SOUTH AFRICAN LAW COMMISSION

DISCUSSION PAPER 84

Project 85

ASPECTS OF THE LAW RELATING TO AIDS:

Compulsory HIV Testing of Persons Arrested in Sexual Offence Cases

CLOSING DATE FOR COMMENT: 15 October 1999

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INTRODUCTION

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

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The Commission is indebted to Ms Ann Strode (Project Committee member) who assisted the researcher in compiling this Discussion Paper.

PREFACE

This Discussion Paper (which reflects information accumulated up to the end of June 1999), has been prepared to elicit responses from key parties and to serve as a basis for the Commission's deliberations. Following an evaluation of the responses and any final deliberations on the matter the Commission may issue a report on this subject which will be submitted to the Minister of Justice for Tabling in Parliament. The views, conclusions and recommendations in this Paper are accordingly not to be regarded as the Commission's final views. The Paper is published in full so as to provide persons and bodies wishing to comment or to make suggestions relating to the reform of this particular branch of the law with sufficient background information to enable them to place focussed submissions before the Commission.

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

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

Respondents are requested to submit **written** comments, representations or requests to the Commission by **15 October 1999** at the address appearing on the previous page. The researcher will endeavour to assist you with particular difficulties you may have.

SUMMARY

1 Recently there has been mounting public concern and pressure on the authorities to take appropriate action with regard to the deliberate transmission of HIV infection. This has come about largely in response to a number of widely publicised incidents of deliberate transmission of HIV, together with the very real concern that for the most part women and young girls are exposed to HIV infection in this manner. As a result, the Commission, at the request of the Justice Portfolio Committee, has been tasked with investigating the possible creation of a statutory offence aimed at harmful HIV-related behaviour, and the compulsory testing of sexual offenders for HIV. The Commission's HIV/AIDS Project Committee has dealt separately with these two issues. Two Discussion Papers have been prepared as a basis for its deliberations.

1.1 *Discussion Paper 80,* previously released for comment until 31 March 1999, dealt with the issue of harmful behaviour by persons with HIV/AIDS, the administrative and criminal law measures available to address such behaviour and possible statutory intervention. Extensive comments have been received and a Draft Report is currently being prepared.

1.2 *The current Discussion Paper* deals with the question of compulsory HIV testing of persons arrested on a charge, or on suspicion, of having committed a sexual offence during which HIV may have been transmitted and the right of alleged victims of such offences to be informed of the test results. (The terms "sexual offence", "arrested person" and "victim" are explained in paragraph 2.18.2.)

2 In general, our law at present provides for HIV testing only with the informed consent of the person concerned; every person is entitled to privacy regarding medical information; and no general legislation exists which allows for disclosures. Furthermore, neither currently available public health law nor criminal procedure

makes provision for compulsory HIV testing of persons arrested for having committed sexual offences with a view to disclosing their HIV status to victims.

2.1 The compulsory medical examinations (which would include HIV testing) currently provided for in the 1987 Regulations and the draft 1993 Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions conceivably provide for HIV testing but not for disclosure of the test results to third parties other than the health authorities (compare chapter 6).

2.2 Although section 37 of the Criminal Procedure Act, 1977 provides for taking the blood of an arrested person to ascertain bodily features (which could arguably include HIV status), this is allowed for evidentiary purposes in a criminal trial only. Moreover, there is no provision which allows for the disclosure outside of criminal proceedings of the information gained (compare chapter 7).

3 This Paper consequently debates the need for legislative intervention concentrating on the following critical issues:

- **The high prevalence of HIV coupled with the high prevalence of rape and other sexual offences (compare paragraph 8.6 - 8.8).**
- **The utility and limitations of HIV testing (compare paragraph 8.9 - 8.20.3).**
- **Women's international and constitutional rights, including victims' rights (compare paragraph 8.21 - 8.24.3).**
- **The arrested person's constitutional rights, especially the right to privacy (compare paragraph 8.25 - 8.29.1).**

4 The Commission arrives at the preliminary conclusion that there is a need for statutory intervention to provide for compulsory HIV testing of arrested persons in sexual offence cases. The intervention is necessary in the light of women's

undoubted vulnerability in South Africa today to widespread sexual violence amidst the increasing prevalence of a nationwide epidemic of HIV and in the absence of adequate institutional or other victim-support measures. In these circumstances there is a compelling argument for curtailing an arrested suspect's rights of privacy and bodily integrity to a limited extent to enable his accuser to know whether he has HIV. The benefit to alleged victims of the knowledge is not only immediately practical in that it enables them to make life decisions and choices for themselves and people around them; it is also profoundly beneficial to their psychological state to have even a limited degree of certainty regarding their exposure to a life-threatening disease. That the arrested person's rights are infringed, must be acknowledged and this must be reflected in safeguards built into the process created.

5 **It is therefore suggested that the proposed change to the law should be based on the following principles:**

° **Compulsory testing of an arrested person should in principle be victim-initiated. This will ensure that only a person with a material interest in the arrested person's HIV status may apply for a compulsory testing order. "Victim initiation" includes initiation of the testing process by the victim or a person acting on his or her behalf.**

° **In order to protect the victim from a further potentially traumatising confrontation, the arrested person should not be allowed to take part or give evidence in an application by the victim for compulsory testing, except to be able to challenge whether information on oath has in fact been placed before the magistrate in compliance with the provisions.**

° **A specified standard of proof should be required on which to base an order for compulsory testing. The Commission is of the opinion that this should consist of the prosecution showing prima facie that the arrested person**

committed the sexual offence in question, and that the act was of a type that could indeed transmit HIV (eg that semen or blood could have been transferred from the assailant to the victim, or that the victim experienced traumatic injury with exposure to semen or blood).

° **Compulsory testing of an arrested person should take place only on authorisation by a court. Furthermore, this should be a discretionary power resting with the presiding officer hearing the application.**

° **In order to safeguard against abuse of the procedure certain procedural and substantive safeguards must be provided for. These should include scrutiny by a magistrate of an application for the compulsory testing of the arrested person; a deposition on oath, whether oral or by affidavit; and prima facie evidence of a sexual offence in which exposure to the body fluids of the arrested person may have occurred.**

° **A deliberately false complaint would amount to perjury and a malicious activation of the procedure would be actionable.**

° **The procedure should ensure confidentiality of the test results so that the information is provided only to the victim and the arrested person. If the victim is a minor or is incapacitated, the information should be relayed to the person acting on his or her behalf.**

° **The use of information relating to the HIV status of an arrested person obtained under the proposed amendment should be clearly limited: test results obtained through compulsory testing should not be admissible as evidence in a criminal trial. For subsequent evidentiary purposes, the existing provisions of section 37 of the Criminal Procedure Act 51 of 1977 permit the ascertainment of an accused person's bodily features (including the taking of a blood sample to show a characteristic, distinguishing feature**

or condition). This appears to be adequate.

- **The procedure need not necessarily be HIV specific.**

6 On the basis of the above, the Commission provisionally recommends the adoption of a specific amendment to section 37 of the Criminal Procedure Act 55 of 1977. The primary purpose of the proposed amendment is to provide a speedy and uncomplicated mechanism whereby the victim of a sexual offence can apply to have an arrested person tested for HIV or any other life-threatening sexually transmissible disease 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 or any other life-threatening sexually transmissible disease during the attack.

7 In coming to this conclusion the Commission has considered other possible legal or policy interventions. These interventions (which were rejected by the Commission) are discussed in paragraph 10.3 and include the following:

- **Retaining the status quo.**
- **Developing and establishing a policy process (guidelines) aimed at the voluntary HIV testing of arrested persons and voluntary disclosure of their HIV test results to victims of crime.**
- **Developing a governmental response (eg in the form of policy and practical guidelines) that answers the very real concerns of victims of sexual offences and provides them with support and assistance in dealing with the possibility of HIV infection.**

8 A draft Bill is attached for comment. To facilitate comments, the terms of the Bill are explained in chapter 11.

REPUBLIC OF SOUTH AFRICA

CRIMINAL PROCEDURE AMENDMENT BILL

(As introduced)

MINISTER OF JUSTICE

BILL

To amend the Criminal Procedure Act, 1977, so as to provide for the compulsory testing of arrested persons in order to provide victims of any sexual offence in which an exchange of body fluids with the arrested person may have occurred, with the result of such test.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:-

Amendment of section 37 of Act 51 of 1977, as amended by section 1(a), (b) and (c) of Act 64 of 1982

1. Section 37 of the Criminal Procedure Act, 1977 (hereinafter referred to as the principal Act,) is hereby amended by the insertion in the principal Act after section 37 of the

following section:

"Compulsory testing of arrested persons for non-evidentiary purposes

37A (1) Any person who alleges that he or she has been the victim of any sexual offence in which exposure to the body fluids of the arrested person may have occurred, may at the earliest possible opportunity after laying a charge and before or after an arrest is effected, apply to a magistrate, orally or in writing, for an order that the person arrested on the charge or on suspicion of having committed the offence in question, be tested for HIV or any other life-threatening sexually transmissible disease.

(2) If the alleged victim is incapacitated or is a minor, any person with legal standing may apply on his or her behalf for an order in terms of subsection (1).

(3) The magistrate of the district in which the offence is alleged to have occurred or in which the victim resides, has jurisdiction to grant the order, and shall as soon as is reasonably practicable consider the application.

(4) The magistrate, if satisfied from information on oath that prima facie evidence exists that an offence as described in subsection (1) has been committed, shall order any designated local health authority to test the person or persons arrested and to inform the magistrate of the result.

(5) Any police officer may take such steps as may be reasonably necessary to carry out the order.

(6) The proceedings shall be held in camera and the magistrate shall not communicate the fact that an order has been granted or the result of the test or tests to any person other than -

(a) the victim of the alleged offence or the person acting on his or her

behalf; and

(b) the arrested person.

(7) No order granted under this section shall be carried out more than four months after the date upon which it is alleged that the offence in question took place.

(8) The Ministers of Health and Justice may promulgate policy on the testing methods and procedures to be used for purposes of this section.

(9) 'Test' in this section means any medically recognised test for determining the presence of HIV or any other life threatening sexually transmissible disease".

Short title and commencement

2. This Act shall be called the Criminal Procedure Amendment Act, 19... and shall come into operation on a date fixed by the President by proclamation in the *Gazette*.

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1 INTRODUCTION

1.1 The Commission has been investigating law reform relating to AIDS and HIV since 1993. An extensive discussion document (Working Paper 58) 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 reports on critical issues.

1.2 The Commission has already adopted the Project Committee's First, Second and Third Interim Reports on Aspects of the Law relating to AIDS. 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.[1]

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

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

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

implemented urgently by the government.[3]

1.2.2 The **Second Interim Report**[4] dealt with the question whether statutory intervention to prohibit pre-employment testing for HIV was warranted. In this report the Commission enunciated the principles it accepted for legislative intervention; offered comment on the Employment Equity Bill[5] 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. The Commission's recommendations were, in principle, embodied in the Employment Equity Act 55 of 1998.[6]

1.2.3 The **Third Interim Report**[7] 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. Subsequent to this the Department of Education on 11 December 1998 published a draft "National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions" for public comment.[8] The Department of Education's draft national policy adopted the Commission's proposed policy almost exactly. The main difference between the two policies is that the Department's draft policy will also be applicable to *educators* in public schools, and to

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3 The Departments of Health and of Labour are attending to the implementation of the recommendations (information supplied on behalf of the Department of Health by Dr G Mtshali, Chief Director National Programmes, Ms Rose Smart, former Director HIV/AIDS and STDs, and Ms Ann Strode, consultant to the Department of Health and Project Committee member on 14 March, 27 August and 8 October 1998 respectively; and on behalf of the Department of Labour by Mr R Curtis, Director Occupational Health and Hygiene on 6 November 1998 and 21 April 1999).

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

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

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

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

8 General Notice 3006 of 1998 in **GG** 19603 of 11 December 1998.

students and educators in further education and training institutions.[9] For reasons set out in the Third Interim Report the Commission's proposed policy was intended primarily for learners in public schools.[10] The closing date for comments on the Department's draft policy was 6 February 1999. As far as could be ascertained the draft national policy is still being finalised by the Department of Education at this stage.

1.3 The current Discussion Paper deals with the issue of compulsory HIV testing of arrested persons in sexual offence cases, the disclosure of their HIV status to victims and the need for statutory intervention in this regard. The current Paper was preceded by a Discussion Paper on the need for a statutory offence aimed at harmful HIV related behaviour (Discussion Paper 80), published by the Commission for public comment in January of this year. The two issues are the subject of a single request by the Justice Portfolio Committee for law reform relating to HIV/AIDS and violence against women.[11]

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

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9 See mainly the enacting provision; definition of "institution" in par 1; and application of the policy as provided for in par 16 of General Notice 3006 of 1998 in **GG** 19603 of 11 December 1998.

10 See fn 210, par 6.25 and 6.70 of **SALC Third Interim Report on Aspects of the Law relating to AIDS**.

11 For more detail see par 2.15-2.16 below.

2 BACKGROUND

2.1 The Commission was requested by the Justice portfolio committee to investigate the possible enactment of legislation for the compulsory HIV testing of sexual offenders. (The Commission's understanding of this mandate concerning whether it refers to consensual or non-consensual, and pre- or post-conviction HIV testing is set out in par 2.18.2 below). 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 which ensures that victims' rights take precedence over the rights of offenders.

2.2 Information is also supplied on previous work by the Commission on HIV testing and disclosure of AIDS related information.

A) SOURCE OF CURRENT ENQUIRY

* Mounting public concern

2.3 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;[12] compulsory HIV testing of sexual offenders; supplying victims

12 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 the research KwaZulu/Natal had more than two-thirds of the 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 (par 2.1-2.1.5 **SALC Discussion Paper 80** and the sources quoted there). A case study conducted in Khayelitsha, Cape Town, which looked at the experiences of pregnant and non-pregnant teenagers quoted by Rees (Unpublished) revealed the high prevalence of coercive sex

with information regarding their assailants' HIV status; providing prophylaxis (medication to reduce the possibility of infection with HIV[13]) after possible exposure to HIV during the sexual assault; clear policy on victims' rights including HIV counselling, testing and treatment; and state funding for such interventions. Public concern has also been expressed about persons who in consensual sexual relationships place others at risk of HIV infection by not disclosing their HIV positive status or refusing or neglecting to use precautionary measures to prevent possible transmission of HIV.[14]

2.4 The public concern has been fuelled by a number of prominent recent incidents 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.

2.4.1 A young woman who was allegedly raped by five assailants on a farm near Balfour, Mpumalanga in September 1998 was reportedly not informed of the existence of prophylaxis. She was however informed a week after the alleged gang rape that one of her attackers had HIV and she has since tested positive for HIV.[15]

2.4.2 In another incident 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. The victim

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and violent practices among youth in their sexual relationships: of the study population interviewed, 71% of pregnant and 60% of non-pregnant teenagers reported being forced to have sex against their will, while 75% of pregnant and 69% of non-pregnant teenagers reported that they would be beaten if they refused sex (Rees [Unpublished] 2 and the sources quoted by the author).

13 See par 3.51 et seq for more information on prophylaxis after sexual exposure to HIV.

14 In one such case 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 (**Venter v Nel** 1997 4 SA 1014(D)). In another recent case a criminal prosecution has been brought in the New Castle (KwaZulu/Natal) magistrates' court on 29 September 1998 against a man who allegedly had sex with two women, knowing that he had HIV and failing to inform them about it (**Natal Witness** 29 September 1998; **Rapport** 15 November 1998). The case has since been transferred to the Supreme Court and has not been finalised at the time of publication of this Discussion Paper. In yet another incident a magistrates' court accepted in mitigation that a KwaZulu/Natal youth who was found guilty of murdering his older male partner (a medical doctor), attacked the partner after the latter had disclosed his HIV positive status which he had previously kept secret from the youth who now has HIV (**Sunday Times** 8 November 1998).

15 **Sunday Times** 14 February 1999.

reportedly soon after the attack received information on prophylaxis from a local Rape Crisis Centre and the District Surgeon. She is currently under medical care at her own cost while it is not yet clear whether her assailants have HIV.[16]

2.4.3 In a third incident a Johannesburg journalist, 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, the exorbitant cost of obtaining prophylaxis from private sources compared to the alleged relative low cost that would be involved if it was supplied by government, and the huge amounts spent by government on the medical treatment of individuals with HIV in prisons.[17]

2.5 Internationally, concern has recently been expressed about growing evidence of a new link between the spread of HIV and rising violence against women.[18] Violence against women may contribute directly and indirectly to the spread of HIV. In situations where women are being deliberately raped or sexually assaulted by HIV positive men, this may be directly increasing the incidence of HIV. On the other hand in situations where 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.[19] Peter Piot, Executive Director of UNAIDS (the Geneva-based United Nations body which coordinates the global fight against the disease) stated on 3 March 1999 that violence against women is contributing to the merciless spread of AIDS.[20] 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"

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

17 **Beeld** 23 and 24 April 1999; **Pretoria News** 23 April 1999. It was alleged that government spent about R54 million during 1998 on treatment for prisoners with HIV in private hospitals (Ibid).

18 **Inter Press Service** 3 March 1999 (Internet); **Sowetan** 9 March 1999.

19 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.)

20 **Inter Press Service** 3 March 1999 (Internet); **Sowetan** 9 March 1999.

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.[21] "Violence against women is not just a cause of the AIDS epidemic, it can also be a consequence of it" Piot said.[22] He specifically singled out South Africa "where roving gangs of young men, many infected with HIV, engaged in what was called 'catch and rape'".[23]

+ *Prevalence of rape and other sexual offences in South Africa*

2.6 Rape and indecent assault are ways in which HIV is transmitted.[24] Statistics on rape are available from a number of different sources. The latest available official statistics show that a total of 30 756 cases of rape (including attempted rape) involving adults, and 537 cases of statutory rape (intercourse with a girl under the prescribed age [i e 16 years] and/or female imbecile) were reported to the South African Police Service (SAPS) during 1997.[25] Because of under-reporting it is impossible to determine with any certainty what the real position is.[26]

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21 Ibid.

22 Ibid.

23 Ibid. See also Leclerc-Madlala 1996 **Acta Criminologica** 31 et seq; Leclerc-Madlala 1997 **Medical Anthropology** 363.

24 See par 3.16 et seq for sexual transmission of HIV.

25 Statistics obtained from the South African Police Service Crime Information Management Centre (Departmental letter N269/98 of 29 June 1998). Totals for 1998 were not available from the SAPS at the time of compilation of this Discussion Paper. However, available figures for the period January-June 1998 indicate that totals may be similarly high (Departmental letter N153/99 of 28 April 1999). The statutory offences referred to are contained in sec 14 of the Sexual Offences Act 23 of 1957.

26 Figures from the SAPS released in 1995 indicate that on average only one in every 35 rapes is reported (**PACSA Factsheet** June 1998 1 [**PACSA Factsheet** cites Human Rights Watch 1995 51 "Violence Against Women in SA" New York, for this information]; see also Rees [Unpublished] 1). More recently Rape Crisis reported that a woman is raped every 23 seconds in South Africa. This estimate seems to represent all rapes that take place in South Africa, including those that are not reported to the SAPS: The latest official SAPS total would rise to 1 076 460 per year if the current SAPS figures were multiplied by 35 - to deal with current under reporting. This total would amount to an average of 2 949 rapes being committed per day, 123 per hour and 2 per minute i e one every 30 seconds. Ms Catherine Day, Counselling Co-ordinator at Rape Crisis, Cape Town however indicated that it would be more realistic to work on a ratio of 1 in every 10 rapes being reported (information supplied to Project Committee member Ann Strode 21September 1998). Other sources indicate that one in four South African women experiences rape each year, i e a total of 380 000 - of whom 95% are black (Horton 1993 **The Lancet**

2.7 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.[27] As far back as 1995, it was found that the most common crime against children was rape.[28] 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: 21 606 cases of rape, attempted rape, and incest with persons under the age of 16 years were recorded for the period January to December 1997.[29] 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.[30]

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

27 Pienaar 1996 **In Focus Forum** 17-18; Leclerc-Madlala 1996 **Acta Criminologica** 35-36. See also **Beeld** 27 June 1998 and 15 August 1998. Government legal personnel from the KwaZulu/Natal towns of Camperdown and Stanger recently 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).

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

29 Information supplied by the SAPS Crime Information Centre (Departmental letter N269/98 of 29 June 1998. As indicted in fn 25 above totals for 1998 were not available from the SAPS at the time of compilation of this Discussion Paper, however available figures for the period January-June 1998 indicate that totals may be similarly high [Departmental letter N153/99 of 28 April 1999]). The SAPS anticipated that the incidence of rape will only start decreasing once the suspected under-reporting is eliminated and a less violent and drug (alcohol) dependent culture has been established among new generations through a process of socialisation. It is expected that policing as such will probably not cause a noticeable decrease in the incidence of rape (**SAPS Quarterly Report 3/97** Internet 10/10/97).

30 Lachman 477.

+ *Prevalence of HIV/AIDS in South Africa*

2.8 The latest statistics on the prevalence of HIV indicate that South Africa has one of the fastest growing epidemics in the world.[31] Although no reliable statistics on the incidence of AIDS itself, or of AIDS-related deaths, appear to be available in South Africa,[32] the prevalence of HIV can be projected from annual studies conducted at antenatal clinics of the public health services. The results of the latest (1998) antenatal seroprevalence survey confirm the alarming progression of the HIV epidemic which appears to be growing throughout the country and in all age groups.[33] In severely affected areas levels of HIV infection are reaching heights that were considered to be pessimistic scenarios in early projections.[34] Estimates based on the latest survey are that 22,8% of women attending antenatal clinics of the public health services nationally were infected with HIV by the end of 1998.[35] Compared to the infection rate of 17,04% of 1997, this represents a"frightening increase" of 33,8% in the prevalence level of HIV infection during the past year - more than actuarial experts would have anticipated.[36] When these figures are extrapolated, estimates are that roughly 8% of the total population or 13% of the adult (i e sexually active) population (compared to 7% of the total or 11% of the adult population in 1997[37])

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31 Deputy President Thabo Mbeki (as he then was), in addressing the South African people on HIV/AIDS on 9 October 1998, indicated that every day a further 1 500 people get infected in our country and that the rate at which HIV spreads in South Africa is one of the fastest in the world (Mbeki **Declaration of Partnership Against AIDS** [Internet]).

32 This situation may change in future as the then Minister of Health published draft regulations for the compulsory notification of AIDS for public comment on 23 April 1999 (Government Notice No R 485 of 23 April 1999 in **GG** No 19946 [Regulation Gazette No 6494] of the same date). See par 5.16 for more information.

33 "Results of the Ninth National HIV Survey of Women Attending Antenatal Clinics of the Public Health Services in South Africa, October/November 1998" released by the Department of Health on 18 February 1999.

34 Ibid. (The worst hit regions include KwaZulu/Natal and Mpumalanga with prevalence rates of 32,5% and 30,0% respectively, while Northern Province has the highest percentage rate of increase at 40,2%[Ibid].)

35 Ibid.

36 Ibid; Official comment by Metropolitan Life on the 1998 Antenatal HIV Survey. For the 1997 infection rate see "Summary Results of the Eighth National HIV Survey of Women Attending Antenatal Clinics of the Public Health Services in South Africa in 1997" released by the Department of Health on 10 March 1998.

37 Information supplied by Dr Thomas Mühr (Metropolitan Life AIDS Researcher) on 30 June 1998.

is infected.[38] It is estimated that approximately 3,3 million people (adults and children - of which 3,1 million are estimated to be adults) were infected with HIV at the end of 1998.[39]

2.9 The latest survey shows women in their twenties as the most heavily infected (between 26,1% and 26,9%).[40] The Department of Health also expressed specific concern about the increasingly higher HIV prevalence rate amongst teenage girls in the 15-19 year age group which has risen from 12,7% in 1997 to 21,0% in 1998 - a 65,4% increase, which is exceedingly high in comparison with percentage increases in other age groups, which are all below 48%.[41]

2.10 According to experts the epidemic of AIDS sickness and AIDS deaths (which lags several years behind infections with HIV), has since 1997 been emerging in all parts of the country with a rapid rise in the number of cases being expected.[42] Since last year many hospitals reported that more than 50% of admissions to medical wards are HIV/AIDS related.[43] Dr Thomas Mühr, AIDS researcher for Metropolitan Life, has inferred that as a worst case scenario South Africa might be following in Zimbabwe's and Botswana's footsteps, with HIV prevalence above 40% in various regions.[44]

2.11 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

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38 Ibid on 29 April 1999.

39 Ibid.

40 "Results of the Ninth National HIV Survey of Women Attending Antenatal Clinics of the Public Health Services in South Africa, October/November 1998" released by the Department of Health on 18 February 1999.

41 Ibid.

42 Kinghorn and Mühr (Unpublished) 2.

43 Ibid.

44 Ibid.

increasing the prevalence of HIV although this is most likely.[45] Statistics however show that sexual transmission account for 80% of HIV transmissions in South Africa.[46]

+ ***Calls for government response***

2.12 Following public concern expressed in the national media, a number of state officials, political parties, government ministers and non-governmental organisations dealing with human rights have called on the government to respond to the plight of victims of sexual crimes in the face of the growing AIDS epidemic. The following are recent examples of such calls and of requests for law reform:

2.12.1 In March 1997 health care workers accused the government of doing little to help rape victims who survive their ordeal only to face the possibility that they might have contracted HIV from their attacker and might die of AIDS: According to press reports they suggested that the government should be providing HIV counselling, testing and post-exposure prophylaxis as part of the treatment package offered to every victim. It was emphasised that currently HIV testing and counselling are done separately from both the medical examination and rape counselling of victims, and that there is no assurance that follow-up services or post-exposure prophylaxis is available to survivors of sexual crimes.[47]

2.12.2 In September 1997 members of the ANC, National Party, Inkatha Freedom Party and Democratic Party endorsed early requests by the Justice Portfolio Committee for

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45 See also par 3.16 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 (**AF AIDS** 30 April 1999 [Internet]). Recently South African research however 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).

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

47 **The Star** 4 March 1997.

compulsory HIV testing of all convicted rapists, in order to inform the victims. Adv Johnny De Lange, Chair of the Justice Portfolio Committee, at the time expressed the opinion that in the case of a rapist, the rights of the victim should take precedence over the criminal's right to privacy.[48]

2.12.3 Western Cape Attorney General, Frank Kahn in October 1997 called on the Justice and Health Parliamentary Portfolio Committees to create new legislation which would allow the state to "test and tell".[49] Attorney General Kahn is reported as having said that the first thing a woman is concerned about when she is raped is whether or not her attacker has AIDS. He expressed the opinion that while the Criminal Law Amendment Act 105 of 1997 (Minimum Sentencing Act, 1997)[50] indicated that Parliament was giving priority to serious offences from the bail stage through to sentencing and parole, the failure of legislation to allow for the testing of rape suspects for HIV was a shortcoming; and called for the infrastructure to allow members of the justice system to effectively relay information regarding suspects' HIV status to rape survivors.[51]

2.12.4 The then Minister of Health reportedly stated in March 1998 that "in order to give victims peace of mind, people who may have infected others, and especially people who have been charged with sexual offences, may in future be subjected to an obligatory test in order to determine whether they are HIV positive".[52]

2.12.5 In reaction to the Pretoria student gang rape in March 1999 the then Deputy Minister of Justice, Dr Manto Tshbalala-Msimang stated that society has a responsibility to promote

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48 **The Citizen** 3 September 1997.

49 **Daily Dispatch** 23 October 1997; **The Eastern Province Herald** 23 October 1997; **Sowetan** 23 October 1997; **Business Day** 23 October 1997. (Referring to the testing of rape suspects for HIV in order to supply rape victims with information regarding the suspect's HIV status, or revealing such information to a rape victim if the suspect volunteered it.)

50 See fn 57 below for more detail on this Act.

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

52 **The Star** 20 March 1998.

women's rights as human rights;[53] while the New National Party's Women's Action requested that the Department of Health establish a programme providing for immediate access to suitable prophylaxis to every rape victim, and the compulsory HIV and DNA testing of every person suspected of rape.[54]

2.12.6 The latest prominent incidents of rape and gang rape referred to in paragraph 2.4 above, triggered a national campaign by human rights organisations urging the government to test suspects for HIV and to make prophylaxis available to rape victims.[55]

2.13 More generally, resolutions taken at the ANC's 50th National Conference in Mafikeng on 16-20 December 1997 reflected a clear emphasis on victims' rights, especially in the case of violence against women and children. The resolutions included the following:[56]

- Shifting emphasis in the criminal justice system to a more victim orientated approach to ensure and restore a more equitable balance between the rights of accused or convicted persons and those of victims.
- Humanising victims' interaction with the criminal justice system - especially in the instance of violence against women and children.
- Further concretising the declaration by government of violence against women and children as a priority crime through the allocation of appropriate resources and practical mechanisms (for instance establishing guidelines for dealing with sexual offences and witness support systems).
- Supporting and endorsing the approach adopted in recent bail and sentencing legislation passed by Parliament (Acts 85 and 105 of 1997[57]) but also

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

54 **Beeld** 19 April 1999; **The Citizen** 11 May 1999.

55 **Beeld** 23 and 24 April 1999; **Pretoria News** 23 April 1999; **The Star** 23 April 1999.

56 **ANC 50th National Conference Resolutions** December 1997 (Internet).

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

The *Criminal Procedure Second Amendment Act* 85 of 1997 (*Bail Act)* provides for stricter bail measures to be taken inter alia in respect of an arrested person who is charged with or convicted of rape. If such a person knew that he had AIDS or HIV, the following applies: The arrested person's bail application

continuously maintaining and improving the implementation of such mechanisms.

2.14 Echoing these resolutions, the then Minister of Justice in his budget vote speech in the National Assembly on 18 March 1999 stated that the major initiatives of the Department of Justice for 1999 are designed to *inter alia* contribute to the fight against AIDS; and to promote human rights - and in this context combat and prevent violence against women and children and promote gender equality and dignity. He emphasised the need to address the concerns of victims:

> The vision of the new democratic government is that we must change the focus of the criminal justice system, so that the needs and concerns of victims are addressed ... There must be a recognition that crime does harm to victims ... and providing justice for victims must be incorporated in the system ... There is nothing wrong with our Constitution [Act 108 of 1996 - the 1996 Constitution] which guarantees procedural justice to an accused. However, our law is totally inadequate in that it fails to address concerns of victims.[58]

*** Request by Justice Portfolio Committee, January1998**

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must be considered by the Regional Court; such person is not entitled to bail (or to an extension of bail after having been convicted) unless he or she can satisfy the court "that exceptional circumstances exist which in the interests of justice permit his or her release"; and if the person is convicted and extension of bail has to be considered, the court is obliged to consider the possible sentence it will impose before granting an extension of bail (sec 1(b), 2, 4(f) and Schedule 6). This Act commenced on 1 August 1998.

The *Criminal Law Amendment Act* 105 of 1997 (*Minimum Sentencing Act*) provides for compulsory minimum sentences to be applied where a person is convicted of certain serious offences. In particular it provides that if a person has been convicted of rape knowing that "he or she" has AIDS or HIV a High Court is obliged to impose a minimum sentence of life imprisonment (sec 51(1) and Part I of Schedule 2; cf fn 716 below for criticism of the recent Namibian rape legislation providing for the rape of men by women). Provision is however 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 (this 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)).

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

58 Budget Vote Speech of Dullah Omar, then Minister of Justice of South Africa: National Assembly 18 March 1999 (departmental copy Maryn@Justice1.pwv.gov.za).

2.15 During debate on the Criminal Law Amendment Bill (B46-97)[59] (Minimum Sentencing Act) in October 1997, Justice Portfolio Committee (National Assembly) members raised public concerns about actions other than rape by persons with HIV/AIDS which endanger the public.[60] 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 (ANC) proposed that the Department of Justice should consider the research, initiation or drafting of:

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

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 Minimum Sentencing Act:

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

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59 Enacted as the Criminal Law Amendment Act 105 of 1997 (Minimum Sentencing Act). See fn 57 above for more detail.

60 See the sources referred to in fn 51.

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.[61]

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

2.18 The Project Committee, in determining the most appropriate way of dealing with the above request, decided to deal separately with the 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. Two discussion papers have been prepared as a basis for the Commission's consultative process.

2.18.1 The first paper (Discussion Paper 80) addressed 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. Discussion Paper 80 was 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.

2.18.2 The second (i e current paper) deals with the question of ***compulsory*** HIV testing of persons ***arrested*** for having committed ***sexual offences*** and the right of the ***victims*** of such offences to be informed of the test results (i e the HIV status of the person arrested).

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61 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 in April 1998. The Project Committee has since published its Discussion Paper 80 which addresses the question of criminalisation of certain HIV-related behaviour (see par 2. 18 below).

2.18.2.1 In this Paper the term "***compulsory*** HIV testing" is used in the sense that the person concerned will have no choice as to whether the testing is to be undertaken or not. It is envisaged that such testing may include consensual as well as non-consensual testing.

