the particular statutory provision was not unconstitutional as it applied equally to infected and noninfected accused persons, and merely criminalised specific conduct (**Canadian HIV/AIDS Policy & Law Newsletter Spring/Summer 2000** 37).

702 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).

8.7.2 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.⁷⁰³

8.8 In an attempt to alter the current federal position, legislation was fairly recently proposed in the House of Representatives. It has however not been enacted yet.

8.8.1 The HIV Prevention Bill was proposed in March 1997.⁷⁰⁴ It stated 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, and directed that states should have in operation laws providing that intentionally infecting others with HIV is a felony.⁷⁰⁵ The Bill (which also covered a range of more traditional public health interventions regarding HIV/AIDS including improved HIV epidemic surveillance; partner notification; and HIV testing of sexual offenders) was not enacted⁷⁰⁶ because of vigorous opposition.⁷⁰⁷

703 **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 (**AIDS Practice Manual** 13-24; Andrias 1993 **Fordham Urban Law Journal** 505-506).

704 HIV Prevention Bill (105th Congress 1997 HR 1062). (The Bill is also known as the "Coburn HIV Prevention Bill" having been introduced by Rep Tom Coburn.)

705 Ibid 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)). (See fn 689 above for the distinction between felony and misdemeanour.)

706 Information supplied to the researcher by Sarah Lightbown, AIDS Action New York 10 August 2000; information supplied to the researcher by Roland Foster, Legislative Director of Rep Tom Coburn on 10 August 2000.

707 See eg **ACLU News** 1 August 1996 (Internet); **AIDS Action Analysis** 21 April 1997 (Internet); **ACLU News** 29 September 1998 (Internet); **ACTUP Report** 23 March 2000 (Internet).

8.8.2 Attempts to return to the traditional, more coercive, public health approach with regard to HIV/AIDS have met with fierce opposition in the United States.⁷⁰⁸ 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. 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.⁷⁰⁹

Canada

8.9 In Canada there are currently no statutory provisions explicitly and specifically aimed at transmitting HIV or exposing another person to infection.⁷¹⁰

708 Burr **The Atlantic Monthly** June 1997 65-67.

709 Ibid 67.

710 Elliot 5-6.

- 8.10 There have however been several instances of criminal prosecutions for transmission or exposure under existing offences of the Criminal Code.⁷¹¹ These include prosecutions for the offences of criminal negligence causing bodily harm,⁷¹² common nuisance,⁷¹³ assault,⁷¹⁴ administering a noxious thing⁷¹⁵ and attempted murder.⁷¹⁶ Most of these cases have involved (apparently) *consensual* sexual activity, several of them have succeeded, and terms of imprisonment ranging from one to over eleven years have been imposed.⁷¹⁷
- 8.11 Some have however suggested increased powers of coercive intervention specifically aimed at HIV. To this end two private members' Bills have been introduced in the House of Commons to amend the Criminal Code. Bill C-290 of 1988 proposed making it an offence for a person with HIV to "knowingly do any act that may expose a person" to HIV. Under the proposed offence no criminal liability would have existed where the accused first informed his or her sexual partner of the risk of infection and the partner knowingly consented in taking such a risk.⁷¹⁸ Bill C-354 of 1995 proposed to outlaw any act of sexual intercourse by a person with HIV, even if a condom is used and the person's partner knows of his or her HIV status. The Bill specified two new offences for wilful or reckless acts by a person who knows or should reasonably know that they have HIV -
- ! "criminal infection" carrying a maximum penalty of life imprisonment if the act transmitted HIV; and
 - ! "reckless infective behaviour" with a penalty of up to seven years imprisonment if the act did not transmit HIV.⁷¹⁹
- Neither of the two Bills was proceeded with.⁷²⁰

711 Ibid.

712 Criminal Code, sec 219 and 221.

713 Ibid sec 180.

714 Ibid sec 265-268.

715 Ibid sec 239 and 229.

716 Ibid.

717 Elliot 6-7.

718 Bill C-290 (A Bill to amend the Criminal Code [Exposure to Human Immunodeficiency Virus] Second Session, Thirty-third Parliament, 35-36-37 Elizabeth II, 1986-87-88) as referred to in Elliot 7-8 and Elliot Appendix D.

719 Bill C-354 (A Bill to amend the Criminal Code [Transmission of HIV] First Session, Thirty-fifth Parliament, 42-43-44 Elizabeth II, 1994-95) as referred to in Elliot 8 and Elliot Appendix D. See also **Canadian AIDS Legal Network Criminal Law and HIV/AIDS Info Sheet No 4** 1999.

720 Elliot 6-7.

- 8.12 The Canadian AIDS Legal Network in a Final Report on criminal law and HIV/AIDS, published in 1997, noted that there is wide-spread concern about the use of criminal sanctions to prosecute persons who engage in activities that risk transmitting HIV and about proposals to amend the Criminal Code to create an HIV-specific offence.⁷²¹ The Report recommended that such an offence should not be created⁷²²
- ! because proposals in this regard are flawed;
 - ! because creating a new offence is unnecessary since existing criminal offences can be adequately used to address conduct that transmits HIV; and
 - ! because it is unlikely that a new offence would achieve any improvement in the body of criminal law that would outweigh the costs of making such an amendment.
- 8.13 In 1998 the Supreme Court of Canada released a significant judgment in dealing with a criminal prosecution of a person with HIV for engaging in sexual activity without disclosing his HIV status. Overruling lower-court decisions, the Supreme Court in **R v Cuerrier**⁷²³ ruled that where sexual activity poses a "significant risk of serious bodily harm", there is a duty on the person with HIV to disclose his or her HIV status. Where this duty exists, not disclosing may constitute "fraud" that renders a sexual partner's consent to that activity legally invalid, thereby making the otherwise consensual sexual act an "assault" under Canadian criminal law. The Supreme Court acknowledged that education and interventions by public health authorities are available to respond to such conduct, but ruled that the criminal law has a deterrent role to play when public health efforts are unsuccessful.⁷²⁴

721 Ibid 8-9. See also **Canadian AIDS Legal Network Criminal Law and HIV/AIDS Info Sheet No 4** 1999.

722 Elliot 107.

723 (1998), 127 CCC (3d) 1.

724 Ibid; **Canadian HIV/AIDS Policy and Law Newsletter** Summer 1999 44. See also the discussion in par 6.8.2.2 above.

8.14 In the first case to be decided by a Canadian court following the **Cuerrier** decision, a man with HIV was convicted in April 2000 of aggravated assault and common nuisance for continuing to have unprotected sex with his girlfriend, after learning he was HIV-positive, without disclosing his status to her.⁷²⁵ He was found not guilty on a charge of criminal *negligence* causing bodily harm.⁷²⁶ The accused was sentenced to five and a half years imprisonment.⁷²⁷ Of significance, the Court *inter alia* noted the following:

- ! The accused's unprotected sex with the complainant *before* he learned of his HIV infection can attract no criminal sanction, because there was no "guilty mind". What was conclusive, was his conduct *after* learning of his infection.⁷²⁸
- ! Anyone, male or female, who engages in unprotected sex, knowing they are HIV-positive, and not disclosing this, endangers not only their sexual partner but every person with whom that partner subsequently has unprotected sex. This constitutes a threat to public health.⁷²⁹
- ! The possibility was raised that the accused could have infected the complainant *before* he knew of his own HIV infection.⁷³⁰ A conviction for aggravated assault under Canadian law would require that he have "endangered the life" of the complainant. If she was already infected by the time the accused learned of his own infection then he did not endanger her life by having unprotected sex with her. Therefore, unless the prosecution could prove, beyond reasonable doubt that the complainant was still HIV-negative at the point when the accused learned of his infection, he could not be convicted of aggravated assault.⁷³¹ (This aptly illustrates the complexity of the issue in question.)

725 **R v Williams** [2000] NJ No 138 (SC-TD).

726 **Canadian HIV/AIDS Policy and Law Newsletter** Spring/Summer 2000 33.

727 *Ibid* 34.

728 *Ibid*.

729 *Ibid*.

730 The accused learned of his own infection a few months after his sexual relationship with the complainant commenced. The complainant tested positive for HIV approximately three years after their relationship commenced (**Canadian HIV/AIDS Policy and Law Newsletter** Spring/Summer 2000 33).

731 **Canadian HIV/AIDS Policy and Law Newsletter** Spring/Summer 2000 33.

United Kingdom

8.15 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 could be applied.⁷³²

8.15.1 In February 2001, in the first case of its kind before a British Court, a jury at the High Court in Glasgow found the accused guilty of culpable and reckless conduct for having unprotected sex with the complainant while he knew that he was infected with HIV.⁷³³ According to the evidence, the accused learned of his HIV infection 18 months before his sexual relationship with the complainant commenced; he never told her of his infection; and she subsequently tested positive for HIV. The accused was sentenced to five years' imprisonment.⁷³⁴

8.16 The available law however suffer from the same problems as their counterparts elsewhere: HIV-related behaviour does not clearly fit the behaviour described as being unlawful, and problems of proving intent and causation are present.⁷³⁵

8.17 In 1992, in the wake of a case that received wide-spread media attention, there were calls from a variety of quarters for Parliament to enact a new offence to address wilful (intentional) transmission of HIV.⁷³⁶ 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

732 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 Person 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).

733 **Her Majesty's Advocate v Stephen Kelly** (unreported trial reference no 1126/2000 in the High Court of Glasgow) (information supplied by Mr K Cumming, Senior Assistant Clerk of Justiciary, High Court Edinburgh on 19 March 2001).

734 See the information at http://news.bbc.co.uk/1/hi/english/uk/scotland/newsid_1223000/1223845.stm.

735 Tierney 1992 **Hastings International and Comparative Law Review** 506; Hamilton in **AIDS: A Guide to the Law** 27-30;

736 Elliot 19. See also Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet).

not be beyond the reach of the criminal law.⁷³⁷ 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.⁷³⁸ The Commission suggested that the amended restatement of the law would cover situations involving the intentional or reckless infection of others with HIV.⁷³⁹ The proposed offence of causing intentional serious injury to others, carries a maximum sentence of life imprisonment.⁷⁴⁰ 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 to be capable of interfering substantially with the others' bodily functions".⁷⁴¹ It is to be noted that this measure, while encompassing HIV, is not HIV-specific. Subsequent indications are that the government has rejected the Law Commission's proposal to criminalise minor illnesses and "reckless" transmission, and proposes to restrict prosecutions to cases where "it can be proved beyond reasonable doubt [that a person] had deliberately transmitted a disease intending to cause a serious illness".⁷⁴²

737 **Law Commission Report No 218** 1993 par 15.17; see also Elliot 24-25.

738 **Law Commission Report No 218** 1993 par 5.10, 5.16 and 5.17; see also clauses 2-4 of the proposed 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 wife 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 proposed draft Bill therefore refers to *causing* harm (**Law Commission Report No 218** 1993 par 5.10, 5.16-5.17; Tierney 1992 **Hastings International and Comparative Law Review** 503-504; Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** [Internet]).

739 **Law Commission Report No 218** 1993 par 15.17; see also Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet).

740 Schedule 2 of the draft Criminal Law Bill (**Law Commission Report No 218** 1993 p121).

741 **Law Commission Report No 218** 1993 par 24.4-24.7 and clause 5 of the proposed Criminal Law Bill; Elliot 24-25; Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet). This is also a proposed amended restatement of the law - cf the reference to sec 23 of the Offences of the Person Act 1861 in fn 732 above.

742 **Canadian HIV/AIDS Policy and Law Newsletter** Spring 1999 47.

- 8.18 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).⁷⁴³ "Serious disabling injury" would include HIV infection according to some commentators. Many are critical of these proposals. Their main concerns include the following:⁷⁴⁴ 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. As far as could be ascertained these proposals have not been finalised.

Australia

- 8.19 The present law dealing with criminal liability for HIV transmission can be found both in the general criminal law dealing with offences against the person and in specific offences contained in various public health Acts and Ordinances.⁷⁴⁵ 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 in others broader offences regarding infectious diseases are available 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.⁷⁴⁶ 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

743 **Law Commission Consultation Paper** No 139 1995 par 4.47-4.52 and p 204; Elliot 25; Ormerod 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).

744 Elliot 25. Cf also Dine and Watt 1998 **Web Journal of Current Legal Issues** (Internet); Ormerod and Gunn 1996 **Web Journal of Current Legal Issues** (Internet).

745 Bronitt 1992 **Criminal Law Journal** 86-87.

746 Elliot 21-23.

behaviour justify the creation of a new crime of culpable transmission.⁷⁴⁷

8.20 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.⁷⁴⁸ The Legal Working Party of the Intergovernmental Committee on AIDS in 1992 approved the application of public health offences to HIV-related behaviour - in preference to the criminal law - but with the following qualifications:⁷⁴⁹

- ! 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 counselling and education; medical and psychological assessment; restriction of movement and activities; and detention and isolation as a last resort.

747 Bronitt 1992 **Criminal Law Journal** 92-93.

748 **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 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).

749 **Australia Final Report on AIDS** 22-23; Elliot 22-23; Gibson 1997 **HIV/AIDS Legal Link** 6-7.

- 8.21 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 1995-1996.⁷⁵⁰ It seems that most people who have been managed experienced drug dependency, intellectual disability and/or mental illness.⁷⁵¹ Only in exceptional cases has the criminal law intervened.⁷⁵² 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.⁷⁵³
- 8.22 In 1998 a Committee preparing a draft Model Criminal Code for enactment in all Australian jurisdictions recommended that the proposed Code should include an offence of reckless endangerment for "conduct that may give rise to a danger of death or serious harm" which is defined as including "exposing a person to the risk of catching a disease that may give rise to a danger of death or serious harm".⁷⁵⁴ As far as could be ascertained these recommendations have not been finalised.

Zimbabwe

- 8.23 Zimbabwe intended introducing legislation since 1994 utilising the criminal law as a response to HIV/AIDS.⁷⁵⁵ The Sexual Offences Bill 2000 provides for the criminalisation of deliberate transmission of or exposure to HIV, and for specific sentences where the person convicted was infected with HIV.⁷⁵⁶

750 Gibson 1997 **HIV/AIDS Legal Link** 7.

751 Ibid.

752 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); and in Tasmania, one person was prosecuted 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).

753 Gibson 1997 **HIV/AIDS Legal Link** 9.

754 **Canadian HIV/AIDS Policy and Law Newsletter** Spring 1999 47.

755 It is not clear whether the measures are proposed with the intention to curb the spread of HIV/AIDS or to punish harmful behaviour.

756 The Sexual Offences Bill 2000 is the amended version of the Criminal Law Amendment Bill 1996 which

8.23.1 The Bill makes it a criminal offence for any person, having actual knowledge that he has HIV, intentionally to do anything or permit the doing of anything which he knows or ought reasonably to know will infect another person with HIV; or is likely to lead to another person becoming infected with HIV.⁷⁵⁷ 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.⁷⁵⁸ The provision will apply irrespective of whether the accused is married to the complainant.⁷⁵⁹ On conviction, the accused will be liable to imprisonment for a period not exceeding 20 years.⁷⁶⁰

8.23.2 The Bill further provides that a court shall sentence a person convicted of rape and certain other sexual offences to imprisonment for a period not exceeding twenty years whether or not the convicted person was aware of his or her HIV infection at the time of commission of the offence.⁷⁶¹ For purposes of this provision it shall be presumed, unless the contrary is shown, that the convicted person was infected with HIV when the offence was committed if it is proved that the accused was infected with HIV within thirty days after committing the offence.

was published for public comment in 1996 (see fn 781 in Chapter 9 below for the relevant provisions of this Bill which was submitted for public comment in **SALC Discussion Paper 80**). The Criminal Law Amendment Bill contained more or less similar provisions regarding the creation of an HIV-specific offence and specific sentences where the convicted person was infected with HIV. At the time the Zimbabwean Minister of Justice expressed the hope that the legislation will be passed by Parliament and several women's organisations in Zimbabwe welcomed the proposals saying it was long overdue (**The Herald** 20 May 1997). Representatives from eight Zimbabwean nongovernmental organisations concerned with human and women's rights were however opposed to the criminalisation of HIV transmission submitting 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". Their comment implies that recalcitrant behaviour would be the exception and would occur mostly in the context of sexual abuse. They argued 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. These organisations submitted 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 believed that the proposed legislation places an unfair responsibility for prevention and protection on those who are already infected in the case of consensual sex (comment on the Criminal Law Amendment Bill 1996 supplied to the researcher by Ms Lynde Francis of The Centre, Zimbabwe on 14 March 1998).

757 Sexual Offences Bill 2000 clause 14(1).

758 Ibid clause 14(2).

759 Ibid clause 14(1).

760 Ibid.

761 Ibid clause 15.

(The Bill provides for the compulsory HIV testing of convicted persons.⁷⁶² The presence in a person's body of HIV antibodies detected through an appropriate test, shall be prima facie proof that the person concerned is infected with HIV.⁷⁶³)

8.23.3 At the time of compilation of this Report the Sexual Offences Bill, 1999 has not yet been approved by the Zimbabwe government.⁷⁶⁴

Namibia

8.24 Following on a 1997 Report by the Law Reform and Development Commission,⁷⁶⁵ the Combatting of Rape Act 8 of 2000 was passed by the Namibian Parliament and came into operation on 5 June 2000.⁷⁶⁶

762 Ibid clause 16(2), 16(4)(a).

763 Ibid clause 17(1).

764 Information provided by Judge E Gwaunza, Deputy Chairperson: Law Development Commission, Zimbabwe on 13 March 2001.

765 **Namibia Report on the Law Pertaining to Rape** 1997.

766 Government Notice 114 of 2000 in **Government Gazette** of the Republic of Namibia 2326 of 10 May 2000. Information on the date of commencement supplied by Mr AF Bampton, Law Reform and Development Commission, Namibia on 3 August 2000.

- 8.25 The Act mainly broadens the common law definition of rape to include other serious sexual violations. In doing so the Act *inter alia* removes "absence of consent" as an element of rape and replaces it with committing a "sexual act"⁷⁶⁷ under "coercive circumstances".⁷⁶⁸ The draft Bill which preceded the Act included in "coercive circumstances" circumstances where the perpetrator knows that he or she is infected with HIV and does not disclose this fact prior to committing the sexual act.⁷⁶⁹ (This would have meant that a person with HIV who did not disclose his or her HIV positive status to his or her sexual partner could be convicted of rape even if precautionary measures were used.) This provision has not been included in the promulgated Act - possibly because of public opposition.⁷⁷⁰ The Act further gives greater protection against the sexual abuse of children; provides for minimum sentences and stricter bail conditions for rapists; eliminates several archaic evidentiary rules relating to rape proceedings; and provides for measures to reduce the trauma for rape victims.⁷⁷¹
- 8.26 The Act also provides for a minimum sentence (fifteen years' imprisonment in the case of a first conviction and 45 years for a subsequent conviction) for any person who is convicted of rape⁷⁷² and who knew that he or she was infected with "any serious sexually transmitted disease" at the time of the commission of the rape.⁷⁷³

767 "Sexual act" is defined broadly and includes -
 * the insertion of the penis of a person into the vagina or anus ... of another person;
 * the insertion of any other part of the body of a person or animal, or any object into the vagina or anus of another person; and
 * cunnilingus or any other form of genital stimulation (section 1 of the Act).

768 "Coercive circumstances" could include *inter alia* the application of physical force or threats; the application of physical force to the complainant; or circumstances where the complainant is under the age of 14, is physically disabled or mentally incapacitated (section 2 of the Act).

769 Clause 2(2)(i) of the Combatting of Rape Bill 1999.

770 Group Submission to the Namibian Parliamentary Standing Committee on Human Resources, August 1999 4.

771 **Namibia Report on the Law Pertaining to Rape** 1997 2-9; The Combatting of Rape Act 8 of 2000.

772 "Rape" refers to a sexual act committed intentionally under coercive circumstances by the perpetrator, or which the perpetrator causes another person to commit with him or herself or with a third person. The Act indicates what "coercive circumstances" might include without exhaustively defining such circumstances (see fn 768 above).

773 "Serious sexually transmitted disease" is not defined by the Act.

Germany

8.27 In Germany the Penal Code provides that "whoever causes bodily harm to another through negligence shall be punished by up to three years' imprisonment or by fine".⁷⁷⁴ This provision is commonly applied to reckless driving and medical negligence, and is regarded as important in view of the increase in traffic and in the use of dangerous instruments in specialised professions eg the medical profession.⁷⁷⁵ The "negligence" referred to could consist of conscious or unconscious negligence and is wide enough to apply also to negligent bodily harm in the case of HIV infection.⁷⁷⁶ This provision has apparently never been applied to persons *not aware* of their HIV positive status.⁷⁷⁷ The opinion has been expressed in German legal literature that there is no obligation on a person to undergo regular blood tests even if such person belongs to so-called "high-risk groups".⁷⁷⁸

774 Section 229.

775 Van Wyk 2000 **Codicillus** 9. See also "Negligent Commitment of Criminal Offences - HIV/AIDS Implications - German Law, Jurisprudence and Literature" Memorandum prepared for the information of the Project Committee by Mr Rainer Phaff, German Technical Cooperation 30 September 2000.

776 *Conscious negligence* would be present where a person with HIV, knowing about his or her infection, fails to take the steps a reasonable person would have taken to prevent infection - perhaps because he or she hopes that infection will not occur. *Unconscious negligence* would be present if a person with HIV does not ascertain his or her serostatus in circumstances where a reasonable person would have gone for testing. Persons who ought to know or who suspect that they have HIV would fall into this category (Van Wyk 2000 **Codicillus** 9). See also par 6.9.3 above.

777 "Negligent Commitment of Criminal Offences - HIV/AIDS Implications - German Law, Jurisprudence and Literature" Memorandum prepared for the information of the Project Committee by Mr Rainer Phaff, German Technical Cooperation 30 September 2000.

778 Van Wyk 2000 **Codicillus** 9 referring to Wokalek and Köster "AIDS und Fahrlässigkeitsstrafbarkeit" 1989 **Medizinrecht** 286. Van Wyk observes that although the term "high-risk group" is no longer acceptable, this view would probably also be applicable to people who follow high-risk life-styles (Van Wyk 2000 **Codicillus** 10).

9 Preliminary recommendations in Discussion Paper 80

9.1 As indicated in Chapter 2⁷⁹ above, the Commission in January 1999 published a discussion document (Discussion Paper 80) for public comment dealing with the administrative and criminal law measures available to address harmful HIV-related behaviour and possible statutory intervention.

9.2 Discussion Paper 80 examined three possible measures to deal with harmful HIV-related behaviour:

- ! *public health measures;*
- ! *existing common law criminal measures; and*
- ! *the creation of an HIV-specific statutory offence/s (be they additional offences criminalising conduct not hitherto criminal, or offences restating the common law).*

(It should be noted that although the material in Discussion Paper 80 did not expressly distinguish between *consensual* and *nonconsensual* sexual acts resulting in exposure or transmission of HIV, the Paper mainly addressed the need for an offence in circumstances of *consensual* sexual exposure to or transmission of HIV. It became necessary to expressly make this distinction in the current Report as a result of an overlap of work done under the Commission's investigations into Aspects of the Law relating to AIDS [Project 85] and Sexual Offences [Project 107] which became evident after publication of Discussion Paper 80. Par 4.13 above sets out the parameters of the current investigation in this context.)

9.3 The Commission doubted the appropriateness of the use of coercive **public health measures** (i.e. isolation and quarantining), primarily because such measures could amount to an infringement of individual rights which might not be justified by the limited advantages to such an approach.

779 Par 2.18-2.21 provide a short overview of the research and consultation undertaken for this investigation.

- 9.4 The Commission indicated that the crimes of murder, culpable homicide, rape and assault are **existing common law crimes** which could all potentially be used to deal with harmful HIV-related behaviour, with no need for further statutory intervention. However, it may be that HIV-related behaviour will not be easy to prosecute under existing common law crimes. For instance, it may be difficult to prove the various elements of these offences, such as fault (whether the accused acted negligently, or with the intention of transmitting HIV) and causation (whether the act of the accused caused, or was likely to cause, the transmission of HIV infection to the other person). It was emphasised that since there has to date been no successful prosecutions under the existing common law to sanction harmful HIV-related behaviour in South Africa, there is no legal clarity on the appropriateness of the common law crimes to deal with these issues.
- 9.5 As regards the possibility of **creating an HIV-specific offence/s**, Discussion Paper 80 left open the question whether such offence/s should be created. The Paper did not propose draft legislation but considered various statutory options based on examples from comparable legal systems. The examples included legislation from certain states in the United States of America and Australia; and draft legislation from the United States and Zimbabwe. The Paper also set out the advantages and disadvantages associated with creating HIV-specific statutory offences and invited comment on a range of questions highlighting the crucial issues to be debated. These included questions regarding the possible prosecutorial difficulties in applying the existing common law crimes; the counter-productive effect the creation of HIV-specific offences may have on public health efforts in curbing the spread of HIV; the viability of utilising public health measures as an alternative to taking recourse to the criminal law; as well as specific questions relating to the formulation of any new statutory offence should it prove to be indicated.

9.5.1 The public's attention was drawn to the following statutory options from comparable foreign legal systems (the examples of these options submitted for comment are included in the footnotes below):⁷⁸⁰

! Criminalising the intentional infection of another with HIV (see eg clause 14 of the **Zimbabwe Criminal Law Amendment Bill 1996**⁷⁸¹ and clauses 2 and 4 of the **United States HIV Prevention Bill 1997**⁷⁸²).

! Criminalising the intentional exposure of another to a risk of HIV infection, or any sexually transmissible disease (see eg §39-13-109 of the **Tennessee Annotated Code 1994 [United States]**⁷⁸³ and §50-18-

780 See also the Annexure to **SALC Discussion Paper 80**.

781 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 antibodies or antigens, detected through an appropriate test shall be prima facie proof that the person concerned was infected with HIV;".

The Bill provides for a person who is alleged to have contravened clause 14, to be tested for HIV (clause 16(2)).

782 SECTIONS 2 and 4 OF THE UNITED STATES 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".

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

783 §39-13-109 OF THE TENNESSEE ANNOTATED CODE 1994

"39-13-109. Criminal exposure to HIV - Defences - 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: ...

- 112 and 113 of the *Montana Annotated Code 1995 [United States]*⁷⁸⁴).
- ! Prohibiting sexual intercourse by a person with HIV with any other person, unless certain conditions exist - such as consent by another who knows of the accused's HIV status (see eg §14-384.24 of the *Florida Annotated Statutes 1997 [United States]*.⁷⁸⁵

-
- (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 defence 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 offence of criminal exposure of another to HIV.
- (e) Criminal exposure of another to HIV is a Class C felony".
- 784 §50-18-112 AND 113 OF THE MONTANA ANNOTATED CODE 1995
"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".
For the purposes of this provision "sexually transmitted disease" includes AIDS. This is an example of legislation aimed at harmful HIV-related behaviour which is not HIV-specific.
- 785 §14-384.24 OF THE FLORIDA ANNOTATED STATUTES 1997
"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 ...".

- ! Requiring a person with HIV to take all reasonable measures to prevent transmission of the disease (see eg section 37 of the **South Australia Public and Environmental Health Act 1987**).⁷⁸⁶

9.5.2 The advantages of creating an HIV-specific statutory offence/s were set out as the following:

- ! Minimising ambiguities associated with the application of the common law crimes.
- ! Reducing the risk of selective application of the law, since the elements of a statutory offence are set out clearly in the statute.
- ! Responding to the public's sense of behaviour deserving of punishment.
- ! Deterring potential offenders.
- ! Protecting the constitutional rights to life and bodily integrity.
- ! Filling a 'gap' which civil law and public health measures are unable to address.
- ! Reducing the vulnerability of women to infection.
- ! Responding to public pressure and the high levels of crime.

9.5.3 The disadvantages associated with creating a specific statutory offence/s to deal with harmful HIV-related behaviour were submitted to be the following:

- ! Duplicating existing common law measures which are already available without overcoming any of the problems associated with proving the commission of the offence.
- ! Running the risk of such offences being applied selectively, in a

Under the above provision 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. 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).

786

SECTION 37 OF THE SOUTH AUSTRALIA PUBLIC AND ENVIRONMENTAL HEALTH ACT 1987

"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".

"AIDS" and "AIDS-Related Complex" (the severe symptomatic phase of HIV infection) 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. 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.)

discriminatory fashion, which may result in the further stigmatisation of certain risk groups.

- ! Creating measures which are counter-productive to public health efforts to address HIV/AIDS.
- ! Creating unnecessary legislation which fails to have a deterrent effect, since the reasons why an individual knowingly exposes another to HIV are social and highly complex.
- ! Infringing human rights (such as the right to equality) of selected marginalised groups who may be targeted by a statutory offence, and infringing the right to privacy without significant public health benefit.
- ! Acting contrary to existing public health strategies (based on voluntary participation and behaviour change) to curb the epidemic.
- ! Failing to reduce the vulnerability of women - since they are most likely to be tested for HIV and therefore know their HIV status.
- ! Failing to reduce the crime rate, since "over-criminalising" may lessen the authority of the criminal law, unnecessarily stigmatise individuals as criminals and overload the criminal justice system.
- ! Legislating at a problem as a substitute for other forms of political and social action.

9.6 The principle issues on which the Commission at the time invited comment included the following.⁷⁸⁷

- (A) The role of the criminal law in the HIV/AIDS context.
- (B) The definition of harmful conduct in the HIV/AIDS context.
- (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.
- (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.⁷⁸⁸
- (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

787 **SALC Discussion Paper 80** par 7.7-7.8.

788 In response to this question respondents did not make a distinction between possible codification of the common law crimes and the creation of a new offence criminalising behaviour not hitherto criminal.

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.

- (F) The need for creating an offence of exposing another to HIV without transmission of HIV actually occurring.
- (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 liable to prosecution under a charge of culpable homicide).
- (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.

Should the creation of a statutory offence be indicated, and with reference to the examples from other legal systems, comment was 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 transmissible 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?)
- (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?
- (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?

9.7 Information regarding the response to the Paper and an analysis of the comments are

contained in Chapter 10 below.

