

SOUTH AFRICAN LAW COMMISSION

Project 85

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

**COMPULSORY HIV TESTING OF PERSONS ARRESTED
IN SEXUAL OFFENCE CASES**

NOVEMBER 2000

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

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

JUSTICE Y MOKGORO

CHAIRPERSON: SOUTH AFRICAN LAW COMMISSION

November 2000

ACKNOWLEDGEMENT

Signal contributions to the compilation of the Report were made by Ms Wilma Louw of the Directorate: Subordinate Legislation, Department of Justice and Constitutional Development, and Ms Ann Strode (Project Committee member). The Project Committee directed that its indebtedness to the researcher, Ms Anna-Marié Havenga, for her exceptional contribution, must be recorded.

CONTENTS		Page
<u>The page numbers refer to the hard copy and may differ in electronic versions</u>		
	Introduction	vii
	Summary	viii
	Sources with mode of citation	xxxv
	Table of cases	lvi
	Selected legislation	lix
1	Introduction	1
2	Background	6
3	Medico-legal information	28
4	Defining the problem	80
5	Current legal position regarding consent for medical treatment and confidentiality of medical information	83
6	Dealing with compulsory HIV testing and disclosure of test results through existing public health measures	101
7	Dealing with compulsory HIV testing and disclosure of test results through existing measures of criminal procedure	109
8	The need for statutory provision for compulsory HIV testing of arrested persons and for disclosure of the test results to victims	119
9	Comparative perspective	149
10	Preliminary recommendations in Discussion Paper 84	174
11	Public consultation: Response to Discussion Paper 84 and	

	subsequent input	184
12	Summary of comments, evaluation and recommendations	189
13	Draft legislation and explanatory notes	280
ANNEXURE A:	Draft Bill included in Discussion Paper 84, September 1999	313
ANNEXURE B:	Respondents to Discussion Paper 84	317
ANNEXURE C:	List of experts who attended a consultative meeting on 4 February 2000	323
ANNEXURE D:	Draft Bill, draft Regulations and issues identified for discussion submitted to experts who attended a consultative meeting on 4 February 2000	327

INTRODUCTION

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

The members of the Commission are -

Madam Justice Y Mokgoro (Chairperson)

Adv JJ Gauntlett SC

Prof C Hoexter

Judge CT Howie

Judge ML Mailula

Mr P Mojapelo

Ms Z Seedat

The Secretary is Mr W Henegan. The Commission's offices are on the 12th floor, Sanlam Centre, corner of Schoeman and Andries Street, Pretoria. Correspondence should be addressed to:

The Secretary

Telephone: (012)322-6440

South African Law Commission

Fax : (012)320-0936

Private Bag X668

E-mail : ahavenga@salawcom.org.za

PRETORIA 0001

URL : <http://www.law.wits.ac.za/salc/salc.html>

The members of the Project Committee for this investigation are -

Mr Justice E Cameron (Chairperson)

Mr Z Achmat

Dr PJ Haasbroek

Ms M Makhalemele

Dr MJ Matjila

Ms L Seftel

Dr N Simelela

Ms AE Strode

Prof CW van Wyk

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

SUMMARY

1 Recently there has been mounting public concern and pressure on the authorities to take appropriate action regarding deliberate transmission of HIV infection. This has come about largely in response to a number of widely publicised incidents of deliberate transmission of HIV, accompanied by the very real concern that it is in most part women and young girls who are being exposed to HIV infection in this manner. As a result, the Commission, at the request of the Parliamentary Justice Portfolio Committee, has been tasked with investigating the compulsory testing of sexual offenders for HIV and the possible creation of a statutory offence aimed at harmful HIV-related behaviour. The Commission's HIV/AIDS Project Committee dealt incrementally with these two issues which entails that two Interim Reports¹ containing the Commission's recommendations have been prepared.

! This Interim Report (*Fourth Interim Report on Aspects of the Law relating to AIDS*),² deals with the question of compulsory HIV testing of persons arrested on a charge, or on suspicion, of having committed a sexual offence and the right of alleged victims of such offences to be informed of the test results.

! The *Fifth Interim Report* (which will be published later) deals 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.

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

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

2 The three preceding Interim Reports covered certain health-related issues (First Interim Report); pre-employment HIV testing (Second Interim Report); and HIV/AIDS and discrimination in schools (Third Interim Report).

medical information; and no general legislation exists which allows for disclosure of such information. Furthermore, neither currently available public health law nor criminal procedure makes provision for compulsory HIV testing of persons arrested for sexual offences with a view to disclosing their HIV status to victims:

! The compulsory medical examinations (which would include HIV testing) currently provided for in the 1987 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 health authorities. Draft 1999 Regulations to amend the 1987 Regulations make provision for the notifiability of HIV and AIDS but not for the disclosure of HIV status to victims of crime (and not for testing arrested persons for HIV).

! 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 for evidentiary purposes in a criminal trial only. Moreover, there is no provision that allows disclosure outside criminal proceedings.

3 The Commission consequently debated the need for legislative intervention concentrating on the following pivotal issues:

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

! The utility and limitations of HIV testing.

! Women's international and constitutional rights, including victims' rights.

! The arrested person's constitutional rights, especially the right to privacy.

4 The Commission concluded that there is a need for statutory intervention to provide for compulsory HIV testing of arrested persons in sexual offence cases at the instance of the victim. 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

person's rights of privacy and bodily integrity to a limited extent to enable his or her accuser speedily to know whether he or she 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 procedural and substantive 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 HIV 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" should include initiation of the testing process by a person acting on the victim's behalf where the victim is too traumatised to bring the application, or lacks legal capacity to act on his or her own.**
- ! 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 be prima facie evidence reflected in depositions on oath that a sexual offence has been committed against the victim by the arrested person; that in the course of the offence the victim may have been exposed to the body fluids of the arrested person (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); and that no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took place. (The latter forms part of the total period of 60 calendar days allowed for execution of an order for compulsory HIV testing which is referred to below.)**
- ! 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 ensure an uncomplicated and speedy process and to protect the victim from a potentially further traumatising confrontation with his or her attacker, the arrested person (or his or her legal representative) should not be allowed to be present or give evidence in an application for compulsory HIV testing. The arrested person should retain his or her right to apply to the High Court for review in the event that an order for compulsory testing is not properly granted in accordance with the prescribed requirements.
- ! The procedure should provide for the confidentiality of the arrested person's HIV test results so as to ensure that this information is disclosed only to the victim (or the person acting on his or her behalf) and to the arrested person.
- ! A limited period of time should be allowed for bringing an application for compulsory HIV testing *and* executing it. This period should coincide with the period during which a victim's own HIV test would not clearly indicate whether he or she had been infected with HIV (the "window period"). The Commission considers a time limit of 60 days to be appropriate.
- ! The state should be responsible for all costs related to an application for compulsory HIV testing of arrested persons and the execution of an order for such testing.
- ! The use of information relating to the HIV status of an arrested person obtained under the proposed legislation should be clearly limited: the HIV test results obtained should not be admissible as evidence in criminal or civil proceedings.
- ! Malicious activation of the proposed procedure or the malicious disclosure of the test results should be punishable.

6 On the basis of the above, the Commission recommends the adoption of the draft Bill and draft Regulations below. The primary purpose of the 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 to HIV during the attack.

7 In coming to a conclusion the Commission has considered other possible legal or policy interventions. These interventions (which were rejected by the Commission) include the following:

- ! Retaining the status quo.
- ! Providing in legislation for the compulsory HIV testing of arrested persons *after* conviction.
- ! Developing and establishing a policy process (eg in the form of practical guidelines) aimed at 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 comprehensive health and social services (including HIV testing and the provision of prophylaxis) in dealing with the possibility of HIV infection.

8 Explanatory notes on the draft Bill and Regulations are provided in Chapter 13.

REPUBLIC OF SOUTH AFRICA

COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS BILL

(As introduced)

MINISTER FOR JUSTICE AND CONSTITUTIONAL DEVELOPMENT

BILL

To provide for a speedy procedure for a victim of an alleged sexual offence in which exposure to the body fluids of the arrested person may have occurred, to apply for the compulsory HIV testing of the arrested person and the disclosure of the test results to the victim.

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

Notice to victim

1. When any sexual offence is reported, or as soon thereafter as is reasonably practicable, the police official to whom the offence is reported shall hand a notice as prescribed containing information regarding compulsory HIV testing of a person arrested in an alleged sexual offence case to the victim, or any person acting on his or her behalf in terms of section 3, and must explain the contents of the notice.

Manner of application

2. (1) Any victim of an alleged sexual offence in which exposure to the body fluids of the arrested person may have occurred, or any person acting on his or her behalf in terms of section 3, may apply to a magistrate for an order that the person arrested on the charge or on suspicion of having committed the offence in question, be tested for HIV.
- (2) The application must be made at the earliest possible opportunity after a charge

has been laid, and may be made before or after an arrest has been effected.

- (3) The application must be made in the prescribed manner and be handed to the investigating officer.
- (4) The investigating officer who receives an application contemplated in subsection (3) shall as soon as is reasonably practicable submit such application to a magistrate who has jurisdiction to consider the application in terms of section 4.

Application may be brought on behalf of victim

3. The application referred to in section 2 may be brought on behalf of the victim by any person who has a material interest in the well-being of such person, including a spouse, family member, care giver, friend, counsellor, health service provider, police official, social worker or teacher: Provided that the application shall be brought with the written consent of the victim, except where the victim is -

- (a) under the age of 14;³
- (b) mentally ill;
- (c) unconscious;
- (d) a person in respect of whom a curator has been appointed in terms of an order of court; or
- (e) a person whom the court is satisfied is unable to provide the required consent.

Jurisdiction

4. A magistrate of the magisterial district in which the sexual offence is alleged to have occurred has jurisdiction to grant the order contemplated in section 7, and shall as soon as is reasonably practicable consider the application contemplated in section 2.

Parties who may appear before magistrate

5. The proceedings contemplated in section 4 -
 - (a) shall be held in camera;
 - (b) shall be held in the absence of the arrested person and his or her legal representative; and
 - (c) need not be attended by the victim or the person acting on his or her behalf in terms of section 3.

3 Sec 39(3)(b) of the Child Care Act 74 of 1983 provides that any person over the age of 14 years shall be competent to consent, without the assistance of his or her parent or guardian to the performance of any medical treatment of him or herself or his or her child.

Arrested person may not give evidence

6. The arrested person and his or her legal representative may not participate in or give evidence at the proceedings contemplated in section 4.

Magistrate's order

7. (1)(a) No order for compulsory HIV testing may be granted unless the magistrate is satisfied from information on oath that prima facie evidence exist that -
- (i) a sexual offence has been committed against the victim by the arrested person;
 - (ii) in the course of such offence the victim may have been exposed to the body fluids of the arrested person; and
 - (iii) no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took place.
- (b) If satisfied as contemplated in paragraph (a), the magistrate shall order -
- (i) the collection on the same occasion from the arrested person of two body specimens;
 - (ii) the performance on the body specimens of one or more HIV tests as are reasonably necessary to determine the presence or absence of HIV infection; and
 - (iii) the disclosure of the HIV test result so obtained to the victim or any person acting on his or her behalf in terms of section 3, and the arrested person.
- (c) If not satisfied as contemplated in paragraph (a), the magistrate shall dismiss the application.
- (2) The magistrate shall make the order contemplated in subsection (1)(b) or (c) in the prescribed manner and make such order available to the investigating officer.

Register of application

8. The investigating officer shall keep a register as prescribed of the application contemplated in section 2 and the magistrate's order contemplated in section 7.

Magistrate's order final

9. An order properly granted in terms of section 7 shall be final and no appeal or review shall lie from it.

Victim and arrested person to be notified of outcome of application

10. The investigating officer shall as soon as is reasonably practicable after the magistrate has considered an application contemplated in section 2 -
 - (a) irrespective of whether an order has been granted or not as contemplated in section 7, inform the victim or the person acting on his or her behalf in terms of section 3 of the outcome of such application; and
 - (b) if an order has been granted as contemplated in section 7, inform the arrested person thereof, hand him or her a notice containing the information as prescribed and if necessary explain the contents of the notice.

Confidentiality of outcome of application

11. The fact that an order for HIV testing of an arrested person has been granted as contemplated in section 7 shall not be communicated to any person other than -
 - (a) the victim or any person acting on his or her behalf in terms of section 3;
 - (b) the arrested person;
 - (c) the investigating officer; and
 - (d) the persons who are required to execute the order as contemplated in section 12.

Execution of order

12. (1) For purposes of executing an order granted in terms of section 7 -
 - (a) the investigating officer shall request a medical practitioner or nurse to on the same occasion take two body specimens from the arrested person and shall make the arrested person available or cause such person to be made available for this purpose;
 - (b) a medical practitioner or a nurse contemplated in paragraph (a) may take two body specimens from the arrested person;
 - (c) the investigating officer shall make the two body specimens contemplated in paragraph (b) available for HIV testing to a person attached to a facility designated in terms of section 14;
 - (d) a person contemplated in paragraph (c) and requested thereto by the investigating officer shall -
 - (i) perform one or more HIV tests on the body specimens of the arrested person as are reasonably necessary to determine the presence or absence of HIV infection in the arrested person;
 - (ii) record the result of the HIV test performed in duplicate in the prescribed manner; and

- (iii) provide the investigating officer with duplicate sealed records of the test result for purposes of making them available to the victim and the arrested person;
- (e) the investigating officer shall collect the two sealed records of the HIV test result from the person contemplated in paragraph (d) and make available to the victim or the person acting on his or her behalf in terms of section 3 of the Act, and to the arrested person -
 - (i) the sealed record of the test result referred to in paragraph (d)(ii); and
 - (ii) a notice containing information as prescribed, and if necessary explain the contents of the notice.
- (2) Any person tasked with executing an order granted in terms of section 7 as contemplated in subsection (1) must take the necessary steps as soon as is reasonably practicable.

Limitation of period to execute magistrate's order

13. No order granted under section 7 may be executed if more than 60 calendar days have lapsed from the date on which it is alleged that the offence in question took place.

Place where HIV testing may take place

14. The testing of body specimens to establish an arrested person's HIV status in terms of this Act may take place only at a facility designated for that purpose by the Minister in consultation with the Minister of Health by notice in the Gazette, subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act.

Confidentiality of HIV test result obtained

15. The result of the HIV test performed on the body specimens of an arrested person in terms of this Act shall be communicated only to -

- (a) the victim or any person acting on his or her behalf in terms of section 3; and
- (b) the arrested person.

Inadmissibility of HIV test result as evidence

16. The result of the HIV test performed on the body specimens of an arrested person in terms of this Act shall not be admissible in evidence in criminal or civil proceedings.

Costs

17. The state shall be responsible for all costs related to the application contemplated in section 2 and the execution of an order granted in terms of section 7 as contemplated in section 12.

Regulations

18. The Minister may make regulations regarding -

- (a) any form required to be prescribed in terms of this Act;
- (b) any matter required to be prescribed in terms of this Act; and
- (c) any other matter the Minister deems to be necessary or expedient to achieve the objects of this Act.

Offences and penalties

19. Any person who with malicious intent uses the procedure contemplated in section 2 or 3 or discloses the result of an HIV test so obtained shall be guilty of an offence and on conviction be liable to a fine or to imprisonment for a period not exceeding six months or both.

Definitions

20. For purposes of this Act -

'AIDS' means the acquired immuno-deficiency syndrome;

'body fluids' means any body substance which may contain HIV but does not include saliva, tears or perspiration;

'*body specimen*' means any body sample which can be tested to determine the presence or absence of HIV infection;

'*HIV*' means the human immuno-deficiency virus;

'*HIV test*' means any validated, medically recognised test for determining the presence or absence of HIV infection in a person and 'HIV testing' has a corresponding meaning;

'*investigating officer*' means a member of the South African Police Service responsible for investigating the charge or any member acting under his or her command;

'*medical practitioner*' means a person registered as such in terms of the Health Professions Act, 1974 (Act No. 56 of 1974);

'*Minister*' means the Minister for Justice and Constitutional Development;

'*nurse*' means a person registered as such in terms of the Nursing Act, 1978 (Act No. 50 of 1978); and

'*prescribed*' means prescribed by regulation made under section 18.

'*victim*' means any person alleging that a sexual offence has been committed against him or her.

Short title and commencement

21. This Act shall be called the Compulsory HIV Testing of Alleged Sexual Offenders Act, 2001, and shall come into operation on a date fixed by the President by proclamation in the Gazette.

DEPARTMENT OF JUSTICE

NO R ... 2000

**REGULATIONS UNDER THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL
OFFENDERS ACT, 2001 (ACT NO ... OF 2001)**

The Minister for Justice and Constitutional Development has under section 18 of the Compulsory HIV Testing of Alleged Sexual Offenders Act, 2001 (Act No ... of 2001), made the regulations in the Schedule

SCHEDULE

Definitions

1. In these Regulations any word or expression to which a meaning has been assigned in the Act shall have that meaning and, unless the context otherwise indicates -

"the Act" means the Compulsory HIV Testing of Alleged Sexual Offenders Act, 2001 (Act No. ... of 2001).

Notice to victim

2. The notice contemplated in section 1 of the Act shall contain the information provided for in Form 1 of the Annexure.

Manner of application

3. A victim of an alleged sexual offence or a person acting on his or her or behalf in terms of section 3 of the Act applies for an order contemplated in section 2 of the Act in the form of Form 2 of the Annexure.

Magistrate's order

4. The order contemplated in section 7(1)(b) or (c) of the Act shall be made in the form of Form 3 of the Annexure.

Register of application

5. The register contemplated in section 8 of the Act shall contain the following information regarding an application contemplated in section 2 of the Act:
 - (a) The application number;
 - (b) the date of the application;
 - (c) the case number or South African Police Service reference number;
 - (d) the full names of the victim or the person acting on his or her behalf in terms of section 3 of the Act;
 - (e) the full names of the arrested person;
 - (f) whether the application was granted or dismissed as contemplated in section 7 of the Act; and
 - (g) the full names of the magistrate hearing the application.

Notice to arrested person of outcome of application

6. The notice contemplated in section 10(b) shall be in the form of Form 4 of the Annexure.

Recording of HIV test result

7. The person performing an HIV test on a body specimen of the arrested person contemplated in section 12(1)(d) of the Act shall record the result of the HIV test in the form of Form 5 of the Annexure.

Notice to victim and arrested person following compulsory HIV testing

8. The notice contemplated in section 12(1)(e)(ii) of the Act shall contain the information provided for in Form 6 of the Annexure.

Short Title

9. These regulations shall be called the Regulations for Compulsory HIV Testing of Alleged Sexual Offenders.

ANNEXURE

FORM 1

[Regulation 2]

NOTICE OF AVAILABILITY OF PROCESS FOR THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS AS CONTEMPLATED IN SECTION 1 OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT No. ... OF 2001)

(To be handed to a victim of an alleged sexual offence or any person acting on his or her behalf)

This information sheet will provide you with information, and give you details on how the South African Police Service (SAPS) will assist with obtaining information on the HIV status of the person who allegedly committed the offence against you.

What is HIV?

HIV refers to infection with the human immuno-deficiency virus. HIV destroys important cells which control and support the immune system. As a result the body's natural defence mechanisms cannot offer any resistance against illnesses. Most people infected with HIV ultimately develop AIDS and die as their bodies can no longer offer any resistance to illnesses such as TB, pneumonia and meningitis. Infection with HIV therefore has serious consequences for you as an individual.

How is HIV transmitted?

HIV is transmitted in three ways: via sexual intercourse; when HIV infected blood is passed directly into the body; and from mother to child during pregnancy, childbirth or whilst breast feeding.

Can I be exposed to HIV during a sexual offence?

Yes you can if you have had any contact with the alleged offender's blood, semen or vaginal fluid. For example, if you have been raped vaginally or anally and the alleged offender's semen entered your body you may have been exposed to HIV.

Can I put other people at risk of HIV infection because of my possible exposure to HIV?

You cannot transmit HIV through daily contact with other people. HIV is not transmitted through hugging, shaking hands, and sharing food, water or utensils. However, because HIV is transmitted through sexual intercourse, you may have become infected through the alleged sexual offence and may in turn infect your sexual partner. You should practice safe sex until you have established with certainty that you have not been infected. If you are pregnant, there is a possibility that you could transmit HIV to your unborn child. If you are breast feeding there is also a possibility that your child may be at risk of contracting HIV infection. You must obtain expert advice to deal with the implications of the risk of infection for yourself, your sexual partner and others.

How could I deal with my possible exposure to HIV during the alleged sexual offence?

You can -

- # consult a health care worker for more information on the risk of HIV transmission, and the possibility of taking medication to prevent transmission of HIV;
- # consult a counsellor at one of the service organisations listed below for counselling and support;
- # apply to have the alleged offender tested for HIV, and the results disclosed to you.

Why should I apply to have the alleged offender tested for HIV?

Knowing the HIV status of the alleged offender may -

- # give you peace of mind as you will be in a better position to determine whether you were exposed to HIV during the alleged offence;
- # enable you to make decisions on whether to take medication to prevent HIV transmission; and
- # empower you to make decisions regarding the protection of your sexual partner and others against HIV infection.

How can I apply for compulsory HIV testing of the person who allegedly committed a sexual offence against me?

- # Lay a charge at the police station nearest to where the offence took place.
- # Inform the Investigating Officer that you wish to apply for compulsory HIV testing of the alleged offender.
- # Complete an application for an order for compulsory HIV testing with the assistance of the Investigating Officer.
- # Hand the completed and signed application to the Investigating Officer.

Who will consider my application?

The Investigating Officer will submit your completed application to a Magistrate who will consider the application during court hours. The Investigating Officer will inform you of the outcome of your application.

What will happen once the Magistrate has ordered that the arrested person must be tested for HIV?

The Investigating Officer will ensure that two body specimens are on the same occasion taken from the arrested person and tested for HIV.

Who will pay for the HIV testing?

The state.

How will I be informed about the HIV test result?

The Investigating Officer will as soon as possible ensure that you receive a sealed envelope containing the HIV test result, and information on where you can get help with understanding the implications of the result.

May I disclose the arrested person's HIV test result to other people?

You may not disclose this information **except** to those who need to know. This will include such persons as your sexual partner, your medical doctor, or those persons who provide emotional support to you. You should discuss the disclosure of the test results with the service organisation providing you with counselling and support before making any disclosures. If you maliciously disclose the arrested person's HIV status, you may be convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also face a civil claim for damages.

Cut-off period for bringing an application

A limited period of time is allowed for compulsory HIV testing of an arrested person. You must apply for such testing before 50 calendar days have lapsed from the date on which the alleged offence took place. The arrested person must be tested for HIV and the results must be disclosed to you before 60 calendar days have lapsed from the date on which the alleged offence took place. It is therefore advised that if you decide to apply for having the arrested person tested for HIV, you do it as soon as possible after the alleged offence.

Service organisations which can provide counselling and support

Expert assistance in dealing with the implications of HIV test results is available at a number of different private and public facilities. These include:

- # Private medical and social facilities (eg a general medical practitioner or psychologist).
- # Public medical and social facilities, including -
 - Ž Life Line
 - Ž Child Line
 - Ž The National Council for Child Welfare
 - Ž Local State Hospitals and Clinics
 - Ž Local AIDS Service Organisations
 - Ž Rape Crisis
 - Ž FAMSA
 - Ž Regional Departments of Social Welfare
 - Ž Local ATTICS

Contact details of the above public facilities are available in the telephone directory, or from the Investigating Officer.

Misuse and abuse of this procedure

The procedure to establish an arrested person's HIV status without obtaining his or her consent for HIV testing has been created strictly for the purpose of assisting victims of sexual offences. If you have not been the victim of a sexual offence, or act on behalf of someone who has not been the victim of a sexual offence, and abuse this procedure to establish another person's HIV status with malicious intent, you may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also face a civil claim for damages.

CIRCUMSTANCES UNDER WHICH AN APPLICATION FOR COMPULSORY HIV TESTING MAY BE BROUGHT ON BEHALF OF A VICTIM

Any person who has a material interest in the well-being of a victim of an alleged sexual offence (eg a spouse or other family member, friend, counsellor, health service provider, police official, social worker or teacher) may apply for compulsory testing on his or her behalf, provided that the victim has given written consent.

Written consent is not necessary if the victim is -

- # under the age of 14;
- # mentally ill;
- # unconscious;
- # a person in respect of whom a curator has been appointed by an order of court; or
- # a person whom the court is satisfied is unable to provide consent.

FORM 2

[REGULATION 3]

APPLICATION TO A MAGISTRATE IN TERMS OF SECTION 2 OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT No. ... OF 2001)

PART A: VICTIM'S DECLARATION

- (1) **PARTICULARS OF VICTIM** *(To be completed by the victim or the person acting on his or her behalf; or by the Investigating Officer)*

Name:

ID No/Date of birth/Passport No:

Home/Temporary Address:

Telephone No:

- (2) **PARTICULARS OF PERSON ACTING ON BEHALF OF VICTIM (IF APPLICABLE)** *(To be completed by the person acting on behalf of the victim; or by the Investigating Officer)*

Name:

ID No/Date of birth/Passport No:

Home/Temporary Address:

Telephone No:

Nature of relationship with victim (eg parent):

Reason why application is made on behalf of victim:

Written consent of victim has been obtained and is attached: **YES/NO**

Written consent is not necessary since the victim is: *(Delete if not applicable)*

! Under the age of 14 years

! Mentally ill

! Unconscious

! A person in respect of whom a curator has been appointed by the court

! Unable to provide consent because:

- (3) **PARTICULARS OF ALLEGED SEXUAL OFFENCE AND POSSIBLE EXPOSURE TO ASSAILANT'S BODY FLUIDS** *(To be completed by the victim or the person acting on his or her behalf; or by the Investigating Officer)*

Date and place of alleged offence:

Description of alleged offence (eg rape):

Was the victim exposed to the body fluids (blood, semen, vaginal fluid) of his/her assailant: **YES/NO**
(Delete if not applicable)

In what way was the victim exposed:

.....

.....

- (4) **SIGNED BY VICTIM OR PERSON ACTING ON HIS OR HER BEHALF**

.....

Signed

Place

Date

5) AFFIDAVIT BY VICTIM OR PERSON ACTING ON HIS OR HER BEHALF

(To be completed by Commissioner of Oaths)

I hereby certify that before administering the oath/taking the affirmation I asked the Deponent the following questions and noted his/her answers in his/her presence as indicated below :-

- (a) Do you know and understand the contents of the above declaration? Answer -
(b) Do you have any objection to taking the prescribed oath? Answer -
(c) Do you consider the prescribed oath to be binding on your conscience? Answer -

I hereby certify that the Deponent has acknowledged that he/she knows and understands the contents of this declaration which was sworn to/affirmed before me, and the Deponent's signature/thumb print/mark was placed thereafter in my presence.

Dated at..... this day of..... 20.....

SIGNED: Justice of the Peace/Commissioner of Oaths

Full names:
Designation:
Area for which appointed:
Business address:

*Delete whichever is not applicable

PART B: ARRESTED PERSON

1) PARTICULARS OF ARRESTED PERSON CHARGED WITH COMMITTING ALLEGED SEXUAL OFFENCE (To be completed by the Investigating Officer)

The person whose particulars appear below has been arrested on a charge or on suspicion of having committed the sexual offence mentioned below against the victim whose particulars appear in PART A.

Name:
ID No/Date of birth:
Home/Temporary Address:
Telephone No:
Case No (or SAPS reference no):
Offence charged with:
In custody/On bail:(Delete if not applicable)
! In custody. If so: Place:
! On bail
Date arrested:

(2) SIGNED BY INVESTIGATING OFFICER

.....