2.18.2.2 The Justice Portfolio Committee and the Department of Justice, in its mandate to the Commission randomly indicated that compulsory HIV testing of "sexual offence perpetrators", "sexual offenders" (i e persons already convicted, in contradistinction to "alleged" sexual offenders) and "those who have been charged with committing sexual offences" should be investigated.[62] The public, in calls for government response, likewise referred to a need for compulsory HIV testing of "convicted" rapists, rape "suspects" and "people charged with sexual offences".[63] In its analysis the Commission has not addressed the possibility of compulsory HIV testing of persons "convicted" of rape and other sexual offences. It will be shown below that in most cases the utility of testing would have disappeared by the time of a conviction.[64] Further, the Commission is of the opinion that the term "suspect" is too wide and uncertain a term to be used in the present context. Since any amendment will probably be to the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act), it is submitted that the terminology of this Act should be adhered to. In current provisions of this Act dealing with the taking of blood samples to ascertain bodily features (section 37)[65] these samples may be taken in respect of "any person arrested upon any charge; and any such person released on bail or on warning under section 72".[66] The Commission thus adhered to the term "***any person***

62 See par 2.15 and 2.16 above.

63 See par 2.3 et seq and 2.12 et seq above.

64 See also par 8.9 et seq below where utility of HIV testing is discussed.

65 See the discussion of sec 37 in Chapter 7 below.

66 Section 72 of the Act deals with release of an accused on warning (i e release of the accused on his or her own recognisance in the case of minor offences where there is no danger of the accused attempting

arrested upon a charge" for having committed a sexual offence.[67] In this regard it should be noted that a person may also be arrested on suspicion of having committed an offence.[68]

2.18.2.3 For purposes of the discussion below, the term "***sexual offence***" is used to refer to any offence where the arrested person compelled the victim to engage in sexual activity, the nature of which is such that it could place the victim at risk of becoming infected with HIV.[69] This may include rape,[70] statutory rape,[71] indecent assault,[72] and incest.[73] Our law does not currently have an offence of "sexual assault".

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to evade his or her trial or otherwise prejudice the course of justice, and where there is thus no necessity for bail conditions to be imposed (Du Toit et al 10-2)).

67 In general the object of an arrest is to bring the "arrested" person before a court to be "charged", tried and convicted or acquitted. The Criminal Procedure Act requires that the person arrested must at the time of his or her arrest, or immediately thereafter, be informed of the cause of the arrest. The effect of an arrest is that the person arrested shall be in lawful custody (Criminal Procedure Act sec 39 (2) and (3); see also Du Toit et al 5-2; Hiemstra 84-87). In a "charge" the relevant offence is set out in such a manner and with such particulars as to the time and place at which such offence is said to have been committed, and the person against whom the offence is alleged to have been committed, as may be reasonably sufficient to inform the accused of the nature of the crime (see the definition of "charge" in sec 1, and the essentials of a charge as set out in sec 84 of the Criminal Procedure Act).

68 Cf sec 50(7) of the Criminal Procedure Act. In such a case a charge has not yet been brought against the arrested person because further investigation is needed. Sec 50(7) however states that the investigation should be completed as soon as reasonably possible, and the person concerned shall as soon as is reasonably possible thereafter, and in any event not later than the day after his or her arrest, be brought before a court of law to be charged.

69 Cf fn 112 below.

70 Rape is unlawful, intentional sexual intercourse with a woman without her consent (Milton 439). Sexual intercourse includes the penetration of the labia majora (outer lips of the vagina). Rape can only be committed by a male of 14 years or older. Girls under the age of 12 years cannot legally consent to sexual intercourse, therefore intercourse with a girl under 12 will always be rape, irrespective of circumstances. Girls between and including the ages of 12 and 15 years can be the victims of statutory rape (see fn 71) (Snyman 490-493). See also fn 72 and 74 below for the position as regards male victims of rape.

71 Statutory rape is intercourse with a girl under the prescribed age (i e 16 years) and/or female imbecile (sec 14 of the Sexual Offences Act 23 of 1957).

72 Indecent assault is unlawful intentional assault with the intent of committing an indecent act (i e an assault which, in itself, is of an indecent nature). Indecent sexual acts which may transmit HIV would include forced male penetration of the anus by the penis (i e sodomy - see fn 74 below); cunnilingus (mouth to vagina); fellatio (mouth to anus or penis); and sexual sadism (eg biting).

73 Incest is unlawful, intentional sexual intercourse between two persons who on account of consanguinity, affinity or adoptive relationship may not marry one another (Milton 234).

2.18.2.4 Finally, "***victim***" (as opposed to "survivor") is used below to refer to any person (male or female,[74] child or adult) who is the direct subject of an alleged sexual offence.[75]

2.19 It is envisaged that two separate reports with final recommendations regarding the two issues will be prepared by the Commission. Where necessary the current Paper will refer to the comments received on Discussion Paper 80.

B) PREVIOUS WORK DONE BY THE COMMISSION WITH REGARD TO HIV TESTING AND DISCLOSURE

2.20 Although the Commission did not deal specifically with the question of HIV testing of sexual offenders in the course of its broad investigation into aspects of the law relating to AIDS, related issues were debated and reported on.

2.20.1 In **Working Paper 58** (published for comment in 1995), testing for HIV, and disclosure of HIV-related information in general were discussed at length. The Commission at the time recommended that legislation should confirm that HIV testing may take place only with fully informed consent except where legislation provides that testing may be carried out without the necessary consent; and in an emergency where the required consent

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74 Although it is so that women will be mostly targeted, men can also be targeted by criminal sexual acts which can transmit HIV, eg non-consensual sodomy (the unlawful intentional sexual intercourse by a man with a man i e forced male penetration of the anus by the penis [Snyman 415-416]). In par 3.16.1 below it is indeed indicated that anal intercourse, as a means of sexual exposure to HIV, carries a higher risk of HIV transmission than vaginal intercourse. Since the advent of the 1996 Constitution, the common law crime of sodomy has been found to be unconstitutional. The Constitutional Court found that the sole reason for the existence of this crime was the perceived need to criminalise a particular form of gay sexual expression. Although non-consensual anal penetration between men can be prosecuted under the common law crime of indecent assault, the Constitutional Court indicated that an offence should be created to criminalise sexual relations per anum, even when they occur in private, where such acts occur without consent or where one partner is under the age of consent (**National Coalition for Gay and Lesbian Equality v Minister of Justice** 1999 1 SA 6 [CC] at 40-42.) The SALC, under its Project 107, is currently investigating this aspect with a view to law reform.

75 Cf the particular use of the term "victim" for rape victims in Pithey et al (Unpublished) 12.

cannot reasonably be obtained.[76] As regards the privacy and confidentiality of AIDS-related information the Commission in general recommended that legislation should be enacted providing for AIDS-related information to be disclosed to third parties only with the consent of the infected person except where legislation or a court order requires the information to be disclosed; and the health or safety of any person is exposed to a substantial risk. Where it is necessary to disclose information it should be disclosed only to persons concerned and to the extent that is necessary for their protection.[77] Comments on these proposals at the time revealed a general consensus on the principles underlying these recommendations.[78] However, the Department of Health and the AIDS Legal Network believed that the Commission should have investigated HIV testing of persons

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76 **SALC Working Paper 58** par 3.30-3.39. Clause 3 of the Commission's HIV/AIDS Bill proposed at the time provided as follows:

> "3(1) Subject to the provisions of any law and the provisions of subsections (2) and (3), no medical procedure for establishing whether a person is an infected person shall be performed in respect of such person without the informed consent of that person or of someone who is legally competent to consent on his or her behalf (in this Act referred to as the legally competent person).
>
> (2) If in the opinion of the medical superintendent of a hospital or, in the case of a clinic or other health care facility, the senior professional health care worker employed in such facility, it is necessary in the interest of any person under legal disability that such person undergo a procedure as contemplated in subsection (1) and the consent thereto of the legal competent person cannot reasonably be obtained, the medical superintendent or the senior professional health care worker concerned may consent thereto.
>
> (3) If a medical practitioner is of the opinion that it is necessary that a procedure as contemplated in subsection (1) be carried out without delay for the protection of him-or herself or of any other person and the consent thereto cannot reasonably be obtained such medical practitioner may dispense with the requirement of subsection (1)" (Ibid Annexure A).

77 **SALC Working Paper 58** par 3.47-3.63. Clause 4 of the Commission's HIV/AIDS Bill proposed at the time provided as follows:

"4(1) Save with the specific and informed consent of the person concerned, or in the case of a person under legal disability, of the legally competent person, the disclosure of HIV or AIDS related information in respect of such person is, subject to the provisions of this Act, prohibited.

(2) In any civil or criminal proceedings in any court or tribunal in which HIV or AIDS related information is relevant, the court or tribunal may -

> (a) order such information to be disclosed to it; and
>
> (b) make such order as it finds appropriate with a view to protecting the privacy of any person concerned.

(3 Should any person come to know of the fact or reasonably suspect or believe that another person is an infected person, he or she shall not disclose such knowledge or suspicion or belief save where the health or safety of other persons is substantially at risk, in which event disclosure may be made only to such persons and to such extent as is necessary for the protection of the other persons concerned" (Ibid Annexure A).

78 **SALC Committee Paper 432** (internal SALC Document August 1996) 9-10.

charged with rape, and confidentiality within the criminal justice system.[79]

2.20.2 The Commission in 1997 in its **First Interim Report on Aspects of the Law relating to AIDS** confirmed the principles of informed consent and confidentiality as regards HIV testing and disclosure in general, and recommended that these principles be enunciated in a national policy on testing for HIV.[80] The Commission's **Second** and **Third Interim Reports on Aspects of the Law relating to AIDS**, published in 1998, likewise confirmed these principles as far as HIV testing in the work place and in the school setting were respectively concerned.[81]

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79 Ibid 23.

80 **SALC First Interim Report** par 6.13 and Annexure D. Par 1 of the proposed National Policy on Testing for HIV provides that :

"1(1) Testing for the human immuno-deficiency virus may be done only -

(a) upon individual request, for diagnostic or treatment purposes, with the informed consent of that individual;

(b) on the recommendation of a medical doctor that such testing is clinically indicated, with the informed consent of the individual;

(c) as part of anonymous and unlinked testing for epidemiological purposes undertaken by the national, provincial or local health authority or an agency authorised by any of these bodies;

(d) where statutory provision or other legal authorisation exists for testing without informed consent; or

(e) where an existing blood sample is available, and an emergency situation necessitates testing the source patient's blood (eg when a health care worker has sustained a risk-bearing accident such as a needle-stick injury and polymerase chain reaction (PCR) testing is not feasible), but only after informing the source patient that the test will be performed, and providing for the protection of privacy. The information regarding the result may be disclosed to the health care worker concerned but must otherwise remain confidential and may only be disclosed to the source patient with his or her informed consent".

81 **SALC Second Interim Report** par 8.26 and 8.59; **SALC Third Interim Report** par 6.27.

3 MEDICO-LEGAL INFORMATION

A) WHAT IS HIV/AIDS?[82]

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.[83] The condition is *acquired* in the sense that it is not hereditary - it is generally accepted that it is caused by the human immunodeficiency virus (HIV) which invades the body from outside. The genetic material of HIV becomes a permanent part of the DNA[84] (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 against illnesses, even those that normally do not involve an extraordinary danger to healthy people. *Syndrome* implies a group of specific symptoms that occur together and that are characteristic of a particular pathological condition. AIDS is described as a syndrome precisely because it does not manifest itself as one disease. It is rather a collection of several conditions that occur as a result of damage which the virus causes to the immune system. Persons thus do not die of AIDS as such.

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82 Virtually every source consulted for the purposes of this investigation presents the medical and empirical facts (as known at the time) with regard to AIDS - some more comprehensively than others. For purposes of this document a relatively simple and synoptic medical information is presented. South African sources consulted in this regard include the following: Arendse 1991 **ILJ** 218-219; FitzSimons **Facing up to AIDS** 13-33; Van Dyk 1-22; Van Wyk 1-80; Whiteside **Facing up to AIDS** 3-12; Evian 5-7, 11-17, 23-29, 35-37, 66, 81-83, 92-94; Lachman 131-132, 156-157, 173-175, 181-183, 187-188, 190-191, 194-199, 313. Foreign sources consulted on the medical background of AIDS and HIV testing include: **Australia Report on Privacy and HIV/AIDS** 9-12; Brett-Smith and Friedland in **AIDS Law Today** 18-45; Jarvis et al 5-26; Krim **AIDS an Epidemic of Ethical Puzzles** 15-20; Carr **AIDS in Australia** 2-23; Crofts **AIDS in Australia** 24-32; **AMFAR AIDS/HIV Treatment Directory** June 1996 94-137; Jürgens 86-90.

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

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

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.[85] 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.[86] 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.[87]

* Course of AIDS[88]

3.3 The course of HIV infection is generally divided into four different stages: the ***initial phase*** (preceding sero-conversion); the ***asymptomatic phase***; the s***ymptomatic phase*** (during which less serious opportunistic diseases occur); and the ***severe symptomatic phase***, during which the patient has full-blown or clinical AIDS.[89]

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85 Ibid.

86 See also par 3.5 below.

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

88 See the sources referred to in fn 82 above.

89 Evian 25-29; cf also the WHO Staging System for HIV Infection and Disease, and theCenters for Disease Control (CDC), United States case definition of AIDS (**CDC Morbidity and Mortality Weekly Report** 1997 [Internet]; Evian 92-94; Lachman 173-175).

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 even later). This period between infection and seroconversion is known as the "***window period***".[90] Blood tests[91] in general use to determine whether a person has been infected with HIV do not trace HIV itself, but react to the presence of antibodies. The fact that antibodies are formed only after a lapse of time 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.[92]

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 phase infected persons are often not aware that they have HIV; they can therefore

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90 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 T**ransfusion Medicine Reviews** 158).

91 For more detail see par 3.25 et seq below.

92 When standard HIV antibody tests are used, the window period may be as short as 25 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]).

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 medication[93] 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). Neurological and psychiatric disorders (known as AIDS dementia) may also occur in this final phase (and in rare cases may occur also earlier).[94] 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.[95] The disease conditions from which people with AIDS suffer are generally not transmissible. Persons with AIDS usually pose no threat of infecting others with opportunistic diseases (as opposed to the

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93 See par 3.46 et seq for recent developments with regard to treatment for AIDS.

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

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

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.[96] In South Africa, severe poverty and malnutrition could possibly be included as reasons why most patients with HIV have a shortened life expectancy.[97]

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.[98]

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

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

98 Evian 1991 16.

B) TRANSMISSION OF HIV[99]

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. However, HIV is not easily transmitted (in contrast with many other serious diseases such as certain sexually transmitted diseases and certain other viral infections[100]).

3.11 HIV has been identified in blood, semen, vaginal and cervical discharge, breast milk, the brain, bone-marrow, cerebrospinal fluid, urine, tears, foetal material and saliva. However, current scientific knowledge indicates that only blood, semen, vaginal and cervical discharge and breast milk contain a sufficient concentration of the virus to be able to transmit HIV.

3.12 At present no scientific evidence exists that HIV can be transmitted in any other mode than the following:[101]

- By hetero- or homosexual intercourse.
- By receipt of or exposure to the blood, blood products,[102] semen, tissues or organs of a person who is infected with HIV. This can occur *inter alia* by the use of dirty or used syringes and/or needles for intravenous drugs[103] or by injecting infected blood into a victim.[104]

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99 See the sources referred to in fn 82 above.

100 Eg hepatitis B (Van Dyk 22).

101 See also par 3.16-3.24 et seq below where the risk of HIV transmission in the criminal context is discussed.

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

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

104 Cf recent 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).

° 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. HIV may possibly be transmitted via mucous membranes.[105] The virus cannot be spread by other forms of personal contact than those described above. Outside the human body and especially outside body fluids, HIV has an extremely limited life span of a few seconds only.[106] The virus is also destroyed by disinfectant.[107]

3.14 There is thus no risk of HIV transmission from casual contact. HIV cannot be transmitted by daily social contact such as breathing, coughing, shaking hands or hugging. It cannot be transmitted through food preparation, by toilet seats, or by sharing food, water or utensils. Even if blood contact did take place, the chances of being infected are small. (The incidence of infection, for instance, among health care workers who received injuries from needle sticks and other sharp objects contaminated with blood known to be HIV infected, is calculated to be approximately 3 in 1 000.[108] Where the status of the blood was not established, but surgical procedures were prone to expose a person to blood, the risk of infection was considered to be at most 1 in 42 000.[109])

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.[110] There is apparently reasonable consensus that 45-

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

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

107 Van Dyk 29-30.

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

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

110 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

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.[111]

* **Possible transmission of HIV through sexual exposure (including rape and indecent assault)**

3.16 HIV may be transmitted through sexual exposure[112] (including rape[113] or indecent assault[114]).[115] 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 object[116]).[117] 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.[118] 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

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1996 6).

111 Krim **AIDS an Epidemic of Ethical Puzzles** 19; Carr **AIDS in Australia** 7. 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.

112 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 Report** 25 September 1998 [Internet]).

113 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.

114 See par 2.18.2.3 above.

115 Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; **AMA Sexual Assault Guideline Resources** (Internet).

116 **CDC Morbidity and Mortality Weekly Report** 25 September 1998 [Internet].

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

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

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 person is often known or can be readily 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 certain).[119]

3.16.1 From the above it is clear that it is especially difficult to quantify the risk of infection with HIV during 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.[120] 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.[121] 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.[122] A woman's risk of becoming infected is further

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119 Ibid.

120 Gostin et al 1994 **JAMA** 1437.

121 Sowadsky "Risk of Transmission Statistics" **The Body** (Internet); see also Evian 12; Van Wyk 11; Gostin et al 1994 **JAMA** 1436-1437. 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 Repor**t 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.

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

increased if she is menstruating or bleeding, or by her own physiology including the presence of any pre-existing disease of the female reproductive organs.[123]

- *The duration of the act*. During prolonged sexual intercourse the victim may be exposed to more of the assailant's body fluids, which may result in increasing the average risk of transmission.[124]
- *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 perpetrator's blood, and provide entry points in the victim's body for the assailant's body fluids.[125]
- *The presence or absence of other sexually transmitted diseases in either the assailant and the victim*. The presence of conditions associated with STDs (eg genital ulcers, sores or inflammatory responses in the genital tract) provide opportunities for HIV to enter the body.[126]
- *The kind of body fluid, and how much of it, the victim was exposed to*. Semen carries a greater concentration of HIV than vaginal fluid, while blood carries a greater concentration of HIV than semen.[127] Studies showed that exposure involving larger volumes of blood exceeds the average risk of HIV transmission.[128] Larger amounts of body fluid transferred during a gang rape would thus increase

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immature cervix and scant vaginal secretions put up less of a barrier to HIV (**Women and AIDS** 3).

123 Evian 147.

124 Ibid.

125 **Women and AIDS** 3; Gostin et al 1994 **JAMA** 1436-1437.

126 Numerous studies on risk factors for HIV transmission have found an association with a history of other STDs - some of which indicated that the presence of an untreated STD could multiply the risk of HIV transmission by up to 10-fold (**Women and AIDS** 3. See also Lachman 8; Evian 12; Rees [Unpublished] 4; Lurie et al 1998 **JAMA** [Internet]; Gostin et al 1994 **JAMA** 1436). It is said that 50%-80% of STD cases in women go unrecognised because the sores or other signs are absent or hard to see and because women, if they are monogamous, do not suspect they are at risk (**Women and AIDS** 3).

127 **Women and AIDS** 3.

128 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 Report** 15 May 1998 [Internet]; **CDC Morbidity and Mortality Weekly Report** 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]).

the risk of HIV transmission.

- *The serological and clinical status of the assailant*. Factors that may affect the infectiousness of an assailant 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.[129] Another variable is the virulence of the viral strain in the assailant.[130]
- *The prevalence of HIV infection in the sexually active population.* The higher the prevalence of HIV infection in the sexually active population (which would include persons arrested for having committed sexual offences), the greater the chances would be for a victim to have been infected through an act of rape or indecent assault.

3.17 *Prima facie*, the risk of infection through a single unprotected sexual exposure appears to be small. However, every single act of unprotected sex presents a risk. Furthermore, although the risk may be small, the consequences of infection are grave. If sexual intercourse is non-consensual, violent or abusive, there may also be an increased risk of transmission due to abrasions which facilitate entry of the virus, and the inability of the victim to control the assailant's behaviour in any way.[131] Gang rape and instances where a woman is repeatedly raped by one assailant pose a statistically higher risk of

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129 Gostin et al 1994 **JAMA** 1437; Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq.

130 Ibid. There are many strains of HIV - some more virulent than others, which may make them more infectious (**Report on Genetic Diversity Conference**, New York June 1999 [Internet])

131 Cf the increased risk factors outlined in par 3.16. See also Lurie et al 1998 **JAMA** (Internet).

infection.[132] 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 non-consensual sexual act such as rape or indecent assault.[133]

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

3.18 Although this paper primarily focusses on the sexual transmission of HIV in a criminal context, it does recognise that HIV may be transmitted by other criminal risk behaviour such as biting and spitting (if blood is present in sputum), fighting, drug abuse and injecting HIV-infected blood.

3.19 In addressing the issue whether HIV may be transmitted through the behaviour referred to, experts emphasise the following:

° The victim must have been exposed to semen, vaginal secretions, blood, or breast milk of a person with HIV;

° the virus must get directly into the bloodstream of the victim (which, apart from intercourse could be through some fresh cut, open sore, abrasion, or the victim's eyes, nose or mouth); *and*

° transmission of blood or body fluids from the assailant with HIV to the victim must take place within minutes of leaving the assailant's body since HIV does not survive more than a few minutes in body fluids that have left the body.[134]

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132 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).

133 Lachman 133-134. See also par 3.48-3.50 below.

134 As far as transmission from environmental sources is concerned, scientists and medical authorities agree that HIV in body fluids does not survive well in the environment, making the possibility of environmental transmission remote. 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. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to essentially zero. No one

If all three these factors are present, the victim could be at risk of contracting HIV.[135]

3.20 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.[136] There has never been a case of HIV transmission through biting where only saliva (untinged by blood), was involved.[137]

3.21 The risk of infection through *spitting,* although theoretically possible (since the virus is found in saliva - albeit in extremely small concentrations), is in realistic terms very small. Saliva would pose a significant risk of transmission only if there were visible blood in the saliva and the blood had direct access to the other person's bloodstream or mucous membranes (eg eyes).[138]

3.22 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.[139] The possibility of direct access to the bloodstream will for instance exist if the blood of a assailant with HIV got directly into a fresh open cut sustained during the fight, or into the eyes, nose or mouth of the victim.[140]

3.23 HIV can be transmitted through *intravenous drug use* when the blood of a drug user with

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has been identified as infected with HIV through contact with an environmental surface. Additionally, since HIV is unable to reproduce outside its living host, except under laboratory conditions, it does not spread or maintain infectiousness outside its host (**CDC HIV/AIDS Prevention: Facts About HIV and its Transmission** July 1997).

135 Sowadsky "Risk from Fighting?" **The Body: Answers to Safe Sex and Prevention Questions** (Internet). See also par 3.10-3.15 above.

136 **CDC Facts About HIV and Its Transmission** July 1997 (Internet); **CDC Morbidity and Mortality Weekly Report** 11 July 1997 620-623.

137 Sowadsky "Kissing and Infection with HIV" **The Body** (Internet). See also par 3.21 below.

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

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

140 Ibid.

HIV is transferred to one without HIV. This occurs almost exclusively through multi-person use, or sharing, of drug injection equipment (needles and syringes).[141] Persons who inject drugs and share drug injection equipment are at high risk of acquiring HIV because HIV is transmitted very efficiently through such sharing.[142]

3.24 Rare incidents of persons intentionally *injecting HIV-infected blood* has been reported.[143] In the United States a medical technician was last year convicted and jailed for life for injecting his son with blood tainted with HIV, while a medical doctor was in February 1999 been convicted of attempted murder and sentenced to 50 years' imprisonment for injecting his former mistress with HIV-tainted blood.[144] In South Africa there has been 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 in public, presumably with the intention to infect them with HIV. Both women tested negative for HIV soon after the alleged incidents but further tests will be necessary to establish whether they were in fact infected with HIV.[145] More recently 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 have been treated with AZT although it has not been established yet whether they had been injected with HIV. The alleged offenders have appeared in court on charges of assault with intent to do grievous bodily harm.[146] As regards transmission risk in this regard medical experts emphasise the

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141 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]).

142 **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 non-injected drugs as trading sex for drugs is often associated with unprotected sex and having multiple sexual partners. Further, the use of non-injected drugs or alcohol can place a person at risk for HIV transmission in part because these substances lessen inhibitions and reduce reluctance to engage in unsafe sex (ibid).

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

144 **Pretoria News** 29 May 1998; **The Citizen** 19 February 1999.

145 **Rapport** 15 November 1998.

146 **Beeld** 22 May 1999.

same factors as mentioned in paragraph 3.19 above: In order to spread HIV to others through needles, a person's blood would have to be directly injected into another person's bloodstream soon after withdrawal of the blood.[147] HIV in body fluids doesn't live long outside the body and the longer the body fluids are outside the body, the less the chance for transmission to occur. The virus is usually dead within minutes once fluids containing it, are outside the body. The greater the volume of blood that the victim of this crime is exposed to, the greater the chance for transmission to occur.[148] However, once the blood is dry, the virus is dead, and transmission will not occur.[149]

C) TESTING FOR HIV[150]

3.25 The legal implications of HIV testing are discussed in Chapter 5. In the paragraphs below basic medical information on HIV testing is provided as background to discussions on the law.

* Types of HIV tests

3.26 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 not at present generally used in the public sector.[151]

3.27 The same blood tests to detect the antibodies to HIV in adults, are generally used in

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

148 Cf fn 128.

149 Ibid.

150 See the sources referred to in fn 82 above. See also Levine and Bayer in **AIDS an Epidemic of Ethical Puzzles** 21-22.

151 See par 3.34 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).

respect of children.[152] 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 form mother to the baby.[153] Until these antibodies disappear, only specific virus detection tests can determine the infection status of an infant.[154]

+ ***ELISA and Western Blot antibody tests***

3.28 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.[155] 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 beyond the window period positively to nearly any infection. Because of its high sensitivity, a single test can deliver a false positive result. For this reason it is necessary to carry out a second, more specific, test to confirm HIV positivity. It is also advisable to perform the tests on a second, different, blood specimen. The WB test, which is such a more specific test, is traditionally used to confirm an initial positive test. However, the WB is expensive[156] and can therefore not always be used in practice. Different types of ELISA tests with a higher degree of specificity have consequently been developed and the World Health Organisation (WHO) has compiled guidelines which indicate the circumstances under which multiple (different types of) ELISA tests will suffice in order

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152 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).

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

154 Ibid.

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

156 The cost of a WB test is approximately R276 to R751; the cost of an ELISA test carried out by a private body varies from R74 to R203 (information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997). The cost of an ELISA test when used in a public facility would probably be around R80 (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 they are too expensive.)

to establish HIV infection.[157] South Africa has accepted the WHO recommendations to diagnose HIV infection by using at least two positive ELISA test results.[158]

3.29 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.[159]

3.30 Currently a positive HIV antibody test generally means that the person concerned is infected with HIV, will remain infected for life, and can infect other persons. The ELISA and WB tests do not indicate the stage of infection which the person tested has reached.[160] 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 merely that antibodies to the virus have not yet developed[161] and thus the person is infected but is in the window period. To obtain a reliable result such a person will after a period of time have to be tested for HIV again.[162]

3.31 It is alleged that where the standard test procedure (an ELISA test followed by one or

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157 According to the WHO guidelines the prevalence of HIV in the population to which the person belongs on whom the blood test is performed, is decisive. The scientific premise is that the higher the prevalence of HIV infection, the greater the probability that a person who in the first instance tests positive, is truly infected (cf Fleming and Martin 1993 **SAMJ** 685-687). UNAIDS and the WHO recently indicated that studies have shown that combinations of ELISA and rapid assays (such as DOT immuno assays [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/Western Blot combination, and at a much lower cost. UNAIDS and the WHO therefore recommended that countries consider testing strategies utilising the ELISA/rapid assay combination (**WHO Weekly Epidemiological Record** 21 March 1997). See par 3.38 et seq below for more information on rapid testing.

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

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

160 Viral load testing has become a marker for disease progression in persons with HIV/AIDS (see par 33.34 et seq below).

161 Banta 5.

162 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).

more confirmatory tests) is followed, a correct result will be obtained in more than 99% of HIV infections.[163]

+ ***Saliva and urine tests***

3.32 Although the standard ELISA and WB tests demonstrate sufficient reliability for diagnostic purposes, utilising blood and handling specimens carry significant risk of HIV transmission. Risks inherent in specimen collecting and handling (needle-stick injury and test tube breakage) exist for health care workers. Tests not using blood as specimen would also be more suitable for haemophiliacs or people on medications that affect bleeding.[164] This risk has recently led to the investigation of other fluids, including oral fluid (saliva[165]) and urine, for HIV antibody tests.[166] Both urine and saliva contain extremely low concentrations of HIV, and are therefore low risk body fluids. However, both would have sufficient detectable antibodies to HIV.[167]

3.33 The saliva and urine tests use the same technique (i e testing for antibodies to HIV) as the standard ELISA and Western Blot tests, are subject to the same window period as the standard tests, and are similar in accuracy to the standard tests.[168] They are however more expensive to perform.[169]

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163 **Australia Report on Privacy and HIV/AIDS** 11; Van Dyk 12; **CDC PATHFINDER** May 1997 (CDC Clearinghouse); Andres 1994 **UMCK Law Review** 457.

164 Emmons 1997 **The American Journal of Medicine** 15-16; Sowadksy "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet).

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

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

167 Sowadksy "Urine HIV Antibody Tests" **The Body** (Internet).

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

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

+ ***Viral load and PCR testing***

3.34 New tests are available that test for HIV itself, rather than antibodies to the virus.[170] These may shorten the period of uncertainty about actual infection to about 16 days.[171] In addition, some of these tests (for instance viral load tests) may more accurately predict future health status by measuring the amount of virus in the blood of people with HIV.[172] However, because of their cost they are not yet recommended for general use.[173]

3.35 Viral load testing is the direct measurement of the amount of HIV in the blood of people with HIV infection. It is currently regarded as the best marker for the progression of HIV disease and is becoming a standard of HIV treatment monitoring. Studies have for instance determined that patients who have higher virus loads will progress more quickly to AIDS than persons with lower virus loads.[174]

3.36 Viral load tests are not normally used to diagnose HIV. 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.[175]

3.36.1 Specific circumstances in which viral load testing, in addition to other tests, is used to assist in diagnosing HIV would be if a person has recently had a high risk exposure to a

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

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

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

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

174 The City of Cape Town Health Department in its comment on **SALC Discussion Paper 72** pointed out that viral load testing is extensively used for private patient management and for monitoring of patients in drug treatment trials. On the above, see **CDC PATHFINDER** May 1997 (CDC Clearinghouse); **Toronto Hospital Immunodeficiency Clinic Newsletter** September 1996 (Internet); **HIV-Infogram** 20 September 1996 (Internet); and par 3.47 et seq below on the significance of viral load testing in administering new combination drug treatments for HIV infection.

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

person known to have HIV and the person to be tested is having symptoms consistent with Acute Viral Syndrome.[176] In these circumstances viral load tests are done together with a battery of other tests to determine if the symptoms are due to HIV or not. Other than this unique situation, using these tests for diagnostic purposes is not recommended.[177]

3.36.2 Viral load testing is also irrelevant in terms of immediate post-exposure treatment: 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;[178] 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.[179]

3.37 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 11 days[180] is also available. The 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.[181] However, PCR tests are more prone to false-positive and false-negative readings as compared to

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176 During the first four to six weeks after infection, up to 70% of people with HIV show symptoms due to "Acute Viral Syndrome". This occurs during the body's initial response against the virus and *all* of these symptoms are similar to symptoms of other illnesses (eg flu, the common cold, a common rash). Not all people will get Acute Viral Syndrome, and in those that do get it, the severity and duration (usually one to two weeks) can vary significantly. Because the symptoms of Acute Viral Syndrome are so general and nonspecific, only viral load testing could determine if a person has HIV at this stage (information supplied by Dr Rick Sowadsky, Communicable Disease Specialist, Nevada US AIDS Hotline Coordinator on 3 May 1999).

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

178 Cf par 3.53 below where the importance of immediate administration of prophylaxis is discussed.

179 Sowadsky "CDC Standards for Needle Sticks? Etc" **The Body** (Internet).

180 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997. 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). (Sowadsky "Approximate Timeline of Testing and Symptoms for HIV/AIDS **The Body** [Internet]).

181 **CDC PATHFINDER** May 1997 (CDC Clearinghouse).

antibody tests.[182] In addition, they are expensive (more so than, eg ELISA antibody tests);[183] complicated and difficult to execute and are thus performed only in specialised or reference laboratories.[184] Generally speaking they have limited diagnostic value and are not designed for routine testing of adults. Because of variability in results, PCR tests are either done more than once, and/or in combination with other diagnostic tests for HIV (eg HIV antibody tests).[185] Experts accordingly advise against the widespread or routine use of PCR tests for victims of rape and other sexual offences and indicate that these tests should be used only on a case-by-case basis.[186]

+ ***Rapid testing***

3.38 Research on the efficacy of a "rapid" HIV test, which would cost only between R12 and R20, is currently being done in South Africa.[187] Rapid testing in general refers to HIV antibody testing, using blood as specimen,[188] which is easier to use (usually requiring no other equipment other than what is provided in the test kit) and which produces results

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182 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.)

183 Ibid.

184 Information supplied by Prof A Heyns of the S A Blood Transfusion Service on 27 October 1997; see also van Dyk 12; Crofts **AIDS in Australia** 26-27. The cost of a PCR test ranges from R150-R200 (information supplied by Prof A Smith, Department of Virology, Medical School, University of Natal/Durban on 27 July 1998).