10 Response to Discussion Paper 80

Background

- 10.1 Discussion Paper 80 was distributed to 690 identified parties during January 1999. These include the prosecuting and adjudicating authorities (judges, magistrates and directors of public prosecution); the South African Police Service (SAPS); criminal law experts; medical experts (eg district medical officers [formerly known as district surgeons] and the organised medical profession); nongovernmental organisations concerned with human rights and HIV/AIDS issues; nongovernmental organisations concerned with women's rights and violence against women; women's organisations; relevant research institutions and government departments; and the organised legal profession.
- 10.2 The release of the Discussion Paper was advertised in the **Government Gazette**⁷⁸⁹ and by way of a media statement. Further copies of the Paper were subsequently distributed to members of the general public.
- 10.3 Insufficient comment was received by the closing date of 28 February 1999. A further 75 copies of the Paper were then distributed to identified persons and bodies and the closing date for comment was extended to 31 March 1999. An additional media statement was released on 3 March 1999 to again advertise the Paper for comment.
- 10.4 Written submissions were received from 60 persons, bodies and organisations. Comments received after the extended date were also taken into account.
- 10.5 The comments reflected a range of relevant interests as is evident from the list of respondents included in ANNEXURE A.

789 Government Notice 4 in **Government Gazette** 19669 of 15 January 1999.

- 10.6 Some of the comments reflect the views of interest groups of considerable extent while other represent the views of private individuals, researchers or small organisations. Amongst the responses were valuable comments received from renowned South African criminal law experts; the prosecuting and adjudicating authorities; prominent nongovernmental organisations concerned with human rights and HIV/AIDS, and with women's rights and violence against women respectively. The AIDS Law Project and its affiliates (a nongovernmental organisation concerned with the rights of persons with HIV/AIDS) and Tshwaranang Legal Advocacy Centre to End Violence Against Women (a nongovernmental organisation concerned with victims' rights and violence against women - referred to as Tshwaranang below) are acknowledged for their extensive comments. Two international experts also responded to the Paper.⁷⁹⁰
- 10.7 The Inkatha Freedom Party, through its spokesperson on health, Dr Ruth Rabinowitz MP, submitted its "Measures to Prevent the Spread of HIV Bill" (containing draft provisions aimed at the criminalisation of certain conduct by persons with HIV or AIDS) to the Commission for comment at the end of March 1999.⁷⁹¹ The Commission, (without commenting on the Bill pending its current investigation on a similar issue) indicated that it will regard the Bill and supporting material submitted, as comment on Discussion Paper 80.⁷⁹²
- 10.8 Significant responses on the Discussion Paper from Cabinet and from the Commission's Sexual Offences Project Committee are included in the comment.
- 10.8.1 The former Minister of Justice, in a letter to the Secretary of the Commission, conveyed concerns raised by Cabinet on the advisability of creating statutory offences aimed at harmful HIV-related behaviour after Discussion Paper 80 had been tabled in the Inter-Ministerial Committee on HIV/AIDS⁷⁹³ in February 1999. The former Minister remarked as follows:

We have carefully looked at Discussion Paper 80 and noted the concerns which have been expressed. We also appreciate that the matter is fraught with difficulty and should be approached with great caution.

790 Dr Lorraine Sherr, Royal Free Hospital School of Medicine: University of London; and Adv David Buchanan SC, Australian Supreme Court.

791 See fn 901 below for the Inkatha Freedom Party's proposed measures.

792 Departmental letter 7/2/1/85 of 31/3/99.

793 Ministerial letter 5/15/7/1/2 (MIN) of 6 April 1999. See par 5.5 above for information on this Committee.

Government is looking forward to the Commission's final report and recommendations with great interest, because of the serious concerns which government has about harmful HIV-related behaviour.

Whilst government has not taken any decision in the matter, government wishes to do whatever is necessary to protect innocent victims against such harmful behaviour. In the main, three questions are of major concern:

1. Should special recommendation, especially with regard to punishment not be made in respect of persons found guilty in cases where, as a result of a crime, the victim is infected with the virus?
2. Should special steps not be taken against persons who deliberately for one or other reason transmit the disease to others?
3. Should steps not be taken against persons who failed to disclose to their partners that they are HIV positive?

I wish to stress that government is not prescribing to the Commission how to respond to these questions. Government has every confidence that the Commission will take into account government's very serious concern and government looks forward to the Commission's report and recommendations in due course.

In response to the Minister's letter, the assurance was given that the Commission and Project Committee itself appreciate the sense of public anxiety which has led government to regard these questions as urgent priorities. The Minister was assured that the concerns raised will be specifically addressed and debated in the development of the current Report and that they will be taken into account by the Project Committee and the Commission in formulating its final recommendations.⁷⁹⁴

10.8.2 As indicated in paragraph 4.13 above, there is an overlap between the HIV/AIDS Project Committee's mandate to investigate the need for a statutory offence aimed at harmful HIV-related behaviour and the Sexual Offences Project Committee's investigation into the codification of the law relating to sexual offences (Project 107). Pending the outcome of the investigation on the need for a statutory offence aimed at harmful HIV-related behaviour, the Sexual Offences Project Committee in its Discussion Paper 85 (which was published for public comment in September 1999) did not address HIV/AIDS issues. That committee however recorded their concern about the following:

- ! The failure to disclose HIV status to sexual partners.
- ! Harmful exposure to HIV/AIDS through nonconsensual sexual acts.

! The sentencing of persons found guilty in cases where, as a result of a crime, the victim is infected with HIV.⁷⁹⁵

(It is indicated in par 4.13 above, that it was subsequently decided that the current Interim Report will deal with the need for creation of an additional new statutory offence in the case of *consensual* sexual acts only. As is clear from the analysis of comments below, the comments of some respondents also bear on the need for intervention in respect possible HIV exposure or transmission during *nonconsensual* sexual acts [eg rape and gang rape]. These comments are included below and are responded to in the Commission's conclusion in Chapter 12.)

Analysis of comments

10.9 It is indicated in Chapter 9 above that Discussion Paper 80 left open the question whether an HIV-specific offence/s should be created, and did not contain draft legislation.⁷⁹⁶ Six examples of different legislative approaches dealing with harmful HIV-related behaviour in comparable foreign legal systems were instead included for public information.⁷⁹⁷ To facilitate comment, a comprehensive list of questions on which public input was required was included in the Discussion Paper.⁷⁹⁸

795 **SALC Discussion Paper 85** par 4.4.1-4.4.3.6 and specifically par 4.4.6.1. Discussion Paper 85, emphasising the complexity of the issues at stake and the danger of evaluating the options for reform without due regard to the motivation underlying it, invited interested readers to obtain copies of Discussion Paper 80 for information and to comment on the concerns expressed.

796 See par 9.5 -9.5.1 above.

797 See par 9.5.1 and the accompanying footnotes.

798 See par 9.6 above.

10.10 Not all respondents commented on every question submitted for comment. Some of the questions concerned technical criminal law issues which the Commission realised might not be readily answered by nonlawyers. Comment generally covered the following broad major issues and will be summarised below under these headings:

- A) *Whether the criminal law has a role to play in the HIV/AIDS epidemic.***
- B) *The need for creation of an HIV-specific statutory offence/s.***
- C) *The content or terms of a new statutory offence/s (should this be indicated).***
- D) *Alternatives to legislative intervention.***

10.11 In general the majority of respondents were of the opinion that the criminal law does have a role to play in the HIV/AIDS epidemic in protecting members of society from harmful behaviour by persons with HIV/AIDS. However, which route to follow in realising this (i.e. dealing with it through the existing common law or creating an HIV-specific statutory offence/s) was a major point of difference. Strongly motivated comments were received both for and against the creation of an offence/s. Of those respondents who expressly indicated a preference for one of the approaches for legislative intervention from comparable foreign legal systems, the majority favoured the Zimbabwe approach.⁷⁹⁹ Although this was not under discussion, some respondents also expressed themselves in favour of the compulsory HIV testing of rape or sexual offence suspects.⁸⁰⁰

10.12 An analysis of the comments follows below.

A) Does the criminal law have a role to play in the HIV/AIDS epidemic?

10.13 Although the majority of respondents conceded that coercive criminal measures would generally not prevent the spread of HIV and would thus not serve a public health rationale, they saw a role for the criminal law in the HIV/AIDS epidemic.⁸⁰¹ These respondents

799 See fn 781 above for the Zimbabwe example.

800 See eg the comments of the National Council for Persons with Physical Disabilities in South Africa; and Prof CR Snyman.

801 See eg the comments of Ms Justice L van den Heever; the Society for Advocates: Natal; the South African Dental Association; the Ministry of Caring of the NG Church: Synod Southern Gauteng; the General Council of the Bar of South Africa; Dr K Vallabhjee of the Department of Health: Provincial

represented a range of interests including members of the prosecuting and adjudicating authorities; certain criminal law experts; SAPS Detective Service;⁸⁰² some organisations concerned with women's rights and violence against women; some members of the organised legal profession; certain provincial, local and community health departments; certain nongovernmental community health organisations; and the Ministry of Caring of the NG Church: Southern Gauteng. Certain organisations working in the field of human rights and HIV/AIDS who were not in favour of the creation of an HIV-specific offence/s (but supported the utilisation of the existing common law), supported this view.⁸⁰³

- 10.14 Tshwaranang Legal Advocacy Centre to End Violence Against Women specifically requested the Commission to take cognisance of women's vulnerability to HIV/AIDS as a backdrop, when considering the role of the criminal law. They submitted that women are submitted to various forms of gender violence including sexual assault (ranging from rape, incest, indecent assault and child abuse) perpetrated against women and girls by strangers, intimate partners, relatives or acquaintances. They argued that this constitutes a form of discrimination against women since it not only inhibits their ability to live their lives free of violence, but also inhibits women from exercising their right to equality.
- 10.15 The role that the criminal law should or could play, and reasons advanced as motivation for such a role included the following:

Administration Western Cape; Dr R Rabinowitz; Prof F Van Oosten; Dr CA Pieterse; Dr JH Olivier; Lawyers for Human Rights, Pietermaritzburg; Regional Court President: Natal Regional Division; Prof S Lötter; and SAPS Detective Service. See however the comments of the Commissioner of Correctional Services and the National Council for Persons with Physical Disabilities in South Africa who submitted that in view of the rapid spread of HIV, the criminal law could serve as an additional means to eliminate further spread of the disease.

802 It is acknowledged, as reflected in ANNEXURE A, that these comments represented the comments of the Legal, and Serious and Violent Crimes Components of the SAPS Detective Service and not the entire SAPS.

803 See par 10.16 below.

- ! *A moral role:* The criminal law has a role to play in preventing harm or punishing harm done to others⁸⁰⁴ - some commentators saw this as a *moral role*.⁸⁰⁵
- ! *A role as accountability mechanism:* Other respondents submitted that persons with HIV who engage in conduct which they know could harm others should be held accountable for their actions by the criminal law. They submitted that in so far as utilisation of the criminal law may lead to an infringement of constitutional rights, accountability would be justified in terms of section 36 of the 1996 Constitution and in particular because of the severe consequences of infection with HIV, and the current lack of an effective vaccine or curative therapy.⁸⁰⁶
- ! *A condemnatory role:* Some commentators emphasised that the criminal law unquestionably has to take cognisance of and deal with unsocial behaviour by certain persons with HIV and the consequences of such behaviour just as other forms of unacceptable behaviour such as assault, culpable homicide or murder are dealt with.⁸⁰⁷ Some of them submitted that persons with HIV who deliberately or recklessly exposed others to or infect them with HIV deserve condemnation and that the strongest manner to express this is through the criminal law.⁸⁰⁸
- ! *A deterrent role:* Some held the view that the criminal law is an ideal mechanism to sanction behaviour which transmitted HIV or could transmit HIV, and to coerce persons with HIV to abstain from harmful conduct through the threat of incarceration.⁸⁰⁹ These respondents believed that sanctioning would be widely publicised and would have a general deterrent effect.⁸¹⁰

804 See eg the comments of the Society for Advocates: Natal; Tshwaranang; EJ Hamilton; Regional Court President: Cape Regional Division; Regional Court President: Natal Regional Division; and SAPS Detective Service.

805 See eg the comments of the Society for Advocates: Natal.

806 See eg the comments of the Society for Advocates: Natal; the General Council of the Bar of South Africa; and Prof CR Snyman. See par 7.9 et seq above for a discussion on the limitation of rights.

807 See eg the comments of the General Council of the Bar of South Africa; and Tshwaranang.

808 See eg the comments of the South African Dental Association.

809 See eg the comments of the South African Dental Association; and SAPS Detective Service. Cf also the comments of Dr R Rabinowitz.

810 See eg the comments of Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape; Prof CR Snyman; the Democratic Nursing Organisation of South Africa; and the Regional Court President: Northern Cape Regional Division.

Sanctioning would also reflect society's justified dissatisfaction with the reprehensibility and danger of such behaviour.⁸¹¹

- ! *A role supportive of public health measures:* Certain respondents suggested that under circumstances where it would appear that the public health approach has failed to significantly lead to behavioural modification, there is a strong case to be made for the criminal law to be utilised for the protection of victims who are incapable of protecting themselves against infection and exposure arising from harmful behaviour.⁸¹² In this context the opinion was expressed that the deliberate and intentional spread of HIV cannot really be regarded as a public health issue.⁸¹³ Such behaviour amounts to a rejection by a person with HIV of the only armamentarium that health authorities have at their disposal to combat the spread of the disease, viz education and counselling.⁸¹⁴ Others suggested that public health measures and criminal law should be synergistic and not mutually exclusive.⁸¹⁵ In this regard the Commission was urged to take cognisance of developments, especially in the developed world, where a balance is progressively being struck between individual and community rights to ensure a proper public health approach to the HIV epidemic, supported by criminal law to deal with HIV-related harmful behaviour.
- ! *A role in supplementing the common law.* Certain respondents saw the criminal law's role as one that should be aimed at providing for those instances where persons who knowingly and intentionally transmits HIV to others are not currently covered by the common law.⁸¹⁶
- ! *An educative role:* Others believed that the criminal law has a role to play, where all other alternatives have failed, to inculcate into persons with HIV to rather subject themselves to counselling and medication than practice high

811 See eg the comments of Prof CR Snyman.

812 See eg the comments of Ms Justice L van den Heever; the South African Dental Association; the Ministry of Caring of the NG Church: Synod Southern Gauteng; Prof F Van Oosten; Dr CA Pieterse; Tshwaranang; the Regional Court President: Cape Regional Division; and Business South Africa. Cf also the comments of Dr R Rabinowitz and the Director of Public Prosecutions: Witwatersrand Local Division.

813 See eg the comments of Dr CA Pieterse; Dr JH Olivier; and Lawyers for Human Rights, Pietermaritzburg.

814 See the comments of Dr CA Pieterse.

815 Comments of Tshwaranang; and Business South Africa. See also the discussion in par 10.37 et seq below.

816 Comments of the Regional Court President: Northern Transvaal Regional Division. See also the comments of Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape; Dr JH Olivier; Prof S Lötter; and the Democratic Nursing Organisation of South Africa.

risk behaviour.⁸¹⁷

10.16 Certain organisations working in the field of HIV/AIDS and human rights submitted that the role of the criminal law should be seen as an extremely limited one taking into account -

- ! that little, if no, evidence exists of the extent of actual harmful HIV-related behaviour;
- ! that other instances of discrimination and human rights abuses (eg those in the health care setting and work place) seem to be far more prevalent and of more concern to people infected and affected by HIV/AIDS; and
- ! that harmful HIV-related behaviour cannot be said to be the major cause of the spread of the HIV epidemic in our society since most persons in South Africa are unaware of their HIV status.⁸¹⁸

10.17 Respondents allocating a role for the criminal law in the HIV/AIDS epidemic were divided on the specific harmful conduct that should be targeted in fulfilling this role. Some restricted the conduct to *intentional*, malicious and reckless behaviour of persons who knowingly harm others;⁸¹⁹ while others indicated that *negligent* conduct should also be included.⁸²⁰ Some restricted the behaviour to acts resulting in *transmission* of or infection with HIV⁸²¹ while others submitted that *exposure* to the virus should also be covered.⁸²² Yet others defined harmful behaviour as failure by a person with HIV to inform his or her sex partner(s) of the infection coupled with failure to take reasonable steps to prevent harm to others; or the latter only.⁸²³

817 Comments of the Regional Court President: North West Regional Division.

818 See the comments of Lawyers for Human Rights, Pietermaritzburg; the AIDS Legal Network: National Office; AIDS Legal Network: KwaZulu-Natal; the National Association of People Living with HIV and AIDS; and the National AIDS Convention of South Africa.

819 See eg the comments of the Society for Advocates: Natal; Prof F Van Oosten; Dr CA Pieterse; and Business South Africa.

820 See eg the comments of the South African Dental Association; the General Council of the Bar of South Africa; Dr JH Olivier; EJ Hamilton; the Regional Court President: Northern Transvaal Regional Division; Prof S Lötter; the Regional Court President: Northern Cape Regional Division; and SAPS Detective Service.

821 See eg the comments of the South African Dental Association; Prof F Van Oosten; and Business South Africa.

822 See eg the comments of the Ministry of Caring of the NG Church: Synod Southern Gauteng; Tshwaranang; and SAPS Detective Service.

823 Comments of the Commissioner of Correctional Services.

10.18 The following respondents expressly indicated that the criminal law should not be afforded a role in the HIV/AIDS epidemic.

10.18.1 Fr H Ennis of the St John Vianney Seminary expressed the view that HIV/AIDS is first and foremost a medical matter, and that sound social behaviour and good public health should preferably be enforced through education programmes. According to Fr Ennis there is unfortunately a perceived notion that legality and morality are one and the same thing in South Africa. To create legislation aimed at harmful HIV-related behaviour would only further perpetuate this fallacy: more laws would not improve either the physical or moral health of a society and are best kept to a minimum.⁸²⁴

10.18.2 The National Council of Women of South Africa held the view that generally speaking, the HIV/AIDS epidemic is a matter for the government departments of Health, Social Welfare and Education. The Department of Welfare and Population Development: Gauteng Province and the Lowveld AIDS Training, Information and Counselling Centre (ATICC) supported this in their views that the HIV/AIDS epidemic should be dealt with by a multi-disciplinary, holistic approach (rather than concentrating on the criminal law).

10.18.3 Johannesburg Regional Court Magistrate LJ van der Schyff and Prof Leslie London held the view that it is unnecessary to involve the criminal law in harmful HIV-related behaviour since anyone acting out of bitterness and self- and other destructive feelings are unlikely to feel constrained by the law, particularly if such a person is dying from AIDS.

824 Prof S Lötter, although recognising a role for the criminal law in the HIV/AIDS epidemic, also emphasised that the criminal law can be misused to address social and moral problems. She submitted that the criminal law should not be used to educate or to reinforce social values.

10.18.4 The AIDS Law Project submitted that in instances where persons with HIV places others at risk of infection, a proper response would be based on sound policy judgments that take cognisance of the realities of the epidemic and that will most effectively reduce the rate of HIV transmission while protecting individual rights. This respondent emphasised that the realities of the epidemic include the fact that less than 10% of persons in South Africa who are infected with HIV have been tested for the virus and informed of their HIV status; and that HIV is therefore most frequently transmitted unwittingly by people who do not know they have HIV. The AIDS Law Project observed that the criminal justice system is ill-suited for purposes of deterrence, retribution and punishment and that the existing common law is available to further these interests in the rare instances where criminal prosecutions are warranted.

B) The need for creation of an HIV-specific statutory offence/s

10.19 As indicated above, commentators were divided on the question whether an HIV-specific offence/s (be it a new, additional statutory offence/s explicitly criminalising conduct not hitherto criminal or offences codifying and restating the common law⁸²⁵) should be created. Comments on this issue can be divided into the following three Categories:

825 See par 4.4 and 4.11.3 above.

- ! **Category 1:** *Respondents supporting legislative intervention.*⁸²⁶
- ! **Category 2:** *Respondents opposing legislative intervention.*⁸²⁷
- ! **Category 3:** *Respondents commenting without expressly supporting or opposing legislative intervention.*⁸²⁸

Many of the respondents in Category 3 however commented on the possible content of an HIV-specific offence/s, and several voiced their concern about the phenomenon of harmful HIV-related behaviour, or indicated that steps of some sort should be taken to address possible harm to the community.⁸²⁹

10.20 Respondents in Categories 1 (supporting) and 2 (opposing) invariably motivated their views with arguments for or against the creation of an HIV-specific offence/s. Their arguments are set out below.

-
- 826 Comments of ZL Kwitshana; the Society for Advocates: Natal; the Ministry of Caring of the NG Church: Synod Southern Gauteng; the General Council of the Bar of South Africa; the Commissioner of Correctional Services; the Department of Education: Provincial Administration Western Cape; Dr R Rabinowitz; Prof F Van Oosten; Family Farmer; Dr JH Olivier; the National Council for Persons with Physical Disabilities in South Africa; Prof CR Snyman; Tshwaranang; EJ Hamilton; Regional Court President: Cape Regional Division; Regional Court President: Northern Transvaal Regional Division; Regional Court President: Natal Regional Division; the Lowveld ATICC; Regional Court President: Northern Cape Regional Division; Business South Africa; and SAPS Detective Service.
- 827 Comments of Fr H Ennis; the National Council of Women of South Africa; Dr Lorraine Sherr; the Director of Public Prosecutions: Cape of Good Hope; Lawyers for Human Rights, Pietermaritzburg; Regional Court President: Southern Transvaal Regional Division; the Department of Welfare and Population Development: Gauteng Province; the AIDS Consortium; the AIDS Legal Network: National Office; the Triangle Project; Sex Worker Education and Advocacy Task Force; AIDS Legal Network: KwaZulu-Natal; the AIDS Law Project; the National AIDS Convention of South Africa; the National Association of People Living with HIV and AIDS; Director of Public Prosecutions: Witwatersrand Local Division; and Mr Ted Leggat. The comment of the AIDS Law Project was endorsed by the AIDS Consortium and the National Association of People Living with HIV and AIDS. The comment of Lawyers for Human Rights, Pietermaritzburg was endorsed by the AIDS Legal Network: National Office, Triangle Project, the National AIDS Convention of South Africa and the National Association of People Living with HIV and AIDS. The comment of the AIDS Legal Network: KwaZulu-Natal was endorsed by the AIDS Legal Network: National Office and the Triangle Project. Reference to comments of the first mentioned organisations include reference to the endorsing organisations.
- 828 Comments of Mr SG Abrahams; Dr A Jaffe; Ms Justice L van den Heever; the South African Dental Association; Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape; Dr CA Pieterse; Adv David Buchanan; Ms Michelle Dimbleby; the South African Medical Association; the Palliative Medical Institute; Prof S Lötter; the Democratic Nursing Organisation of South Africa; Mr Martin Williams; the Department of Correctional Services: Port Elizabeth Management Area; Dr PJ Haasbroek; the District Medical Officer: Pretoria; SALC Sexual Offences Project Committee; and Dr AM Omar, then Minister of Justice.
- 829 See eg the comments of Ms Justice L van den Heever; the South African Dental Association; Dr CA Pieterse; Ms Michelle Dimbleby; the South African Medical Association; the Palliative Medical Institute; Prof S Lötter; the Democratic Nursing Organisation of South Africa; Dr PJ Haasbroek; SALC Sexual Offences Project Committee; and Dr AM Omar, then Minister of Justice.

- 10.21 Many respondents in Categories 1 (supporting) and 3 (indefinite) commented on the content of a statutory offence. Organisations working in the field of HIV/AIDS and human rights in general did not comment on this issue. The Aids Law Project indicated in this regard that any HIV-specific law would be unjustified.
- 10.22 Several of the respondents in Category 2 (opposing), and some in Category 3 (indefinite), suggested possible alternatives to legislative intervention. These are also set out below.

Comments in Category 1 (Supporting the creation of an HIV-specific statutory offence/s)

- 10.23 A range of interests was represented under these comments. These include some members of the prosecuting and adjudicating authorities; certain criminal law experts; SAPS Detective Service; the Commissioner of Correctional Services; an education specialist; the Inkatha Freedom Party; members of the general public; the National Council for Persons with Physical Disabilities in South Africa; some organisations concerned with women's rights and violence against women; certain members of the organised legal profession; representatives of the health profession; certain community health organisations; members of the business fraternity; and the Ministry of Caring of the NG Church: Synod Southern Gauteng.
- 10.24 Several arguments were submitted by respondents motivating their preference.⁸³⁰ The major reason however, frequently recurring in these comments, was that the common-law offences insufficiently cover the area of unlawful intentional or negligent exposure to or infection with HIV, which clearly establishes the need for a statutory offence to protect society.
- 10.25 Some commentators in this Category held the view that creating a statutory offence and utilising the common law or public health measures should not be mutually exclusive.⁸³¹
- 10.25.1 The General Council of the Bar of South Africa and Prof CR Snyman

830 For these see par 10.26 et seq below.

831 See also the remarks in par 10.15 above.

submitted that a statutory offence and the common law crimes could be used effectively in conjunction with each other (i.e. a perpetrator could be charged with an appropriate common law offence with a charge of contravening the statutory offence in the alternative).

10.25.2 The Democratic Nursing Organisation of South Africa stated that public health policies to effect behaviour change are not successful. They suggested that a combination of public health efforts and a statutory offence may be the solution. Several commentators agreed with this.⁸³² Specific suggestions in this regard were the following:

- ! Public health measures such as isolation and quarantine should be incorporated in a statutory offence (presumably modelled on the Australian example where a graduated procedure exists with isolation and quarantine as the final procedure).⁸³³
- ! Contact tracing and/or making HIV/AIDS a notifiable disease should be instituted alongside the creation of a statutory offence.⁸³⁴ It was suggested that persons who came forward for HIV testing or treatment should be compelled by law to name their contacts to enable health authorities to do the necessary follow-up to prevent the spread of the disease. It might also be considered making it a criminal offence if a person with HIV refuses to name his or her contacts.⁸³⁵
- ! Business South Africa in addition suggested that information on the implications of any statutory offence created, should be included in all AIDS awareness campaigns and AIDS counselling.

10.26 The arguments advanced by respondents supporting the creation of an HIV-specific statutory offence/s included the following:

! *The existing common law crimes are insufficient and unsuitable*

832 See eg the comments of SAPS Detective Service; the Commissioner of Correctional Services; Regional Court President: Cape Regional Division; Business South Africa; and the Law Society of the Cape of Good Hope.

833 Comments of the Commissioner of Correctional Services; and SAPS Detective Service

834 Comments of the Regional Court President: Cape Regional Division; Business South Africa; the Law Society of the Cape of Good Hope; and SAPS Detective Service.

835 Comments of the Regional Court President: Cape Regional Division.

to deal with harmful HIV-related behaviour

- 10.26.1 Prof F Van Oosten submitted that the common law offences insufficiently cover the area of intentional or negligent and unlawful HIV infection.⁸³⁶ He emphasised that, for instance, a negligent and even grossly negligent infection of another person with HIV will only be criminally punishable if and when such other person dies. However, the chances that the perpetrator will survive the infected person to stand trial for culpable homicide will frequently be either fairly remote or nonexistent. Culpable homicide as a common law offence is therefore, apart from the other difficulties it presents, hardly an effective measure in protecting victims who were negligently and even grossly negligently infected by a person with HIV.⁸³⁷ Tshwaranang supported this view, especially with regard to negligent transmission of HIV during consensual heterosexual intercourse. They submitted that the vulnerability of women due to their inferior position in society warrants their legal protection in this regard.⁸³⁸
- 10.26.2 Regional Court Magistrate PJ Johnson drew attention to the fact that a person with HIV who donates blood would probably not be guilty of assault. Assault is not a consequential crime and the consequence arising in this instance (i.e. the fact that the recipient becomes infected with HIV) would not justify a prosecution for assault. If the recipient dies, the perpetrator may be charged with murder - however it will take years for the consequence to realise and the perpetrator with HIV would probably die before the recipient.
- 10.26.3 Tshwaranang submitted that the common law offences are unsuitable also because of the limited interests they protect which do not coincide with the interests violated by harmful HIV-related behaviour. Some interests are left unprotected which points to the need for a specific offence:
- P The common law crime of *murder* fundamentally protects human life. However, Tshwaranang emphasised that before a victim who contracted

836 See also the comments of the Regional Court President: Cape Regional Division; Regional Court President: Northern Transvaal Regional Division; and Regional Court President: Northern Cape Regional Division.

837 See par 6.12 et seq above for information on culpable homicide.

838 Because of women's inferior position in society, most women do not have control over their bodies and over their sexuality. As a result they are not in a position to insist on safer sex practices, making them vulnerable to HIV infection. Tshwaranang submitted that the scarcity of the female condom further adds to the problem.

HIV ultimately dies, he or she is no longer in a position to lead a meaningful life and the psychological and physical harm that such person suffers before death is not addressed by the crime of murder. The same argument would apply to *culpable homicide*.

- P In the case of *rape and other types of sexual assault* the possibility of the rapist being HIV positive exacerbates the trauma and harm already suffered by the victim as a result of the rape: the uncertainty of being infected with the virus; the insensitivity of health care providers; and the lack of information about the availability of post exposure prophylaxis (PEP). In addition, these drugs are not freely available, their cost is high and would have to be borne by the victim. The perpetrator on the other hand may, if not convicted, be quite happy to know that he has infected his victim and will not die alone. If convicted, his medical costs will be borne by government.⁸³⁹ Tshwaranang submitted that this imbalance points to the need for legislative intervention.
- P Tshwaranang disagreed with the Commission's statement in Discussion Paper 80 that *assault with the intention to do grievous bodily harm (assault GBH)*⁸⁴⁰ may be the most appropriate common law charge for addressing harmful HIV-related behaviour. They submitted that assault GBH is not a serious offence in relation to the harm or potential harm caused by exposure to or actual transmission of HIV. In addition, they pointed out that the extent of harm caused to the victim determines the sentence likely to be imposed by the court. At present the court relies on the assessment of injuries suffered by a victim as recorded by the district medical officer on the standard J88 form designed for this purpose. The form does not provide for psychological assessment nor for the assessment of any long-term effects of the perpetrator's conduct. If the victim has *contracted* HIV, the district medical officer will assess him or her during the window or asymptomatic period and depict the victim as a healthy individual - the long-term effects of the disease will be ignored because future harm cannot be proved at that stage. If the victim has only been *exposed* to HIV infection, the mental anguish and the psychological harm suffered by the victim would also be ignored. Finally,

839 See eg **C v Minister of Correctional Services** 1996 (4) SA 292 (T).

840 See par 6.14 et seq above for a discussion on assault GBH.

assault GBH cases are normally heard in the District Courts with a sentencing jurisdiction limit of two years imprisonment. Tshwaranang submitted that utilising the crime of assault GBH would only serve to trivialise harmful HIV-related behaviour.

- P Similar arguments would apply in respect of a prosecution for *attempt* to commit any of the above crimes (excluding culpable homicide in respect of which attempt is not possible).⁸⁴¹ Tshwaranang stated that an attempt to commit any of these crimes is considered a lesser charge attracting a lesser penalty and would thus only serve to trivialise harmful HIV-related behaviour.