Signed Place Date

(3) AFFIDAVIT BY INVESTIGATING OFFICER

(To be completed by Commissioner of Oaths)

I hereby certify that before administering the *oath/taking the affirmation I asked the Deponent the following questions and noted *his/her answers in *his/her presence as indicated below :-

(a) Do you know and understand the contents of the above declaration?

Answer -

(b) Do you have any objection to taking the prescribed oath?

Answer -

(c) Do you consider the prescribed oath to be binding on your conscience?

Answer -

I hereby certify that the Deponent has acknowledged that *he/she knows and understands the contents of this declaration which was sworn to/affirmed before me, and the Deponent's *signature/thumb print/mark was placed thereafter in my presence.

Dated at..... this day of..... 20.....

.....
SIGNED: Justice of the Peace/Commissioner of Oaths

Full names:

Designation:

Area for which appointed:

Business address:

**Delete whichever is not applicable*

FORM 3

[REGULATION 4]

ORDER OF THE COURT IN TERMS OF SECTION 7(1)(b) OR (c) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001)

(To be completed by the magistrate considering the application)

IN THE MAGISTRATES COURT

FOR THE DISTRICT OF:

HELD AT:

APPLICATION NO:

PART A: VICTIM

(1) PARTICULARS OF VICTIM

Full names:

(2) PARTICULARS OF PERSON ACTING ON BEHALF OF VICTIM (IF APPLICABLE)

Full Names: **PART B:**

ARRESTED PERSON

(1) PARTICULARS OF ARRESTED PERSON CHARGED WITH COMMITTING SEXUAL OFFENCE

Full Names:

Case No (or SAPS reference no):

PART C: ORDER BY THE COURT

THE COURT ORDERS THAT:

*(*Delete if not applicable)*

- *The application is dismissed.
- *The application is granted for -
 - Ž the collection on the same occasion from the arrested person of two body specimens;
 - Ž the performance on the body specimens of one or more HIV tests as are reasonably necessary to determine the presence or absence of HIV infection; and
 - Ž the disclosure of the test results to -
 - a) the victim or the person acting on his or her behalf; and
 - b) the arrested person.

.....
MAGISTRATE

.....
DATE

FORM 4

[Regulation 6]

NOTICE IN TERMS OF SECTION 10(b) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001) REGARDING AN ORDER OF COURT THAT THE HIV STATUS OF AN ALLEGED SEXUAL OFFENDER MUST BE ESTABLISHED

(To be handed to the arrested person)

The purpose of this notice is to provide you with information about an order of court which has been obtained to have you tested for HIV without your consent, and for your HIV status to be disclosed to your alleged victim.

What is HIV?

HIV refers to infection with the human immuno-deficiency virus. HIV destroys important cells which control and support the immune system. As a result the body's natural defence mechanisms cannot offer any resistance against illnesses. Most people infected with HIV ultimately develop AIDS and die as their bodies can no longer offer any resistance to illnesses such as TB, pneumonia and meningitis. Infection with HIV therefore has serious consequences for you as an individual.

How is HIV transmitted?

HIV is transmitted in three ways: via sexual intercourse; when HIV infected blood is passed directly into the body; and from mother to child during pregnancy, childbirth or whilst breast feeding.

Can HIV be transmitted during a sexual offence?

Yes. If there has been any exposure to HIV infected blood, semen or vaginal fluid during the alleged offence, HIV may have been transmitted.

Why should I be tested for HIV?

You may have exposed the victim to HIV during the alleged sexual offence with which you are charged. In the light of the serious consequences of HIV infection and victims' fear of becoming infected with HIV, they have been granted a right to apply for the HIV testing of their alleged offenders and for the disclosure of the test results.

How will knowledge about my HIV status help the alleged victim?

The information may help him or her -

- # to decide whether to submit him or herself to medical treatment which is costly and has serious side effects but could prevent him or her contracting the virus;
- # to take measures to prevent the virus from being further transmitted from him or herself to other people (eg to the victim's sexual partner, or to her baby if she is pregnant or breast-feeding).
- # to provide the victim with peace of mind regarding his or her possible exposure to HIV during the sexual

offence.

Who has granted the order that I be tested for HIV?

A magistrate from the magistrate's office in the district in which you allegedly committed the sexual offence has granted the order.

On what basis has the court order been granted?

The magistrate has granted the order after considering evidence on oath by the person who applied to have you tested for HIV and by the investigating officer. The magistrate is satisfied on a prima facie basis -

- # that you committed a sexual offence against the victim who applied, or on whose behalf it was applied, to have you tested for HIV;
- # that in the course of such offence the victim may have been exposed to your body fluids (semen blood or vaginal fluid); and
- # that no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took place.

You must note that the existence of prima facie evidence against you does not mean that if the criminal case against you went to trial you would be convicted of the crime. The state will still have to prove beyond reasonable doubt that you committed the offence you were charged with. Prima facie evidence is being used only for the application to have you tested for HIV without your consent.

Why was I not given an opportunity to be present and to give evidence in the application to have me tested for HIV?

The legislation providing the victim or a person acting on his or her behalf with the right to apply to have you tested for HIV does not give you the right to respond to the application. The reason for this is that a victim of a sexual offence needs to establish the HIV status of the alleged sexual offender as soon as possible if he or she wants to use this information to make important decisions regarding their own health. Allowing you to be present or to give evidence and participate in the proceedings will delay the process. Furthermore, it has been decided by Parliament that the limitation of your right to bodily integrity and privacy in this instance is both reasonable and justifiable in the light of the grave danger of HIV infection to which you have allegedly exposed your victim.

What if the charge against me is a false charge?

Any person who misuses or abuses the procedure to obtain information about your HIV status may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also bring a civil claim for damages against such person.

How will I be tested for HIV?

The investigating officer will take you to a registered medical practitioner or nurse who will on the same occasion take two body specimens from you. The investigating officer will take the properly identified specimens to a designated facility where they will be tested for HIV.

Who will pay for the HIV test?

The state.

Will I be informed about the result of the HIV test?

Yes. The investigating officer will ensure that you receive the HIV test result and information on where you can get help with understanding the implications of the result.

Will the test result be disclosed to other people?

The test result will be disclosed only to you and the victim or a person acting on his or her behalf. Your HIV status is confidential medical information which is not for public information. Any person who has obtained information about your HIV status through this process and who maliciously discloses it to others may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also bring a civil claim for damages against such person.

Will the test result be used in the trial against me?

No. The HIV test result obtained through this procedure may not be used as evidence in any criminal or civil trial. The investigating officer may however, under the provisions of the Criminal Procedure Act, 1977 have you tested for HIV for evidentiary purposes (which would include evidence for sentencing) if necessary.

How does my HIV status affect others?

Your HIV status does not only have serious implications for your alleged victim, but also for your own health and the health of others (eg your sexual partner). Every person has a responsibility to ensure that they don't put others at risk of HIV infection. It is important that you get expert advice, assistance and information on how to protect yourself and others against infection with HIV.

Service organisations which can provide counselling and support

Expert assistance in dealing with the implications of HIV test results is available at a number of different private and public facilities. These include:

Private medical and social facilities (eg a general medical practitioner or psychologist).

Public medical and social facilities, including -

Ž	Life Line	Ž	Rape Crisis
Ž	Child Line	Ž	FAMSA
Ž	The National Council for Child Welfare	Ž	Regional Departments of Social Welfare
Ž	Local State Hospitals and Clinics	Ž	Local ATTICS
Ž	Local AIDS Service Organisations		

Contact details of the above public facilities are available in the telephone directory, from the Investigating Officer, and from the Prison authorities.

FORM 5

[REGULATION 7]

RECORD OF HIV TEST RESULT OBTAINED IN TERMS OF AN ORDER GRANTED UNDER SECTION 7(1)(b) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001)

(To be completed by an authorised person attached to a facility designated to carry out compulsory HIV testing under Government Notice No R ... of ... 2001)

PART A: PARTICULARS OF ARRESTED PERSON

Case No (or SAPS reference no):

Full names:

ID No:

PART B: PARTICULARS OF HIV TEST/S PERFORMED

Type of HIV test/s performed:
.....
.....
.....

PART C: RESULT OF HIV TEST

Positive 9

Negative 9 *(Mark relevant block with a cross)*

Indeterminate 9

PART D: PARTICULARS OF DESIGNATED FACILITY PERFORMING HIV TEST/S:

Name of facility:

Address:

Telephone No:

FORM 6

[REGULATION 8]

NOTICE REGARDING HIV TEST RESULT OBTAINED FOLLOWING COMPULSORY HIV TESTING OF AN ARRESTED PERSON IN TERMS OF SECTION 7(1)(b) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001)

(To be handed to: a) The victim or the person acting on his or her behalf who applied to have the arrested person tested

for HIV; and

b) The arrested person who has been tested for HIV)

The purpose of this information sheet is to provide a victim or a person acting on his or her behalf, and the arrested person with information on how to deal with receiving information about the outcome of a compulsory HIV test.

How will I be told about the HIV Test Results?

The results will be made available to you in a sealed envelope.

What will be contained within the sealed envelope?

The sealed envelope will contain a document completed by a person attached to the facility who performed the HIV testing on the body specimens of the arrested person. The form will state whether the HIV test result was:

- # positive;
- # negative; or
- # indeterminate (i.e. the test is not clear either way).

If I am the victim, may I disclose the arrested person's HIV status to other people?

You may not disclose the arrested person's HIV status **except** to those who need to know. This will include such persons as your sexual partner, your medical doctor, or those persons who provide emotional support to you. You should discuss the disclosure of the test results with the service organisation providing you with counselling and support before making any disclosures. If you maliciously disclose the arrested person's HIV status, you may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also face a civil claim for damages. The same applies to a person acting on behalf of the victim.

If I am the arrested person, may I refuse to receive the HIV test result?

No.

What should I do with the HIV test result?

Every person receiving an HIV test result should get expert assistance in understanding and dealing with it regardless of whether the test result was positive, negative or indeterminate. Expert assistance will help you to -

- # understand the test result;
- # deal with immediate emotional reactions and concerns;
- # understand how the result will affect your future health and the health of others (eg your sexual partner);
- # identify the need for social and medical care; and
- # discuss the need to disclose the test result to others.

Service organisations which can provide counselling and support

Expert assistance in dealing with the implications of HIV test results is available at a number of different private and public facilities. These include:

- # Private medical and social facilities (eg a general medical practitioner or psychologist).
- # Public medical and social facilities, including -

Ž	Life Line	Ž	Rape Crisis
Ž	Child Line	Ž	FAMSA
Ž	The National Council for Child Welfare	Ž	Regional Departments of Social Welfare
Ž	Local State Hospitals and Clinics	Ž	Local ATTICS
Ž	Local AIDS Service Organisations		

Contact details of the above public facilities are available in the telephone directory, or from the Investigating Officer.

If, after reading this notice, there is anything you do not understand ask the Investigating Officer or the Department of Correctional Services' Social Worker for assistance.

SOURCES WITH MODE OF CITATION

A "mode of citation" as well as the full particulars of sources referred to, are recorded in the list below. Sources are referred to by way of the "mode of citation" in the text and footnotes of the Report.

Abdool Karim 1998 Agenda - Empowering Women for Gender Equity

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

ACLU Freedom Network (Internet)

"Mandatory AIDS Testing Ruled Unconstitutional in New Jersey" Press Release by the **American Civil Liberties Union Freedom Network** 13 March 1995
(Internet <http://www.aclu.org/news/n031395.html>)

ACLU News 1 August 1996 (Internet)

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

ACLU News 29 September 1998 (Internet)

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

ACTUP Report 23 March 2000 (Internet)

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

AFAIDS 30 April 1999 (Internet)

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

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

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

AIDSScan March 1994

"Use of Post Exposure AZT Requires Careful Consideration" **AIDSScan** March 1994 6

AIDSScan March/April 1996

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

AIDSScan March 1997

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

1997 9

AIDSScan September/October 1998

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

12

AIDSScan October/November 2000

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

AIDS Action January - March 1998

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

AIDS Action Analysis 21 April 1997 (Internet)

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

AIDS Alert August 1994 (Internet)

"Experts, Senate Favor HIV Testing of Sex Offenders" **AIDS Alert** August 1994 111
(Internet <http://www.aegis.com/news/ads/1994/ad941491.htm>)

AIDS Practice Manual

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

Albertyn (Unpublished [Internet])

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

Albertyn and Goldblatt 1998 **SAJHR**

Cathi Albertyn "Cases and Comments: The Decriminalization of Gay Sexual Offences: *The National Coalition for Gay and Lesbian Equality v The Minister of Justice and Others* 1998 (6) BCLR 726 (W) 1998 **South African Journal on Human Rights** Vol 14 No 3 461-472

AMA Sexual Assault Guideline Resources (Internet)

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

AMFAR AIDS/HIV Treatment Directory June 1996

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

ANC 50th National Conference Resolutions December 1997 (Internet)

ANC 50th National Conference Resolutions Mafikeng, December 1997
(Internet www.anc.org.za/ancdocs/history/conf/conference50/resolutions6.html#Justice)

Andres 1994 **UMKC Law Review**

Paula Andres "Sticking it to the Fourth Amendment: The Failure of Missouri's Mandatory HIV Testing Law For Juvenile Sex Offenders" 1994 **University of Missouri-Kansas City Law Review** Vol 63 No 3 455-474

Andrias 1993 **Fordham Urban Law Journal**

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

Australia Discussion Paper Public Health

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

Australia Final Report on AIDS

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

Beeld 27 June 1998

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

Beeld 15 August 1998

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

Beeld 26 August 1998

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

Beeld 10 March 1999

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

Beeld 10 March 1999

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

Beeld 12 March 1999

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

Beeld 12 March 1999

"Verkragte Vrou 'In Ekstase' Oor Middel" **Beeld** 12 March 1999

Beeld 19 April 1999

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

Beeld 19 April 1999

"Vroueaksie van NNP Vra Sterk Stappe teen Verkragters" **Beeld** 19 April 1999

Beeld 23 April 1999

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

Beeld 23 April 1999

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

Beeld 24 April 1999

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

Beeld 29 April 1999

"Regering 'Sal AZT Verskaf as Vervaardigers Prys Verlaag' " **Beeld** 29 April 1999

Beeld 7 May 1999

" 'Geld vir AZT Eerder vir Vigsvoorkoming Gebruik' " **Beeld** 7 May 1999

Beeld 21 May 1999

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

Beeld 22 May 1999

"Geprikte KZN-leerlinge Kry AZT" **Beeld** 22 May 1999

Beeld 12 July 2000

" 'Gedwonge Seks die Monster in Vigs krisis' "

Birmingham 1999 **Nature Medicine**

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

BMJ (SA Ed) August 1997

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

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

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

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

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

Brett-Smith and Friedland in **AIDS Law Today**

Helena Brett-Smith and Gerald H Friedland "Transmission and Treatment" in **AIDS Law Today - A New Guide for the Public** edited by Scott Burris, Harlon L Dalton, Judith Leonie Miller and the Yale AIDS Law Project, New Haven and London: Yale University Press 1993 18-45

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

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

Burchell and Hunt Vol 1

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

Burgess et al 1990 **Journal of Emergency Nursing**

Ann W Burgess, Barbara Jacobsen, MS Joyce, E Thompson, Timothy Baker and Christine Grant "HIV Testing of Sexual Assault Populations: Ethical and Legal Issues" **Journal of Emergency Nursing** September/October 1990 331-338

Burr **POZ** July 1997 (Internet)

Chandler Burr "Tom Coburn Talks AIDS" **POZ** July 1997
(Internet <http://thebody.com/poz/backissues/797/coburn.html>)

Burris in **AIDS Law Today**

Scott Burris "Testing, Disclosure and the Right to Privacy" in **AIDS Law Today A New Guide for the Public** edited by Scott Burris et al London: Yale University Press 1993 115-149

Business Day 23 October 1997

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

Cameron 1997 **SALJ**

Edwin Cameron "Rights, Constitutionalism and the Rule of Law" 1997 **South African Law Journal** Vol 114 504-510

Cameron (Unpublished)

Mr Justice E Cameron "Confidentiality" (Unpublished paper delivered at a Judges' Workshop on HIV/AIDS Mumbai 7-8 January 1999)

Cameron and Swanson 1992 **SAJHR**

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

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

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

Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 15

"Forced HIV Testing after Occupational Exposure or Assault?" Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 15 2000

- Canadian HIV/AIDS Legal Network **Policy & Law Newsletter** 1997 (Internet)
 "No Compulsory HIV-Antibody Testing of Persons Accused or Convicted of Sexual Assault" Canadian HIV/AIDS Legal Network **Policy & Law Newsletter** 1997 Issue 1 No 3 (Internet
<http://hivinsite.ucsf.edu/topics/women/2098.22a7.html>)
- CDC Drug Use and HIV/AIDS** (Internet)
 "Drug Use and HIV/AIDS" Centers for Disease Control 1993
 (Internet <http://www.thebody.com/cdc/factdrug/html>)
- CDC Facts About Recent HIV/AIDS Treatment** July 1997 (Internet)
 "Facts about Recent HIV/AIDS Treatment Advances and the Implications for Prevention" Centers for Disease Control and Prevention July 1997
 (Internet <http://thebody.com/cdc/treatment.html>)
- CDC Frequently Asked Questions** February 1999 (Internet)
 "Hepatitis B and the Vaccine that Protects You" Centers for Disease Control Frequently Asked Questions August 12 1998, revised February 5 1999
 (Internet <http://www.thebody.com/cdc/hepbvaccine.html>)
- CDC Frequently Asked Questions** May 2000 (Internet)
 "Does HIV Cause AIDS?" Centers for Disease Control Frequently Asked Questions May 2000
 (Internet <http://www.aegis.com/topics/faq.html>)
- CDC Morbidity and Mortality Weekly Reports** 18 December 1992 (Internet)
 "1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS among Adolescents and Adults" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 18 December 1992
 (Internet <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00018871.htm>)
- CDC Morbidity and Mortality Weekly Reports** 2 May 1997
 "Contraceptive Practices Before and After an Intervention Promoting Condom Use to Prevent HIV Infection and Other Sexually Transmitted Diseases among Women - Selected US Sites, 1993-1995" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 2 May 1997 373-377
- CDC Morbidity and Mortality Weekly Reports** 11 July 1997
 "Transmission of HIV Possibly Associated with Exposure of Mucous Membrane to Contaminated Blood" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 11 July 1997 620-623
- CDC Morbidity and Mortality Weekly Reports** 27 March 1998
 "Update: HIV Counselling and Testing Using Rapid Tests - United States, 1995" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 27 March 1998
- CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet)
 "Public Health Service Guidelines for the Management of Health-Care Worker Exposures to HIV and Recommendations for Post Exposure Prophylaxis" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 15 May 1998
 (Internet http://www.cdc.gov/nchstp/hiv_aids/pubs/mmwr.htm)
- CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet)
 "Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, including Considerations Related to Antiretroviral Therapy" Centers for Disease Control **Morbidity and Mortality Weekly Reports** 25 September 1998
 (Internet http://hivinsite.ucsf.edu/medical/tx_guidelines/2098.3e58.html)
- CDC PATHFINDER** May 1997 (Internet)
 "Guide to Information and Resources on HIV Testing" Centers for Disease Control **PATHFINDER** May 1997
 (Internet <ftp://ftp.cdcnpi.org/Pathfinders/testing.txt>)

CDC Update March 1998 (Internet)

"Rapid HIV Tests - Questions/Answers" Centers for Disease Control **Update** March 1998
(Internet <http://www.thebody.com/cdc/rapidfaq.htm>)

CDC Update June 1998 (Internet)

"Facts about Recent HIV/AIDS Treatment Advances and the Implications for Prevention" Centers for Disease Control **Update** June 1998
(Internet <http://www.thebody.com/cdc/treatment.html>)

CDC Update September 1998

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

CDC Update October 1998 (Internet)

"Human Immunodeficiency Virus Type 2" Centers for Disease Control **Update** October 1998
(Internet <http://www.cdc.gov/hiv/pubs/facts/hiv2.html>)

Chaskalson et al

Matthew Chaskalson et al **Constitutional Law of South Africa** Kenwyn: Juta 1996 (Including Revision Service 5 1999)

Clark in **Human Rights for the Police**

Dellene Clark "The Constitutionality of the Ascertainment of Bodily Features" in **Human Rights for the Police** compiled by F Nel and J Bezuidenhout First Edition 1995 Kenwyn: Juta 1995 251-261 (See also the Afrikaans version of the Second Edition of this publication Dellene Clark "Die Grondwetlikheid van die Vasstelling van Liggaamlike Kenmerke" in **Polisiëring en Menseregte** compiled by F Nel and J Bezuidenhout Second Edition Kenwyn: Juta 1997 259-273)

Cohn 1997 **BMJ**

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

Colella 1995 **The Journal of Legal Medicine**

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

Correl et al **NSW Public Health Bulletin** July 2000

Patricia Correll, Don Smith and Andrew Grulich "Post Exposure Prophylaxis for Non-occupational Exposure to HIV: Experience in NSW One Year After the Introduction of the Guidelines" **New South Wales Public Health Bulletin** July 2000 113-117

Crichton (Unpublished)

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

Currier (Unpublished [Internet])

Judith Currier "Post Exposure Prophylaxis (PEP)" Coverage at AIDS 2000 - XIIIth International AIDS Conference Durban, South Africa 9-14 July 2000
(Internet <http://www.thebody.com/confs.durban/currier1.html>)

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

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

Daily Dispatch 23 October 1997

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

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

Pamela De Carlo "Three Fact Sheets on Condoms" **Veterans Administration AIDS Information Newsletter** April 1995

(Internet <http://www.hsph.harvard.edu/Organizations/hai/researchtemp/vaain/110.html>).

Also published on the Internet as Pamela De Carlo "Do Condoms Work?" **The Journal of the American Medical Association HIV/AIDS Information Centre**

(Internet <http://www.ama-assn.org/special/hiv/preventn/prevent2.htm>)

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

Risa Denenberg "Commentary: Post Exposure Antiretroviral Treatment for Rape Survivors?" **The Body: Gay Men's Health Crisis Treatment Issues** July 1997

(Internet <http://www.thebody.com/gmhc/issues/julaug97/abuse.html>)

Deniaud 1997 **Sante** (Internet)

F Deniaud "Reseau IEC-Population, Abidjan, Cote d'Ivoire" [Current Status of the Female Condom in Africa] 1997 **Sante** 405-415

(Internet <http://www.aegis.com/pubs/aidsline/1998/jun/m9861199.html>)

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

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

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

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

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

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

Dorrington 2000 **SAMJ** 452-453

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

Du Toit et al

Ettienne Du Toit, Frederick J De Jager, Andrew Paizes, Andrew St Quintin Skeen and Steph Van Der Merwe **Commentary on the Criminal Procedure Act** Cape Town: Juta and Co Ltd (including revision service 19, 1997)

Edgar and Sandomire 1990 **AMJLM**

Harlod Edgar and Hazel Sandomire "Medical Privacy Issues in the Age of AIDS: Legislative Options" **American Journal of Law and Medicine** 1990 Vol XVI Nos 1-2 155-222

Elliot and Jürgens

Richard Elliot and Ralf Jürgens **Rapid HIV Screening at the Point of Care: Legal and Ethical Questions** Montreal: The Canadian HIV/AIDS Legal Network 2000

Emmons 1997 **The American Journal of Medicine**

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

Evian

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

Field 1990 **AMJLM**

Martha A Field "Testing for AIDS: Uses and Abuses" 1990 **American Journal of Law and Medicine** Vol XVI Nos 1-2 34-106

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

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

Fleming and Martin 1993 **SAMJ**

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

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

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

Forbes **WORLD** September 1998 (Internet)

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

Gerberding in **The Medical Management of AIDS**

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

Gostin and Lazzarini

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

Gostin et al 1994 **JAMA**

Lawrence O Gostin, Zita Lazzarini, Diane Alexander, Allan M Brandt, Kenneth Mayer and Daniel Silverman "HIV Testing, Counselling, and Prophylaxis after Sexual Assault" **The Journal of the American Medical Association** 11 May 1994 Vol 271 No 18 1436-1444

Groopman **The New Republic** 12 August 1996

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

Guay et al 1999 **The Lancet**

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

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

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

Guidelines for the Management of Non-Occupational Exposure to HIV and HBV June 2000

Communicable Diseases Unit, Public Health Services, Queensland Health **Guidelines for the Management of Non-Occupational Exposure to HIV and HBV** June 2000

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

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

Hankins **Canadian HIV/AIDS Policy & Law Newsletter** July 1996 (Internet)

Catherine Hankins "Human Rights, Women, and HIV" **Canadian HIV/AIDS Policy & Law Newsletter** July 1996
(Internet <http://www.aids.aw.ca/Newsletter/July1996/01hankine.html>)

Health Professions Council of SA Guidelines on HIV/AIDS 1994

Health Professions Council of South Africa (formerly known as the South African Medical and Dental Council) "The Management of Patients with HIV Infection or AIDS" Pamphlet published by the Health Professions Council of South Africa Pretoria: 1994

Henderson 1999 **JAMA** (Internet)

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

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

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

Heyns (Unpublished)

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

Heywood (Unpublished)

Mark Heywood "The Implications of 'AIDS Notification' for Human Rights and HIV/AIDS Prevention in South Africa - An Analysis of the Proposed Amendment to the Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions" (Unpublished draft submission of the AIDS Law Project to the Department of Health, July 1999)

Hiemstra

VG Hiemstra **Suid-Afrikaanse Strafproses** Fifth Edition by Johann Kriegler Durban: Butterworths 1993

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

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

HIV-Infogram 20 September 1996 (Internet)

"Viral Load Testing" **HIV-Infogram** Seattle-King County Department of Public Health
(Internet <http://www.metrokc.gov/health/apu/infograms/vltest.htm>)

HIV Insite "Accuracy of Tests" (Internet)

"Accuracy of Tests" **HIV Insite** Information provided by CDC NAC, 1997
(Internet <http://hivinsite.ucsf.edu/topics/testing/2098.e075.html>)

HIV Insite "Announcement of Human Testing of HIV Vaccine for Africa" (Internet)

"Announcement of Human Testing of HIV Vaccine for Africa" **HIV Insite** Report at AIDS 2000 -XIIIth International AIDS Conference Durban, South Africa 11-14 July 2000
(Internet http://hivinsite.ucsf.edu/medical/conference_updates/3098.0006.html)

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

"My Partner's HIV Test was Inconclusive - What Does This Mean?" **HIV Insite** Question answered by Nicolas Sheon, HIV Insite Prevention Editor October 1998
(Internet <http://hivinsite.ucsf.edu/prevention/ask/2098.3e63.html>)