185 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist, Nevada US AIDS Hotline Coordinator on 3 May 1999.

186 Ibid. (Cf however the recent Canadian HIV/AIDS Legal Network Report on HIV Testing and Confidentiality which recommended that the question whether PCR testing should be made available to survivors of sexual assault should be examined as part of possible services which could be made available to sexual assault survivors [Jürgens 179]).

187 **Beeld** 26 August 1998; see also **Department of Health Policy Guidelines on Rapid HIV Tests and Testing April 1999**. Information on cost of rapid testing supplied by Dr Clive Evian, consultant to the Department of Health on 18 May 1999.

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

more quickly (within 10 to 30 minutes) than the standard ELISA test.[189] 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 accurate enough to exclude HIV infection if the test is negative.[190] Rapid testing does not shorten the window period.[191] 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;[192] can usually be operated and read by non-laboratory personnel; and some are even being marketed to the lay public for "self-testing" purposes.[193]

3.39 The rapid test under research in South Africa is a simple test which provides the result within minutes of the user pricking his or her finger and mixing the blood with the chemical solutions supplied.[194] Research has already shown that the test results are reliable if the test is performed properly and read accurately.[195] South African experts and

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189 **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 Report** 27 March 1998 (JAMA NEWSLINE); Jürgens 86-87.

190 **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).

191 **CDC Update** March 1998 (Internet); Sowadksy "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet); Sowadsky "15 Minute Test" **The Body** (Internet).

192 Prices may however differ and some rapid test kits are actually more expensive than an ELISA test. However, performance of an ELISA requires expensive laboratory equipment and the time and expertise of laboratory technicians which should be taken into account (**CDC Update** March 1998 [Internet]).

193 **CDC Update** March 1998 (Internet); **CDC Morbidity and Mortality Weekly Report** 27 March 1998 (JAMA NEWSLINE); Sowadksy "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.

194 **Beeld** 26 August 1998.

195 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/Western Blot combination. However, only one rapid test, approved by the Food and Drug Administration, is currently commercially available in the United States (**CDC Morbidity and Mortality Weekly Report** 27 March 1998 [JAMA NEWSLINE]; **CDC Update** March 1998 [Internet]). 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**

the Department of Health however strongly discourage indiscriminate use of any rapid HIV test and marketing such tests as "self testing kits". They emphasise that a second confirmatory test (in the form of a laboratory test), should be done in respect of all positive test results.[196] Furthermore, they emphasise that rapid testing should be executed under the supervision of a health care worker to ensure proper counselling.[197]

3.40 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.[198] It is envisaged that the test currently under research will become available during 1999 and that it will be of specific value in regions lacking laboratory facilities.[199]

+ ***DNA tests***

3.41 Another promising area of research is the new tests (commonly referred to as DNA[200] tests) that aim at determining the full genome sequence of the HIV-1. Through these tests molecular biologists are able to distinguish the different subtypes of HIV as well as to match those that have identical genome sequences. This level of precision will not only help epidemiologists to trace the spread of infections, it will also enable criminal

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on Rapid HIV Tests and Testing April 1999 par 6).

196 The negative predictive value of rapid tests is such that infection can often be confidently excluded if the test it negative. However they are more likely to miss 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 Report** 27 March 1998 [Internet]; **CDC Update** March 1998 [Internet]).

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

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

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

200 See fn 84 above.

investigators to state with some degree of certainty the source of infection.[201]

3.41.1 The DNA technique was used in the early 1990s to verify that a Florida, United States dentist with HIV infected six of his patients.[202] To date however, the test is too costly for general use and, depending on the circumstances surrounding transmission, not necessarily conclusive. (An arrested person could, for instance, after having infected a victim, engaged in high risk activities with other infected persons and as a result of those activities be infected with a different strand of the virus which means that the victim and the arrested person would no longer have matching DNA.) 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.[203] The SAPS currently already uses the DNA technique for evidentiary proposes in sexual offence cases where necessary.[204]

* Accessibility and cost of HIV testing

3.42 HIV testing is available at private and public facilities. In the public sector any person may approach a primary health care clinic or ATICC[205] for free HIV testing.[206] 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

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201 Information supplied by Dr J Matjila (Department Community Health) and Prof G Lecatsas (Department of Virology) at the Medical University of South Africa on 21 October 1998. See also Salminen et al (Unpublished); McCutchan and Birx (Unpublished); Colella 1995 **The Journal of Legal Medicine** fn 34 on 41.

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

203 Ibid.

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

205 AIDS Training Counselling and Information Centres established at the health departments of certain local authorities.

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

another service.[207]

3.42.1 There are no official statistics on the number of HIV tests undertaken in the private and public sectors around the country. However, information supplied by Professor Allan Smith of the Department of Virology, University of Natal/Durban indicates that 8 000 -10 000 HIV tests are done every month in KwaZulu/Natal.[208]

3.43 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.[209] Full-time and part-time district surgeons (employed by the Department in the larger centres and by the provincial administrations in the rural areas) fulfil this function.[210]

3.43.1 Taking of a blood sample of a person arrested or released on bail or warning on a criminal charge to ascertain whether the body of such person shows any condition, may be undertaken by authorised medical practitioners[211] for the purposes of collecting evidence under section 37(2)(a) of the Criminal Procedure Act 51 of 1977.[212] The Act does not authorise blood testing which would not be used for evidentiary purposes in criminal

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207 Information supplied by Ms Rose Smart, Director HIV/AIDS and STD Directorate, Department of Health on 24 July 1998.

208 Information supplied by Prof Alan Smith or the Department Virology, University of on 27 July 1998. It seems however that at present access to HIV testing is mainly limited to urban areas. Nationally only 56% of public sector clinics offer HIV testing. This figure represents 33% of rural clinics and 77% of of urban clinics. Moreover, quite often access to an HIV test at public sector clinics is most limited in the provinces where HIV prevalence is highest (Heywood [Unpublished] 7).

209 This may change in future as Draft 9 (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).

210 **SALC Report on Women and Sexual Offences in SA** par 5.39.

211 In terms of sec 37(2)(a) this would include any medical officer of any prison or any district surgeon or, if requested thereto by any policy official, any registered medical practitioner or registered nurse.

212 Cf Hiemstra 80-81; Du Toit et al 3-1 - 3-2A; Clark **Polisiëring en Menseregte** 260 et seq. (For a full discussion of section 37 of the Criminal Procedure Act, see Chapter 7 below.)

proceedings.[213]

3.43.2 As far as victims of sexual crimes are concerned, expert evidence in the form of evidence of a medical practitioner (usually the district surgeon) supported by a medico-legal report in which his or her findings are recorded,[214] is usually submitted by the prosecution. Such a report, in addition to simple pathological findings of trauma, usually also contain conclusions drawn by the district surgeon based on his or her observations of the injuries sustained.[215] As the victim is examined for evidentiary purposes, the examination does not include HIV testing or any form of treatment.[216] Victims of sexual offences are referred to government or private hospitals for treatment if it is required (eg in the instance of a rape victim with physical injuries to be attended to).[217]

3.44 It is clear from the above information that neither HIV testing of the arrested person for purposes of informing the victim, nor HIV testing of victims themselves is currently being done by district surgeons or other authorised medical practitioners in the course of criminal proceedings following rape and indecent assault.[218]

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213 Ibid. See also the discussion of sec 37 of the Criminal Procedure Act in Chapter 7 below.

214 **S v Heller and another** (1)1964 (1)SA 520 (W).

215 Cf Du Toit et al 24-31. (Cf also the current J88 form to be completed by the district surgeon or other medical practitioner in a case of an alleged assault which allows for the following information regarding the victim: general state of health; condition of clothing; bruises and abrasions; fractures or dislocations; and microscopic examination of stains. Where the assault is alleged to be a sexual crime, the following information regarding the victim should in addition be supplied: physical condition; mental condition; and external and internal injuries to breasts and genitalia.)

216 See also par 7 of **SAPS National Instruction 22/1998** issued in terms of sec 25 of the South African Police Service Act, 68 of 1995 which provides as follows: "The object of the medical examination of any person who is a victim of an alleged sexual offence is to examine the body of the victim in order to establish whether there is any evidence relating to the alleged sexual offence on or in the victim's body and to ascertain the victim's mental state".

217 Information supplied by Dr WJ Pietersen, Principal Medical Officer, Office of the District Surgeon, Pretoria on 1 July 1998. Dr Pietersen emphasised that the District Surgeons' current protocol with regard to HIV in any event requires informed consent and patient (victim) counselling before testing; and further, the relevance of testing the victim in the context of a criminal prosecution concerning another person is questionable as testing of the victim would only supply base-line information about the victim's HIV status, at most. Dr Soni, part-time district surgeon from Pietermaritzburg confirmed that rape victims are provided with a referral letter to the closest public health facility for treatment, including HIV testing if requested by a victim (information supplied to Ms A Strode, project committee member on 17 May 1999).

218 This was confirmed by Dr WJ Pietersen, Principal Medical Officer, Office of the District Surgeon, Pretoria on 1 July 1998; and Dr Soni part-time District Surgeon, Pietermaritzburg on 17/5/99.

3.45 The cost of HIV testing will be relevant in a criminal context if such testing has to be provided for either victims or arrested persons. As indicated above, the cost of the Western Blot and ELISA tests carried out by a private body varies between R276 to R751, and R74 and R203 respectively.[219] The cost of an ELISA test carried out in a public institution would be around R80.[220] Apparently Western Blot tests are currently not often used in public facilities because they are too expensive.[221] The state currently uses public sector testing facilities, such as the ATICCS,[222] when they have the arrested person's consent for an HIV test or where the test is ordered by the court.[223] The possibility exists that a rapid test may be available soon at a cost of between R12 - R20.[224] However, in instances of a positive result to a rapid test, a second (laboratory) test (which would be more expensive) would still be necessary to confirm a positive test result.[225]

D) TREATMENT

3.46 There is at present no cure for HIV infection or AIDS. The best-known drug for the treatment of persons with HIV infection and AIDS, until recently has been zidovudine (AZT).[226] This drug does not cure AIDS, but brings temporary relief for persons with symptomatic HIV infection: AZT delays the increase of HIV in the body, decreases the

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219 See fn 156 above.

220 Information supplied by Dr Clive Evian, consultant to the Department of Health on 18 May 1999.

221 Ibid.

222 Information supplied by Adv Dellene Clark SAPS Legal Services on 16 January 1998. See also fn 217 above.

223 SAPS Departmental letter 1/2/2 of 12 March 1998. See also par 7.2 below.

224 See par 3.38 above.

225 Ibid.

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

number of opportunistic infections and increases the number of healthy cells.[227]

3.47 Significant progress has however been made in recent years with regard to the successful treatment of HIV infection and associated opportunistic infections. Wider use of medications for preventing tuberculosis and pneumocystis carinii can, for instance, assist in reducing the number of people with HIV who develop these serious illnesses and die prematurely from AIDS.[228] Also, several new compounds in a new class of drugs, called protease inhibitors, have been developed and approved during 1996/97 to treat HIV infection. Subsequently further classes of drugs and refinements have been developed. These drugs, when taken in combination with previously approved drugs for the treatment of HIV infection (such as AZT), may reduce the viral load (i e the level of HIV particles circulating the blood) to undetectable levels, thus providing the means of maintaining or restoring immunological function and substantially postponing disease progression and death.[229] Application of these combination treatments may also improve results of prophylaxis for HIV transmission, reducing perinatal transmission and the risk of HIV infection for health care workers or persons exposed to HIV during sexual intercourse or rape.[230]

3.47.1 Studies found that people with the highest viral load had a 13 times greater risk of developing AIDS, and an 18,5 times greater risk of death than people with the lowest viral load.[231] Recent reports indicate that some combination treatments may be so

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

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

229 Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487; Groopman **The New Republic** 12 August 1996; Gyldmark and Tolley in **The Economic and Social Impact of AIDS in Europe** 30-37; **CDC Update** June 1998 (CDC Clearinghouse).

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

231 As indicated in par 3.34 above, viral load tests are used to measure the amount of HIV in the blood. Viral load is frequently reported as an absolute number - i e the number of virus copies/ml blood. A result below 5 000-10 000 copies/ml is generally considered a low level, while a result over 5 000-10 000copies/ml is generally considered a high level (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

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.[232]

3.47.2 Although the new combination drug therapies have proved to be more effective than any previously available, their long-term effectiveness and safety are still unknown because they are so new.[233] They reduce the concentration of HIV circulating in the blood of most individuals, but it is increasingly accepted that the therapies do not completely eradicate the virus from all parts of the body, nor that they will in the long run be effective in maintaining reduced levels of HIV in the bloodstream.[234] The drugs do not work for all people with HIV; they require patients to follow complex treatment regimens taking multiple medications several times each day; and many people develop serious side effects which prevent them from continuing the regimen.[235] Furthermore, the drugs are extremely expensive and are thus not widely available in developing countries.[236] There is however some hope that HIV and AIDS may eventually, for those who

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[Internet]).

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

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

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

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

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

can afford treatment, become manageable in ways similar to diabetes, epilepsy, and heart disease.[237]

E) PREVENTION OF HIV TRANSMISSION

* Effectiveness of condoms in reducing the risk of HIV transmission

3.48 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.[238] The Department of Health in South Africa has consistently promoted condom use as part of its HIV/AIDS strategy. As a result of this 184 million condoms were for instance distributed free of charge during 1997.[239] 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.[240] However, in another study of HIV transmission within heterosexual couples it was

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

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

239 **Red Hot News** Jan/Feb 1998 1.

240 **CDC Facts About Condoms** February 1996 (CDC National AIDS Clearinghouse); De Carlo **VAAIN** April 1995; Guide to Clinical Preventive Services: US Preventive Services Task Force 1996 in **JAMA HIV/AIDS Information Centre** (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 4 weeks prior to the survey included condoms (**AIDSScan** September-October 1998 12).

calculated that "regular" condom use reduced transmission from an HIV-infected partner by 69% compared to infrequent users.[241]

3.49 Female condoms have 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 transmitted diseases, further clinical research is necessary to determine its effectiveness in preventing transmission of HIV.[242] As the female condom is the only 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.[243]

3.50 It is however unlikely that condoms will be used in the case of rape or indecent assault.[244]

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

\+ ***What is PEP?***

3.51 PEP is an antiviral therapy designed to reduce the possibility of an individual becoming infected with HIV after a known exposure to the virus. The treatment usually involves

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

242 **CDC Facts About Condoms** February 1996 (CDC National AIDS Clearinghouse); Volker 1997 J**AMA** 460; Palmer 1999 **Infectious Disease News** 28. Cf however another source which claims that the typical failure rate of the female condom is 21% (much higher than the male latex condom) (Sowadsky "How Safe are Condoms?" **The Body** [Internet]).

243 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 STDs and HIV because of their political, educational, social and sexually subordinate position to men (Deniaud 1997 **Sante** 405-415 [Internet]).

244 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]).

administration of a group of drugs (or AZT alone) which act against HIV.[245]

3.51.1 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 which antiviral treatment may abort infection by inhibiting HIV replication and allowing the host's immune defences to eradicate the virus.[246] The sooner the treatment is started, the better the chance of reducing viral replication and enabling the body to eliminate viable virus.[247] 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).[248] 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 sero-conversion after occupational percutaneous exposure (skin perforating needle-stick injury). 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.[249]

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245 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); Sowadsky "Postexposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet).

246 Katz and Gerberding 1998 **Annals of Internal Medicine** 306; **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to the HIV** March 1999 4.

247 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 (**CDCMorbidity and Mortality Weekly Report** 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).

248 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 4.

249 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); Flexner in **The Hopkins HIV Report** (Internet); 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 Report** 25 September 1998 [Internet]). Cf however also par 3.57 below where scientists' divergent opinions on the success rate of

+ ***Possible advantages and disadvantages of PEP***

3.52 The biggest advantage of PEP is that it could drastically reduce the chances of 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. 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.[250]

3.53 PEP thus has serious possible disadvantages and limitations, including the following:

° Treatment should be initiated promptly, preferably immediately, within one to two hours after exposure. Although the interval after which there is no benefit from using prophylaxis is not yet defined, experts consider 24-36 hours too late.[251]

° The standard combination drug regimen is onerous to follow and carries a long list of potential side effects. 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.[252] 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

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prophylaxis are referred to.

250 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 5.

251 Animal studies suggest that prophylactic treatment is probably not effective when started later than 24-36 hours post-exposure. Animal studies of 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 prophylactic treatment 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 Report** 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).

252 Dahir **The Body: POZ Gazette** (Internet); **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet).

indigestion).[253] Among health care workers receiving combination drugs as post exposure treatment, 50%-90% reported side effects that caused 24%-36% to discontinue treatment.[254]

- Moreover, 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. Administration of prophylaxis thus carries the remote risk of multidrug-resistant virus developing.[255]
- All the treatments recommended may have potentially serious drug interactions when used with certain other drugs. This requires careful evaluation of concomitant medications being used before prescribing PEP and close monitoring for toxicity.[256] It has recently been said that although the efficacy of antiretrovirals in suppressing HIV infection is no longer in question, the toxic effects associated with the long-term administration thereof can be formidable.[257]
- 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).[258]
- The use of PEP in children has not been studied, and therefore the safety and effectiveness of PEP administered to child victims of sexual offences would be

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253 Ibid. However, adverse effects have been reported primarily for persons with advanced disease and therefore may not reflect the experience of the drug regimen of persons with less advanced disease or those who are uninfected; and serious side effects rarely occur within the first four weeks of therapy (**CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999).

254 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); see also Mirken 1998 **Bulletin of Experimental Treatments for AIDS** (Internet).

255 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet); Dahir **The Body: POZ Gazette** (Internet).

256 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet).

257 Henderson 1999 **JAMA** (Internet).

258 Ibid. See also Henderson 1999 **JAMA** (Internet) where it is indicated that although CDC Guidelines on PEP after occupational exposure clearly state that pregnancy should not preclude the use of PEP, most authorities argue that the decision for treatment in pregnant health care workers should remain in the hands of the exposed worker. Cf also the advice of international experts to the ALN regarding the administration of PEP in rape victims who could be pregnant - referred to in fn 297 below.

completely uncertain.[259]

° Finally the regimen is extremely expensive to complete.[260]

+ ***PEP after occupational exposure***

3.54 Since 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), it is becoming common practice for public health services to, under certain circumstances, recommend the administration of prophylaxis to health care providers who are exposed to HIV infected blood or other body fluids in the workplace. Studies on prophylaxis after occupational needle-stick injury currently form the basis of discussions on prophylaxis after sexual exposure. Background information on the former is thus provided below.

3.55 The South African Department of Health in March 1999 issued policy guidelines on the management of occupational exposure to HIV for health care workers specifying a standard drug regimen for PEP.[261]

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259 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist, Nevada US AIDS Hotline Coordinator on 11 June 1999.

260 According to Dr Clive Evian, drafter of the **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 referred to above, the cost of a two-drug combination regime taken for 30/31 days is R1 493 if the drugs are obtained directly from a pharmaceutical wholesaler. The cost could be less if the drugs were purchased by way of government tender and distributed through state institutions (information supplied by Dr Evian on 13 August 1998). Similar prices were recently quoted in the press: The total price of a starter pack (R171) and a 28 day (i e the 31 day regimen minus the 3 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 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]).

261 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999). The Guideline states that its focus is occupational exposure to blood and blood products as saliva, tears, sweat, urine and breast milk are not associated with risk of HIV transmission in an occupational setting. The Guideline defines "health care worker" as "all personnel working in health care settings and laboratories who handle blood products; professional (eg doctors, nurses, therapists) and nonprofessional (eg cleaners, porters, and laundry workers) (ibid 1).

3.55.1 The Guidelines include the following practical recommendations for initiation and administration of PEP:

° PEP is recommended for any high risk exposure.[262] Guidelines on what could be regarded as a high risk exposure include any percutaneous (skin-perforating needle-stick) injury involving -[263]

+ visible blood on the needle;

+ the needle having been used in a vein or artery of the source person; or

+ any deep intra-muscular injury or injection into the body

where -

> the source person has clinical AIDS or a high viral load;

> large volumes of blood or body fluid are involved; or

> there has been prolonged contact with infected blood or body fluid.[264]

In respect of low risk exposures the use of PEP should be assessed by balancing the lower risk of exposure with the uncertain efficacy and toxicity of the drugs.[265] Guidelines on what could be considered low risk exposures include mucosal and skin contacts with possibly infected blood.[266] PEP is not recommended where such contact involved unbroken, healthy skin. However, it recommended that PEP be considered where a small volume of blood or body fluid and brief contact was involved; while PEP is recommended where large volumes of blood or body fluid and/or prolonged contact was involved.[267]

° An attempt should be made, as soon as possible to determine the HIV status of the source person. It is recommended that a reliable rapid HIV test should be used

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262 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 10, 14.

263 Ibid 14.

264 Ibid 11-12.

265 Ibid 11, 12, 14.

266 Ibid 14.

267 Ibid.

(and confirmed by a formal laboratory test thereafter). [268] Testing of the source person should be done in a proper and ethical manner i e with informed consent. If the source person refuses to have his or her blood taken then a medical practitioner caring for the such person should be consulted as to the likelihood of him or her being HIV positive - clinical signs indicating possible HIV infection should then be used as indicative of HIV infection.[269] Using clinical parameters is however far from ideal as many source persons will be in the asymptomatic phase.

- If the source person is HIV positive; or if the rapid HIV test of the source person is positive; or in the absence of this information if the source person is found to have one or more of the clinical signs suggesting HIV infection; or if there is a high index of suspicion that the source person is HIV positive, then PEP is recommended.[270]
- PEP should be initiated promptly, preferably immediately, within one to two

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268 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 9.

269 Clinical signs indicating possible HIV infection include TB infection; signs of immune deficiency such as oral thrush, and/or oral hairy cell leukoplakia on the tongue; recent herpes zoster or molluscum contagiosum infection; Kaposi's sarcoma; recurrent infectious conditions such as diarrhoeal diseases, pneumonia, meningitis, or skin sepsis; or unexplained weight loss, seborrhoeic dermatitis or persistent glandular lymphadenopathy (**Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 9).

270 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 9).

hours after the exposure to HIV.[271]

- The standard drug regimen recommended consists of the administration of a combination of two or more drugs, depending on the seriousness of the risk of exposure to HIV.[272]
- Treatment should be continued for four weeks; and should only be discontinued if there are serious toxicities or intolerance and should be continued even in the presence of mild side effects.[273]
- An ELISA antibody test should be done and documented on the exposed person at baseline (i e within 24 hours of the exposure), at six weeks, 12 weeks and six months. PCR tests are not routinely recommended as their results are not infrequently falsely positive or falsely negative and they are costly.[274]
- If the source person's HIV status is not known, initiation of treatment should be decided upon on a case by case basis, based on the exposure risk and the likelihood of HIV infection in such person. In situations where the availability of resources is not a major consideration, the health care worker should ideally make the final decision as to whether PEP should be initiated.[275]
- In order to avoid delays in starting PEP, "starter packs" (the first 3 days' supply of a 28 day treatment[276]) of PEP drugs should be available in all health care settings for the immediate initiation of PEP whilst steps are being taken to assess the source person's HIV status or in cases where the source person is known to

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271 Ibid 10.

272 Although there are no data to directly support the addition of other antiretroviral drugs to AZT to enhance the effectiveness of the PEP regimen, combination regimens have proved superior to monotherapy regimens in reducing HIV viral load (**CDC Morbidity and Mortality Weekly Report** 15 May 1998 [Internet]). The Department of Health recommends a standard combination of reverse transcriptase inhibitors (eg AZT and 3TC) with a protease inhibitor (eg Indinivir) which could be added for highest risk exposures (**Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 10).

273 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 10.

274 Ibid 11.

275 Ibid.

276 **The Citizen** 27 April 1999. This information was confirmed by Dr Soni, part-time district surgeon from Pietermaritzburg on 17/5/99.

be HIV positive.[277] The cost of a starter pack if supplied by a wholesale distributor to the government would be R194.[278]

- If an HIV test on the source person is negative, it could be assumed that there is an insignificant risk of exposure to HIV (unless there is reasonable information to suggest that the such person is in the window period) and no further prophylactic action is recommended.[279]

3.56 In the United States the Centers for Disease Control (CDC) formally recommends the administration, under certain circumstances, of prophylaxis to health care workers who have been exposed to HIV infected blood or other fluids by needle-stick injury. The CDC in its latest recommendations in this regard dated May 1998 proposes treatment that includes a basic four week regimen of two drugs[280] for most HIV exposures (in respect of which a risk assessment showed the need for prophylaxis), and an expanded regimen including the addition of a protease inhibitor[281] for exposures that pose an increased risk of transmission or where resistance to one or more of the antiretroviral agents recommended is known or suspected.[282] The CDC emphasises that assessments of the risk for infection resulting from the exposure, and of the infectivity of the source person are key determinants of offering PEP. For this purpose HIV testing of a source

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277 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 12. Starter packs would in the instance of rape victims provide victims with valuable time to assess their risk of exposure and to decide whether PEP with its possibility of side effects and toxicity should be initiated (information supplied by Dr WJ Pietersen, Principal Medical Officer, Office of the District Surgeon, Pretoria on 1 July 1998).

278 Information supplied by Dr Clive Evian, consultant to the Department of Health on 18 May 1999. Cf other sources which indicated that it would be in the region of R171 (see fn 260 above).

279 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 12.

280 AZT and Lamivudine (**CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet).

281 Indinavir or Nelfinavir (**CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet).

282 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet).

person should be performed as soon as possible. If the source person, or the serostatus of the source person, is unknown, it is recommended that use of PEP be decided on a case-by-case basis after considering the severity of the exposure and the epidemiologic likelihood that there was indeed exposure to HIV.[283]

3.57 In spite of current practice regarding occupational post exposure prophylaxis, scientists remain bitterly divided on its success rate.[284] There is little information with which to assess the efficacy of PEP in humans.[285] United States CDC studies published in 1995 found that treatment with AZT for occupational exposure decreased the risk of acquiring HIV by approximately 81%.[286] However, critics disputed this figure as probably inflated.[287] The CDC conceded that the limitations of research studies must be considered when reviewing evidence of PEP efficacy, and records that failure of AZT PEP to prevent HIV infection in health care workers has been reported in at least 14 instances.[288] Although there is general agreement that in theory PEP should work, its actual effectiveness is ultimately unprovable: The successes - those who test negative after taking it - may never have been exposed to the virus in the first place.[289] It seems that the only sure factor is that knowledge about the biology of the AIDS virus and about the drugs used for PEP, suggests that early intervention works.[290]

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283 Ibid.

284 Iibid; Dahir **The Body: POZ Gazette** (Internet).

285 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet).

286 Denenberg **The Body: GMHC Treatment Issues** (Internet). It was pointed out that this study did not show that treatment with AZT and other drugs will always prevent an infection - only that treating immediately after an exposure will prevent infection about 81% of the time in persons occupationally exposed to the virus (Sowadsky "A Few Questions From a Student" **The Body** [Internet]).

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

288 **CDC Morbidity and Mortality Weekly Report** 15 May 1998 (Internet).

289 Dahir **The Body: POZ Gazette** (Internet); Henderson 1999 **JAMA** (Internet).

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

+ ***PEP after sexual exposure***

3.58 It should be noted that providing PEP after sexual exposure to HIV would include the possibility of treatment after consensual sex as well as after criminal exposure to HIV eg exposure caused by rape and indecent assault. Although reference is made to PEP after consensual sex by way of background below, this Paper deals only with the issue of PEP after criminal conduct.

3.59 Unlike prophylaxis for occupational exposures, there is no data on the effectiveness of PEP after sexual exposures. Nor are there, as far as we could ascertain, any governmental guidelines on this issue in the comparable legal systems dealt with in Chapter 9 below.[291] Definitive studies on the issue are unlikely because of the large sample sizes required and the ethical obstacles to a placebo-controlled trial.[292] Experts moreover disagree on the viability of administering prophylaxis after sexual exposure to HIV:

° ***Proponents*** of prophylaxis after sexual exposure base their recommendations on evidence that treatment with AZT is associated with a significant decrease in risk for occupational HIV exposure. They submit that although no direct evidence shows that prophylaxis prevents infection after sexual exposure, this is biologically plausible given the efficacy of treatment after percutaneous occupational exposure (skin-perforating needle-stick injury) and the similarities between the immune responses to percutaneous and transmucosal exposures (exposure through a mucosal surface such as the vagina, rectum, or mouth).[293] In the United States,

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291 Cf **CDC Morbidity and Mortality Weekly Report** 25 September 1998 (Internet); Sowadsky "Post-Exposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet). Research did however reveal institutional guidelines eg the Guideline of the American Medical Association (which eg states that although there are no proven prophylactic intervention for HIV infection, patients may wish to discuss their concerns and desires regarding such treatment with their physician) (**AMA Sexual Assault Guideline Resources** [Internet]) and those referred to in par 3.61 below.

292 Gostin et al 1994 **JAMA** 1438; **CDC Morbidity and Mortality Weekly Report** 25 September 1998 (Internet); Lurie et al 1998 **JAMA** (Internet); Torres 1998 **GMHC Treatment Issues** (Internet).

293 Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; Dahir **The Body: POZ Gazette** (Internet); Lurie et al 1998 **JAM** (Internet). See par 3.55.1 above for instances in which mucosal occupational exposure may justify the administration of PEP.

for instance, certain researchers recommend routine post exposure prophylaxis 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 after that used for occupational exposures, with similar base-line HIV testing, follow-up care and surveillance for HIV infection.[294] 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%.[295] 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 methods.[296]

° ***Opponents*** to prophylaxis after sexual exposure submit that there are too many factors differentiating transmission after needle-stick exposure from transmission during sexual intercourse to recommend treatment in instances of sexual exposure on the basis of the CDC studies in respect of occupational exposure: These include host factors (genetics, the type of membrane exposed to HIV, the presence of other sexually transmitted 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).[297] Moreover, as indicated

294 Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq.

295 Ibid.

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

297 Torres 1998 **GMHC Treatment Issues** (Internet); Sowadsky "Post-Exposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet). Cf also Gostin et al 1994 **JAMA** 1438 for issues to be considered in risk assessment for nonoccupational PEP. International experts, for instance, recently 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

above in respect of occupational exposure, PEP has serious implications for an individual's short and long term health.[298]

3.60 The United States CDC in September 1998 published a report on management of possible sexual or other nonoccupational exposure to HIV to address concerns in this regard.[299] 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 recommendations for or against the use of post exposure prophylaxis for sexual exposure.[300] 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) against the uncertain effectiveness, potential toxicities and cost of drugs, as well as the patient's anticipated adherence to the therapy.[301] It was firmly stated that post exposure prophylaxis 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.[302]

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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).

298 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 3.53 above.

299 **CDC Morbidity and Mortality Weekly Report** 25 September 1998 (Internet).

300 Ibid.

301 Ibid.

302 Ibid.

3.61 In some countries, on the basis that prophylaxis 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 prophylaxis in cases of sexual assault throughout the United States and Canada.[303] 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.[304]

3.62 As regards the cost-effectiveness of PEP after sexual exposure, the CDC in its 1998 report (referred to in paragraph 3.60 above), stated that uncertainties about key factors make it difficult to estimate the cost-effectiveness of treating non-occupational 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

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303 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. It is reported that of the 28 women started on the treatment only two completed the regimen (neither has tested HIV positive). The physician in charge of this programme conceded that in most rape cases, the victim is just as ignorant of her rapist's HIV status (and thus the likelihood of exposure) as someone who has an unsafe one-night stand with a stranger. But she believes that the two risks yield different PEP policies: "The difference is that the one case is the result of a consensual act, while the rape is the result of a crime"(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]). In Canada, the British Columbia Centre for Excellency in HIV/AIDS has published *A Guideline for Accidental Exposure to HIV*, which recommends antiretroviral agents for rape victims. To allow PEP to be initiated quickly, a free "starter kit" of five days of therapy with ZDV (AZT) and lamivudine (3TC) is provided to emergency rooms where specialised teams care for the victims of sexual assault, or to physicians upon request (**CDC Morbidity and Mortality Weekly Report** 25 September 1998 [Internet]).

304 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 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]). See also par 3.56 above for the standard drug regime in the case of occupational exposure in the United States.

positive.[305] 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.[306]

3.63 South Africa has no official guidelines on PEP after sexual exposure and victims of crime are not supplied with PEP at government cost.[307] Apparently some District Surgeons (who are responsible for medical examination of victims of sexual crimes for evidentiary purposes)[308] offer information to victims on the need for PEP and on its availability in private facilities. Victims who can afford it then approach such facilities for prophylaxis at their own cost.[309] After considerable public outcry in the wake of prominent incidents of rape and gang rape in the past 18 months and the alarming increase of HIV infection in the population, continuous pressure is being exerted on the government to provide prophylaxis to rape victims at state cost.[310] In response Government indicated at the end of May 1999 that it has initiated controlled research into prophylaxis after sexual exposure.[311] This is a world first, as any existing protocols on PEP after sexual exposure are currently based on research regarding PEP after occupational exposure.[312]

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305 **CDC Morbidity and Mortality Weekly Report** 25 September 1998 (Internet).

306 Ibid. See also Katz and Gerberding 1998 **Annals of Internal Medicine** (Internet) stating that post exposure treatment has been shown to be cost effective.