10.26.4 Several commentators in Category 1 emphasised that the application of the common law to harmful HIV-related behaviour will, for reasons inherent to the nature of HIV/AIDS and the behaviours by which it is transmitted, be problematic.⁸⁴² HIV/AIDS has a long incubation period and therefore there is seldom any direct manifestation of infection after transmission of HIV for a considerable period of time. It will thus be difficult to establish who is responsible for transmission of the virus and consequently it will 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 crime.⁸⁴³ Commentators submitted that this clearly establishes the need for a statutory offence to protect society. In particular, Prof Van Oosten stated that the common law crimes were obviously not created to deal with the AIDS pandemic.⁸⁴⁴ Taking into consideration the serious threat which HIV/AIDS holds for the nation as a whole, a statutory offence which will indicate to potential offenders that the community and government regard harmful HIV-related behaviour in a very serious light, is therefore indicated.

841 See par 6.15 above for a discussion on attempt.

842 See the comments of the Society for Advocates: Natal; the Ministry of Caring of the NG Church: Southern Gauteng; the General Council of the Bar of South Africa; the Commissioner of Correctional Services; Dr R Rabinowitz; Prof F Van Oosten; the South African Medical Association; Regional Court President: Cape Regional Division; Regional Court President: Northern Transvaal Regional Division; and Prof S Lötter. Cf also the comments of the Director of Public Prosecutions: Witwatersrand Local Division - confirming this view - although this respondent was not in favour of the creation of a statutory offence.

843 See the comments of the Society for Advocates: Natal; the Ministry of Caring of the NG Church: Synod Southern Gauteng; the General Council of the Bar of South Africa; the Commissioner of Correctional Services; and Dr R Rabinowitz.

844 Business South Africa and SAPS Detective Service endorsed this view.

- 10.26.5 Tshwaranang submitted that the fact that the common law crimes are seldom used to specifically prosecute those who go about infecting others with HIV, points to a definite need for statutory intervention.
- 10.26.6 According to Business South Africa the unsuitability and insufficiency of the criminal law also lie in the fact that it is not a visible enough deterrent to be effective in respect of harmful HIV-related behaviour.

! *The creation of a statutory offence/s could minimise some of the difficulties associated with the application of common law crimes*

- 10.26.7 Respondents in Category 1 in general conceded that a statutory offence will not necessarily overcome all evidentiary obstacles associated with the utilisation of the common law. It is also conceded that a solution does not lie in recourse to provisions relying on strict liability, presumptions, and reverse onus clauses since these would be constitutionally questionable. However some respondents submitted that it is at least possible to develop statutory provisions which focus on behaviour likely to transmit HIV (i.e. exposing another to HIV without transmission of HIV actually occurring) rather than requiring proof of actual infection to overcome *some* of the current evidentiary problems.⁸⁴⁵

845 See eg the comments of the Society for Advocates: Natal; and the General Council of the Bar of South Africa.

! A statutory offence/s could bring greater clarity and certainty in the law and would thus have a greater deterrent impact than the existing common law crimes

10.26.8 The Society for Advocates: Natal submitted that common law crimes are generally not clearly circumscribed. A statutory offence could provide ordinary citizens with clear guidelines on what is acceptable and what is unacceptable behaviour in the HIV context and would thus send a clear signal of what will be punished. The publicity inherent in a statutory offence will moreover facilitate public knowledge of such offence and will thus have a greater deterrent impact than the mere existence and availability of common law crimes. Other commentators shared this view.⁸⁴⁶ Prof F Van Oosten for instance submitted that a well-defined HIV specific statutory offence with an express maximum penalty would not only accord with the principle of legality of the 1996 Constitution, but would notwithstanding any problems it may present, at least remove the most serious common law obstacles standing in the way of a successful prosecution of intentional or negligent harmful HIV-related behaviour.⁸⁴⁷

10.26.9 Tshwaranang submitted that court decisions utilising common law crimes in respect of harmful HIV-related behaviour run the risk of being challenged on appeal: If the courts extended existing common law crimes to cover harmful HIV-related behaviour (which is not currently explicitly covered by the common law) they may be criticised for violating the doctrine of *trias politicae* (i e the doctrine of separation of executive, legislative and judicial powers in terms of which the legislature makes laws while the judiciary interprets those laws).

846 See eg the comments of SAPS Detective Service; the General Council of the Bar of South Africa; the Commissioner of Correctional Services; Dr R Rabinowitz; and Prof F Van Oosten.

847 Referring to sec 35(3)(i) of the 1996 Constitution which provides that every accused person has a right to a fair trial, which includes the right to adduce and challenge evidence.

- 10.26.10 With regard to the predicament of medical practitioners in persuading patients with HIV to inform their sex partners of their infection, the South African Medical Association, without expressly supporting the creation of a statutory offence, stated that should there be a new offence, it would be easier for doctors to persuade patients to inform their sexual partners. The Association believed that the possibility of prosecution under a statutory offence in the event of a sexual partner becoming infected with HIV, would encourage patients to inform sexual partners of their infection.⁸⁴⁸

! *Legislative intervention is necessary to deal with the reality of persons with HIV engaging in harmful HIV-related behaviour*

- 10.26.11 L Kwitshana, chief research technologist at the Medical Research Council, indicated that personal experience in post test counselling revealed that a large percentage of persons with HIV who were counselled, verbalised their anger at becoming infected, indicating that they wanted to deliberately spread the disease in the community where they contracted it. He submitted that it would seem that some persons with HIV are taking advantage of the current position and under these circumstances legislative intervention is necessary.
- 10.26.12 Tshwaranang submitted that there is sufficient evidence of individuals and/or gangs who go about perpetrating acts of sexual violence against women and children (intentionally or indifferently as to whether they spread HIV) to justify the creation of a statutory offence. Although some of these perpetrators are successfully prosecuted for such conduct under the common law crimes (eg rape), these offences do not protect all the interests violated by the transmission of or exposure to HIV.⁸⁴⁹ Business South Africa agreed, stating that many of the people currently infected in South Africa have been infected by individuals well aware of their HIV status; and that this could be regarded as a failure of both public health and the criminal law to contain such harm. According to this respondent the only reason why society has tolerated this up to now is probably because HIV spreads silently and invisibly.

848 The Palliative Medical Institute also highlighted this specific predicament.

849 See also par 10.26.3 above.

! *The increasing incidence of deliberate HIV infection coupled with the vulnerability of women and children to acts of sexual violence requires that harmful HIV-related behaviour be dealt with through specific legislation*

10.26.13 Several respondents in Categories 1 and 3 expressed concern about the high incidence of HIV coupled with the high incidence of violence against women and the high incidence of sexual crimes.⁸⁵⁰

10.26.14 Prof F Van Oosten stated that the increasing incidence of deliberate and malicious HIV infection of innocent members of the public demonstrates the need for adequate measures to protect the public. He added that failure to take the necessary steps may be perceived by the public to amount to a dereliction of duty. In this context he observed that the known arguments in support of HIV-specific legislative intervention are obviously more convincing, cogent, concrete and society-orientated than those against the creation of such an offence - which are, according to the respondent, noticeably more ideological, abstract, vague and society-unfriendly.⁸⁵¹ Since one of the main purposes of the criminal law is to protect the interests of society, the former should take precedence of the latter. He observed that it is significant and surprising that the Commission has been able to come up with well-defined statutory measures to protect persons with HIV and AIDS⁸⁵² but is unable to come forward (in Discussion Paper 80) with equally specific statutory criminal law measures to protect the public against harmful HIV-related behaviour. Business South Africa reiterated that the impression that this creates is once again one of bias in favour of persons with HIV and relative unconcern towards the protection of society.

10.26.15 Tshwaranang submitted that as a result of the high prevalence of HIV/AIDS, victims of sexual violence face a possible death warrant. Given the increase

850 See eg the comments of the Ministry of Caring of the NG Church: Synod Southern Gauteng; Dr R Rabinowitz; Prof F Van Oosten; Business South Africa; Tshwaranang; and the more general concerns expressed in the responses of Cabinet and the Commission's Sexual Offences Project Committee referred to in par 10.8-10.8.2 above.

851 Cf the debate for and against the creation of an HIV-specific offence/s in par 7.20 et seq above.

852 See **SALC Second Interim Report on Aspects of the Law relating to AIDS** and sec 55 of the Employment Equity Act 55 of 1998.

in the prevalence of HIV/AIDS over the last 15 years, the probability of a woman contracting HIV as a result of sexual assault has increased.⁸⁵³ The unacceptable behaviour of certain individuals or gangs, who wilfully or out of ignorance perpetrate acts of sexual violence against women and children further exacerbates the problem. Within this context, particularly given the vulnerability of women and children, a statutory offence is needed.

10.26.16 Business South Africa pointed out that it has always been argued by the Commission that the sheer magnitude of the HIV/AIDS epidemic deserves dedicated legislation to prevent unfair discrimination. Of serious concern is the increasing number of persons with HIV reported who adopt fatalistic behaviour patterns and knowingly infect others. Under these circumstances the risk to society is huge and deserves to be addressed explicitly.

10.26.17 Adv David Buchanan, SC observed that the gender politics involved in risk of heterosexual transmission of HIV seem to be a major issue in the South African context which may indicate that solutions different from those in for instance Australia, are indicated.⁸⁵⁴

! *Public health law is insufficient to deal with recalcitrant behaviour*

10.26.18 Some commentators submitted that current public health measures⁸⁵⁵ are neither appropriate nor adequate to deal with harmful HIV-related behaviour.⁸⁵⁶ They emphasised that these measures (including quarantine and isolation) are clearly never exercised in respect of persons with HIV. It was argued that a statutory offence would in particular restrict sex workers who consistently continue soliciting despite much and prolonged education and admonishment from the side of the health authorities.⁸⁵⁷

853 See also the comments referred to under par 10.31 below.

854 See par 8.19 et seq above for information on the position in Australia.

855 Referring to the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 discussed in par 5.8 et seq above.

856 Comments of Dr CA Pieterse; Tshwaranang; and Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape.

857 Comments of Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape. (Because this commentator argued both for and against a new offence his comments has been acknowledged mainly under Category 3 below).

10.26.19 Prof F Van Oosten observed that the argument that society can be adequately protected by public health measures rather than the criminal law, loses much of its punch on account of the fact that HIV/AIDS is not currently a notifiable disease.⁸⁵⁸ Prof CR Snyman was also of the opinion that harmful HIV-related behaviour could not be left to be dealt with through public health measures only.

! *The lack of a specific offence/s may encourage citizens to take the law into their own hands*

10.26.20 The General Council of the Bar of South Africa emphasised that with the common law being unsuitable and insufficient, unacceptable HIV-related behaviour will remain unpunished. Such a state of affairs will encourage usually law abiding citizens to take the law into their own hands.⁸⁵⁹

858 Draft Regulations to make AIDS notifiable under certain circumstances were published by the Minister of Health in April 1999 (Government Notice R485 Regulation Gazette 6496 in **Government Gazette** 19946 of 23 April 1999). At the time of compilation of this Report they have not been finalised and according to media reports the government has dropped its intention to make AIDS notifiable as a result of public pressure and lack of support for such a step (see fn 7 in Chapter 1 above).

859 See also the comments of the Society for Advocates: Natal; and Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape.

! *Creation of a statutory offence/s will enable the state to comply with its constitutional obligation to respect, protect, promote and fulfill fundamental rights*

10.26.21 SAPS Detective Service submitted that the state carries the legal responsibility to protect the freedom, security, dignity, life, labour relations and environment of the people in the Republic of South Africa. The state should specifically create an environment that is not harmful to the health or well-being of the people of the Republic and should legislate to such ends. In the absence of such legislation the state will fail to realise its constitutional duties to protect the said rights. Legislative intervention is thus seen to be necessary.

! *Creating a statutory offence/s will change the milieu under which preventive health is currently practised*

10.26.22 Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape stated that HIV prevention efforts (i.e. using condoms and practising safe sex) is currently directed emphatically at the potential recipient of HIV infection. A statutory offence/s would also place emphasis on persons with HIV - those persons having to insist on preventive measures from their side too.⁸⁶⁰

! *A statutory offence/s will assist poor and rural women who have little defence against irresponsible partners*

10.26.23 Dr R Rabinowitz on behalf of the Inkatha Freedom Party submitted that the only way to turn the AIDS epidemic around is to adopt a coherent strategy and implement drastic measures that are more practical than politically correct: She suggested that a legislative intervention making it an offence not to divulge HIV positive status to sexual partners will be conducive to openness and responsibility. Such intervention will assist poor and rural women in particular who have little defence against irresponsible partners. The Inkatha Freedom Party was of the opinion that the fear that such a step would encourage people to go underground would be minimised as more and more people become infected and reveal their serostatus.⁸⁶¹

860 This commentator did not expressly support the creation of a statutory offence and his comments are also discussed under par 10.29.6 and 10.29.11.

861 See the discussion on the possible influence of a statutory offence on public health measures in par 7.30 et seq above.

Comments in Category 2 (Opposing the creation of an HIV-specific offence/s)

- 10.27 Respondents in this Category consisted mainly of organisations working in the field of human rights and HIV/AIDS. Others included Fr H Ennis of the St John Vianney Seminary; the National Council of Women of South Africa; Dr Lorraine Sherr of the Royal Free Hospital School of Medicine: University of London; certain representatives of the prosecuting and adjudicating authorities; the Department of Welfare and Population Development: Gauteng Province; and Mr Ted Leggatt, researcher in social development studies.
- 10.28 The main argument advanced by respondents in this Category was that the existing common law offences sufficiently cater for those rare instances of harmful HIV-related behaviour which may indeed occur, and that there is consequently no need for statutory intervention.
- 10.29 The following arguments were submitted by respondents against the creation of a statutory offence/s:

! *Existing common law measures are sufficient to address harmful HIV-related behaviour*

- 10.29.1 This was the major argument submitted by opponents to HIV-specific legislation although several of them acknowledged the evidentiary difficulties inherent in utilising the common law crimes.⁸⁶²
- 10.29.2 The National Council of Women of South Africa submitted that the incidence of HIV infection spread maliciously and with intent to harm, would be so small a factor in the AIDS epidemic as to make the creation of a special criminal sanction unnecessary. Under these circumstances the currently available common law (and civil actions for damages) could be utilised. Fr H Ennis of

862 See eg the comments of the National Council of Women of South Africa; Lawyers for Human Rights, Pietermaritzburg; AIDS Legal Network: National Office; AIDS Legal Network: KwaZulu-Natal; and AIDS Law Project.

the St John Vianney Seminary agreed with this in submitting that existing criminal law is sufficient to both protect society and to punish perpetrators of harm.

- 10.29.3 The AIDS Law Project emphasised that past experience has shown that criminal laws are not in fact effective against the deliberate spread of HIV. Whilst attempts to spread HIV through rape (i e *nonconsensual* sexual acts) have aroused particular public concern, rape is already a crime subject to severe criminal penalties, and individuals who are undeterred by these penalties are not likely to be deterred by the threat of the similar penalties under an HIV-specific law. Likewise, other forms of conduct that are intended to harm others carry severe criminal penalties under the existing common law crimes of murder; attempted murder; actual and attempted assault and assault with intent to do grievous bodily harm; and *crimen iniuria*. Individuals who are undeterred by the threat of severe penalties for committing these crimes of harming and attempting to harm others are likely to be similarly undeterred by additional measures forbidding actual and attempted harm to others through exposure to HIV.⁸⁶³ In similar vein Johannesburg Regional Court Magistrate LJ Van der Schyff submitted that if a person is in the process of dying from AIDS, the threat of possible criminal sanction in the form of a statutory offence will have very little deterrent effect, and any minimum sentences provided for would be of academic interest only.

863 See also the comments of the National Association of People Living with HIV and AIDS.

! *An HIV-specific offence/s will not provide the flexibility and accommodation available under the range of current common law crimes*

10.29.4 Commentators opposing the creation of an HIV-specific offence/s submitted that utilising the common law crimes provides a flexible and comprehensive approach to dealing with HIV-related harmful behaviour, in that a perpetrator could be prosecuted for one of the crimes of murder, culpable homicide, rape or assault.⁸⁶⁴ This will also mean that some of the more difficult issues raised in Discussion Paper 80 (such as defining harmful conduct and requirements of fault in the HIV/AIDS context) will be dealt with on a case by case basis (eg victims of harmful HIV-related behaviour would not be restricted to a prescribed set of circumstances for bringing a charge - rather each case would depend on the particular circumstances and facts). In a diverse society such as ours, and with so many factors impacting upon a person's ability to determine his or her sexual relationships, the respondents believed a flexible approach to punishing harmful HIV-related behaviour is vital.

10.29.5 For the same reasons it was submitted that it would be preferable to allow for the common law to develop a definition of harmful HIV-related behaviour on a case by case basis, under the existing common law crimes.⁸⁶⁵ Such an approach would also allow for this definition to develop in accordance with the development of medical and scientific knowledge regarding HIV transmission. Likewise, it was believed that it may be preferable to allow the form of fault required in the context of harmful HIV-related behaviour, be it intention or negligence, to develop in a flexible manner and on a case-by-case basis.⁸⁶⁶ However, as far as negligence as a form of fault is concerned, the Commission was urged to note the most recent statistics according to which, in the most affected province (KwaZulu-Natal), around a third of all women are infected with HIV.⁸⁶⁷ This means that allowing a criminal charge to be brought

864 Comments of Lawyers for Human Rights, Pietermaritzburg; AIDS Law Project; and AIDS Legal Network: KwaZulu-Natal.

865 Comments of Lawyers for Human Rights, Pietermaritzburg.

866 Ibid.

867 According to the results of the 2000 National HIV Survey of Women Attending Antenatal Clinics of the Public Health Services in South Africa, 36,2% of women attending antenatal clinics of the public health services in KwaZulu-Natal were infected with HIV by the end of 2000 (**National HIV and Syphilis Seroprevalence Survey of Women Attending Public Antenatal Clinics in South Africa 2000** 9. See also par

against a person for unknowingly, but negligently infecting another person with HIV could potentially open the floodgates for a vast number of persons to be charged with culpable homicide. It could also create a situation in terms of which certain groups in society perceived to be at high risk of HIV infection, (for instance, women resident in KwaZulu-Natal, gay men and commercial sex workers) are more likely to be prosecuted for culpable homicide, where negligence is a consideration. This argument was supported by the Director of Public Prosecutions: Witwatersrand Local Division. He further submitted that due to the socio-economic context of the South African society, its limited resources and the nature of the recent campaign against the spread of HIV, the criminalisation of negligent behaviour where negligence does not result in death, cannot at this stage be fairly and practically implemented. He stressed that the following factors should be considered in this regard:

- ! The low levels of general education, especially in rural areas.
- ! The social attitudes and perspectives of society.
- ! The lack of socio-economic and emotional support for persons with HIV.
- ! The fact that the most rapid spread of the disease is amongst young people who cannot necessarily be held accountable for their unsafe and irresponsible sexual behaviour.

! *A statutory offence/s would only be justified if it would minimise the difficulties associated with the application of common law crimes*

10.29.6 Several opposing respondents from the legal fraternity (including the Directors of Public Prosecutions: Cape of Good Hope, and Witwatersrand Local Division) submitted that statutory crimes will not provide simple answers to the perceived gaps in common law crimes. They were of the opinion that statutory offences will bring their own problems, not the least of which will be ones relating to the burden of proof and constitutional issues.⁸⁶⁸ It was argued that current evidentiary problems as set out in Discussion Paper 80 are largely a result of the nature of HIV and AIDS and the behaviour by which it is

2.12 above for information on the infection rate of women in general.)

868 See also the comments of the Regional Court President: Northern Cape Regional Division; Regional Court Magistrate LJ Van der Schyff; Prof S Lötter; Lawyers for Human Rights, Pietermaritzburg; and the AIDS Law Project. Others supporting these arguments included Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape; and Dr Lorraine Sherr.

transmitted, and thus cannot be surmounted by adoption of an HIV-specific offence.⁸⁶⁹ It was in particular pointed out that some HIV-specific offences adopted in other jurisdictions have eliminated the need for proof that the accused actually infected the accuser. This was achieved by criminalising conduct that poses a risk of exposure to HIV in addition to conduct that actually results in HIV infection.⁸⁷⁰ However, even these offences generally require proof that the accused had HIV and was aware of his or her HIV status at the time of the contact with the accuser - facts which are often difficult to prove. Provisions specifically aimed at HIV exposure and transmission would therefore offer few, if any, practical advantages over existing common law crimes in furthering the deterrent and retributive objectives of the criminal law.⁸⁷¹ The Director Public Prosecutions: Witwatersrand Local Division suggested that under these circumstances the common law crimes have the advantage that it is readily available. He was of the view that, once practically applied to HIV-related behaviour, there would be certainty as to how to apply these crimes and that where there are loopholes, they can be supplemented by statutory provisions. He concluded that the common law crimes should be applied in practice before the exact need for statutory intervention can be determined.

! *Legislation is not the proper or suitable means for enforcing either health or morality*

10.29.7 Fr H Ennis of the St John Vianney Seminary expressed the view that HIV/AIDS is first and foremost a medical matter, and that sound social behaviour and good public health should preferably be enforced through education programmes. According to the respondent there unfortunately is a perceived notion that legality and morality are one and the same thing in South Africa. To create legislation aimed at harmful HIV-related behaviour would only further perpetuate this fallacy: more laws would not improve either the physical or moral health of a society and are best kept to a minimum.⁸⁷²

869 See the comments of Lawyers for Human Rights, Pietermaritzburg; and the AIDS Law Project.

870 Comments of the AIDS Legal Network: National Office; and AIDS Legal Network: KwaZulu-Natal.

871 Ibid.

872 See also the comments of Prof S Lötter in this regard.

! *Creating a statutory offence/s will not necessarily deal with the most fundamental problems at the heart of the issue of harmful HIV-related behaviour and may therefore lessen the authority of the criminal law*

- 10.29.8 Some opposing commentators submitted that the vulnerability of women and youth (especially young girls) coupled with the high rate of criminal activity, inadequacies of the criminal justice system and disregard for the law in the country respectively lie at the heart of the issue under investigation.⁸⁷³
- 10.29.9 These commentators argued that the creation of a statutory offence/s will not benefit the lives of women and young girls and could in fact be to their detriment.⁸⁷⁴ In South Africa, very few of those infected are actually aware of their HIV status. However, more women than men generally know their HIV status as a result of being tested at antenatal clinics. Under these circumstances the responsibility will be placed upon women, rather than their partners, to take the necessary measures in order to escape possible prosecution. They will be forced to disclose their HIV status and, in the present climate, may face domestic violence or even murder. Once they have disclosed their HIV status, their husbands and sexual partners may be able to lay charges against them for any behaviour which could be termed "harmful HIV-related behaviour". At the same time, it may be difficult to obtain evidence of the sexual partner's knowledge of his HIV status, and with present technology available in South Africa, it would be extremely difficult to prove who had in fact infected whom.
- 10.29.10 They further submitted that the creation of a new statutory offence will not solve the high rate of criminal acts. They observed that despite strong criminal laws in South Africa, the high rate of criminal activity persists. They believed that the creation of additional criminal measures may result in a lessening of the authority of the criminal law, without assisting the criminal justice system in any way to cope with the arrest, conviction, imprisonment and rehabilitation of offenders.⁸⁷⁵

873 Comments of Lawyers for Human Rights, Pietermaritzburg; and the AIDS Law Project.

874 Ibid.

875 Ibid.

! *Because of its low occurrence, HIV infection spread maliciously and with intent to harm does not justify the creation of a statutory offence/s*

10.29.11 Organisations working in the field of human rights and HIV/AIDS invariably expressed the opinion that little if no evidence exists of the extent of actual harmful HIV-related behaviour and that their experience indicates that it is not as wide-spread as the media would have us believe.⁸⁷⁶ They were of the opinion that the perception created through media reports and (what they regarded as misquoted) research findings that persons with HIV and AIDS are seeking to deliberately infect others so they do not die alone, is erroneous.⁸⁷⁷ The Association of People Living with HIV and AIDS in particular submitted that deliberate infection on a mass scale is largely conjecture and that there are virtually no studies, surveys or statistics to back these allegations. (SAPS Detective Service in their comment confirmed that statistics are not kept by them on intentional or negligent transmission of or exposure to HIV; and stated that they are not aware of any specific complaints pertaining to deliberate HIV infection.) Moreover, since most persons in South Africa are unaware of their HIV status, harmful HIV-related behaviour cannot be said to be the major cause of the spread of the epidemic in our society. Harmful behaviour is thus the exception and not the rule and any steps taken to address such behaviour should take into account that these will be directed at limited and exceptional behaviour. The Director of Public Prosecutions: Cape of Good Hope supported this view.⁸⁷⁸ He submitted that the extent of the *criminal* problem of HIV transmission should be examined closely and should not be over-exaggerated. He questioned whether there are potentially enough cases (which can be

876 Lawyers for Human Rights, Pietermaritzburg commented that during the past five years (with approximately 300 telephonic calls and visits for legal advice per year) only three incidents of persons (all women) who claimed to have been deliberately or fraudulently infected with HIV by a partner who knew himself to be HIV positive, came to their attention. These alleged victims were more concerned with instituting civil claims for compensation, rather than laying criminal charges against their partners. See also the comments of the AIDS Consortium; the AIDS Legal Network: National Office; the AIDS Legal Network: KwaZulu-Natal; the AIDS Law Project; and the National Association of People Living with HIV and AIDS. Refer also to the circumstances surrounding the civil case of **Venter v Nel** 1997 (4) SA 1014 (D) discussed in par 7.38 above.

877 Cf the anthropological research referred to in Chapter 2, fn 39 above.

878 See also the comments of Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape.

proved) to justify legislative interference.

! *The current lack of application of the common law to harmful HIV-related behaviour may indicate that there is no need for punitive measures in practice*

10.29.12 Dr Lorraine Sherr of the Royal Free Hospital School of Medicine: University of London observed that there seems to be no evidence that the prevailing common law cannot handle harmful HIV-related behaviour and found it significant that despite this, prosecutions have not been instituted for such behaviour.⁸⁷⁹

! *A statutory offence/s may be open to misuse and abuse*

10.29.13 The Director of Public Prosecutions: Cape of Good Hope cautioned that an HIV-specific statutory offence/s may lead to witch hunts and false charges and that these dangers should not be underestimated. Dr Leslie London supported this in his observations that an already overburdened legal system may be overwhelmed by individuals who have been diagnosed with HIV and who lay charges against their recent sexual partners in a first angry response to having become infected.

879 As indicated in par 2.6.2 above our research have revealed a single prosecution in South African courts (for attempted murder) in a case of alleged exposure to HIV. The prosecution was withdrawn at the request of the complainant. See also par 11.31 et seq below for a discussion of this case.

! *A statutory offence/s could add to the current problems of an overburdened criminal justice system*

10.29.14 Johannesburg Regional Court Magistrate JL Brink submitted that there is no sense in creating statutory offences for behaviour which is adequately catered for by the common law under circumstances where a plethora of new Acts and amendments to existing ones is confusing to many prosecutors who have little experience.

! *A statutory offence/s will be counter-productive to public health efforts to curb the spread of the disease*

10.29.15 Some respondents in Category 2 (opposing) held the view that a statutory offence will negatively influence voluntary testing for HIV.⁸⁸⁰ Public awareness is the best method of reducing HIV transmission. However, while the creation of a statutory offence may increase such awareness, it is more likely that statutory intervention will drive those at risk of HIV infection underground. People might not go for HIV testing if there is a chance that they will be prosecuted. If persons with HIV can claim that they do not know their HIV status, they may not be liable to prosecution. There will be no incentive for voluntary HIV testing and the effects may even be to increase transmission.⁸⁸¹ The Director of Public Prosecutions: Witwatersrand Local Division supported this, stressing that the criminal law must only be used to protect society and not deter persons with HIV from testing because of fear of possible prosecution.

10.29.16 It was also argued that the creation of a statutory offence will foster false expectations that responsibility for preventing the spread of HIV can be shifted to people currently living with the disease: It may create the perception that persons who are HIV positive will be aware of their status and inform their sexual partners in order to avoid criminal liability. The result will be that those who are not aware of their status or are not positive, will not consider it necessary to protect themselves as they believed they could resort to the criminal justice system for protection. This is contrary to the central principles of education campaigns urging all sexually active people to consistently take

880 See eg the comments of Dr Lorraine Sherr; and Lawyers for Human Rights, Pietermaritzburg.

881 Ibid.

precautions against high-risk activities.⁸⁸²

10.29.17 Some commentators opposing the creation of a new offence submitted that the publicity attracted by the creation of an HIV-specific offence may have serious public health implications in that it sends a message to the community at large that the main risk of HIV infection is by ways of criminal acts of deliberate or reckless infection, and not through the behaviour of each individual.⁸⁸³ This may impact negatively on the goals of the government's AIDS initiatives,⁸⁸⁴ and may mislead the public into believing that other public health strategies - such as life skills education and the distribution of condoms - are not successful strategies, and that we should rather seek to "remove" people living with HIV/AIDS from society.⁸⁸⁵

! *A statutory offence/s may create an uneven approach to curbing the spread of the HIV/AIDS epidemic*

10.29.18 It was submitted that a statutory offence may create an uneven approach to curbing the HIV epidemic, as currently the government's public health response to HIV/AIDS is based on human rights principles such as voluntary participation, noncoercion and individual behaviour change.⁸⁸⁶ The introduction of a statutory offence dealing with HIV-related harmful behaviour may give the impression of the introduction of coercive control measures.⁸⁸⁷

882 Comments of the AIDS Law Project; the AIDS Legal Network: National Office; and the AIDS Legal Network KwaZulu-Natal.

883 Comments of Lawyers for Human Rights, Pietermaritzburg.

884 See par 5.3 et seq above for information on the government's current public health response to HIV/AIDS.

885 Comments of Lawyers for Human Rights, Pietermaritzburg.

886 Ibid. See par 5.3 et seq above for information on the government's current public health response to HIV/AIDS.

887 Ibid.

! *A statutory offence/s will entrench further discrimination and stigmatisation of persons with HIV*

10.29.19 Several organisations working in the field of human rights and HIV/AIDS submitted that a statutory offence will further stigmatise people living with HIV.⁸⁸⁸ The National Association of People Living with HIV and AIDS in particular submitted that the use of criminal law is not a means to create an accepting and supportive social environment which enables persons living with HIV/AIDS to be open about their status. The undoubted increase in stigma and discrimination that such a measure would generate will create a hostile and unsupportive environment for those living with the disease. It is believed that all efforts to empower persons living with HIV/AIDS to promote openness, will be undermined by statutory intervention and that the negative outcome thereof will have an adverse effect on current HIV/AIDS educational efforts.