- HIV Insite** "State Restrictions on Persons" (Internet)
"State Restrictions on Persons" **HIV Insite** Social Issues
(Internet <http://hivinsite.ucsf.edu/social/kaiser-family-found/2098.2c50.html>)
- HIV Insite** "Vaccines - The Overall Picture" (Internet)
"Vaccines - The Overall Picture" **HIV Insite** Key Topics
(Internet http://hivinsite.ucsf.edu/topics/vaccines/the_overall_picture/)
- Hirschowitz et al
Ros Hirschowitz, Seble Worku and Mark Orkin **Rape in South Africa - Quantitative Research Findings on Rape in South Africa** Pretoria: Statistics South Africa 2000
- Hoskins 1998 **Body Positive** (Internet)
Valerie Michelle Hoskins "Dangerous Liaisons: Rape and HIV" 1998 **Body Positive** Vol XI No 11 November 1998
(Internet <http://www.thebody.com/bp/nov98/rape.html>)
- Howard 1999 **San Francisco Bar Area Reporter** (Internet)
Don Howard "What we Don't Know about Reinfection" **San Francisco Bar Area Reporter** 11 March 1999 as published in ACTUP Golden Gate
(Internet <http://www.actup.org/BAR/art031199.html>)
- Human Rights Watch **World Report 1999** (Internet)
"Women's Human Rights" Human Rights Watch **World Report 1999**
(Internet <http://www.hrw.org/wr2k/Wrd.htm>)
- IAS Satellite Symposium at the XIIIth International AIDS Conference 2000** (Internet)
"Our Commitment to the Next Generation: Vaccine Development" IAS Satellite Symposium at AIDS 2000 - XIIIth International AIDS Conference Durban, South Africa 7-11 July 2000
(Internet http://www.webcast.aids.com/dailysummaries/ias_symposium.cfm)
- IAVI Information Sheet** (Internet)
"End AIDS for All Times (Phases in Testing of Vaccines)" International AIDS Vaccine Initiative Information Sheet
(Internet http://www.iavi.org/science_z_phases.html)
- Inter Press Service** 3 March 1999 (Internet)
"Health: UN Sees Link between AIDS and Gender Violence" **Inter Press Service** 3 March 1999
(Internet <http://ww2aegis.com/news/ips/1999/ip990301.html>)
- IRIN** 17 January 2000 (Internet)
"AFRICA-AIDS: How Reliable are the Figures?" **Integrated Regional Information Network** 17 January 2000
(Internet <http://www.aegis.com/news/irin/2000/ir000101.htm>)
- Jackson in **AIDS Agenda**
Mark H Jackson "The Criminalization of HIV" in **AIDS Agenda - Emerging Issues in Civil Rights** edited by Nan D Hunter and William B Rubenstein New York: The New Press 1992 239-270
- JAMA HIV/AIDS Information Center** July 1997 (Internet)
"Effectiveness of Condoms" (Information from the Centers for Disease Control and Prevention July 1997)
The Journal of the American Medical Association HIV/AIDS Information Center
(Internet <http://www.ama-assn.org/special/hiv/support/transmis/transf.htm>)
- Johns Hopkins University **Report on AIDS Litigation** 1996 (Internet)
Georgetown/Johns Hopkins University Program on Law and Public Health **The AIDS Litigation Project - A Look At HIV/AIDS in the Courts of the 1990s** (Report prepared in 1996)
(Internet http://hivinsite.ucsf.edu.social/kaiser_family_found.2098.2c57.html)

Jürgens

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

Katz and Gerberding 1998 **Annals of Internal Medicine**

Mitchell H Katz and Julie L Gerberding "The Care of Persons with Recent Sexual Exposure to HIV" 1998 **Annals of Internal Medicine** 15 February 1998 306-312

King **AIDS Treatment Update** August 1996 (Internet)

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

Kirby 1994 **AIDS Care**

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

Kleinman et al 1997 **Transfusion Medicine Reviews**

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

Lachman

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

Law Commission Report No 218 1993

The Law Commission "Criminal Law: Legislating the Criminal Code: Offences Against the Person And General Principles" (Report No 218) HMSO: London 1995

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

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

Leclerc-Madlala 1996 **Acta Criminologica**

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

Leclerc-Madlala 1997 **Medical Anthropology**

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

Los Angeles Times Washington Edition 1 October 1994 (Internet)

(Information distributed by the Centers for Disease Control on <http://www.aegis.com/news/>)

Lötter 1994 **Codicillus**

Sunette Lötter "From the Law Reports - Obstructing the Course of Justice - What Constitutes - Refusal to the Taking of a Blood Sample *S v Binta* 1993 (2) SACR 553 (C)" **Codicillus** May 1994 58-59

LoveLife 2000

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

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

Peter Lurie, Suellen Miller, Frederick Hecht, Margaret Chesney and Bernard Lo "Post Exposure Prophylaxis after Nonoccupational HIV Exposure" 1998 **The Journal of the American Medical Association** 25 November 1998 1769-1773 (Internet <http://www.ama-assn.org/special/hiv/library/readroom/jama98/jsc7065.htm>)

Maartens 1999 **SAMJ**

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

Mail and Guardian 21-27 May 1999

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

Marseille et al 1999 **The Lancet**

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

Martin (Unpublished)

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

McCutchan and Birx (Unpublished)

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

McKay and Wannenburg (Unpublished)

Ann McKay and Gail Wannenburg "Rape and HIV" (Unpublished preliminary report commissioned by the Rape and AIDS Sub-Committee of the Pietermaritzburg AIDS Action Group March 1998)

Meintjies-Van der Walt 1998 **SACJ**

Lirieka Meintjies-Van der Walt "Towards Victims' Empowerment Strategies in the Criminal Justice Process" 1998 **South African Journal of Criminal Justice** Vol 11 No 2 157- 172

Milton

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

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

Bruce Mirken "Post Exposure Prophylaxis: Still More Questions than Answers" **Bulletin of Experimental Treatments for AIDS** October 1998
(Internet <http://ww2.aegis.com/pubs/beta/1998/be981009.html>)

MRC News September 1999 (Internet)

"SAAVI - New Hope for Millions?" **Medical Research Council News** September 1999
(Internet <http://www.mrc.ac.za/mrcnews/september99/saavi.htm>)

NACOSA National AIDS Plan 1994-1995

The National AIDS Convention of South Africa **A National AIDS Plan for South Africa 1994-1995** Sunnyside: NACOSA National Secretariat July 1994

Namibia Report on the Law Pertaining to Rape

Namibia Law Reform and Development Commission **Report on the Law Pertaining to Rape** (LRDC 4) Windhoek, Namibia: July 1997

Neethling et al

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

NIAID Fact Sheet March 2000 (Internet)

"Developing New Tools to Protect Women from HIV/AIDS and Other STDs" **National Institute of Allergy and Infectious Diseases Fact Sheet** March 2000
(Internet <http://www.thebody.com/niaid/topmicro/htm>)

NIAID News Release 8 February 1999 (Internet)

"NIAID Opens First AIDS Vaccine Trial in Africa" **National Institute of Allergy and Infectious Diseases News Release** 8 February 1999
(Internet <http://www.thebody.com/niaid/uganda299.html>)

PACSA Factsheet June 1998

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

Palmer 1999 **Infectious Disease News** 28

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

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

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

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

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

Pienaar 1996 **In Focus Forum**

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

Pithey et al (Unpublished)

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

Pretoria News 29 May 1998

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

Pretoria News 22 April 1999

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

Pretoria News 23 April 1999

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

Pretoria News 26 April 1999

"Zuma Praised for AIDS Decision" **Pretoria News** 22 April 1999

PRNewswire 9 July 2000 (Internet)

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

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

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

Rape Statistics Rape Crisis Cape Town (Internet)

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

Rapport 15 November 1998

"'Vigs'-man in Hof oor Slapery by Vroue" **Rapport** 15 November 1998

Rapport 15 November 1998

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

Red Hot News Jan/Feb 1998

"Condom Use in South Africa" **Red Hot News** (Publication of the South African Department of Health, Directorate: HIV/AIDS and STDs) January/February 1998 1-2

Rees (Unpublished)

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

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

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

Reuters NewMedia 4 October 2000 (Internet)

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

Robling 1995 **Cleveland State Law Review**

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

Robson et al 1994 **SAMJ**

SC Robson, B Schoub and SS Abdool Karim "Viral Hepatitis B - An Overview" 1994 **South African Medical Journal** Vol 84 No 8 August 1994 530-535

Rotenberg 1997 **Medicine and Law**

Vadim S Rotenberg "To Inform or Not to Inform - A Decision with Psycho-Biological Implication" 1997 **Medicine and Law** Vol 16 49-52

SA Medical Association HIV/AIDS Ethical Guidelines 1998

South African Medical Association "HIV/AIDS Ethical Guidelines 1998 (Revised Edition)" Pamphlet published by the South African Medical Association Pinelands: 1998

Sadler 1992 **Washington Law Review**

Bernadette Pratt Sadler "When Rape Victims' Rights Meet Privacy Rights: Mandatory HIV Testing, Striking the Fourth Amendment Balance" 1992 **Washington Law Review** Vol 67 195-213

SALC Committee Paper 432

South African Law Commission **Committee Paper 432** (Internal Document) **Aspects of the Law relating to AIDS: Synopsis of Comments on Working Paper 58** August 1996

SALC Discussion Paper 68

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

SALC Discussion Paper 72

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

SALC Discussion Paper 73

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

SALC Discussion Paper 80

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

SALC Discussion Paper 84

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

SALC Discussion Paper 85

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

SALC Discussion Paper 91

South African Law Commission **Sentencing** (Project 82) **Discussion Paper 91** Pretoria: April 2000

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

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

SALC Issue Paper 7

South African Law Commission **Sentencing - Restorative Justice (Compensation for Victims of Crime and Victim Empowerment)** (Project 82) **Issue Paper 7** Pretoria: 1997

SALC Research Paper on Domestic Violence

South African Law Commission **Research Paper on Domestic Violence** (Project 100) Pretoria: April 1999

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

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

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

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

SALC Working Paper 58

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

Salminen et al (Unpublished)

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

Salyer **Survival News** May 1999 (Internet)

David Salyer "The ABC's of Hepatitis" **Survival News** May 1999 (Internet <http://www.thebody.com/asp/may99/hepatitis.html>)

Salyer **Survival News** June 1999 (Internet)

David Salyer "The Reinfection Debate" **Survival News** June 1999 (Internet <http://www.thebody.com/asp/june99/reinfection.html>)

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

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

SAPS National Instruction 22/1998

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

SAPS Semester Report 1/2000 (Internet)

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

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

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

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

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

Schmidt

CWH Schmidt **Bewysreg** Third Edition Durban: Butterworths 1989

Schoub

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

Schwikkard 1995 **SACJ**

PJ Schwikkard "Recent Cases - Evidence - Blood Samples" 1995 **South African Journal of Criminal Justice** Vol 8 No 1 92

Schwikkard 1996 **SACJ**

PJ Schwikkard "Recent Cases - Evidence - Ascertainment of Bodily Features" 1996 **South African Journal of Criminal Justice** Vol 9 No 1 112-114

Snyman

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

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

Rick Sowadsky "A Few Questions from a Student" **The Body: Answers to Safe Sex and Prevention Questions** (Internet <http://www.thebody.com/sowadsky/answers/quest580/html>)

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

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

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

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

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

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

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

Rick Sowadsky "David Imagawa, MD Studied Window Period for CDC. What Results Were Misinterpreted by Public Health Officials and Media?" **The Body: Answers to Safe Sex and Prevention Questions**

(Internet <http://www.thebody.com.sowadsky/answers/quest333.html>)

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

Rick Sowadsky "HIV Antibody Tests - Now you Have Several Choices" **The Body**

(Internet <http://www.thebody.com.sowadsky/tests2.html>)

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

Rick Sowadsky "How Long Does HIV Survive Outside the Body" **The Body**

(Internet <http://www.thebody.com/sowadsky/answers/quest439.html>)

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

Rick Sowadsky "How Safe Are Condoms?" **The Body**

(Internet <http://www.thebody.com/sowadsky/answers/quest113.html>)

- Sowadsky "Kissing and Infection with HIV" **The Body** (Internet)
Rick Sowadsky "Kissing and Infection with HIV" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet <http://www.thebody.com.sowadsky.answers/quest407/html>)
- Sowadsky "Let's Clear Something up ..." **The Body** (Internet)
Rick Sowadsky "Let's Clear Something up ..." **The Body: Answers to Safe Sex and Prevention Questions**
(Internet <http://www.thebody.com/sowadsky/answers/quest526.html>)
- Sowadsky "Post Exposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet)
Rick Sowadsky "Post Exposure Prophylaxis (PEP) for Sexual Exposures" **The Body**
(Internet <http://www.thebody.com/sowadsky/pep/html>)
- Sowadsky "Rapid HIV Tests" **The Body** (Internet)
Rick Sowadsky "Rapid HIV Tests" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet <http://www.thebody.com/cdc/rapidfaq.htm>)
- Sowadsky "Risk from Fighting?" **The Body** (Internet)
Rick Sowadsky "Risk from Fighting" **The Body: Answers to Safe Sex and Prevention Questions** (Internet
http://www.thebody.com/cgi/safe_ans/17185ris.html)
- Sowadsky "Risk of Transmission Statistics" **The Body** (Internet)
Rick Sowadsky "Risk of Transmission Statistics" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet <http://www.thebody.com.sowadsky.answers/quest628.html>)
- Sowadsky "Spreading HIV Intentionally" **The Body** (Internet)
Rick Sowadsky "Spreading HIV Intentionally" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet <http://www.thebody.com.sowadsky.answers/quest223.html>)
- Sowadsky "Taking Unnecessary Tests: A Waste of Valuable Resources" **The Body** (Internet)
Rick Sowadsky "Taking Unnecessary Tests: A Waste of Valuable Resources" **The Body**
(Internet <http://www.thebody.com/sowadsky/tests.html>)
- Sowadsky "The New Saliva HIV Tests" **The Body** (Internet)
Rick Sowadsky "The New Saliva HIV Tests" **The Body**
(Internet <http://www.thebody.com/sowadsky/saliva.html>)
- Sowadsky "Urine HIV Antibody Tests" **The Body** (Internet)
Rick Sowadsky "Urine HIV Antibody Tests" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet http://www.thebody.com/cgi/safe_ans/17878Uri.html)
- Sowadsky "15 Minute Test" **The Body** (Internet)
Rick Sowadsky "15 Minute Test" **The Body: Answers to Safe Sex and Prevention Questions**
(Internet <http://www.thebody.com/sowadsky/answers/quest427.html>)
- Sowetan** 23 October 1997
"Victims Should Have Right to Know if Attacker has AIDS or is HIV-positive" **Sowetan** 23 October 1997
- Sowetan** 2 June 1998
"Rape Gang Suspect in Court" **Sowetan** 2 June 1998
- Sowetan** 9 March 1999
"Violence against Women Linked to Spread of AIDS" **Sowetan** 9 March 1999
- Steytler
Nico Steytler **Constitutional Criminal Procedure** Durban: Butterworths 1998

Stine

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

Strauss

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

Strauss 1996 **THRHR**

SA Strauss "Privaatheidskending en die Toestemmingsvereiste by Bloedtoetsing vir Vigs" 1996 **Journal of Contemporary Roman-Dutch Law** Vol 59 No 3 492-497

Strauss **Huldigingsbundel vir WA Joubert**

SA Strauss "Employees with AIDS: Some Legal Issues" in **Huldigingsbundel vir WA Joubert** edited by SA Strauss Durban: Butterworths 1988 140-163

Sunday Independent 25 October 1998

"Medical AIDS Schemes Take a Kinder Look at AIDS" **Sunday Independent** 25 October 1998

Sunday Independent 2 May 1999

"Zuma Pledge on Cost of Anti-HIV Drug" **Sunday Independent** 2 May 1999

Sunday Times 8 November 1998

"Doctor Gave Me AIDS" **Sunday Times** 8 November 1998

Sunday Times 14 February 1999

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

Sunday Times 4 April 1999

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

Sunday Times 2 May 1999

"Zuma Rejects Cheap AZT" **Sunday Times** 2 May 1999

TAGline August/September 1996 (Internet)

"Viral Load Comes of Age: Propelled by Results from Multiple Studies, Viral Load Monitoring Lunges to the Forefront of HIV Medicine" **TAGline** Vol 3 Issue 6 August/September 1996 (Internet <http://www.thebody.com/tag/aug96b.html>)

Taitz 1992 **SAJHR**

Jérolde Taitz "Cases and Comments: AIDS Patients are Entitled to the Right of Medical Confidentiality" 1992 **South African Journal on Human Rights** 577-586

Talis 1998 **Agenda - Empowering Women for Gender Equity**

Vicci Talis "AIDS is a Crisis for Women" 1998 **Agenda - Empowering Women for Gender Equity** No 39 6-14

The AIDS Knowledge Base (Internet)

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

The Citizen 3 September 1997

"Rapists May Face AIDS Tests" **The Citizen** 3 September 1997

The Citizen 19 February 1999

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

The Citizen 11 May 1999

" 'Rapists Should Have HIV Tests' " **The Citizen** 11 May 1999

The Citizen 13 October 1999

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

The Eastern Province Herald 20 October 1997

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

The Herald 20 May 1997

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

The Nedcor Project

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

The South African STD/HIV/AIDS Review July 1997

Department of Health **The South African STD/HIV/AIDS Review** (Comprehensive Report) July 1997

The Star 4 March 1997

"No Lifeline for Rape Survivors Facing AIDS" **The Star** 4 March 1997

The Star 20 March 1998

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

The Star 23 April 1999

"Rape Survivors Champions Anti-HIV Drugs" **The Star** 23 April 1999

Toronto Hospital Immunodeficiency Clinic Newsletter September 1996 (Internet)

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

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

Gabriel Torres "PEPping up your HIV Defenses" **Gay Men's Health Crisis Treatment Issues** May 1998: **The Body**
(Internet <http://www.thebody.com/gmhc/issues/may98/pep.html>)

UNAIDS Briefing Paper - Children and HIV/AIDS February 1999

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

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

"HIV/AIDS in Africa" Joint United Nations Programme on HIV/AIDS (UNAIDS) Fact Sheet June 2000 (Internet <http://www.unaids.org/fact-sheets/files/Africa-Eng.html>)

UNAIDS Press Release 13 July 2000

"African Scientists Launch Vaccine Strategy for the Continent" **UNAIDS Press Release** 13 July 2000 (Internet http://www.thebody.com/un aids/african_vaccine.html)

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

Peter J Ungvarski "Post Exposure Prophylaxis" in **HIV/AIDS A Guide to Primary Care Management** edited by Peter J Ungvarski and Jacquelyn Haak Flaskerud Fourth Edition Philadelphia: WB Saunders Company 1999 519-524

US Department of Justice Information (Internet)

"Chapter 12 - Testing Certain Offenders for HIV" **United States of America Department of Justice Information**
(Internet <http://www.ojp/usdoj.gov/BJA/txt/chap12.txt>)

Van Dyk

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

Van Oosten

Ferdinand FW Van Oosten **The Doctrine of Informed Consent in Medical Law** (Thesis submitted in accordance with the requirements for the degree of Doctor Legum) Pretoria: University of South Africa 1991

Van Wyk

Christa Wilhelmina Van Wyk **Aspekte van die Regsproblematiek Rakende VIGS** (Thesis submitted in accordance with the requirements for the degree of Doctor Legum) Pretoria: University of South Africa 1991

Van Wyk 1988 **THRHR**

CW Van Wyk "Vigs en die Reg: 'n Verkenning" 1988 **Journal of Contemporary Roman-Dutch Law** 317-332

Van Wyk 1993 **De Jure**

Christa Van Wyk "Die Grense van Geheimhouding ten opsigte van VIGS" 1993 **De Jure** 140-152

Van Wyk 1994 **THRHR**

CW Van Wyk "Vigs, Vertroulikheid en 'n Plig Om In Te Lig" 1994 **Journal of Contemporary Roman-Dutch Law** Vol 57 No 1 141-147

Voelker 1997 **JAMA** 460

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

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

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

Volberding 1996 **The Lancet**

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

Volberding in **The Medical Management of AIDS**

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

Weiss **HIV-Law Digest** 3 June 1998

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

Whiteside and Wood (Unpublished)

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

WHO Weekly Epidemiological Record 16 September 1994

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

WHO Weekly Epidemiological Record 21 March 1997

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

WHO Fact Sheet June 2000 (Internet)

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

Wolhuter 1998 **THRHR**

L Wolhuter "Levelling the Playing Field: A Feminist Redefinition of the Crime of Rape" 1998 **Journal of Contemporary Roman Dutch Law** Vol 61 443-5462

Women and AIDS

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

ZA Now 3 April 2000

(Internet)

"Smith's Rapist Gets 30 Year Sentence" **ZA Now** 3 April 2000
(Internet www.mg.co.za/mg/za/archive/2000apr/03aprpm-news.html)

TABLE OF CASES

South Africa

- Bernstein and others v Bester NO and others** 1996 (4) BCLR 449 (CC)
(and 1996 (2) SA 751 (CC))
- Broude v McIntosh and others** 1998 (3) SA 60 (SCA)
- Burger v Administrateur, Kaap** 1990 (1) SA 483 (C)
- C v Minister of Correctional Services** 1996 (4) SA 292 (T)
- Case and another v Minister of Safety and Security and others** 1996 (3) SA 617 (CC)
(and 1996 (5) BCLR 609 (CC); 1996 (1) SACR 587 (CC))
- Castell v De Greef** 1994 (4) SA 408 (C)
- Coetzee v Government of the Republic of South Africa and others** 1995 (10) BCLR 1382 (CC)
- Director of Public Prosecutions: Cape of Good Hope v Bathgate** 2000 (2) BCLR 151 (C)
(and 1999 (2) SACR 272 (C); 2000 (2) SA 535 (C))
- Esterhuizen v Administrator of the Transvaal** 1957 (3) SA 710 (T)
- Ferreira v Levin NO and others and Vryenhoek and others v Powell NO and others** 1996 (1) BCLR 1 (CC)
(and 1996 (1) SA 984 (CC))
- Financial Mail (Pty) Ltd and others v Sage Holdings Ltd and another** 1993 (2) SA 451 (A)
- Fraser v Children's Court, Pretoria North and others** 1997 (2) BCLR 153 (CC)
(and 1997 (2) SA 261 (CC))
- Hoffmann v South African Airways** 2000 (2) SA 628 (W)
- Hoffmann v South African Airways** 2000 (11) BCLR 1211 (CC)
- Holtzhauzen v Roodt** 1997 (4) SA 766 (W)
- Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A)
- Lampert v Hefer NO** 1955 (2) SA 507 (A)
- Lymbery v Jefferies** 1925 AD 236
- N v T** 1994 (1) SA 862 (C)
- National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others** 1999 (1) SA 6 (CC)
(and 1998 (2) SACR 556 (CC); 1998 (1) BCLR 1517 (CC))
- Nel v Le Roux NO and others** 1996 (4) BCLR 592 (CC)
(and 1996 (1) SACR 572 (CC); 1996 (3) SA 562 (CC))
- Nkosi v Barlow NO and others** 1984 (3) SA 148 (T)
- Prinsloo v Van der Linde and another** 1997 (6) BCLR 759 (CC)
(and 1997 (3) SA 1012 (CC))

Protea Technology Ltd v Wainer 1997 (9) BCLR 1225 (W)

R v McCoy 1953 (2) SA 4 (SR)

S v A and another 1971 (2) SA 293 (T)

S v Baloyi and others 2000 (1) SACR 81 (CC)
(and 2000 (2) SA 425 (CC))

S v Binta 1993 (2) SACR 553 (C)

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

S v Huma and another (2) 1995 (2) SACR 411 (W)

S v Kiti 1994 (1) SACR 14 (E)

S v Makwanyane and another 1995 (3) SA 391 (CC)
(and 1995 (2) SACR 1 (CC); 1995 (6) BCLR 665 (CC))

S v Manamela and another 2000 (5) BCLR 491 (CC)

S v Maphumulo 1996 (2) SACR 84 (N)

S v Oberbacher 1975 (3) SA 815 (SWA)

S v Zuma and others 1995 (2) SA 642 (CC)
(and 1995 (1) SACR 568 (CC))

Sapat and others v The Director: Directorate for Organised Crime and Public Safety and others 2000 (2) BCLR 200 (C)
(and 1999 (2) SACR 435 (C))

Scagell and others v Attorney-General, Western Cape and others 1996 (11) BCLR 1446 (CC)
(and 1996 (2) SACR 579 (CC))

Stoffberg v Elliott 1923 CPD 148

Venter v Nel 1997 (4) SA 1014 (D)

Canada

R v Beaulieu Roberge J CQ Bedford (Cowansville) 455-01-000963-920, 1992-11-03 Decision No 92-1769 (Court of Québec)

R v JPB [1992] NWTJ No 207 [North West Territories Youth Court]

DC v Paul Bernardo et al Court File No 93-CQ46124 unreported decision of 23 September 1996

Thompson Newspapers Ltd v Canada (1990) 67 DLR (4th) 161 (SCC) 220

Germany

BGH v O 4.11.1988 - StR 262/88

United States

Breithaupt v Abram 352 US 432, 1 L ed 2d 448, 77S Ct 408

Doe v Connell 583 NYS 2d 707 (App Div 4Dept 1992)

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

Fosman v State 664 S0 2d 1163 (Fla App 4 Dist 1995)

In re Michael WW 616 NYS 2d 480 (NY 1994)

People v Adams 579 NE 2d 574, 583 (Ill 1992)

People v Frausto 42 Cal Rptr 2d 450 (Cal Ct App 1995)

People v Guardado 1996 Cal LEXIS 1519 Mar 13 1996

People v Wealer 642 NE 2ed 1299 (Ill 1994)

State ex rel JG A-3585-94T5 1996 NJ Super LEXIS 163 (NJ Super 1996)

State v Abbott 901 P 2d 1296 (Haw App 1995)

State v Foster 915 P 2d 567 (Wash App Div 1996)

Syring v Tucker 505 NW 2d 142 (Wis 1993)

Velasquez Rodriguez Case Judgement of 27 July 1988, Inter-American Court of Human Rights, Ser C, Vol 4 par 166

SELECTED LEGISLATION

South African legislation

Births and Deaths Registration Act 51 of 1992

Child Care Act 74 of 1983

Constitution of the Republic of South Africa 108 of 1996

Criminal Law Amendment Act 105 of 1997

Criminal Procedure Act 51 of 1977

Criminal Procedure Second Amendment Act 85 of 1997

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

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

Draft National Policy on Testing for HIV 1999

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

Draft Regulations for Hazardous Biological Agents 1999

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

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

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

Employment Equity Act 55 of 1998

Employment Equity Bill 1997

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

Health Act 63 of 1977

Health Professions Act 56 of 1974

Medical Schemes Act 131 of 1998

Mental Health Act 18 of 1973

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

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

Nursing Act 50 of 1978

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

Regulations on the Registration of Births and Deaths 1992

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

Regulations relating to Blood and Blood Products 1990

Government Notice R 1935 in **Government Gazette** 12695 of 17 August 1990

Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987
Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987

Sexual Offences Act 23 of 1957

South African Police Service Act 68 of 1995

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

Foreign legislation

Australia

Criminal Code Act 1995

HIV/AIDS Preventive Measures Act 25 of 1993 (Tasmania)

Botswana

Penal Code (Amendment) Act 1998

Canada

Criminal Code 1985

Namibia

Combatting of Rape Act 8 of 2000

United Kingdom

Offences Against the Person Act 1861

United States

HIV Prevention Bill (105th Congress 1997 HR 1062)

United States Code Title 18 (USC 18) (Crimes and Criminal Procedure)

United States Code Title 42 (USC 42) (The Public Health and Welfare)

Victims of Rape Health Protection Bill (106th Congress 1999 HR 3088)

Zimbabwe

Criminal Law Amendment Bill 1996

Sexual Offences Bill 1999

International instruments

International Partnership Against AIDS in Africa 1999

Joint United Nations Programme on HIV/AIDS (UNAIDS) Policy on HIV Testing and Counselling 1997

Southern African Development Countries (SADC) Declaration on Gender and Development 1997

United Nations Convention on the Elimination of all Forms of Discrimination Against Women 1979 (CEDAW)

United Nations Convention on the Rights of the Child 1989

United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power 1985

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

1 Introduction

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

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

Working Paper 58

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

First, Second and Third Interim Reports

- 1.3 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.²
- 1.4 The **First Interim Report**³ (tabled in Parliament by the then Minister of Justice on 30 August 1997) dealt with the following:
- ! A limitation on the use of non-disposable syringes, needles, and other hazardous material in health care settings.

1 **SALC Working Paper 58.**

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

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

- ! The implementation, in relevant occupational legislation, of universal precautions in the work place.
- ! The statutory implementation of a national compulsory standard for condoms in accordance with international standards.
- ! The promulgation of a national policy on testing for HIV infection.
- ! The amendment, finalisation and promulgation of the Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1993⁴ (which deschedule AIDS as a communicable disease in respect of which certain coercive measures apply mandatorily).