307 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 May 1999).

308 See par 3.43-3.44.

309 Information supplied by Dr WJ Pietersen, District Surgeon Pretoria on 29 April 1998.

310 **Beeld** 29 April 1998. (It is not clear whether the appeal is made in respect of starter packs only or for the complete treatment. It was indicated in par 3.55 above that the cost of a starter pack, supplied by a wholesale distributor to government would be about R194.)

311 **Beeld** 21 and 24 May 1999. Information confirmed by Dr Nono Simelela, Director HIV/AIDS/STDs, Department of Health on 21 June 1999.

312 See par 3.59.

4 DEFINING THE PROBLEM

4.1 Rape and indecent assault are ways in which HIV is transmitted. As a result of the concerns of victims[313] who wish to establish whether they have been exposed to or infected with HIV during sexual offences, the Commission has been tasked with investigating the possibility of enacting legislation for the compulsory HIV testing of persons arrested for having committed sexual offences[314] to relay the results to victims. This Chapter defines the problem in a legal context.

4.2 As was the case with the Commission's enquiry regarding the related issue of the creation of a specific offence to address harmful HIV-related behaviour,[315] the question first arises whether the South African law currently has available measures to deal with compulsory HIV testing of arrested persons and the disclosure of HIV related information to victims of crime.

4.3 There is at present no specific statutory provision in South African law expressly providing for compulsory HIV testing of the arrested person. There is also no provision for disclosure of an arrested person's HIV status to victims of crime. However, current public health and criminal procedure measures exist dealing respectively with compulsory medical examination (which would include HIV testing) in the public health context, and ascertaining of bodily features of an arrested person in the criminal context.

4.3.1 Some argue that any instance involving a possible infection with HIV is first and foremost a public health issue and that its implications which are not criminally related should not be dealt with by the criminal law and procedure but rather by ***public health measures***.[316]

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313 See par 2.3 et seq above. These concerns are also expanded on in the arguments submitted for and against compulsory HIV testing of arrested persons in Chapter 8 below.

314 See the definition of "sexual offence" for purposes of this Paper in par 2.18 above.

315 See **SALC Discussion Paper 80** par 3.2 et seq.

316 Similar arguments are raised in respect of the criminalisation of HIV transmission (**SALC Discussion Paper 80** par 3.2.1 et seq).

The Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 (the 1987 Regulations)[317] issued by the Minister of Health (and proposed Draft Regulations of 1993 to replace these) contain measures which may be suitable.

4.3.2 The ***Criminal Procedure Act 51 of 1977*** (the Criminal Procedure Act) in section 37 provides the South African Police Services with certain powers to ascertain the bodily features of arrested persons, including the taking of a blood sample.[318] However, first the constitutionality of the measures in section 37 will have to be ascertained; and second, section 37 does not provide for the disclosure of information gained to victims of crime. Its purpose is evidentiary only.

4.4 Questions which need to be explored are:

- Whether current public health measures are adequate for compulsory HIV testing and disclosure of AIDS related information in the criminal context (and if so whether this would be constitutional?);
- Whether section 37 of the Criminal Procedure Act can indeed be used for compulsory HIV testing of the arrested person; whether such utilisation would be constitutional; and whether section 37 could also be used for other than evidentiary purposes, such as disclosure to victims.
- Whether disclosure of HIV test results to victims of crime is justified; and hence whether section 37 of the Criminal Procedure Act could be applied or whether it needs to be amended (or other provisions of public health or criminal procedure enacted) to provide for compulsory HIV testing and disclosure.
- Whether the common law notion of "necessity" may provide for the disclosure of an arrested person's HIV status to a victim.

4.5 These issues are debated in the following chapters against the background of the current law with regard to consent for medical treatment (which would include HIV testing) and confidentiality of medical information. The discussions below include an overview of

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

318 Criminal Procedure Act sec 37(2).

relevant international legal and policy provisions.

5 CURRENT LEGAL POSITION REGARDING CONSENT FOR MEDICAL TREATMENT (HIV TESTING) AND CONFIDENTIALITY OF MEDICAL INFORMATION

5.1 Any law reform proposals for compulsory HIV testing of arrested persons and the disclosure of HIV status, will by necessity involve an understanding of the general principles of informed consent for medical treatment, and confidentiality regarding medical information (including information regarding the result of an HIV test).

A) CONSENT FOR MEDICAL TREATMENT (INCLUDING HIV TESTING)

5.2 The current legal position with regard to consent for medical treatment, is that every person has the right to privacy and bodily integrity, in terms of both the 1996 Constitution[319] and our common law.[320] This means that a patient must consent to all forms of medical treatment (including the drawing of blood), and has the right to refuse medical treatment.[321] Only limited exceptions exist to this general rule of consent before any medical procedure. For example in an emergency, where treatment is necessary for the patient's survival but he or she is not able to give consent, or where a statutory duty requires a person to submit him or herself to medical treatment.[322] The leading case regarding consent for medical intervention is **Stoffberg v Elliot**[323] where Watermeyer J held that -

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319 The 1996 Constitution sec 14 and s 12(1).

320 In terms of the common law every person has *personality rights* such as the right to dignity, autonomy and bodily integrity (**Stoffberg v Elliot** 1923 CPD 148; **Lymbery v Jefferies** 1925 AD 235; **Lampert v Hefer** 1955 (2) SA 507 (A); **Esterhuizen v Administrator Transvaal** 1957 (3) SA 710 (T)).

321 Strauss 9-10, and 19-20. See also **Castell v De Greef** 1994 4 SA 408 (C) at 420I-J.

322 See eg the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions (GN R 2438 of 1987 in **GG** 11014 of 30 October 1987). See also par 5.15 below.

323 1923 CPD 148.

> (I)n the eyes of the law, every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract, but they are rights to be respected, and one of the rights is absolute security to the person. Nobody can interfere in any way with the person of another, except in certain circumstances ... Any bodily interference with or restraint to a man's person which is not justified in law, or excused in law or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.[324]

5.3 Furthermore, there can as a general rule be no question of legal consent unless the person who gives the consent is fully informed and understands what he or she is consenting to.[325] This has become known as the principle of informed consent which was confirmed in the case of **Castell v De Greef** .[326] In this case the court accepted the principle that consent to treatment is vitiated if the patient is given inadequate information on the medical intervention to be performed.[327] The application of this principle is consistent with an increasing emphasis in medico-legal fields on patient autonomy.[328]

5.4 It follows that to take a patient's blood without consent may amount to an invasion of the right to bodily integrity which could result in a medical practitioner being prosecuted for assault or crimen injuria,through the criminal courts or held liable in a civil action for damages.[329]

5.5 In applying the general rule of informed consent to medical treatment to the taking of blood samples for HIV testing, it was held in **C v Minister of Correctional Services**[330] that -

> ... there can only be consent if the person appreciates and understands what the object and purpose of the test is, what an HIV positive test result entails and

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324 Ibid at 148.

325 Strauss 8 - 9.

326 1994 (4) SA 408.

327 Ibid at 426H.

328 Strauss 8; Van Oosten 69.

329 Strauss 3; Van Wyk 130.

330 1996 (4) SA 292 (T) at 301.

> what the probability of AIDS occurring thereafter is. Evidence was led in this case on the need for informed consent before the HIV test is performed. Members of the medical profession and others who have studied and worked with people who have tested HIV positive and with AIDS sufferers have developed a norm or recommended minimum requirement necessary for informed consent in respect of a person who may undergo such a blood test. Because of the devastation which a positive test result entails, the norm so developed contains as a requirement counselling both pre- and post-testing, the latter in the event of a positive test result.

5.6 Ethical guidelines for medical practitioners on HIV testing endorse the concept of informed consent for HIV testing, and set out clearly what a medical practitioner must do to obtain such consent.[331] The Guidelines state that:

> The patient should, whenever possible, clearly understand what advantages or disadvantages testing may hold for him, why the doctor wants this information, and what influence the result of such a test may have on his treatment. The counselling procedure should be one that is appropriate to the setting and is the least burdensome to the person being tested, as well as to those responsible for testing.[332]

These Guidelines at the very least create an ethical duty (and probably a legal duty)[333]to obtain the informed consent of the individual through pre-test counselling as outlined above.

5.7 Consent for medical treatment (i e HIV testing) must be obtained from someone who is able in law to give it. Any adult who has legal capacity may consent to HIV testing.[334] Those who do not have this capacity, such as those who are mentally ill or unconscious,

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331 **Health Professions Council of South Africa Guidelines on HIV/AIDS 1994** 4(formerly known as the **South African Medical and Dental Council Guidelines** 1994); **SA Medical Association HIV/AIDS Ethical Guidelines 1998** 5.

332 **SA Medical Association HIV/AIDS Ethical Guidelines 1998** 5. The **Health Professions Council of South Africa Guidelines on HIV/AIDS 1994** contain a similar provision at 4.

333 Cf **Jansen van Vuuren and Another NNO v Kruger** 1993 4 SA 842(A) at 854, where directives contained in the Health Professions Council of South Africa Guidelines (in casu, the 1989 Guidelines) were taken into account in ascertaining the legal position. Cf also Taitz 1992 **SAJHR** 585; **C v Minister of Correctional Services** 1996 (4) SA 292 (T). In terms of similar guidelines of the South African Medical Association, similar requirements are set out (**SA Medical Association HIV/AIDS Ethical Guidelines 1998** 5-6).

334 Strauss 4.

must be assisted by another person.[335]

5.7.1 Consent for HIV testing of mentally ill patients must be given by any of the following persons in the following prescribed order: their curator appointed by the court; or a spouse, parent, major child, brother or sister. If the patient is in an institution the medical superintendent of that institution may consent on the patient's behalf if there are no such relatives as referred to, or if they cannot be found, and the life of the patient is being endangered or is being seriously threatened, and his or her condition necessitates the testing.[336]

5.7.2 Where a patient is unconscious, treatment may be provided if: A real state of emergency exists; the patient is unaware or unable to appreciate the situation; the treatment (i e testing) is not against his or her express will; and the treatment is provided with the patient's best interests in mind.[337] In such circumstances the medical practitioner treating the patient consents on the latter's behalf.

5.7.3 Children do not have the legal capacity to consent to treatment on their own. In terms of the Child Care Act[338] a child above the age of 14[339] years may consent to any form of medical treatment (except an operation), which arguably includes an HIV test. In the case of children below the age of 14 years, the parent or guardian of the child must consent to the medical treatment on the child's behalf. Section 39 of the Child Care Act provides for situations where the child needs treatment and the parent or guardian of such child either refuses to give their consent, cannot be found, is mentally ill, or is dead. In such instances the medical practitioner must approach the Minister of Welfare, or an official in that Department, for permission to treat the child.[340] In an emergency situation the

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335 Ibid; Van Wyk 134-137.

336 Mental Health Act 18 of 1973 sec 60A.

337 Strauss 93.

338 Act 74 of 1983 sec 39.

339 Ibid.

340 Ibid sec 39(1). It is submitted that if a parent or guardian is not available to consent for HIV testing of a child younger than 14, this section of the Act would have to be invoked.

medical superintendent of a hospital may consent to treatment provided that such treatment is necessary to preserve the life of the child or to save him or her from lasting physical injury.[341] The position in the Child Care Act does not detract from the rule that the High Court as the upper guardian of all minors may be approached to give consent to medical treatment on behalf of a minor.[342]

5.8 It is indicated above that a person must consent to all forms of medical treatment (including HIV testing) for it to be legal. It follows that taking an arrested person's blood without his or her consent may amount to an invasion of his or her right to bodily integrity which could result in a medical practitioner being prosecuted for assault or crimen iniuria. Some argue that HIV testing of arrested persons may be justified on the ground of necessity under certain circumstances.

5.8.1 The common law defence of necessity is available as a general defence to criminal liability and its rationale is essentially utilitarian: it is considered desirable, on grounds of social and legal policy, to allow a person who is faced with a choice of evils (i e testing the arrested person without consent, or endangering the victim's and others' health by not attempting to ascertain the arrested person's HIV status), to choose the lesser evil in order to avoid a greater evil.[343]

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341 Act 74 of 1983 sec 39(2).

342 Strauss 6.

343 Milton 85; Snyman 121-122.

5.8.2 For non-consensual HIV testing of the arrested person by a medical practitioner to be justified as an act of necessity a legal interest of the victim of a sexual offence (or others)[344] must have been endangered by a threat which had commenced or was imminent but which was not caused by the victim's fault; testing must have been necessary to avert the danger; and the means used for this purpose must have been reasonable in the circumstances.[345] Tested against these requirements it is submitted that compelled testing of the arrested persons would not be justified as an act in necessity: Although the threat which HIV infection holds for the lives and health of the victim and others commenced with an act of rape or indecent assault, and although testing may not seem unreasonable under these circumstances, it could not be said that testing the arrested person for HIV will avert the danger to the victim's (and others') lives and health. It is indicated in paragraph 8.14-8.14.4 below that testing the arrested person cannot ensure that the victim's life is saved, although it may arguably assist in alleviating his or her psychological stress brought about by the rape or indecent assault.[346]

5.9 At a policy level the South African Law Commission in its *First Interim Report on Aspects of the Law relating to AIDS* recommended that the Department of Health adopt a national policy on HIV testing and informed consent based on the current legal position.

5.9.1 It was recommended that the proposed policy include a provision that HIV testing may be done only in the following five circumstances:

With informed consent :

- Upon individual request for diagnostic or treatment purposes.
- On a clinical recommendation from a doctor.

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344 The interest of a third party can also justify necessity (Milton 104; Snyman 124).

345 Milton 87.

346 See par 8.13 below.

Without informed consent:

- As part of anonymous and unlinked testing for epidemiological purposes.
- Where statutory provision or other legal authorisation exists for testing without informed consent.
- On an existing blood sample, if following an occupational accident an emergency situation exists which necessitates obtaining information on the patient's HIV status.[347]

5.9.2 The draft policy further recommends that all HIV testing should be carried out with pre-test counselling. To date the Department of Health has not promulgated a national policy on HIV testing and informed consent.[348]

B) CONFIDENTIALITY AND DISCLOSURE

5.10 Every human being is entitled to the right to privacy. This right protects personal information about the person from others. It is up to the individual to decide on the content and extent of his or her interest in his or her own privacy. In our law this principle is both part of our common law and enshrined in our constitution as a fundamental human right.[349]

5.11 People with HIV or AIDS are entitled to privacy regarding their medical condition. In limited circumstances disclosure of a person's HIV status to a third party is authorised in law or in terms of ethical guidelines.[350]

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347 SALC **First Interim Report on Aspects of the Law relating to AIDS** 50 - 51.

348 See par 1.2.1 above.

349 Neethling 31 et seq; the 1996 Constitution sec 14.

350 See par 5.21 below.

5.12 Breaches of privacy without justification or consent could lead to an action for damages against the person who disclosed the information.[351]

5.13 Neither the constitutional right nor the common law right to privacy is absolute. Limitations therefore may be justified in certain circumstances where the limitation is reasonable and justifiable.[352]

* Limitations on the right to privacy

5.14 In general, disclosure of private information can be justified if the individual gives his or her informed consent thereto;[353] if legislation requires that the information be disclosed;[354] if a person is ordered by a court to disclose the information;[355] or if the disclosure would be in the public interest or would save the life or limb of a third party.[356] These are discussed below.

+ *Legislation authorises disclosure of medical information relating to HIV/AIDS*

5.15 Currently in South Africa limited legislative provision exists which authorise disclosure of otherwise confidential medical information to third parties. Relevant examples of such

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351 Neethling 268 et seq.

352 Van Wyk AH 1991 **Stell LR** 46; cf also Strauss **Huldigingsbundel vir WA Joubert** 145; Van Wyk 386 - 388; **Jansen van Vuuren v Kruger** 1993 4 SA 842 (A); cf the limitation clause, sec 36 of the 1996 Constitution.

353 The same requirements in respect of the capacity to consent to medical treatment would also apply to consent to disclose medical information (see par 5.7-5.7.3 above).

354 Provided this legislation conforms to the provisions of sec 36 of the 1996 Constitution.

355 Strauss 103.

356 See **SALC Third Interim Report** par 3.23 for a discussion.

legislation which may be applicable to the disclosure of HIV status are the 1987 Regulations and the Criminal Procedure Act.

5.16 Public health legislation in the form of the 1987 Regulations referred to in Chapter 6 below authorises disclosure of HIV related information to health authorities for epidemiological purposes under certain circumstances. These instances are discussed fully in par 6.9 below. In April 1999 the Department of Health published draft amendments to these Regulations providing for the notification of AIDS disease and AIDS death.[357] Draft regulations 19(1) - (4) provide as follows:

> 19(1) When a medical practitioner, a practitioner registered as such under the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act No 63 of 1982), or any other person legally competent to diagnose and treat a person with regard to notifiable medical conditions, diagnoses a notifiable medical condition in a person, he or she shall report his or her findings -
>
> (a) in cases where the condition concerned is also a communicable disease, without delay orally, and this must be confirmed in writing within 24 hours.[358]...
>
> (2) In cases where the medical condition diagnosed as contemplated in subregulation (1) is the acquired immuno deficiency syndrome (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 acquired immuno deficiency syndrome (AIDS) death, the persons responsible for the preparation of the body of such person.
>
> (3) On making a report referred to in subregulation 1(a)... with regard to acquired immuno deficiency syndrome (AIDS), 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.

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357 Notice No R485 of 23 April 1999, Regulation Gazette 6496 in **GG** 19946 of 23 April 1999. See also par 6.14 below.

358 The wide definition of "communicable disease" in sec 1 of the Health Act 63 of 1977 clearly encompasses HIV infection and AIDS. A "communicable disease" is defined in this section as "any disease which can be communicated directly or indirectly from any animal or through any agent to any person or from any person suffering therefrom or who is a carrier thereof to any other person".

> (4) The local authority concerned shall forward, weekly via the regional director, particulars of all reports referred to in subregulation (1)(a)... in respect of the preceding week to the Director-General on a form drawn up and made available by the Department of Health.

5.16.1 It is clear that these proposed amendments do not provide for victims of sex crimes to be informed of the HIV status of their attacker.

5.17 The Criminal Procedure Act 55 of 1977 in section 37 provides for the taking of a blood sample to ascertain the bodily features of an arrested person, including a characteristic, distinguishing feature or condition of the arrested person's body. The purpose of this provision is to facilitate the collection of evidence for criminal trials.[359] As indicated in chapter 7 below, disclosure of medical information for other purposes is not provided for.

+ ***Disclosure of medical information authorised by Court***

5.18 Strauss states that medical information is not subject to professional privilege. Therefore a medical practitioner may be subpoenaed to give evidence in a court of law. As providing such information is in breach of their professional ethics, he or she may object to being requested to provide the information. The presiding officer may, despite the objection, direct the medical practitioner to provide the information. Failure to answer questions may result in the medical practitioner being in contempt of court.[360]

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359 See Chapter 7 below.

360 Strauss 103.

+ *Disclosure of medical information in the public interest*

5.19 The state generally protects or maintains public interest by placing conditions or restrictions on certain rights and freedoms in the public interest.[361] These restrictions are justified on the grounds of the statutory or official capacity of the state.[362]Although there could be instances where disclosure of medical information in general could be in the public interest it is unlikely that such situations would arise ordinarily, in the light of the specific modes whereby HIV is transmitted.

5.20 However particular third parties whose interests could be affected may for instance be sexual partners, health care workers, and victims of rape or sexual crimes who are exposed to the body fluids or blood of the infected person. In such instances it may be argued that the disclosure to that person of the otherwise confidential HIV related information is in the public interest.

5.21 Medical practitioners, by virtue of their relationship with patients, are in the possession of confidential information. Some argue that in certain circumstances this information should be disclosed, in the public interest. However, legally or ethically, medical practitioners who have confidential information regarding the HIV status of a person may not disclose this information without acting in accordance with the law or accepted ethical guidelines.

5.21.1 The general ethical rule regarding confidentiality is described by the Health Professions Council of South Africa (formerly the South African Medical and Dental Council) as:[363]

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361 Neethling et seq 266.

362 Ibid.

363 Our courts have held that patients are entitled to expect that their medical practitioner will act in accordance with ethical codes (**Jansen van Vuuren v Kruger** 1993 4 SA 842 (A) at 856 E-F).

> (no practitioner may) divulge verbally or in writing any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient or, in the case of a minor, with the express consent of his guardian, or in the case of a deceased patient, with the consent of his next of kin or the executor of his estate. [364]

5.22 Any medical practitioner who does not act in accordance with these guidelines would be infringing a patient's rights and may be found liable in a civil court to pay delictual damages.[365] The legal position regarding patient confidentiality is that our courts recognise the right to confidentiality or privacy as a common law personality right. [366] The Supreme Court of Appeals in **Jansen van Vuuren and Another NNO v Kruger** (the locus classicus with regard to protection of privacy in the HIV/AIDS context), held that a doctor acted unlawfully when he informed two other doctors on the golf course of a patient's HIV status. In the Jansen van Vuuren case the court did however hold that in determining whether or not the confidential relationship could be breached the conflicting interests would have to be balanced :

> ... the right of a patient and the duty of a doctor are not absolute but relative. One is, as always weighing up the conflicting interests ... a doctor may be justified in disclosing his knowledge where his obligation to society would be of greater weight than his obligation to the individual.[367]

5.23 In order to provide some guidance on how such a balancing should occur the Health Professions Council of South Africa in its 1994 Guidelines on HIV/AIDS proposes that the following three steps should be taken before any breach of confidentiality:

- Careful consideration of why a breach of confidentiality may be necessary;
- a full explanation to the patient and an attempt to obtain his or her consent for the disclosure; and

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364 Rule 16 of the Health Professions Council of South Africa's **Rules of Practice** as quoted in Strauss 454.

365 **Esterhuizen v Administrator Transvaal** 1957 3 SA 710 (T). See also Strauss 31.

366 Hassan (Unpublished).

367 **Jansen van Vuuren v Kruger** at 850 E - H. For a detailed discussion of this case see Van Wyk 1994 **THRHR** 141 et seq.

° full acceptance of responsibility for the implications of a breach of confidentiality.[368]

5.24 In its 1998 Guidelines, containing similar principles, the South African Medical Association enunciated these principles on a practical level as follows:[369]

> Doctors should use their discretion whether or not to discuss confidentially a patient's serostatus with any other HCW (health care worker) who is at risk of infection from the patient. It is essential to attempt to obtain the patient's free and informed consent to this disclosure, but exceptional circumstances may necessitate that the other HCW be informed without the patient's consent.
>
> Doctors may divulge information on the serostatus of a patient to other HCWs without the patient's consent only when all of the following circumstances pertain:
> 1. An identifiable HCW or team is at risk.
> 2. The doctor is not certain what universal precautions[370] are being applied.
> 3. The doctor has informed the patient that under the circumstances the is obliged to inform the other HCWs involved.
>
> The HCW or team thus informed is duty bound to maintain confidentiality.
>
> Where such information may affect the treatment of the patient in that patient's own best interest, the doctor should be duty bound confidentially to discuss the patient's serostatus with all members of the health care team administering such treatment, but only with the patient's consent.
>
> Doctors should use their discretion whether or not to ensure that third parties who are at risk of infection, particularly known sex partners of an HIV-positive patient, are made aware of the situation. This should preferably be done by the patient, or with the consent and participation of the patient. If the patient withholds co-operation, this may be done directly and without the patient's consent. However, the risk to a third party would have to be grave and clearly defined before such a breach of confidentiality could be justified.
>
> Doctors may divulge information on the serostatus of a patient to third parties without the patient's consent only when all of the following circumstances pertain:

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368 **Health Professions Council of South Africa HIV/AIDS Ethical Guidelines 1994** at 5.

369 **South African Medical Association HIV/AIDS Guidelines 1998** 8-10.

370 "Universal precautions" refers to the concept used world-wide in the context of HIV/AIDS to indicate standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission from one person to another and includes instructions concerning basic hygiene and the wearing of protective clothing such a rubber gloves (cf **SALC Third Interim Report on Aspects of the Law Relating to AIDS** 203).

1. An identifiable third party is at risk.
2. The patient, after appropriate counselling, does not personally inform the third party.
3. The doctor has made every reasonable effort to inform the patient that, under the circumstances, he intends breaking confidentiality.

Where the patient has a known sexual partner, every effort should be made to encourage shared counselling, at both the pre- and post-test phase.

In general no doctor may transmit confidential information on his patient to any third party without the consent of the patient or, in the case of a deceased patient, without the written consent of his next of kin or the executor of his estate

5.24.1 It is clear that these Guidelines do not provide for victims of crime to be informed of the HIV status of their attackers.

C) CONCLUSION

5.25 The general legal principles are that when a person is tested for HIV and when a disclosure is made regarding his or her HIV status, the informed consent of the person affected must be obtained. Although exceptions exist to these general principles, they are limited to situations where legislation authorises them, where a court has the power to order such an invasion, and where it would be in the public interest.

6 DEALING WITH COMPULSORY HIV TESTING AND DISCLOSURE OF TEST RESULTS THROUGH EXISTING PUBLIC HEALTH MEASURES

6.1 As indicated in the Chapter 4 above, some argue that HIV/AIDS is first and foremost a public health issue and that its implications which are not criminally related should not be dealt with by the criminal law and procedure but rather by public health measures.

6.2 To this end the Government's current public health response to the epidemic, and existing relevant public health measures which allow for HIV testing without consent are set out below.

A) THE GOVERNMENT'S CURRENT PUBLIC HEALTH RESPONSE TO THE HIV/AIDS EPIDEMIC[371]

6.3 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.[372] The National Programme is assisted by the Government AIDS Action Programme (GAAP)[373] and nine Provincial AIDS Programmes (based within the

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371 Information for this section was supplied by Ms Ann Strode (project committee member with the assistance of Dr N Simelela, Director HIV/AIDS and STDs, Department of Health.

372 The Programme's mission statement is "to reduce the transmission of sexually transmitted 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 (Department of Health Directorate HIV/AIDS and STDs Operational Plan, April l998). In order to concretise the Government's commitment to HIV/AIDS issues, the National Programme, although situated within the Department of Health, was in 1995 elevated to the level of a RDP (Reconstruction and Development Programme) presidential lead project. Furthermore, the existing HIV/AIDS budget has been supplemented with both additional departmental and donor funds.

373 GAAP is aimed at expanding the Department of Health's National AIDS Programme beyond the Department to other government departments and all sectors of society.

provinces' respective health departments) which are primarily responsible for the implementation of the national HIV/AIDS policy. In addition, the National Programme works closely with 15 ATICCS (AIDS Training, Information and Counselling Centres, located within local Government AIDS programmes) and with numerous non-governmental organisations and community-based organisations.

6.4 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.[374] 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.[375]

6.5 The Department of Health has adopted four major goals to guide the National AIDS Programme until the year 2000. These include reducing HIV and STD prevalence; monitoring the HIV/AIDS epidemic; reducing the impact of HIV/AIDS at the personal, family and community level; and protecting the rights of persons living with HIV/AIDS. Currently these goals have led to the following implementation programmes:

- Mobilising every sector of the community to respond to the epidemic.[376]
- Initiating the full involvement of all sectors of society in the development and implementation of the National AIDS Programme.
- Involving persons living with HIV/AIDS in every aspect of the Government's HIV/AIDS response.
- Developing a life skills programme targeted at youth.

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

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

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

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

6.6 In 1997 the Department of Health undertook a National Review of all its HIV/AIDS activities in an attempt to determine the impact its AIDS Programme was having on the spread of the epidemic. The Review established that the Department needed to focus on six key issues when addressing the epidemic: the need for political and public leadership; the importance of strengthening inter-departmental and inter-sectoral responses to the epidemic; developing the capacity of communities to respond; strengthening collaboration between HIV and TB programmes; involving persons living with HIV/AIDS meaningfully in all interventions and protecting their human rights; and countering discrimination and reducing stigmatisation associated with HIV/AIDS.[377] In response to the Review findings, an Inter-Departmental Committee on HIV/AIDS was set up by the Department in 1997. The Committee is representative of all Government departments and it aims at ensuring that the responsibility for combatting the epidemic does not fall on the shoulders of the Department of Health alone. Furthermore, an Inter-Ministerial Committee on

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377 Relevant to the current investigation the Report notes:

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

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

6.7 With regard to the Law Commission's current investigation the following general statements from the NACOSA Plan can be noted:[378] "HIV testing without informed consent constitutes an injurious and actionable invasion of a person's personal rights". However, it was also stated that it should be ensured that "women are enabled through respect for their autonomy and human rights to take appropriate protective action against exposure to HIV.[379] The following two implementation programmes forming part of the National AIDS Programme's current goals are also relevant: Educating and empowering women so as to enable them to exercise sexual autonomy; and ensuring that the rights of persons with HIV/AIDS are protected.[380]

6.8 In summary the Government's response to the AIDS epidemic is based upon public health principles which rely on voluntary participation and behaviour change.[381] Coercive measures have not been part of the National AIDS Programme's response to the epidemic.[382] With the recent publication for public comment of draft regulations providing for the compulsory notification of AIDS,[383] it appears that the government may be moving towards a more coercive approach. However, it is not clear at this stage whether this is part of a national policy change or not.[384]

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378 The NACOSA National AIDS Plan did not specifically address the issues in question.

379 **NACOSA National AIDS Plan 1994-1995** 47-48.

380 See par 6.5 above.

381 This has been confirmed by Dr N Simelela, Director HIV/AIDS and STDs, Department of Health on 21/5/99. Cf also the Department's goals and implementation programmes referred to in par 6.5 above.

382 Ibid.

383 Notice No R485 of 23 April 1999, Regulation Gazette 6496 in **GG** 19946 of 23 April 1999.

384 The Department of Health indicated that this step has been necessitated by the severity of the AIDS epidemic in South Africa and that it will enable the government to more accurately plan resource

B) EXISTING PUBLIC HEALTH REGULATIONS

6.9 The Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 (the 1987 Regulations)[385] issued by the Minister of Health in terms of sections 32, 33 and 34 of the Health Act 63 of 1977 (the Health Act) contain measures for medical examination (which would include HIV testing) without consent under certain circumstances:

* ***Any person*** may be tested for HIV without his or her consent under the following circumstances: A medical officer of health or a medical practitioner in the employ of the State[386] may, at his discretion, in order to prevent the spread of a communicable disease [387] referred to in Annexure 1 to the Regulations (i e AIDS) or in order to control or restrict AIDS, medically examine any person or have any person examined (i e tested for HIV). The medical officer or medical practitioner must immediately after such action give a full account of the circumstances to the local authority concerned, or to the relevant regional director or the Director-General of the Department of Health. (Regulation 6(1)(b) and (2).) Under these

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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 is supported by Cabinet and by the Inter Ministerial Committee on AIDS (Media Release by the Department of Health 23 April 1999; see also **Beeld** 19 April 1999; **Pretoria News** 22 April 1999). For more detail on the proposed Regulations see par 6.14 below.

385 G N R 2438 in **GG** 11014 of 30 October 1987.

386 Which would include a district surgeon (cf sec 14(f) of the Health Act 63 of 1977 and par 3.43 above).

387 The 1987 Regulations are applicable to persons with "communicable diseases". The wide definition of "communicable disease" in sec 1 of the Health Act (a disease that "can be communicated directly or indirectly ... through any agent to any person or from any person suffering therefrom or who is a carrier thereof to any other person") clearly encompasses HIV infection and AIDS. However, the Regulations also provide for certain specific measures in respect of communicable diseases referred to in Annexure 1 to the Regulations. The Annexure expressly lists "AIDS" (but not HIV).

provisions HIV testing of arrested persons could conceivably be included. There is however no provision for disclosure of the test results to victims of crime.

* ***Any person suspected to have HIV*** may be tested for HIV without his or her consent under the following circumstances: If a medical officer of health suspects on reasonable grounds that a person is a carrier of a communicable disease (i e has HIV[388]) and who as such constitutes a danger to the public health, such person could be instructed to subject him or herself to a medical examination (i e HIV testing) in order to establish whether he or she has HIV. If an instruction for testing has been issued under this regulation, the medical officer of health is obliged to, without delay, submit a report on his actions to the regional director of Health in the region in which the person with HIV finds him or herself (Regulation 14(1) and 14(5).) Also under these provisions HIV testing of arrested persons may arguably be included. Again, these provisions contain no authorisation for disclosure of the test results to victims of crime.

* ***Any person with or suspected to have AIDS*** could be tested for HIV without his or her consent under the following circumstances: Any person who in the opinion of a medical officer of health is suffering or could be suffering from a communicable disease referred to in Annexure 1 to the Regulations (i e has AIDS or could have AIDS[389]), must if so instructed by such officer subject him or herself to a medical examination (i e HIV testing) and treatment as prescribed by the person undertaking the examination. The decision to give such instruction is in the discretion of the medical officer of health. (Regulation 17(a).) Some may argue that under this provision an arrested person could be tested for HIV without

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

389 See the previous footnote for the distinction between "sufferer" and "carrier".

his or her consent. There is however no provision for disclosure of the test results to victims of crime.