! *Creating a statutory offence/s will drain away scarce resources*

10.29.20 Certain respondents submitted that using the criminal law as a response to HIV would divert scarce resources from the most effective HIV prevention programmes such as targeted education campaigns, condom distribution initiatives, and the provision of voluntary, accessible testing, counselling and medical treatment.⁸⁸⁹ In addition, legal presumptions which assist the state may result in a substantial number of convictions and further increase of the prison population.⁸⁹⁰ Johannesburg Regional Court Magistrate JL Brink specifically pointed out that the cost of treating such persons while in prison will be high and may also lead to infected victims claiming similar treatment at government cost.

888 See the comments of the AIDS Consortium; the AIDS Legal Network: National Office; the AIDS Legal Network: KwaZulu-Natal; and the AIDS Law Project.

889 Comments of the AIDS Legal Network: National Office; and the Department of Welfare and Population Development: Gauteng Province.

890 Ibid.

! *Specific criminal sanctions aimed at HIV exposure and transmission will result in severe invasions of individual rights of privacy*

10.29.21 The AIDS Legal Network emphasised that HIV is often transmitted through sexual behaviours which implicate some of the most intimate aspects of human interaction. The enforcement of HIV-specific criminal offences is likely to call for exhaustive inquiry into the medical histories as well as the sexual affairs of both the accused and his or her sexual partners. The organisation submitted that these inquiries invade the realm of privacy in personal affairs which are valued in society and protected under the 1996 Constitution. According to the respondent such invasions are not justified since an HIV-specific criminal offence/s would not further the asserted public purposes of deterrence, retribution, or protection of public health. Moreover, it would in fact impede efforts to combat the spread of HIV, because official scrutiny into otherwise confidential medical records will discourage people from consulting health professionals about their health and their involvement in high-risk activities, thus impeding constructive interventions which can help prevent the transmission of HIV.

! *Sex workers may be marginalised by a statutory offence/s*

10.29.22 The Sex Worker Education and Advocacy Task Force submitted that precisely because of their profession and its continued criminalisation, sex workers are likely to remain easy targets to blame for the transmission of HIV.⁸⁹¹ They stated that a possible outcome of legislative intervention may be that sex workers would be required to be tested for HIV and other sexually transmissible diseases on a regular basis. As this implies that sex workers alone - as opposed to their clients - are responsible for the transmission of HIV and other sexually transmissible diseases, such a result would reinforce the current stigmatisation of sex workers.

891 See also the comments of the AIDS Legal Network: KwaZulu-Natal.

! *The controversy currently surrounding HIV/AIDS precludes legislative intervention at this stage*

10.29.23 The Director of Public Prosecutions: Cape of Good Hope observed that the entire issue of HIV/AIDS is clouded by controversy at present and that it is therefore inappropriate at this stage to legislate specific crimes to address the criminal aspects of the issue. In this regard the respondent referred to the belief that the orthodox view (that HIV necessarily leads to AIDS or in fact is at all linked to it) is by no means a universal view among a small group of dissidents.⁸⁹² Moreover, medical science is advancing to a stage where HIV infection is no longer regarded as a terminal condition but more as a chronic medical condition.⁸⁹³ The need to criminalise exposure to HIV may thus already be (or soon become) obsolete.⁸⁹⁴

Comments in Category 3 (neither supporting nor opposing the creation of an HIV-specific offence/s)

10.30 The bulk of comments in this Category came from nonlawyers (members of the general public and representatives of the medical and health care professions). However it also included the comments of two legal experts namely Ms Justice L van den Heever and Prof S Lötter. The responses of Cabinet and the Commission's Sexual Offences Project Committee (which both voiced concerns without expressing preferences) are also included in this Category. Some of the respondents in this Category argued both for and against the creation of a statutory offence without choosing either. Their arguments are included in the discussions on Categories 1 and 2 above.⁸⁹⁵

892 See fn 977 in Chapter 11 below for information on this theory.

893 See par 3.21 et seq above for information on new developments in HIV/AIDS treatment.

894 Dr Lorraine Sherr of the Royal Free Hospital School of Medicine: University of London in her comments also drew attention to the dramatic effect of new treatments on morbidity and mortality of persons with HIV.

895 See eg the comments of Dr K Vallabhjee of the Department of Health: Provincial Administration Western Cape.

- 10.31 As indicated in paragraph 10.19 above, several of the respondents in this Category expressed concern about the high prevalence of HIV, the high incidence of rape, the apparent increase in the deliberate transmission of HIV, and the great need for women to be protected against acts of sexual violence.⁸⁹⁶ Concerns in this regard coincide with those raised by Cabinet and the Commission's Sexual Offences Project Committee which are referred to in paragraph 10.8.2 above.
- 10.32 Significantly, Adv David Buchanan SC, Australian barrister and former Chairperson of the New South Wales AIDS Council, observed that if a relatively effective environment supportive of people with HIV (i.e. an environment where confidentiality and nondiscrimination will be enforced) prevails, one can possibly safely move away from the premise of abjuring criminalising HIV transmission lest it scares people with HIV (or at risk of HIV) underground.

C) Respondents' suggestions regarding the content of a possible HIV-specific statutory offence/s

- 10.33 Respondents who commented on this aspect in general submitted their comments with reference to the six examples of legislation addressing harmful HIV-related behaviour from comparable foreign legal systems which were included in Discussion Paper 80⁸⁹⁷ and the issues identified for comment by the Commission.⁸⁹⁸ The Society for Advocates: Natal submitted independently drafted legislation.⁸⁹⁹ Prof CR Snyman submitted an amended version of the

896 See eg the comments of the South African Dental Association; Ms Michelle Dimbleby; the Palliative Medical Institute; and Dr PJ Haasbroek.

897 See par 9.5.1 and fn 781-786 above.

898 See par 9.6 above.

899 The Society suggested the following formulation:

"CRIMINAL EXPOSURE OF ANOTHER TO THE RISK OF HIV INFECTION

- (1) Any person who, having knowledge that he or she is infected with HIV, intentionally does anything or permits the doing of anything which he or she knows or ought reasonably to know could expose another person to the risk of HIV infection shall be guilty of an offence and liable to imprisonment for a period not exceeding ten years.
- (2) It shall be a defence to a charge of contravening subsection (1) that the other person concerned:
- (a) knew that the person charged was infected with HIV, and
 - (b) consented to the act in question, and
 - (c) knew that the act in question could expose him or her to the risk of HIV infection.

Zimbabwe example (the Zimbabwe Criminal Law Amendment Bill 1996).⁹⁰⁰ Dr R Rabinowitz submitted a private members' Bill compiled by the Inkatha Freedom Party.⁹⁰¹

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- (3) In order for a person to have committed the offence of criminal exposure ... it is not necessary that actual transmission of HIV be proved".
- 900 The Zimbabwe Example is reflected in fn 781 above. Prof Snyman suggested the following formulation:
- "(1) Any person who, while being aware that he is infected with HIV, does anything or permits the doing of anything which he knows or foresees will infect another person with HIV or is likely to lead [to] another person becoming infected with HIV shall be guilty of an offence.
- (2) Any person who while being aware that he is infected with HIV, does anything or permits the doing of anything by which he infects another person with HIV or which is likely to lead [to] another person becoming infected with HIV, shall be guilty of an offence, if he ought reasonably to have foreseen the possibility that his conduct may have such an effect".
- 901 The Inkatha Freedom Party's suggested measures included the following:
- "2. CERTAIN OFFENCES FOR PERSONS INFECTED WITH HIV AND PENALTIES THEREFORE
- (1) Any person who, whilst infected with HIV and who has knowledge of such fact:-
- (a) participates in any manner, in any unprotected sexual activity ... with any other person ... and who has failed prior to the commencement of sexual activity ... to disclose to the other person ... his or her HIV positive status shall be guilty of an offence and liable on conviction to a sentence:
- (i) In the event of ... the other persons ... becoming infected with ... HIV ... a sentence of 10 years imprisonment; or
- (ii) in the event of ... the other persons ... becoming infected with ... HIV and subsequently contracting [AIDS] ... a sentence of 20 years to life imprisonment; or
- (iii) in the event of none of such persons becoming so infected, 5 years imprisonment.
- (b) Any person who, whilst infected as described in subsection (a) ... commits the acts referred to in subsection (a) ... except that such person indulges in protected sexual activity, shall be guilty of an offence and liable on conviction as follows:-
- (i) If no infection of the other person ... results, a sentence of 2 to 5 years imprisonment;
- (ii) if the other person or persons becomes infected with ... HIV ... a sentence of 5 to 10 years imprisonment;
- (iii) if the other person ... becomes infected with ... HIV ... and subsequently contracts [AIDS] ... a sentence of 10 to 20 years imprisonment.
- (c) If, subsequent to the conviction and sentence of any offender in terms of section 2 ... the other person's ... status becomes HIV positive or [he or she] acquires [AIDS] ... the ... offender [may] ... be brought before ... any Court having jurisdiction and apply for the sentence imposed ... to be increased concomitantly as if such offender had been convicted of the relevant offence.
- (2) Any person who *reasonably should have suspected* that he ... was infected with HIV and:-
- (a) Participates in ... unprotected sexual activity ... and who has failed, prior to the commencement of such sexual activity ... to disclose to the other person ... his or her possible HIV positive status and who is subsequently proved to be infected with HIV and it is proved that a strong likelihood exists that at the time of the commission of the offence the offender was HIV positive shall be guilty of an offence and liable on conviction to a sentence:
- (i) In the event of any of the other persons ... becoming infected with ... HIV ... a sentence of 5 to 10 years imprisonment;
- (ii) in the event of any of the other persons ... becoming infected with ... HIV and subsequently contracting [AIDS] ... a sentence of 10 years imprisonment; or
- (iii) in the event of none of such persons becoming so infected 2 years imprisonment.
- (b) Any person who whilst infected as described in ... (a) ... commits the acts referred to ... except that such person indulges in protected sexual activity, shall be guilty of an

- 10.34 Respondents who expressly preferred one of the six examples from comparable foreign systems almost unanimously chose the Zimbabwe example.⁹⁰² Some respondents also commented favourably on the graduated approach followed in Australia,⁹⁰³ and that of Tennessee, United States.⁹⁰⁴
- 10.35 Respondents were divided on the content of a statutory offence, should it be indicated. Different views on the following crucial issues were as follows:

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- offence and liable on conviction as follows:-
- (i) If no infection of the other person ... results, a sentence of 1 year imprisonment;
 - (ii) If the other person ... becomes infected with ... HIV ... a sentence of 2 to 5 years imprisonment;
 - (iii) if the other person ... becomes infected with ... HIV... and subsequently contracts [AIDS] ... a sentence of 5 to 10 years imprisonment.
- (3)(1) Any person who, whilst infected with HIV and who has knowledge of such a fact:-
- (a) Participates in any manner, in any activity with any other person ... during which there is likely to arise as a reasonable possibility [of] the infection of such other person ... with HIV and who has failed, prior to the commencement of such activity, to disclose to the other person ... his or her ... HIV positive status, shall be guilty of an offence and liable on conviction to a sentence:
 - (i) in the event of any of the other persons ... becoming infected with HIV ... a sentence of 5 years imprisonment;
 - (ii) in the event of any of the other persons becoming infected with HIV ... and subsequently contracting [AIDS] ... a sentence of 5 to 10 years imprisonment; or
 - (iii) in the event on none of such persons becoming so infected 2 years imprisonment".

In terms of the above suggestions -

"*sexual activity*" is defined as "insertive vaginal, anal or oral intercourse on the part of an infected male, receptive vaginal intercourse on the part of an infected woman with a male partner, or receptive anal intercourse on the part of an infected man or woman with a male partner"; and "*protected sexual activity*" is defined as "sexual activity with the use of a condom".

- 902 See eg the comments of Prof CR Snyman; Regional Court President: Northern Cape Regional Division; and Regional Court President: Cape Regional Division. Prof Snyman, in preferring the Zimbabwe approach, suggested a reformulation of this approach - see fn 900 above for his suggested reformulation. (Refer to fn 781 above for the Zimbabwe example. See also the discussion on the Zimbabwe draft legislation in par 8.23 et seq above.)
- 903 See eg the comments of the General Council of the Bar of South Africa; and Prof CR Snyman. Both these respondents supported the Australian approach (i e public health approach) in conjunction with either the criminal law (General Council of the Bar of South Africa) or the Zimbabwe approach (Prof Snyman). (Refer to fn 786 above for the Australian example.)
- 904 See eg the comments of the Regional Court President: Natal Regional Division. (Refer to fn 783 above for the Tennessee example.)

- ! ***Behaviour to be targeted by a statutory offence (which could include transmission of HIV; exposure to HIV; nondisclosure of HIV status; any act likely to transmit HIV; transmission and/or exposure to other sexually transmissible diseases; other modes of transmission of or exposure to HIV; or a combination of these)***⁹⁰⁵

10.35.1 Respondents were divided on this issue. The majority suggested that "transmission" of as well as "exposure" to HIV should be targeted.⁹⁰⁶ Single respondents suggested that "attempt" to transmit or expose others to HIV⁹⁰⁷ and "failure to inform sexual partners of HIV status" should in addition be included in a statutory offence.⁹⁰⁸ The majority believed that transmission of or exposure to "HIV only" (i.e. not including other sexually transmissible diseases) should be targeted.⁹⁰⁹ Some respondents expressly suggested that transmission or exposure to HIV "in any manner" (including mother to child transmission, and transmission of or exposure resulting from blood transfusion and injecting HIV infected blood) should be covered while several chose the Zimbabwe approach (which is similar).⁹¹⁰

905 See also par 10.21 above.

906 See eg the comments of Tshwaranang; the General Council of the Bar of South Africa; Prof CR Snyman; Business South Africa; SAPS Detective Service; Regional Court President: Regional Division Northern Transvaal; and the Society of Advocates: Natal. Prof S Lötter was the only respondent commenting on this issue who believed that *exposure* to HIV should *not* be targeted.

907 See the comments of Tshwaranang.

908 See eg the comments of SAPS Detective Service.

909 See eg Prof CR Snyman's formulation in fn 900 above and that of the Society of Advocates: Natal in fn 899 above which are confined to transmission or exposure to HIV. The General Council of the Bar and the Regional Court President: Northern Cape Regional Division suggested that new legislation should also cover transmission of or exposure to other STDs.

910 See eg Prof CR Snyman's formulation in fn 900 and that of the Society of Advocates: Natal in fn 899 above. See also the comments of Dr JH Olivier; Regional Court President: Northern Transvaal Regional Division; Lowveld ATICC; and Business South Africa. (Refer to fn 781 above for the Zimbabwe example.)

! *What form of fault (if any) should be required*

10.35.2 Commentators were divided on this issue. Several respondents indicated that negligent exposure or transmission should also be targeted by a statutory offence, emphasising that negligent exposure is currently not covered by the common law crimes.⁹¹¹ (While organisations concerned with human rights and HIV/AIDS in general did not comment on the contents of an offence, their other comments indicated that they will not support making negligent exposure to HIV an offence. Some expressly indicted that ignorance of infection should not be punishable.⁹¹²) Single nonlawyer respondents indicated a preference for strict liability. However the rest were almost unanimous in commenting that strict liability would be constitutionally questionable.

! *What should be regarded as an appropriate defence to a criminal prosecution for HIV transmission or exposure?*

10.35.3 Respondents were divided on the express inclusion of a defence in the formulation of a statutory offence. The majority agreed that consent should be a defence (whether expressly included in the formulation of a new offence or not) and that it should amount to "informed" consent.⁹¹³ Single respondents (mostly from the medical profession) suggested that prevention (eg condom use) would also be an appropriate defence (presumably not necessarily coupled with consent).⁹¹⁴ Some respondents suggested that consent coupled with prevention should be a defence.⁹¹⁵

911 See eg the comments of Prof F van Oosten; the General Council of the Bar of South Africa; Tshwaranang; SAPS Detective Service; Business South Africa; Regional Court President: Northern Cape Regional Division; Regional Court Magistrate PJ Johnson of the Northern Transvaal Regional Division; and Prof CR Snyman.

912 Comments of Lawyers for Human Rights, Pietermaritzburg; and the AIDS Law Project.

913 See the formulation of the Society of Advocates: Natal in fn 899 above; and the comments of the General Council of the Bar of South Africa. Both Prof CR Snyman and Tshwaranang were of the opinion that "consent" should not be available as a defence as consenting to HIV transmission or exposure would be contrary to public policy.

914 See eg the comments of Dr JH Olivier, City Medical Officer of Health: Pretoria.

915 See eg the comments of the Lowveld ATICC; and SAPS Detective Service.

! *Where should the burden of proof with regard to consent lie?*

10.35.4 The majority of respondents indicated that reverse onus clauses would probably be unconstitutional. Some expressly indicated that the general rules applicable to onus in a criminal prosecution should prevail - i e proof beyond reasonable doubt should be required from the prosecution that the person harmed did not consent.⁹¹⁶

! *The need for providing for HIV testing for evidentiary purposes in a statutory offence*

10.35.5 Some respondents indicated that provision for testing for evidentiary purposes would be necessary. Others were however of the opinion that the current provisions of section 37 of the Criminal Procedure Act 51 of 1977 would be sufficient.⁹¹⁷

! *The need for providing for presumptions with regard to the accused's HIV status*

10.35.6 Some commentators, mostly nonlawyers, suggested that it may be desirable to create a presumption with regard to the accused's HIV status.⁹¹⁸ The majority of lawyers who responded indicated however that including presumptions would probably be unconstitutional.

! *Suitable punishment in the case of conviction on a statutory offence involving harmful HIV-related behaviour*

10.35.7 Respondents generally emphasised the seriousness of harmful HIV-related behaviour and suggested sentences similar to convictions for murder, rape and assault with intent to do grievous bodily harm ("assault GBH").⁹¹⁹ The majority suggested a period of imprisonment - with a single respondent suggesting life imprisonment.⁹²⁰ The Department of Education: Provincial Administration

916 Prof S Lötter suggested that the accused should prove on a balance of probabilities that the complainant consented to the behaviour in question.

917 Cf the Commission's view on this (i e that sec 37 of the Criminal Procedure Act 51 of 1977 would be sufficient) in its Fourth Interim Report on Aspects of the Law relating to AIDS par 7.12-7.15.

918 See eg the comments of Dr JH Olivier, City Medical Officer of Health: Pretoria.

919 See eg the comments of the General Council of the Bar of South Africa.

920 The Commissioner of Correctional Services commented that the provisions of the Criminal Law Amendment Act 105 of 1997 should be applicable to persons transmitting HIV, exposing others to HIV

Western Cape, and Tshwaranang held the view that imprisonment or a fine is insufficient to compensate a victim of harmful HIV-related behaviour. The former suggested that a combination of imprisonment (or a fine) and payment of compensation should be considered. Such compensation should be sufficient to cover long-term medical care and treatment of HIV infection in the victim as well as costs related to counselling. Tshwaranang suggested that provision for victim empowerment programmes should be included in any proposed legislation; and that funds collected from monetary fines be put in a fund for the benefit of victims.

D) Alternatives to legislative intervention

10.36 Several alternatives to taking recourse to creating a statutory offence/s were suggested by respondents. These suggestions mostly came from respondents in Category 2 (opposing the creation of a new offence/s), and in some instances also from respondents who did not expressly choose between utilising the common law and statutory intervention. In some instances different alternatives were suggested in respect of HIV transmission or exposure during consensual and nonconsensual sex respectively.

10.37 Some commentators, in suggesting possible alternatives, examined possible reasons why deliberate infection would occur in the first place.⁹²¹

10.37.1 Dr A Jaffe, Acting Director Health Service: KwaZulu-Natal Provincial Administration, drew the Commission's attention to the view that deliberate infection may not be surprising given the general lack of respect for human life in South Africa today, the legacy of years of institutionalised violence, and the brutalisation of apartheid.⁹²² Other reasons for deliberate infection may include lack of proper post test counselling to assist the newly diagnosed

or attempting such behaviour. (As indicated in fn 360 above, the Criminal Law Amendment Act provides for a minimum sentence of life imprisonment where a person has been convicted of rape knowing that he has AIDS or HIV.)

921 The Project Committee gathered more information on this aspect from experts at a consultative meeting on 3 February 2000 (see the presentation by Ms Nolwazi Gasa in par 11.26 et seq below).

922 See Pierre Brouard "Deliberate Infection with HIV: Myth or Reality" **AIDS Bulletin** December 1998 11.

person to accept and integrate an HIV positive result;⁹²³ pre-existing antisocial tendencies in a person with HIV; feelings of not having contracted HIV by choice and thus not being prepared to give his or her next sexual partner the choice either; in the case of heterosexual transmission, many men see sexually transmissible infection as "women's diseases" and a man who finds himself HIV positive might want to infect women as part of his misogyny, sexism and patriarchy; and finally rage prompted by a climate of intolerance and stigma that may exist around HIV. The latter reason was also recorded by L Kwitshana, chief research technologist from the Medical Research Council. According to this respondent's experience with post test counselling, a high percentage of persons newly diagnosed verbalise their anger saying they would become more promiscuous and would not use condoms because they want to deliberately spread the disease in the community where they contracted it. The AIDS Legal Network: KwaZulu-Natal added to the above the inability of women to disclose their HIV status because of fears of domestic violence, losing a life partner and even death; and the inability of many women to successfully introduce safer sex practices into their relationships.

10.38 The following alternatives - either in conjunction with the common law or a statutory offence/s, or as alternative to it - were suggested by respondents:

! *Promoting family values and a healthy morality coupled with improved sexually transmissible disease management*

10.38.1 Mr SG Abrahams expressed the opinion that the root of the problem is casual and promiscuous consensual sex which is responsible for the spread of sexually transmissible diseases including HIV and suggested that these should rather be proactively addressed by government. He highlighted a prevailing morality which allows and encourages promiscuity among young people, and the perception that sexually transmissible diseases are not very serious. He suggested that government works towards creating a climate for the promotion of family values and family life by introducing an additional tax rebate to parents of school-going children. He also proposed that government should re-evaluate current morality legislation to protect persons under 18 years

923 See also the comments of the AIDS Legal Network: National Office.

(amongst whom HIV is spreading at alarming rates) from indecent and obscene matter. Coupled with this, government should acknowledge the two-way interaction between sexually transmissible diseases and HIV infection⁹²⁴ and concentrate on improved sexually transmissible disease case management at primary health care level in order to bring about a reduction in new HIV infections. Others who supported the view that harmful HIV-related behaviour is a result of current social values, specifically referred to values relating to violence as a form of disciplining women in sexual relationships and the role of "real men" in our society.⁹²⁵

! *Initiating HIV/AIDS education and information programmes*

10.38.2 Respondents who believed that HIV/AIDS is first and foremost a medical matter with moral ramifications suggested that sound social behaviour and good public health are best left to good educational programmes and awareness campaigns regarding the nature, spread and control of HIV/AIDS.⁹²⁶ It was submitted that such programme should be broad based, be characterised by a multi-disciplinary approach and should encourage a culture of responsibility.

! *Acknowledging the importance of support services and post test counselling for persons with HIV*

10.38.3 Certain commentators drew the Commission's attention to the importance of proper post test counselling in accepting and integrating an HIV positive diagnosis, which, if it is not done may lead to acts of deliberate infection.⁹²⁷ They also emphasised the need for proper support services for persons with HIV - which should include the development of respect for the rights of persons without HIV.⁹²⁸

! *Introducing partner notification and promoting disclosure of HIV*

924 Persons with sexually transmissible diseases are more susceptible to HIV and vice versa (see par 3.47.1 above for more detail).

925 Comments of Dr A Jaffe.

926 Comments of Fr H Ennis; Dr A Jaffe; Johannesburg Regional Court Magistrate LJ van der Schyff; and the AIDS Legal Network: KwaZulu-Natal.

927 See eg the comments of Dr A Jaffe; and the Department of Welfare and Population Development: Gauteng Province.

928 Comments of the AIDS Legal Network: KwaZulu-Natal.

status

10.38.4 Dr Lorraine Sherr of the Royal Free Hospital School of Medicine: University of London suggested that disclosure of HIV status should be encouraged and promoted, and that the possibility of a partner-contacting or HIV/AIDS notification programme should be considered. Others who shared this view suggested that HIV infection should be declared a notifiable disease in terms of the Health Act 1977, with mandatory counselling and follow-up of the infected individual as well as all sexual contacts.⁹²⁹ See also par 10.15 above for suggestions that public health measures should be used in conjunction with the creation of a new offence.

! *Addressing HIV transmission and exposure during acts of nonconsensual sex through broadening of existing common law crimes*⁹³⁰

10.38.5 Mr SG Abrahams submitted that rape accounts for less than 1% of the cases of transmission of HIV and suggested that harmful behaviour in the context of rape should rather be addressed as part of ongoing efforts to combat crime and violence.

929 Comments of Business South Africa.

930 As indicated in par 10.8.2 above, the need for additional measures relating to the transmission of or exposure to HIV during *nonconsensual* sexual acts falls outside the parameters of this Report.

10.38.6 Ms Justice L van den Heever, without expressing herself for or against creation of a statutory offence, suggested that the legislature might, with much advertising, provide that for purposes of the law relating to rape, "consent" means *informed* consent, not consent obtained by fraud or by concealing what should have been revealed - such as the "latent defect" of HIV/AIDS. She is of the opinion that the advent of HIV/AIDS has made rape once more the extremely serious crime that it was in Victorian times, by reason of its potentially disastrous consequences. The comments of Adv David Buchanan, SC supported this in that he suggested that a way forward for countries with the English common law tradition is to embrace the recent decision of the Canadian Supreme Court in **R v Cuerrier**.⁹³¹ (In this case the court held that where, to the knowledge of the accused, harm [or risk of harm] flows from an act of sex, then consent to the sex is vitiated or inadequate or deemed procured by fraud, unless the consent is also to those harmful consequences.⁹³²)

! *Providing for increased sentences in cases of HIV transmission or exposure during nonconsensual criminal sexual acts (eg rape)*⁹³³

10.38.7 To curb practices according to the myth that intercourse with a virgin cures males of sexually transmissible diseases (including HIV), Ms Justice L van den Heever suggested that the legislature should provide ruthless compulsory sentences for anyone having intercourse with a female child under the age of 12; to be doubled where the accused suffers at the time of the intercourse from a sexually transmissible disease, including HIV/AIDS; with a reverse onus on the accused to prove on a balance of probabilities that he was unaware of his infection and could not reasonably have been aware of his being so infected.⁹³⁴ North West Regional Court President PB Monareng (without dealing expressly with the position of girls under 12) however stated that the punitive jurisdiction of the Regional Court in matters relating to rape has

931 (1998), 127 CCC (3d) 1.

932 See par 6.8.2.2 above for information on this case.

933 As indicated in par 10.8.2 above, the need for additional measures relating to the transmission of or exposure to HIV during nonconsensual sexual acts falls outside the parameters of this Report.

934 Cf the current provisions of the Criminal Law Amendment Act 105 of 1997 referred to in fn 360 and par 7.27 above.

already been increased and a further tampering with that to curb the spread of HIV, would be an exercise in futility.

- 10.38.8 Other respondents submitted that where HIV is transmitted as part of a nonconsensual criminal sexual act (eg rape) the presence of HIV infection in the accused should be an aggravating factor in sentencing.⁹³⁵

! *Broader social issues underlying harmful HIV-related behaviour should be recognised and addressed*

- 10.38.9 Lawyers for Human Rights, Pietermaritzburg and the AIDS Legal Network: KwaZulu-Natal believed that harmful HIV-related behaviour is a complex social issue, and that the use of the criminal law to punish harmful behaviour fails to recognise many of the broader issues underlying such behaviour. These issues include the following:⁹³⁶

- P The vulnerable position of women and young girls in society, and their inability to determine the parameters of their sexual relationships.
- P The prevailing climate of discrimination and stigmatisation of HIV/AIDS, which impacts upon the willingness of individuals to disclose their HIV status.
- P Women's fears and experiences of rejection and violence if they choose to disclose their HIV status.
- P Insufficient access to health care services, including HIV education and information, HIV testing, pre- and post test counselling and preventive methods.

Other organisations working in the field of human rights and HIV/AIDS shared this view and in general urged the Commission to respond to the problem of harmful HIV-related behaviour in a nondiscriminatory, humane manner based on the principles enshrined in the 1996 Constitution.⁹³⁷ It was suggested that public health and other programmes to deal with the broader social issues impacting upon women and youth's vulnerability to HIV/AIDS are therefore of primary importance in dealing with harmful HIV-related behaviour. Government

935 Comments of the National Council of Women of South Africa; and the Department of Welfare and Population Development: Gauteng Province. See the discussion of the Criminal Law Amendment Act 105 of 1997 in fn 360 and par 7.27 above.

936 Comments of Lawyers for Human Rights, Pietermaritzburg; and the AIDS Legal Network: KwaZulu-Natal.

937 See eg the comments of the AIDS Consortium; and the AIDS Legal Network: National Office.

departments will need to ensure that they take all necessary steps to assist in dealing with these issues.⁹³⁸

! *Practical mechanisms should be put in place to ensure appropriate implementation of the existing common law instead of creating a statutory offence*

10.38.10 Certain organisations concerned with human rights and HIV/AIDS believed that statutory intervention involving the criminalisation of consensual sexual acts between adults is an extremely difficult legal issue and will be difficult to enforce.⁹³⁹ Practical mechanisms to assist in making the use of the existing common law appropriate in dealing with harmful HIV-related behaviour are therefore vital. Key personnel in the SAPS and the Department of Justice will need to be trained in how to support and deal with cases of harmful HIV-related behaviour within the confines of the common law. These organisations thus suggested that the Commission consider the development of a set of practice guidelines or directives, in consultation with relevant role players, to assist judicial officers, police officers, district medical officers and other key personnel to deal with certain key elements of common law offences related to harmful HIV-related behaviour. It is believed that guidance regarding the following would be needed:

- P The definition of harmful behaviour in the HIV/AIDS context.
- P The determination of unlawfulness in the HIV/AIDS context.
- P The form of fault required in an HIV-related offence.
- P The role of HIV testing in an HIV-related offence.
- P Possible defences to a charge of harmful HIV-related behaviour.

938 See also the comments of the Department of Welfare and Population Development: Gauteng Province. Respondents holding this view suggested that the Department of Health prioritise the following:

- * The creation of an enabling environment which supports all those infected and affected by HIV/AIDS and allows people to feel free to disclose their HIV status without fear of violence, intimidation and discrimination.
- * HIV testing facilities should be made widely available.
- * The provision of services should be designed to encourage people to test for HIV and ensure that support in the form of counselling and care is provided to those who have tested HIV positive.
- * Health care workers and HIV counsellors should ideally all receive training on issues related to harmful HIV-related behaviour, so that concerns in this regard are discussed with clients.
- * The Department's programmes will need to focus on special measures to reduce the vulnerability of women and youth to infection.