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

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

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

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

7 The Commission recommended that the 1993 Draft Regulations be finalised and promulgated. The motivation for this was that uncertainty exists in the public mind about the status of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 (Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987) and whether they may be used in respect of persons with HIV infection or AIDS, particularly as the 1987 Regulations have never been applied to HIV/AIDS and as the 1993 Draft Regulations removed AIDS from the Annexure listing certain *communicable* diseases (**SALC First Interim Report on Aspects of the Law relating to AIDS** par 5.1-5.16). Note that the Commission's recommendations did not deal with the *notification* of HIV and/or AIDS. As regards notification, the Department (without input by the Commission) in April 1999 proposed amendments to the 1987 Regulations in order to make AIDS a notifiable medical condition (Government Notice R485, Regulation Gazette 6496 in **Government Gazette** 19946 of 23 April 1999). When the current Report was drafted these amendments have not been finalised. According to media reports the Government may drop its intention to make AIDS notifiable as a result of public pressure and lack of support for such a step (**The Citizen** 13 October 1999).

syringes and the utilisation of universal precautions in the work place.⁸

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

8 In November 1999 the Department of Labour published draft Regulations for Hazardous Biological Agents (Government Notice R 1248 in **Government Gazette** 20555 of 1 November 1999) for public comment. The draft Regulations incorporate the Commission's recommendations. Representatives of the HIV/AIDS Project Committee were on two occasions requested by the Department to comment on its drafts before they were published for comment (meetings with Mr R Curtis, Director Occupational Health and Hygiene, Department of Labour and representatives of the Infection Control Association of SA on 16 November 1998 and 21 April 1999). Public comments on the Regulations have been processed and it is expected that the Regulations will be promulgated before the end of 2000 (information supplied by Mr Curtis on 21 July 2000).

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

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

- 1.7 The **Second Interim Report**¹¹ 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 Bill¹² which accommodated many of the Commission's recommendations in principle; and also proposed an alternative Bill dealing directly with pre-employment HIV testing, should the provisions of the Employment Equity Bill not be enacted. The Report was tabled in Parliament on 13 August 1998.
- 1.8 The principles of the Commission's recommendations against pre-employment testing for HIV were embodied in the Employment Equity Act 55 of 1998.¹³
- 1.9 The **Third Interim Report**¹⁴ covered the issue of HIV/AIDS and discrimination in schools and contained final recommendations with regard to the promulgation of a national policy on HIV/AIDS in public schools. The Report was tabled in Parliament on 13 August 1998.
- 1.10 The Department of Education adopted the Commission's recommendations in promulgating a "National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions" in August 1999.¹⁵ The Commission's recommendations lead to Universities also starting to address the position of students with HIV/AIDS in tertiary education institutions. A policy in this regard is currently being drafted.

This Interim Report

- 1.11 This Interim Report (the **Fourth Interim Report**) deals with the issue of compulsory HIV

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

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

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

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

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

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 need for a statutory offence aimed at harmful HIV-related behaviour will be dealt with in a subsequent interim report. Paragraph 2.21 et seq below sets out the Commission's approach in dealing with these two issues, (which were the subject of a single request by the Justice Portfolio Committee for law reform relating to HIV/AIDS and violence against women).

2 Background

Source of enquiry; the Commission's approach; brief overview of research and consultation undertaken; terminology used; previous work by the Commission on HIV testing and disclosure

- 2.1 In the course of its debates on violence against women, the Parliamentary Justice Portfolio Committee requested the Commission to investigate the possible enactment of legislation for the compulsory HIV testing of sexual offenders; and the criminalisation of deliberate and negligent behaviour by persons with HIV who infect others. 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 Detail is provided on the Portfolio Committee's request, the Commission's approach in dealing with this request, the research and consultation undertaken, and the terminology used in this Report.
- 2.3 To place the recommendations in this Report in the context of the Commission's broad investigation into aspects of the law relating to AIDS, information regarding its previous work on HIV testing and disclosure of AIDS-related information is also given below.

Source of enquiry

Mounting public concern

- 2.4 The high incidence of rape and other sexual offences coupled with the growing prevalence of HIV in South Africa has led to increasing public calls for the criminalisation

of harmful HIV-related behaviour;¹⁶ compulsory HIV testing of sexual offenders; supplying victims with information regarding their assailants' HIV status; providing prophylaxis (medication to reduce the possibility of infection with HIV¹⁷) 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.¹⁸

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

2.5.1 A young woman who was allegedly raped by five assailants on a farm near Balfour, Mpumalanga in September 1998 was reportedly not informed of the

16 Anthropological research, undertaken in 1995, found that teenagers with HIV in KwaZulu-Natal displayed an attitude of wanting to spread HIV in what seemed to be a type of emotional coping strategy for dealing with the reality of a deadly and growing epidemic in their province. Whether or not such attitudes are translated into actual behaviour is still questionable, at this time. However, the results of the study suggest that behaviour such as sexual violence against women and children and the recent increases in these types of crimes may be linked to the ongoing AIDS epidemic in South Africa. More empirical studies are needed to test the relationship between violence and HIV (Leclerc-Madlala 1996 *Acta Criminologica* 36). (At the time of Leclerc-Madlala's research KwaZulu-Natal had more than two-thirds of the 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) revealed the high prevalence of coercive sex and violent practices among youth in their sexual relationships. Of the study population interviewed, 71% of pregnant and 60% of 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).

17 See par 3.58 et seq for more information on prophylaxis after sexual exposure to HIV.

18 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 1999 a criminal prosecution for attempted murder was instituted in the Pietermaritzburg High Court against a man who allegedly had sex with a woman with whom he co-habited, knowing that he had HIV and failing to inform her about his infection. The case was however subsequently withdrawn by the prosecution at the request of the complainant (information supplied by Adv Gert Nel, Deputy Director of Public Prosecutions at a consultative meeting hosted by the Project Committee on 3 February 2000). 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).

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.¹⁹

2.5.2 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 reportedly soon after the attack received information on prophylaxis from a local Rape Crisis Centre and the District Surgeon (now the District Medical Officer). She underwent medical care at her own cost while it was unclear whether her assailants had HIV.²⁰

2.5.3 In a third incident a Johannesburg journalist, Ms Charlene Smith, who was attacked and raped in her home in April 1999, spoke publicly about her ordeal emphasising the lack of available information on prophylaxis for rape victims, 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.²¹ In sentencing her assailant, the court took into account the psychological effect HIV testing had on Smith, and also that she herself had to carry the cost of prophylaxis to prevent contracting HIV.²²

2.6 Internationally, concern has more recently been expressed about growing evidence of a link between the spread of HIV and rising violence against women.²³ 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

19 **Sunday Times** 14 February 1999.

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

21 **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).

22 **ZA Now** 3 April 2000 (Internet).

23 **Inter Press Service** 3 March 1999 (Internet); **Sowetan** 9 March 1999; Human Rights Watch **World Report 1999** (Internet); **WHO Fact Sheet** June 2000 (Internet); **Beeld** 12 July 2000; **AIDS 2000 - XIIIth International AIDS Conference** 12 July 2000 (Internet).

contribute to their vulnerability to HIV in that such women would find it difficult to control the sexual and other aspects of their lives.²⁴ Peter Piot, Executive Director of UNAIDS²⁵ stated on 3 March 1999 that violence against women is contributing to the merciless spread of AIDS.²⁶ He regarded this as "one of the most insidious aspects of the AIDS epidemic which is only now beginning to receive the international recognition it deserves" and pointed out that domestic violence, rape and other forms of sexual abuse were gross violations of human rights and were closely linked to the spread of HIV.²⁷ "Violence against women is not just a cause of the AIDS epidemic, it can also be a consequence of it" Piot said.²⁸ He specifically singled out South Africa "where roving gangs of young men, many infected with HIV, engaged in what was called 'catch and rape'".²⁹

Incidence of rape and other sexual offences in South Africa

2.7 Rape and indecent assault are ways in which HIV is transmitted.³⁰ Statistics on rape are available from a number of different sources. The latest available official statistics show that a total of 39 262 cases of rape (including attempted rape) were reported to the South African Police Service (SAPS) during 1999.³¹ According to estimates this

24 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** par 12; Abdool Karim 1998 **Agenda - Empowering Women for Gender Equity** 24; see also more recently Albertyn [Unpublished] 33 [Internet]).

25 The Geneva-based Joint United Nations Programme on HIV/AIDS which coordinates the global fight against the disease.

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

27 Ibid.

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

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

30 See par 3.16 et seq for information on sexual transmission of HIV.

31 Information provided by the SAPS Crime Information Analysis Centre Departmental letter 410/2000 of 22 August 2000. The total for adults was 23 142 and for persons under the age of 17 years 16 552 (Ibid). In its Semester Report 1/2000 the SAPS indicated that the crime trend as regards rape showed a stabilisation during 1999. According to the Report the majority of rape cases occur within the family and/or friendship circles. Internationally, victims find it extremely difficult to report these crimes to the police - precisely because they may involve spouses, parents, children, boyfriends or girlfriends. The SA Government have since 1994 launched various initiatives aimed at increasing the reporting of rape,

amounts to a ratio of 119 rapes per 100 000 of the population - more than double the murder rate of 51,25 per 100 000.³² Because of under-reporting it is impossible to determine with any certainty what the real position is.³³

- 2.8 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.³⁴ As far back as 1995, it was found that the most common crime against children was rape.³⁵ According to the latest available official statistics released by the Crime Information Management Centre of the SAPS, figures regarding sexual abuse of children are alarmingly high: 221 072 cases of rape, attempted rape, statutory rape, indecent assault and incest with persons under the age of 17 years were recorded for the period January to December 1999.³⁶

including user-friendly specialised units created or expanded to make it easier for women and children to report rape. The Semester Report suggests that these initiatives are delivering positive results (**SAPS Semester Report 1/2000** [Internet]).

- 32 **SAPS Monthly Bulletin on Reported Crime in South Africa** May 2000 (Internet).
- 33 According to press reports on average only one in every 36 rapes was reported (**World African Network** 28 October 1999 [Internet]; see also **PACSA Factsheet** June 1998 1 [**PACSA Factsheet** cites Human Rights Watch 1995 51 "Violence Against Women in SA" New York, for similar information]; see also Rees [Unpublished] 1). In response to this Rape Crisis Cape Town indicated that the organisation takes a more conservative view on the issue and estimates that 1 in 20 rapes are reported to the SAPS. They stated that according to statistics for the last three years around 50% of their client group have reported the matter to the police (Rape Statistics Rape Crisis Cape Town [Internet]; and information supplied by Ms Kathleen Dey, Counselling Coordinator Rape Crisis Cape Town on 2 August 2000). This estimate is also supported by other studies (see Hirschowitz et al 1). Rape Crisis Cape Town however emphasised that while rape is under-reported in metropolitan areas (where their estimate of 1 in 20 originated), studies have shown that there is even greater under-reporting in rural areas because of the lack of permanent police stations; that rape within relationships is very high and are mostly not reported; and that there is both a high incidence of sexual violence and a high level of under-reporting among young people starting their sexually active lives. Whatever the real position, it seems to be clear that South Africa has the highest per capita rate of *reported* rapes in the world (Rape Statistics Rape Crisis Cape Town [Internet]; information supplied by Ms Kathleen Dey, Counselling Coordinator Rape Crisis Cape Town on 2 August 2000; see also the recently published study by Statistics South Africa which supports this [Hirschowitz et al 3]). Several sources confirm that it can be safely argued that there is substantial and significant discrepancy between the number of rapes that are reported to the police, the number of rapes that are revealed as a result of research and the actual number of rapes that occur in South Africa (see eg Pithey et al [Unpublished] 2-3; Hirschowitz et al 1-2, 34).
- 34 Pienaar 1996 **In Focus Forum** 17-18; Leclerc-Madlala 1996 **Acta Criminologica** 35-36; **Beeld** 27 June 1998 and 15 August 1998; **AIDS 2000 - XIIIth International AIDS Conference** 12 July 2000 (Internet). Governmental legal personnel from the KwaZulu-Natal towns of Camperdown and Stanger confirmed this phenomenon: Ashen Singh, magistrate at Camperdown stated that at least five child rape victim cases are being dealt with daily, while a Stanger Court prosecutor Ayesha Bissessar, said that they deal with between 50 and 80 cases of child rape a month. Both indicated that the alleged rapists in many instances refer to sex with a virgin in order to rid them of HIV infection as a reason for their crimes (**Sunday Times** 4 April 1999).
- 35 **The Nedcor Project** 3. See also **Beeld** 15 August 1998.
- 36 Information supplied by the SAPS Crime Information Centre (Departmental letter 410/2000 of 22 August 2000).

Other researchers found that children and adolescents who are subjected to sexual abuse are increasingly found to be infected with HIV. This is regarded as a disturbing feature of the whole scenario of HIV infection.³⁷

Prevalence of HIV/AIDS in South Africa

- 2.9 Although no reliable statistics on the incidence of AIDS itself, or of AIDS-related deaths, appear to be available in South Africa,³⁸ the prevalence of HIV can be projected from annual studies conducted at antenatal clinics of the public health services. Statistics indicate that South Africa has one of the fastest growing epidemics in the world.³⁹ The results of the latest available (1999) antenatal sero-prevalence survey however suggest that infection rates may have reached a plateau after the alarming progression of the epidemic during the preceding years.⁴⁰
- 2.10 Estimates based on the latest survey are that 22,4% of women attending antenatal clinics of the public health services nationally were infected with HIV by the end of 1999.⁴¹ When this figure is extrapolated, it is estimated that roughly 10% of the total population (compared to 8% of the total in 1998⁴²) is infected.⁴³ It is further estimated that approximately 4,2 million people were infected with HIV at the end of 1999. This comprises an estimated 2,2 million women and 1,9 million men in the 15-49 year age

- 37 Boland et al in **HIV/AIDS A Guide to Primary Care Management** 68; Lachman 477; **UNAIDS Briefing Paper Children and HIV/AIDS** February 1999 12-14.
- 38 This situation may change in future as the the Department of Health may develop surveillance mechanisms for recording the number of AIDS diagnoses and deaths. See also fn 7 above.
- 39 "Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 1999" Department of Health, March 2000. This has also been observed in a recent UNAIDS Report (**UNAIDS Fact Sheet - HIV/AIDS in Africa** June 2000 [Internet]) and by various experts at AIDS 2000 - XIIIth International AIDS Conference (see eg Cameron [Unpublished]).
- 40 "Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 1999" Department of Health, March 2000; Address by the Minister of Health in Parliament 18 April 2000 on the release of data regarding the 1999 National Antenatal HIV Survey; Official Comment by Metropolitan Life on the 1999 Antenatal HIV Survey (made available to the researcher by Metropolitan AIDS Research on 31 July 2000); cf also Dorrington 2000 **SAMJ** 452-453.
- 41 "Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 1999" Department of Health, March 2000.
- 42 Information supplied by Dr Thomas Mühr (Metropolitan Life AIDS Researcher) on 29 April 1999.
- 43 "Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 1999" Department of Health, March 2000.

group, and 94 608 -102 000 babies.⁴⁴

2.11 The 1999 survey shows that women in their twenties continue, as in the previous year, to be the most heavily infected (26,9% in 1998 and 26,4% in 1999).⁴⁵ It also suggests an upward shift in HIV prevalence in relation to age: In 1999 the age group 35-44 was found to have slightly higher HIV prevalence rates (12%-16,2%) than the same group in the previous year (10,5%-13,4%).⁴⁶ The Department of Health further noted that HIV prevalence amongst teenagers was lower in 1999 (16,5%) than in 1998 (21%).⁴⁷

2.12 The estimates for the years 1990 to 1998 showed a steady increase from 0,73% in 1990 to 22,8% in 1998.⁴⁸ The 1999 prevalence rate of 22,4% however suggests that HIV prevalence rates have not increased and that there may be a slight change in the epidemiological trends of the epidemic in South Africa.⁴⁹ This observation is based on the following:⁵⁰

! The overall prevalence rate has not changed significantly.⁵¹

! There is no significant drop in prevalence in the under 20 and the 20-24 year age groups, and there is an apparent stabilisation of the prevalence rate in the 25-29 year age group between 1998 and 1999.⁵²

44 Ibid.

45 Ibid. While not fully representative, a recent KwaZulu-Natal voluntary survey of university students demonstrated infection rates of 26% in women and 12% in men, aged 20-24; and 36% in women and 23% in men, aged 25-29 (**LoveLife** 2000 3).

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

47 Ibid.

48 Ibid. See also **LoveLife** 2000 5.

49 See the sources referred to in fn 39.

50 "Summary Report - National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 1999" Department of Health, March 2000; Address by the Minister of Health in Parliament 18 April 2000 on the release of data regarding the 1999 National Antenatal HIV Survey; cf also Dorrington 2000 **SAMJ** 452-453.

51 From 22,8% in 1998 to 22,4% in 1999 (see sources referred to in fn 39).

52 HIV prevalence in these age groups are as follows: Under 20 years: 21% (1998) and 16,5% (1999); 20-24 years: 26,1% (1998) and 25,6% (1999); 25-29 years: 26,9% (1998) and 26,4% (1999) (see sources referred to in fn 35).

! There is no generalised HIV increase in all geographic areas.⁵³

- 2.13 Although the latest figures seem to suggest a change in the HIV infection rate in South Africa, the Minister of Health as well as actuarial and other experts cautioned against reading too much into the current data, emphasising that HIV antenatal data by its nature contains substantial bias which can shift as the epidemic matures. The Minister of Health emphasised that stabilisation does not necessarily mean that fewer cases of HIV infection are occurring, or that there is necessarily a change in HIV incidence. She suggested that other factors (including higher mortality amongst persons with HIV and fewer pregnancies amongst women with HIV) may influence the prevalence rate.⁵⁴ Actuarial experts urged the government to allow access to raw grouped data from future surveys in order that the data may be subjected to deeper scrutiny.⁵⁵ Others observed that a plausible explanation for the suggested stabilisation may lie in the quality of the survey results rather than stabilisation of the epidemic.⁵⁶ In general the prevailing view was that other supporting data and HIV incidence studies are required to confirm the suggestion that infection rates have reached a plateau.⁵⁷
- 2.14 Statistics are not available on the risk of HIV transmission during rape and other sexual offences. It is therefore difficult to determine whether HIV-related criminal behaviour is increasing the prevalence of HIV although this is most likely.⁵⁸ Statistics however show that sexual transmission accounts for 80% of HIV transmissions in South Africa.⁵⁹

53 A continuous increase in HIV prevalence is observed in only five of the nine provinces (Free State, Gauteng, North West, Eastern Cape and Western Cape), while there was no significant increase in prevalence rates in KwaZulu-Natal (which remains the province with the highest infection rate at 32,5%), the Northern Cape and the Northern Province. Mpumalanga reported a lower prevalence rate (27,3%) than in the previous year (27,3% in 1999 compared to 30% in 1998) (see sources referred to in fn 39).

54 Address by the Minister of Health in Parliament 18 April 2000 on the release of data regarding the 1999 National Antenatal HIV Survey.

55 Official comment by Metropolitan Life on the 1999 Antenatal HIV Survey (made available to the researcher by Metropolitan AIDS Research on 31 July 2000).

56 Dorrington 2000 **SAMJ** 452-453.

57 See sources referred to in the previous three footnotes; see also **IRIN** 17 January 2000 (Internet).

58 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 (**AFAIDS** 30 April 1999 [Internet]). 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).

59 See comment by Tshwaranang Legal Advocacy Centre on **SALC Discussion Paper 80** 3.

Calls for government response

2.15 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 examples of such calls and of requests for law reform:

2.15.1 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 (PEP) 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 PEP is available to survivors of sexual crimes.⁶⁰

2.15.2 In September 1997 members of the ANC, National Party, Inkatha Freedom Party and Democratic Party endorsed early requests by the Justice Portfolio Committee for 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.⁶¹

2.15.3 Western Cape Attorney General, Adv Frank Kahn SC, 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".⁶² Attorney General Kahn

60 **The Star** 4 March 1997.

61 **The Citizen** 3 September 1997.

62 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 (**Daily Dispatch** 23 October 1997; **The Eastern Province Herald** 23 October 1997; **Sowetan**

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 (the Criminal Law Amendment Act) ⁶³ 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.⁶⁴

2.15.4 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".⁶⁵

2.15.5 In reaction to the Pretoria student gang rape in March 1999 the then Deputy Minister of Justice, Dr Manto Tshabalala-Msimang, stated that society has a responsibility to promote women's rights as human rights,⁶⁶ 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.⁶⁷

2.15.6 The prominent incidents of rape and gang rape referred to in paragraph 2.5 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.⁶⁸

23 October 1997; **Business Day** 23 October 1997).

63 See fn 70 below for more detail on this Act.

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

65 **The Star** 20 March 1998.

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

67 **Beeld** 19 April 1999; **The Citizen** 11 May 1999. See par 3.45 below for information on DNA testing.

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

2.16 More generally, resolutions taken at the African National Congress' (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:⁶⁹

- ! 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 (eg 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 1997⁷⁰) but also

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

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

The *Criminal Procedure Second Amendment Act* 85 of 1997 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 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* 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)). The period of operation has since been extended until 1 May 2001 (Proclamation R 23 in **Government Gazette** 21122 of 28 April 2000). Cf also a similar provision in the *Zimbabwe Sexual Offences Bill, 1999*. According to the latter provision however, a maximum sentence of 20 years imprisonment may be imposed after conviction of rape as well as certain other sexual offences irrespective of whether the convicted person was aware of his infection at the time of the offence (clause 15). (At the time of compilation of this report the Zimbabwe draft legislation has not yet been approved by the Zimbabwean Government.)

continuously maintaining and improving the implementation of such mechanisms.

- 2.17 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.⁷¹

As far as could be ascertained the provision relating to life imprisonment for a conviction of rape where HIV/AIDS is involved has not yet been applied in South African courts at the time of compilation of this Report. The Commission is of the opinion that section 37 of the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act) provides sufficient authorisation for the SAPS to have persons arrested on a charge of rape, tested for HIV for purposes of the possible application of section 51 of the Criminal Law Amendment Act (see par 7.10, 7.14, 12.20, 12.26 and 12.82 below).

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

Request by Justice Portfolio Committee, January 1998

2.18 During parliamentary debate on the Criminal Law Amendment Bill (B46-97)⁷² 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.⁷³ 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 -

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

2.19 In response, the Department of Justice on 26 January 1998 formally informed the Commission of the discussions within the Portfolio Committee with respect to the Criminal Law Amendment Bill:

During its deliberations on the Bill, ... some members of the (Portfolio) Committee raised concerns regarding persons, who, knowing that they have the acquired immune deficiency syndrome or the human immuno-deficiency virus, deliberately perform certain acts in order to infect others with the said syndrome or virus.

The Committee recommends that the Minister of Justice be requested to direct that -

- (a) the criminalising of acts by persons with the acquired immune deficiency syndrome or the human immuno-deficiency virus who deliberately or negligently infect others with the said virus; and
- (b) in view of the fact that persons who may have been infected with the human immuno-deficiency virus, may only show symptoms of such infection after a protracted period of time, and in order to give victims of offences committed by persons who have the said syndrome or virus peace of mind, the possibility that persons who may have infected others, especially in the case of those who have been charged with committing sexual offences, be subjected to an obligatory test in order to determine whether or not they have the acquired immune deficiency syndrome or the human immuno-deficiency virus,

be investigated with a view to the submission to Parliament of legislation,

72 Enacted as the Criminal Law Amendment Act 105 of 1997. See fn 70 above for more detail.

73 See the sources referred to in fn 64.

if any, at the earliest opportunity...

- 2.20 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.⁷⁴ Since then the Portfolio Committee had been kept up to date on a regular basis of the progress made with the investigation.

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

- 2.21 The Project Committee, in determining the most appropriate way of dealing with the above request, decided to deal separately with the two issues in question primarily to ensure that both issues are thoroughly dealt with and that the public is provided with an opportunity of commenting independently on two complex issues.
- 2.22 Two discussion papers were prepared as a basis for the Commission's consultative process.
- 2.22.1 The first paper (**Discussion Paper 80**)⁷⁵ 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

74 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.

75 **SALC Discussion Paper 80.**

comment was 28 February which was extended to 31 March 1999.

2.22.2 The second paper (**Discussion Paper 84**)⁷⁶ dealt 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). Discussion Paper 84 was published for public comment at the beginning of September 1999. The closing date for comment was 15 October 1999, which was extended to 30 October 1999.

2.23 In neither instance did the comment on the Discussion Papers supply the Project Committee with clear-cut solutions.

2.23.1 The Committee considered the comments on **Discussion Paper 80** on 22 September 1999 and subsequently. The majority of respondents were of the opinion that the criminal law does have a role to play in the AIDS epidemic in protecting members of society from harmful behaviour by persons with HIV/AIDS. However, which route to follow in realising this (i.e. dealing with it through the existing common law crimes, or creating a new statutory offence) was a point of difference. This difference of opinion also manifested itself within the Committee. On 18 October 1999 the Committee considered undertaking additional research in an effort to resolve the difference. This proved to be impractical. In acknowledging the divergence of the comments and of the views within the Committee, it was decided to discuss the dilemmas facing the Committee with experts from different interest groups. A consultative meeting with a range of experts was held on 3 February 2000.⁷⁷ The Project Committee considered the outcome of the consultative meeting on 6 April 2000. It was then resolved that the prevailing range of opinion within the Committee would be accommodated within a draft report to the Commission. The draft Report will be submitted to the Commission early in 2001. The Commission's Report (the **Fifth Interim Report on Aspects of the Law relating to AIDS**) is published under separate cover.

76 **SALC Discussion Paper 84.**

77 A list of persons who attended the consultative meeting is attached to the Fifth Interim Report (**SALC Fifth Interim Report on Aspects of the Law relating to AIDS**). Detailed information on the meeting and its outcome is also provided in that Report.

2.23.2 The Project Committee considered the comments on **Discussion Paper 84** on 6 December 1999. An overwhelming majority of respondents were in principle in favour of creating legislation for the compulsory HIV testing of persons arrested in sexual offence cases. However, several respondents raised concerns about the infringement of the arrested person's rights, victim protection, and the practical implementation of the proposed testing procedure. Also in this instance the Committee identified a need for consultation with experts. The Committee redrafted its proposed Bill, added draft regulations to deal with the practical implementation of the testing procedure and submitted these to a group of experts for debate at a meeting held on 4 February 2000.⁷⁸ The Committee also explored comprehensive proposals by Prof PWW Coetzer, Head of the Department of Community Health, MEDUNSA for extension of its proposed legislation.⁷⁹ The Committee rejected Prof Coetzer's proposals for widening its focus on 6 May 2000, but again extensively amended its proposed draft legislation and regulations after having considered Prof Coetzer's input. The Committee's draft Report was submitted to the Commission on 17 November 2000. The current Report is published as the Commission's **Fourth Interim Report on Aspects of the Law relating to AIDS**.

Terminology used in this Report

2.24 As indicated above, this Report deals with the **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). The Commission's understanding and interpretation of its mandate from the Justice Portfolio Committee and its corresponding use of terminology are clarified below.

2.24.1 In this Report 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

78 A list of persons who attended the meeting is attached as ANNEXURE B. More information on the consultative meeting and its outcome is set out in Chapters 11 and 12 below.

79 More information on Prof Coetzer's proposals appear in Chapters 11 and 12 below.

undertaken or not. It is envisaged that such testing may include consensual as well as non-consensual testing.