6.10 Although the 1987 Regulations conceivably provide for testing of arrested persons, they do not provide for the disclosure of HIV-related information to third parties other than the health authorities.[390]

6.11 The 1987 Regulations have apparently never been applied in respect of HIV or AIDS and have been criticised in that many of the provisions contained in the Regulations are inappropriate to HIV/AIDS.[391] The criticism was not aimed expressly at the testing provisions referred to above but at other provisions relating to, amongst others, isolation of persons with HIV or AIDS, and prevention of persons suspected to have AIDS to handle or prepare food.[392] In criticism it was submitted that these provisions would be inappropriate to HIV/AIDS as neither HIV infection nor AIDS corresponds with the other highly contagious diseases in respect of which these provisions are applicable.[393]

6.12 Draft Regulations, intended to replace the 1987 Regulations, were published for comment in 1993.[394] In these Regulations, apart from the fact that AIDS was removed from the Annexure listing specific communicable diseases, provisions similar to regulations 6 and 14(1) referred to above have not been included for re-enactment.[395] The effect is that

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390 The 1987 Regulations, reg 6(2) and 14(5).

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

392 See eg reg 14(3). See also **SALC Discussion Paper** 80 par 4.9 and 4.10.

393 See also the discussion in **SALC Discussion Paper 80** par 4.10. Other diseases listed in Annexure 1 to the 1987 Regulations include inter alia 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 in which HIV is transmitted, casual contact between infected and otherwise healthy persons presents no threat to public health (see **SALC First Interim Report on Aspects of the Law relating to AIDS** par 5.5).

394 Notice 703 of 1993 in **GG** No 15011 of 30 July 1993.

395 The new reg 6 no longer contain any reference to medical examinations. The only other provision relevant to medical examinations is reg 11. Reg 11(1) - which seems to replace the former regs 14(1) and 17(a) referred to in par 6.9 above - refers to medical examinations with regard to communicable diseases listed in the Annexure (now not including AIDS any longer); while reg 11(3) refers to medical examination of a "carrier" or a person who "suffers" from a communicable disease. It is submitted that

the 1993 Draft Regulations contain no provision for medical examination (i e HIV testing) without consent as described in par 6.9 above.

6.13 The Draft Regulations published in 1993 have however not been finalised and promulgated in the **Government Gazette**. The position as set out in paragraph 6.9 above with regard to the 1987 Regulations thus currently prevails.[396]

6.14 The Department of Health in April 1999 published proposed amendments to the 1987 Regulations in order to make AIDS a notifiable medical condition.[397] These proposed amendments contain no provision for HIV testing or disclosure of HIV-related information to victims of crime and therefore apparently do not propose to alter the position with regard to medical examination and testing as set out in paragraph 6.9 above.[398]

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the latter provision is not applicable to situations where HIV status has not yet been established and is thus not relevant with regard to testing of arrested persons.

396 The Commission indicated in previous publications that the position of uncertainty with regard to the 1987 Regulations (which have never been applied to HIV/AIDS) and the 1993 Draft Regulations (which have in the past six years not been finalised) should be resolved by promulgation of the 1993 Draft Regulations. (**SALC First Interim Report on Aspects of the Law relating to AIDS** par 5.1-5.6; **SALC Discussion Paper 80** par 4.12). Parliament on 19 September 1997 (after tabling of the First Interim Report) indicated that this recommendation should be implemented urgently.

397 Notice No R485 of 23 April 1999, Regulation Gazette 6496 in **GG** 19946 of 23 April 1999.

398 The proposed amendments are quoted in full in par 5.16 above.

7 DEALING WITH COMPULSORY HIV TESTING AND DISCLOSURE OF TEST RESULTS THROUGH EXISTING MEASURES OF CRIMINAL PROCEDURE

7.1 As indicated in Chapter 4 above, there is in South Africa no express statutory authorisation for the compulsory HIV testing of persons charged with having committed a sexual offence. Nor is there provision for relaying the results of such tests (i e information regarding the HIV status of persons charged) to victims of crime.

7.2 Section 37 of the Criminal Procedure Act however provides for the ascertainment of bodily features of an accused (including the taking of a blood sample to show a characteristic, distinguishing feature or condition in respect of an accused's body) which seems on rare occasion to have been utilised by our lower courts to authorise HIV testing of persons charged.[399] This section states as follows:

> 37(1) Any police official[400] may -
>
> (a) take the finger-prints, palm-prints or foot-prints or may cause any such prints to be taken -
>
> (i) of any person arrested upon any charge;
>
> (ii) of any such person released on bail or on warning under section 72; .....
>
> (c) take such steps as he may deem necessary in order to ascertain whether the body of any person referred to in paragraphs (a)(i)or (ii) has any mark, characteristic or distinguishing feature or shows any condition or appearance: Provided that no police official shall take any blood sample of the person concerned .....;

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399 According to McKay and Wannenburg (Unpublished) the KwaZulu/Natal lower courts have rendered conflicting decisions on the issue of testing the accused for HIV in child abuse cases (at 25). Information supplied by the SAPS also indicates that courts on rare occasions may have utilised sec 37 of the Criminal Procedure Act to order HIV testing (information supplied by Adv Dellene Clark, SAPS Legal Services 21 March 1998). It is however not clear whether such testing is referred to in the context of gathering of evidence.

400 A "police official" is a "member" of the South African Police Force established by sec 5(1) of the South African Police Service Act 68 of 1995 and includes any member of the Reserve, any temporary member employed in the Service, and any person appointed in terms of any other law to the Service (sec 1 of the Act).

(2) (a) Any medical officer of any prison or any district surgeon or , if requested thereto by any police official, any registered medical practitioner or registered nurse may take such steps, including the taking of a blood sample, as may be deemed necessary in order to ascertain whether the body of any person referred to in paragraph (a)(i) or (ii) of subsection (1) has any mark, characteristic or distinguishing feature or shows any condition or appearance ...

(3) Any court before which criminal proceedings are pending may -

(a) in any case in which a police official is not empowered under subsection (1) to take ... steps in order to ascertain whether the body of any person has any mark, characteristic or distinguishing feature or shows any condition of appearance, order that ... the steps, including the taking of a blood sample, be taken which such court may deem necessary in order to ascertain whether the body of any accused at such proceedings has any mark, characteristic or distinguishing feature or shows any condition or appearance;

(b) order that the steps, including the taking of a blood sample, be taken which such court may deem necessary in order to ascertain the state of health of any accused at such proceedings. ...

(5) ... the record of steps taken under this section shall be destroyed if the person concerned is found not guilty at his trial or if his convection is set aside by a superior court or if he is discharged at a preparatory examination or if no criminal proceedings with reference to which such ... record was made are instituted against the person concerned in any court or if the prosecution declines to prosecute such person.

7.3 Section 37 should be read in conjunction with section 225 of the Criminal Procedure Act, dealing with "Evidence of prints or bodily appearance of accused" and which provides as follows:

225(1) Whenever it is relevant at criminal proceedings to ascertain whether ... the body of ... an accused (at such proceedings) has or had any ... characteristic, or distinguishing feature or shows or showed any condition or appearance, evidence ... that the body of the accused has or had any ... characteristic or distinguishing feature or shows or showed any condition or appearance, including evidence of the result of any blood test of the accused, shall be admissible at such proceedings.

(2) Such evidence shall not be inadmissible by reason only thereof that the ... characteristic, feature, condition or appearance in question was not ascertained in accordance with the provisions of section 37, or that it was taken or ascertained against the wish or the will of the accused concerned.

7.4 As indicated in Chapter 4 above, three issues need to be explored with regard to section 37: Whether the section allows for (compulsory) HIV testing of persons charged with

having committed a sexual offence; whether such testing would in general be regarded as constitutional; and whether the test result could be relayed to victims of crime.

*** Does section 37 of the Criminal Procedure Act allow HIV testing of persons arrested on a charge?**

7.5 Section 37(2)(a) authorises the taking of blood "as may be deemed necessary" in order to ascertain whether the body of any person arrested upon any charge, or any such person released on bail or on warning has any "characteristic or distinguishing feature or shows any condition". No consent is required for taking the blood sample. Blood samples may be taken on own authority only by medical practitioners - and primarily by the medical officer of any prison or by any district surgeon.[401] If a police official requests a blood sample to be taken, it may also be taken by any registered medical practitioner or registered nurse.[402] (Section 37(1)(c) authorises a police official to take the necessary steps in order to ascertain whether a person arrested, or released on bail, shows any condition provided that the police official shall not take the blood sample.) Blood samples may of course also be taken with the consent of the person charged.

7.6 In addition, section 37(3)(a) and (b) provide for a court before which criminal proceedings are pending to order the taking of a blood sample where a police official is not empowered to take the necessary steps. It is accepted that this is for purposes of ascertaining the health condition of the arrested person in instances where there is a possibility of such person being referred to a hospital or mental institution pending criminal proceedings;[403] or such cases where a person has not been arrested but has been warned or summonsed to appear before court.[404]

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401 Criminal Procedure Act sec 37(2)(a). Cf also Hiemstra 81; Du Toit et al 3-13.

402 Ibid.

403 Hiemstra 76. See also par 7.9 below for the purposes of the authorisation to take a blood sample in terms of sec 37.

404 **Nkosi v Barlow** 1984 3 SA148 (T); **S v Maphumulo** 1996 SACR 84 (N); see also Du Toit et al 3-15.

7.7 Although evidence of a blood sample taken by a police official personally is not allowed, a police official may assist a registered medical practitioner or registered nurse to draw a blood sample of an "unwilling" person in circumstances where the police official requested the doctor or nurse to take the sample.[405] Reasonable force would presumably be permissible to take the blood sample if the accused refuses, or behaves in such a manner as to make it clear that he or she does not want to co-operate.[406] However, there is no statutory provision compelling a person under sanction of penalty to submit to the taking of a sample of his or her blood. In this respect section 37 merely grants powers to certain specified persons to take blood samples or to cause such samples to be taken.[407]

7.8 It is submitted that the above provisions would allow the taking of a blood sample to ascertain whether a person charged has HIV. The presence of HIV antibodies in the blood of a person charged, could arguably be regarded as a characteristic feature of that person's body, while a blood test could certainly show the condition of HIV infection. However, the purpose for which a blood sample is taken will be decisive in ascertaining whether taking such sample could be regarded as constitutionally sound.[408]

*** The constitutionality of HIV testing under section 37**

7.9 In line with practices of international policing agencies, section 37 empowers a police official to ascertain bodily features in specified circumstances.[409] The powers granted are

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405 Du Toit et al 3-13.

406 Cf sec 37(1)(c) and sec 37(2)(a) read with sec 225(2) of the Criminal Procedure Act. The latter provision states that evidence of bodily appearance of an accused "shall not be inadmissible by reason only thereof that the ... characteristic, feature (or) condition ... in question was not ascertained in accordance with the provisions of section 37, or that it was taken or ascertained against the wish or the will of the accused concerned". See also Du Toit et al 3-13; Hiemstra 75.

407 **S v Oberbacher** 1975 3 SA 815 (SWA); **S v Binta** 1993 2 SACR 553 (C); **S v Kiti** 1994 1 SACR 14 (E); see also Du Toit et al 3-13 - 3-14; Lötter 1994 **Codicillus** 58-59.

408 See par 7.9 below.

409 Clark in **Polisiëring en Menseregte** 261.

far-reaching.[410] A medical officer when so requested by a police official may take a blood sample of a person who is in custody or has been arrested but released, "as may be deemed necessary" in order to ascertain a characteristic or a condition. The lawfulness of the taking of the blood sample is thus dependent on first, the lawfulness of the arrest and custody, and second, its deemed necessity. The latter requirement would refer to the evidential need for a blood sample.[411] In this regard the opinion has been expressed that it stands firm that finger and other prints, and bodily features can be intended for evidentiary purposes only and that it would be improper for a police official to take finger prints or ascertain bodily features where it is inconceivable that it would be necessary as evidence.[412]

7.10 HIV testing of a person charged with a sexual offence would thus possibly be illegal if it is not relevant to the trial per se.[413] The test results may only be relevant where a charge of murder, assault with the intent to do grievous bodily harm, an attempt to commit these offences, or culpable homicide is brought;[414] and in argument relevant to the imposition of life imprisonment for rape in terms of section 51 of the Criminal Law Amendment Act

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410 Cf Steytler 76; Du Toit 3-1; Hiemstra 73.

411 See also Steytler 97.

412 "This [provision] subjects the citizen to a humiliating process, namely the taking of finger and other prints. The powers granted are exceptionally wide and may not be executed arbitrarily. It is seemingly already preposterous to allow even a junior police official to take the fingerprints [or ascertain the bodily features] of a *person in custody* without placing any limitation on the type of offence in question. It stands firm that finger or other prints and bodily features can be intended for evidentiary purposes only and that it would be improper for a police official to take finger prints or ascertain bodily features where it is inconceivable that it would be necessary as evidence. With *conviction*, in contradistinction, it is totally acceptable to retain the prints in case the person in question again commits an offence. ... The nature of the crimes intended can be deduced from par (iv), which limits the application of sec 37 after conviction to offences listed in Part I of Schedule 3. These are exclusively crimes of violence" (Hiemstra 73 - our translation). See also **Nkosi v Barlow** 1984 3 SA 144 (T) at 148 where it was held that "the clear terms of section 37(1) authorise a police official to take the fingerprints of a person for a legitimate purpose (regmatige doel)" (our translation).

413 The HIV status of the person charged is irrelevant in proving rape or indecent assault as it not an element of either of these crimes (cf Milton 439).

414 In these instances the fact that the person charged has HIV may be relevant in proving the respective crimes (cf Milton 310, 364, 406, 431; Burchell and Hunt Vol I 342).

1997.[415] In addition, where the accused does not plead incapacity to stand trial or it is not manifest, it seems unlikely that a court would order that blood samples be taken to ascertain his or her health status.

7.11 The constitutionality of section 37 should thus be analysed in the context of its application for evidentiary purposes only, as indicated in the previous paragraph.

7.11.1 Section 8(1) of the Constitution provides for the vertical application of the Bill of Rights.[416] Any offence or investigative procedure provided for in national legislation would thus be subject to constitutional review.[417] The constitutionality of the taking of a blood sample as authorised by section 37 could be disputed on the grounds of infringement, for instance, of the right to privacy, the right to freedom and security of the person, and perhaps even the right not to give self-incriminating evidence.[418] The 1996 Constitution however also provides for the limitation of rights in certain instances where the limitation is reasonable and justifiable. Section 36 permits limitations which are contained in a law of general application and which are reasonable and justifiable given, inter alia, the nature of the right, the importance of the limitation, its nature and extent, and the availability of less restrictive means to achieve the objective of the restriction. The rights referred to are thus not absolute and could be limited in certain circumstances.

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415 Sec 51 of the Criminal Law Amendment Act, 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 or she has AIDS or HIV, a High Court is obliged to impose a minimum sentence of life imprisonment (sec 51(1) and Part I of Schedule 2). Provision is however 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)). Cf also McKay and Wannenburg (Unpublished) 26.

416 Sec 8(1) states that the Bill of Rights "applies to all law, and binds the legislature, the executive, the judiciary and all organs of state".

417 Cf also Steytler 15.

418 Du Toit et al 3-1 - 3-2A; Steytler 76, 97 and 115; Schwikkard 1995 **SACJ** 92. Clark in **Polisiëring en Menseregte** 260. See also the 1996 Constitution sec 14 (the right to privacy), sec 12 (the right to freedom and security of the person), and sec 35(3)(j) (the right not to give self-incriminating evidence).

7.11.2 Section 14 of the 1996 Constitution states that everyone has the *right to privacy*.[419] This right derives from the right to dignity[420] and is also closely intertwined with the right to bodily and psychological integrity.[421] Compulsory subjection to a medical examination constitutes an interference with privacy rights.[422] Privacy rights may however be overridden by legitimate reasons such as interests of national security, public safety, the prevention of crime, the protection of health or the protection of rights and freedoms of others, provided that such intrusion complies with section 36 of the Constitution. It has been submitted that, in the context of criminal justice, an intrusion on privacy (eg taking of a blood sample and testing of such sample for the presence of HIV antibodies) would be regarded as legitimate for the purpose of securing evidential material in a prosecution.[423] International case law indeed recognises that "modern community living requires modern scientific methods of crime detection lest the public go unprotected".[424] In the light of this it has been contended that medical intervention (which would include HIV testing) in terms of section 37 of the Criminal Procedure Act (a law of general application) will be deemed reasonable and justifiable if the importance of the purpose of the limitation (eg protection of the rights of others) is proved and if the least restrictive means to achieve the purpose were used.[425] Thus, if information regarding HIV status is in general necessary for the effective prosecution of crime in the current climate of

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419 See also **Jansen van Vuuren v Kruger** 1993 4 SA 842 (A); **C v Minister of Correctional Services** 1996 4 SA 292 (T) (where the right to privacy, under both common law and constitutional law, was upheld in the context of HIV as well as more generally); and **S v A** 1971 2 SA 294 (T).

420 Sec 10 of the 1996 Constitution provides that everyone has the right to dignity and the right to have their dignity respected and protected.

421 Sec 12(2) of the 1996 Constitution provides that everyone has the right to bodily and psychological integrity. See also **Jansen van Vuuren v Kruger** 1993 4 SA 842 (A) at 849E-F; **S v A** 1991 2 SA 294 (T).

422 Strauss 3-13; Van Wyk 129 et seq; Clark in **Polisiëring en Menseregte** 265; see also the extensive discussion in **SALC Second Interim Report on Aspects of the Law relating to AIDS** par 5.11 et seq.

423 Cf Steytler 86-87; 97.

424 See eg the United States Supreme Court decision in **Breithaupt v Abram** 352 US 432,1 L ed 2d 448, 77S Ct 408.

425 Clark in **Polisiëring en Menseregte** 265-266; Scwikkard 1995 **SACJ** 92. Cf also **S v Huma** (2) 1995 2 SACR 411 at 316j-317a.

lawlessness, and if the effective prosecution of a specific crime in particular (eg attempted murder) was practically impossible without utilising the powers under section 37,[426] and if there were no other way in which the HIV status of a person arrested or released on bail or warning could be ascertained than by taking a blood sample from that person and testing it for HIV antibodies, the intrusion into privacy under section 37 would be regarded as constitutional.[427]

7.11.3 Section 12(1) of the 1996 Constitution provides that everyone has the *right to freedom and security of the person*, which includes the right not to be treated in a degrading way.[428] Where a person submits him or herself to the control of police officials on the reasonable ground that there is not other choice - be it for a breathaliser test or a blood test - a deprivation of freedom within the meaning of section 12(1) would occur.[429] Internationally, the right embodied in section 12(1) is absolute, non-derogable and unqualified.[430] Our constitutional jurisprudence accordingly indicated that infringement of this right would take place only when the purpose of the deprivation of freedom was "hostile to the values" of an open and democratic society based on freedom and equality.[431] The question of justification therefore does not arise.[432] Thus, if taking of a blood sample from a person arrested on a charge (eg attempted murder) for purposes of testing it for HIV, is done in pursuance of the legitimate objective of evidence gathering (an essential component of the investigation of crime and in many respects a prerequisite

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426 Steytler 23 where he refers to **Scagell v Attorney-General of the Western Cape** 1996 11 BCLR 1446 (CC) par 9.

427 Cf also Clark in **Polisiëring en Menseregte** 265-266; Scwikkard 1995 **SACJ** 92; and **S v Huma** (2) 1995 2 SACR 411 at 316j-317a.

428 The 1996 Constitution sec 12(1)(e). Cf the remarks of Hiemstra quoted in fn 412 above.

429 Cf Steytler 49.

430 Ibid 42-45, 50; Clark in **Human Rights for the Police** 256.

431 See **Bernstein v Bester** 1996 4 BCLR 449 (CC) par 144-151;

432 Steytler 42-45, 50, 76; See also **Bernstein v Bester** 1996 4 BCLR 449 (CC) par 144-151 where O' Regan J held (in respect of the corresponding sec 11(1) of the 1993 Interim Constitution), that "only where a criminal prohibition or governmental regulation is 'hostile to the values' of the Constitution, will there be a prima facie breach of section 11(1).

for the effective administration of any criminal justice system, including the proper adjudication of a criminal trial[433]) there would probably be no violation of section 12(1).[434]

7.11.4 The 1996 Constitution further provides that every accused person has the right to a fair trial, which includes *the right not to be compelled to give self-incriminating evidence*.[435] This is a common law right which has now also been constitutionally entrenched. With regard to self-incrimination our courts distinguish between testimonial evidence (eg confessions and admissions) and non-testimonial evidence (eg participating in identification parades and giving of real evidence such as blood samples and fingerprints).[436] According to Du Toit et al "the common law ambit of the privilege against self-incrimination is confined to communications, whereas section 37 deals with the ascertainment of an accused's bodily or physical features or conditions which are not obtained as a result of a communication emanating from the accused."[437] It has subsequently been held that the common-law distinction has not been affected by constitutional provisions.[438]

*** Could HIV test results be relayed to victims of crime under current criminal procedure measures?**

7.12 It would seem from the above that the testing of blood for HIV antibodies in terms of section 37 of the Criminal Procedure Act is only authorised if it is necessary for evidentiary purposes in criminal proceedings, or if the state of health of an arrested person

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433 Clark in **Human Rights for the Police** 260.

434 Cf Steytler 76.

435 The 1996 Constitution sec 35(3)(j).

436 **S v Maphumulo** 1996 2 BCLR 167 (N).

437 Du Toit et al (3-1) refers to **S v Binta** 1993 2 SACR 553 (C) in this regard.

438 **S v Huma** (2) 1995 2 SACR 422 (W) and **S v Maphumulo** 1996 2 BCLR 167 (N) were decided in terms of the 1993 interim Constitution (sec 25); while **Ferreira v Levin No** 1996 1 BCLR 1 (CC) was decided in terms of the 1996 Constitution (sec 35). Cf also Scwikkard 1995 **SACJ** 92.

or his or her condition is in issue. Moreover, section 37(5) provides for the obligatory destruction of the prints or record of steps taken in terms of section 37 if no prosecution is instituted.[439]

7.13 The conclusion seems to be apparent that section 37 in its current form cannot be utilised to relay information gained in terms of this provision outside of criminal proceedings. Victims of crime can thus not be supplied with information gained in the process of ascertaining bodily features under section 37 - even if this process included ascertaining the HIV status of a person charged.

7.14 In order to implement the provisions of section 51 of the Criminal Law Amendment Act, 1997 (i e imposition of life imprisonment if a person has been convicted of rape knowing that he or she has AIDS or HIV), presumably a post conviction procedure taking recourse to the provisions of section 37 would have to be resorted to.

8 THE NEED FOR STATUTORY PROVISION FOR COMPULSORY HIV TESTING OF ARRESTED PERSONS AND FOR DISCLOSURE OF THE TEST RESULTS TO VICTIMS

A) SUITABILITY OF CURRENTLY AVAILABLE MEASURES OF PUBLIC HEALTH AND CRIMINAL PROCEDURE

8.1 It seems to be clear from the overview of the currently available measures of public health and criminal procedure in Chapters 6 and 7 above, that these provisions can be used to test an arrested person for HIV infection without his or her consent. The problem however seems that these measures do not provide for disclosing information regarding the test results (i e the arrested person's HIV status), to victims.

8.1.1 ***Public health measures*** have as their chief aim the promotion of public health. In

439 Cf also Du Toit et al 3-15.

accordance with this, the compulsory medical examinations (which would include HIV testing) currently provided for in the 1987 Regulations[440] are either aimed at curbing the spread of a communicable disease (which would include HIV), or at treatment of the infected person. The current measures do not provide for the disclosure of the findings of the medical examination (i e the HIV test results) to third parties other than the health authorities.[441]

8.1.2 As far as the currently available ***criminal procedural measures*** are concerned, it seems to be accepted that the taking of a blood sample to ascertain bodily features as provided for in section 37 of the Criminal Procedure Act,[442] will generally be found to be constitutional: Although this provision makes serious inroads upon the bodily integrity and right to privacy of an arrested person, it is argued that these inroads should be seen as valid limitations on such rights in the light of the fact that the ascertainment of the bodily features of an arrested person often forms an essential component of the investigation of a specific crime, and is in many respects a prerequisite for the effective administration of any criminal justice system, including the proper adjudication of a criminal trial.[443] Section 37 thus only applies to the limited circumstances of collection of evidence for the purposes of a criminal prosecution, or where the ability of the arrested person to stand trial is in question.[444] The aim of collecting data relating to bodily features is either for the identification of the offender, or obtaining of evidence which links the suspect irrevocably to the crime scene or the act committed in contravention of the

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440 See par 6.9 above.

441 See reg 6(2) and 14(5). See also par 6.10 and 6.14 above. The proposed 1999 amendment to the 1987 Regulations to make AIDS a notifiable medical condition provides for a medical practitioner (or other authorised person) who diagnosed AIDS in a person, to inform the immediate family members and the persons who are giving care to the person with AIDS. The proposed amendment contain no provision for disclosure of HIV-related information to victims of crime - see par 5.16 and 6.14 above.

442 See par 7.2 et seq above.

443 Du Toit et al 3-1. See also Clark in **Polisiëring en Menseregte** 271-272.

444 Du Toit et al 3-1 - 3-2A; Hiemstra 69; see also McKay and Wannenburg (Unpublished) 26 and Clark in **Polisiëring en Menseregte** 271-272.

law.[445] The testing of blood for HIV antibodies under section 37 may thus only be undertaken if it is of evidential value to criminal proceedings or if the state of health of the arrested person is in issue.[446] Section 37 does not provide for the disclosure of the information gained to victims of crime for their personal use. As indicated in Chapter 7 above, HIV testing of the arrested person in a sexual offence case would thus possibly be illegal if it is not relevant to trial per se.[447] The test results may only be relevant where a charge of murder, assault with the intent to do grievous bodily harm, an attempt to commit these offences, or culpable homicide is brought;[448] and in argument relevant to the imposition of life imprisonment for rape in terms of section 51 of the Criminal Law Amendment Act 1997.[449] In addition, where the arrested person does not plead incapacity to stand trial or such capacity is not manifest, it seems unlikely that a court would order that blood samples be taken to ascertain his or her health status. It should be noted as indicated in Chapter 2 above, that the Commission has also been requested to investigate the possibility of criminalisation of HIV transmission.[450] Should a crime of HIV transmission and/or exposure be created by the legislator, section 37 would be available for HIV testing for evidentiary purposes. However, even in this context, where HIV testing would be permissible, it would not be permissible to disclose the test results to the victim.

B) THE NEED FOR LEGISLATIVE INTERVENTION

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445 Clark in **Polisiëring en Menseregte** 271-272.

446 See par 7.10.

447 The presence of HIV would not be relevant for a prosecution under any of the sexual offences referred to in par 2.18.2.3 above.

448 In these instances the fact that the person charged, has HIV may be relevant in proving the respective crimes.

449 See par 7.10 above.

450 This issue was debated in **SALC Discussion Paper 80** which was distributed for comment in January 1998. See also par 2.15 et seq.

8.2 On the premise that the current law does not provide for compulsory HIV testing of the arrested person in order to disclose the test results to the victim, the possibility of creating a statutory provision to this effect is explored below.

8.3 The motivation behind any proposed introduction of statutory measures that allow for HIV testing of the arrested person in sexual offence cases, would be the victim's understandable desire to know his or her assailant's HIV status. Positive test results will provide the victim with information that may be important in deciding whether or not to take precautions to avoid spreading the virus to his or her sex partners; and to assist with deciding what medical testing and treatment should be pursued to prevent possible infection with HIV.[451] Moreover, a pregnant woman who has been the victim of rape may wish to make reproductive decisions based on the arrested person's HIV status (i e she might consider abortion were there is a possibility of her having been exposed to HIV).[452] Such decisions would not be possible for her were she to wait at least the average of a twelve week period (or even longer if follow-up tests at six and 12 months were to be done) for her own antibodies to develop.[453]

8.4 On the other hand, the HIV test is no ordinary medical test. Though its procedure is that of a simple blood test, its ramifications for both society and the individual are cataclysmic: AIDS is a devastating, deadly disease that spawns irrational fears and blatant prejudice and discrimination.[454] This argument was also raised by those persons and bodies who did not support the recent public outcry for compulsory HIV testing of arrested persons : they voiced doubts as to whether coercive measures would only serve to strengthen the

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451 Sadler 1992 **Washington Law Review** 209-210; Gostin et al 1994 **JAMA** 1441. Compare also the motivation behind the public outcry for law reform as set out in par 2.3 et seq above.

452 Cf **AIDS Alert August** 1994 111.

453 See par 3.4 for information on the "window period". Compare also par 8.9 et seq below on the limits of HIV testing of the arrested person.

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

stigma attached to HIV/AIDS.[455] Moreover, they fear that forced HIV testing and disclosure of the test results would involve a serious intrusion into the arrested person's privacy rights.[456]

8.5 An analysis of the question whether an arrested person should be statutorily compelled to submit him- or herself to HIV testing requires a balancing of the government's interest in the testing of the arrested person, the victim's interest in the information regarding the arrested person's HIV status, and the arrested person's constitutionally protected rights. Factors impacting on the conflicting interests at stake, are debated below. In its analysis the Commission has not addressed the possibility of compulsory HIV testing of persons *convicted* of a sexual offence. In most cases the utility of testing would have disappeared by the time of a conviction.[457] Unless victims themselves underwent testing shortly after the attack, seropositivity in the arrested person at the conviction stage would tell nothing concerning transmission of HIV. And if the victim had become infected because of the arrested person, the victim's own seropositivity is likely to show up on tests by the time of conviction.[458]

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455 See par 2.3 et seq for information on the public outcry for government action on the issue of rape and HIV. Attorney General Khan's proposal for compulsory HIV testing of arrested persons was not supported by the Human Rights Commission and some non-governmental organisations dealing with AIDS and rape victims: Human Rights Commissioner Jody Kollapen reportedly said the request for compulsory testing was a problem in light of the presumption of innocence entrenched in the 1996 Constitution. Rape Crisis legal adviser Bronwyn Pithey expressed the opinion that the issue should be decided by the Constitutional Court. She added that the state should rather be spending money on preventive treatment for women who had been raped (**Sowetan** 23 October 1997; **Daily Dispatch** 23 October 1997).

456 See par 8.25 et seq below.

457 For various technical reasons rape is difficult to prove, and a certain level of expertise and experience with respect to the investigation and prosecution of a rape case would be necessary to obtain a conviction. For these reasons investigating and prosecuting such cases may be time consuming and may not always result in convictions. It has recently been reported that only 8% of rapes reported to the SAPS resulted in convictions (**Mail and Guardian** 21-27 May 1999). See also par 8.16 et seq below where the utility of HIV testing is discussed.

458 Because of this, many state legislatures in the United States (taking into account that it would not be justifiable to test an arrested person prior to conviction because of constitutional reasons) have concluded that no tests should be mandated as the test results would have little utility (Andres 1990 **American Journal of Law and Medicine** 102; Andrias 1993 **Fordham Urban Law Journal** 507).

*** The high prevalence of HIV coupled with the high prevalence of rape and other sexual offences**

8.6 The prevalence of HIV on the one hand, and of sexual offences, especially rape, on the other hand have recently increased markedly in our country.[459] Proponents of compulsory HIV testing of arrested persons emphasise several reasons for concern over possible HIV transmission to victims in this context. These include the following: many victims will not only be violated by a single assailant as the incidence of gang rape (which may also increase the possibility of infection of the victim) is also increasing;[460] persons arrested for having committed sexual offences often have multiple consenting sexual partners and a number of victims which could increase the risk of HIV transmission;[461] and when a convicted sex offender is released, the probability of that offender committing another similar offence is high.[462]

8.7 Although this Paper recognises that males are also the victims of sexual offences and that anal intercourse indeed carries a higher risk of HIV transmission than vaginal intercourse,[463] it is accepted that women are mostly targeted by rape and other sexual offences. Against the background of the current high prevalence of these crimes, women's well-documented biological vulnerability to HIV is thus also of special relevance.[464] Studies in many countries show that male-to-female transmission of HIV

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459 See par 2.6 above.

460 See par 2.3 and 3.16 et seq above. See also **Mail and Guardian** 21-27 May 1999 which reported that 75% of all rapes treated at the Groote Schuur Hospital Rape Unit, Cape Town were gang rapes.

461 Cf Burgess et al 1990 **Journal of Emergency Nursing** 331.

462 Ibid.

463 See par 2.18.2.4 and 3.16.1above.

464 Talis 1998 **Agenda Empowering Women for Gender Equity** 9 et seq; Abdool Karim 1998 **Agenda Empowering Women for Gender Equity** 21 et seq; **Women and AIDS** 3; Rees (Unpublished) 1, 2 5; Hankins 1996 **Canadian HIV/AIDS Policy and Law Newsletter** (Internet).

appears to be 2 to 4 times more efficient than female-to male transmission.[465] Young girls are particularly vulnerable as a result of the lack of maturation of the cervix and because of their relatively low vaginal mucous production which presents less of a barrier to HIV.[466] Women are also more vulnerable to HIV because they are more likely to have untreated STDs, in part due to lack of access to adequately equipped and culturally appropriate medical services, and in part due to the fact that women do not recognise low grade infections, particularly if these are the result of their partners' behaviour and not their own.[467]

8.8 Despite the natural sympathy for victims of rape and sexual offences, and despite the considerable importance of responding to these victims' needs, opponents however submit that the likelihood of assisting victims' interests are diminished by the relatively small probability of HIV transmission in the case of sexual offences.[468] They argue that scientific sources indicate that the possibility of contracting HIV through sexual assault is very small indeed - even for female victims.[469] They feel that the special measures called for (i e compulsory HIV testing and disclosure of the test results) would constitute considerable inroads into the arrested person's right to privacy[470] and is simply not justified in the exceptionally limited circumstances where it would in all likelihood be relevant.