939 See the comments of Lawyers for Human Rights, Pietermaritzburg; AIDS Legal Network: National Office; and AIDS Legal Network: KwaZulu-Natal.

11 Further consultation: Input by experts

- 11.1 It is evident from the analysis in Chapter 10 that the comments on Discussion Paper 80 did not provide the Project Committee with clear-cut solutions. The majority of persons and bodies commenting were of the opinion that the criminal law does have a role to play in the AIDS epidemic in protecting members of society from harmful behaviour by persons with HIV/AIDS. However, which route to follow in realising this (i.e. dealing with it through the existing common law crimes, or creating an HIV-specific statutory offence/s) was a major point of difference.
- 11.2 In acknowledging the divergence of the comments, the Project Committee identified a need to gather further information and to discuss the dilemmas facing it with experts from different interest groups. A range of experts on 3 February 2000 participated in a consultative meeting with the Project Committee. Persons who attended the meeting (which was chaired by Mr Justice Edwin Cameron, project leader) included experts in the fields of criminal law; constitutional law; human rights and HIV/AIDS; women's rights; HIV/AIDS and behavioural science; police practice; prosecuting and judicial practice; and representatives of the Department of Health's HIV/AIDS/STD Directorate. Members of the Commission's Sexual Offences Project Committee were included because of their special interest in the matter.⁹⁴⁰ A list of participants is included in ANNEXURE B. Six of the experts invited were requested to set out specific perspectives against which the Project Committee could debate certain crucial issues with participants. These perspectives and the subsequent debate are reflected in this Chapter. In background information provided to participants it was emphasised that the current investigation does not address the question whether additional offences should be created where HIV transmission or exposure is the result of a *nonconsensual sexual act*.⁹⁴¹ It was also emphasised that a range of views prevailed within the committee on whether an HIV-specific statutory offence/s should be created.

940 See par 4.13 and 10.8 above.

941 This issue is dealt with by the Commission's Sexual Offences Project Committee (see par 4.13 and 10.8.2 above).

11.3 The Project Committee submitted the following four crucial questions to experts for discussion at the meeting:

I *Is it necessary for there to be an additional, legislated crime in South African law?*

The common law regarding criminal conduct contains three distinct omissions: There are no crimes of *negligent injury; deliberately exposing another to danger short of assault; or negligent endangerment* (exposure) in South African law.

! What is proposed in all three cases is radically innovative - the creation of a new crime of negligent injury and/or of negligent or intentional endangerment. Are such innovations necessary? If so, should such conduct be criminalised exceptionally in respect of HIV only?

! Forensic practice presents specific problems in regard to proof of knowledge of HIV status; consent on the part of the endangered person; and whether conduct occurred which created endangerment (eg whether a condom was used). Should these difficulties, or some of them, be eliminated or eased by statutory intervention? What constitutional rights questions will arise if this is done?

! Is there evidence that offences are occurring in regard to which statutory intervention along the lines envisaged is necessary? To what extent are we operating on the basis of factual information (as opposed to a moral clamour or panic)?

II *What will be the practical utility of the newly legislated offence?*

! Given the present array of common law offences; the resources available to the state prosecution services; and the likelihood of complainants coming forward.

! Will a newly legislated offence be of practical use, or will its enactment be largely symbolic?

III *Is there virtue in codifying the existing common law crimes pertaining to exposure or transmission of HIV in a statute?*

IV *What will be the social impact on the spread of HIV; and the lives of those living with HIV/AIDS if a statutory offence is enacted?*

! Beneficial consequences: A clear statement of public policy against transmission; and a possible deterrent effect.

! Detrimental consequences: Further stigma of the disease and of those living with HIV/AIDS with resultant added discrimination; possibly misplaced executive and legislative priorities; and possible reluctance on the part of those who may have HIV/AIDS to come forward for testing and counselling.

Information and perspectives

Criminal law perspectives

Prof John Milton (James Scott Wylie Prof of Law, School of Law, University of Natal Pietermaritzburg)

11.4 Prof Milton addressed the question whether South African law should have a crime of negligent injury (i.e. whether negligent conduct which brings about harm to another person should be criminalised), with specific reference to negligent injury by transmitting HIV.⁹⁴² He pointed to the long weight of legal history which led to it being accepted that negligence may only be used as a determinant of desert of punishment in the case of homicide, and in no other crime. However, negligence has since come to serve as a determinant of desert in other instances. In South African law for example we have the crimes of reckless and negligent driving of a motor vehicle, and negligent causing of bodily injury by using a firearm. These crimes are characterised by the following:

- ! They are statutory crimes (i.e. aimed at conduct which has been criminalised by the decision of a competent law making body).
- ! They are a response to a technological development which in both cases have become a part of modern society but which are capable of wreaking great social harm because of the inherent threat of danger to others.
- ! Social attitudes demanded that persons who used motor vehicles and firearms should be required to recognise the inherent danger of these instruments and be expected to use them with a degree of care, prudence and circumspection that would minimise the risk to others (i.e. with the degree of prudent caution which the ideal citizen ["reasonable person"] would display in the same circumstances). If not, the accused is deserving of blame and should undergo punishment.

942 JRL Milton "Do We Need a Crime of Negligent Injury to Another?" (Paper delivered at SALC consultative meeting 3 February 2000).

The negligence concept can thus lead to a rationale for imposing punishment. However, there must be justification for doing so.

11.5 In posing the question "What would justify the criminalisation of causing negligent injury to another?" Prof Milton emphasised the following:

- ! ***The decision to criminalise has both a social cost*** (the cost for individuals - the stigma attached to a conviction and the resultant criminal record) ***and an economic cost*** (the cost of maintaining and operating a criminal justice system) which have to be weighed against the benefit that will be produced by penalising specific conduct. If the benefits to society are not commensurate to the social or economic costs of creating a particular crime, then the decision to criminalise cannot be justified.
- ! ***The negative results of over-criminalisation*** of conduct, which include:
 - P Lessening the authority of the criminal law. (The effect of which is to diminish the stigma attached to conviction, and thus to diminish the moral authority of the criminal law.)
 - P Stigmatising individuals as criminals. (The effect of the hardship and social degradation involved in conviction may well outweigh the social harm involved in the prohibited conduct.)
 - P Overloading the criminal justice system. (A proliferation of crimes with a consequent increase in the incidence of criminal acts that must be investigated and prosecuted will tend to clog the machinery of law enforcement possibly leading to selective and arbitrary enforcement and a general decline in the effectiveness of the system as a whole.)
- ! ***Established criteria which would indicate to the lawmaker when it is appropriate to criminalise.***⁹⁴³ These criteria would in the context of the subject under discussion lead one to ask whether causing injury to another by *negligently* transmitting HIV is so substantially damaging to society as to invoke the same rationales for punishing negligent driving or negligent use of

943 Prof Milton referred to the criteria suggested by Packer (H Packer **The Limits of the Criminal Sanction** 1969 op cit 296), which consist of the following in relation to the relevant conduct:

- 1) It is prominent in most people's view of socially threatening behaviour, and is not condoned by any significant segment of society.
- 2) Subjecting it to punishment is not inconsistent with the goals of punishment.
- 3) Suppressing it will not inhibit socially desirable conduct.
- 4) It may be dealt with through even-handed and nondiscriminatory enforcement.
- 5) Controlling it through the criminal process will not expose that process to severe qualitative or quantitative strains.
- 6) There are no reasonable alternatives to the criminal sanction for dealing with it.

a firearm. Departing from the premise that HIV/AIDS is a phenomenon which is substantially damaging to society and that preventing its transmission is an obvious and efficacious way of protecting society, Prof Milton analysed the possible benefits and costs of criminalising negligent transmission of HIV.

It was argued that benefits could include the following:

- P In principle, the threat of punishment should deter persons from transmitting HIV. Prof Milton however submitted that this being arguably true in cases where a crime is committed intentionally, it is arguably not true in the case of crimes of negligence.⁹⁴⁴
- P By proclaiming the negligent transmission of HIV to be a crime, citizens are warned that it is expected of them that they should be prudent and cautious when engaging in activities which may cause transmission of HIV and are thus taught how to behave (i.e. utilising the criminal law as an educative medium).

Costs, on the other hand, could include the following:

- P The *individual social costs* are those of stigmatising the individual and subjecting him or her to the ordeal of imprisonment. In this regard Prof Milton emphasised that negligence is not a state of conscious awareness of the relevant harm but rather a type of conduct involving the failure to take precautions. As such it involves a failure to be aware of risk of harm to others. In the context under discussion it would therefore involve an individual who is not aware that he or she has HIV, and in this state of ignorance unknowingly transmits the disease to another. This person neither knows nor foresees the possibility that he or she has HIV.⁹⁴⁵ ***The question should therefore be answered whether it is just and right that a person who is ignorant of his or her health status, but ought to have known that he or she is HIV positive, should be punished. In effect such person will be punished for his or her failure to have***

944 "Where a person acts intentionally, they are aware that they are about to commit a crime, and are thus aware that they face the threat of punishment. They thus will make their own cost-benefit analysis, in which the fear of punishment may well have the deterring effect of dissuading them from proceeding. In the case of crimes of negligence, the offender is not aware that what he or she is about to do is a crime. Thus there is no personal cost benefit analysis in which the threat of punishment can have an effect. To thereafter proceed to punish the person - it is argued - is an inefficient and ultimately arbitrary use of punishment" (Paper referred to in fn 942 6).

945 Prof Milton contrasted the latter with an individual who, while ignorant of his or her health status, realises that there is a possibility that he or she is infected i.e. who subjectively thinks that it is possible that he or she has HIV. He stressed that in law a person with this state of mind and who nevertheless proceeds to transmit the disease, is acting intentionally.

known their HIV status.

P The *institutional costs* are those of committing the resources of the criminal justice system to the pursuit, investigation, trial and imprisonment of offenders. The more prevalent the offence, the greater the costs. The fewer offenders, the lower the costs.⁹⁴⁶

11.6 Prof Milton in conclusion submitted that there appears to be no substantial barrier in terms of the principles of criminal law to criminalise the negligent transmission of HIV. However, the real question to be addressed is whether the costs (to the individual and to society) of doing so will be outweighed by the benefits of punishing those persons who, having failed to foresee that they have HIV, transmit it to others.⁹⁴⁷

***Prof CR Snyman (Prof in Criminal and Procedural Law,
University of South Africa)***

11.7 Prof Snyman addressed the feasibility of creating a statutory offence consisting in the negligent transmission of or exposure to HIV (i.e. an HIV-specific offence).⁹⁴⁸

11.8 He emphasised the following about the concept of negligence in general:

! *The double meaning of the concept of negligence:* First, it refers to the act itself. A negligent act bears the characteristic that it fell short of the standard of care and diligence which the law requires in the circumstances (i.e. that the perpetrator acted, objectively seen, "unreasonably"). Second, it refers to the culpability of the person who acted. Whether negligence in the latter sense was present is in principle also objectively established, although subjective considerations may play a role.

! *The distinction between "conscious" and "unconscious" negligence* (indicating the state of mind of the perpetrator - which is linked to the question whether

946 This leads to the paradox that if the incidence of negligent transmission of HIV is indeed high, there seems to be a more powerful imperative to criminalise it, although this will impose greater costs on the criminal justice system (Paper referred to in fn 942-8).

947 Prof Milton observed that in answering this question it would help greatly to have some idea of how many people transmit HIV negligently.

948 CR Snyman "Is There a Need for a New Statutory Offence Aimed at Harmful HIV-related Behaviour? A Criminal Law Perspective" (Paper delivered at SALC Consultative meeting 3 February 2000).

negligence should be objectively or subjectively established).⁹⁴⁹

P *Unconscious negligence* is present when the perpetrator does not foresee the prohibited result or circumstances whereas he or she should have foreseen.

P With *conscious negligence* the perpetrator does foresee but unreasonably decides that the result will not ensue.

P Conscious negligence should be distinguished from *dolus eventualis* where the perpetrator does foresee, but reconciles him or herself with the prohibited result or circumstances.⁹⁵⁰

Prof Snyman submitted that in practice almost all cases of negligence are cases of unconscious negligence.

- ! The fact that in South African law the slightest degree of negligence is sufficient to render the perpetrator guilty of a crime requiring negligence.
- ! The difference of opinion on whether negligence should be punishable. There are those who strongly contend that negligence (i.e. unconscious negligence) should not (or only in exceptional circumstances) be punishable since on moral grounds only those perpetrators who consciously foresaw the possibility of harm should be punished. Linked to this is the theory that a person is only deterred from wrongdoing on the assumption that he or she is conscious of the dangerous and potential harmful character of his or her activity and that punishment of (unconscious) negligence can thus not be justified on grounds of deterrence. Even more doubtful is whether rehabilitation can be justification for punishment of (unconscious) negligence.

949 See also par 6.9.2-6.9.3 above.

950 See also par 6.9.3 above.

11.9 By way of comparison, Prof. Snyman referred to relevant provisions in German and Austrian law:

- ! German law has no crime specifically punishing either intentional or negligent transmission of HIV. However, provisions of the German Penal Code which may be relevant in addressing conduct which infects another with HIV are the following:
 - P Provisions punishing the intentional or negligent causing of another's death. (These crimes are comparable to the crimes of murder and culpable homicide in South African law.)
 - P Section 223 of the Penal Code: Making it a crime to inflict bodily injury to another. German courts have held that an accused who, with knowledge of his or her HIV status, has sexual intercourse with another with the latter's consent but without protection, and who actually infects the other with HIV may be convicted under this section. If infection of the other person cannot be proved, the accused may be convicted of attempt to commit the crime. (This crime is defined much wider than the corresponding crime of assault in South African law.)
 - P Section 224 of the Penal Code: Providing for special penalties if the bodily injuries to another results in the complainant becoming infected with a chronic disease.
 - P Section 230 of the Penal Code: Punishing the negligent causing of bodily injury to another. This provision will only be applicable where infection actually occur.
- ! According to the Austrian Penal Act a person commits an offence if he or she commits an act which is calculated to create a danger of spreading a transmissible disease among people (section 178); or if the same act is committed in a negligent manner (section 179).

11.10 Prof. Snyman concluded that the punishment of negligent conduct in certain circumstances is justified. The reasons for this are the following: First, while we live in a highly technological society in which there are many potentially dangerous activities, it is necessary for the law to impress upon members of society the importance of acting in accordance with a certain minimum degree of prudence and foresight, especially when dealing with potentially very harmful behaviour. Although the punishment of negligence does not deter all people at all times, it deters a fair number of people, and in so doing

contributes to the maintenance of standards of care (eg in the area of motor traffic). In this way the law may be said to inform and educate citizens. Second, justification for punishment of negligence may be present in the sense that the perpetrator has revealed a certain "egotistic mentality" in that he or she considered only his or her own interests and failed to take into consideration the impact of the relevant conduct upon the legitimate rights of others, and therefore acted in a blameworthy way. Third, if one accepts that culpability is always normative in character (i.e. based on a normative assessment of grounds upon which the perpetrator may be blamed for his or her conduct in contradistinction to a psychological concept of culpability which consists in a "mind-set" of consciously infringing legal norms) punishment of negligence is justified. And fourth, the degree of potential harm which the law seeks to avoid may be justification for punishing negligence (eg in punishing negligent and reckless driving, the law seeks to protect human life, bodily integrity and property). From a comparative point of view he also drew attention to two other statutory crimes involving negligence which are of significance:

- ! According to section 39(1)(l) of the Arms and Ammunitions Act 75 of 1969 a person commits a crime if he or she discharges an arm and thereby negligently injures, endangers the life or limb of another person or damages property of any other person; or if he or she handles an arm in any negligent manner, whether that arm discharges or not.
- ! The unlawful possession of arms or ammunition in contravention of section 12 (read with section 39(1)(a)) of the Arms and Ammunition Act 75 of 1969.⁹⁵¹

11.11 Prof Snyman further submitted that the creation of a statutory offence consisting in the intentional or negligent **transmission** of HIV is justified. He motivated his submission with the following: Negligent transmission of HIV is life-threatening. The value of human life is so important, and its infringement so harmful, that the law is justified in punishing negligent conduct whereby HIV is transmitted. Further, the difficulties in proving intent (including *dolus eventualis*) (where eg perpetrators allege that they did not know that they have HIV or honestly believed that they would not pass on the infection) necessitates the creation of making negligence punishable. Negligence on the other hand may be established by proof that the perpetrator knew or foresaw the possibility that he or she has HIV, yet nevertheless proceeded with intercourse without taking precautions; or proof that the reasonable person in the same position as the perpetrator would have known

951 It was decided in **S v Mnisi and another** 1996 (1) SACR 496 (T) that negligence is the form of culpability required for a conviction of this offence (Paper referred to in fn 948 11).

that he or she has HIV.

- 11.12 Prof Snyman finally believed that the creation of an offence specifically punishing the (intentional) **exposure** of another to the risk of becoming HIV infected (by way of sexual act) is justified. He argued that formidable difficulties with proving that a complainant became infected with HIV as a result of the behaviour of the perpetrator calls for the creation of an offence targeting exposure to HIV. However, such an offence should be restricted to *intentional* exposure, and exposure by way of a *sexual act* only. Sexual behaviour by a person who knows that he or she has HIV and who uses precautionary measures (i e a condom) should not amount to exposure.

General public interest perspective

Prof Christa Van Wyk (Department of Jurisprudence, University of South Africa)

- 11.13 Prof Van Wyk addressed the question of how the public interest is protected by the law in dealing with the different scenarios⁹⁵² of possible HIV transmission or exposure.⁹⁵³
- 11.14 She emphasised that the "worst case scenario" (forecast for South Africa in 1993 by actuaries from Metropolitan Life to be an HIV infection rate of 16% by the year 2000) is becoming a reality while no economically viable cure nor AIDS vaccine is yet in sight and while we can infer from growing rates of HIV infection that no meaningful change in sexual behaviour is taking place. Further, that the noncoercive model for combatting AIDS (emphasising the rational nature of people and their fundamental rights by supplying information and education about HIV/AIDS and establishing the principle of no unfair discrimination towards persons with HIV/AIDS) which has rather consistently been

952 These scenarios cover a range of possible factual situations from where a person, unaware of his or her HIV status, exposes another to or transmits the virus without taking precautions (although the reasonable person in the circumstances would have foreseen the possibility and would have gone for testing) to where a person who knows about his or her HIV positive status deliberately withholds this information and has unprotected sex with his or her partner (Van Wyk 2000 **Codicillus** 4).

953 Christa Van Wyk "The Need for a New Statutory Offence Aimed At Harmful HIV-related Behaviour: The General Public Interest Perspective" (Paper delivered at SALC consultative meeting 3 February 2000). See also Van Wyk 2000 **Codicillus** 2-10 for her view.

applied in South Africa⁹⁵⁴ has not been successful, and has probably been too idealistic.⁹⁵⁵

- 11.15 The law currently deals with the different possible scenarios⁹⁵⁶ of transmitting HIV to others or exposing them to infection through administrative and criminal law measures: **Administrative law measures** include the isolation and quarantining of infected persons under certain circumstances in terms of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987.⁹⁵⁷ Prof Van Wyk however pointed out that these Regulations have never been applied to persons with HIV/AIDS, have been widely criticised as not being appropriate with regard to HIV/AIDS, and doubts furthermore exist as to their constitutionality.⁹⁵⁸ Under the **criminal law** prosecutions for the common law crimes of murder, assault, *crimen iniuria*, and attempt to commit these crimes can be used in cases of deliberate transmission of or exposure to HIV; and culpable homicide in the case of negligently infecting another in cases where the victim dies. Prof Van Wyk however pointed out that successful prosecution under the common-law crimes may be extremely difficult due to the specific characteristics of HIV infection, the long incubation period of AIDS, problems regarding proof of causation and intent and those surrounding consent, and the kind of sexual behaviour that is to be regarded as socially responsible and acceptable. Moreover, as indicated, our law does not know the crime of negligent injury or negligent assault.

954 A national AIDS Prevention Programme, and an AIDS Advisory Group were established as early as 1988, while a massive education and information campaign was launched and leaflets in nine languages, as well as free condoms were distributed. In 1990 an inter-departmental AIDS committee was established which had to finalise a national strategy, while in 1993 a special Project Committee (a precursor of the present one) was set up by the South African Law Commission to investigate the legal aspects of HIV with a view to possible law reform. A policy which aimed at preventing foreigners and immigrants with HIV from entering South Africa, was, for example, abandoned early in the 1990's. These efforts have since 1994 been repeated by the new democratically elected government, which also established an Inter-Ministerial Committee on HIV/AIDS and more recently a National AIDS Council. This noncoercive approach is also reflected in, for example, the schools policy on HIV which was introduced in 1999 by the Department of Education, and which confirms the principle of no unfair discrimination against learners with HIV/AIDS. Legislation was also adopted to prevent unfair discrimination against people with HIV in the employment sector (cf the Employment Equity Act 55 of 1998) (Paper referred to in fn 953 2-3).

955 This model can be contrasted with the coercive model which emphasises state intervention and coercion in the private lives of people. The coercive model probably overestimates the success of state control.

956 See fn 952 above for these scenarios.

957 GN R 2438 in **Government Gazette** 11014 of 30 October 1987.

958 The Regulations allow for serious inroads into the individual's rights for extended periods of time at the discretion of local authorities and public health officials (see eg reg 2 and 14). (See par 5.8 et seq above for a discussion of these measures.)

11.16 Against the above background she suggested that a middle course between, or a combination of, the coercive and noncoercive approach in combatting AIDS should rather be adopted as a solution to the South African problem. Such an approach would accept that rights to equality and nondiscrimination go hand in hand with duties and responsibilities, and that once a certain level of awareness and information about HIV/AIDS is reached in a community, those who continue to act in an irresponsible manner must be held accountable. In this sense coercive measures should be seen as a suitable back-up for the accommodating and enabling efforts made by public health authorities. In suggesting this approach Prof Van Wyk submitted the following options for law reform:

! ***Transforming the common-law crimes into statutory offences.***

- P *Advantages* of this approach would include the following: a clear signal will be sent that certain conduct will not be tolerated; the state will show its commitment to the protection of the interests of society and the constitutional rights to life and bodily integrity; statutory crimes will have a strong deterrent effect on the individual offender and other potential offenders, which in turn will slow the spread of the HIV epidemic; maximum penalties will be prescribed and people who pose a danger may be removed from society for fixed periods of time; legal clarity will be obtained on aspects such as causation and defences (eg whether using a condom is a recognised defence or whether a sexual partner should in addition be informed of seropositivity); statutory crimes will include a definition of the specific unlawful act, conduct or omission which is prohibited; and statutory crimes will be better publicised than common-law crimes with such publicity resulting in a further deterrent effect.
- P The *disadvantages* of this approach most commonly cited are that statutory crimes will have a negative effect on the preventive programmes of the health authorities in the sense that the successes gained with encouraging voluntary testing and counselling would be lost if people knew that their criminal liability depends on their knowledge of their own serostatus. The epidemic will thus be driven underground and infected people will be alienated. However, counter arguments are that the possibility of this scenario occurring already exists in respect of the common-law crimes. It can moreover be argued that fear of possible future prosecution for something which may never occur is most unlikely

to deter anyone from testing and seeking whatever treatment is available. And secondly, the threat of criminal sanction will not deter people who are already dying of AIDS. The counter argument to this is that many people with HIV are living longer and relatively healthy lives, and that the fear of punishment and further misery may indeed act as a powerful deterrent.

! Criminalisation of negligent or unintentional behaviour.

Prof Van Wyk advanced the following reasons why this may be a viable option:

- P Although our common law does not punish negligent harm or negligent endangerment, (because negligent behaviour is normally not regarded as blameworthy) this general approach may be adopted when the public interest is seriously threatened by negligent behaviour.
- P The legislature has already intervened in the case of firearms and motor vehicles - which are regarded as dangerous tools and a threat to the safety of others which require special diligence in their use - by creating offences under the Road Traffic Act,⁹⁵⁹ and the Arms and Ammunitions Act.⁹⁶⁰ Prof Van Wyk points to the appropriateness of the preamble to the Firearms Control Bill 1999 for statutory provisions criminalising the negligent transmission of or exposure to HIV.⁹⁶¹
- P The community is entitled to protect its interests at the expense of the rights of the individual, provided that these interests must be so valuable

959 Secs 120(1) and (2) of the Road Traffic Act 29 of 1989 provide that no person shall drive a vehicle on a public road recklessly or negligently. A fine not exceeding R24 000,00 or imprisonment for a period not exceeding six years or both the fine and imprisonment may be imposed for reckless driving (sec 149(5)(a)). For negligent driving, a fine not exceeding R12 000,00 or imprisonment for a period not exceeding three years or both such fine and imprisonment, may be imposed (sec 149(5)(b)).

960 The Arms and Ammunitions Act 75 of 1969 provides that any person who discharges an arm and thereby negligently injures or endangers the life or limb of another person, or who handles an arm in any negligent manner, whether that arm discharges or not, is guilty of an offence (sec 39(l)). The Firearms Control Bill 1999 (which was at the time debated), provides that a person who causes bodily injury to any person by negligently using a firearm, who discharges or otherwise handles a firearm in a manner likely to injure or endanger the safety of any person or with reckless disregard for the safety of any person, or who has a loaded firearm under his or her control in circumstances where it creates a risk to the safety of any person and who does not take reasonable steps to avoid the danger, is guilty of an offence and may be sentenced to five years' imprisonment (clause 130(3)(a)).

961 The preamble refers to the right to life and security of the person, including the right to be free from all forms of violence. It further states that the adequate protection of such rights is fundamental to the well-being and the social and economic development of every person and that it is the constitutional duty of the state to respect, protect, promote and fulfil the rights of individuals as enshrined in the Bill of Rights, including the right to life and security of the person. It further sets out the aim of the envisaged legislation as the provision of a more secure environment in which there is greater safety and protection for everyone; and to the state's responsibility to ensure that the envisaged legislation is effectively implemented in the interest of the general public and in the interest of the security of the state.

that peaceful societal existence cannot be guaranteed without their protection. Such interests would include human life, physical integrity and dignity (interests which would be at stake in cases of exposure to or transmission of HIV).

- P The criminalisation of negligence seems to be justified in terms of the 1996 Constitution.⁹⁶²
- P In Germany (a country and society which could be regarded as open and democratic and based on human dignity, and where HIV/AIDS is no longer an issue), for example, sec 229 of the Penal Code contains a provision targeting the causing of bodily harm to another through negligence. The provision is commonly applied to reckless driving and medical negligence but is wide enough to apply also to negligent bodily harm brought about by HIV infection and could cover both conscious and unconscious negligence.⁹⁶³ In practice this provision has however only been applied to persons who were actually aware of their HIV positive status (i e to cases of conscious negligence). In the latter regard the opinion has been expressed in German legal literature that there is no obligation on a person to undergo regular blood tests even if such person belongs to so-called "high risk" groups.

11.17 Prof Van Wyk concluded by submitting that it should be seriously considered to criminalise the negligent exposure to and transmission of HIV (i e creating an HIV-specific offence targeting negligence) as a uniquely South African solution to the problem of harmful HIV-related sexual behaviour. She qualified this by proposing that such criminalisation could be limited to cases where the perpetrator has actual knowledge of his or her HIV infection (i e targeting conscious negligence only). The latter approach will be in accordance with current practice in Germany, and with legislation targeting negligent HIV-related behaviour in comparable legal systems of which the Project

962 The limitation of the basic civil rights of liberty and property of the perpetrator 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, inter alia the nature of the right, the importance of the purpose of the limitation, the relation between the limitation and its purpose, and whether less restrictive means exist to achieve the purpose (cf sec 36 of the 1996 Constitution).

963 The "negligence" mentioned in sec 229 could consist of a person with HIV knowing about his or her infection but failing to take the steps a reasonable person would have taken to prevent infection (i e conscious negligence); or of a person with HIV not ascertaining his or her status in circumstances where a reasonable person would have gone for testing (i e unconscious negligence). Persons who ought to know or who suspect that they have HIV would fall into this latter category (Paper referred to in fn 953 12).

Committee has already taken cognisance in its Discussion Paper 80 (i.e. Zimbabwe, and certain states of the United States of America).⁹⁶⁴

Victims' and women's rights perspectives

Ms Lebo Malepe (Researcher, Tshwaranang Legal Advocacy Centre to End Violence Against Women⁹⁶⁵)

11.18 Ms Malepe in general urged the Project Committee to take into account women's experiences and realities in considering the creation of a new offence, stressing that the success of any intervention will depend on the extent to which gender power relations are acknowledged as a central factor in efforts to curb the transmission of HIV.⁹⁶⁶ She submitted that it is critical that the following three factors inform the committee's deliberations:

! *Women's specific vulnerability to HIV/AIDS.*

Pointing to current statistics on the HIV infection rate in South Africa (which show that the prevalence of HIV infection is the highest among women under 30 years), Ms Malepe submitted that HIV/AIDS does not affect all people equally, but flourishes in conditions of gender inequality. The following factors account for women's vulnerability to HIV:

- P The high levels of violence against women - including domestic violence and rape.
- P Women's physiological makeup - which is thought to make the efficacy of HIV transmission from men to women seven times greater than from women to men.
- P The relative inaccessibility of protective devices to protect women against

964 See par 9.5.1 above and fn 781-786 for examples of such legislation. Cf also the Supreme Court of Canada's view in this regard as referred to in par 8.14 above.

965 Tshwaranang is a nongovernmental organisation established in 1997, to use the legal system as a vehicle for social change for women, and to eradicate the victimisation of women by the legal system by influencing policy and legislation through advocacy, lobbying, education, training and research on violence against women.

966 Lebo Malepe "Is There a Need for a Statutory Offence Aimed At Harmful HIV-related Behaviour? Victims' and Women's Rights Perspectives" (Paper delivered at SALC consultative meeting 3 February 2000). See also Tshwaranang's comment on Discussion Paper 80 referred to in par 10.14, 10.26.1, 10.26.3 and 10.26.12 above.

transmission of or exposure to HIV (eg the female condom and vaginal cream that kills HIV).

P The imbalance of power between men and women (in the sense of women's lack of education, low social status and economic dependence on male partners) which limit their ability to negotiate safer sex with their partners.