2.24.2 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" (i.e. persons who have not yet been convicted) should be investigated.⁸⁰ 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".⁸¹ From the analysis below it is clear that the Commission has not considered the possibility of compulsory HIV testing of persons "convicted" of rape and other sexual offences to be a viable option. It will be shown below that in most cases the utility of testing would have disappeared by the time of a conviction.⁸² As regards terminology referring to persons who have not yet been convicted, the Commission is of the opinion that the term "suspect" is too wide and uncertain a term to be used in the present context. The Commission decided to adhere to the terminology of the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act) where it deals with the taking of blood samples to ascertain bodily features (section 37).⁸³ Under this section blood 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".⁸⁴ The Commission thus adhered to the term "**any person arrested** upon a charge" for having committed a sexual offence.⁸⁵ In this regard it should be noted that a person may also be arrested

80 See par 2.15 and 2.16 above.

81 See par 2.4 and 2.15 et seq above.

82 See par 12.13.2. Cf also par 8.9 et seq where utility of HIV testing is discussed.

83 See the discussion in Chapter 7 below on the possible relevance of sec 37 to the HIV testing of an arrested person with the purpose to supply his or her victim with the test results.

84 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 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]).

85 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

on suspicion of having committed an offence.⁸⁶ It should also be noted that the terms "arrested", "detained" and "accused" persons are distinguished from each other for purposes of rights afforded these persons in the 1996 Constitution.⁸⁷

2.24.3 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.⁸⁸ This may *currently* include the offences of rape,⁸⁹ statutory rape,⁹⁰ indecent assault,⁹¹ and incest.⁹² It should however be noted that the Commission is also engaged in an investigation into sexual offences which, inter alia, aims to codify the current range of sexual offences.⁹³ At the time of compilation of this Report the new legislation (which will include a definition of

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).

86 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.

87 If arrest is detention with the purpose of charging ("vryheidsontneming met die doel om aan te kla") it can hardly be coextensive with charging itself (Hiemstra **Suid-Afrikaanse Strafproses** 87 as referred to in Chaskelson et al 27-60B). See also section 35(1) (2) and (3) of the 1996 Constitution which affords different rights to arrested, detained and accused persons.

88 Cf fn 145 below.

89 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 86) (Snyman 490-493). See also fn 91 and 95 below for the position as regards male victims of rape.

90 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).

91 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 95 below); cunnilingus (mouth to vagina); fellatio (mouth to anus or penis); and sexual sadism (eg biting).

92 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).

93 See **SALC Discussion Paper 85**.

"sexual offence") has not been finalised. This Report's wide interpretation of "sexual offence", the express omission of a definition of "sexual offence" in the proposed Bill, and the qualification in the proposed Bill that the offence should be such that it was an offence "in which exposure to the body fluids of the arrested person may have occurred"⁹⁴ are aimed at making the proposals below compatible with any new definition of "sexual offence".

2.24.4 Finally, "*victim*" (as opposed to "survivor" or "complainant") is used below and also in the proposed legislation to refer to any person (male or female,⁹⁵ child or adult) who is the direct subject of an alleged sexual offence.⁹⁶

Previous work by the Commission with regard to HIV testing and disclosure

2.25 In the course of the Commission's previous work on HIV/AIDS it emphasised certain principles relating to HIV testing and the disclosure of AIDS-related information. These are as follows:

2.25.1 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

94 See clause 2(1) of the proposed draft Bill in Chapter 13 below. See also par 12.44-12.45 and 13.6.

95 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.)

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

provides that testing may be carried out without the necessary consent; and in an emergency where the required consent cannot reasonably be obtained.⁹⁷ 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.⁹⁸ Comments on these proposals at the time revealed a general consensus on the principles underlying these recommendations.⁹⁹ However, the Department of Health and the AIDS Legal Network believed that the Commission should explicitly have investigated HIV testing of persons charged with rape, and confidentiality within the criminal justice

97 **SALC Working Paper 58** par 3.30-3.39 and ANNEXURE A. 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)".

98 **SALC Working Paper 58** par 3.47-3.63 and ANNEXURE A. 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".

99 **SALC Committee Paper 432** 9-10.

system.¹⁰⁰

2.25.2 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.¹⁰¹ As indicated in Chapter 1 above the Department of Health is in the process of enacting these proposals.¹⁰²

2.25.3 The Commission's **Second and Third Interim Reports on Aspects of the Law relating to AIDS**, published in 1998, again confirmed the principles of informed consent and confidentiality in the work place and in the school environment respectively.¹⁰³ As indicated in Chapter 1 above, the Department of Labour and the Department of Education included the proposed principles in legislation as recommended by the Commission.¹⁰⁴

100 Ibid 23.

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

102 See par 1.5 above.

103 **SALC Second Interim Report on Aspects of the Law relating to AIDS** par 8.26 and 8.59; **SALC Third Interim Report on Aspects of the Law relating to AIDS** par 6.27.

104 See par 1.8 and 1.10 above.

3 Medico-legal information

What is HIV/AIDS?¹⁰⁵

- 3.1 AIDS is the acronym for "acquired immune deficiency syndrome". It is the clinical definition given to the onset of certain life-threatening infections in persons whose immune systems have ceased to function properly as a result of infection with HIV. The condition is *acquired* in the sense that it is not hereditary - it is generally accepted that it is caused by the human immuno-deficiency virus (HIV) which invades the body from outside.¹⁰⁶ The genetic material of HIV becomes a permanent part of the DNA¹⁰⁷ (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

105 Virtually every source consulted for the purposes of this investigation presents the medical and empirical facts (as known at the time) with regard to AIDS - some more comprehensively than others. For purposes of this document relatively simple and synoptic medical information on the disease is presented. Sources consulted in general include the following: Van Dyk 9-47, 77-92; Evian 1-54; Lachman 131-132, 156-157, 173-175, 181-183, 187-188, 190-191, 194-199, 313; Schoub 20-202; Stine 9-40, 59-103, 129-151, 154-203, 214-227, 238-251, 292-295, 310-347; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 1-25; and **AMFAR AIDS/HIV Treatment Directory** June 1996 94-137.

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

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

disease. It is rather a collection of several conditions that occur as a result of damage which the virus causes to the immune system. Persons thus do not die of AIDS as such. They die of one or more diseases or infections (such as pneumonia, tuberculosis or certain cancers) that are described as "opportunistic" because they attack the body when immunity is low. AIDS can therefore 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.¹⁰⁸ 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.¹⁰⁹ 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.¹¹⁰

Course of AIDS¹¹¹

- 3.3 The course of HIV infection is generally divided into four different stages: the **initial phase** (preceding sero-conversion); the **asymptomatic phase**; the **symptomatic phase** (during which less serious opportunistic diseases occur); and the **severe symptomatic phase**, during which the patient has full-blown or clinical AIDS.¹¹²
- 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,

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

109 See also par 3.5 below.

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

111 See the sources referred to in fn 105 above.

112 Evian 28-34; Schoub 31-35; Maartens 1999 **SAMJ** 1255-1258; cf also the World Health Organisation (WHO) staging system for HIV Infection, and the Centers for Disease Control (CDC), United States and WHO case definition for AIDS surveillance (**WHO Weekly Epidemiological Record** 16 September 1994 273-275; **CDC Morbidity and Mortality Weekly Reports** 18 December 1992 [Internet]).

muscular pain, skin rashes and swollen glands). This phase continues until sero-conversion occurs (when antibodies develop in the person's blood in an ineffective attempt to protect the body against HIV). Sero-conversion takes place on average six to twelve weeks after infection - in exceptional cases earlier or even later.¹¹³ This period between infection and sero-conversion is known as the "**window period**".¹¹⁴ Blood tests¹¹⁵ 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 (sero-negative) 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.¹¹⁶

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 unknowingly transmit the virus to others.

3.6 The **symptomatic phase (HIV-related disease)** also can continue for several years.

113 Antibody tests to HIV can however detect antibodies to HIV after approximately three weeks - cf par 3.29.

114 A distinction should be made between the "infectious window period" and the "conventional window period". The former can be defined as the interval between the time a person becomes infectious and the time that a particular laboratory test becomes positive. The latter can be defined as the interval between the time a person acquired the infection and the development of a positive laboratory test. The infectious window period will differ from the conventional window period if there is a lag between the acquisition time of infection and the person's ability to transmit the infection to others. Theoretically such a lag would exist if, on initial exposure to HIV the person were able to sequester the virus in the organs of the immune system before becoming viremic. Experimental animal evidence suggests that the difference between the conventional and infectious windows may range from 2 to 14 days (Kleinman et al 1997 **Transfusion Medicine Reviews** 158).

115 More recently tests which detect HIV itself in the blood have become available. These tests are known as viral load tests. They are however not normally used to diagnose HIV. For more detail on HIV testing see par 3.25 et seq below.

116 When standard HIV antibody tests are used, the window period may be as short as 22 days in some instances. However, the usual length of the window period is 12 weeks (meaning that most, but not all people, will show positive on the test by this time), while the maximum length of the window period has been shown to be six months (meaning that more than 99% of infected persons will test positive for HIV by this time) (Sowadsky "David Imagawa, MD Studied Window Period for CDC. What Results Were Misinterpreted By Public Health Officials and Media?" **The Body** [Internet]).

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 medication¹¹⁷ he or she usually dies within two years as a result of these diseases.

3.7.1 Diseases that generally occur are pneumonia, tuberculosis and Kaposi's sarcoma (a rare type of skin cancer). Not infrequently the nervous system is affected and there may be a meningitis (inflammation of the covering of the brain) or an encephalitis (inflammation of brain tissue itself) with a spectrum of neurological and psychiatric disorders (previously known as AIDS dementia). This can occur in the final phase (and in rare cases may occur also earlier).¹¹⁸ 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.¹¹⁹ The disease conditions from which people with AIDS suffer are generally not transmissible. Persons with AIDS usually pose no threat of infecting others with opportunistic diseases (as opposed to the transmission of HIV itself).

3.8 The course of HIV infection varies from person to person. The period before sero-conversion can last on average from six to twelve weeks. The average duration in Africa

117 See par 3.49 et seq for recent developments with regard to treatment for AIDS.

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

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

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 (eg tuberculosis) and to a lack of adequate medical treatment.¹²⁰ In South Africa, severe poverty and malnutrition could possibly be included as reasons why most patients with HIV have a shortened life expectancy.¹²¹

- 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.¹²²

Transmission of HIV¹²³

- 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 infections¹²⁴).
- 3.11 HIV has been identified in varying concentrations in blood, semen, vaginal and cervical discharge, breast milk, the brain, bone-marrow, cerebrospinal fluid, urine, tears, foetal material and saliva. Current scientific knowledge indicates that only blood, semen,

120 Stine 103.

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

122 Evian 125-128; Schoub 41-43; van Dyk 18.

123 See the sources referred to in fn 105 above.

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

vaginal and cervical discharge and breast milk contain a sufficient concentration of the virus to be able to transmit HIV.¹²⁵

3.12 At present no scientific evidence exists that HIV can be transmitted in any other mode than the following:¹²⁶

- ! By hetero- or homosexual intercourse.
- ! By receipt of or exposure to the blood, blood products,¹²⁷ 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 drugs¹²⁸ or by injecting infected blood into a victim.¹²⁹
- ! 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.¹³⁰ HIV does not survive well outside the specific environment of the human body, making environmental transmission remote.¹³¹ Once outside the human body the virus rapidly weakens and dies. The longer it is outside the body the less the chance is for transmission to occur.¹³² There are many variables that determine how long the virus will live outside the body, including whether the conditions surrounding the virus are wet or dry. The virus cannot survive in a dry environment (eg in dried blood or dried

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

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

127 In comment on **SALC Discussion Paper 73** (1997), the Department of Health pointed out that this mode of transmission is extremely rare and that "blood transfusion in South Africa is as safe as it could possibly be". The Department also pointed out that Factor XII (a blood product supplied to people with bleeding disorders) is sterilised through heat treatment. See also Van Dyk who emphasised that blood is currently far safer than it was in the past (at 38).

128 Intravenous drug users inject drugs directly into their blood stream. To ensure that the needle has struck a vein, they usually draw blood into the syringe before the drug is injected (without removing the needle). Thus a small amount of blood always remains in the needle and/or syringe and is consequently injected directly into the bloodstream of the next injector (Van Dyk 39; Schoub 112).

129 Cf reports in the media of a case in the United States where a father injected his young son with HIV infected blood from the medical laboratory where he was employed. The child was subsequently found to be infected with HIV (**Pretoria News** 29 May 1998). See also par 3.24 below.

130 This could also include transmission via mucous membranes such as the mouth, nose and eyes (cf par 3.14 and fn 139, 3.19-3.22 below).

131 **CDC Frequently Asked Questions** May 2000 (Internet); Sowadsky "Let's Clear Something Up ..." **The Body** (Internet); Evian 18.

132 Ibid.

semen).¹³³ How long it will survive in wet conditions (eg in body fluid spills) is uncertain and depends on the specific conditions.¹³⁴ Generally speaking, under most circumstances, the virus can survive only for a few minutes outside the body.¹³⁵ Blood spills (which would carry a large concentration of virus) should however always be handled with extreme care.¹³⁶ The virus is destroyed by disinfectant.¹³⁷

- 3.14 The virus cannot be spread by other forms of personal contact than those described above. There is thus no risk of HIV transmission from casual contact. HIV cannot be transmitted by daily social contact such as breathing, coughing, shaking hands or hugging.¹³⁸ Casual contact through closed-mouth or "social" kissing is not a risk for transmission. Open-mouth kissing may however carry some risk because of the potential for contact with blood during such kissing.¹³⁹ HIV can also not be transmitted through food preparation, by toilet seats, or by sharing food, water or utensils. Even if blood contact did take place in these circumstances the chances of being infected are small.¹⁴⁰ (The incidence of infection, for instance, among health care workers who received injuries from needle-sticks and other sharp objects contaminated with blood known to be HIV infected, is calculated to be approximately three to four in 1 000.¹⁴¹ Where the status of the blood was not established, but surgical procedures were prone

- 133 Ibid. In order to obtain data on the survival of HIV, laboratory studies have required the use of artificially high unnatural concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the number of infectious viruses by 90-99% within several hours. The CDC cautioned that these results should not be used to assess specific personal risk of infection because the high concentrations of virus used in laboratory studies are not found in human specimens or elsewhere in nature; and because no one has been identified as infected with HIV through contact with an environmental surface. The CDC concluded that extrapolated to personal circumstances, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to essentially zero (**CDC Frequently Asked Questions** May 2000; see also Sowadsky "How Long Does HIV Survive Outside the Body?" **The Body** [Internet]).
- 134 Sowadsky "Lets Clear Something Up ..." **The Body** (Internet).
- 135 Ibid.
- 136 Van Dyk 40.
- 137 Ibid 69.
- 138 **CDC Frequently Asked Questions** May 2000; Van Dyk 42-43; Schoub 101, 120-125.
- 139 A case was reported in the United States of HIV transmission as a possible result of open-mouth kissing. Both the man and the woman involved however had mouth lesions and blood stained saliva (**CDC Morbidity and Mortality Weekly Reports** 11 July 1997 620 et seq; **CDC Frequently Asked Questions** May 2000 [Internet]; Schoub 101). The CDC regards the risk of HIV transmission through open-mouth kissing as low (**CDC Frequently Asked Questions** May 2000 [Internet]).
- 140 **CDC Frequently Asked Questions** May 2000; Van Dyk 42-43; Schoub 101, 120-125.
- 141 Van Dyk 48; Tereskerz et al 1996 **New England Journal of Medicine** 1150-1153 as quoted in **AIDSScan** March 1997 9; Gerberding in **The Medical Management of AIDS** 75. See also par 3.16 below.

to expose a person to blood, the risk of infection was considered to be at most one in 42 000.¹⁴²⁾

- 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.¹⁴³ There is apparently reasonable consensus that 45%-50% of infected persons will develop AIDS after 10 years, but it has also been estimated that between 65%-100% of infected persons are likely to develop the disease within 16 years.¹⁴⁴

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

- 3.16 HIV may be transmitted through sexual exposure¹⁴⁵ (including rape¹⁴⁶ or indecent assault¹⁴⁷).¹⁴⁸ 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-

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

143 One study went as far as to suggest that 20% of infected individuals could remain symptom-free for at least 25 years. Only observation over time will provide meaningful percentages (**AIDSScan** March/April 1996 6). Cf also Schoub 41-42; Flaskerund and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 17-18.

144 Van Dyk 20; Schoub 42; Stine 137-139. Cf also par 3.8 above where it is indicated that the average period of time in Africa from infection with HIV until the development of full-blown AIDS is generally accepted to be less than 10 years.

145 A *sexual exposure* that can place a person at risk for HIV infection has been defined by the CDC as "a discrete penetrative sex act (eg acts involving the insertion of the penis into the vagina, anus, or mouth) involving vaginal, anal, penile, or oral contact with the sex partner's potentially infectious body fluids, including substances that have been implicated in the transmission of HIV infection (i.e. blood, semen, vaginal secretions, or other body fluids when contaminated with visible blood) (**CDC Morbidity and Mortality Weekly Reports** 25 September 1998 [Internet]).

146 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.

147 See par 2.24.3 above.

148 Van Dyk 87; Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; **AMA Sexual Assault Guideline Resources** (Internet).

stick injury, injection, piercing or cut with a sharp object¹⁴⁹).¹⁵⁰ 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.¹⁵¹ This is so because the probability of HIV transmission is a function of three factors: the frequency of exposure (while repeated exposures are infrequent in the occupational setting, they are common with sexual contact); the probability that the source person is HIV positive (in the occupational setting, the HIV status of the source 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 non-occupational exposures is less certain).¹⁵²

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.¹⁵³ 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

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

150 CDC Morbidity and Mortality Weekly Reports 25 September 1998 (Internet); Denenberg **The Body: GMHC Treatment Issues** (Internet); Lurie et al 1998 **JAMA** (Internet); Katz and Gerberding 1998 **Annals of Internal Medicine** 306-312; PEP: **Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS** July 2000 20. Experts estimate that on average the theoretical risk of HIV transmission from a single incident of occupational percutaneous exposure is small: They estimate that it could be ,4% (four in 1 000) on average (CDC Morbidity and Mortality Weekly Reports 25 September 1998 [Internet]). Prof A Heyns at a consultative meeting hosted by the Project Committee on 4 February 2000 confirmed that theoretically the average risk of becoming infected through a single act of rape is small. He however emphasised that certain factors which may be present in the case of rape or sexual assault (eg the presence of sexually transmitted diseases in the victim, and excessive violence with the presence of blood) will increase this risk (see also par 3.76.1, fn 389 below).

151 Schoub 121; Lurie et al 1998 **JAMA** (Internet); cf also Van Dyk 87. Prof A Heyns at a consultative meeting hosted by the Project Committee on 4 February 2000 confirmed this - see fn 150.

152 Ibid.

153 Schoub 121; Van Dyk 87.

to enter the body more easily.¹⁵⁴ 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.¹⁵⁵ A woman's risk of becoming infected is further 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.¹⁵⁶

- ! ***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.¹⁵⁷
- ! ***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.¹⁵⁸
- ! ***The presence or absence of other sexually transmitted diseases in either the assailant and/or the victim.*** The presence of conditions associated with sexually transmitted diseases (eg genital ulcers, sores or inflammatory responses in the genital tract) provide opportunities for HIV to enter the body.¹⁵⁹

-
- 154 Sowadsky "Risk of Transmission Statistics" **The Body** (Internet); see also Evian 14; Schoub 96-97. Although few studies have assessed the per-episode risk for HIV infection with specific sexual practices, it is estimated that the probability is highest with unprotected receptive penile-anal intercourse. The risk with receptive vaginal intercourse is estimated to be lower (**CDC Morbidity and Mortality Weekly Reports** 25 September 1998 [Internet]); cf also Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; Lurie et al 1998 **JAMA** [Internet]). Women run a similar risk than men from unprotected receptive anal intercourse - sometimes preferred because it preserves virginity and avoids the risk of pregnancy, this form of sex often tears delicate tissues and affords easy entry to the virus (**Women and AIDS** 3). It follows that anal rape carries a greater risk of infection than vaginal rape.
- 155 Schoub 100; Evian 193-194; Van Dyk 37-38; Kirby 1994 **AIDS Care** 248 adds that this demonstrates that AIDS is another issue in the contemporary struggle concerning women's rights. As compared to men, women have a bigger surface area of mucosa exposed during intercourse to their partner's sexual secretions. And semen infected with HIV typically contains a higher concentration of virus than a woman's sexual secretions. Younger women are at even greater biological risk: the physiologically immature cervix and scant vaginal secretions put up less of a barrier to HIV (**Women and AIDS** 3).
- 156 Evian 193-194; Van Dyk 37-38.
- 157 Ibid.
- 158 **Women and AIDS** 3; Van Dyk 87.
- 159 Numerous studies on risk factors for HIV transmission have found an association with a history of other sexually transmitted diseases - some of which indicated that the presence of an untreated sexually transmitted disease could multiply the risk of HIV transmission by up to 10-fold (**Women and AIDS** 3; Evian 14; Rees [Unpublished] 4; Lurie et al 1998 **JAMA** [Internet]). It is said that 50%-80% of sexually

- ! ***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.¹⁶⁰ Studies showed that exposure involving larger volumes of blood exceeds the average risk of HIV transmission.¹⁶¹ Larger amounts of body fluid transferred during a gang rape would thus increase 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.¹⁶² Another variable is the virulence of the viral strain in the assailant.¹⁶³
- ! ***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.
- ! ***Whether the victim was a child.*** The risk of becoming infected through sexual assault is greater with children for anatomical and physical reasons including the greater risk of trauma.¹⁶⁴ It is however not certain how much greater the risk is. Because of the increased risk, early intervention with post exposure prophylaxis (PEP) is even more important than in the case of adult victims.¹⁶⁵

transmitted disease cases in women go unrecognised because the sores or other signs are absent or hard to see and because women, if they are monogamous, do not suspect they are at risk (**Women and AIDS 3**).

160 **Women and AIDS 3.**

161 With regard to occupational exposure due to needle-stick injuries, it has been found that exposures involving a larger volume of blood, particularly when the source patient's viral load is probably high, exceeds the average transmission risk, while an estimated 95% of recipients become infected with HIV from transfusion of a single unit of infected whole blood (**CDC Morbidity and Mortality Weekly Reports 15 May 1998 [Internet]; CDC Morbidity and Mortality Weekly Reports 25 September 1998 [Internet]**). See also Sowadsky "Risk of Transmission Statistics" **The Body** (Internet); Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; Lurie et al 1998 **JAMA** (Internet).

162 Evian 17; Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq.

163 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]).

164 Comments by Dr Neil McKerrow attending the Project Committee's consultative meeting on 4 February 2000.

165 Ibid.

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.¹⁶⁶ Gang rape and instances where a woman is repeatedly raped by one assailant pose a statistically higher risk of infection.¹⁶⁷ 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.¹⁶⁸

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 in rare circumstances through other criminally related risk behaviour such as biting and spitting (if blood is present in sputum), fighting, drug abuse and injecting HIV-infected blood.

166 Cf the increased risk factors outlined in par 3.16. See also Lurie et al 1998 **JAMA** (Internet); Van Dyk 87.

167 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).

168 Lachman 133-134. See also par 3.58-3.61 below.

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; *and*
- ! 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 soon after leaving the assailant's body since HIV does not survive well outside the specific environment of the human body. As indicated above, once the virus is outside the body it is in an environment in which it cannot survive unless it gets into another person's body within minutes.¹⁶⁹

If all three these factors are present, the victim could be at risk of contracting HIV.¹⁷⁰

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.¹⁷¹ There has never been a case of HIV transmission through biting where only saliva (untinged by blood), was involved.¹⁷²

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 (including access through mucous membranes such as the eyes).¹⁷³

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

169 See par 3.13 above.

170 Sowadsky "Risk from Fighting?" **The Body** (Internet); Schoub 120-122. See also par 3.10-3.15 above.

171 **CDC Morbidity and Mortality Weekly Reports** 11 July 1997 620-623; **CDC Frequently Asked Questions** May 2000 (Internet); Schoub 120-125.

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

173 **CDC and Mortality Weekly Reports** 11 July 1997 620-623; **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); **CDC Frequently Asked Questions** May 2000 (Internet); Sawyer **The Body: Lambda Legal Defense and Education Fund** (Internet); Schoub 120-125. Researchers at the Laboratory for AIDS Virus Research at New York Hospital found that a natural sugar protein in human saliva (thrombospondin) may block HIV from entering the body (Hess **The Body: POZ Gazette** [Internet]).

body.¹⁷⁴ The possibility of direct access to the bloodstream will for instance exist if the blood of an assailant with HIV got directly into a fresh open cut sustained during the fight, or into the eyes, nose or mouth of the victim.¹⁷⁵

- 3.23 HIV can be transmitted through *intravenous drug use* when the blood of a drug user with HIV is transferred to one without HIV. This occurs almost exclusively through multi-person use, or sharing, of drug injection equipment (needles and syringes).¹⁷⁶ 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.¹⁷⁷
- 3.24 Rare incidents of persons intentionally *injecting HIV-infected blood* have been reported.¹⁷⁸ In the United States a medical technician was in 1998 convicted and jailed for life for injecting his son with blood infected with HIV, while a medical doctor was in 1999 convicted of attempted murder and sentenced to 50 years' imprisonment for injecting his former mistress with HIV-infected blood.¹⁷⁹ In South Africa there were reports in November 1998 of the South African Police Service (SAPS) investigating two alleged incidents in Welkom, Free State of women having been stabbed in the back with injecting needles, presumably with the intention to infect them with HIV. Both women tested negative for HIV soon after the alleged incidents but further tests would have been necessary to establish whether they were in fact infected with HIV.¹⁸⁰ During May 1999 there were reports of twenty primary school learners in Chatsworth, Durban allegedly being injected with HIV by three fellow learners. The victims were treated with zidovudine (AZT) although it was not established at the time whether they had been injected with

174 Sowadsky "Risk from Fighting?" **The Body** (Internet). See also Schoub 121-122.

175 Ibid.

176 There are two drug injection activities that involve introducing blood into the needle and syringe: The first activity is to draw blood into the syringe to verify that the needle is inside a vein (so the drug can be injected intravenously). The second, following drug injection, is to refill the syringe several times with blood from the vein to "wash out" any heroin, cocaine, or other drug left in the syringe after the initial injection. If even a tiny amount of HIV infected blood is left in the syringe, the virus can be transmitted to the next user (**CDC Drug Use and HIV/AIDS** [Internet]). See also Van Dyk 59; Schoub 112-113.

177 **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). See also Schoub 112-113.

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

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

180 **Rapport** 15 November 1998.

HIV.¹⁸¹ As regards transmission risk in this regard medical experts emphasise the same factors as mentioned 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;¹⁸² HIV in body fluids does not live long outside the body and the longer the body fluids are outside the body, the less the chance for transmission to occur;¹⁸³ the greater the volume of blood that the victim of this crime is exposed to, the greater the chance for transmission to occur;¹⁸⁴ however, once the blood is dry the virus is dead and transmission will not occur.¹⁸⁵

Testing for HIV¹⁸⁶

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.¹⁸⁷

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

181 **Beeld** 22 May 1999.