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465 This is thought to be due to the larger mucosal surface area exposed to the virus in women and the greater viral inoculum present in semen as compared with vaginal secretions (Hankins 1996 **Canadian HIV/AIDS Policy and Law Newsletter** [Internet]).

466 Hankins 1996 **Canadian HIV/AIDS Policy and Law Newsletter** (Internet).

467 Ibid.

468 Cf par 3.16 above.

469 It is indicated in par 3.16 above that the probability of HIV infection from a single unprotected sexual exposure to HIV through a mucosal surface (eg vagina) may be similar (1 in 1 000) to that from a single occupational percutaneous exposure (eg skin perforating needle-stick injury) - which is theoretically regarded as "minimal".

470 See Chapter 5 above; and par 8.25 et seq below.

*** Utility and limitations of HIV testing**

8.9 In international legal literature, the most significant debates concerning compulsory HIV testing of the arrested person probably centre on the utility and limitations of HIV testing.[471]

8.9.1 Proponents for testing submit that becoming infected with HIV has grave consequences and may impact on several aspects of a person's life - including the ability to find employment,[472] to join a medical aid and insurance fund,[473] and to relate with family, friends and sexual partners.[474] 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.[475] In addition to this, persons with HIV face a degree of social stigmatisation and discrimination.[476] The long-term effectiveness and safety of new combination drug treatments (which may substantially postpone death for persons with HV) are still unproven. These drugs carry the possibility of serious side effects,[477] they are

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471 Cf eg Sadler 1992 **Washington Law Review** 196 et seq; Andres 1994 **UMKC Law Review** 457 et seq; see also Brett-Smith and Friedland in **AIDS Law Today** for the limits of HIV testing.

472 It is expected that the Employment Equity Act 55 of 1998 recently passed by Parliament, and the envisaged equality legislation currently being drafted by the Department of Justice and the Human Rights Commission in terms of the 1996 Constitution, will bring relief to persons with HIV in the work place.

473 South African medical aid schemes are however starting to recognise that sound HIV and AIDS management strategies will be more cost-effective in the long run than continuing to ignore the disease. It has recently been suggested by Metropolitan Life that AIDS should be viewed by medical schemes as a chronic disease and that it be approached proactively by using managed-care principles (**The Sunday Independent** 25 October 1998 7). In addition, the Medical Schemes Act 131 of 1998 is expected to bring relief to persons with HIV/AIDS by providing, amongst others, that a medical scheme may not exclude, or offer deferential benefits to, a person on the basis of past or present state of health (sec 30(1)(h)).

474 Cf the leading German case on deliberate HIV infection (**BGH v O4.11.1988 - 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.

475 Cf **Venter v Nel** 1997 4 SA 1014 (D); Robling 1995 **Cleveland State Law Review** 678-681.

476 Ibid. See also Sadler 1992 **Washington Law Review** 208-209.

477 See par 3.47.2 above.

also extremely expensive and may simply not be available to victims of sexual offences in developing countries where over 90% of new HIV infections are occurring.[478] 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.[479] The most pessimistic view is that without a cure victims of sexual offences who have contracted HIV through such offences will eventually develop AIDS and die prematurely.[480] Because HIV is transmitted through sexual contact, a victim of rape (or any sexual offence involving transmission of an HIV carrying bodily fluid)[481] logically fears infection and thus desires information on the HIV status of his or her assailant.[482]

8.9.2 Opponents however emphasise that government imposed HIV testing of the arrested person must demonstrably further the interest of victims of sexual offences before the intrusion into the arrested person's privacy, which will be created by such testing, will be acceptable. Therefore the utility of HIV testing must be measured by the degree in which test results actually benefit the victim. They argue that HIV testing has its limits and lacks true utility for victims of sexual crimes - not only with regard to the limitations of the test

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478 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. A basic retroviral course of a minimum of two drugs, and possibly three, may cost between R1 500-R4 000 per month depending on the drugs and how the drugs are acquired (eg by government tender, direct pharmaceutical supply or private sector outlet) (Information supplied on 27 July 1998 by Dr Clive Evian, Consultant to the Directorate HIV/AIDS and STDs in the Department of Health).

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

480 See par 3.46-3.47 above.

481 See par 2.18.2.3.

482 Cf Sadler 1992 **Washington Law Review** 196 et seq; Gostin et al 1994 **JAMA** 1438 et seq.

itself, but also with regard to practical problems around the criminal process.

+ *Scientific utility and limitations of HIV testing*

8.10 As indicated in paragraph 3.25 et seq above HIV antibody testing is generally used to establish whether an individual is infected with the virus. The traditional ELISA and Western Blot HIV tests utilised for this purpose are scientifically regarded as "highly reliable"[483] and could be an important means of providing victims of sexual crimes with valuable information enabling them to protect their own physical and mental health as well as the health of those with whom they come into contact.[484] Although false positive and false negative test results may occur,[485] rape and sexual offence victims in South Africa could probably accept that a positive test result in respect of an assailant is indeed positive on the basis of scientific indications that the higher the prevalence of HIV infection in the population tested, the greater the probability that a person testing positive is truly infected with HIV.[486] (It was indicated in paragraph 2.8 above that South Africa currently has a high prevalence rate of HIV infection.)

8.11 Opponents to testing however submit that the medical limitations of HIV testing may make testing of the arrested person meaningless. Although the CDC considers currently available HIV tests highly reliable,[487] opponents argue that the tests are subject to error for a variety of reasons.[488] These include the fallibility of HIV tests (which may result in

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483 See par 3.31 above where it is indicated that where the standard testing procedure is followed, a correct result will be obtained in more than 99% of cases of HIV infection.

484 Cf Sadler 1992 **Washington Law Review** 196.

485 Cf par 3.28 above.

486 Cf **WHO Weekly Epidemiological Record** 21 March 1997. See also par 3.28 and fn 157 above.

487 See also par 3.31 above.

488 Some evidence of inaccurate diagnosis does exist (Robling 1995 **Cleveland State Law Review** 659-666; Sadler 1992 **Washington Law Review** 198-199; Andres 1994 **UMKC Law Review** 457-458; Field 1990 **AMJLM** 37-39).

false positive or false negative results),[489] technical errors,[490] unskilled staff,[491] and biological ambiguity.[492] Most importantly however is the scientific limitations of the tests in detecting antibodies to HIV during the window period. As indicated in Chapter 3 above, most individuals undergo seroconversion and produce detectable levels of HIV antibodies within six to 12 weeks of infection. However, many may have an extended window period before seroconversion and a few infected individuals may never test positive for the virus.[493] If an arrested person is in the window period, his HIV test will be negative and it will cause the false impression that the victim has not been exposed to HIV.[494] It follows that the arrested person will have to be tested again to ensure that he was not infected. By this time the information regarding his HIV status would no longer be useful for the administration of PEP (which has to be initiated promptly - not later than 24-36 hours to be effective).[495]

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489 As indicated in par 3.28 above the most commonly used method to establish HIV infection is to test for antibodies (created in response to an invasion by HIV) by using the ELISA and Western Blot tests. Despite follow-up techniques used in the HIV testing process, false-positive results occur with both types of tests. With respect to the ELISA, extreme sensitivity affects the accuracy of the test and may yield false positive results; while similarly in the Western blot it is not uncommon for individuals to yield slight reactions to HIV proteins even though they have never been exposed to the virus (Robling 1995 **Cleveland State Law Review** 660-66; Field 1990 **AMJLM** 37-43). Depending upon the prevalence of the virus in the population being tested (the prevalence level in the South African population - currently estimated as 13% of the sexually active population - is high), 30-80% of repeatedly positive ELISA results are determined to have been false by Western Blot (Burris in **AIDS Law Today** 117). It has thus been said that these tests are "neither foolproof nor always accurate" (Robert Jarvis et al AIDS Law in a Nutshell 1991 17 as quoted by Andres 1994 **UMKC Law Review** 457; see also Field 1990 **AMJLM** 37-43).

490 Technical errors of many types can occur, such as mislabeling of test tubes, or carry-over in pipetting of solution from a positive to a negative sample (Robling 1995 **Cleveland State Law Review** 660-661).

491 Determining whether a person has been infected with HIV involves complex laboratory testing procedures. Human error is thus a real possibility in HIV testing and only skilled laboratory staff can usually differentiate the false positives from genuine HIV infection (Robling 1995 **Cleveland State Law Review** 660-663).

492 Biological ambiguity exists in respect of HIV tests as in all medical indicator tests, since unrelated but functionally similar biologic substances can yield a false positive result (Robling 1995 **Cleveland State Law Review** 661).

493 See par 3.4.

494 Cf Sadler 1992 **Washington Law Review** 199.

495 Cf par 3.53 above.

+ ***Utility and limitations of HIV testing as regards victims' physical and mental health***

8.12 Proponents (arguing from the premise of their acceptance of the scientific value of currently available HIV tests), submit that knowing their assailants' HIV status would allow victims of rape and sexual offences to take early steps to protect their own and others' *physical health*.[496]

8.12.1 First, such knowledge will assist a victim to make an informed decision as regards the initiation of treatment for the prevention of HIV infection (PEP[497]). As indicated above, one of the primary factors in initiating PEP is establishing the HIV status of the source person.[498] Even although an HIV test result in respect of an assailant would not be definitive as to whether the victim has become infected with HIV, it could be one of the most important factors in the process of accessing risk of actual exposure with a view to initiating PEP. Second, knowledge of his or her assailant's HIV status will allow a victim to take precautions to prevent spreading the disease to others (eg by not engaging in unprotected sexual activity; not becoming pregnant; not nursing a baby; and taking special precautions to avoid spreading the virus if the victim is employed in the health care setting.)[499] Significantly, in the case of a pregnant victim, information on the HIV status of her assailant will be invaluable in assisting her with a decision on whether or not to terminate an existing pregnancy.[500] As indicated in par 8.3 above, such victim might consider abortion where there is a possibility of having been exposed to HIV.[501] A

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496 Cf Jackson in **AIDS Agenda** 253, 255; Andres 1994 **UMKC Law Review** 468-469.

497 See par 3.51 et seq for details on this treatment.

498 Par 3.55.1 above.

499 Gostin et al 1994 **JAMA** 1441.

500 Cf **AIDS Alert** August 1994 111; Jackson in **AIDS Agenda** 256. Cf also Gostin et al 1994 **JAMA** 1438.

501 Ibid.

decision in this regard would not be possible were the victim to wait the minimum six to twelve week period (or even longer) to see if she develops her own antibodies, even though the assailant's test results may not give her the definitive answer she sought.[502]

8.13 Moreover, knowing their assailants' negative HIV status would on a *psychological level* alleviate rape trauma syndrome in victims and dispel their fears of becoming infected with HIV.[503] Some proponents for compulsory HIV testing of arrested persons argue that this is the strongest justification.[504]

8.13.1 Psychological trauma is common among female rape and sexual offence victims. Extensive research shows that trauma associated with sexual offences may include fear, loss of self-esteem, and problems of relationship, social adjustment, and sexual dysfunction. Psychiatric symptoms can include depression, social phobia, obsessive-compulsive behaviour and anxiety. The chronic psychological effects of sexual assault initially were described as the "rape trauma syndrome" and now are accepted as special examples of posttraumatic stress disorder.[505] The trauma may also include anxiety about becoming pregnant and acquiring a sexually transmitted disease such as HIV.[506] The fear of contracting particularly HIV following rape, appears to be a significant stressor adding to the incidence, prevalence, and severity of psychiatric morbidity in rape survivors.[507] Further, the emotional trauma of sexual assault, including the fear of HIV, frequently is also experienced by persons closest to the survivor, particularly sexual partners.[508]

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502 Ibid. See par 3.4 for information on the "window period". Compare also par 8.14 below on the limits of HIV testing of the arrested person.

503 Cf McKay and Wannenburg (Unpublished) 17-19; Rees (Unpublished) 4; Andres 1994 **UMKC Law Review** 471; Gostin et al 1994 **JAMA** 1442. Cf also Field 1990 **AMJLM** 100-101;

504 Gostin et al 1994 **JAMA** 1442; cf also Field 1990 **AMJLM** 100-101.

505 Gostin et al 1994 **JAMA** 1437. Rape trauma syndrome has been recognised by South African courts in **N v T** 1994 1 SA 862 (C); **Holtzhauzen v Roodt** 1997 4 SA 766 (W).

506 Gostin et al 1994 **JAMA** 1437, 1442.

507 Ibid.

508 Ibid.

Finally, the burden of anxiety persists for a substantial period of time in both victims and sexual partners. Without testing the arrested person, the victim has to rely on his or her own infection status - which may not be established with certainty for six to 12 weeks after the rape or assault because of the window period.[509] Authorising early HIV testing of arrested persons could help relieve this concern in many cases and may abate the severe trauma suffered by victims. Although the arrested person's test result will not indicate whether the virus was in fact transmitted, the information has the potential to offer some comfort or eliminate some uncertainty and thus should be made available to the victim if desired.[510] Of course, where testing reveals that the arrested person is infected, the victim could experience additional psychological stress. This burden, while heavy, would fall on far fewer victims than those who currently worry about infection.[511] Knowledge of exposure might even allow victims to begin psychological preparation for the results of their own testing.[512] Moreover, knowing their assailants' HIV status would assist victims in making decisions regarding the initiation of PEP to prevent HIV transmission.[513] Initiating PEP might in turn help survivors gain a sense of control after the attack, and decrease their anxiety.[514] In those cases where the assailant is apprehended relatively soon after the rape or assault, compulsory testing could thus mitigate one of the primary ongoing harms of the assault - the victim's fear and uncertainty about the risk of contracting HIV.[515]

8.14 Opponents of compulsory testing, on the other hand, (arguing from the premise of the scientific limitations of HIV tests) submit that such testing will not necessarily aid the victim's (or others') *physical* health.

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509 Cf par 3.4 above on the window period.

510 Cf Field 1990 **AMJLM** 100-101; Gostin et al 1994 **JAMA** 1442.

511 Gostin et al 1994 **JAMA** 1442.

512 Ibid.

513 Cf par 3.55.1 above for guidelines on the assessment of risk before initiating PEP.

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

515 Gostin et al 1994 **JAMA** 1442.

8.14.1 They emphasise that a positive HIV test result in respect of the arrested person does not mean that the victim has been infected with HIV.[516] First, there is the possibility of a false positive resulting from the flaws of the testing procedure.[517] Second, the fact that the arrested person tests positive, only means that the victim has been exposed to HIV, not that the exposure has, or will actually result in infection. In fact, as indicated in Chapter 3 above the risk of infection from a single sexual exposure involving heterosexual sex may be very slight (although it may be higher in the case of rape and anal intercourse).[518]

8.14.2 Likewise knowledge of a negative test result of an arrested person may not contribute to the victim's physical health.[519] He or she may choose to disregard the possibility that their assailant is in the window period and accept the negative test result with a false sense of security. In this case, victims may decline to be regularly tested, thereby putting their own health in jeopardy because if they are infected if may not be detected at the earliest possible point. The victim may also act recklessly, increasing his or her chance of spreading the virus by donating blood, breast feeding, or engaging in unprotected sexual activity.[520]

8.14.3 Opponents stress that the reality is that AIDS is currently still incurable.[521] If the victim has in fact been infected during the assault, testing the arrested person cannot ensure that the victim's life is saved. Although PEP after occupational exposure is regarded as relatively successful in preventing HIV transmission, there is no conclusive proof about

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516 Cf Sadler 1992 **Washington Law Review** 212-213; Andrias 1993 **Fordham Urban Law Journal** 506-507.

517 See par 8.11 above.

518 See par 3.16 above. See also Sadler 1992 **Washington Law Review** 210-211.

519 Sadler 1992 **Washington Law Review** 211; Jackson in **AIDS Agenda** 255; Andrias 1993 **Fordham Urban Law Journal** 506-507.

520 Sadler 1992 **Washington Law Review** 211.

521 Cf par 3.46 above.

the success of PEP after sexual exposure.[522] PEP can be administered to a victim irrespective of the arrested person's HIV status. A decision to take PEP is not only influenced by the arrested person's HIV status, but by a variety of factors, both personal and medical.[523] If an assailant can for instance not be traced within the limited time period required for PEP to be administered, many victims would choose to err on the side of caution and take the treatment regardless of the HIV test results of their assailant.[524]

8.14.4 Opponents submit that it would be clear from the above that HIV test results of an arrested person cannot tell victims anything conclusive about their ***own*** health as far as HIV status is concerned.[525] Victims are in virtually the same position whether or not they are provided with the HIV test results of the arrested person or not: Either way the victim would have to have him or herself periodically tested for HIV to establish whether infection has in fact occurred after the rape or assault; and either way they would have to take precautions to inhibit the spread of the virus to others (eg by not engaging in unprotected sexual activity; not becoming pregnant; not nursing a baby; and taking special precautions to avoid spreading the virus if the victim is employed in the health care setting).[526] In reality the only way for any person to know if he or she has been infected with HIV is thus to have themselves tested regularly.[527]

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522 Cf par 3.59-3.60 above.

523 Cf par 3.55.1 above.

524 Jackson in **AIDS Agenda** 256. Cf also the instances referred to in par 2.3 et seq above where rape victims have recently initiated PEP without knowing the HIV status of the assailant.

525 Sadler 1992 **Washington Law Review** 212-213; Jackson in **AIDS Agenda** 255;

526 Sadler 1992 **Washington Law Review** 212-213.

527 Sadler 1992 **Washington Law Review** 212-213; Andres 1994 **UMKC Law Review** 460; Jackson in **AIDS Agenda** 255-256. A New Jersey, United States Superior Court in 1995 for instance found a mandatory HIV testing statute to be harmful rather than helpful to the victims of sexual assault. The Court found that "the only rational, scientifically viable method of assisting the victim in diagnosing her HIV status is to test her. The assailant's test results are simply irrelevant". People commenting on the judgment said that "the law's pretense that information about the assailant will be helpful, keeps the victim of sexual assault tied needlessly and cruelly to her assailant. It can only divert her attention from her true goals: regaining control of her life". They further agreed that the victims of sexual assault - regardless of the HIV status of their alleged assailants - should be counselled to consider being tested for

8.15 Opponents further submit that HIV testing of the arrested person will also not aid victims' *mental health*.

8.15.1 Knowledge of arrested persons' HIV status will not necessarily assist victims of crime and may add to rape trauma syndrome.[528] Some argue that if the arrested person for instance tests negative for HIV antibodies, the victim's psychological trauma will continue unabated.[529] The test result could be falsely negative because of either the failure rate of the tests or the window period between infection and seroconversion. Under such circumstances victims will still speculate about their own HIV status because they cannot safely assume that their assailants are indeed not infected. Alternatively, a positive test result may well unnecessarily further frighten and traumatise the victim.[530] As indicated above, a positive result of the assailant is inconclusive as to the victim's HIV status[531] and can serve only to acerbate the victim's fear. Despite the scientific realities which allow for false positive results, a victim faced with the knowledge that his or her assailant is HIV seropositve will undoubtedly suffer tremendous psychological trauma while awaiting the onset of a disease that may never occur.[532] Moreover, if it could be established with

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HIV, and to consider certain precautionary and temporary life-style changes. Information regarding the HIV status of assailants would in no way change responsible advice to the victim of sexual assault since neither a positive nor a negative HIV test result in respect of the assailant would give a definitive indiction whether the victim is truly infected or not (**ACLU Freedom Network** [Internet]).

528 See also Andres 1994 **UMKC Law Review** 455-474 at 460. McKay and Wannenburg (Unpublished 17).

529 Sadler 1992 **Washington Law Review** 210; cf also Jackson in **AIDS Agenda** 255.

530 Ibid.

531 See par 8.14.1 above.

532 Emotional distress is a guaranteed consequence of an HIV-positive test result. Medical studies indicate that nearly all HIV-infected individuals will eventually develop AIDS. AIDS is unusual in several respects - in addition to being fatal, the disease still has serious stigmatising and discriminatory aspects. Moreover, because HIV is acquired, unlike many other fatalities, many people regard HIV-positive individuals as having "only themselves to blame". These notions, combined with misconceptions about how HIV is transmitted, cause society to treat persons with HIV in an irrational and often arbitrary manner. Fearing a slow and painful death, people with HIV must simultaneously bear the burdens of possible harassment, job discrimination and social ostracism. The commingling of these burdens necessarily produces guilt, shame, anxiety and humiliation. Thus, as could be expected, when an individual becomes aware of his or her own HIV positive status, such knowledge represents one of the

certainty that the alleged offender is HIV positive, knowledge of his or her HIV status would not necessarily assist the victim - it could worsen the trauma: If it is known that the arrested person is HIV positive, this could add to the negative consequences in sexual partner and family member reactions towards the victim.[533]

8.15.2 The question of self-testing for victims is an extremely complex one involving profound personal and psychological issues. Opponents therefore suggest that proper counselling and support for victims of sexual offences, including clear information on the possibility of HIV transmission and the availability of PEP, can go a long way in alleviating victims's fears.

+ *Utility and limitations of HIV testing in the criminal process*

8.16 Opponents to testing are of the view that limitations inherent in the criminal process may also render HIV testing of the arrested person meaningless. In the event of the assailant not being apprehended soon after the assault, a positive test several weeks or perhaps months after the assault does not tell the victim when his or her assailant became infected: It is entirely possible that the assailant's infection may have occurred some time after the attack, or even in prison while awaiting trial. It may also be useless to require HIV testing of an arrested person for the sake of the victim's peace of mind after the period during which PEP could be useful in preventing HIV transmission (i e not later than 24-36 hours after exposure).[534] In many instances assailants will not have been apprehended within this short space of time. Similarly, many victims of rape and other sexual offences will not come forward to timeously receive PEP. Also in the latter instances it would serve no meaningful purpose to test the arrested person for HIV.

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strongest and most invariable connections with emotional distress to date. It follows that false-positive results necessarily entail genuine emotional distress (Robling 1995 **Cleveland State Law Review** 658-659, and 680-681).

533 Mc Kay and Wannenburg (Unpublished 11, 17); cf also Robling 1995 **Cleveland State Law Review** 679.

534 See also par 3.53 above.

8.17 Opponents conclude that in view of the above it is clear that the only meaningful HIV tests are the ones the victim can undergo. Since having the arrested person tested will only tell whether he or she had detectable levels of HIV in his blood at the time of the test, such test will not indicate whether the victim has become infected. Victims of sexual offences will eventually have to submit themselves to HIV testing in order to ascertain whether they were in fact infected. Compulsory testing of the arrested person will thus be a waste of resources if the victim will in any event have him or herself tested to establish whether HIV was in fact transmitted.[535]

8.18 Proponents, although conceding that PEP should preferably be initiated promptly (at most 36 hours after exposure), argue that providing for the compulsory HIV testing of the arrested person would be an incentive to rape victims to come forward timeously, and thus also possibly improving the rate at which the SAPS apprehends such offenders. If assailants are apprehended soon after the commission of sexual crimes, testing could be carried out. According to information, 90% of all victims who contacted Rape Crisis, Cape Town for instance, had reported that they were raped to the SAPS immediately after the commission of the alleged crime.[536]

+ ***Utility and limitations of HIV testing in the context of PEP (treatment for the prevention of HIV infection after sexual exposure)***

8.19 It is indicated in Chapter 3 above that fairly recent scientific evidence shows that administering certain antiviral drugs shortly after HIV is communicated occupationally, has substantial beneficial effects with regard to the prevention of transmission of HIV.[537] Some experts submit that the same treatment would be successful after sexual exposure,

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535 Cf Field 1990 **American Journal of Law and Medicine** 105.

536 Information supplied by Ms Catherine Day, counselling co-ordinator, Rape Crisis Cape Town on 21 September 1998. Ms Day further noted that 9% of victims waited a few days before reporting the alleged rape and a further 1% waited a couple of weeks before reporting.

537 See par 3.51 et seq above for a full discussion on PEP after occupational and sexual exposure.

given the similarities between the immune responses to percutaneous exposures (skin perforating needle-stick injuries) and transmucosal exposures (exposure through a mucosal surface such as the vagina, rectum, or mouth).[538] The latter has become the basis for arguments that victims of rape and other sexual offences should be allowed to require that the arrested person be tested for HIV so that if he or she is HIV positive, the preventive treatment could be administered to victims.[539]

8.19.1 Scientific guidelines for the initiation and administration of PEP in the occupational setting suggest that it should not be administered on a routine basis.[540] Risk of possible exposure should be assessed in every instance before a decision is taken to initiate the drug regimen. A key factor in the assessment of risk is an attempt to determine as soon as possible after exposure to a possible source of infection the HIV status of the source person. If the source person is HIV positive, then administration of PEP is recommended.[541]

8.20 Opponents however submit that the availability of the current treatment options for prevention of HIV infection does not constitute reasonable justification for compulsory testing of the arrested person for the reasons set out below.

8.20.1 As indicated in the discussion on PEP in Chapter 3 above, this treatment can be highly toxic and it has several adverse side effects.[542] Bearing in mind that even a positive HIV test on the arrested person will not conclusively show whether the victim is infected with HIV, not all medical practitioners would prescribe the treatment to a victim when it is in fact uncertain whether he or she may devel HIV infection. This view is supported in a recent report by the United States' CDC on management of possible sexual or other

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538 Ibid.

539 Cf Jackson in **AIDS Agenda** 256; Field 1990 **American Journal of Law and Medicine** 102-103; Gostin et al 1994 **JAMA** 1438; Sadler 1992 **Washington Law Review** 212.

540 See the CDC and South African Department of Health guidelines referred to in par 3.54-3.56 above.

541 Ibid.

542 Sadler 1992 **Washington Law Review** 212-213. See also par 3.53 above.

nonoccupational exposure to HIV.[543] The CDC indicated that an assessment of risk in order to ascertain viability of initiating PEP should take into account the uncertain effectiveness and potential toxicities of the drugs. It was firmly stated that PEP should never be administered routinely or solely at the request of a patient (i e victim).[544]

8.20.2 The studies that are used to support the theory that certain combination drugs may prevent transmission of HIV, are not applicable to victims of sexual assault.[545] The studies were conducted on health care workers where it was possible to assess the risk of exposure, and to administer treatment immediately following exposure.[546] The extremely short time interval between exposure and treatment appears to be a critical aspect of the therapy.[547] Apart from the fact that there is thus no conclusive information regarding the efficacy of the treatment to prevent HIV infection in persons with nonoccupational HIV exposure (including sexual exposure), this dramatically reduced time frame is impossible in the sex offence context because of the realities of criminal process.[548]

8.20.3 Moreover, some argue that compulsory HIV testing of arrested persons would be justifiable only if strategies for the immediate treatment of victims are in fact in place, or the development of such strategies is certain. The position in South Africa is that no official guidelines for PEP after sexual exposure (including exposure during rape or other sexual offences) currently exist. PEP is available at private establishments for victims who can afford the treatment. Because of the cost involved PEP would thus not be available

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543 See par 3.60 above.

544 Ibid.

545 See par 3.59-3.60 above.

546 Sadler 1992 **Washington Law Review** 212; **CDC Morbidity and Mortality Weekly Report** 25 September 1998 (Internet).

547 See par 3.53 above.

548 In most instances assailants will not have been apprehended within this short space of time. Similarly, many victims of rape and sexual offences will not come forward for PEP to be timeously initiated.

to most victims of sexual offences in our country.[549] The Government indicated at the end of May 1999 that it would initiate controlled research on the efficacy of PEP after sexual exposure before it would consider developing policy on making such treatment available to victims of sexual offences at government cost.[550]

* Women's international and constitutional rights, including rights as victims of crime

8.21 Violence against women and children has reached epidemic levels in South Africa.[551] Violence against women takes many forms - including rape, incest, indecent assault and child abuse. They are perpetrated against women and girls by strangers, intimate partners, relatives or acquaintances. These acts of sexual violence constitute a form of discrimination against women since they inhibit women's ability to live their lives free of violence, and they further prevent women from exercising their rights to equality.[552] As a result of the high prevalence of HIV in South Africa the probability of a woman contracting HIV as a result of sexual violence has increased. This is borne out by the fact that increasing numbers of women and children are subjected to rape and gang rape where transmission of HIV is a reality.[553]

8.22 As indicated in Chapter 9 below, during the last decade gender-based violence has received increasing attention in international human rights law, with concomitant emphasis

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549 It is indicated in par 3.53 above that the cost of starter pack and 28 days' supply of a two drug regimen would amount to R1 493 if the drugs are obtained directly from a pharmaceutical wholesaler (information supplied by Dr Clive Evian, Consultant to the Department of Health on 13 August 1998).

550 **Beeld** 22 May 1999.

551 Wolhuter 1998 **THRHR** 443 et seq; Meintjies-Van der Walt 1998 **SACJ** 157-158; see also comment by the Tshwaranang Legal Advocacy Centre to End Violence Against Women on SALC Discussion Paper 80 2-3.

552 Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW) Recommendation 19. See also comment by the Tshwaranang Legal Advocacy Centre to End Violence Against Women on **SALC Discussion Paper 80** 2-3; Wolhuter 1998 **THRHR** 443-444; and par 9.10-9.14 below where international human rights instruments relevant to the current enquiry are discussed.

553 See par 2.3-2.6 above.

on the determination of state obligations to address such violence. Reference is made there to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women, 1979 (CEDAW);[554] the United Nations Convention on the Rights of the Child 1989;[555] and the Southern African Development Countries (SADC) Declaration on the Prevention and Eradication of Violence Against Women and Children.[556] These instruments emphasise the principles of equality between women and men;[557] of protection of women and children from all forms of physical violence, including sexual violence;[558] and of ensuring justice and fairness to both the victim and the arrested person in cases of sexual violence.[559]

8.23 International law may also be important in the interpretation of the fundamental rights entrenched in the 1996 Constitution.[560]

8.23.1 Sections 9(1) and 9(3) of the 1996 Constitution provide that everyone "is equal before the law and has the right to equal protection and benefit of the law". The objective of this section has been expressed as follows by the Constitutional Court in **Prinsloo v Van der Linde**:[561]

> ... the state is expected to act in a rational manner. It should not regulate in an arbitrary manner or manifest 'naked preferences' that serve no legitimate governmental purpose, for that would be inconsistent with the rule of law and the fundamental premises of the constitutional state ...

Moreover, section 9(3) provides that "(t)he state may not unfairly discriminate

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554 See par 9.11-9.12 below.

555 See par 9.13 below.

556 See par 9.14 below.

557 See par 9.11 below.

558 See par 9.12 and 9.13 below.

559 See par 9.14 below.

560 Cf sec 39(1)(b) of the 1996 Constitution; **SALC Research Paper on Domestic Violence** 17-18.

561 1997 6 BCLR 759 (CC) par 26.

directly or indirectly against anyone on one or more grounds, including race, gender [or] sex ..." . It is submitted that as required under CEDAW, sexual violence could constitute a stumbling block to the attainment of women's equality.[562] In this context and against the background of the growing prevalence of rape and sexual offences, and the growing prevalence of HIV infection, it could be argued that the specific plight of victims of sexual violence (women and girls) should receive precedence over arrested persons' right to privacy.[563] Proponents for compulsory HIV testing submit that a suspect in a rape or sexual offence case should suffer a diminished expectation of privacy with respect to a blood test for HIV in view of the acute anxieties and psychological needs of the complainant. Because HIV can be transmitted through sexual contact, there is a direct nexus between the alleged criminal behaviour and the government's action (i e compulsory HIV testing). Therefore, the suspect should suffer the invasion that testing him for the virus represents in order to palliate the victim's distress. It is argued that a rape suspect stands on a threshold of trial and possible conviction with resultant significant curtailment of freedom.[564]

8.23.2 Section 12(1)(c) of the 1996 Constitution provides that "everyone has the right to freedom and security of the person, which includes the right - ... to be free from all forms of violence from either public or private sources". In terms of section 7(2) of the Constitution, the state is required to "respect, protect, promote and fulfil the rights in the Bill of Rights". It may be said that the provisions of section 7(2) read with section 12(1)(c) impose a positive duty on the state to provide protection against sexual violence.[565] In this respect international human rights jurisprudence holds that states have certain positive duties to establish and maintain the necessary legal and extra-legal

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562 Cf **SALC Research Paper on Domestic Violence** 17.

563 See par 5.2 et seq above and par 8.25 et seq below on privacy rights.

564 See the United States Supreme Court decision in **People v Adams** 579 NE 2d 574, 583 (Ill 1992).

565 Cf **SALC Research Paper on Domestic Violence** 18.

institutions and remedies through which human rights can be guaranteed.[566] It is submitted that the constitutional duty to provide protection from violence includes a duty to enact legislative provisions which, firstly are effective, and secondly, do not subject victims of sexual violence to secondary victimisation.[567] Since the right to equality, substantively conceived, requires a court to consider the effect of a challenged provision in the social context in which disadvantaged parties live,[568] and since the right to equality is the foundation of the right to freedom from violence,[569] it follows that the right to freedom from violence must also be interpreted in such a manner as to make a substantive difference to the conditions of life of those claiming it.[570] A substantive conception of the right to freedom from sexual violence therefore necessitates not only the prevention of sexual violence, but also the eradication of the detrimental effects of such violence on victims.[571] Proponents hold that legislative intervention for the compulsory HIV testing of arrested persons would serve this purpose.