! ***The status of violence against women in South Africa.***

Although the lack of statistics on the extent of violence against women makes it difficult to know the extent of the problem, there is general agreement among relevant role-players that the extent of gender violence in South Africa has reached endemic proportions. Violence against women is a human rights abuse as it violates several constitutionally entrenched rights (eg the right to life, equality, dignity, and freedom and security of the person). As such it constitutes a form of discrimination against women. The form of violence against women most relevant to the issue in question is domestic violence, since HIV transmission or exposure as a result of a consensual sexual act in most cases occurs in the ambit of domestic relationships recognised in terms of the Domestic Violence Act 116 of 1998.

! ***The link between domestic violence and HIV/AIDS.***

Ms Malepe submitted that domestic violence is both a cause and a consequence of the disempowerment of women in sexual decision making (referring to the lack of rights to insist on partners using condoms; to refuse sex if partners refuse to use a condom; to enquire from partners about affairs with other women; to insist on monogamy; or to ask partners to undergo HIV testing) which has serious repercussions in respect of the likelihood of women contracting sexually transmissible diseases, including HIV.

11.19 Ms Malepe conceded that proposals for a statutory offence may be radically innovative, but suggested that these innovations are necessary for the following reasons:

! Criminal law has a role to play in combatting the spread of HIV/AIDS and in protecting vulnerable groups such as women.

! Existing common law crimes are not adequate for the prosecution of harmful HIV-related behaviour mainly as interests currently protected by common law offences do not coincide with those violated by the consequences of nondisclosure of HIV status to a partner. The resultant harms to the victim

include reduced life expectancy, a compromised quality of life and livelihood, compromised reproductive choices, and increased vulnerability to domestic violence.

- ! Common law crimes are rarely used to prosecute HIV-related behaviour.
- ! Uncertainty currently prevails as to whether the common law crimes can be used to prosecute HIV-related behaviour.
- ! The nature of HIV/AIDS makes the common law unsuitable for the prosecution of HIV-related behaviour.
- ! HIV is a relatively new phenomenon - if consequences of the disease highlight gaps in the law, it is the role of the legislature to intervene by addressing those gaps.

11.20 Ms Malepe submitted that the practical utility of an HIV-specific statutory offence will lie in the following:

- ! Taking into account the debilitating nature of HIV/AIDS currently not accommodated by common law crimes.
- ! Sending a clear message regarding the role of individuals - particularly those living with HIV/AIDS - in combatting the spread of the disease.

11.21 In conclusion she submitted the following counter arguments in response to concerns raised about the creation of an HIV-specific statutory offence:

- ! *On the concern that such an offence will lead to further stigmatisation of the disease:* This is pure speculation as a new offence will not target everyone living with HIV/AIDS, but will specifically target those who negligently or intentionally fail to disclose⁹⁶⁷ their HIV status to their partners and in addition fail to take precautionary measures to prevent transmission of or exposure to HIV.⁹⁶⁸
- ! *On the concern that creating a statutory offence will utilise much needed funds for combatting the disease in an unproductive way:* Availability of resources should not override the need for new legislation aimed at protecting vulnerable groups.
- ! *On the strong feminist argument⁹⁶⁹ that the creation of a statutory offence may result in a violent backlash against women by their partners:* This argument brings into question the role of the law in protecting women from domestic violence and from the risk of HIV infection at the hands of their partners. Until very recently the private sphere has been regarded by lawmakers and the courts as a domain in which legal intervention is inappropriate. Ironically, it is in their homes that women and children suffer most forms of violence and are most unsafe. The approach of nonintervention has changed over the past decade with recent legislative developments which are in line with women's international and constitutionally guaranteed rights (eg the Prevention of Family Violence Act 133 of 1993 and its successor the Domestic Violence Act 116 of 1998). Moreover, not creating a statutory offence for HIV-related consensual sexual behaviour while statutory offences are being created in

967 Ms Malepe, on a question by Judge Cameron, indicated that nondisclosure of HIV positive status should in itself be an offence regardless of whether there has been exposure to HIV.

968 This proposal differs from that submitted to the HIV/AIDS Project Committee by the Commission's Sexual Offences Project Committee on 18 October 1999 in that the latter Committee at the time indicated that persons who do not disclose their HIV positive status (whether precautions were used or not) should be targeted by a new offence. However, when questioned by Judge Cameron about this, Ms Malepe indicated that she does not want to compromise herself and that she addresses the consultative meeting in her personal capacity.

969 It is argued that if a statutory offence is created a possible backlash of violence from women's partners may be expected, given -

- * women's vulnerability to HIV as a consequence of their inferior position in society and their physiological make up; and

- * women's likelihood of discovering their positive HIV status before their partners do, as a consequence of women's rapid utilisation of medical services as dictated by women's health requirements (Paper referred to in fn 966 8).

respect of HIV-related nonconsensual sexual behaviour (which, according to Ms Malepe, the Sexual Offences Project Committee is strongly considering) will perpetuate the outdated notion that it is acceptable for women to be exposed to the risk of harm by their partners and that it is not the role of the law to protect them. Failure to create an HIV-specific statutory offence will thus undermine current legislative initiatives and judicial pronouncements to break away from the outdated jurisprudence that has regarded the private sphere as not being worthy of legal intervention.

- ! *On the likelihood of a statutory offence impacting negatively on current public health initiatives aimed at encouraging persons to come forward for HIV testing and counselling:* Ms Malepe believes that this is speculation. She submitted that an HIV-specific offence will instead sensitise persons living with HIV/AIDS and those who suspect that they have the disease to act responsibly by confirming their HIV status and taking precautions. She submitted that public health initiatives and the creation of a statutory offence will instead complement each other.

Human rights perspectives

Mr Mark J Heywood (Head: AIDS Law Project,⁹⁷⁰ Centre for Applied Legal Studies, University of the Witwatersrand)

- 11.22 Mr Heywood primarily focussed on the question whether a specific statutory offence that aims to deter and punish wilful or negligent behaviour will reduce individual and social vulnerability to HIV or lead to greater vulnerability.⁹⁷¹

970 The AIDS Law Project is a nongovernmental organisation providing legal advice and advocacy for people with HIV.

971 Mark J Heywood "Is There a Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour? Human Rights Perspectives" (Paper delivered at SALC consultative meeting 3 February 2000).

11.23 He drew attention to the complexity of the issue at hand in pointing out that although in the experience of the AIDS Law Project there are a small number of known cases where people have alleged that they were "wilfully infected" and there has been a desire for retribution and blame from those infected in these cases, the vast majority of people owe their HIV infection to a combination of other reasons and causes: eg sexual inequality, lack of knowledge, and risk behaviour that they lack the power to change. Against this background Mr Heywood submitted that there are two human rights perspectives involved in deciding whether to create a statutory offence: The perspective of the vulnerable or infected person - and their rights to life, dignity etc; and the perspectives of persons with HIV - who desire to avoid further stigma, blame and interference with their rights to privacy and bodily autonomy, and to avoid a "major life activity" interfered with and possibly criminalised.

11.24 In considering whether the above rights can be balanced or reconciled in a manner that benefits both perspectives, Mr Heywood emphasised the following:

! *A human rights approach (as opposed to a bio-medical or purely legal approach) should be adopted.* Such an approach recognises that in the case of HIV/AIDS the individual's interest in the protection of his or her human rights, and society's interest in the protection of public health are inter-twined. This approach offers three unique insights:

P First, that the absence of rights and the absence of equality is a major determinant of vulnerability to HIV infection.

P Second, that people with HIV frequently experience human rights violations on account of their HIV status.

P Third, that these further violations undermine public health initiatives, particularly those that aim at improving individual autonomy in decisions about sex and disclosure.

Mr Heywood observed that the Project Committee's Discussion Paper 80 fails to apply the law to this context: Although the end result of HIV transmission may be aptly described as murder or culpable homicide, etc, the questions of *cause* and *intent* are far more complex than anything the law has had to deal with hitherto.

! *A human rights perspective identifies problems with the very terms of reference used by the Project Committee in Discussion Paper 80.*

Mr Heywood suggested that in targeting "harmful HIV-related behaviour" (

which he submitted refers to sexual behaviour since most HIV infection is sex related) the following picture of the HIV epidemic in South Africa should be kept in mind before the question whether such sexual behaviour is in fact "harmful" could be answered:

- P Most people in South Africa (90%) do not know their HIV status.
- P Those that do know, frequently discover their status in unlawful circumstances (i e without informed consent having been given for HIV testing, or without receiving appropriate pre- or post test counselling).
- P Discovering HIV status in unlawful circumstances impacts upon the debate about what constitutes "knowledge", and thus about what constitutes "intent". Mr Heywood submitted that applying the "reasonable person" test in these circumstances would be ludicrous, because this would assume equal access to knowledge about HIV and to barrier methods, equal power in the use of condoms, a common cultural perception of HIV/AIDS and a common response to it - while there is no such equality.
- P There are persons who cannot change their behaviour or disclose their HIV status without grave personal risks (referring eg to the Gugu Dlamini case,⁹⁷² and the position of impoverished sex workers). It would therefore be foolish to describe most negligence as "intentional, egotistic, or hedonistic".⁹⁷³

! *While one of the reasons advanced for the creation of a statutory offence is that it will prevent the selective application of the common law, the Project Committee's exposition in Discussion Paper 80 centres upon a selective definition of potentially "harmful HIV-related behaviour". Mr Heywood pointed out that the Project Committee in its Discussion Paper focussed on a possible statutory intervention in respect of sexual transmission (which scientifically is one of the least harmful of actions that persons with HIV can engage in with only a 1-2% risk per sexual act), while ignoring the implications for other forms of HIV exposure where the risk is in fact greater than through sex. According to Mr Heywood the latter include:*

- P A woman with HIV who proceeds with a decision to have a child, knowingly exposes her child to a 30% risk of HIV infection before and after

972 Ms Dlamini was stabbed and stoned to death by her community in KwaZulu-Natal in 1989 after having disclosed that she has HIV.

973 Mr Heywood referred to Prof CR Snyman's exposition of negligence (see par 11.8 -11.11 above).

birth.

P A woman who does not know her HIV status but knows that breast-feeding is a route of infection, exposes her child to risk of HIV infection through breast-feeding.

P A hospital patient who does not disclose his or her HIV positive status to a health care provider (or vice versa) exposes the other person to a risk of HIV infection in the event of a needle-stick injury.

! *The widening invasion of fundamental rights (especially the rights to dignity, privacy, and freedom and security of the person) implicit in the creation of a statutory offence.* Mr Heywood submitted that if it is alleged that harmful HIV-related behaviour has taken place, the process of detection would require an investigation that by its very nature would impinge upon fundamental rights as it would require: HIV testing of the accused (an invasion of privacy, and freedom and security of the person); HIV testing of other sexual partners of the victim (an invasion of privacy); and inquiry into the accused's sexual life (an invasion of privacy and dignity). Although these rights of the accused may be limited, their limitation must be shown to be just, open and democratic. Moreover, it would be nearly impossible (except with the use of DNA testing), in a country with the high HIV prevalence and incidence as South Africa, to establish beyond a reasonable doubt that an accused was responsible for a specific act of HIV transmission or exposure.

! *Prevailing international consensus against the creation of special statutes aimed at criminalising HIV-related behaviour.* Mr Heywood referred to the United Nations' International Guidelines on HIV/AIDS and Human Rights, 1996⁹⁷⁴ which stipulates that criminal and/or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but should rather apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.

! *The likely negative impact of an HIV-specific offence on public health.* Mr Heywood submitted that the connection between public health and human rights is indivisible. Actions that have a negative impact on human rights will therefore have a negative impact on public health in that creating a new

974 See also par 8. 2 et seq above.

offence will further stigmatise the disease and persons living with HIV/AIDS; and will cause confusion about key public health messages regarding safer sex (eg that all people are responsible to practice safe sex and not only persons with HIV).

- 11.25 In conclusion he referred to a recent resolution by the South African Catholic Bishop's Conference opposing the use of condoms and preaching abstinence, as evidence of the social complexities that encompass individual volition. He submitted that the reality about the cause of vulnerability to HIV and thus to violations of a series of human rights is not the failure of public health campaigns, but insufficient commitment and investment to raising public understanding of HIV/AIDS; and intractable social, sexual and economic inequalities. He believes that the proposal for the creation of an HIV-specific statutory offence is an avoidance of recognising the above: It is a short-cut that risks substantial injustice and will not be an effective public health tool. He proposed that it will be far better to continue to rely on the common law (weak as it is) to punish wilful infection than to introduce a new statute that will legitimise human rights violations and undermine public health messages.

The impact of the creation of a statutory offence/s on HIV and behaviour

Ms Nolwazi Gasa (Department of Psychology, University of Natal)

- 11.26 Ms Gasa reflected on factors impacting on behaviour which may provide insights on when it would be appropriate to hold persons with HIV responsible for exposure to or transmission of HIV.⁹⁷⁵
- 11.27 She stated first, that in the absence of a vaccine or cure for HIV/AIDS, health education programmes have been designed to educate the public about the virus and its transmission. Whether these education programmes are successful in changing behaviour has a bearing on whether persons can be held responsible if they claim to have

975 Nolwazi Gasa "The Impact of the Creation of a New Offence on HIV and Behaviour" (Paper delivered at SALC consultative meeting 3 February 2000).

unknowingly infected others with HIV. Ms Gasas informed the meeting that evaluation research showed that although health education programmes have resulted in increased awareness about the nature of HIV/AIDS, they have not resulted in significantly increasing behaviour modification in the form of voluntary HIV testing and practising safe sex. Various reasons have been advanced for this:

! ***People's perception of own risk to HIV infection is low.***

The "it won't happen to me attitude" remains prevalent even when a person has been exposed to various educational programmes. This attitude is largely determined by fear. Many people do not know their HIV status, are scared to know and have therefore not gone for HIV testing.

! ***Openness about HIV status is rare.***

Very few people have been open about their HIV positive status, largely because of feared stigmatisation and risk to life. Silence about the disease is exacerbated by persons with HIV who having reached the AIDS stage tend to emphasise opportunistic infections (eg tuberculosis) as the main cause for their illness. Moreover, families of infected individuals often support the infected individual's explanations for various reasons. This scenario tends to limit behaviour change as people know very few people who admit to being infected with HIV.

! ***The role of the long incubation period.***

The long period of time between infection and clinical signs of AIDS has the effect that "high risk" behaviour is not easily perceived as associated with HIV infection.

! ***The impact of cultural beliefs and practices.***

Cultural beliefs and practices (eg attribution of HIV infection to bewitchment) negatively impact on individuals taking responsibility for behaviour modification and practising safe sex. Many educational programmes tend to overlook the importance of understanding communities' or groups' beliefs before designing strategies for preventing the spread of HIV.

! ***The current economic crisis negatively impacts on behaviour change.***

She submitted that the economic crisis has a twofold impact: First, people tend to focus on basics (eg acquisition of food, housing and money) in their relationships rather than on safe sex. Second, the resultant limited resources have made it difficult for organisations to provide ongoing education and support programmes in the rural areas where most people cannot afford to

buy newspapers, magazines, radios and televisions, which are often used for educational purposes. Limited financial resources also result in limited HIV testing facilities and limited condom availability (eg in most rural areas testing facilities and condom distribution are still limited to main hospitals). In addition, people who have limited resources to start off with have to travel long distances to reach hospitals where testing and other relevant facilities are available.

! ***The impact of targeting "high risk" groups only.***

Many educational programmes targeting "high risk" groups (eg commercial sex workers and drug users) have further stigmatised these groups as carriers of HIV and have through this focus maintained the perception that "ordinary" members of the public are not susceptible to HIV infection.

! ***The role of peer influence.***

Peer pressure does not always benefit education programmes aimed at behaviour modification.

! ***The impact of focussing mainly on women.***

HIV/AIDS educational programmes have largely targeted women - possibly because they can be easily found in large groups at public health institutions such as hospitals and antenatal clinics and are often at home because of the high level of unemployment among them. The focus on women has meant that HIV/AIDS has been interpreted as a female problem. Programmes that focus on women seem to be operating on the assumption that men are not motivated to change their behaviour, while HIV/AIDS also needs to be conceptualised as a men's health issue for increased behaviour modification.

! ***Ignoring power differentials in sexual relationships.***

Education programmes often encourage women to promote the use of condoms in their relationships, not taking into account that men tend to make sexual decisions regarding the use of condoms and whether or not to have an HIV test conducted as a couple. Programmes rarely focus on developing the social skills women need for equal participation in sexual decision-making within relationships.

11.28 Ms Gasa posed the question whether people should be held responsible if they have unknowingly infected another person with HIV even when it has been indicated that HIV/AIDS educational programmes have not had significant increases in behaviour

modification. If indeed, she submitted that this may maintain the perception that safe sex is the responsibility of persons with HIV (who may or may not know about their status) only, and not of the general public.

11.29 Secondly, she submitted that an HIV-specific statutory offence may fail to deter since individual reasons for exposing others to HIV are social and highly complex. In this regard she proposed that any discussion on the possible creation of such an offence may have to consider the psychological effect of being informed about one's HIV status. She stressed that this effect is possibly one of the main reasons why people are reluctant to be tested for HIV. Ms Gasa pointed out that being informed of a positive HIV test result may give rise to most of the following feelings:

- ! Denial - an initial phase during which the person may refuse to admit that he or she is HIV positive and place others at risk of infection.
- ! Severe shock and anxiety regarding unknown future outcomes (eg future health and decisions regarding family responsibilities).
- ! Anger, which may be directed at the person perceived to be responsible for the infection, or at members of the general public who are blissfully unaware about their serostatus. Anger, subsequent resentment and the possibility of acting out are exacerbated by limited psychological support.
- ! Listlessness and obsessiveness about becoming infected.
- ! A deteriorating sense of self-worth.
- ! Feelings of helplessness and hopelessness which may result in depression which may in turn manifest in loss of interest in life and future goals, pessimism and suicidal tendencies.
- ! Fear of imminent death.

11.30 Ms Gasa emphasised that although each person's personal response to being informed about being HIV positive will be determined by his or her social context, the feelings referred to above may impact on an individual's cognitive capacity and the ability to exercise social judgment. A person with HIV may start to behave in a manner that he or she would never have thought possible - including paying less attention to the possibility of causing injury in the form of exposing others to HIV or transmitting HIV to others. Coping mechanisms may be affected and past maladaptive strategies (eg substance abuse) may resurface. Moreover, the psychological reactions outlined above may be exacerbated by the fact that HIV/AIDS is still a largely stigmatised condition and social

support is limited. She thus appealed to the Project Committee to take into consideration the psychological reaction to being informed about one's HIV status and the limited support that such individuals often receive.

Discussion and debate

11.31 Participants were invited to take part in an open discussion on the issues raised by experts in their presentations. Adv Gert Nel, Deputy Director of Public Prosecutions was specifically called on to supply information on the recent prosecution by the Office of the Director of Public Prosecutions, Pietermaritzburg for alleged harmful HIV-related behaviour under the common law crimes.⁹⁷⁶ The concerns and views expressed by participants are recorded below.

11.32 Adv Nel supplied the following information:

! ***The facts of the case:***

The accused and his spouse were informed on 24 November 1997 by a medical practitioner in Harare, Zimbabwe that they were both HIV positive. They were both counselled by the practitioner, which included receiving information about HIV and its spread, and the importance of abstaining from sexual intercourse or practising safe sex by using a condom. The practitioner requested them to advise previous sexual partners about their HIV status and to have their children tested for HIV. A few months later the accused and his family relocated to Newcastle, KwaZulu-Natal where the accused's spouse died of tuberculosis (an opportunistic infection) on 19 June 1998. On 27 June 1998 the accused was involved in a motor vehicle accident. On this occasion he told the police that he was HIV positive and cautioned them about the risk of exposure. On 4 July 1998 the accused met the complainant and told her that his spouse died of cancer. From 10 July 1998 to 10 September 1998 he co-habited with the complainant during which time they had intercourse on a daily basis. The accused did not inform the complainant that he was HIV positive. He also refused to use a condom for contraceptive purposes indicating that he is unable to have children. On 27 September 1998 the

976 See also par 2.6.2 above for reference to this case.

complainant discovered that the accused was HIV positive. She reported it to the police and the accused was charged with attempted murder on the basis that HIV leads to AIDS which is terminal. The complainant (at the time of the consultative meeting) still tested negative for HIV.

! ***Problems encountered by the prosecution:***

Adv Nel indicated that the case was subsequently withdrawn at the request of the complainant. Although the state would have proceeded with the case, the following problems relating to proof and practice were encountered which would have complicated the prosecution:

Problems relating to proof:

- P The accused denied that he had any intention to kill the complainant.
- P The accused denied that he had HIV.
- P The accused relied on the Duesberg theory (proclaiming that HIV is not the cause of AIDS) and therefore submitted that he did not place the complainant at risk.⁹⁷⁷
- P The accused averred that the medical limitations of the ELISA and Western Blot tests are such that the tests cannot be indicative of HIV infection.

Practical problems regarding the following were experienced:

- P Having the accused tested for HIV.
- P Gaining access to the accused's previous medical records indicating his HIV positive status.
- P Concern about the negative impact on public health efforts to curb the spread of the disease, should the accused's defence that HIV does not cause AIDS receive wide press coverage.
- P Identifying willing medical experts to give evidence for the state.

11.33 Adv Nel conceded that the issue in question contains overwhelming complexities. He however believed that victims of harmful behaviour should have recourse to the law with the possibility of more success than currently offered by application of the common law

977 Prof Peter Duesberg, a retrovirologist at the University of California has since 1987 claimed that HIV is not the cause of AIDS, but that certain life style factors (including the administration of blood transfusions or drugs [including AZT], promiscuous male homosexual activity associated with drugs, acute parasitic infections, and malnutrition) cause AIDS. While Duesberg's theory has been thoroughly and repeatedly rejected by mainstream AIDS researchers and medical authorities, he has a vocal group of supporters in some scientific circles (see eg "The Evidence that HIV Causes AIDS, National Institute of Allergy and Infectious Diseases Fact Sheet" US Department of Health and Human Services, July 1995 [Internet www.niaid.nih.gov/factsheets/evidhiv.htm]).

crimes. He suggested that solutions may be found in the following:

- ! A medical practitioner having informed the accused of the existence of a criminal offence for transmission or exposure of HIV when the accused tested HIV positive, would have assisted the prosecution.
- ! Proving failure to disclose HIV status to a sexual partner would be easier than proving attempted murder by way of exposure to HIV.
- ! A suitable punishment may be one of a restitutive nature (eg payment of a fine to benefit AIDS organisations or hospices).

11.34 The following aspects were raised during the open discussion between members of the Project Committee and participants, and in written comments received after the meeting.

! ***Lack of scientific basis for the proposed reform.***

Concern was expressed that the extent of the problem which is to be addressed by legislation targeting harmful HIV-related behaviour has not been statistically established. A change to the law would therefore probably be based on general fears and urban legend about alleged wilful or negligent behaviour by persons with HIV rather than on scientifically based information.⁹⁷⁸ A representative of the Office of the Director of Public Prosecutions indeed indicated that he has knowledge of only four matters which were reported countrywide in the past few years where the envisaged law could have become relevant, and that creating a dead letter is thus a real possibility.⁹⁷⁹ It was indicated that the relevant statistics are not available because of lack of recorded information on harmful HIV-related behaviour, and that it would be a daunting if not impossible task to gather such statistics.⁹⁸⁰ In response it was suggested that one should work on the presumption that in view of the high prevalence of HIV in South Africa and the high infection rate, most of the 1 600 persons who are (according to available statistics) infected every day, are infected through negligent acts.⁹⁸¹ This proposal was however rejected on the basis that negligence can only be established on facts and that negligence should not be assumed.⁹⁸² It was thus proposed that reform

978 Views expressed by Mr Ronald Louw; and Mr Pierre Brouard.

979 Written comments by Adv Z Van Zyl, Deputy Director of Public Prosecutions: Witwatersrand Local Division.

980 Comments by Mr Mark Heywood.

981 Suggestion by Prof Christa Van Wyk. (The figure quoted referred to the 1999 HIV prevalence statistics available at the time.)

982 Comments by Prof F Van Oosten.

would instead be based on the law's role in sensitising and educating members of society (eg as in the many instances of statutory intervention aimed at sensitising the community and setting specific standards [cf the Child Care legislation] already on our statute book).⁹⁸³

! ***Relevance of comparison with the German position.***

Concern was expressed about the relevance of comparing the South African situation with the German position.⁹⁸⁴ Some believed that the comparison with the German position is valid in view of the high incidence of HIV in South Africa, and the need to address this.⁹⁸⁵ These proponents however qualified their proposal by suggesting that South Africa consider creating an *HIV-specific* offence, whereas the German Penal Code provides for a *general* offence of negligently causing harm to another.⁹⁸⁶

! ***Uncertainty about and criticism of the "reasonable person test".***

Several participants expressed concern that the "reasonable person test" may not be a fair measure to apply in respect of negligent HIV-related behaviour in the diverse South African situation.⁹⁸⁷ In this regard it was emphasised that social circumstances currently hinder the supply of AIDS education and information to all people; that most people do not have ready access to obtaining HIV/AIDS information; that cultural practices influence the acquisition of HIV/AIDS information; and that most people do not have ready access to HIV testing facilities.⁹⁸⁸ Proponents of an HIV-specific statutory offence however pointed out that the notion of the "reasonable person" will differ from case to case in accordance with the specific circumstances of a specific accused.⁹⁸⁹ Proponents also pointed out that what precisely should be "reasonable behaviour" (eg informing a partner of HIV status; using precautions; or the supply of information together with the use of precautions) has not been discussed by participants.⁹⁹⁰

! ***Overestimating the role of the law.***

983 Ibid.

984 Views expressed by Dr John Matjila; and Ms Mercy Makhalemele.

985 View expressed by Prof Christa Van Wyk.

986 Ibid.

987 Dr John Matjila; Mr Mark Heywood; Judge RW Nugent; Mr Pierre Brouard.

988 Comments by Mr N Nxesi.

989 Comments by Prof Christa Van Wyk.

990 Comments by Prof Christa Van Wyk. Cf also Judge Nugent's remarks that the content of "reasonable behaviour" should not be left for the presiding officer to decide.

The Project Committee was cautioned not to regard a possible HIV-specific statutory offence:

- P As a means to prohibit conduct in order to dispel social fears about the transmission of HIV.⁹⁹¹
- P As a social re-engineering tool. It was stressed that such drastic action (referred to by some as "fiddling with the soul of a nation and the lawgiver entering the bedroom of the citizen"⁹⁹²) should only be resorted to if there is not other option.⁹⁹³ In this regard it was also questioned how the existence of a statutory offence will be publicised, especially in rural areas, for it to have the envisaged deterrent and educational effect on people who are not aware of their HIV status and who do not have ready access to HIV testing facilities.⁹⁹⁴
- P As a public health tool.⁹⁹⁵ It was submitted that the notion of responsible sexual behaviour which would be brought about by the creation of a statutory offence targeting negligence (as suggested by Prof Van Wyk) is based on the notion of a person who has the power to act "reasonable". In South Africa this notion cannot be applied universally as there are social reasons why the same reasonable standard of sexual behaviour cannot apply to all people (eg the same standards of reasonableness cannot apply to black mineworkers who have sex with commercial sex workers and to other members of society).⁹⁹⁶

It was stressed that in utilising the law for the above purposes extreme caution should be exercised, and the Project Committee was cautioned that creation of an HIV-specific offence may not solve problems with regard to exposure or transmission of HIV by persons not aware of their HIV status.⁹⁹⁷ It was further submitted that the problems surrounding transmission of HIV are social problems for which social and political solutions should be sought rather than

991 Comments by Judge RW Nugent.

992 Written comments by Adv Z Van Zyl, Deputy Director of Public Prosecutions: Witwatersrand Local Division; comments by Dr Tertius Geldenhuys.

993 Written comments by Adv Z Van Zyl, Deputy Director of Public Prosecutions: Witwatersrand Local Division. (This view was supported by Dr Tertius Geldenhuys.)