182 See par 3.13 and 3.19 above; Sowadsky "Spreading HIV Intentionally" **The Body** (Internet).

183 See par 3.13 and 3.19 above.

184 Cf par 3.16.1 above where this issue is discussed with regard to sexual exposure to HIV.

185 See par 3.13 and fn 133 above.

186 See the sources referred to in fn 105 above.

187 Van Dyk 29-30; Schoub 126-130. See par 3.35 et seq below. The public sector would exclude the South African Blood Transfusion Services which utilises other tests, such as the P24 antigen test, on a routine basis (cf Heyns [Unpublished] 5).

respect of children.¹⁸⁸ However, the result of any HIV antibody test performed on an infant less than 15 months of age may reflect the mother's HIV status, because HIV antibodies are transferred from mother to the baby.¹⁸⁹ Until these antibodies disappear, only specific virus detection tests can determine the infection status of an infant.¹⁹⁰

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 immuno-sorbent assay (ELISA) and the Western Blot (WB) tests.¹⁹¹ 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 expensive¹⁹² and can therefore not always be used in practice. Different types of ELISA tests with a higher degree of specificity have consequently been developed and the World Health Organisation (WHO) has compiled guidelines which indicate the circumstances under which multiple (different types of) ELISA tests will suffice in order to establish HIV infection.¹⁹³ South Africa has accepted the WHO recommendations to

188 Boland et al in **HIV/AIDS A Guide to Primary Care Management** 70. It has been pointed out that the new saliva antibody test could also carry advantages in respect of HIV testing of children since oral fluid should be much easier to collect than venous blood (Emmons 1997 **The American Journal of Medicine** 16).

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

190 Ibid.

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

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

193 According to the WHO guidelines the prevalence of HIV in the population to which the person belongs on whom the blood test is performed, is decisive. The scientific premise is that the higher the prevalence of HIV infection, the greater the probability that a person who in the first instance tests positive, is truly infected (cf Fleming and Martin 1993 **SAMJ** 685-687). UNAIDS and the WHO more recently indicated

diagnose HIV infection by using at least two positive ELISA test results.¹⁹⁴

- 3.29 Current antibody tests can detect antibodies to HIV from 22 days after infection.¹⁹⁵
- 3.30 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.¹⁹⁶
- 3.31 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.¹⁹⁷ 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 and thus the person is infected but is in the window period.¹⁹⁸ To obtain a reliable result such a person will after a period of time have to be tested for HIV again.¹⁹⁹ Sometimes an indeterminate result is given. This means the test is not clear either way. To establish whether the person tested is infected, testing could be repeated after three months; alternative antibody tests could be performed; or tests which identify the virus itself (eg PCR or HIV antigen tests) could be performed.²⁰⁰

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 also Evian 42. See par 3.40 et seq below for more information on rapid testing.

- 194 Fleming and Martin 1993 **SAMJ** 685-687. This was confirmed by comments by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000.
- 195 Information supplied by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000.
- 196 Information supplied by Prof A Heyns of the SA Blood Transfusion Service on 27 October 1997. Van Dyk indicates that in practice it would be four to 10 days: Although the actual testing does not require much time, blood samples are generally tested in groups to decrease testing costs, and confirmatory testing also takes time (Van Dyk 29; cf also Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 9).
- 197 Viral load testing has become a marker for disease progression in persons with HIV/AIDS (see par 3.35 et seq below).
- 198 Van Dyk 29-32; Evian 43-44.
- 199 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).
- 200 An "indeterminate" result usually refers to the result of the WB test (i.e. the confirmatory test - see par 3.28 above). An indeterminate result may mean that the person tested is in the process of developing antibodies to HIV (i.e. still in, or just coming out of the window period). However some people may have

- 3.32 It is alleged that where the standard test procedure (an ELISA test followed by one or more confirmatory tests) is followed, a correct result will be obtained in more than 99% of HIV infections.²⁰¹

Saliva and urine tests

- 3.33 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 the specimen would also be more suitable for haemophiliacs or people on medication that affects bleeding.²⁰² These risks have recently led to the development of HIV antibody tests using other fluids, including oral fluid (saliva²⁰³) and urine.²⁰⁴ 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.²⁰⁵
- 3.34 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

an indeterminate result for reasons unrelated to HIV infection, including: prior blood transfusions - even with non-HIV infected blood; prior or current infection with syphilis or malaria parasites; auto-immune disease (eg diabetes); infection with other human retroviruses; or association with large animals (animal trainers and veterinarians are sometimes exposed to viruses which do not cause human disease but may interfere with HIV antibody tests (**HIV Insite** "My Partner's HIV Test was Inconclusive - What Does This Mean?" [Internet]; **HIV Insite** "Accuracy of Tests"[Internet]; see also Evian 44).

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

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

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

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

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

the standard tests; and are similar in accuracy to the standard tests.²⁰⁶ They are however more expensive to perform.²⁰⁷

Viral load, HIV PCR and HIV antigen testing

- 3.35 More recently tests became available that test for HIV itself, rather than antibodies to the virus.²⁰⁸ These may shorten the period of uncertainty about actual infection to about 16 days.²⁰⁹ In addition, some of these tests (eg viral load tests) may more accurately predict future health status by measuring the amount of virus in the blood of people with HIV.²¹⁰ However, because of their cost they are not yet recommended for general use.²¹¹
- 3.36 ***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.²¹²
- 3.37 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

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

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

208 Van Dyk 30-31; Schoub 132.

209 Information supplied by Prof A Heyns of the SA Blood Transfusion Service at a consultative meeting with the Project Committee on 4 February 2000.

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

211 Evian 46; view expressed by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000. But see also Volberding 1996 **The Lancet** 71-73.

212 **CDC PATHFINDER** May 1997 (Internet); **Toronto Hospital Immuno-deficiency Clinic Newsletter** September 1996 (Internet); **HIV-Infogram** 20 September 1996 (Internet); Evian 102-103; and par 3.47 et seq below on the significance of viral load testing in administering new combination drug treatments for HIV infection.

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.²¹³

3.37.1 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 person known to have HIV and the person to be tested is having symptoms consistent with Acute Viral Syndrome.²¹⁴ 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.²¹⁵

3.37.2 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;²¹⁶ 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.²¹⁷

3.38 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,²¹⁸ is also available. The PCR tests can probably be regarded

213 Sowadsky "Taking Unnecessary Tests: A Waste of Valuable Resources" **The Body** (Internet); Evian 102-103; Schoub 132-133; views expressed by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000.

214 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 non-specific, only viral load testing could determine if a person has HIV at this stage (information supplied by Dr Rick Sowadsky, Communicable Disease Specialist Nevada, United States AIDS Hotline Coordinator on 3 May 1999).

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

216 Cf par 3.62 et seq below where the importance of immediate administration of prophylaxis is discussed.

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

218 Information supplied by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000; cf also Van Dyk 30, Evian 46. It has however been pointed out that PCR tests are not usually considered reliable until about one month after exposure to HIV (information supplied by Dr Rick Sowadsky, Communicable Disease Specialist Nevada, United States AIDS Hotline Coordinator on 3 May 1999). (Sowadsky "Approximate Timeline of Testing and Symptoms for HIV/AIDS **The Body** [Internet]).

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.²¹⁹ However, PCR tests are more prone to false-positive and false-negative readings as compared to antibody tests.²²⁰ In addition, they are expensive (more so than eg ELISA antibody tests).²²¹ 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).²²² 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.²²³ They suggest that the PCR test should be limited to cases where it is necessary to know the HIV test result very early; and where antibody tests are indeterminate.²²⁴ As far as testing of the arrested person is concerned the view was expressed that it would be an over-reaction to utilise PCR testing in respect of every assailant - it should be reserved for cases where the test result obtained is indeterminate; or where a victim insists on paying for the testing.²²⁵

3.39 **P24 antigen** is a protein fragment of HIV which characteristically appears early and late during infection.²²⁶ It can be measured by the P24 antigen test. A positive test result suggests active HIV replication. HIV is detected within a similar period as is the case

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

220 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist Nevada, United States 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.)

221 Ibid.

222 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist Nevada, United States AIDS Hotline Coordinator on 3 May 1999.

223 Ibid. See also Evian 46; this view was also confirmed by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000. (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]).

224 Evian 46.

225 View expressed by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000. The Commission in the draft legislation proposed did not provide for HIV testing to be carried out at the expense of victims of sexual offences - see par 12.59 below.

226 Following HIV infection, the sequence of markers to identify infection in chronological order of appearance in blood are: viral RNA (detected by the PCR test), p24 antigen (detected by the P24 antigen test) and HIV antibody (detected by HIV antibody tests such as the ELISA and WB). P24 antigen appears during *acute* infection (i.e. early after infection due to the initial burst of virus replication; it then decreases and is often no longer demonstrable when antibodies to HIV become detectable - most likely due to antigen-antibody complexing in the blood; and appears again late in the course of infection) (**The AIDS Knowledge Base** [Internet]).

with the PCR test (16 days after infection).²²⁷ At R102-50 this test is less expensive than the PCR.²²⁸ The P24 antigen test has a higher false positive rate in the very early stage of HIV infection and is not recommended for HIV diagnosis under normal circumstances.²²⁹ Experts suggest that its use be limited to cases where it is necessary to know HIV status very early (eg for establishing infection in victims post rape); screening blood; diagnosing infection in the newborn; and monitoring antiviral therapy.²³⁰ The P24 antigen test is not recommended for testing arrested persons.²³¹

-
- 227 Information supplied by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000. See also Evian 46.
- 228 Information supplied by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000.
- 229 Evian 46; **The AIDS Knowledge Base** (Internet).
- 230 Ibid.
- 231 View expressed by Prof A Heyns at a consultative meeting with the Project Committee on 4 February 2000.

Rapid testing

- 3.40 Rapid testing in general refers to HIV antibody testing, using blood as specimen,²³² which is easier to use (usually requiring no equipment other than what is provided in the test kit) and which produces results more quickly (within 10 to 30 minutes) than the standard ELISA test.²³³ 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.²³⁴ Rapid testing does not shorten the window period.²³⁵ 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,²³⁶ can usually be operated and read by non-laboratory personnel; and some are even being marketed to the lay public for "self-testing" purposes.²³⁷
- 3.41 A rapid test under research in South Africa during 1999 was reported to be a simple test which provides the result within minutes of the user pricking his or her finger and mixing the blood with the chemical solutions supplied.²³⁸ Research has already shown that the test results are reliable if the test is performed properly and read accurately.²³⁹ South

-
- 232 Several rapid tests are however currently being developed, including one for use with oral fluids (**CDC Update** March 1998 [Internet]).
- 233 **Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 1. See also **CDC Update** March 1998 (Internet); **CDC Morbidity and Mortality Weekly Reports** 27 March 1998 211; Jürgens 86-87; Evian 46-47; Schoub 131; Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 9.
- 234 **Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 1. See also Sowadsky "Rapid HIV Tests" **The Body** (Internet); **WHO Weekly Epidemiological Record** 21 March 1997; **CDC Update** March 1998 (Internet); Evian 46-47; Schoub 131; Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 9.
- 235 **CDC Update** March 1998 (Internet); Sowadsky "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet); Sowadsky "15 Minute Test" **The Body** (Internet).
- 236 Information received from the Department of Health indicated that rapid tests may be as inexpensive as between R7,00-R12,00 (Departmental letter N6/4/3/1 of 26 October 2000). Prices may however differ and some rapid test kits are actually more expensive than an ELISA test. Prof A Heyns at the consultative meeting with the Project Committee on 4 February 2000 indicated that the price of some rapid tests used in the private sector are currently between R150,00-R180,00.
- 237 **CDC Update** March 1998 (Internet); **CDC Morbidity and Mortality Weekly Reports** 27 March 1998 212-214; Sowadsky "HIV Antibody Tests - Now You Have Several Choices" **The Body** (Internet); Sowadsky "15 Minute Test" **The Body** (Internet). Cf also **Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 1 and 3.
- 238 **Beeld** 26 August 1998.
- 239 *Ibid.* See also **Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 1. According to the press report referred to in the previous footnote, the test has been shown to be correct in 99% of cases utilised. In studies conducted outside the United States, specific combinations of two or more different rapid HIV tests have provided results as reliable as those from the ELISA/WB combination. However, only one rapid test, approved by the Food and Drug Administration, is currently

African experts and the Department of Health however strongly discourage indiscriminate use of any rapid HIV test and marketing such tests as "self testing kits". They emphasise that a second confirmatory test (in the form of a laboratory test), should be done in respect of all positive test results.²⁴⁰ Furthermore, they emphasise that rapid testing should be executed under the supervision of a health care worker to ensure proper counselling.²⁴¹

- 3.42 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.²⁴² It is envisaged that the test will be of specific value in regions lacking laboratory facilities.²⁴³
- 3.43 Experts attending a consultative meeting with the Project Committee on 4 February 2000 supported the use of rapid testing as a means to test the arrested person for HIV, emphasising that these tests are probably just as reliable as an ELISA test.²⁴⁴ They however expressed the view that rapid tests on a bodily specimen (which could in the case of rapid testing be either blood or urine) of an arrested person should not be performed by untrained persons or health care workers, but by medical practitioners.²⁴⁵ The view was also expressed that rapid testing could especially be used to ascertain

commercially available in the United States (**CDC Update** March 1998 [Internet]). As regards the position in South Africa, the Department of Health indicated that only rapid tests approved and validated by the National Institute of Virology or other specified institutions will be recommended for use. It is also envisaged that the Department will make recommendations to the Pharmaceutical Association before the marketing of rapid tests to the public (**Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 6).

- 240 The negative predictive value of rapid tests is such that infection can often be confidently excluded if the test is negative. However they are more likely to miss recent sero-conversion or late stage HIV infection because they are often less able to detect low levels of antibody. A confirmatory test must be done on all reactive (i.e. positive) test results (**Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 1 and 4.4; **CDC Morbidity and Mortality Weekly Reports** 27 March 1998 213; **CDC Update** March 1998 [Internet]).
- 241 **Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 2 and 5. Cf also Elliot and Jürgens 34-37 who expressed the opinion that there may be some benefit with respect to making PEP initiation and continuation decisions to be gained from the availability of rapid testing.
- 242 **Department of Health Discussion Document on Rapid HIV Tests and Testing and Proposed Quality Assurance Regulations** August 1998 1-3.
- 243 **Beeld** 26 August 1998. **Department of Health Policy Guidelines on Rapid HIV Tests and Testing** April 1999 par 3.1.
- 244 Views expressed by Prof A Heyns and Dr Graham Nielsen.
- 245 View expressed by Prof A Heyns.

whether PEP must be discontinued in a situation where PEP is supplied to all victims at state expense.²⁴⁶

DNA tests

3.44 Another promising area of research is the more recent tests (commonly referred to as DNA²⁴⁷ tests) that aim at determining the full genome sequence of the HIV-1.²⁴⁸ Through these tests molecular biologists are able to distinguish the different subtypes of HIV as well as to match those that have identical genome sequences. This level of precision will not only help epidemiologists to trace the spread of infections, it will also enable criminal investigators to state with some degree of certainty the source of infection.²⁴⁹

3.44.1 The DNA technique was used in the early 1990s to verify that a Florida, United States dentist with HIV infected six of his patients.²⁵⁰ 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, engage 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.²⁵¹ The SAPS currently already uses the DNA technique for evidentiary purposes in sexual offence cases where necessary.²⁵²

246 View expressed by Dr Graham Nielsen.

247 See fn 107 above.

248 See fn 106 above for information on the different strains of HIV (HIV-1 and HIV-2).

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

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

251 Ibid.

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

Accessibility and cost of HIV testing

3.45 HIV testing is available at private and public facilities. In the public sector any person may approach a primary health care clinic or ATICC²⁵³ for free HIV testing.²⁵⁴ HIV testing is also offered in all state hospitals where such facilities may charge for their services. Although most clinics provide this service, those who do not have trained counsellors or facilities to take the blood to a laboratory, will have to refer patients to another service.²⁵⁵

3.45.1 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.²⁵⁶

3.46 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.²⁵⁷ Full-time and part-time District Medical Officers (formerly known as "District Surgeons" and currently employed by the Provincial Departments of Health) fulfil this function.²⁵⁸

3.46.1 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

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

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

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

256 Information supplied by Prof Alan Smith of the Department Virology, University of Natal/Durban 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 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).

257 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).

258 Information supplied by Prof PWW Coetzer, Head Department of Community Health, MEDUNSA on 7 April 2000.

condition, may be undertaken by authorised medical practitioners²⁵⁹ for the purposes of collecting evidence under section 37(2)(a) of the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act).²⁶⁰ The Act does not authorise blood testing which would not be used for evidentiary purposes in criminal proceedings.²⁶¹

3.46.2 As far as victims of sexual crimes are concerned, expert evidence in the form of evidence of a medical practitioner (usually the district medical officer) supported by a medico-legal report in which his or her findings are recorded,²⁶² is usually submitted by the prosecution. Such a report, in addition to simple pathological findings of trauma, usually also contains conclusions drawn by the district medical officer based on his or her observations of the injuries sustained.²⁶³ As the victim is examined for evidentiary purposes, the examination does not include HIV testing or any form of treatment.²⁶⁴ Victims of sexual offences are referred to government or private hospitals for treatment if it is required (eg in the case of a rape victim with physical injuries to be attended to).²⁶⁵

3.47 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 medical officers or other authorised medical practitioners in the course

259 In terms of sec 37(2)(a) of the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act) 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.

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

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

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

263 Cf Du Toit et al 24-31. (Cf also the current J88 form to be completed by the district medical officer 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.)

264 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".

265 Information supplied by Prof PWW Coetzer, Head Department of Community Health, MEDUNSA on 7 April 2000.

of criminal proceedings following rape and indecent assault.²⁶⁶

3.48 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 WB and ELISA tests carried out by a private body varies between R276,00-R751,00 and R74,00-R203 respectively.²⁶⁷ The cost of an ELISA test carried out in a public institution would be around R80,00.²⁶⁸ Apparently WB tests are currently not often used in public facilities because they are too expensive.²⁶⁹ The state currently uses public sector testing facilities, such as the ATICCS,²⁷⁰ when they have the arrested person's consent for an HIV test or where the test is ordered by the court.²⁷¹ The possibility exists that a rapid test may be available soon at a cost of R7,00- R12,00.²⁷² 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.²⁷³

266 This was confirmed by Prof PWW Coetzer, Head Department of Community Health, MEDUNSA on 7 April 2000.

267 See fn 192 above.

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

269 Ibid.

270 Information supplied by Adv Dellene Clark, SAPS Legal Services on 16 January 1998.

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

272 See fn 236 above.

273 Ibid.

Treatment

- 3.49 There is at present no cure for HIV infection or AIDS.
- 3.50 The most widely-used drug for the treatment of persons with HIV infection and AIDS is AZT.²⁷⁴ This drug does not cure AIDS, but brings temporary relief for persons with symptomatic HIV infection: AZT delays the increase of HIV in the body, decreases the number of opportunistic infections and increases the number of healthy cells.²⁷⁵ Since significant progress has been made during the past few years with the development of new drugs for the more successful treatment of HIV infection and associated opportunistic diseases, monotherapy (the use of one drug at a time) is not recommended for HIV therapy any more.²⁷⁶ Monotherapy, with AZT alone, is however still prescribed in the following two instances: As a short-term limited course treatment of HIV in pregnant mothers to prevent vertical transmission to babies,²⁷⁷ and as PEP in non-infected individuals exposed to infection.²⁷⁸
- 3.51 Current emphasis in treatment is on antiretroviral therapy to inhibit disease progression by keeping the viral count as low as possible; treating opportunistic diseases; and attempting to restore the immune system.²⁷⁹

274 Schoub 171; Van Dyk 15.

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

276 Van Dyk 84; Schoub 178. The reduction of viral load (see fn 281 below) on monotherapy is transient and resistance develops within weeks to months (Van Dyk 84).

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

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

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

3.51.1 There are currently three main categories of antiretroviral drugs.²⁸⁰ Until 1995 antiretroviral therapy concentrated on the development of drugs (known as nucleoside analogs) which prevented the spread of HIV to new cells - they however did not interfere with viral replication in cells that are already infected. These were the first anti-HIV drugs developed and included AZT. In 1995 a second group (commonly known as protease inhibitors) were approved. They disturb the life cycle of HIV by interfering with viral replication and included drugs such as indinavir and nelfinavir. A third type of drug (known as non-nucleoside reverse transcriptase inhibitors) was introduced in 1996. These also prevent the spread of HIV to new cells (like the first group of drugs) but have a different mode of action and include drugs such as nevirapine. Over the past few years scientists have learned that a major factor decreasing the durability and efficacy of antiretroviral therapy is the use of monotherapy. Combination drug therapy produces a more sustained effect, has reduced viral load below detectable levels²⁸¹ thus substantially postponing disease progression and death and dramatically improving the overall health and well-being of persons with HIV.²⁸² Combination drug therapy goes hand in hand with the regular monitoring of viral load in the blood of persons with HIV to assess the response to therapy.²⁸³ 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

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

281 It is however uncertain whether replication is ever totally suppressed (Evian 81). As indicated in par 3.36 above, viral load tests are used to measure the amount of HIV in the blood. Viral load is frequently reported as an absolute number - i.e. the number of virus copies/ml of blood. A result below 5 000-10 000 copies/ml is generally considered a low level, while a result over 5 000-10 000 copies/ml is generally considered a high level. Studies found that people with the highest viral load had a 13 times greater risk of developing AIDS, and an 18,5 times greater risk of death than people with the lowest viral load. Recent reports indicate that some combination treatments may be so effective that people living with HIV/AIDS may be able to refrain from drug therapy for periods of up to one year without experiencing any rise in viral load (King **AIDS Treatment Update** August 1996 [Internet]; see also Quinn **The Hopkins HIV Report** 2 September 1996 [Internet]; **Toronto Hospital Immunodeficiency Clinic Newsletter** September 1996 [Internet]; **HIV-Infogram** 20 September 1996 [Internet]).

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

283 Schoub 179-180; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 18-19; See par 3.36 and fn 281 for more on viral load testing.

intercourse or rape.²⁸⁴

3.51.2 The treatment of opportunistic infections in AIDS is particularly difficult as the organisms which cause the infections are often unusual organisms which do not respond to the more commonly used treatments; and because of the severe suppression of their immune systems which hinders recovery in persons with HIV/AIDS. New and highly effective treatments for the prevention and treatment of certain opportunistic infections have significantly contributed to the improvements in the prognosis of AIDS in recent times. Important examples of this have been the treatment of pneumocystis carinii, tuberculosis, and candida.²⁸⁵

3.51.3 The development of drugs for immune reconstitution therapy has up till now been limited by the fact that knowledge of the interaction between HIV, immune cells and various cytokines²⁸⁶ is just emerging and at present attempts to reconstitute the immune system still plays little role in the treatment of persons with HIV.²⁸⁷

3.52 Although the new combination drug therapies have proved to be more effective than any previously available treatment, their long-term effectiveness and safety are still unknown because they are so new.²⁸⁸ Although they have been shown to be effective in reducing HIV in the blood stream, they do not completely eradicate the virus from all parts of the body and it is not known whether they will in the long-term be effective in maintaining the low levels of HIV in the bloodstream.²⁸⁹ The drugs do not work for all people with HIV and they require patients to follow complex treatment regimens taking multiple medications several times each day. Many people develop serious side effects which lead to discontinuation or change of treatment regimens.²⁹⁰ Furthermore, the drugs are

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

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

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

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

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

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

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

extremely expensive, are thus not widely available in developing countries and unaffordable to most people with HIV.²⁹¹ There is however some hope that HIV and AIDS may eventually, for those who can afford treatment, become manageable in ways similar to diabetes, epilepsy, and heart disease.²⁹²

Prevention of HIV transmission

Development of a vaccine to prevent HIV infection

- 3.53 Developing an effective and safe HIV vaccine²⁹³ has become a global public health priority. These efforts have focussed on creating either a vaccine that will protect people from HIV infection (a preventive vaccine) or a vaccine that will protect people from becoming ill after they have already acquired the virus (a therapeutic vaccine). In both approaches, the effectiveness of the vaccine depends on its ability to elicit a protective immune response.²⁹⁴
- 3.54 Vaccine research is a lengthy process and ongoing efforts towards the above end has been in progress throughout the world since 1987.²⁹⁵ Human trials for safe and effective

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

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

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

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

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

preventive and therapeutic vaccines on some 30 different types of candidate vaccines have taken place in the United States, France, England, Switzerland, Israel, Brazil, Thailand, China and Japan since then.²⁹⁶ To date no one candidate vaccine has been proven effective and currently many vaccines are undergoing clinical trials.²⁹⁷

- 3.55 AIDS vaccine trials have up to very recently not been conducted in Africa mainly for ethical and practical reasons. Moreover, most vaccine efforts have focussed on HIV subtypes that are prevalent in the United States and Europe, despite the fact that two-thirds of the estimated amount of people infected world-wide live in Sub-Saharan Africa.²⁹⁸ The first (and up to now the only) vaccine trial conducted in Africa (i e on an African population) has been a small scale Phase I trial conducted in Uganda since 1999. The preventive vaccine to be tested had already been tested on populations in Europe and the United States and targets the HIV subtype (clade B) predominantly found in those countries. The Uganda trial however focusses on looking for cross-reactive immune responses (i e immune responses not only to clade B, but also to clades A and D which cause most HIV infections in Uganda).²⁹⁹

trials of candidate AIDS vaccines are generally expected to require a minimum of three years for enrollment, immunisations, and assessments of efficacy (**IAVI Information Sheet** [Internet]; **UNAIDS Press Release** 13 July 2000 [Internet]).

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

297 Virological difficulties (the rapid mutation of the virus which seems to make an effective HIV vaccine impossible to design), ethical difficulties (eg the choice of volunteers, and the evaluation of the efficacy of candidate volunteers) and economic difficulties have been major obstacles in the development of an HIV vaccine (Schoub 192 et seq; Flaskerud and Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 19; **IAS Satellite Symposium at the XIIIth International AIDS Conference 2000** [Internet]).

298 **AIDSScan** October/November 2000 11-12; **UNAIDS Press Release** 13 July 2000 (Internet); **NIAID News Release** 8 February 1999 (Internet).

299 Ibid.

- 3.56 At the XIIIth International Conference on AIDS in Durban, July 2000 the International AIDS Vaccine Initiative³⁰⁰ in its Scientific Blueprint 2000 called for a greater focus on vaccines targeting the specific HIV subtypes prevalent in developing countries.³⁰¹ Primary concerns regarding the development of such vaccines are: low cost and ease of administration.³⁰² Trials for the first preventive HIV vaccine designed specifically for use in Africa are expected to commence in Nairobi (Kenya) and Oxford at the end of 2000.³⁰³
- 3.57 South Africa joined the international search for a vaccine through the establishment of the South African AIDS Vaccine Initiative (SAAVI) under the management of the South African Medical Research Council in 1999. SAAVI is a public-private initiative aimed at developing an effective, affordable vaccine for use in South Africa and Southern African Development Community countries by 2005.³⁰⁴ Eight candidate vaccines specifically targeting the HIV subtype prevalent in South Africa (clade C) are currently at various stages of development in South Africa and human trials on one or more of these are expected to commence in 2001.³⁰⁵

Effectiveness of condoms in reducing the risk of HIV transmission

- 3.58 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

300 An international organisation founded in 1996 to ensure the development of safe, effective and accessible preventive HIV vaccines for use throughout the world.

301 **PRNewswire** 9 July 2000 (Internet).

302 Ibid; Bowers 1996 **Bulletin of Experimental Treatments for AIDS** (Internet).

303 The rationale for the specific approach in developing this vaccine comes from extensive studies of sex workers in Nairobi. Despite frequent exposure to HIV a small minority of these women has resisted infection over many years. The vaccine aims at creating the same immune response to HIV that has been seen in these women. This vaccine is targeted at developing immunity against the HIV viral subtype specifically found in East Africa (clade A) (**HIV Insite** "Announcement of Human Testing of HIV Vaccine for Africa" [Internet]).