8.24 Proponents of compulsory HIV testing of arrested persons also argue that adequate legal response to the phenomenon of sexual violence is wanting because of lack of adequate recognition of victims' rights in our country.[572]

8.24.1 Victims' rights would inter alia include the constitutional rights of equality before the law

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566 **Velasquez Rodriguez** Case Judgement of 27 July 1988, Inter-American Court of Human Rights, Ser C, Vol 4, paragraph 166.

567 "Secondary victimisation" would include unsympathetic and inappropriate responses (exacerbating the effects of the sexual violence) that women experience at the hands of society in general and in the criminal justice process (cf the definition of Stanton and Lochrenberg 1 quoted in **SALC Research Paper on Domestic Violence** 18).

568 Cf the 1996 Constitution sec 9(2).

569 See **Fraser v Children's Court, Pretoria North and Others** 1997 2 BCLR 153 (CC) where the court held that "the guarantee of equality lies at the very heart of the Constitution".

570 Cf Goldblatt and Albertyn 1998 **SAJHR** 657 et seq. Cf also **SALC Research Paper on Domestic Violence** 18 et seq.

571 Ibid.

572 See comment by the Tshwaranang Legal Advocacy Centre to End Violence Against Women on **SALC Discussion Paper 80** 2-3.

and the right to equal protection by the law;[573] the right to life;[574] and the right to bodily integrity.[575] Despite the fact that South Africa is a signatory to the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, [576] current victim-support strategies in our country are inadequate.[577] The Declaration stipulates inter alia that victims should be treated with compassion; that the responsiveness of judicial and administrative processes to the needs of victims should be facilitated; and that offenders should make fair restitution to victims - including the restoration of rights.[578]

8.24.2 Since the enactment of the 1996 Constitution which entrenches several procedural rights of detained, arrested and accused persons, there has been a public perception that there is undue emphasis on the rights of suspected criminals and that the lawlessness (which would include the high prevalence of rape and other sexual offences) and subsequent victimisation that are experienced, are the consequences of the new human rights order.[579] This is a fallacious and dangerous belief.[580] Fair procedures indeed benefit both parties. However, the legitimacy of a justice system lies in its ability to give even-handed protection to the human rights of *all* citizens, and failure by authorities to address the position of victims of crime undermines the legitimacy of the justice system. This has been recognised by the Government through the then Minister of Justice in his 1999 budget vote speech which called for the needs and concerns of victims to be addressed

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573 The 1996 Constitution sec 8(1).

574 Ibid sec 11.

575 Ibid sec 12(2).

576 See par 9.8 below.

577 Meintjies-Van der Walt 1998 **SACJ** 158; **SALC Issue Paper on Restorative Justice** par 4.2; see also par 9.8-9.9 below.

578 See par 9.8 below for more detail on the Declaration.

579 Meintjies-van der Walt 1998 **SACJ** 158-159.

580 Cf Cameron 1997 **SALJ** 504 et seq.

and for recognition of the fact that crime does harm to victims.[581] Proponents of compulsory testing of the arrested person maintain that legislative intervention in this regard would constitute a much needed recognition of victims' rights in the area of sexual violence without substantial inroads into the arrested person's rights. Sexual assault causes ongoing harm, including the continuing fear of HIV infection, which can postpone or limit recovery. It is this dynamic and ongoing nature of the harm that suggests that public policy should do everything possible to limit future harm and to preserve the health of the victim and that of his or her partners and children, including psychological health.[582] It would be fundamentally unfair to place all the burden of limiting future harm on the victim. In the case of sexual offences, victims usually bear the whole burden of continuing anxiety and protecting themselves, partners, and families. If testing the arrested person for HIV could limit future harm to the victim and ease the burden of unfairness, this would provide a persuasive argument for compulsory testing of the arrested person.[583]

*** The arrested person's constitutional rights, especially the right to privacy**

8.25 As indicated in Chapter 5 above, the right to privacy is protected by both the common law and the 1996 Constitution.[584] The diverse values privacy protects has led to the distinction being formulated between the freedom "to make certain important decisions about what happens to one's own body" ("autonomy privacy") and the right "to keep personal information private" ("informational privacy").[585] Compulsory subjection to a medical examination constitutes an interference with privacy rights. So does disclosure

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581 See par 2.14 above. See also Meintjies-van der Walt 1998 **SACJ** 158-159.

582 Ibid.

583 Ibid.

584 Neethling et al 239 et seq. Sec 14 of the 1996 Constitution provides that everyone has the right to privacy.

585 Burris in **AIDS Law Today** 115. See also Cameron (Unpublished) par 8. Cf also **S v A** 1971 2 SA 294 (T); **Financial Mail (Pty) Ltd v Sage Holdings Ltd** 1993 2 SA 451 (A) 462E-F; **Jansen van Vuuren v Kruger** 1993 4 SA 842 (A) at 849.

of AIDS related information without the consent of the person concerned.[586] Compulsory HIV testing of the arrested person, and the disclosure thereafter of the test results would thus represent a considerable intrusion into the privacy rights of such a person.

8.26 The Constitutional Court in **Bernstein v Bester**,[587] emphasised the connection between the common law and constitutional right to privacy, and underscored the importance of the rights to autonomy and dignity. Through this emphasis the judgment suggests that the zone of privacy which is protected by the law could include protection from intrusions into *personal decision making*. The decision to take an HIV test has been recognised, in the United States and Europe,[588] as a highly private act. Because of the stigma and discrimination that often result from a disclosure that a person has HIV, HIV status is the kind of information that he or she might want to keep private and/or not to know at all.[589] Furthermore, forced discovery of one's own HIV status may further have an extremely grave impact on one's life.[590] Compelling arrested persons to undergo HIV tests may thus affect their right to privacy, by imposing upon them, prematurely and inopportunely, invasive decisions or knowledge regarding their bodily integrity.[591]

8.27 The Appellate Division (now the Supreme Court of Appeals) in **Jansen van Vuuren v Kruger**[592] accepted that the *need for confidentiality* in the case of AIDS was especially

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586 Strauss 3-13; Clark in **Polisiëring en Menseregte** 265; see also the extensive discussions in **SALC Second Interim Report on Aspects of the Law relating to AIDS** par 5.11 et seq.

587 1996 4 BCLR 449 (CC).

588 See **Doe v The City of New York Commission on Human Rights** 15 F 3d 264 (1994); **Woods v White** 689 F Supp 874 (1988); **X v Commission of the European Communities** European Court of Justice 1995 IRLR 320.

589 1996 **Draft UNAIDS Policy Statement on Counselling and Testing 1996** 3.

590 It can, for instance, affect insurability, disrupt families and lead to stress and depression.

591 The 1996 Constitution, sec 12(2) guarantees the right to bodily and psychological integrity. This certainly includes protection of an individual's mind and body from unwarranted intrusion. It is unclear whether this right will also be interpreted to protect the full autonomous interests that Ackermann J refers to at 65-79 in **Bernstein v Bester** 1996 4 SA BCLR 449 (CC).

592 1993 4 SA 842 (A).

compelling:

> There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality... Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.[593]

Opponents of compulsory HIV testing of arrested persons submit that disclosure of the test results after forced HIV testing would involve a serious intrusion into privacy rights.[594] They argue that tests for HIV are different from other medical tests. HIV tests are considerably more disturbing because the implications of disclosing a positive result impact upon every aspect of a person's life. The social ramifications of disclosure may be devastating as AIDS carries with it a tremendous degree of social stigmatisation and can lead to intense discrimination against infected persons.[595] This should be weighed against the health concerns and psychological needs of rape and sexual offence victims. Opponents concede that to provide these victims with worthwhile information about whether they may have been exposed to HIV, is a logical and human course of action. They submit however that, for various scientific and practical reasons (which have been discussed in detail in paragraphs 8.9 to 8.20.3 above), HIV testing of arrested persons lacks utility and therefore does not serve the interests of victims of sexual offences.

8.28 Opponents also hold the view that overuse and abuse of any statutory intervention for compulsory HIV testing of the arrested person pose a potential invasion of his or her privacy. They argue that victims' requests for information regarding the arrested person's HIV status, could create an opportunity for individuals to claim that they were sexually attacked as a way of discovering the HIV status of a sexual partner or other person.[596] This could result in overuse and abuse of any statutory process created, which

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593 Ibid at 8541J.

594 See also Stadler 1992 **Washington Law Review** 207 et seq; Jackson in **AIDS Agenda** 245; Robling 1995 **Cleveland State Law Review** 674-686; Cameron (Unpublished) par 22, 28 and 31.5.

595 Ibid.

596 Cf Field 1990 **American Journal of Law and Medicine** 102-103; **Los Angeles Times** Washington Edition 1 October 1994 (Internet).

may in turn lead to further harassment, discrimination and marginalisation of arrested persons who have been identified through a compulsory testing process as being HIV positive.[597]

8.28.1 Proponents however argue that legislative intervention could be narrowly drafted to achieve the goals of providing victims of sexual offences with necessary information while at the same time protecting the privacy interests of arrested persons. Procedural safeguards - aimed at reducing the likelihood of testing persons wrongly accused of rape and sexual offences, limiting disclosure of the test results, and preventing punitive use of the information regarding HIV status - could be provided for to prevent any envisaged overuse or abuse of a process of compulsory HIV testing.[598] A malicious activation of the provision enabling compulsory testing would itself be actionable.

8.29 Opponents further maintain that there are less intrusive measures to provide support and assistance to the victims of sexual offences in protecting their own and others' health. These would include victims abstaining from sexual intercourse or resorting to safer sex practices, delaying pregnancy and avoiding breast-feeding until they have had themselves tested for HIV; and the government offering free HIV testing and counselling to victims of sexual offences.[599]

8.29.1 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.[600] As regards the limitation of rights in the HIV/AIDS context, it was submitted that there must be some intellectual criterion of rationality and some acceptable consensus on ethical values

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597 Ibid.

598 Cf Gostin et al 1994 **JAMA** 1441-3.

599 Ibid.

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

against which every measure sought to combat AIDS must be tested.[601] The following criteria were suggested:[602]

- 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?

Opponents suggest that statutory intervention for compulsory HIV testing of arrested persons would fail to meet these criteria in that it does not combat the spread of HIV, and it does invade a crucial right (i e the right to privacy) while there is no social need for the testing.

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601 Cameron and Swanson 1992 **SAJHR** 202-203.

602 Ibid. See also Elliot (Discussion Paper) 36 where he suggests that any coercive legislative response must be guided by the principle of "most effective, least intrusive".

9 COMPARATIVE PERSPECTIVE

9.1 By way of comparison this Chapter looks at international instruments and guidelines relevant to HIV testing of sexual offenders, as well as to victims', women's and children's rights. Recent developments in comparable legal systems (including the United States, the United Kingdom, Australia, Canada, Zimbabwe and Namibia) are also set out below.

A) RECENT INTERNATIONAL INSTRUMENTS

9.2 Several international human rights instruments impact on the current enquiry. These are briefly referred to below. From the information supplied, it is clear that these international instruments contain both legally binding obligations (eg in the case of the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, 1985;[603] the United Nations Convention on the Elimination of all forms of Discrimination Against Women, 1979 [CEDAW];[604] and the United Nations Convention on the Rights of the Child, 1989[605]) as well as persuasive guidelines (eg in the case of the United Nations Guidelines on HIV/AIDS and Human Rights;[606] and the Southern African Development Countries (SADC) Declaration on Gender and Development.[607]

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603 See par 9.8 below.

604 See par 9.11 below.

605 See par 9.13 below.

606 See par 9.3 below.

607 See par 9.14 below.

*** Relevant international instruments on HIV/AIDS**

9.3 The United Nations in 1997 adopted **Guidelines on HIV/AIDS and Human Rights**[608] 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.[609] The essential conclusion underlying the Guidelines is that public health interests need not conflict with human rights of those at risk of infection.[610] They stress that the promotion and protection of human rights are essential components in preventing transmission of HIV and reducing the impact of HIV/AIDS. Furthermore, that the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection.[611]

9.4 As regards HIV testing in general, the Guidelines state that HIV testing of an individual should be performed only with the specific informed consent of that individual, and that information on the HIV status of an individual should be protected from unauthorised use.[612] Exceptions to voluntary testing would need specific judicial authorisation, granted only after due evaluation of the important considerations involved in terms of privacy and

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608 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.

609 The Guidelines are seen as the culmination of various international, regional and national activities, including prestigious international studies on HIV/AIDS and human rights, and an attempt to draw on the best features of these documents. These include studies from the British Medical Association Foundation for AIDS, Harvard School of Public Health, International Federation of Red Cross Societies, National Advisory Committee on AIDS in Canada, Pan-American Health Organisation, Swiss Institute of Comparative Law, Danish Centre of Human Rights, and the Johns Hopkins University Program on Law and Public Health. More than 20 documents, including charters and declarations which specifically or generally recognise the human rights of people living with HIV/AIDS, and which have been adopted at national and international conferences and meetings over the last decade, are cited. These include documents from Europe, Latin America, the United Kingdom, Australia, Eastern-Europe, the United Nations, Malaysia, Thailand, the Asia-Pacific region, India, and Canada (**United Nations International Guidelines on HIV/AIDS and Human Rights** 1-4, 60-61).

610 **United Nations International Guidelines on HIV/AIDS and Human Rights** 5.

611 Ibid 39-40, 58-61.

612 Ibid 12-13.

liberty.[613]

9.5 However, the Guidelines also provide that although certain rights are non-derogable and cannot be restricted under any circumstances,[614] international human rights law, under narrowly defined circumstances, allows Sates to impose restrictions on some rights if such restrictions are necessary to achieve overriding goods, such as public health, the rights of others, morality, public order, the general welfare in a democratic society and national security. For such restrictions to be legitimate, a State must establish that -[615]

- 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 established in a decision-making process consistent with the rule of law).

9.6 Governments are specifically urged to promote a supportive and enabling environment for women and children by addressing underlying prejudices and inequalities.[616] Positive measures, including support services should be established in relation to violence against

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613 Ibid 12.

614 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 (**United Nations International Guidelines on HIV/AIDS and Human Rights** 42-43).

615 **United Nations International Guidelines on HIV/AIDS and Human Rights** 42-43. Cf sec 36 of the 1996 Constitution (the limitations clause) which provides that the rights in the South African Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose; and less restrictive means to achieve the purpose.

616 **United Nations International Guidelines on HIV/AIDS and Human Rights** 22-24 (Guideline 8).

women and sexual abuse.[617] The Guidelines further point out that international human rights obligations essential to effective state responses to HIV/AIDS would *inter alia* include the elimination of all forms of discrimination against women, and the right to share in scientific advancement and its benefits.[618] With regard to the prevention of infection, the former would include the rights of women and girls to freely receive HIV-related information - which should be applied to include equal access to HIV-related information, education, means of prevention and health services;[619] while the right to enjoy the benefits of scientific progress and its applications is important in view of the rapid and continuing advances regarding HIV testing and treatment therapies.[620] In the latter connection, it is however conceded in the Guidelines that developing countries experience severe resource constraints which would limit the availability of such scientific benefits.[621]

9.7 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), 1996 in which South Africa was a participant.[622] They were issued in response to a call for guidelines that outline clearly how human rights standards apply in the area of HIV/AIDS and were compiled for the benefit of participating governments. It was envisaged that one of the principal users of the Guidelines would be participating States in the persons of legislators and government policy makers.[623]

*** Relevant international instruments relating to victims' rights**

9.8 South Africa is a signatory to the **United Nations Declaration of Basic Principles of**

617 Ibid 23.

618 Ibid 41-42.

619 Ibid 44-45.

620 Ibid 49.

621 Ibid.

622 **United Nations International Guidelines on HIV/AIDS and Human Rights** v, 62.

623 Iibid v-vi.

Justice for Victims of Crime and Abuse of Power, 1985.[624] The Declaration inter alia refers to four levels at which victims[625] should be empowered namely, fair treatment, restitution, compensation and assistance. In this regard the Declaration provides as follows:

- Victims should be treated with compassion and respect for their dignity.[626]
- The responsiveness of judicial and administrative processes to the needs of victims should be facilitated by, inter alia, allowing the concerns of victims to be presented and considered at appropriate stages of the proceedings where their personal interests are affected, without prejudice to the accused and consistent with the relevant national criminal justice system.[627]
- Offenders should, where appropriate make fair restitution to victims. Such restitution should include the provision of services and the restoration of rights.[628]
- When compensation is not fully available from the offender or other sources, States should endeavour to provide financial compensation to victims who have sustained significant bodily injury or impairment of physical or mental health as a result of serious crimes.[629]
- Victims should receive the necessary material, medical, psychological and social assistance through government, voluntary, community-based and indigenous means.[630]

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624 **United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power** (Internet).

625 The **United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power** defines "victims" as persons who, individually or collectively have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are in violation of criminal laws (**United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power** [Internet] par A1).

626 **United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power** (Internet) par A4.

627 Ibid par A6(b).

628 Ibid par A8.

629 Ibid par A12(a).

630 Ibid par A14.

- Victims should be informed of the availability of health and social services and other relevant assistance and be readily afforded access to them.[631]
- Police, justice, health, social service and other personnel concerned should receive training to sensitise them to the needs of victims and guidelines to ensure proper and prompt aid.[632]
- In providing services and assistance to victims, attention should be given to those who have special needs because of the nature of the harm inflicted or because of factors such as inter alia sex and age.[633]

9.9 The South African Law Commission pointed out in a recent Issue Paper on Restorative Justice that although South Africa is a signatory to the above, community participation in the criminal justice process is almost non-existent, reparation to the victims of crime is inadequate and only limited services are at present being provided to victims of crime.[634] It was emphasised that present support services for victims of crime and violence in our country seem to be limited, fragmented, uncoordinated, reactive in nature and therefore ineffective.[635]

*** International instruments relating to violence against women and children**

9.10 During the last decade gender-based violence has received increasing attention in international human rights law, with concomitant emphasis on the determination of state obligations to address gender-based violence. International instruments may therefore be of specific significance in determining the nature of the duties of the South African Government to address gender based-violence, including sexual violence. In addition, international law may also be important in the interpretation of the fundamental rights

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631 Ibid par A15.

632 Ibid par A16.

633 Ibid par A17.

634 **SALC Issue Paper 7** par 3.14.

635 Ibid par 4.2.

entrenched in the 1996 Constitution.[636]

9.11 South Africa on 15 December 1995 ratified the **United Nations Convention on the Elimination of All Forms of Discrimination Against Women, 1979 (CEDAW)**. States Parties to the Convention undertake to condemn all forms of discrimination against women.[637] In this regard states must inter alia include the principle of equality between women and men in its national constitution and laws, making sure that this principle becomes a reality in everyday life; punish people who discriminate against women; and change or remove all laws, regulations, customs and practices which discriminate against women. Further, States must use all possible measures to improve the position of women in all areas of their lives.[638] As regards sex role attitudes and prejudice CEDAW requires that states must take measures to correct the view and attitude that women are less important than men or that women must act in a certain way because they are women.[639] Women and men must have equal access to health care.[640] Finally, the law must treat women and men equally.[641]

9.12 Although not expressly dealt with in CEDAW, "violence against women" has been characterised by CEDAW as gender-based discrimination within the meaning of its article 1.[642]

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636 Cf **SALC Research Paper on Domestic Violence** 10-11.

637 **CEDAW** art 2.

638 Ibid art 3.

639 Ibid art 5.

640 Ibid art 12.

641 Ibid art 15.

642 General Recommendation 19 (11th Session, 1992) UN Document CEDAW/C/1991/L/1/Add.15 1992. See also **SALC Research Paper on Domestic Violence** 12; Wolhuter 1998 **THRHR** 446. Gender based violence is defined by CEDAW as "(v)iolence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty" (art 1).

9.13 Under the **United Nations Convention on the Rights of the Child, 1989** (ratified by South Africa on 16 June 1996) States Parties inter alia undertake to take all appropriate legislative measures to protect the child from all forms of physical violence - including sexual abuse while in the care of any person who has the care of the child;[643] and further, to protect the child from all forms of sexual abuse.[644]

9.14 In terms of an addendum to **The Southern African Development Countries (SADC) Declaration on Gender and Development, 1997** the following measures specifically relevant to the current enquiry were adopted for implementation by SADC members: Reviewing and reforming the criminal laws and procedures applicable to cases of sexual offences to eliminate gender bias and ensure justice and fairness to both the victim and the accused;.[645] and providing easily accessible information on services available to women and children victims or survivors of violence.[646]

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643 **United Nations Convention on the Rights of the Child, 1989** article 19.1. A "child" is defined in the Convention as "every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier" (article 1).

644 **United Nations Convention on the Rights of the Child, 1989** article 34.

645 **SADC Declaration on Gender and Development, 1997** par 12.

646 Ibid par 21.

B) EXPERIENCE IN OTHER LEGAL SYSTEMS

* United States

9.15 In the United States federal law since 1992 requires states to test convicted sexual offenders for HIV infection as a condition of receiving 10% of the funds allocated to a state under federal Bureau of Justice Assistance Grant programs.[647] Five elements are to be met in such legislation:[648]

- Mandatory HIV testing at the request of the victim for all persons convicted of a sexual act should be the norm. There should be no exception to this norm. This standard would be met even in the absence of a requirement for victim request - however the standard would not be met if the State statute would allow any avoidance of the testing process.
- The State statute must provide for an agency of the State to direct the test to be administered, although the actual physical testing may be delegated to another, such as a physician, laboratory etc. Typically, the State statute would provide the the presiding judge to order the testing before sentencing.
- The persons to be tested should include persons entering a plea of guilty to a charge of a criminal sexual act[649] as well as those being found guilty - including juveniles.
- The state statute must provide for the disclosure, at the request of the victim, of the test results to both the victim and the person convicted. Some states have chosen to provide that the results be disclosed to others as well, such as the spouses of the victim and the defendant.
- State statutes should include provision for certain services available to the victims of these sexual acts at their request - including counselling regarding HIV/AIDS;

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647 42USC 3756(f), Crime Control Act,1990 §1804. See also Gostin et al 1994 **JAMA** 1439; Jürgens 173.

648 Ibid; see also **US Department of Justice Information** (Internet).

649 "Sexual act" is being defined as contact between the penis and the vulva or the penis and the anus, including penetration, however slight; and contact between the mouth and the penis, vulva or anus (42USC 3756(f)(3) read with 18USC 2245(1)).

HIV testing in accordance with applicable law; and referral for appropriate health care and support services. It is implied that these services are to be provided at the expense of State governments, rather than at the victim's expense.

9.16 As of 1994, 32 states explicitly authorised compulsory HIV testing in the criminal context.[650] However, the provisions of these statutes vary widely in form and detail on the following aspects: the stage of the criminal process when the person can be tested; the range of persons to whom the test results may be disclosed; and whether or not testing must be triggered at the request of a victim.[651] In some states only the victim and the person tested receive the test results while in others the victim as well as spouses of the person tested receive the results.[652] Moreover, the courts' interpretation of these statutes vary from state to state:[653] Despite complaints that compulsory testing violates the privacy rights of "criminal defendants",[654] (i e accused persons) many courts have upheld such testing as constitutional.[655] Courts have reasoned that, although compulsory testing may encroach on some rights, the practice is reasonably related to the non-punitive and important state objective of impeding the spread of HIV. Furthermore, courts have found blood tests to be relatively non-invasive, and to pose a minimal physical risk to the criminal defendant.[656] It has also been held that fairness dictated compulsory HIV testing

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650 **HIV InSite** (Internet); Jürgens 173.

651 The majority of states (15) permit post-conviction testing only eg Indiana, Michigan, Mississippi, Missouri and Oregon. Five authorised pre-conviction testing only eg California, North Carolina, Nevada and Ohio; while seven authorised both pre-conviction and post-conviction testing eg Georgia, Idaho Maryland and Wyoming. In 30 of the 32 states which introduced compulsory HIV testing of sexual offenders, the test result may be disclosed to the victim; and four states also provided funding for testing or counselling of survivors or victims (Gostin et al 1994 **JAMA** 1439-1440; **AIDS Practice Manual** 13-10; Edgar and Sandomire 1990 **AMJLM** 194-196; Jürgens 173).

652 **US Department of Justice Information** (Internet); **AIDS Practice Manual** 13-9

653 Jürgens 173; **HIVInsite** (Internet).

654 "Criminal defendant" presumably refers to persons charged (as opposed to "persons convicted").

655 See eg **People v Wealer** 642 NE 2ed 1299 (Ill 1994); **People v Frausto** 42 Cal Rptr 2d 450 (Cal Ct App 1995); **State ex rel JG** A-3585-94T5 1996 NJ Super LEXIS 163 (NJ Super 1996); **Fosman v State** 664 S0 2d 1163 (Fla App 4 Dist 1995). See also **HIVInsite** (Internet).

656 **HIVInsite** (Internet).

to help mitigate the plaintiff's emotional suffering.[657] Several courts however, have limited the states' ability to test criminal defendants.[658] It has accordingly been held that in the absence of an authorising statute, a court could not compel a rape defendant (i e accused) to be tested. A New York court ruled that even with statutory authorisation, compulsory testing could be conducted only if the evidence sought was reasonably related to establishing the allegations.[659]

9.17 In addition to the above, new federal legislation in the form of the HIV Prevention Bill was proposed in the House of Representatives in March 1997. The proposed Bill (which has not yet been enacted because of vigorous opposition) inter alia provides that States should enact legislation for the compulsory HIV testing of criminal defendants in cases of sexual activity where force or threats of force were involved.[660]

9.17.1 The proposed Bill provides that States require that a criminal defendant (i e accused) be tested for HIV if the nature of the alleged crime is such that the sexual activity would have placed the victim at risk of becoming infected with HIV; or if the victim requests that the defendant be so tested.[661] Further, that the defendant should undergo the test not later than 48 hours[662] after the date on which the indictment is presented and that as soon thereafter as is practicable the results of the test be made available to the victim, the

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657 **Syring v Tucker** 505 NW 2d 142 (Wis 1993). In this instance the plaintiff was bitten by the defendant. The court held that equitable principles justified the compulsion of the medical examination (i e HIV testing). The uncertainty regarding the defendant's HIV status profoundly affected the plaintiff and his future life. It was held that the need of the plaintiff to know the HIV status of the defendant outweighed the defendant' right to privacy (**HIVInsite** [Internet]).

658 **Doe v Connell** 583 NYS 2d 707 (App Div 4Dept 1992); **State v Abbott** 901 P 2d 1296 (Haw App 1995); **State v Foster** 915 P 2d 567 (Wash App Div 1996); **People v Guardado** 1996 Cal LEXIS 1519 Mar 13 1996). See also **HIVInsite**[Internet]).

659 **In re Michael WW** 616 NYS 2d 480 (NY 1994). See also **HIVInsite** (Internet).

660 HIV Prevention Bill (105th Congress, 1st Session in the House of Representatives 1997 HR 1062 - clauses 3(a)(3)(A), (B), and (D).

661 Ibid clause 3(a)(3)(A)(i) and (ii).

662 According to the medical information supplied in par 3.53 a time lapse of 48 hours after possible infection, would however be too late to successfully administer PEP.

defendant (or his/her legal guardian if he/she is a minor), the attorneys of the victim and of the defendant, the prosecuting attorneys, the judge presiding at the trial and the principal public health official for the local governmental jurisdiction in which the crime is alleged to have occurred.[663] The victim may also request that the defendant undergo such follow-up tests for HIV as may be medically appropriate, and provision is made that the results of such tests be disclosed to the victim.[664] Finally, if the test results indicate that the defendant has HIV, such fact may be considered in judicial proceedings conducted with respect to the alleged crime.[665] Representative Tom Coburn who introduced the Bill indicated that the main motivation for the provision of HIV testing of sexual offenders is the availability of treatment therapies to avert seroconversion.[666]

9.18 Existing American literature on HIV testing after sexual assault is divided as to whether or not compelled testing of the criminal defendant is justified.[667] Many of the above

663 HIV Prevention Bill (see fn 660 above) clause 3(a)(3)(B).

664 Ibid clause 3(a)(3)(C).

665 This is allowed on condition that the defendant continues to be the defendant in the judicial proceedings involved, or is convicted in the proceedings (HIV Prevention Bill clause 3(a)(3)(D)).

666 Burr **POZ** July 1997 (Internet).

667 Even if testing is authorised by statute, it has been argued that in most instances testing an accused for the non-evidentiary purpose of disclosing HIV status to an exposed person would violate the fourth amendment to the United States Constitution, which requires that all searches be reasonable. (The United States Supreme Court long recognised that extraction of a blood sample triggers a fourth amendment interest.) In order to satisfy the requirement of "reasonableness" a blood test must be authorised by a search warrant issued upon a showing of probable cause to believe the test will yield material evidence (which will not be the case if the object is solely to inform the victim). Moreover, the government's interest in obtaining the blood sample must outweigh the defendant's expectation of privacy in the information that will be revealed by the test. It has been argued that even where probable cause is shown, an objective assessment of reasonableness would still preclude involuntary HIV testing in most cases: In determining reasonableness, a court must balance the state's interest in obtaining the test results against the defendant's interest in maintaining the privacy of this information. The asserted state interest is invariably to advise the exposed person whether he or she has been exposed to HIV. This interest is not addressed by testing the defendant in the majority of cases, as information about the defendant's HIV status has scant practical value for the exposed person: Testing the defendant for HIV will not reveal whether the exposed person has become infected, as that question can be resolved only by testing the exposed person. On a balance the defendant has a significant interest in not being compelled to submit to a test that will reveal the presence of a fatal illness, since a positive result will inevitably have a devastating personal impact. Disclosure of the test results will also subject the defendant to discrimination and harassment in all aspects of life (**AIDS Practice Manual** 13-9 - 13-14). A number of court decisions however suggested that when the government is trying to achieve an important public purpose (it has been argued for instance that the government has a compelling interest in obtaining

mentioned state statutes have been criticised in that they have limited value in predicting the likelihood of infection of another individual, particularly where there is no "exchange of bodily fluids" requirement for testing.[668] In addition, statutes authorising testing of persons who have merely been accused of a crime met with strong opposition.[669] On the other hand the usefulness of knowing the accused's serostatus in mitigating the ongoing harm to the survivor and others (particularly the psychological benefit and the potential protection of the survivor's partner and future children) has been emphasised.[670]

9.19 Although some health care providers have proposed offering antiretroviral drugs to persons with unanticipated sexual HIV exposure, and although informally protocols or programmes for providing the drugs to victims of sexual assault are in force in some United States hospitals,[671] no official guidelines regarding the provision of these drugs to victims of sexual assault exist in the United States. The CDC in September 1998 published a report on management of possible sexual or other nonoccupational exposure to HIV to address concerns in this regard.[672] The report emphasised that as no data exist regarding the efficacy of drug therapies to prevent HIV infection in persons with nonoccupational HIV exposure, it should be considered an unproven clinical intervention. Under these circumstances the CDC was not prepared to make definitive recommendations for or against the use of post exposure prophylaxis for sexual exposure.[673] 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

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information that directly affects the physical and mental well-being of survivors of sexual assault) and when the intrusion on privacy is not substantial, testing will be upheld (Gostin et al 1994 **JAMA** 1442).

668 **AIDS Practice Manual** 3-9, 13-9. This requirement refers to a certain standard of proof as regards the possibility that bodily fluids could indeed have been exchanged between the defendant and the victim (thus establishing the possibility of HIV transmission through the act committed).

669 **AIDS Practice Manual** 3-9.

670 Gostin et al 1994 **JAMA** 1443.

671 Cf par 3.61 above.

672 CDC **Morbidity and Mortality Weekly Report** 25 September 1998 (Internet).

673 Ibid.

antiretroviral treatment will be likely restricted to situations in which the risk for infection is high, the intervention can be initiated promptly, and 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 against the uncertain effectiveness, potential toxicities and cost of drugs, as well as the patient's anticipated adherence to the therapy.[674] It was firmly stated that post exposure prophylaxis 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.[675]

* United Kingdom

9.20 The United Kingdom has currently no legislative provisions aimed at the compulsory HIV testing of sexual offenders.

9.21 In a Law Commission report on the codification of English criminal law in 1993 the government reacted to public outcries for the enactment of a new offence to address wilful (i e intentional) transmission of HIV.[676] The Commission proposed legislation restating the position in the Offences Against the Person Act, 1861 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.[677] HIV testing of offenders was not provided for in this restatement of the law.

9.22 Enquiries on the issue of official policy regarding the provision of prophylaxis for victims of sexual assault showed that there are no formal guidance in this regard in the United

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674 Ibid.

675 Ibid. For more detail on the CDC report see par 3.60 above.

676 **Law Commission Report No 218** 1993 par 15.17. See also **SALC Discussion Paper 80** par 6.13 and the sources quoted there.

677 See **SALC Discussion Paper 80** par 6.13 and the accompanying footnotes for more information.

Kingdom.[678] The Department of Health in Guidelines on Post Exposure Prophylaxis for Health Care Workers Occupationally Exposed to HIV issued in June 1997, state that the efficacy of post exposure prophylaxis following possible sexual exposure (eg rape) has not been studied. The Department advises that should clinicians be approached for advice in such circumstances, they will need to consider the individual circumstances of each case.[679]

* Australia

9.23 In Australia the federal Government's HIV/AIDS Strategy (or Whitepaper) in 1989 recommended compulsory HIV testing *inter alia* in respect of the following:[680]

- persons charged with a sexual offence, at the request of the alleged victim;
- where such testing is necessary to decide on the urgent medical treatment of another person; and
- where a person is suspected on reasonable grounds to be HIV positive and persistently behaves in such a way as to place other persons at risk of infection and there is a clear indication that the person is likely to continue to behave in such a way.