994 Comments by Dr Tertius Geldenhuys.

995 Comments by Mr Mark Heywood.

996 Ibid.

997 Views expressed by Judge RW Nugent; and Mr Ronald Louw.

to attempt to address them through the criminal law.⁹⁹⁸

! ***The current public health crisis caused by the AIDS epidemic calls for extraordinary measures.***

Certain participants were strongly of the view that although the law is a blunt instrument and not always the desired instrument to address social problems, the public health crisis caused by the HIV epidemic calls for extraordinary measures of some sort especially in view of the silence surrounding the disease.⁹⁹⁹

! ***A statutory offence/s will not be of any value to persons with HIV/AIDS, especially women.***

Emphasising that since the onset of the epidemic very little has been done to protect the rights of persons with HIV in general, and the importance to take into account the possible effect that a statutory offence will have on persons with HIV/AIDS (women in particular), the argument that such an offence may result in a violent backlash against women by their partners¹⁰⁰⁰ was stressed and the committee was urged to take this possible effect into consideration.¹⁰⁰¹

! ***Problems inherent in attempting to target consensual conduct with criminal sanctions.***

The Project Committee was urged to exercise extreme caution in creating an HIV-specific offence which will in essence be aimed at consensual conduct; and to bear in mind the consequences that accompany consensual sex (including pregnancy, sexually transmissible diseases and HIV infection).¹⁰⁰² It was submitted that targeting consensual conduct with criminal sanction is problematic in the sense that the duties or responsibilities of the two partaking parties have to be outlined in order to establish the culpability of one of them.¹⁰⁰³ To prohibit "unreasonable" conduct does not take the matter further as the presiding officer will then have to decide what "unreasonableness" is. Under circumstances where most people in South Africa do not know their HIV status because they do not have themselves tested, this will be

998 Comments by Mr Ronald Louw.

999 View expressed by Ms Joan van Niekerk.

1000 See Ms Lebo Malepe's presentation in par 11.21 and fn 969 above which referred in detail to this argument.

1001 Comments by Ms Mercy Makhalemele.

1002 Comments by Judge RW Nugent.

1003 Ibid.

problematic.¹⁰⁰⁴ The statute book contains many offences aimed at negligent conduct (eg negligence related to mines, motor vehicles, firearms, machines, factories etc). These offences are all aimed at behaviour which society regards as "potentially dangerous". However, the difference between exposure to HIV and the behaviour targeted by these offences is that in respect of the latter, the victim has no choice as to whether being exposed to the potential danger. In contradistinction, in the case of consensual sex, the victim participates in and consents to the act. Where a victim participates in an act one would expect that the victim would also have responsibilities.¹⁰⁰⁵ A statutory offence as suggested will however ignore this responsibility and thus create the impression that only certain persons can transmit HIV.¹⁰⁰⁶ The fact that there are power differentials in sexual relationships (with little if no equality for the majority of women in such relationships) makes this aspect even more complex.¹⁰⁰⁷

! *Will an HIV-specific offence/s reduce the high rate of HIV infection and reduce the high rate of violence against women?*

It was suggested that this should be the crucial question in deciding whether an offence should be created.¹⁰⁰⁸ In response it was submitted that no HIV- or AIDS-specific criminal measure will be able to normalise the current situation of a vastly spreading epidemic.¹⁰⁰⁹

! *Should a possible statutory offence/s be limited to transmission or exposure through sexual conduct only, and to transmission or exposure to HIV only?*

Some participants questioned why a possible statutory offence should be limited to sexual intercourse only as a way of HIV transmission or exposure and referred the Project Committee to the risk of transmission or exposure through needle-stick injury in the health care setting.¹⁰¹⁰ It was submitted that as far as the health care setting is concerned it may be more suitable to create

1004 Ibid.

1005 Ibid.

1006 Ibid.

1007 Comments by Mr Mark Heywood.

1008 Comments by Dr John Matjila.

1009 View expressed by Prof F Van Oosten.

1010 Dr Tertius Geldenhuys; and Prof F Van Oosten. Prof Van Oosten eg stated that 30 incidents of needle-stick injury occur per month at the Pretoria Academic Hospital, and he submitted that this number may be much higher in hospitals in rural areas.

an offence of failure to disclose HIV status (a patient should eg be obliged to disclose his or her HIV status in instances where transmission or exposure is possible).¹⁰¹¹ Other participants were concerned as to why a statutory offence should be exclusively aimed at HIV while other sexually transmissible diseases may also be life-threatening.¹⁰¹²

! *If a statutory offence/s is to be created, it will have to seek to address evidential problems in the application of the common law crimes.*

It was submitted that there would not be much sense in creating a statutory offence if it would not alleviate the problems inherent in applying the common law crimes to cases of HIV transmission and exposure.¹⁰¹³ The Project Committee was cautioned that the same problems that may currently be experienced in the application of the common law crimes¹⁰¹⁴ will most probably also arise in relation to a statutory offence, and that additional problems may even be experienced.¹⁰¹⁵ As regards an offence targeting negligence in particular, the opinion was expressed that creating such an offence will result in a legal quagmire and will be extremely difficult, if not virtually impossible, to prove.¹⁰¹⁶ It was suggested that it may be necessary to solve the envisaged evidential problems by creating statutory presumptions - which in itself may however give rise to constitutional problems.¹⁰¹⁷

! *A statutory offence/s will not bring about the desired change of behaviour envisaged.*

It was emphasised that because of the lack of integration of messages relating to HIV prevention (mainly because of the influence of social, cultural and

1011 View expressed by Prof F Van Oosten.

1012 Comments by Dr John Matjila.

1013 Comments by Dr Tertius Geldenhuys.

1014 Eg:

* With relation to proof of culpa where -

+ the accused alleged that he or she disclosed their HIV status to the other person; or
+ the accused alleged that the other person consented to intercourse knowing about the accused's health status.

* With relation to allegations by the accused that he or she was in fact infected by the complainant.

* With relation to the gathering of evidence in ways which may infringe the accused's right to privacy.

1015 Views expressed by Dr Tertius Geldenhuys; and Adv Retha Meintjes. Their views were supported by the written comments of Adv Z Van Zyl, Deputy Director of Public prosecutions: Witwatersrand Local Division.

1016 Written comments by Adv Z Van Zyl, Deputy Director of Public prosecutions: Witwatersrand Local Division.

1017 Comments of Dr Tertius Geldenhuys. Adv Z Van Zyl, Deputy Director of Public Prosecutions: Witwatersrand Local Division in written comments expressed the opinion that the problems that have, or would have, hampered the Pietermaritzburg-case (see par 11.31 above), will remain the same even if a constitutionally sound statute is created.

educational circumstances in our country); and because of the lack of resources for the amount of HIV testing which would be required to bring about a change of behaviour, it is strongly doubted whether an HIV-specific offence will bring about the desired change of behaviour.¹⁰¹⁸ Proponents of a new offence however submitted that by creating such an offence the law would at least set a certain standard of required behaviour.¹⁰¹⁹

1018 View expressed by Mr Pierre Brouard. See also the presentation by Ms Gasa in par 11.26 et seq above.

1019 View expressed by Prof Christa Van Wyk.

! ***Current law is sufficient.***

The opinion was expressed that our civil courts provide an acceptable avenue for redress in the event of negligent infection with HIV. As far as HIV-related criminal behaviour is concerned, legislative intervention should only be considered if the available common law remedies have been proved to be inadequate. This has not been shown to be the case and thus criminal behaviour may be dealt with adequately under the common law.¹⁰²⁰

Outcome of consultative meeting

11.35 As is clear from the perspectives by experts and the sentiments expressed during debate and discussion, there was not consensus among participants on what route to follow. It was agreed that it was not possible to conclude the meeting with a consensus statement. In the absence of a consensus statement, it was agreed that the following specific proposals to deal with the issue at hand emerged from the discussion:

! ***Codification of common law crimes***

This approach would not create any new or additional criminal offence, but will put into statutory form what is already illegal (i e transforming the common law into statutory offences to restate them) but which, Prof Van Wyk argued, would have a salient public effect.¹⁰²¹ This could include the creation of presumptions which may assist with the problems identified by Adv Gert Nel as having been experienced in the Pietermaritzburg High Court prosecution - such as presumptions regarding the accused's HIV status; or regarding the existence of AIDS.¹⁰²² Opponents of codification submitted that by following this approach one removes HIV from the realm of all other criminal offences and further stigmatises something which is already stigmatised.

1020 Written comments by Adv Z Van Zyl, Deputy Director of Public Prosecutions: Witwatersrand Local Division.

1021 See Prof Van Wyk's proposal in par 11.16 above.

1022 See par 11.31-11.33 et seq above for the practical problems experienced by the prosecution in this case.

! ***Criminalising behaviour not hitherto criminal***

This approach could consist of one or a combination of the following:

P *The creation of measures aimed at conduct that **transmits** HIV to others.*

The actual transmission of HIV is already criminal in a number of respects:

- > If a person knew that he or she had HIV, he or she can be prosecuted for assault or attempted murder (before the death of the other person).
- > If a person did not know that he or she had HIV, but should have known, and the other person dies, the perpetrator can be prosecuted for culpable homicide.

The question is whether *negligent* actual transmission of HIV, before the death of the other person, should be made a criminal offence. In this regard Prof CR Snyman suggested that the German law should be followed.¹⁰²³

As in the case of codification, creating a new HIV-specific statutory offence/s would also provide for the possibility of creating presumptions to assist the prosecution.

P *The creation of measures aimed at conduct that **exposes others to HIV.***

Intentional exposure to HIV by a person who knows that he or she has HIV already constitutes criminal conduct.¹⁰²⁴ The question was debated whether *negligent* exposure (i.e. exposure by a person who does not know that he or she has HIV) should be criminalised. The argument raised in favour of such an offence was that it will give people an incentive for testing.¹⁰²⁵ The complexity of the issue of negligent exposure was however brought to light. Several participants referred to social circumstances as arguments against the creation of such an offence.¹⁰²⁶

1023 See par 11.9 et seq above.

1024 See par 6.11-6.15 above. See also Adv Nel's presentation in par 11.31-11.33.

1025 See Prof Van Wyk's view in par 11.16 et seq above.

1026 See in particular the presentations by Mr Mark Heywood in par 11.24 et seq and Ms Nolwazi Gasa in par 11.26 et seq above. See also the concerns expressed by participants in par 11.34.

P *The creation of measures aimed at disclosure of HIV status.*

As far as this is concerned, Ms Malepe suggested that disclosure would always be required, even if a condom was used i e if preventive measures were taken.¹⁰²⁷

! ***Maintaining the present position***¹⁰²⁸

It is indicated above that strong arguments emerged during the consultative meeting for maintaining the present position.¹⁰²⁹ (This would mean that persons with HIV who transmit HIV to others or expose others to HIV, may be prosecuted under the existing common law crimes under certain circumstances. These have been extensively discussed in Chapter 6 above.)

1027 See par 11.21 above and fn 967.

1028 See eg the view of Mr Mark Heywood in par 11.22-11.25 above.

1029 See in particular the presentations of Mr Mark Heywood in par 11.22 et seq and that of Ms Nolwazi Gasa in par 11.26 et seq and the concerns that were raised during debate as reflected in par 11.34 above.

12 Evaluation, conclusion and recommendation

Introduction

12.1 In the evaluation and conclusion below the Commission relies on the background information, comments and inputs set out in the preceding Chapters of this Report. This information is not repeated in detail below. Comprehensive references in the footnotes refer to the detailed supporting information and arguments.

The Commission's mandate

12.2 The Commission's mandate from the Parliamentary Justice Portfolio Committee via the Department of Justice was to investigate "the criminalising of acts by persons with the acquired immune deficiency syndrome or the human immunodeficiency virus who deliberately or negligently infect others ... with a view to the submission to Parliament of legislation, if any ...".¹⁰³⁰

12.3 The Project Committee interpreted this mandate as a task to consider the creation of a new, separate statutory offence/s explicitly criminalising conduct not hitherto criminal.¹⁰³¹ As indicated at the outset of this Report, and as is evident from the discussion of comments on Discussion Paper 80 and input gained from a consultative meeting with experts, the possibility of codifying the existing common law crimes (i.e. transforming the common law crimes into statutory offences to restate them) was also raised and some

1030 See par 2.15-2.16.

1031 See par 4.3 and 4.4 above for the Project Committee's interpretation of the Commission's mandate.

experts suggested that this could be a solution to the issue under discussion.¹⁰³² Both approaches would amount to the creation of an HIV-specific offence/s.¹⁰³³

Range of views within the Project Committee

12.4 At the outset of this Report it is stated that the difference of opinion between interested parties and stakeholders commenting on Discussion Paper 80 on whether an HIV-specific statutory offence/s should be created, was also reflected within the Project Committee.¹⁰³⁴ To resolve the divergent comments received and to assist the Committee in coming to a conclusion, a consultative meeting with a range of experts was held on 3 February 2000.¹⁰³⁵

12.4.1 The perspective of Project Committee member Prof Christa Van Wyk (who felt inclined towards creating an HIV-specific offence in the public interest and whose view differed from that of the majority of Project Committee members) was included in this process of deliberation.¹⁰³⁶ As is apparent from the previous Chapter, although consensus was not reached at the meeting, the momentum was against a statutory offence/s being created and there were express and considerable reservations about such a step being taken.¹⁰³⁷ Prof Van Wyk after the consultative meeting acknowledged that the Project Committee had exhaustively researched the issue in question and that the strong indications emanating from the meeting did not support legislative intervention. Having given her views at the consultative meeting and throughout the investigation process, she abides by the conclusion reached by the majority of Project Committee members and the preponderance of the

1032 See pars 4.4, 9.2, 11.3, the presentation of Prof Christa Van Wyk discussed in par 11.16 above, and the outcome of the consultative meeting reflected in par 11.34 above.

1033 Ibid.

1034 Par 2.21.

1035 See Chapter 11 for information on the input received.

1036 Prof Van Wyk presented the general public interest perspective as part of the background to debating the need for a new offence (see par 11.13 et seq). See also Van Wyk 2000 **Codicillus** 2-10 for her view.

1037 See Prof John Milton's cautionary remarks in par 11.6; Mr Mark Heywood's presentation in par 11.22 et seq; Ms Nolwazi Gasa's concerns in par 11.28-11.30; and the concerns expressed during the debate reflected in par 11.34.

views expressed at the consultative meeting.¹⁰³⁸

Is it necessary for there to be an HIV-specific statutory offence/s in South African law?

Possible options

12.5 Three possible options for responding to the Justice Portfolio Committee's request, set out in Chapter 2 above, were identified in the course of this investigation - including the comment from respondents and the input from a range of experts at the consultative meeting discussed in Chapters 10 and 11:

! **Codification of common law crimes**

12.5.1 As indicated in Chapter 6 above, *deliberate* conduct in the form of deliberate transmission of or exposure to HIV would already be liable to prosecution under the common law crimes of murder, assault, assault with the intent to do grievous bodily harm, rape or indecent assault.¹⁰³⁹ *Negligent* conduct would be liable to prosecution under existing law if HIV is transmitted and the victim died as a result of this.¹⁰⁴⁰ It may however be that HIV-related behaviour is difficult to prosecute successfully under these crimes.¹⁰⁴¹ Some commentators and experts believe that it may be necessary to codify the common law to eliminate these difficulties or some of them:

1038 Where applicable, Prof Van Wyk's different perspectives are reflected within the conclusions and recommendations below.

1039 See par 6.11-6.15.1 where the application of these crimes to HIV-related behaviour is discussed.

1040 See par 6.12 et seq.

1041 See the discussion in par 6.5-6.10 and the comments recorded in par 10.26.4; see also Van Wyk 2000 **Codicillus** 6-7.

- P Prof Christa Van Wyk suggested that this could be a middle course between, or a combination of the coercive and noncoercive approach in combatting AIDS.¹⁰⁴² It would not entail creating any new offence, but would put into statutory form what is already illegal.¹⁰⁴³ Such codified HIV-specific offences would then be a clear confirmation of the existing common law position.¹⁰⁴⁴
- P Dr Tertius Geldenhuys submitted that codification might provide an opportunity for the creation of presumptions to deal with current difficulties in the application of the common law.¹⁰⁴⁵

! *Criminalising behaviour not hitherto criminal*

12.5.2 The second option stems from the fact that our common law contains three distinct omissions: There are no crimes of negligent injury or of deliberately exposing another to danger short of assault or of negligent endangerment (exposure).¹⁰⁴⁶ Scenarios of HIV-related harmful behaviour which could be targeted by the creation of such offences (and which are not currently addressed by the common law) would cover a range of possible factual situations ranging from where a person, unaware of his or her HIV status, exposes another to or transmits HIV without taking precautions (although the reasonable person in the circumstance would have foreseen the possibility and would have gone for testing) to where a person who knows about his or her HIV positive status deliberately withholds this information and has unprotected sex.¹⁰⁴⁷

In this regard the following proposals were made:

- P The creation of measures enforcing the *disclosure* of their HIV status by

1042 See Prof Christa Van Wyk's proposals in par 11.16 above; and the discussion of the outcome of the consultative meeting in par 11.35. (Refer also to par 4.5-4.10 for information on the coercive and noncoercive approach in combatting AIDS.)

1043 Ibid.

1044 Ibid.

1045 See the discussion of the outcome of the consultative meeting in par 11.35 above. See also fn 1017.

1046 See the discussion on the applicable common law crimes in Chapter 6 above. See also the questions posed for discussion at the consultative meeting with experts recorded in par 11.3; the presentations of Prof CR Snyman, Prof John Milton and Prof Christa Van Wyk in par 11.4 et seq, 11.10 et seq, and 11.16 et seq; and Van Wyk 2000 **Codicillus** 7-9.

1047 Cf Prof Christa Van Wyk's presentation in par 11.13 (fn 952).

persons with HIV before engaging in certain sexual activities. Ms Lebo Malepe suggested that disclosure would always be required, even if preventive measures (such as a condom) were used.¹⁰⁴⁸

- P Prof Christa Van Wyk suggested that creating an HIV-specific offence targeting both *negligent exposure* to and *negligent transmission* of HIV could be considered a uniquely South African solution to the problem of harmful HIV-related sexual behaviour. She qualified her proposal by suggesting that criminalisation could be limited to cases where the perpetrator had actual knowledge of his or her HIV infection.¹⁰⁴⁹ Prof CR Snyman supported this although he limited his proposal regarding negligent conduct to targeting negligent *transmission* of HIV. Prof Snyman suggested that an offence of *intentional exposure* to HIV could in addition be created.¹⁰⁵⁰

! *Maintaining the present position*

- 12.5.3 As indicated in paragraph 11.35 above, this possibility received strong support from experts attending the consultative meeting hosted by the Project Committee. Maintaining the present position would mean that a person with HIV who transmits HIV to others or exposes others to HIV, may be prosecuted under the existing common law crimes under certain circumstances.¹⁰⁵¹

Guiding principles

- 12.6 The background material in this Report and the divergent responses and perspectives from commentators and experts bear testimony to the complexity of the issues.¹⁰⁵² In seeking a solution the Commission was guided by the following principles:

1048 See the outcome of the consultative meeting discussed in par 11.35.

1049 See par 11.16-11.17. Cf also the Supreme Court of Canada's view in this regard as referred to in par 8.13-8.14 above.

1050 Par 11.10-11.12.

1051 See the comprehensive discussion on the application of the common law crimes to harmful HIV-related behaviour in Chapter 6 above.

1052 See eg the strong comments expressed both for and against the creation of an offence in par 10.26 et seq and 10.29 et seq; and the different perspectives of experts reflected in Chapter 11.

- ! Respect for human rights.¹⁰⁵³ This approach on the one hand recognises women's specific vulnerability to HIV/AIDS, the epidemic of sexual violence in our country and women's unequal position regarding their physical integrity.¹⁰⁵⁴ On the other hand it recognises the invasion of fundamental rights (especially the right to privacy and dignity) implicit in the creation of a statutory offence.¹⁰⁵⁵ In addition, it has to take into account that changes to the law should conform to international human rights norms with regard to HIV/AIDS.¹⁰⁵⁶
- ! The primary objective of the creation of an HIV-specific statutory offence/s should be HIV prevention and the protection of the uninfected. If HIV/AIDS is identified for specific measures in addition to the common law crimes - which already provide for other criminal law goals such as retribution - then the single most important objective in doing so must be preventing the spread of HIV.¹⁰⁵⁷
- ! Legislative intervention should be rationally and scientifically based and not emotionally motivated. Justice Michael Kirby of the High Court of Australia has enunciated this principle thus:

As in any area of the law, it is essential to base legal responses - if they are to be effective - upon a good empirical understanding of the target to which it is hoped the law will attach ... AIDS laws must not be based upon ignorance, fear, political expediency and pandering to the demand of the citizenry for 'tough' measures ... Good laws, like good ethics, will be founded in good data.¹⁰⁵⁸

Conclusion

12.7 The conclusion reached by the Commission is that statutory intervention is neither

1053 See the presentation of Mr Mark Heywood in par 11.24 et seq. Cf also Elliot (Unpublished) 3-4.

1054 See the presentation of Ms Lebo Malepe in par 11.18 et seq.

1055 See par 7.34 et seq and the presentation of Mr Mark Heywood in par 11.24.

1056 See par 8.2 et seq for the **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** which provide that states should reform criminal laws 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. See also par 7.10 on the limitation of rights.

1057 Cf also Elliot (Unpublished) 4.

1058 Kirby "HIV and Law - A Paradoxical Relationship of Mutual Interest" (Paper presented at IUVDT World STD/AIDS Congress, Singapore 22 March 1995) as referred to in Elliot (Unpublished) 4.

necessary nor desirable and that the present position should be maintained.¹⁰⁵⁹ The Commission is of the view that arguments against legislative intervention in the form of HIV-specific offences (be they the creation of an offence/s targeting conduct not hitherto criminal, or an offence/s codifying the common law crimes), indeed override arguments supporting such step.

12.8 As indicated in the preceding Chapters, the Commission was not convinced at the stage of publication of Discussion Paper 80 to make preliminary recommendations for legislative intervention and the question was left open for debate.¹⁰⁶⁰ Strong comments were received both opposing and supporting legislative intervention and it became necessary to discuss further with a wide range of experts the dilemmas faced by the Project Committee.¹⁰⁶¹ Again consensus was not reached.¹⁰⁶² However, as is evident from Chapter 11, the strong momentum of opinion was against legislative intervention with considerable reservations being expressed about the creation of an offence targeting negligent behaviour.¹⁰⁶³ Concerns that were raised and which should especially be noted included the following:¹⁰⁶⁴

- ! The lack of scientific basis for the proposed reform.
- ! The overestimation of the role of the criminal law in reducing the high rate of HIV infection, in reducing the high rate of violence against women, and in changing risk behaviour.
- ! The possible detrimental effect of an HIV-specific offence/s on the position of women already affected by or vulnerable to HIV.
- ! Problems inherent in attempting to target consensual conduct with criminal sanctions.

12.9 The Commission believes that the strong indications from the entire process of research and deliberation are not supportive of legislative intervention and that recommending

1059 Cf also the Commission's conclusion regarding the role of the criminal law in par 7.17 above.

1060 See par 9.5 et seq.

1061 See par 10.11, 10.26 et seq, and 10.29 et seq.

1062 Refer to the divergent views expressed by experts and during the debate (par 11.6; 11.12; 11.17; 11.18 et seq; 11.25; 11.30 and 11.34-11.35).

1063 See the presentations by Prof John Milton, Mr Mark Heywood and Ms Nolwazi Gasa in par 11.4 et seq, 11.22 et seq and 11.26 et seq respectively, and the debate reflected in par 11.34.

1064 See par 11.34.

legislation under these circumstances would not be principled.

12.10 Major reasons for this conclusion are the following:

! *Lack of evidence that offences are occurring in regard to which statutory intervention along the lines envisaged is necessary*

12.10.1 There is no scientific, empirical or even informal evidence that the behaviour to be targeted is occurring to such an extent that the creation of an HIV-specific statutory offence/s is necessary. Media reports referred to at the outset of this Report which highlighted the need for intervention, mainly dealt with cases of rape and gang rape.¹⁰⁶⁵ As indicated above, the possible need for an additional offence in the case of *nonconsensual* sexual acts will be dealt with by the Commission under another investigation.¹⁰⁶⁶ As regards *consensual* sexual acts, a single criminal prosecution for HIV exposure was instituted (and not proceeded with at the request of the complainant).¹⁰⁶⁷ Furthermore, a single reported civil case is scant evidence to the fact that recalcitrant behaviour is occurring.¹⁰⁶⁸ Significantly, the claimant in this case did not seek to have the defendant criminally charged.¹⁰⁶⁹ The lack of a scientific basis for legislative intervention was also raised by commentators and experts.¹⁰⁷⁰ Certain commentators emphasised that the fact that existing common law crimes are not applied to harmful HIV-related behaviour may indicate that in practice there is no need for additional punitive measures.¹⁰⁷¹ Experts remarked that a change to the law would therefore probably be based on general fears and "urban legends" about alleged wilful or negligent behaviour by persons with HIV.¹⁰⁷² A representative of the Director of Public Prosecutions indeed

1065 See par 2.5 et seq.

1066 See par 4.13.

1067 See par 2.6.2 and 11.32.

1068 Par 2.6.1.

1069 According to media reports she commented that laying a criminal charge would not have assisted her - she took recourse to available civil measures "to get money to pay for her medical expenses - not revenge" (see par 7.38).

1070 See par 10.29.11 and 11.34.

1071 Cf par 10.29.12.

1072 Comments of Mr Pierre Brouard and Mr Ronald Louw (see par 11.34 above).

indicated that he has knowledge of only four matters which were reported country-wide in the past few years where the envisaged change to the law could have become relevant.¹⁰⁷³

! *An HIV-specific statutory offence/s will have no or little practical utility*

12.10.2 The Commission believes that creation of an HIV-specific statutory offence/s is not necessary in view of the existence of an array of common law crimes which could be utilised against harmful HIV-related behaviour.¹⁰⁷⁴ Moreover, the creation of such offence/s would have no practical utility if it would not minimise the difficulties associated with the application of the common law crimes.¹⁰⁷⁵ Several respondents from the legal fraternity (including certain Directors of Public Prosecutions) submitted that statutory offences would not provide simple answers to the perceived gaps in common law crimes but will bring their own problems - not the least of which will be ones relating to the burden of proof and constitutional issues.¹⁰⁷⁶ The Commission agrees that under these circumstances the common law crimes have the advantage that they are readily available.¹⁰⁷⁷ These crimes would first have to be more extensively applied in practice and proved to be inadequate before a need for statutory offences can be determined.¹⁰⁷⁸

12.10.3 The practical utility of any HIV-specific statutory offence will also be dependent on the resources available to the state prosecution services. The Commission believes that a statutory offence/s could add to the problems an overburdened criminal justice system is currently experiencing.¹⁰⁷⁹ This is confirmed by the input of the Office of the Director of Public Prosecutions, Pietermaritzburg

1073 Written comment of Adv Z Van Zyl, Deputy Director of Public Prosecutions: Witwatersrand Local Division (see par 11.34 above). See also the presentation by Mr Mark Heywood referred to in par 11.23.

1074 See also the comments in par 10.29.1 et seq.

1075 Par 10.29.6.

1076 Ibid. Cf also for the complexity of the evidentiary issues in practice, par 8.14 referring to the Canadian law.

1077 Ibid.

1078 See the comments in par 11.34 above.

1079 See also the comments in par 10.29.8 and 10.29.14 above.

which identified problems relating to resources (especially those concerning a standard of policing, investigation and prosecution which would ensure successful prosecutions) as inhibiting factors in the single prosecution targeting harmful HIV-related behaviour that was undertaken under existing common law crimes.¹⁰⁸⁰

12.10.4 Moreover, in view of the lack of prosecutions under existing criminal measures, the Commission is concerned about the likelihood of complainants coming forward to utilise any HIV-specific statutory offence/s. The enactment of any such offence/s might thus be largely of symbolic value.

12.10.5 The codification of existing common law crimes may, in addition, have the effect of promoting exceptionalism in dealing with HIV and AIDS.¹⁰⁸¹

! *The social costs entailed in creating an HIV-specific statutory offence are not justified*

12.10.6 As indicated in Chapters 7 and 11 above, the decision to criminalise - and thereby to use society's most drastic legal sanction - implies a cost to society and the individual involved.¹⁰⁸² The benefits and social gains to be obtained from the successful prevention or reduction of the conduct in question have to be commensurate with the social, human and economic cost of recognising the particular crime. Otherwise a decision to criminalise cannot be justified.¹⁰⁸³

In accordance with the 1996 Constitution the limitation on the basic rights of the person with HIV who is accused under an HIV-specific statutory offence would be justified only if reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account inter alia 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

1080 Cf the comments of Adv Gert Nel in par 11.31 et seq above. See also the comments in par 10.38.10.

1081 As indicated in fn 349 above "AIDS exceptionalism" refers to the phenomenon of singling out HIV/AIDS for special treatment as opposed to other infectious diseases. Some argue that this may draw undue attention to the issue and in turn promote more subtle discriminatory practices against persons with HIV and AIDS (cf **SALC Second Interim Report on Aspects of the Law relating to AIDS** par 7.19-7.20).

1082 Par 7.2-7.6. See also the presentation by Prof John Milton reflected in par 11.5.

1083 Ibid. See also Van Wyk 2000 **Codicillus** 9-10.

purpose, and whether less restrictive means exist to achieve the purpose.¹⁰⁸⁴ In weighing the possible beneficial consequences of an HIV-specific statutory offence/s against the possible detrimental consequences, the Commission is of the opinion that the social costs inherent in the creation of such offence/s are not justified.

12.10.7 The Commission believes this to be the case especially as regards the creation of a new additional offence targeting *negligent* behaviour: Negligence is not a state of conscious awareness of the relevant harm but rather a type of conduct involving the failure to take precautions. As such, it involves a failure to be aware of risk of harm to others.¹⁰⁸⁵ In the context under discussion it would therefore involve an individual who is not aware that he or she has HIV and in this state of ignorance unknowingly transmits HIV or exposes another to HIV.¹⁰⁸⁶ The Commission is convinced that under the prevailing circumstances in which the majority of persons in South Africa are unaware of their HIV status and in which there are insufficient resources for the HIV testing that would be required to enable a change of behaviour, it is not just and right that persons who are ignorant of their health status (but ought ideally to have known that they are infected), should be punished.¹⁰⁸⁷ In effect such individuals would be punished for their failure to know their HIV status¹⁰⁸⁸ - which may lie outside their control.¹⁰⁸⁹

12.10.8 Additional important factors related to the social costs of creating an HIV-specific statutory offence/s include the fact that it is generally believed that such offence/s would be counter-productive to public health efforts to curb the spread of the disease;¹⁰⁹⁰ it will entrench further discrimination and

1084 Sec 36 of the 1996 Constitution. See also par 7.9-7.11.

1085 See Prof John Milton's exposition in par 11.5.

1086 Ibid.

1087 See par 3.19, 7.30, and 10.29.15. Cf also the presentations by Mr Mark Heywood and Ms Nolwazi Gasa reflected in par 11.24 and 11.26 et seq.

1088 See also Prof John Milton's exposition in par 11.5.

1089 See par 3.19; 7.30; 10.29.15 and 11.24. Cf also the presentation by Ms Nolwazi Gasa reflected in par 11.26 et seq.

1090 Cf the comments referred to in par 10.29.15 above.

stigmatisation of persons with HIV;¹⁰⁹¹ and it will drain away scarce resources from the most effective HIV prevention programmes such as targeted education campaigns, condom distribution initiatives, and the provision of voluntary, accessible testing, counselling and medical treatment.¹⁰⁹²

! *An HIV-specific statutory offence/s will infringe the right to privacy to an extent that is not justified*

12.10.9 Another compelling reason why the Commission believes that creation of an HIV-specific statutory offence/s is not justified is the potential of intrusion into sexual privacy.¹⁰⁹³ It is stated at the outset of this Report that this investigation concentrates on the sexual transmission of HIV in *consensual* relationships. The transmission of or exposure to HIV in this context involves the most intimate aspects of human interaction. The importance of the right to privacy and the fact that it should not be infringed lightly was stressed in Chapter 7 above.¹⁰⁹⁴ The enforcement of an HIV-specific offence/s will call for inquiry into the medical histories and sexual interaction of both the accused and his or her sexual partner/s which will entail a considerable infringement of privacy rights. The Commission is of the opinion that such infringement is unjustified in circumstances where the creation of an HIV-specific offence/s is not based on evidence establishing a need for such an offence/s;¹⁰⁹⁵ where such offence/s may serve no additional purpose than the existing common law offences;¹⁰⁹⁶ and would have no impact on diminishing or preventing the spread of HIV.¹⁰⁹⁷

12.11 Arguments for the creation of an HIV-specific offence/s, raised by commentators and experts, are counter-weighted as follows:

1091 Cf the comments referred to in par 10.29.19 above.

1092 Cf the comments referred to in par 10.29.20 above. See also the presentation of Mr Mark Heywood reflected in par 11.24.