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

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

and consistently.³⁰⁶ 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 1997.³⁰⁷ 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.³⁰⁸ However, in another study of HIV transmission within heterosexual couples it was calculated that "regular" condom use reduced transmission from an HIV-infected partner by 69% compared to infrequent users.³⁰⁹

- 3.59 Female condoms have more recently also become available. Although laboratory studies indicate that the female condom serves as a mechanical barrier to viruses, and are as effective as the male condom in reducing the average incidence of sexually transmitted diseases, further clinical research is necessary to determine its effectiveness in preventing transmission of HIV.³¹⁰ 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

306 Stine 215; **CDC Frequently Asked Questions** May 2000 (Internet); **JAMA HIV/AIDS Information Center** July 1997; De Carlo **VAAIN** April 1995 (Internet); **CDC Morbidity and Mortality Weekly Reports** 2 May 1997 373; Crichton (Unpublished). The *correct* use of condoms refers inter alia to using a new condom for each act of intercourse, with adequate water-based lubrication to prevent condom breakage. Several studies of correct and consistent condom use clearly show that condom breakage rates in the United States are less than 2%. *Consistent* use means using a condom with each act of intercourse (**CDC Frequently Asked Questions** May 2000 [Internet]; **JAMA HIV/AIDS Information Center** July 1997).

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

308 **CDC Frequently Asked Questions** May 2000 (Internet); De Carlo **VAAIN** April 1995 (Internet); cf also Lachman 135. It has however been said that findings from European studies may not necessarily reflect the risks of HIV transmission in the African context because of different sexual attitudes (cf Lachman 135). In the latter regard a survey on condom usage in a developing country (Brazil) reported on in 1997, may be more indicative. According to the latter survey 500 persons between the ages 18-49 indicated that only 19% of sexual encounters in the four weeks prior to the survey included condoms (**AIDSScan** September/October 1998 12).

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

310 **CDC Frequently Asked Questions** May 2000 (Internet); Voelker 1997 **JAMA** 460; Palmer 1999 **Infectious Disease News** 28; Stine 222-223. Cf however another source which claims that the typical failure rate of the female condom is 21% (much higher than the male latex condom) (Sowadsky "How Safe are Condoms?" **The Body** [Internet]).

possible.³¹¹

- 3.60 It is however unlikely that condoms will be used in the case of rape or indecent assault.³¹²

Development of microbicides as an alternative or in addition to condoms

- 3.61 Avoiding infection with sexually transmitted diseases, including HIV, is often more problematic for women than for men. Although condoms, if used correctly and consistently during sexual intercourse, provide a good physical barrier against infection, condom use ultimately requires the consent and cooperation of the male partner. To address the need for effective female-controlled strategies to avoid infection, researchers have recently increasingly focussed on the development of chemical barriers which destroy HIV in the vagina.³¹³ Microbicides (in the form of foam, gel, cream or suppository products) are chemical barriers currently being researched and developed for this purpose.³¹⁴

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

312 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]).

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

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

PEP after recent sexual exposure to HIV

What is PEP?

3.62 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 administration of a group of drugs (or AZT alone) which act against HIV.³¹⁵

3.62.1 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.³¹⁶ The sooner the treatment is started, the better the chance of reducing viral replication and enabling the body to eliminate viable virus.³¹⁷ 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).³¹⁸ 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. 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

315 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); Sowadsky "Post Exposure Prophylaxis (PEP) for Sexual Exposures" **The Body** (Internet).

316 Katz and Gerberding 1998 **Annals of Internal Medicine** 306; Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 519; **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to the HIV** March 1999 4.

317 HIV replication is rapid and continues unless controlled by the immune system or other mechanisms. Theoretically, initiation of antiretroviral PEP soon after exposure may prevent or inhibit systemic infection by limiting the proliferation of virus in the initial target cells or lymph nodes (**CDC Morbidity and Mortality Weekly Reports** 15 May 1998 [Internet]). In order for the drugs to be protective, they must be inside the target cell. There is therefore a need to initiate PEP as soon as possible. In most instances however, there is a several hour delay between the time of initial exposure and initiation of antiretroviral therapy (**Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 5).

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

pregnancy and labour and to their infants for six weeks postpartum.³¹⁹

Possible advantages and disadvantages of PEP

- 3.63 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.³²⁰
- 3.64 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.³²¹
 - ! 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.³²² The potential side effects include anaemia, malaise, insomnia, debility, fatigue, headache, liver inflammation, kidney stones and

319 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); Flexner in **The Hopkins HIV Report** (Internet); Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 519; Lurie et al 1998 **JAMA** (Internet); Henderson 1999 **JAMA** (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 4. In a Thailand drug trial, perinatal HIV transmission was reduced by 51% for women treated from 36 weeks' gestation until delivery. However, perinatal transmission despite the use of AZT prophylaxis in pregnancy also has been reported (**CDC Morbidity and Mortality Weekly Reports** 25 September 1998 [Internet]). Cf however also par 3.69 below where scientists' divergent opinions on the success rate of prophylaxis are referred to.

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

321 Animal studies suggest that prophylactic treatment is probably not effective when started later than 24-36 hours after 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 Reports** 15 May 1998 6-7; Denenberg **The Body: GMHC Treatment Issues** [Internet]; Sowadsky "A Few Questions from a Student" **The Body** [Internet]; see also **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 5).

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

gastro-intestinal symptoms (abdominal pain, nausea, vomiting, diarrhea and indigestion).³²³ Among health care workers receiving combination drugs as post exposure treatment, 50%-90% reported side effects that caused 24%-36% to discontinue treatment.³²⁴

- ! 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.³²⁵
- ! 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.³²⁶ 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.³²⁷
- ! 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).³²⁸
- ! 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 completely uncertain.³²⁹

-
- 323 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 Reports** 15 May 1998 (Internet); **Department of Health Policy Guideline for Management of Occupational Exposure to HIV** March 1999 5).
- 324 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); see also Mirken 1998 **Bulletin of Experimental Treatments for AIDS** (Internet).
- 325 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet); Dahir **The Body: POZ Gazette** (Internet).
- 326 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet).
- 327 Henderson 1999 **JAMA** (Internet).
- 328 Ibid. Henderson also indicates 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 AIDS Law Project regarding the administration of PEP in rape victims who could be pregnant - referred to in fn 373 below.
- 329 Information supplied by Dr Rick Sowadsky, Communicable Disease Specialist Nevada, United States AIDS Hotline Coordinator on 11 June 1999.

! Finally the regimen is extremely expensive to complete.³³⁰

PEP after occupational exposure

3.65 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.

3.66 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.³³¹

3.66.1 The guidelines include the following practical recommendations for initiation and administration of PEP:

! PEP is recommended for any high risk exposure.³³² Guidelines on what could be regarded as a high risk exposure include any percutaneous

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

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

331 **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).

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

(skin- perforating needle-stick) injury involving -³³³

- P visible blood on the needle;
- P the needle having been used in a vein or artery of the source person; or
- P 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.³³⁴

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.³³⁵ Guidelines on what could be considered low risk exposures include mucosal and skin contacts with possibly infected blood.³³⁶ PEP is not recommended where such contact involved unbroken, healthy skin. However, it is recommended that PEP should 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.³³⁷

- ! 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 (and confirmed by a formal laboratory test thereafter).³³⁸ 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

333 Ibid 14.

334 Ibid 11-12. Cf also Ungavarski in **HIV/AIDS A Guide to Primary Care Management** 519.

335 **Department of Health Policy Guideline on Management of Occupational Exposure to HIV** March 1999 11, 12, 14.

336 Ibid 14.

337 Ibid.

338 Ibid 9.

then be used as indicative of HIV infection.³³⁹ 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.³⁴⁰
- ! PEP should be initiated promptly, preferably immediately, within one to two hours after the exposure to HIV.³⁴¹
- ! 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.³⁴²
- ! 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.³⁴³
- ! 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.³⁴⁴
- ! If the source person's HIV status is not known, initiation of treatment

339 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).

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

341 Ibid 10. See also Van Dyk 86-87.

342 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 Reports** 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). See also Van Dyk at 86 where she recommends a two drug regimen.

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

344 Ibid 11.

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.³⁴⁵

- ! In order to avoid delays in starting PEP, "starter packs" (the first three days' supply of a 28-day treatment) 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 be HIV positive.³⁴⁶ The cost of a starter pack if supplied by a wholesale distributor to the government would be R194,00.³⁴⁷
- ! 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.³⁴⁸

3.67 In the United States the Centers for Disease Control and Prevention (CDC)³⁴⁹ 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 drugs³⁵⁰ 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 inhibitor³⁵¹ for exposures that pose an increased risk of transmission or where resistance to one or more of the

345 Ibid.

346 Ibid 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.

347 Information supplied by Ms L Coetzer of the Department of Health Directorate: HIV/AIDS and STDs on 17 October 2000.

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

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

350 AZT and Lamivudine (**CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet).

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

antiretroviral agents recommended is known or suspected.³⁵² 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 person should be performed as soon as possible. If the source person, or the sero-status 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.³⁵³

3.68 In the United Kingdom similar formal guidelines on the administration of PEP after occupational exposure to HIV have been updated in July 2000.³⁵⁴ According to these a basic four week regimen of three drugs are recommended.³⁵⁵ As in the United States, the guidelines emphasise the importance of urgent risk assessment and ascertainment of the source person's HIV status if the exposure has been significant (i.e. with the potential for HIV transmission).³⁵⁶ If the source person's HIV status cannot be established, risk assessment should be on an individual basis including a consideration of the circumstances of the exposure and the epidemiological likelihood of HIV in the source person.³⁵⁷

3.69 In spite of current practice regarding occupational PEP, scientists remain bitterly divided on its success rate.³⁵⁸ There is little information with which to assess the efficacy of PEP in humans.³⁵⁹ United States CDC studies published in 1995 found that treatment with AZT for occupational exposure decreased the risk of acquiring HIV by approximately 81%.³⁶⁰ However, critics disputed this figure as probably inflated.³⁶¹ The CDC

352 **CDC Morbidity and Mortality Weekly Reports** 15 May 1998 (Internet). See also Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 520-523.

353 Ibid.

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

355 Ziduvudine, lamivudine and indinavir (**PEP: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS** July 2000 10, 25 et seq).

356 **PEP: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS** July 2000 7-9.

357 Ibid.

358 Ibid; Dahir **The Body: POZ Gazette** (Internet).

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

360 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]).

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

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.³⁶² 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.³⁶³ 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.³⁶⁴

PEP after sexual exposure

- 3.70 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 or 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.
- 3.71 Unlike prophylaxis for occupational exposures, there is no data on the effectiveness of PEP after sexual exposures.³⁶⁵ 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.³⁶⁶ Definitive studies on the issue are unlikely because of the large

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

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

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

365 Experience with the use of PEP for victims of sexual assault in Paris, Europe since June 1999 to June 2000 has been reviewed at AIDS 2000 - XIIIth International AIDS Conference held in Durban, South Africa, 11-14 July 2000: According to Benais et al a three drug combination had been administered to 100 victims of sexual assault who presented within 48 hours after the assault. None of them sero-converted after following treatment for 30 days. Two perpetrators were known to be HIV positive while the rest were of unknown status. This study is however regarded as too small to document the efficacy of PEP (see JP Benais, A Miara, S Brion, D Delaitre, P Werson, A Soussy and M Garnier "Treatment of Sexual Assault - A Multicenter Study in Emergency Medico-Legal Units in the Paris Region" as referred to in Currier (Unpublished [Internet]).

366 Cf **CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet); Volberding in **The Medical Management of AIDS** 115; 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 at the Rape Crisis Centre at the British Columbia Women's Hospital in Vancouver referred to in fn 380 below.

sample sizes required and the ethical obstacles to a placebo-controlled trial.³⁶⁷ Experts moreover disagree on the viability of administering prophylaxis after sexual exposure to HIV.³⁶⁸

! **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).³⁶⁹ In the United States, for instance, certain researchers recommend routine PEP after unprotected receptive and insertive anal and vaginal intercourse with a partner who is, or is likely to be, HIV infected. They advise that the treatment regimen for sexual exposures should be modelled after that used for occupational exposures, with similar base-line HIV testing, follow-up care and surveillance for HIV infection.³⁷⁰ Taking into account the estimated medical costs of HIV disease versus the cost of PEP per sero-conversion averted, proponents submit that PEP after (consensual) sexual exposure would be cost-effective even if its efficacy was only 40%.³⁷¹ 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

We are also aware that the New South Wales Health Department currently runs a trial PEP protocol for sexual exposure to HIV (the participants in this trial however having acquired HIV mostly during consensual sexual intercourse) (see par 9.22 below).

367 **CDC Morbidity and Mortality Weekly Reports** 25 September 1998 (Internet); Lurie et al 1998 **JAMA** (Internet); Torres 1998 **GMHC Treatment Issues** (Internet).

368 See also Currier (Unpublished [Internet]) for the coverage of this issue as discussed at AIDS 2000 - XIIIth International AIDS Conference Durban, South Africa 11-14 July 2000 - where this was confirmed.

369 Katz and Gerberding 1998 **Annals of Internal Medicine** 306 et seq; Dahir **The Body: POZ Gazette** (Internet); Lurie et al 1998 **JAMA** (Internet); Ungvarski in **HIV/AIDS A Guide to Primary Care Management** 519. See par 3.66.1 above for instances in which mucosal occupational exposure may justify the administration of PEP.

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

371 Ibid.

primary prevention methods.³⁷²

- ! **Opponents** of prophylaxis after sexual exposure contend 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).³⁷³ Moreover, as indicated above in respect of occupational exposure, PEP has serious implications for an individual's short and long term health.³⁷⁴

3.72 The United States CDC in September 1998 published a report on management of possible sexual or other non-occupational exposure to HIV to address concerns in this regard.³⁷⁵ The report emphasised that as no conclusive data exist regarding the efficacy of drug therapies to prevent HIV infection in persons following non-occupational HIV exposure, it should be considered an unproven clinical intervention.³⁷⁶ Under these circumstances the CDC was not prepared to make definitive recommendations for or against the use of PEP for sexual exposure.³⁷⁷ 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

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

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

374 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 3.64 above.

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

376 Ibid.

377 Ibid.

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.³⁷⁸ It was firmly stated that PEP should never be administered routinely or solely at the request of a patient - it is a complicated medical therapy, not a form of primary HIV prevention.³⁷⁹

- 3.73 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.³⁸⁰ In these instances the treatment regimen is usually modelled on that used for occupational exposures which basically consist 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.³⁸¹

378 Ibid.

379 Ibid.

380 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 Reports** 25 September 1998 [Internet]).

381 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 3.67 above for the standard drug regime in the case of occupational exposure in the United

3.74 As regards the cost-effectiveness of PEP after sexual exposure, the CDC in its 1998 report (referred to in paragraph 3.73 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 positive.³⁸² 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.³⁸³

3.75 South Africa has no official guidelines on PEP after sexual exposure and victims of crime are not supplied with PEP at government cost.³⁸⁴

3.75.1 At a consultative meeting hosted by the Project Committee on 4 February 2000³⁸⁵ it was suggested that the following protocol could be followed should PEP ultimately become available for all victims of sexual offences:³⁸⁶

! PEP should be initiated immediately, or as soon as possible, to all victims of alleged sexual offences. (Victims with HIV, i e victims who have been infected with HIV prior to the attack in question, should however not take PEP as it is harmful.)

States.

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

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

384 Our research however revealed a single instance where AZT is administered to rape victims free of charge by a state hospital (Groote Schuur, Cape Town) as part of a pilot project aimed at research on prophylaxis after rape. The project is funded from the hospital's pharmaceutical budget (**Beeld** 21 May 1999; **Mail and Guardian** 21-27 May 1999). Tshwaranang Legal Advocacy Centre in their comment on Discussion Paper 84 stated that in terms of the pilot project the following services are included in the support offered to victims of sexual offences at Groote Schuur:

- * Informing victims of the risk of HIV infection and offering them an HIV test.
- * Having victims assessed individually by a gynaecologist with a view to discussing the possibility of administering PEP with a resident hospital HIV expert, who authorizes the provision of AZT.
- * Providing AZT to women who have been raped, provided they present for treatment within 48-72 hours of being raped.
- * Providing AZT for a period of one month after the alleged incident. In cases where a woman cannot afford PEP, the hospital carry the costs of PEP.
- * Making AZT available 24 hours a day to ensure that the treatment starts immediately.
- * Routinely treating victims for other sexually transmitted diseases (eg syphilis, chlamydia, gonorrhoea).
- * Routinely giving the "morning after" pill to prevent the possibility of pregnancy.
- * Following up treatment in the outpatient division and monitoring the side effects of PEP.

385 See Chapter 11 below for more information on this meeting.

386 As submitted by Prof A Heyns, Head of the South African Blood Transfusion Services.

! HIV testing of the alleged assailant, which should be seen as adjacent to initiation of PEP, should then be set in motion. This should consist of the following:

P Two blood samples should on the same occasion be taken from the arrested person.³⁸⁷

P An ELISA test should be performed on the first sample.

P If positive, a confirmatory ELISA should be performed on the second sample while the victim should continue with PEP.³⁸⁸ If the second test is also positive, the victim should continue with a full course of PEP. The victim should be tested for HIV at the end of the first month after initiating PEP, and then again at the end of the sixth month.

P If the result of the first ELISA test performed on the assailant's blood is negative, it should be accepted that the assailant is not infected or that he or she is in the window period. This information should be used to assess the risk of actual infection and thus to decide whether the victim should discontinue using PEP. In coming to a decision, all the other risk factors as set out in par 3.16.1 above, should be borne in mind. The theoretical risk of becoming infected is however small and it is therefore advised that if the first ELISA test performed on the assailant's blood tests negative for HIV, PEP should be discontinued.³⁸⁹

387 Prof Heyns (see previous footnote) supplied the following reasons for the need for obtaining two body specimens from an arrested person: the risk of carry-over contamination during a second test on a single sample of blood; the time factor (a victim should stop taking PEP as soon as possible if it proves that the risk of actual infection is so insignificant that taking PEP should be discontinued, and time should not be wasted to obtain a second sample from the assailant at a later stage should that be necessary); and testing a second sample yields more accurate results. He emphasised that the two specimens must be properly identified and stored separately. (Cf also the comments of Prof AN Smith of the Department of Virology, University of Natal, Durban of 17 February 2000 to the Department of Health on the draft National Policy on Testing for HIV [Government Notice R 1479 of 1999 in **Government Gazette** No 20710 of 10 December 1999] for confirmation of the need for two samples to be taken [Prof Smith's comments were made available to the researcher by Ms Ann Strode, consultant to the Department of Health]).

388 Prof Heyns submitted that the ideal would be to perform an ELISA test on the first specimen, and a WB or PCR on the second specimen. However, in terms of costs a second ELISA test could be performed on the second sample according to the WHO's directions for HIV testing in a population with a sufficiently high HIV prevalence (see par 3.28 above).

389 Par 3.16 above. Prof Heyns (referring to the possible theoretical similarity between the risk of becoming infected through a single occupational percutaneous exposure to HIV and a single act of rape) expressed the opinion that the theoretical risk of a victim becoming infected through a single act of rape is small. The risk of an assailant being in the window period is, according to him, also small. However, the presence of sexually transmitted diseases in the victim and excessive violence with the presence of

3.75.2 Apparently some District Medical Officers (who are responsible for medical examination of victims of sexual crimes for evidentiary purposes)³⁹⁰ 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.³⁹¹ After considerable public outcry in the wake of prominent incidents of rape and gang rape in the past two years 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.³⁹² In response Government indicated at the end of May 1999 that it has initiated controlled research into prophylaxis after sexual exposure.³⁹³ However, at the time of compilation of this Report the Department has not yet published any results of the research undertaken. This would be a world first, as any existing protocols on PEP after sexual exposure are currently based on research regarding PEP after occupational exposure.³⁹⁴

blood, will increase the risk of the victim of becoming infected. Even with this, the risk is small - and therefore the question whether the victim is infected or not is really more of a psychological issue.

390 Formerly known as "District Surgeons". See par 3.46.

391 Information supplied by Dr K Müller, District Medical Officer, Pretoria on 4 February 2000.

392 **Beeld** 29 April 1999. (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 3.64 above that the cost of a starter pack, supplied by a wholesale distributor to government would be about R194,00.)

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

394 See par 3.71.

4 Defining the problem

- 4.1 Sexual offences which involve the transfer of bodily fluid from the assailant to the victim (such as rape, incest and indecent assault) are ways in which HIV is transmitted.³⁹⁵ As a result of the concerns of victims³⁹⁶ who wish to establish whether they have been exposed to or infected with HIV during sexual offences,³⁹⁷ the Commission has been tasked with investigating the possibility of enacting legislation for the compulsory HIV testing of persons arrested for having committed such offences to relay the results to victims. This Chapter states the problem in a legal context.
- 4.2 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 bodily features (which would include HIV testing) 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**.³⁹⁸ The Regulations Relating to Communicable

395 See par 3.16-3.24.

396 See par 2.4 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.

397 See the definition of "sexual offence" for purposes of this Report in par 2.24.3 above.

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

Diseases and the Notification of Notifiable Medical Conditions 1987³⁹⁹ issued by the Minister of Health (and proposed Draft Regulations of 1993 to replace these⁴⁰⁰) 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 Service (SAPS) with certain powers to ascertain the bodily features of arrested persons, including the taking of a blood sample.⁴⁰¹ 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 the information gained to victims of crime. Its purpose is of an evidentiary nature only.

4.4 Questions which therefore 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 the common law notion of "necessity" may provide for the disclosure of an arrested person's HIV status to a victim.
- ! 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 enacted, to provide for compulsory HIV testing and disclosure.
- ! Whether any measures enacted should provide for a broader spectrum of HIV testing (such as testing of persons indicated in sharps injuries and testing of deceased persons).⁴⁰²
- ! Whether any measures enacted should provide for the HIV test results obtained

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

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

401 Sec 37(2).

402 See the proposals of Prof PWW Coetzer, Head of the Department of Community Health, MEDUNSA discussed in Chapters 11 and 12.

to be publicly recorded for it to be accessible also for purposes other than disclosure to victims of crime.⁴⁰³

- 4.5 These issues are debated in Chapters 5 to 8 against the background of the current law with regard to consent for medical treatment and confidentiality of medical information. Chapter 9 includes an overview of relevant international legal and policy provisions. Chapters 10 to 12 set out the process of public consultation followed in this investigation, the response received on preliminary proposals published for public comment, an evaluation of this response and the Commission's conclusions. The Commission's final recommendations for draft legislation are contained in Chapter 13.

5 Current legal position regarding consent for medical treatment and confidentiality of medical information

- 5.1 Any law reform proposal concerning compulsory HIV testing and the disclosure of the test results to others of necessity requires an understanding of the general principles regarding consent for medical treatment, and confidentiality of medical information.

Consent for medical treatment

- 5.2 A medical practitioner or health care worker has no general right to treat a person. The freedom "to make certain important decisions about what happens to one's own body" is protected by the right to privacy in terms of both our common law⁴⁰⁴ and the 1996 Constitution.⁴⁰⁵ This has been referred to as *autonomy privacy rights*⁴⁰⁶ and means that a person must consent to all forms of medical treatment (including the drawing of blood for an HIV test), and has the right to refuse medical treatment.⁴⁰⁷

404 In terms of the common law every person has *personality rights* such as the right to dignity, autonomy and bodily integrity (**Stoffberg v Elliott** 1923 CPD 148; **Lymbery v Jefferies** 1925 AD 235; **Lampert v Hefer NO** 1955 (2) SA 507 (A); **Esterhuizen v Administrator of the Transvaal** 1957 (3) SA 710 (T). See also Neethling et al 38).

405 Sec 14 of the 1996 Constitution provides that "(e)veryone has the right to privacy ...".

406 Burris in **AIDS Law Today** 115. Cameron (Unpublished) par 8. Cf also **S v A and another** 1971 (2) SA 294 (T); **Financial Mail (Pty) Ltd and others v Sage Holdings Ltd and another** 1993 (2) SA 451 (A) at 462E-F; **Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A) at 849.

407 Strauss 9-10, 19-20; Strauss 1996 **THRHR** 492; Van Wyk 131 et seq. See also **Castell v De Greef** 1994 (4) SA 408 (C) at 420 I-J.

- 5.2.1 The leading case regarding consent for medical intervention is **Stoffberg v Elliott**⁴⁰⁸ where Watermeyer J held that -

(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.

- 5.2.2 The Constitutional Court in **Bernstein and others v Bester NO and others**⁴⁰⁹ emphasised the connection between the common law and constitutional right to privacy, and underscored the importance of the rights to autonomy and dignity:

The scope of privacy has been closely related to the concept of identity and it has been stated that rights, like the right to privacy, are not based on a notion of the unencumbered self, but on the notion of what is necessary to have one's own autonomous identity. ... In South African common law the right to privacy is recognised as an independent personality right which the courts have included within the concept of *dignitas*. ... [a] breach of privacy can occur either by way of an unlawful intrusion upon the personal privacy of another, or by way of unlawful disclosure of private facts about a person.⁴¹⁰

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.

- 5.2.3 The Constitutional Court also adopted the approach of confining claims to privacy only to aspects in regard to which a "legitimate expectation" of privacy can be harboured.⁴¹¹ Such "legitimate expectation" requires an actual (i e subjective) expectation of privacy which society recognises as objectively reasonable.⁴¹²

408 1923 CPD 148.

409 1996 (4) BCLR 449 (CC).

410 Ibid at 483F-484F citing **Financial Mail (Pty) Ltd and others v Sage Holdings Ltd and another** 1993 (2) SA 451 (A) at 484F.

411 **Bernstein and others v Bester NO and others** supra at 484, 487-488.

412 Ibid; **Protea Technology Ltd v Wainer** 1997 (9) BCLR 1225 (W) at 1239H. See also Steytler 83.

This approach is underpinned by the premise that as a person moves into communal relations and activities, the scope of personal space shrinks accordingly.⁴¹³ An individual's reasonable expectations of privacy may thus vary significantly depending upon the activity that brings him or her into contact with the state.⁴¹⁴

5.3 In order to be valid, consent must meet certain requirements:

5.3.1 There can be no question of legal consent unless the consent is voluntary.⁴¹⁵ There are cases where consent is indeed given, but cannot be considered voluntary as a result of some form of coercion.⁴¹⁶

5.3.2 Consent must be obtained from someone who is able in law to give it.⁴¹⁷ Any adult with legal capacity may consent to HIV testing.⁴¹⁸ Persons who do not have this capacity, such as those who are mentally ill⁴¹⁹ or who are unconscious,⁴²⁰ or children below the age of 14⁴²¹ must be assisted by someone with legal

413 **Bernstein and others v Bester NO and others** supra at 484, 487-488.

414 **Thompson Newspapers Ltd v Canada** (1990) 67 DLR (4th) 161 (SCC) 220 as referred to in Steytler 83.

415 **R v McCoy** 1953 (2) SA 4 (SR). Neethling et al 106, 274-275.

416 Eg consent cannot be considered truly voluntary where a prospective employee, as a prerequisite for employment, is compelled to undergo HIV testing (**SALC Second Interim Report on Aspects of the Law relating to AIDS** par 8.19.5; cf also Neethling et al 275).

417 Neethling et al 106-108; Strauss 4; Van Wyk 134-137.

418 Ibid.

419 Consent for HIV testing of mentally ill persons 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 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 treatment (which would include HIV testing) (Mental Health Act 18 of 1973 sec 60A).

420 Where a person is unconscious, treatment (including HIV testing) may be provided if a real state of emergency exists; if the patient is unaware or unable to appreciate the situation; if the treatment is not against his or her express will; and if the treatment is provided with the patient's best interests in mind. In such circumstances the medical practitioner treating the patient consents on the latter's behalf (Strauss 93).

421 In terms of sec 39 of the Child Care Act 74 of 1983 a child above the age of 14 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 medical treatment on the child's behalf. The Act also provides for situations where the parent or guardian either refuses to give consent, cannot be found, is mentally ill, or is dead. Sec 39(1) provides that in such circumstances the medical practitioner must approach the Minister of Welfare, or an official in that

capacity.