According to the recommendations compulsory testing under these circumstances should only occur as a last resort and be ordered by a court sitting in camera using the following criteria: testing should be necessary and/or in the interests of public health; HIV transmission should have previously occurred or others should have been exposed to the possibility of wilful or reckless transmission of HIV.[681] If a person refused to obey such

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678 Information supplied by Dr Lorraine Sherr, Senior Lecturer in the Department of Primary Care and Population Sciences, Royal Free and University College Medical School, University College London on 13 March 1999.

679 Ibid. See also **Guidelines on Post-Exposure Prophylaxis for Health Care Workers Occupationally Exposed to HIV** 3.

680 **Australia Discussion Paper Public Health** 27.

681 Ibid.

court order he or she would be in contempt of court. It was noted that in the case of rape, blood may have already been taken for other purposes[682] and the court could then order the testing of the existing blood sample. The White Paper also mentioned that a court, in deciding to order compulsory HIV testing, should take into account the availability of a proven prophylactic treatment, such as AZT in the case of rape.[683]

9.24 In 1991 these issues were reviewed by the Legal Working Party of the Intergovernmental Committee on AIDS. Their investigations revealed that only New South Wales and South Australia provided for court- ordered compulsory testing in public health laws in instances of persistent HIV-related behaviour placing others at risk of infection. They therefore stated that there was a need for clear and structured criteria to be contained in public health legislation country-wide, together with procedural safeguards such as notice, reasons for decision, opportunity to be heard, and notification of review rights.[684] In their final report the Legal Working Party recommended that HIV testing should only be carried out with informed consent except in specified cases authorised by law as recommended in the 1989 White Paper.[685]

9.25 HIV testing in a criminal context is apparently addressed by legislation in only one Australian State - Tasmania. The HIV/AIDS Preventive Measures Act 25 of 1993 provides for compulsory HIV testing of persons charged with having committed crimes of a sexual nature - including rape and sexual assault.[686] In terms of this Act the Secretary of the Department of Health may require a person charged with a crime of a sexual nature under the Criminal Code to undergo an HIV test.[687] Where a person so

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682 Presumably evidentiary purposes.

683 **Australia Discussion Paper Public Health** 27.

684 Ibid 28.

685 **Australia Final Report on AIDS** 4.

686 Information confirmed by Adv David Buchanan SC, member of the board of the AIDS Council of New South Wales on 9 April 1999). See also Jürgens 173.

687 HIV/AIDS Preventive Measures Act, 1993 sec 10(1). Testing may also be required where it is necessary to determine the medical treatment of another person who may be at risk of becoming infected with HIV

required refuses to be tested the Secretary may apply to a magistrate for an order requiring the person to oblige to testing.[688] In determining whether to make such an order, the possibility of someone having been exposed to HIV transmission, the right to information of a person at risk or infection, and the availability of a proven HIV treatment must be taken into account.[689] However it is further provided that a magistrate shall not order HIV testing unless satisfied on the balance of probabilities that it is in the interests of public health to make such order.[690] The person tested is to be informed of the test result and a positive result must also be relayed to the Secretary.[691] Information regarding the test result may not be disclosed without the written consent of the person tested except in circumstances listed in the Act, including disclosure to a court where that information is directly relevant to the proceedings before the court.[692] In any proceedings a court may disclose information relating to the HIV status of a person if it is of the opinion that disclosure is necessary.[693] Under such circumstances the court may order that only specified persons may be present during the whole or any part of the proceedings because of the social and economic consequences to the person with HIV.[694] This Act contains no provision to disclose HIV-related information directly to victims of crime.

9.26 Research revealed no official guidelines or policies regarding the provision of prophylaxis

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and whose condition, or suspected condition, in the opinion of a medical practitioner, is directly or indirectly caused by the person required to undergo the HIV test; or where the Secretary has reasonable grounds to believe that the person to be tested has HIV, behaves in such a way as to place other persons at risk of becoming infected with HIV, and is likely to continue to behave in such a way (Ibid sec 10(2)).

688 HIV Preventive Measures Act, 1993 sec 11(1).

689 Ibid sec 11(3).

690 Ibid sec 11(4).

691 Ibid sec 15(1).

692 Ibid sec 19(1)(a) and (i).

693 Ibid sec 42.

694 Ibid sec 42(b).

to victims of sexual offences in Australia.[695] It needs to be remembered that in Australia 80-85% of cases of HIV are homosexually acquired. Although every state has clear post exposure prophylaxis protocols for occupational exposure to HIV, and the New South Wales Health Department currently runs a trial post exposure prophylaxis protocol for sexual exposure to HIV (the participants in this trial having acquired HIV mostly during consensual sexual intercourse) HIV transmissions through non-consensual intercourse in Australia are so few as to mean this has not emerged as an issue.[696]

* Zimbabwe

9.27 In Zimbabwe the issue of testing of sexual offenders was recently addressed in draft legislation providing for the criminalisation of deliberate transmission of or exposure to HIV.[697] The proposed testing provision will apparently operate only for evidentiary purposes. No provision is made for the results of such tests to be relayed to the victims of sexual offences.

9.27.1 The proposed Criminal Law Amendment Bill, 1996 makes it a criminal offence for any person, having actual knowledge that he or she has HIV, intentionally to do anything or permit the doing of anything which he knows or ought reasonably to know will infect another person with HIV; or is likely to lead to another person becoming infected with HIV.[698] The Bill further provides that when an alleged sexual offender appears before a

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695 Information supplied by Adv David Buchanan SC, member of the board of the AIDS Council of New South Wales on 9 April 1999.

696 Ibid. Julia Cabassi, Policy Officer of the New South Wales Aids Council pointed out that the New South Wales protocol can also cover PEP in cases of sexual assault although she conceded that risk assessment in sexual assault settings will be complex - quite possibly involving police statements and forensic examinations which may make unlikely the capacity of a person to take a decision in favour of PEP because of the time constraints (comment by Ms Cabassi on 13 April 1999).

697 Zimbabwean Criminal Law Amendment Bill 1996 clause3 (cf proposed new section 14). For more detail see **SALC Discussion Paper 80** par 6.18- 6.18.4.

698 Zimbabwean Criminal Law Amendment Bill, 1996, clause 3 (proposed sec14(1)). See also **The Citizen** 5 July 1997.

court for the first time in connection with a "sexual offence",[699] the court is obliged to direct that an appropriate sample (blood, urine or other tissue) be taken from such person to ascertain whether such person is infected with HIV.[700] The court may decline to direct the testing if it is satisfied that the alleged sexual offender could not have infected anyone with HIV in the course of the sexual offence with which he has been or is to be charged.[701] In the event of a direction for testing being given, a medical practitioner or designated person[702] must take an appropriate sample on the written request of a senior police officer.[703] If necessary reasonable force may be used to take the sample, but a medical practitioner may also decline to take the sample if he considers taking it would be prejudicial to the health, proper care or treatment of the alleged sexual offender.[704] Any person who unreasonably hinders or obstructs taking the sample shall be guilty of an offence and liable to a fine not exceeding five thousand dollars or imprisonment not exceeding two years or to both.[705] The presence in a persons body of HIV anti-bodies detected through an appropriate test, shall be prima facie proof that the person concerned was infected with HIV.[706]

9.27.2 The Zimbabwean Minister of Justice expressed the hope that the legislation will be passed by Parliament. Several women's organisations in Zimbabwe welcomed the proposals

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699 A "sexual offence" is defined as rape; sexual intercourse with a girl under the age of 16 years or with an idiot or imbecile; incest; sodomy; indecent assault; and the deliberate transmission of HIV as provided for in sec 14 of the Criminal Law Amendment Act, 1998 (Criminal Law Amendment Bill 1996 clause 3 [proposed sec 16(1)]). Cf the definition of the term "sexual offence" for purposes of this Discussion Paper in par 2.18.2.3 above.

700 Criminal Law Amendment Bill, 1996,clause 3 (proposed sec 16(2)).

701 Ibid proposed sec 16(3).

702 Referring to a member of a class of persons designated for the purposes of this clause by the Minister of Health (clause 3 [proposed sec 16(1) and (3)]).

703 Criminal Law Amendment Bill, 1996,clause 3 (proposed sec16(3)).

704 Ibid.

705 Ibid proposed sec 16 (6).

706 Ibid.

saying it was long overdue.[707] Representatives from eight NGOs concerned with human and women's rights, although opposed in comments on the Bill to the criminalisation of HIV transmission,[708] suggested that as a general rule the perpetrator should be tested for HIV. They suggested that a decision to test should not be left to the discretion of a magistrate alone, but that medical opinion should also be sought. In their view, the question whether an offender may have infected a victim is a medical question and not a judicial one.[709] Following a process of public consultation, the proposed legislation has subsequently been withdrawn to enable the incorporation of further amendments. The new Bill has been renamed the Sexual Offences Bill (1998) and is still in the process of being redrafted.[710]

9.28 As far as could be ascertained no official guidelines with regard to the provision of prophylaxis to victims of sexual offences exist in Zimbabwe at this stage.

*** Canada**

9.29 While survivors of sexual assault may request that their assailant ***voluntarily*** undergo HIV testing, current Canadian law does not allow for mandatory HIV testing of persons accused or convicted of sexual assault.[711]

9.30 In examining the question whether this should be changed, the Canadian AIDS Legal Network and AIDS Society in a 1998 report on the issue concluded that compulsory

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707 **The Herald** 20 May 1997.

708 For more detail see **SALC Discussion Paper 80** par 6.18.3.

709 Comment on the Zimbabwean Criminal Law Amendment Bill, 1996 by Women and AIDS Support Network; Women in Law and Development in Africa; Zimbabwe AIDS Network; The Centre; Musasa Project; Zimbabwe National Network of People with AIDS; NG Development Agency; Zinatha; and SAFaids (Information supplied by Ms Lynde Francis of The Center on 14 March 1998) - refer to p4 of their Comment. (This was one of several points of criticism on the proposed legislation in general. Neither the proposed legislation nor the comments indicate whether the purpose of the legislation was to specifically curb the spread of the disease.)

710 Information provided by Mr A McMillan, Deputy Chairman Law Development Commission, Zimbabwe on 12 April 1999.

711 Jürgens 164-169.

testing of persons ***convicted*** of sexual assault cannot provide the survivor with useful information and is therefore not justified.[712] Although compulsory testing (at the request of the survivor) of persons ***accused*** of sexual assault may provide some psychological reassurance to the survivor, it generally has few benefits and many potential harms.[713] The report suggests that what is required instead is a governmental response that answers the very real concerns of survivors of sexual assault and provides them with assistance such as best-practice counselling, short- and long-term care, and treatment. According to the report the latter should iter alia include access to HIV testing and counselling for all sexual assault survivors, provided by trained staff of sexual crisis centres or similar facilities; the possible availability of PCR testing to survivors; and access to post-exposure prophylaxis.[714]

9.31 Although no official protocols for post exposure prophylaxis after sexual assault exist, prophylaxis for survivors of sexual assault has become available for survivors in a few areas of the country eg at the British Columbia Women's Hospital.[715]

*** Namibia**

9.32 Following on a 1997 Report by the Law Reform and Development Commission, the Combatting of Rape Bill has been introduced in the Namibian Parliament in June 1999. The Bill mainly broadens the common law definition of rape to include other serious sexual violations; 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

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712 Ibid 179.

713 Ibid.

714 Ibid.

715 Ibid 169.

trauma for rape victims.[716]

9.33 The proposed legislation has reportedly been eagerly awaited by women since Namibia's independence.[717] The proposed Bill however contains no provision for HIV testing of rapists or for the disclosure of rapists' HIV status to victims of sexual crimes.

716 **Namibia Report on the Law Pertaining to Rape** 1997 2-9; The Combatting of Rape Bill, 1999. The Bill *inter alia* also provides for the rape of men by women, something that has evoked heated discussion in the Namibian Parliament with some women Members of Parliament reportedly strongly criticising this (**Mail and Guardian** June 11-17 1999).

717 Hubbard (Unpublished) 1.

10 PRELIMINARY CONCLUSION AND RECOMMENDATION

10.1 It is evident from the discussions above that as a general principle our law provides for HIV testing only with the informed consent of the person concerned, that every person is entitled to privacy regarding medical information, and that no general legislation exists which allows for disclosures. Furthermore, the discussion of the current law in chapters 5, 6 and 7 above, shows that neither public health law nor criminal procedure currently makes provision for compulsory HIV testing of *arrested persons* in sexual offence cases with a view to disclosing their HIV status to victims of crime.

10.2 In the light of the high prevalence of HIV, the violent epidemic of rape and other sexual crimes in South Africa; the fact that HIV may be transmitted through certain sexual offences; and that the possibility of contracting HIV in this way has been identified by victims as one of their key concerns, the Commission is of the opinion that the current legal position needs to be amended to provide for the compulsory HIV testing of persons arrested in sexual offence cases in order to provide victims with information regarding their assailants' HIV status.[718] The crux of the issue is women's undoubted vulnerability in South Africa today to widespread sexual violence amidst the increasing prevalence of a nationwide epidemic of HIV and in the absence of adequate institutional or other victim-support measures.[719] In these circumstances there is a compelling argument for curtailing an arrested person's rights of privacy and bodily integrity to a limited extent to enable his accuser to know whether he has HIV. The benefit to the alleged victims of the knowledge is not only immediately practical in that it enables them to make life decisions and choices for themselves and people around them; it is also profoundly beneficial to

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718 Cf however the view of Pithey et al (Unpublished) 153-154. The authors are sceptical about the utility of testing the accused in a rape case at the time of his arrest and do not believe that compulsory testing will address the problems facing rape victims and the possibility of their contracting HIV from the accused rapist. Their conclusion is however based on the current legal position and does not foresee the implementation of a speedy and uncomplicated procedure as proposed in this Paper.

719 Although this Paper recognises that males are also the victims of sexual offences (see par 2.18.2.4 above), and that anal intercourse indeed carries a higher risk of HIV transmission than vaginal intercourse, it is accepted that women are mostly targeted by rape and other sexual offences (see par 8.7).

their psychological state to have even a limited degree of certainty regarding their exposure to a life-threatening disease. That the arrested person's rights are infringed, must be acknowledged and must be reflected in safeguards built into the process created.

10.3 The Commission has in coming to this conclusion considered other possible legal or policy interventions. These could include:

A) Retaining the status quo.

Arguments for retaining the status quo are based on the fact that knowledge of the arrested person's HIV status does not on its own protect the victim from becoming infected with HIV. Such knowledge simply provides her with information on whether or not she has been exposed to HIV. Proponents of this argument submit that the Department of Health has indicated on 21 May 1999[720] that it will be initiating controlled research into prophylaxis after sexual exposure. Should this research show that providing PEP to victims of sexual crimes will reduce the possibility of HIV infection, a national policy decision may be taken to provide PEP to all sexual offence victims. This would mean that legislative intervention regarding compulsory HIV testing of an arrested person is no longer needed. The Commission has however rejected this approach as it does not deal with the key issues at stake, namely providing victims with peace of mind regarding their possible exposure to HIV. Scientific evidence also shows that PEP should not be administered as a matter of course.[721] Furthermore, considering the public outcry in the wake of prominent incidents of rape and gang rape in the past 18 months and the alarming increase of HIV infection in the population, which has led to continuous pressure being placed on the Government to amongst others provide HIV testing and prophylaxis to rape victims at state cost, it appears necessary to deal with this issue directly. More critically, there is no indication at this stage that the Government will indeed be in a position to provide PEP on a routine basis to all sexual

720 **Beeld** 21 May 1999.

721 See par 3.60 above.

offence victims.[722]

B) ***Developing and establishing a policy process (guidelines) aimed at the voluntary HIV testing of arrested persons and voluntary disclosure of their HIV test results to victims of crime.*** This would entail counselling an arrested person to obtain his or her consent for HIV testing and for the disclosure of the test results. This procedure is currently the preferred protocol within the health care setting in the case of occupational exposure to HIV.[723] If it is assumed that HIV testing of an arrested person indeed benefits victims, then voluntary testing of such person could hold the same benefits - provided he or she consents to testing and to the disclosure of the test results. The disadvantage of voluntary testing is that arrested persons will control the process of testing and disclosure and they may have little motivation to participate in such process and to assist victims of crime.

C) ***Developing a governmental response (eg in the form of policy and practical guidelines) that answers the very real concerns of victims of sexual offences and provides them with support and assistance in dealing with the possibility of HIV infection.***[724] This could include ensuring access to -

- free HIV testing and counselling for all sexual offence victims, provided by trained staff at sexual assault crisis centres or at similar facilities established by the government;
- assessment of the risk of exposure to HIV; and (provided that the efficacy of PEP is proved) access to PEP for sexual offence victims where necessary; accompanied by counselling about its impact and medical monitoring of its

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722 Government has already rejected the possibility of providing AZT to pregnant mothers because of the high costs associated with this treatment, despite extensive evidence being available showing that the treatment can reduce vertical transmission of HIV (**Beeld** 7 May 1999; **Sunday Times** 2 May 1999; **Sunday Independent** 2 May 1999).

723 It is only allowed to test patients for HIV without their consent in emergency situations where it is impossible to obtain consent, or where the patient has refused consent - which implies that consent must first be sought (**Health Profession of South Africa Guidelines on HIV/AIDS 1994** 5). See also **South African Medical Association Ethical Guidelines 1998** par 3.

724 This approach is favoured by Pithey et al (Unpublished) 154-155.

side-effects;

° governmental assistance providing HIV/AIDS related training of staff at sexual assault crisis centres and of other professionals who have contact with survivors of sexual offences.[725]

The Commission is of the opinion that practice and policy guidelines would however not supply sexual offence victims with the psychological benefit of peace of mind which knowing their attacker's HIV status may do. Moreover, guidelines as mentioned, may in any case be developed alongside statutory provision for compulsory HIV testing. The Commission, under its investigation into Sexual Offences (Project 107) is currently doing research which may lead to in principle recommendations in this regard.[726]

10.4 The Commission has thus come to the preliminary conclusion that the most effective intervention would be a legislative provision for compulsory HIV testing of arrested persons in sexual offence cases. The Commission recognises however that there are competing interests at stake in such intervention which need to be reconciled. It is submitted that this can be effectively done if the envisaged intervention contains safeguards to protect the rights of the arrested person, including authorisation of testing only if it is victim-initiated; requiring a certain standard of proof on which a court will base the authorisation for testing; testing only on court authorisation; limiting disclosure of the test results to the victim and the arrested person; and limited use of the information gained through compulsory testing.

10.5 In the light of the above the Commission is of the opinion that a legislative intervention should be based on the following principles:[727]

° The process providing for compulsory testing of an arrested person must be

725 Cf Jürgens 179.

726 See **SALC Discussion Paper Sexual Offences**. This Discussion Paper is currently available for comment.

727 Cf Gostin et al 1994 **JAMA** 1441.

speedy and accessible so as to ensure that it provides a tangible benefit for sexual offence victims.

° Compulsory HIV testing of an arrested person should in principle be victim-initiated.[728] This will ensure that only a person with a material interest in the arrested person's HIV status may apply for a compulsory testing order. "Victim initiation" include initiation of the testing process by the victim or a person acting on his or her behalf.

° In order to protect the victim from a further potentially traumatising confrontation, the arrested person should not be allowed to take part or give evidence in an application by the victim for compulsory HIV testing, except to be able to challenge whether information on oath has in fact been placed before the magistrate in compliance with the provisions.

° A specified standard of proof should be required on which to base an order for compulsory HIV testing. The Commission is of the opinion that this should consist of the prosecution showing prima facie that the arrested person committed the sexual offence in question, and that the act was of a type that could indeed transmit HIV (eg that semen or blood could have been transferred from the assailant to the victim, or that the victim experienced traumatic injury with exposure to semen or blood).

° Compulsory HIV testing of an arrested person should take place only on authorisation by a court. Furthermore, this should be a discretionary power resting with the presiding officer hearing the application.

° In order to safeguard against abuse of the procedure certain procedural and substantive safeguards must be provided for. These should include scrutiny by a

728 Cf also Andrias 1993 **Fordham Urban Law Journal** 507.

magistrate of an application for the compulsory HIV testing of the arrested person; a deposition on oath, whether oral or by affidavit; and prima facie evidence[729] of a sexual offence in which exposure to the body fluids of the arrested person may have occurred.

° A deliberately false complaint would amount to perjury and a malicious activation of the procedure would be actionable.

° The procedure should ensure confidentiality of the test results so that the information is provided only to the victim and the arrested person. If the victim is a minor or is incapacitated, the information should be relayed to the person acting on his or her behalf.

° The use of information relating to the HIV status of an arrested person obtained under the proposed amendment should be clearly limited: HIV test results obtained through compulsory testing should not be admissible as evidence in a criminal trial.[730]

° The procedure need not necessarily be HIV specific.[731]

10.6 On the basis of the above, the Commission provisionally recommends the adoption of a specific amendment to section 37 of the Criminal Procedure Act 55 of 1977 in order to

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729 Generally, a requirement for prima facie evidence implies that evidence should have been produced "that calls for an answer". In **R v Mantell** 1959 1 SA 771 (C) at 776 H the court stated that prima facie evidence is evidence "of such a character that if unanswered it would justify men of ordinary reason and fairness in affirming the question which the party on whom the onus lies is bound to maintain". See also **Ex Parte Minister of Justice: In re R v Jacobson and Levy** 1931 AD 466 at 478. See also Schmidt 88; Schwikkard et al 17-18.

730 Section 37 of the Criminal Procedure Act, 1977 could be utilised for taking of blood samples of an arrested person for evidentiary purposes if this is necessary (eg if a charge of attempted murder is brought against a person with HIV [cf par 7.15 above]; or if a statutory offence of HIV transmission or exposure should be created [cf **SALC Discussion Paper 80** where this possibility was left open for public comment]). This appears to be adequate.

731 See also par 11.16 below.

provide for the compulsory testing for HIV and other life-threatening sexually transmissible diseases of persons arrested in sexual offence cases with a view to disclose information on the HIV or other status of the arrested person to victims of crime.

10.7 A draft Bill to this effect is attached for comment.

REPUBLIC OF SOUTH AFRICA

CRIMINAL PROCEDURE AMENDMENT BILL

(As introduced)

MINISTER OF JUSTICE

BILL

To amend the Criminal Procedure Act, 1977, so as to provide for the compulsory testing of arrested persons in order to provide victims of any sexual offence in which an exchange of body fluids with the arrested person may have occurred, with the result of such test.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:-

Amendment of section 37 of Act 51 of 1977, as amended by section 1(a), (b) and (c) of Act 64 of 1982

1. Section 37 of the Criminal Procedure Act, 1977 (hereinafter referred to as the principal

Act,) is hereby amended by the insertion in the principal Act after section 37 of the following section:

"Compulsory testing of arrested persons for non-evidentiary purposes

37A (1) Any person who alleges that he or she has been the victim of any sexual offence in which exposure to the body fluids of the arrested person may have occurred, may at the earliest possible opportunity after laying a charge and before or after an arrest is effected, apply to a magistrate, orally or in writing, for an order that the person arrested on the charge or on suspicion of having committed the offence in question, be tested for HIV or any other life-threatening sexually transmissible disease.

(2) If the alleged victim is incapacitated or is a minor, any person with legal standing may apply on his or her behalf for an order in terms of subsection (1).

(3) The magistrate of the district in which the offence is alleged to have occurred or in which the victim resides, has jurisdiction to grant the order, and shall as soon as is reasonably practicable consider the application.

(4) The magistrate, if satisfied from information on oath that prima facie evidence exists that an offence as described in subsection (1) has been committed, shall order any designated local health authority to test the person or persons arrested and to inform the magistrate of the result.

(5) Any police officer may take such steps as may be reasonably necessary to carry out the order.

(6) The proceedings shall be held in camera and the magistrate shall not

communicate the fact that an order has been granted or the result of the test or tests to any person other than -

(a) the victim of the alleged offence or the person acting on his or her behalf; and

(b) the arrested person.

(7) No order granted under this section shall be carried out more than four months after the date upon which it is alleged that the offence in question took place.

(8) The Ministers of Health and Justice may promulgate policy on the testing methods and procedures to be used for purposes of this section.

(9) 'Test' in this section means any medically recognised test for determining the presence of HIV or any other life-threatening sexually transmissible disease".

Short title and commencement

2. This Act shall be called the Criminal Procedure Amendment Act, 19... and shall come into operation on a date fixed by the President by proclamation in the *Gazette*.

11 EXPLANATORY NOTES ON THE BILL

11.1 Explanatory notes on the Bill proposed in Chapter 10 are provided below to facilitate comments on the proposed provisions.

A) PURPOSE OF STATUTORY INTERVENTION

11.2 The primary purpose of the statutory intervention is to provide a speedy and uncomplicated mechanism whereby the victim of a 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 during the attack.

11.3 It is also the intent, in enacting this provision to protect the health of victims of crime and others by providing victims with information which may be important in deciding whether or not to take precautions to avoid spreading HIV to his or her sex partners; to assist with deciding what medical testing and treatment should be pursued to prevent possible infection; and in the case of a pregnant woman who has been the victim of rape, to make reproductive decisions based on the arrested person's HIV status (i e the victim might consider abortion where there is a possibility of her having been exposed to HIV).

B) AMENDMENT OF SECTION 37 OF THE CRIMINAL PROCEDURE ACT 51 of 1977

11.4 It seems appropriate to link the proposed intervention to section 37 of the Criminal Procedure Act as this provision already deals with authorisation for taking a blood sample from an arrested person to ascertain bodily features (which would include HIV testing),

albeit for evidentiary purposes. The proposed amendment will form an extension of this provision by providing for taking the arrested person's blood for non-evidentiary purposes in certain limited circumstances.

C) COMPULSORY TESTING LIMITED TO ARRESTED PERSONS (cf subclause (1) of draft clause 37A)

11.5 As stated in par 8.5 above, the Commission in its analysis has not addressed the possibility of compulsory HIV testing of persons *convicted* of sexual offences. In most cases the utility of testing would have disappeared by the time of a conviction.[732] As stated, the purpose of the proposed intervention is to allow HIV testing of arrested persons, and providing the information regarding the test results to victims so as to enable them to use the information in making decisions regarding their, and others' future health. Unless victims themselves underwent testing shortly after the attack, seropositivity in the attacker at the conviction stage would provide little information concerning the possible transmission of HIV during the attack. And if the victim had become infected because of the attacker, the victim's own seropositivity is likely to show up on tests by the time of conviction.[733] Furthermore, taking a blood sample of an arrested person during the trial or at sentencing stage, may be ordered by the court in terms of section 37 of the Criminal Procedure Act, provided the information is to be used for evidentiary purposes.[734]

11.6 As indicated in Chapter 2 above, it should be noted that a person may also be arrested on

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732 For various technical reasons rape is difficult to prove, and a certain level of expertise and experience with respect to the investigation and prosecution of a rape case would be necessary to obtain a conviction. For these reasons investigating and prosecuting such cases may be time consuming and may not always result in convictions. It has, for instance, recently been reported that only 8% of rapes reported to the SAPS resulted in convictions (**Mail and Guardian** 21-27 May 1999).

733 Because of this, many state legislatures in the United States (taking into account that it would not be justifiable to test an accused attacker prior to conviction because of constitutional reasons) have concluded that no tests should be mandated as the test results would have little utility (Field 1990 **AMJLM** 102; Andrias 1993 **Fordham Urban Law Journal** 507).

734 See the discussion of sec 37 of the Criminal Procedure Act in Chapter 7 above.

suspicion of having committed an offence.[735]

D) COMPULSORY TESTING LIMITED TO ALLEGED SEXUAL OFFENCES (cf subclause (1) of clause 37A)

11.7 The proposed provision for compulsory testing is limited to cases where a person has been the victim of an alleged sexual offence. (A sexual offence may include rape, statutory rape, indecent assault, and incest.[736]) Although this Paper recognises that HIV may be transmitted in the criminal context other than through sexual acts,[737] in view of the violent epidemic of rape and other sexual offences in South Africa the primary purpose of the proposed intervention is to provide peace of mind for victims of sexual violence. In cases of the alleged injection of HIV infected body fluid (of which there have recently been press reports)[738] it will moreover not be certain whether the arrested person is in fact the source of the (body) fluid to which the victim has been exposed. It would thus serve no purpose to test the arrested person in such cases.

E**) VICTIM-INITIATED COMPULSORY HIV TESTING ONLY** (cf subclauses (1) and (2) of clause 37A)

11.8 In order to limit the invasion into arrested persons' privacy, the proposed amendment has been drafted in such a way that HIV testing can be authorised only if initiated by either the victim or a person acting on his or her behalf. (A person may act on the victim's behalf if such victim is a minor, or if he or she is incapacitated and unable to act on their own.) This is in line with the purpose of the proposed amendment which aims at providing for

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735 See par 2.18.2.2 above.

736 See par 2.18.2.3 above for definitions of these offences.

737 See par 3.18-3.24 above.

738 See par 3.24 above.

the compulsory testing of the accused primarily for the *victim's* peace of mind and future health.

11.9 The proposed intervention does not provide for the arrested person to take part or give evidence in an application for testing - except to the extent of challenging whether information on oath has been placed before the magistrate in compliance with the prescribed provisions. This procedure is recommended in order to protect the victim from a potentially further traumatising confrontation with his or her alleged attacker. And further, to ensure that an application for testing remains a speedy process whereby the victim can obtain the information on his or her attacker's health status without having to participate in lengthy proceedings which may delay the initiation of treatment to prevent possible HIV infection in the victim.

F) JURISDICTION (cf subclause (3) of clause 37A)

11.10 Subclause (3) of the proposed amendment is intended to facilitate easy and speedy access to the HIV testing procedure. The magistrate of the district in which the offence is alleged to have occurred or in which the victim resides, has jurisdiction to grant the order for testing. This will allow victims to approach their closest court.

11.11 Provision is also made that an application for testing should be considered "as soon as is reasonably practicable". It is envisaged that magistrates should be readily available to hear applications for compulsory HIV testing on a similar basis as is the case with bail applications.

G) COURT'S DISCRETION TO AUTHORISE TESTING (cf subclause (4) of clause 37A)

11.12 In order to protect arrested persons against misuse and abuse of the proposed intervention, evidence on oath (orally or in writing), a certain standard of proof, and authorisation of testing by a court only are provided for. In terms of subclause (4) of the proposed amendment the court is however *obliged* to order the testing should prima facie evidence exist that the alleged sexual offence took place and that the offence was one that involved possible exposure to the body fluids of the arrested person.

H) CONFIDENTIALITY AND LIMITED DISCLOSURE (cf subclause (6) and (7) of clause 37A)

11.13 Strict confidentiality provisions have been created within the proposed draft amendment so as to ensure that an arrested person's right to privacy is protected as far as is possible. Subclause (6) provides that the application for HIV testing must be held in camera, and that the test results may be disclosed by the court only to the victim (or a person acting on his or her behalf), and to the arrested person.

11.14 Moreover, it is proposed that an order for compulsory testing may not be carried out more than four months after the date upon which it is alleged that the offence in question took place. This is in accordance with the primary purpose of the statutory intervention. After four months the utility of testing would have disappeared: The time within which post exposure prophylaxis should have been administered for it to be successful would have lapsed; and if the victim had become infected because of the attack, the victim's own seropositivity is likely to show up on tests after a period of four months.

I) IMPLEMENTATION OF COURT ORDER (cf subclauses (4) and (8) of clause 37A)

11.15 Subclause (4) of the proposed amendment provides that the testing and disclosure will be undertaken by the local health authority and the court respectively. The Commission is

of the view that the proposed amendment should be supported by protocols which detail the nature and type of tests that should be carried out; the provision of counselling; the availability of other social support services; and the procedure for disclosure of HIV test results. The Ministers of Health and Justice are thus provided with the power to promulgate policy to deal with these issues.

J) PROPOSED INTERVENTION NOT NECESSARILY HIV-SPECIFIC (cf subclause (1) of clause 37A)

11.16 HIV is a life-threatening sexually transmissible disease. In the light of the existence of other such diseases which could potentially be transmitted through rape and other sexual offences, the proposed amendment has been widely drafted so as to allow a victim to apply for the testing of the blood sample taken from the arrested person also for such diseases. The latter would include a disease such as viral hepatitis B.[739] The proposed amendment has also been broadly drafted so as to avoid the criticism of "AIDS exceptionalism".[740] It should however be noted that the Commission has, at this stage, not done specific research on other life-threatening sexually transmissible diseases. Comment is invited on whether the proposed provision for compulsory testing should be extended to include such diseases.

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739 Hepatits B is a serious disease caused by the hepatitis B virus which is present in the blood and body fluids of an infected individual. The virus is transmitted in the same way as HIV - i e also through unprotected sexual contact. It is however much more infectious than HIV. There are several tests that can be used to detect the virus, including both antigen and antibody tests. Infection with the hepatitis B virus can cause severe and potentially life-threatening health problems including *chronic* hepatits B infection that may lead to liver damage (cirrhosis), liver cancer, and death. Although treatment for chronic hepatitis B infection is available, the efficacy and safety thereof are not conclusive - currently chronic hepatitis B infection is still incurable (**CDC Frequently Asked Questions** February 1999 (Internet); Salyer 1999 **Survival News** (Internet); Robson et al 1994 **SAMJ** 530-535).

740 I e singling out HIV for special treatment which, some argue, promotes discrimination and stigma against persons with HIV as it emphasises the difference between HIV and other diseases.