1093 See in general par 7.35.2; the comments in par 10.29.2; and the presentation of Mr Mark Heywood in par 11.24.

1094 See par 7.35.2.

1095 Cf the conclusion in par 12.10.1.

1096 Cf the conclusion in par 12.10.2.

1097 Cf the conclusion in par 12.10.4 and 12.10.8.

! "The existing common law crimes are insufficient and unsuitable to deal with harmful HIV-related behaviour and an HIV-specific offence/s could minimise some of the difficulties associated with application of the common law"¹⁰⁹⁸

12.11.1 This argument mainly referred to the current lack of the criminal law to provide for punishment of negligent acts. As indicated in paragraph 12.10.6 et seq above, the Commission is of the opinion that the social costs inherent in the creation of an HIV-specific offence/s targeting negligence are not justified.

12.11.2 In response to Tshwaranang's concern that the current common law offences are insufficient and unsuitable because they do not protect the specific interests violated by harmful HIV-related behaviour (i.e. the psychological and physical harm that a person suffers because of exposure to or transmission of HIV),¹⁰⁹⁹ the Commission believes that the legislature has already addressed victims' interests related to psychological harm in providing for a minimum sentence of life imprisonment where a person is convicted of rape knowing that he has AIDS or HIV.¹¹⁰⁰ The Commission is further of the opinion that the mere creation of an HIV-specific statutory offence/s will in any event not deal satisfactorily with this concern. To satisfy public expectations any newly legislated statutory offence/s (whether to restate the common law or to criminalise behaviour not hitherto criminal) will have to result in successful prosecutions. This seems unlikely if it is accepted that such an offence/s will

1098 See the comments in par 10.26.7 and 10.29.3 above. Cf also the presentation by Prof Christa Van Wyk reflected in par 11.13-11.17 and that of Prof CR Snyman in par 11.7-11.12.

1099 See their comments in par 10.26.3 above.

1100 The Criminal Law Amendment Bill (B46-97) which preceded the Criminal Law Amendment Act 105 of 1997 (referred to in fn 360 above), expressly provided for a compulsory minimum sentence of imprisonment of not less than 15 years for a first offender, and not less than 25 years for a third offender if convicted of rape which "caused psychological harm" to the victim (clause 52(1)(a) read with Part I of Schedule 2). This provision was amended by the Parliamentary Justice Portfolio Committee to its present formulation which provides for life imprisonment of a persons convicted of rape under certain circumstances. In the final formulation the words "caused psychological harm" has been omitted and replaced with an express list of circumstances which could cause such harm. These include inter alia multiple rape by one or more persons, rape by more than one person (i.e. gang rape), and *rape by a person knowing that he has HIV or AIDS* (substituted clause 52 and Part I of Schedule 2 Portfolio Committee Amendments to Criminal Law Amendment Bill B46A-97). It is clear from this history of the current provision (sec 51) that the legislature intended to address victims' interests related to psychological harm in enacting this provision.

not necessarily overcome the evidentiary problems currently perceived to exist with regard to application of the common law crimes, and that a current lack of resources and an overloaded criminal justice system may impact negatively on their creation. Moreover, the Commission is of the view that victims' interests related to psychological and physical harm could, in addition to legislative measures, be more suitably met by addressing their practical need for comprehensive health and social support.¹¹⁰¹ The Commission has also acknowledged this need in its Fourth Interim Report on Aspects of the Law relating to AIDS which recommended legislative intervention for the compulsory HIV testing of persons arrested in sexual offence cases.¹¹⁰² (The Project Committee's mandate leading to the Fourth Interim Report did not include investigating the provision of support services to victims of sexual offences. This issue is being dealt with by the Commission's Sexual Offences Project Committee under its investigation into sexual offences.)

- 12.11.3 The Commission is further of the opinion that the common law provides a flexible and comprehensive approach to dealing with HIV-related harmful behaviour in that any one of a range of crimes is available under which such behaviour could be prosecuted.¹¹⁰³ The Commission agrees with experts from the prosecuting authorities who believe that an HIV-specific statutory offence/s will not necessarily provide simple solutions to the perceived problems of the common law.¹¹⁰⁴ Current perceived evidentiary problems are largely a result of the nature of HIV/AIDS and the behaviour by which the virus is transmitted, and thus would not necessarily be surmounted by adoption of an HIV-specific offence/s.¹¹⁰⁵

! *"An HIV-specific statutory offence/s could bring greater clarity and certainty in the law and would thus have a greater deterrent*

1101 Cf par 12.105 et seq of **SALC Fourth Interim Report on Aspects of the Law relating to AIDS**.

1102 See par 12.110 of **SALC Fourth Interim Report on Aspects of the Law relating to AIDS**; and the proposed legislation included in Chapter 13 of that Report.

1103 See par 6.11-6.15 where the applicability of the common law crimes are discussed. See also the arguments raised by commentators in par 10.29.4-10.29.5 above.

1104 Cf the comments reflected in par 10.29.4-10.29.6 and 11.34 above.

1105 See par 10.29.6 and 11.31-11.33.

impact than the existing common law crimes"¹¹⁰⁶

- 12.11.4 As indicated in paragraph 12.10.1-12.10.5 above, the Commission believes that an HIV-specific statutory offence/s would be largely symbolic and of no or little practical value. It further remains an open question whether the creation of such an offence/s will deter, and whether it will reduce the spread of the disease. Virtually no complainants have come forward to make use of the existing criminal measures and it is doubtful whether a statutory offence/s will result in prosecutions.

1106 Cf the comments recorded in par 10.26.8 et seq. Cf also the presentations of Proff CR Snyman and Christa Van Wyk in par 11.10 and 11.16 respectively.

! *"Legislative intervention is necessary to deal with the reality of persons with HIV engaging in harmful HIV-related behaviour"*¹¹⁰⁷

12.11.5 As indicated in paragraph 12.10.1 above there is no scientific or other evidence to support the allegation that harmful HIV-related behaviour occurs to an extent that necessitates legislative intervention.

! *"The increasing incidence of deliberate HIV infection coupled with the vulnerability of women and children to acts of sexual violence requires that harmful HIV-related behaviour be dealt with through specific legislation"*¹¹⁰⁸

12.11.6 The Commission supports the view expressed by certain experts that no HIV-specific criminal measure will be able to normalise the current situation of a rapidly spreading epidemic.¹¹⁰⁹ It is also believed that such a step will not solve the high rate of sexual violence in South Africa: Despite strong criminal laws (including the crimes of rape and indecent assault which could currently be applied to acts of sexual violence, and severe sentences) the high rate of criminal activity persists.¹¹¹⁰ The creation of an HIV-specific statutory offence/s may to the contrary result in a lessening of the authority of the criminal law if the criminal justice system is either not able to cope with the demands on resources which would be brought about by the creation of such an offence/s, or, contrariwise, if such offence/s merely remains a dead letter.¹¹¹¹ The Commission is of the opinion that more effort (especially as regards the standard of policing, investigation and prosecution necessary to ensure successful prosecutions) should be put into applying the existing common law crimes to harmful HIV-related behaviour.¹¹¹²

1107 See the comments in par 10.26.11 et seq.

1108 See the comments referred to in par 10.26.13 et seq; and the presentation by Ms Lebo Malepe reflected in par 11.18-11.20.

1109 See par 11.34.

1110 Cf also briefing of the Inter-Ministerial Committee by the AIDS Programme, Department of Health, February 1999; and the comments referred to in par 10.29.8-10.29.10 above. See also in general par 7.40.

1111 Ibid.

1112 See also the comments in par 10.38.10.

! "Public health law is insufficient to deal with recalcitrant behaviour"¹¹¹³

12.11.7 The Commission agrees, as indicated in paragraph 5.13, that currently available public health measures of isolation and quarantine are inadequate and unsuitable to deal with harmful HIV-related behaviour.¹¹¹⁴ The Commission however believes, in view of the overriding arguments against the creation of a specific offence/s, that this unsuitability and inadequacy do not justify the creation of a specific offence/s.¹¹¹⁵

! "The lack of a specific offence/s may encourage citizens to take the law into their own hands"¹¹¹⁶

12.11.8 The Commission believes that this is not sufficient reason for the creation of a specific statutory offence/s as this argument does not apply only to harmful HIV-related behaviour. The current lack of successful prosecutions for rape and other violent crimes may also encourage the suggested behaviour.

12.11.9 In any event, the *creation* of a specific statutory offence/s may indeed also have the suggested result if citizens feel disappointed and frustrated by new legislation that does not meet their expectations. The Commission has been warned that a statutory offence/s will not necessarily do away with evidentiary problems currently perceived to be in the way of successful application of the common law crimes to HIV-related behaviour.¹¹¹⁷ The Commission has also been cautioned that the role of the law as a means to prohibit conduct in order to dispel social fears about the transmission of HIV, as a social re-engineering tool and as a public health tool should not be overestimated.¹¹¹⁸ Under these circumstances it seems highly probable that an HIV-specific statutory offence/s will not have the desired effect in practice.

1113 See the comments in par 10.26.18 et seq.

1114 See par 5.13 above.

1115 See the motivation in par 12.10.1-12.10.8.

1116 See the comments in par 10.26.20 above.

1117 Comments reflected in par 10.29.1-10.29.6; and 11.34. See also the general information in par 7.27-7.29.

1118 Par 11.34.

! "Criminalising unacceptable HIV-related behaviour not hitherto criminal will enable the state to comply with its constitutional obligation to respect, protect, promote and fulfill fundamental rights"¹¹¹⁹

12.11.10 In this regard proponents of legislative intervention place emphasis especially on victims' right to life and bodily integrity and their right to have these interests protected.¹¹²⁰ As indicated in par 12.9.6-12.9.9 above, the Commission is of the view that the limitation of rights that a new additional HIV-specific offence would entail will not be constitutionally justified.

! "Criminalising unacceptable HIV-related behaviour not hitherto criminal will change the milieu under which preventive health is currently practised"¹¹²¹

12.11.11 A single commentator pointed out that current prevention efforts are directed at the potential recipient of HIV infection. He believes that an HIV-specific offence criminalising *negligent* behaviour or *failure to disclose HIV status* will also place emphasis on the fact that persons with HIV must take preventive steps.¹¹²² The Commission is however of the view that a new offence may foster false expectations that responsibility for preventing the spread of HIV can be placed solely on persons with HIV. The Commission is of the opinion that rational public health policy does not place responsibility for maintaining preventive measures solely on those who are infected. A new offence/s as suggested may create the impression that persons who are HIV positive will be aware of their serostatus and will inform their sexual partners accordingly in order to avoid criminal liability. The result will be that those who are not aware of their serostatus or who are not infected, may not consider it necessary to protect themselves as they could mistakenly rely on the criminal

1119 See the comments in par 10.26.21 above. See also the presentation of Ms Lebo Malepe reflected in par 11.18-11.21.

1120 See the comments in par 10.26.21, and in general par 7.35 et seq above.

1121 See the comments in par 10.26.22 above.

1122 Ibid.

justice system for protection.¹¹²³

! *"An HIV-specific statutory offence/s will assist poor and rural women who have little defence against irresponsible partners"*¹¹²⁴

12.11.12 The Commission is of the opinion that this is not necessarily true as strong arguments have been submitted that the creation of an HIV-specific statutory offence/s may indeed be to the detriment of women in general.¹¹²⁵ It is submitted in this regard that in South Africa, very few of those infected are actually aware of their HIV status. However, it is more women than men generally who know their HIV status as a result of being tested at antenatal clinics. This means that a specific offence/s aimed at punishing deliberate infection will impact disproportionately on and further victimise women without dealing with the broader social issues which place women in situations where they already face severe violence, abandonment and rejection as a result of disclosing their HIV status to their partners.¹¹²⁶ Women living in rural areas will be even more vulnerable to this detrimental effect of an HIV-specific offence/s in having no ready access to health services, education and employment. These women would in particular also need social services and support to make them aware that an offence/s as envisaged exist and could be utilised.¹¹²⁷ A statutory offence/s would moreover not address the fundamental cause of rural women's specific vulnerability - gender inequality.¹¹²⁸

Additional issues of concern

1123 See also the comment in par 10.29.8-10.29.9 above.

1124 Comments in par 10.26.23 above. Cf also the presentation of Ms Lebo Malepe reflected in par 11.21.

1125 See par 11.21. Cf also the presentation of Ms Nolwazi Gasa reflected in par 11.26 et seq.

1126 Ibid. See also briefing of the Inter-Ministerial Committee by the AIDS Programme, Department of Health, February 1999.

1127 See also the comments in par 10.38.9 and the concern expressed in par 11.34 about how the existence of a statutory offence will be publicised, especially in rural areas.

1128 See also the comments in par 10.28.10.

12.12 In comment on Discussion Paper 80, the then Minister of Justice (on behalf of Cabinet), and the Commission's Sexual Offences Project Committee expressed concern about particular issues. These, with the Project Committee's response, are set out in the following paragraphs.

The need for special recommendations with regard to punishment in respect of persons found guilty in cases where, as a result of a crime, the victim is infected with HIV¹¹²⁹

12.13 The Project Committee is of the view that transmission of HIV (or the risk of its transmission) will always be regarded an aggravating factor in view of the added anguish and heightened risk to life and well-being which the offender's HIV infection necessarily entails. It is reflected in this Report that our civil¹¹³⁰ and criminal¹¹³¹ courts as well as the legislature¹¹³² have already (directly or indirectly) enunciated this principle. There thus is no need for further recommendations on this issue.

The need for special steps to be taken against persons who deliberately transmit HIV to others¹¹³³

1129 Comments of Cabinet (par 10.8.1 above) and the Commission's Sexual Offences Project Committee (par 10.8.1 and 10.8.2).

1130 See the civil case of **Venter v Nel** 1997 (4) SA 1014 (D) where the court awarded substantial damages to the plaintiff on ground of the grave implications of possible infection with HIV. Refer to par 2.6.1 and 7.38 above for more information.

1131 See fn 430 in Chapter 6 above where it is indicated that our criminal courts have indeed taken the presence of HIV infection 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 HIV infection could be (or was) *amitigating* factor (see the cases referred to in fn 430). Naturally, where HIV is shown to be directly related to the offence committed - for instance in the case of a prosecution for rape - same should be regarded as an *aggravating* factor (Hassan [Unpublished] 4).

1132 See the provisions of the Criminal Law Amendment Act 105 of 1997 reflecting the fact that the presence of AIDS or HIV in convicted persons, when directly related to the offence committed, is regarded by the legislature as aggravation (see fn 360 in Chapter 4 above for detailed information on these provisions). Note that these provisions apply irrespective of whether HIV was transmitted.

1133 Comments of Cabinet (par 10.8.1 above).

12.14 *Deliberate* transmission of HIV to another is already covered by our common law. Depending on whether the victim died, any person who deliberately transmits HIV to another could be charged with murder, assault with the intent to do grievous bodily harm, assault, or an attempt to commit any of these crimes. The applicability of these crimes to HIV-related behaviour has been discussed in Chapter 6.¹¹³⁴ The possibility of codifying these crimes has been raised, considered and rejected in this Report.¹¹³⁵ As indicated in the previous paragraph, in the event of the alleged offender being found guilty, the transmission of HIV or the risk of its transmission would in addition always be regarded as an aggravating factor.

The need for steps to be taken against persons who fail to disclose to their sexual partners that they have HIV¹¹³⁶

12.15 This issue has been raised and considered in the course of the current investigation.¹¹³⁷ As indicated above, the conclusion is drawn that a new additional offence (i.e. criminalising behaviour hitherto not criminal - which could have included failure to disclose HIV status) should not be created.¹¹³⁸ Currently there is the possibility that our courts may follow the approach in the recent Canadian Supreme court case of **R v Cuerrier**.¹¹³⁹ If applied to South African law, it would entail that persons with HIV who engage in unprotected sex and who do not inform their sexual partners of their infection may be guilty of rape.¹¹⁴⁰

The need for measures addressing harmful exposure to

1134 See par 6.11, 6.14 and 6.15.

1135 See discussion of this possibility in par 11.16 et seq; see also par 12.5, and 12.7-12.10.9 above.

1136 Comments of Cabinet (see par 10.8.1 above); and the Commission's Sexual Offences Project Committee (see par 10.8.2 above).

1137 See par 10.35.1, 11.35 and 12.5.

1138 See the relevant motivation in par 12.7-12.10.9 above.

1139 (1998), 127 CCC (3d) 1.

1140 See the discussion in par 6.8.2.2 and 6.13.1 above. Cf also the comments of Ms Justice L van den Heever and Adv David Buchanan, SC referred to in par 10.38.6.

HIV/AIDS through nonconsensual sexual acts¹¹⁴¹

12.16 *Nonconsensual* sexual conduct is already inevitably an offence, whether it be assault, assault with the intent to do grievous bodily harm, indecent assault, or rape. The Project Committee thus considered it to be outside its mandate to further investigate this concern.¹¹⁴² Moreover, there is already statutory provision for addressing *knowing* transmission of or exposure to HIV during commission of a sexual offence: In terms of section 51(1) read with Part I of Schedule 2 of the Criminal Law Amendment Act 105 of 1997 a person convicted of rape knowing that he has AIDS or HIV, is liable to an obligatory life sentence.¹¹⁴³ Note that this provision applies irrespective of whether HIV is actually *transmitted*.¹¹⁴⁴ The Act also provides for a minimum sentence of life imprisonment in cases of gang rape, or where the victim is raped more than once by the same person.¹¹⁴⁵ Nevertheless, even where a man *does not know* that he had AIDS or HIV, and where the provisions referred to are therefore not applicable, the fact that a rapist has AIDS or HIV will necessarily be aggravating whether or not HIV is transmitted in view of the added anguish and heightened risk to life and well-being that the rapist's condition necessarily entails.¹¹⁴⁶ Other more indirect measures relevant to the concern raised are contained in the Criminal Procedure Act 51 of 1977 and provide for stricter bail measures to be taken in respect of an accused who is charged with or convicted of rape and who knew that he had AIDS or HIV.¹¹⁴⁷

12.16.1 As indicated in Chapter 4, the Commission's Sexual Offences Project Committee will nevertheless in the course of its investigation into sexual offences investigate the necessity for any further measures targeting exposure to HIV in the commission of nonconsensual sexual acts.¹¹⁴⁸ All comments received by respondents pertaining to this issue, have been made available to

1141 Comments of the Commission's Sexual Offences Project Committee (see par 10.8.2).

1142 See par 4.3-4.4 above.

1143 See fn 360 in Chapter 4 above for detailed information on this provision.

1144 In terms of sec 51(3) the Court could however impose a lesser sentence if it is satisfied "that substantial and compelling circumstances exist which justify the imposition of a lesser sentence".

1145 Par (1)(i) and (ii) of Part I of Schedule 2 to Act 105 of 1997.

1146 See par 12.13 above.

1147 See fn 360 in Chapter 4 above for detailed information on these provisions.

1148 See par 4.13 above.

this Committee.

Recommendation

12.17 For the reasons set out above, legislative intervention in the form of the creation of an HIV-specific offence/s (whether this entails the codification of applicable common law crimes or the creation of a new additional offence/s targeting behaviour not hitherto criminal [eg negligent behaviour by persons with HIV or failure to disclose HIV status]) is not recommended.

12.18 In making this recommendation the Commission also identifies a need for the development of practical mechanisms by relevant government departments to utilise effectively the existing common law crimes in cases of harmful HIV-related behaviour;¹¹⁴⁹ and encourage a culture of responsibility with relation to HIV status. This may include the following:

- ! Strong public statements by the Department of Justice and Constitutional Development and the South African Police Service to make the public aware of the applicability of existing common law crimes to harmful HIV-related behaviour coupled with the assurance that our existing criminal law will indeed be used for this purpose.¹¹⁵⁰

- ! Implementation of practical measures by the Department of Justice and Constitutional Development and the South African Police Service to ensure the successful prosecution of harmful HIV-related behaviour through the training of and the development of guidelines and protocols for prosecutors, judicial officers, police officers, district medical officers and other key personnel in handling cases of harmful HIV-related behaviour.¹¹⁵¹

1149 See the comments of Adv Gert Nel in par 11.31-11.33 above. See also briefing of the Inter-Ministerial Committee by the AIDS Programme, Department of Health, February 1999; and Elliot (Unpublished) 24-25.

1150 See the need for this reflected in the comments discussed in par 10.26.6, 10.29.6 and 11.34 above.

1151 See the need for this reflected in the information supplied by Adv Gert Nel (par 11.31-11.33). Cf also the comments in par 10.38.5-10.38.6 and 10.38.10 above.

- ! Steps by the Department of Health to ensure increased presentation of education programmes and conduction of awareness campaigns regarding the nature, spread and control of HIV coupled with increased access to HIV testing and counselling. Such activities should be aimed at encouraging a culture of responsibility.¹¹⁵²

1152 Cf the comments in par 10.38.2-10.38.3 and 10.38.9 above.

ANNEXURE A

Respondents to Discussion Paper 80 in order of receipt of submissions

Respondents to Discussion Paper 80 in order of receipt of submissions

- 1 **Mr SG Abrahams**
- 2 **Dr A Jaffe, Acting Director Health Service: KwaZulu-Natal Provincial Administration**
- 3 **L Kwitshana, Chief Research Technologist: Medical Research Council**
- 4 **Ms Justice L van den Heever**
- 5 **St John Vianney Seminary**
 Comment by Fr H Ennis
- 6 **The Society for Advocates: Natal**
 Comment by Adv JE Hewitt SC
- 7 **The South African Dental Association**
 Comment by Dr JT Barnard, Executive Director
- 8 **Ministry of Caring of the NG Church: Synod Southern Gauteng**
- 9 **General Council of the Bar of South Africa**
 Comment by the Laws and Administration Committee
- 10 **National Council of Women of South Africa**
 Comment by Ms Eily Murray, National Adviser: Laws and the Status of Women
- 11 **Commissioner of Correctional Services**
 Comment by Ms TM Magoro, Director: Health and Physical Care
- 12 **Department of Education: Provincial Administration Western Cape**
 Comment by Mr BP O'Connell, Head: Education
- 13 **Department of Health: Provincial Administration Western Cape**
 Comment by Dr K Vallabhjee, Directorate: Policy and Planning; and Prof Leslie London of the
 Department Community Health, University of Cape Town. The respondents indicated that the
 response should not be regarded as an official view of the Department of Health: Provincial
 Administration Western Cape
- 14 **Inkatha Freedom Party**
 Comment by Dr Ruth Rabinowitz, IFP Spokesperson on Health. The IFP's proposed
 "Measures to Prevent the Spread of HIV Bill" and supporting research material were regarded
 as part of the comment
- 15 **Prof F Van Oosten, Department of Public Law: University of Pretoria**
- 16 **Dr CA Pieterse, City Medical Officer of Health: Durban**
- 17 **Family Farmer**
- 18 **Dr Lorraine Sherr, Royal Free Hospital School of Medicine: University of London**
- 19 **Adv David Buchanan SC, Australian Supreme Court**
- 20 **Dr JH Olivier, City Medical Officer of Health: Pretoria**
- 21 **Ms Michelle Dimbleby**
- 22 **National Council for Persons with Physical Disabilities in South Africa**

Comment by Mr Johan Viljoen

23 **Prof CR Snyman, Department Criminal and Procedural Law: University of South Africa**

24 **Tshwaranang Legal Advocacy Centre to End Violence Against Women**

Comment by Ms Lebo Malepe

25 **The South African Medical Association**

Comment by Mr A Volschenk, Head: Human Rights, Law and Ethics

26 **EJ Hamilton**

27 **Director of Public Prosecutions: Cape of Good Hope**

28 **Regional Court President: Free State Regional Division**

Comment by Regional Court President WA Du Plessis and Regional Court Magistrate IM Menong

29 **Regional Court President: Cape Regional Division**

Comment by Acting Regional Court President AP Kotze

30 **Regional Court President: Northern Transvaal Regional Division**

Comment by Regional Court Magistrates PJ Johnson and RS Matlapeng

31 **Lawyers for Human Rights**

Comment by Lawyers for Human Rights' HIV/AIDS and Human Rights Programme, Pietermaritzburg

32 **Regional Court President: Natal Regional Division**

Comment by Regional Court Magistrate WC Singh

33 **Regional Court President: Southern Transvaal Regional Division**

Comment by Regional Court Magistrates LJ Van der Schyff and JL Brink

34 **Department of Welfare and Population Development: Gauteng Province**

35 **The AIDS Consortium**

Comment by Ms Morna Cornell, Director

36 **AIDS Legal Network: National Office**

Comment consisted of a combined response by the following individuals and organisations: Ms M Caesar (National Coordinator, AIDS Legal Network); Mr S Margardie (Campus Law Clinic, University of Natal); Dr A Grimwood (National Chairperson, NACOSA and Medical Officer of Health, City of Cape Town); Ms A Strode and Ms C Barrett (Lawyers for Human Rights, Pietermaritzburg); Ms S Shutte (Life Line, Cape Town); Mr D Smit (private legal consultant); Ms L Hatane (NACOSA, Western Cape Province); Mr P Moodley (NACOSA Lobbying Office); Ms C Bower (Rape Crisis, Cape Town); Mr G Hendriks (Triangle Project); Ms J Gallenetti (Legal Aid Clinic, University of Cape Town); Ms A Van den Bergh (Legal Aid Clinic, University of the Western Cape)

37 **Triangle Project**

Comment by Ms Annie Leat, Acting Director

38 **Sex Worker Education and Advocacy Taskforce (SWEAT)**

Comment by Ms Jill Sloan, Director

39 **Palliative Medical Institute**

Joint response compiled by Ms NG Duba, Coordinator

- 40 **Prof S Lötter, Faculty of Law: University of South Africa**
- 41 **AIDS Legal Network: KwaZulu-Natal**
- 42 **Democratic Nursing Organisation of South Africa**
- 43 **Lowveld AIDS Training, Information and Counselling Centre (ATICC)**
- 44 **Mr Martin Williams**
- 45 **Regional Court President: North West Regional Division**
 Comment by Regional Court President PB Monareng
- 46 **The Law Society of the Cape of Good Hope**
 Comment by the Criminal Law and Procedure Committee
- 47 **AIDS Law Project**
 Comment researched and compiled by Ms Hilary Axam with assistance from Ms Anita Kleinsmidt, Ms Fatima Hassan and Mr Mark Heywood
- 48 **National AIDS Convention of South Africa (NACOSA)**
- 49 **Regional Court President: Northern Cape Regional Division**
 Comment by Regional Court Magistrate CJS Möller
- 50 **Department of Correctional Services: Port Elizabeth Management Area**
- 51 **National Association of People Living with HIV and AIDS (NAPWA)**
- 52 **Business South Africa**
- 53 **Dr PJ Haasbroek**
- 54 **Director of Public Prosecutions: Witwatersrand Local Division**
 Comment by Adv AP De Vries SC
- 55 **South African Police Service (Legal Component, and Serious and Violent Crimes Component of the SAPS Detective Service - referred to in the Report as SAPS Detective Service)**
- 56 **District Medical Officer: Pretoria**
 Comment by Dr AF Ferreira
- 57 **Mr Ted Leggat, Researcher: Centre for Social Development Studies University of Natal**
 Comment as published in the *Mail and Guardian* of 5-11 March 1999
- 58 **South African Law Commission: Sexual Offences Project Committee**
 Extract from South African Law Commission Discussion Paper 85: Sexual Offences, The Substantive Law
- 59 **Cabinet**
 Comment by Dr AM Omar, MP then Minister of Justice on behalf of Cabinet
- 60 **Adv Z Van Zyl, Deputy Director of Public Prosecutions: Witwatersrand Local Division**

ANNEXURE B

List of experts who attended a consultative meeting on 3 February 2000

List of experts who attended a consultative meeting on 3 February 2000

Criminal law and procedure

- 1 Prof John Milton, School of Law: University of Natal Pietermaritzburg
- 2 Prof CR Snyman, School of Law: University of South Africa
- 3 Prof Ferdi Van Oosten, School of Law: University of Pretoria
- 4 Mr Ronald Louw, School of Law: University of Natal Pietermaritzburg
- 5 Mr Justice RW Nugent, High Court of South Africa Johannesburg
- 6 Mr PB Monareng, Regional Court Mmabatho
- 7 Ms HH Honono, Magistrates' Court Pretoria
- 8 Adv Zaais Van Zyl, Office of the Director of Public Prosecutions Johannesburg
- 9 Adv Gert Nel, Office of the Director of Public Prosecutions Pietermaritzburg
- 10 Adv Retha Meintjes, Office of the Director of Public Prosecutions Pretoria
- 11 Dr Tertius Geldenhuys, Legal Services: South African Police Service
- 12 Mr Garry Prins, Detective Services: South African Police Service

Human rights issues

- 13 Mr Mark Heywood, AIDS Law Project: Centre for Applied Legal Studies at the University of the Witwatersrand
- 14 Ms Lebo Malepe, Tshwaranang Legal Advocacy Centre to End Violence against Women
- 15 Ms Bronwyn Pithey, Rape Crisis
- 16 Ms Vicci Tallis, Private Consultant: Gender and HIV/AIDS
- 17 Ms Promise Mtembu, Young Positive Living Ambassadors
- 18 Ms Mary Caesar, AIDS Legal Network
- 19 Mr Nkululeko Nxesi, National Association of People Living with HIV/AIDS

Public health

- 20 Dr David Allen, Directorate HIV/AIDS and STDs: Department of Health
- 21 Dr Graham Nielsen, Directorate HIV/AIDS and STDs: Department of Health

HIV/AIDS and behavioural science

- 22 Ms Nolwazi Gasa, Department of Psychology: University of Natal Pietermaritzburg
- 23 Mr Pierre Brouard, Centre for the Study of AIDS: University of Pretoria

Members of the South African Law Commission Sexual Offences Project Committee

- 24 Ms Zubeida Seedat, member of the South African Law Commission
- 25 Ms Joan Van Niekerk, Child Line
- 26 Ms Charlotte McClain, South African Human Rights Commission

- 27 Ms Edmara Mtombeni, Department Correctional Services
- 28 Dr Rose September, Institute for Child and Family Development: University of the Western Cape
- 29 Adv Gordon Hollamby, researcher South African Law Commission
- 30 Adv Puleng Matshelo-Busakwe, researcher South African Law Commission

Members of the South African Law Commission HIV/AIDS Project Committee

- 31 Mr Justice Edwin Cameron, Judge of the Constitutional Court of South Africa (at the time) (Chairperson)
- 32 Dr Maila John Matjila, Department of Community Health MEDUNSA
- 33 Prof Christa Van Wyk, Department of Jurisprudence University of South Africa
- 34 Prof Thandabantu Nhlapo, full-time member of the South African Law Commission (at the time)
- 35 Ms Ann Strobe, Lawyers for Human Rights
- 36 Ms Mercy Makhalemele, National Association of People Living with HIV/AIDS
- 37 Adv Anna-Marié Havenga, researcher South African Law Commission