5.3.3 The person who gives consent must be fully informed and must understand what he or she is consenting to. This has become known as the principle of *informed consent* which was confirmed in the case of **Castell v De Greef**.⁴²² The court in this case accepted the principle that consent to treatment is vitiated if a person is given inadequate information on the medical intervention to be performed.⁴²³ The application of this principle is consistent with an increasing emphasis in medico-legal fields on patient autonomy.⁴²⁴

5.3.3.1 In applying the principle of informed consent to the taking of blood samples for HIV testing, it was held in **C v Minister of Correctional Services**⁴²⁵ that -

... there can only be consent if the person appreciates and understands what the object and purpose of the test are, what an HIV positive test result entails and 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.⁴²⁶

5.3.3.2 Ethical guidelines for the medical profession dealing with HIV testing endorse the legal

Department, for permission to treat the child. (It is submitted that if a parent or guardian is not available to consent to HIV testing of a child younger than 14, this section would have to be invoked). In an emergency the medical superintendent of a hospital may consent to treatment provided that the treatment is necessary to preserve the life of the child or to save him or her from lasting physical injury (sec 39(2)). The statutory position 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 (Strauss 6).

422 1994 (4) SA 408 (C).

423 Ibid at 426H. Cf **Broude v McIntosh and others** 1998 (3) SA 60 (SCA) referred to in footnote 370 below.

424 Strauss 8; Van Oosten 69.

425 1996 (4) SA 292 (T). See also Strauss 1996 **THRHR** 494-497.

426 **C v Minister of Correctional Services** supra at 301.

concept of informed consent and at the very least create an ethical duty (and probably a legal duty)⁴²⁷ to obtain informed consent through pre-test counselling:

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.⁴²⁸

5.3.3.3 At a policy level the South African Law Commission in its First Interim Report on Aspects of the Law Relating to AIDS⁴²⁹ recommended that the Department of Health adopt a national policy on HIV testing based on the current legal position. It was recommended that the proposed policy requires that HIV testing may be done in the following circumstances only:

- ! ***With informed consent:*** upon individual request for diagnostic or treatment purposes; or on a clinical recommendation from a doctor.
- ! ***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; or in the case of testing an existing blood sample if, following an occupational accident, an emergency situation exists which necessitates obtaining information on the patient's HIV status.⁴³⁰

The Commission further recommended that all HIV testing should

427 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 on HIV/AIDS (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).

428 **SA Medical Association HIV/AIDS Ethical Guidelines** 1998 5. The **Health Professions Council of South Africa Guidelines on HIV/AIDS** 1994 (formerly known as the **South African Medical and Dental Council Guidelines**) contain a similar provision at 4.

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

430 Ibid 50-51.

be carried out with pre-test counselling.⁴³¹ The proposed policy is expected to be promulgated before the end of 2000.⁴³²

5.3.4 The consent must not be *contra bonos mores* (i.e. against public policy).⁴³³ Consent to bodily injury is normally *contra bonos mores* unless the contrary is evident, for example in cases of participation in lawful sporting activities, or medical treatment⁴³⁴ (or cases where the injury is of a very minor nature).⁴³⁵

5.4 It follows that to take a person's blood for HIV testing without consent may amount to an invasion of the right to privacy which could result in a medical practitioner being prosecuted for assault or *crimen iniuria* through the criminal courts or held liable for damages in a civil action.⁴³⁶

5.5 However, neither the common law nor the constitutional right to privacy is absolute, and circumstances may exist in which it may be reasonable or justifiable to test a person for HIV without his or her consent.

431 Ibid 30, 51-52. In a draft based on the Commission's recommendations and published for public comment on 10 December 1999, the Department of Health placed more emphasis on the need for pre- and post-test counselling. The policy published for comment provides as follows:

"(4) Pre-test counselling should occur before an HIV test is undertaken. ...

(5) ... (P)amphlets and other media may be used in making information on HIV/AIDS available, but cannot be regarded as a general substitute for pre-test counselling ...

(7) A doctor, nurse or trained HIV counsellor should also ensure that post-test counselling takes place as part of the process of informing an individual of an HIV test result.

(8) Where a health facility lacks the capacity to provide a pre-test or post-test counselling service, a referral to a counselling agency or another facility with the capacity to provide counselling should be arranged before an HIV test is performed, and when an HIV test result is given".

(Government Notice 1479 in **Government Gazette** 2071 of 10 December 1999).

432 See par 1.5 above.

433 Neethling et al 107, 275.

434 **Burger v Administrateur, Kaap** 1990 (1) SA 483 (C) at 489.

435 Neethling et al 108.

436 Strauss 3; Van Wyk 130. Cf the recent Supreme Court of Appeals decision where the court held that "it was a strange notion that the surgical intervention of a medical practitioner whose sole object had been to alleviate the pain or discomfort of the patient, and who had explained to the patient what was intended to be done and obtained the patient's consent to it being done, should be pejoratively described and juristically characterised as an assault simply because the practitioner had omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent" (**Broude v McIntosh and others** 1998 (3) SA 60 (SCA) at 67J-68A).

5.5.1 The common law recognises the following limited exceptions to the general rule requiring consent for medical treatment (including HIV testing):

- ! In an emergency, where HIV testing is necessary for a person's survival but he or she is unable to give consent.⁴³⁷
- ! Where there is a statutory duty on a person to submit him or herself to HIV testing.⁴³⁸
- ! Where HIV testing would be in the overriding public interest.⁴³⁹
- ! Some also argue that HIV testing without consent may be justified on the ground of "necessity" under certain circumstances.⁴⁴⁰ 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.⁴⁴¹ For non-consensual HIV testing of an 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)⁴⁴² 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

437 Eg where a person is unconscious or semi-unconscious or is in such a state of shock that he or she cannot consent (Van Wyk 132).

438 See eg reg 6, 14 and 17 of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987); and sec 37 of the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act). For a detailed discussion of these provisions see Chapters 6 and 7 below respectively.

439 Public interest includes national safety and health, economic welfare of the country and the protection of religious, moral and intellectual values (Van Wyk 1993 **De Jure** 142). Cf also **SALC First Interim Report on Aspects of the Law relating to AIDS** 50-51; **SALC Third Interim Report on Aspects of the Law relating to AIDS** 52.

440 Cf eg the discussions of this issue by Neethling et al 105-106; Van Wyk 132.

441 Milton 85; Snyman 121-122.

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

have been reasonable in the circumstances.⁴⁴³ Tested against these requirements it is submitted that compelled HIV testing of 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 Chapter 8 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.⁴⁴⁴

5.5.2 According to section 36 of the 1996 Constitution the rights in the Bill of Rights (in this case the right to privacy) may be limited -

(1) ... in terms of law of general application to the extent that the limitation is reasonable, and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including -

- (a) the nature of the right;
- (b) the importance of the purpose of the limitation;
- (c) the nature and extent of the limitation;
- (d) the relation between the limitation and its purpose;
- (e) and less restrictive means to achieve the purpose.

The Constitutional Court's approach in ascertaining whether it is justified to limit an entrenched right in terms of section 36 is to determine the proportionality between the extent of the limitation of the right considering the nature and importance of the infringed right on the one hand, and the purpose, importance and effect of the infringement, taking into account the availability of less restrictive means available to achieve that purpose.⁴⁴⁵ The Constitutional Court further held

443 Cf Milton 87.

444 See par 8.13 and 8.14 below.

445 **S v Manamela and another** 2000 (5) BCLR 491 (CC) at 519G-520A referring to **S v Makwanyane and another** 1995 (3) SA 391 (CC) and **National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others** 1999 (1) SA 6 (CC). See also **Director of Public Prosecutions: Cape of Good Hope v Bathgate** 2000 (2) BCLR 151 (C). Note that constitutional analysis under sec 36 is a two-stage procedure which the Constitutional Court held requires first, an establishment that the activity

that there is no absolute standard which can be laid down in this regard: The application of these principles to particular circumstances can only be done on a case-by-case basis.⁴⁴⁶ O'Regan J and Cameron AJ in **S v Manamela and another** formulated the above approach thus:

The level of justification required to warrant a limitation upon a right depends on the extent of the limitation. The more invasive the infringement, the more powerful the justification must be.⁴⁴⁷

In giving appropriate effect to the factor of "less restrictive means", the Constitutional Court further pointed out that it must be taken into consideration that legislative choices are not only made with regard to constitutional rights, but are also influenced by considerations of cost, practical implementation, the prioritisation of certain social demands and needs and the need to reconcile conflicting interests.⁴⁴⁸ In ascertaining whether it is justified to limit an arrested person's constitutional right to "autonomy privacy" the above approach will thus have to be followed.

Confidentiality and disclosure of medical information

for which constitutional protection is sought falls within the sphere of activity protected by a particular constitutional right; and second, a determination whether the infringement is justified or not (**S v Zuma and others** 1995 (2) SA 642 (CC); see also Chaskalson et al 12-3).

446 **S v Makwanyane and another** supra at 436D; **S v Manamela and another** supra 508D.

447 **S v Manamela and another** supra at 521A. Cf also Cameron and Swanson who (before the constitutional dispensation) submitted that as regards the limitation of rights in the HIV/AIDS context, there must be some intellectual criterion of rationality and some acceptable consensus on ethical values against which every measure sought to combat AIDS must be tested. The following criteria were suggested: Does a particular proposed measure actually achieve its objective in combatting the spread of HIV? Does the measure proposed invade a crucial and fundamental human right? If so, is there a pressing social need for the infringement and is it the least restrictive way possible of attaining the particular objective? (1992 **SAJHR** 202-203).

448 **S v Manamela and another** supra at 508H and 529A-B, the court referring with concurrence to the minority judgment of O'Regan J and Cameron AJ.

5.6 A quintessential aspect of the right to privacy is the ability of every person to control information about him or herself i e to keep it confidential (*informational privacy rights*).⁴⁴⁹ This principle is part of our common law⁴⁵⁰ and enshrined in the 1996 Constitution as a fundamental human right.⁴⁵¹ The Constitutional Court in **Case and another v Minister of Safety and Security and others**⁴⁵² noted the backdrop of South African history and the need to be aware of violations of the right to privacy where it concerned the disclosure of private information:

It [the right to privacy] is a right which, in common with others, was violated often with impunity by the legislature and the executive. Such emphasis is therefore necessary particularly in this period when South African society is still grappling with the process of purging itself of those laws and practices from our

449 Burris in **AIDS Law Today** 115; Cameron (Unpublished) par 8. Cf also **S v A and another** 1971 (2) SA 294 (T); **Financial Mail (Pty) Ltd and others v Sage Holdings Ltd and another** 1993 (2) SA 451 (A) 462E-F; **Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A).

450 **S v A** 1971 (2) SA 294 (T); **Financial Mail (Pty) Ltd and others v Sage Holdings Ltd and another** 1993 (2) SA 451 (A) 462E-F; **Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A). Neethling et al 248 define the principle thus: "The infringement of privacy through an act of disclosure arises where, contrary to the determination and will of the plaintiff, an outsider reveals to third parties personal facts regarding the plaintiff, which, although known to the outsider, nonetheless remain private".

451 The 1996 Constitution sec 14 quoted in fn 405 above.

452 1996 (5) BCLR 609 (CC).

past which do not fit in with the values which underpin the Constitution if only to remind both authority and citizen that the rules of the game have changed.⁴⁵³

- 5.7 In the medical context the concept of privacy is especially important as an expectation of privacy allows individuals to trust and confide freely.⁴⁵⁴ Upholding an individual's right to privacy extends a certain level of protection to private information once it has been disclosed within a special relationship, as in the provision of health care.⁴⁵⁵ Persons with HIV/AIDS have strong incentives to protect their privacy since disclosure of a person's HIV status may cause stigma and embarrassment.⁴⁵⁶ Moreover, it can lead to discrimination on several levels including the ability to find employment, to join a medical aid and insurance fund and to relate with family, friends and sexual partners.⁴⁵⁷ The need for confidentiality with regard to AIDS-related information is confirmed in ethical guidelines of the medical profession which provide as follows:

The results of HIV positive patients should be treated at the highest possible level of confidentiality.⁴⁵⁸

- 5.8 In the locus classicus on the protection of privacy with regard to AIDS-related information, the Appellate Division (now the Supreme Court of Appeals) in **Jansen van Vuuren and another NNO v Kruger**⁴⁵⁹ held that a doctor acted unlawfully when he informed two other doctors on the golf course of a patient's HIV status and accepted that the need for confidentiality in the case of AIDS was especially compelling:

453 Ibid at 649 (Langa J).

454 Neethling et al 250-252; Strauss 454; Strauss **Huldigingsbundel vir WA Joubert** 145; Van Wyk 347, 379-389; Cameron (Unpublished) par 12-13; **Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 at 849-850. Cf also Johns Hopkins University **Report on AIDS Litigation** 1996 (Internet);

455 Ibid.

456 This is so because sexual intercourse - for many still a taboo subject - is the major form of HIV transmission; and because HIV infection is traditionally associated with marginalised groups (in North America and Western Europe the disease initially manifested amongst gay men against whom social stigma already operated) (Cameron [Unpublished] par 15 and 17; Gostin and Lazzarini 51-52; Leary and Schreindorfer in **HIV & Social Interaction** 12 et seq).

457 See par 8.9.1 below; Cameron (Unpublished) par 15 and 17.

458 **Health Professions Council of South Africa Guidelines on HIV/AIDS** 1994 5. The **SA Medical Association HIV/AIDS Ethical Guidelines** 1998 reflect the same position at 8-9.

459 1993 4 SA 842 (A). For a detailed discussion of this case see Van Wyk 1994 **THRHR** 141 et seq.

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.⁴⁶⁰

5.9 Violation of the legal duty of confidentiality (the reverse of the right to privacy) could lead to a delictual claim.⁴⁶¹

5.10 As indicated in paragraph 5.5 above, the right to privacy is not absolute and other interests may justify or necessitate the violation of both the common law and the constitutional duty of confidentiality.⁴⁶²

5.10.1 Disclosure of AIDS-related information may be justified under the following circumstances in terms of the common law:

- ! If the individual concerned gives his or her informed consent to disclosure of the information.⁴⁶³ The same requirements applicable to the capacity to consent to medical treatment (as set out in paragraphs 5.3.1-5.3.4 above) also apply to consent to disclose medical information.
- ! Where legislation requires that the information be disclosed.⁴⁶⁴ Current examples of such legislation are certain provisions of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (the 1987 Regulations)⁴⁶⁵ and the Criminal

460 **Jansen van Vuuren and another NNO v Kruger** supra at 854J.

461 Neethling et al 43 et seq; Van Wyk 1988 **THRHR** 323-324. Violation of the right to privacy can result in liability in terms of the *actio iniuriarum*. Where a plaintiff also suffers patrimonial loss as a result of a violation of privacy, he or she should be able to recover damages through the *actio legis Aquiliae* (Neethling et al 43 et seq, 70 et seq). The possibility of liability for criminal defamation also exists (Van Wyk 385).

462 Strauss **Huldigingsbundel vir WA Joubert** 145; Van Wyk 386-388; Cameron (Unpublished) par 4, 14, 19, 20.

463 Neethling et al 274-275; Van Wyk 390.

464 Neethling et al 262; Van Wyk 390. Provided this legislation conforms to the provisions of sec 36 of the 1996 Constitution. See par 5.5.2 above for the text of sec 36.

465 Reg 6, 14 and 17 of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987). See the discussion of these provisions in Chapter 6 below.

Procedure Act 51 of 1977 (the Criminal Procedure Act).⁴⁶⁶ The following proposed amendments to the 1987 Regulations, aimed at the notification of AIDS disease and AIDS death (published by the Department of Health in April 1999), will also fall in this category should they be enacted.⁴⁶⁷

- 19 (1) When a medical practitioner ... 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.⁴⁶⁸
- ...
- (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.
- (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.

466 Sec 37. See the discussion of this provision in Chapter 7 below.

467 Government Notice R 485 Regulation Gazette 6496 in **Government Gazette** 19946 of 23 April 1999. The proposed amendments have not been promulgated at the time of compilation of this Report. According to media reports the Government may drop its intention to make AIDS notifiable as a result of public pressure and lack of support for such a step (**The Citizen** 13 October 1999). See also par 6.14 below.

468 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 sec 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".

None of the above examples provide for the information obtained (i.e. the HIV status of the persons concerned) to be disclosed to victims of sexual offences.⁴⁶⁹

- ! Where a person is ordered by the court to disclose the information.⁴⁷⁰ 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 medical information is in breach of a medical practitioner's professional ethics, he or she may object to being requested to provide the information. The presiding officer may however, despite the objection, direct the medical practitioner to provide the information. Failure to supply the information requested may result in the medical practitioner being in contempt of court.⁴⁷¹
- ! Where disclosure of the information would be in the overriding public interest.⁴⁷² The state generally protects or maintains public interest by placing conditions or restrictions on certain rights and freedoms. These restrictions are justified on the grounds of the statutory or official capacity of the state.⁴⁷³ Infection with HIV is life long, incurable and, for those without access to the latest treatment, probably fatal. It thus involves serious potential harm for individuals and society and it is generally accepted that an overriding public interest could constitute justification for the removal of the duty of confidentiality.⁴⁷⁴ However, in view of the specific and limited modes by which HIV is transmitted, 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

469 See also par 6.10, 6.14 and 7.12-7.15 below.

470 Neethling et al 262; Strauss 103; Van Wyk 390.

471 Strauss 103; Van Wyk 390. See eg sec 37(3) of the Criminal Procedure Act which provides that a court may order that steps be taken to ascertain whether the body of any person has any characteristic or distinguishing feature (which would include HIV infection). (See Chapter 7 below for a discussion of sec 37.)

472 Neethling et al 266 et seq.

473 Ibid.

474 Strauss **Huldigingsbundel vir WA Joubert** 145; Van Wyk 1993 **De Jure** 142 et seq; Van Wyk 1994 **THRHR** 141 et seq. See also **SALC Third Interim Report on Aspects of the Law relating to AIDS** 52-53 and Cameron (Unpublished) par 14-15.

are exposed to the body fluids (including the blood) of a person with HIV.⁴⁷⁵ 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.⁴⁷⁶ The general ethical rule regarding confidentiality of medical information is stated by the Health Professions Council of South Africa (formerly the South African Medical and Dental Council) as follows:

[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.⁴⁷⁷

Any medical practitioner who does not act in accordance with the above would be infringing a person's rights and may be found liable in a civil court to pay delictual damages.⁴⁷⁸ In **Jansen van Vuuren and another NNO v Kruger** the court however held that in determining whether or not the confidential relationship could be breached, the conflicting interests would have to be balanced:

475 Strauss 16; Van Wyk 1993 **De Jure** 145.

476 Our courts have held that a patient is entitled to expect that his or her medical practitioner will act in accordance with ethical codes (**Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A) at 856E-F).

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

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

... (T)he 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.⁴⁷⁹

In this regard the Health Professions Council of South Africa in its 1994 Guidelines on HIV/AIDS advises medical practitioners as follows:

The decision [whether to divulge information to other parties] must be made with the greatest care, after explanation to the patient, and with acceptance of full responsibility at all times.⁴⁸⁰

In its 1998 Guidelines, containing similar principles, the South African Medical Association enunciated these principles on a practical level as follows:⁴⁸¹

Doctors should use their discretion whether or not to discuss confidentially a patient's sero-status 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 sero-status 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 precautions⁴⁸² are being applied.
3. The doctor has informed the patient that under the circumstances he 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

479 1993 (4) SA 842 (A) at 850E-H. For a detailed discussion of this case see Van Wyk 1994 **THRHR** 141 et seq.

480 **Health Professions Council of South Africa Guidelines on HIV/AIDS** 1994 5.

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

482 "Universal precautions" refer 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 as rubber gloves (**SALC Third Interim Report on Aspects of the Law relating to AIDS** 203).

the patient in that patient's own best interest, the doctor should be duty bound confidentially to discuss the patient's sero-status 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 sero-status of a patient to third parties without the patient's consent only when all of the following circumstances pertain:

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.

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

- ! Infringement of privacy may also be justified on grounds of "necessity" as discussed in paragraph 5.5.1 above. Disclosure of private information (which would include information regarding the HIV status of persons arrested in sexual offence cases) may thus be justified on the ground of necessity - but only if disclosure is the only reasonable alternative for protecting the legitimate interests of victims of sexual offences.⁴⁸³ It is submitted that, tested against the legal requirements of necessity, disclosure of an arrested person's HIV status to the victim of a sexual offence without the necessary consent would not be justified: Although knowledge of the arrested person's HIV status may arguably assist in

483 See the general principles governing the common law defence of "necessity" set out in par 5.5.1 above. Cf also the discussions in Neethling et al 263-264; Van Wyk 428-429.

alleviating the victim's psychological stress brought about by rape or indecent assault, it is not the only reasonable alternative for protecting the life of the victim.⁴⁸⁴

5.10.2 As indicated in paragraph 5.5.2 above, the constitutional right to privacy is not absolute and may be limited in certain circumstances provided for in section 36 of the 1996 Constitution. The principles set out in that paragraph also apply to the constitutional limitation of "informational privacy rights".

Conclusion

5.11 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, where it would be in the overriding public interest, or where it would be the only reasonable alternative for protecting the legitimate interests of another person.

484 See par 8.13 and 8.14 below.

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.

The government's current public health response to the HIV/AIDS epidemic⁴⁸⁵

- 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.⁴⁸⁶ The National Programme is assisted by the Government AIDS Action

485 Information for this section was supplied by Ms Ann Strode (Project Committee member) on 9 September 2000.

486 According to the 1998 operational plan of the Department of Health's Directorate: HIV/AIDS and STDs 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". In order to concretise the Government's commitment

Programme (GAAP)⁴⁸⁷ and nine Provincial AIDS Programmes (based within the provinces' respective health departments) which are primarily responsible for the implementation of the national HIV/AIDS policy. In addition, the National Programme works closely with 15 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.⁴⁸⁸ 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.⁴⁸⁹
- 6.5 In its latest strategic planning on HIV/AIDS for the years 2000-2005 the Department of Health has adopted four priority intervention areas with regard to which it will direct its response to the epidemic. These include prevention; care, treatment and support; research, monitoring and surveillance; and human rights issues.⁴⁹⁰
- 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

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.

487 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.

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

489 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.
- * The government has a crucial responsibility with regard to the provision of education, care and welfare to all people of South Africa.

490 **HIV/AIDS & STD Strategic Plan for South Africa 2000-2005** 19-25.

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.⁴⁹¹ 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 HIV/AIDS has been set up which is chaired by the Deputy President. This Committee's object was to ensure that the Government's AIDS Programme receives political commitment at the highest level. One of its key achievements thus far has been the development of a national HIV/AIDS awareness campaign. The Inter-Ministerial Committee has however been disbanded recently and replaced with the South African National AIDS Council which is also chaired by the Deputy President. This is a multi-sectoral body that oversees the national response to the epidemic and the implementation of the five-year Strategic Plan referred to in paragraph 6.5 above. It further facilitates collaboration between government and other sectors. The Council consists of representatives from many sectors (including human rights organisations, non-governmental organisations, organised sport, business, and trade unions).

- 6.7 With regard to the Law Commission's current investigation the following general statements from the NACOSA Plan can be noted:⁴⁹² "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

491 Relevant to the current investigation the Report noted the following: "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** July 1997 22).

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

against exposure to HIV".⁴⁹³ 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.⁴⁹⁴ The five-year Strategic Plan inter alia identified the development of an appropriate legal and policy environment as a priority. In this regard the Plan envisages the following: "Develop(ing) criminal law measures which protect the rights of victims of sexual violence"; and "investigat(ing) the provision of post exposure prophylaxis (PEP) to the victims of sexual violence".⁴⁹⁵

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.⁴⁹⁶ Coercive measures have not been part of the National AIDS Programme's response to the epidemic.⁴⁹⁷ With the recent publication for public comment of draft regulations providing for the compulsory notification of AIDS,⁴⁹⁸ 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.⁴⁹⁹ At the time of compilation of this Report the proposed amendments have not been promulgated.⁵⁰⁰

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

494 See par 6.5 above.

495 **HIV/AIDS & STD Strategic Plan for South Africa 2000-2005** 25.

496 This has been confirmed by Dr N Simelela Director: HIV/AIDS and STDs, Department of Health on 21 May 1999. Cf also the Department's goals and implementation programmes referred to in par 6.5 above.

497 Ibid.

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

499 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 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.

500 See fn 467.

Existing public health regulations

6.9 The Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (the 1987 Regulations)⁵⁰¹ 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 State⁵⁰² may, at his discretion, in order to prevent the spread of a communicable disease⁵⁰³ 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 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 HIV⁵⁰⁴) and who as such constitutes a danger to the public

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

502 Which would include a medical officer in the employ of the State who performs forensic duties (cf sec 14(f) of the Health Act 63 of 1977 and par 3.46 above).

503 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).

504 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

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 AIDS⁵⁰⁵), 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 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 health authorities.⁵⁰⁶
- 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.⁵⁰⁷ The criticism was not aimed expressly at the testing

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.

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

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

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

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.⁵⁰⁸ 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.⁵⁰⁹

- 6.12 Draft Regulations, intended to replace the 1987 Regulations, were published for comment in 1993.⁵¹⁰ 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.⁵¹¹ The effect is 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.⁵¹²
- 6.14 The Department of Health in April 1999 published proposed amendments to the 1987

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

509 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).

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

511 The new reg 6 no longer contains any reference to medical examinations. The only other provision relevant to medical examinations is draft reg 11. Draft reg 11(1) - which seems intended to replace the current 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 (not including AIDS in its redrafted form); while draft reg 11(3) refers to medical examination of a "carrier" or a person who "suffers" from a communicable disease. It is submitted that 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.

512 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 seven 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. See also par 1.5 above.

Regulations in order to make AIDS a notifiable medical condition.⁵¹³ 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.⁵¹⁴ The proposed amendments have not been enacted at the time of compilation of this Report.⁵¹⁵

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

514 The proposed amendments are quoted in full in par 5.10.1 above.

515 See also fn 467 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 arrested for 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 51 of 1977 (the Criminal Procedure Act) however provides for the ascertainment of bodily features of an arrested person (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 arrested persons.⁵¹⁶ This section states as follows:

- 37(1) Any police official⁵¹⁷ 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

516 According to McKay and Wannenburg (Unpublished 25) the KwaZulu-Natal lower courts have rendered conflicting decisions on the issue of testing the accused for HIV in child abuse cases. Information supplied by the South African Police Service (SAPS) also indicated 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 on 21 March 1998). It is however not clear whether such testing was referred to in the context of gathering of evidence.

517 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).

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 ...;
- (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 conviction 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 arrested for having committed a sexual offence.
- ! Whether such testing would in general be regarded as constitutional.
- ! 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.⁵¹⁸ If a police official requests a blood sample to be taken, it may also be taken by any registered medical practitioner or registered nurse.⁵¹⁹ (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

518 Sec 37(2)(a). Cf also Hiemstra 81; Du Toit et al 3-13.

519 Ibid.

criminal proceedings,⁵²⁰ or such cases where a person has not been arrested but has been warned or summonsed to appear before court.⁵²¹

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.⁵²² 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.⁵²³ 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.⁵²⁴

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.⁵²⁵

The constitutionality of HIV testing under section 37

7.9 In line with practices of international policing agencies, section 37 empowers a police

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

521 **Nkosi v Barlow NO and others** 1984 (3) SA 148 (T); **S v Maphumulo** 1996 (2) SACR 84 (N); see also Du Toit et al 3-15.

522 Du Toit et al 3-13.

523 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.

524 **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 and 3-14; Lötter 1994 **Codicillus** 58-59.

525 See par 7.9 below.

official to ascertain bodily features in specified circumstances.⁵²⁶ The powers granted are far-reaching.⁵²⁷ 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.⁵²⁸ 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.⁵²⁹

- 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.⁵³⁰ 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;⁵³¹ and in argument relevant to the imposition of life imprisonment for rape in terms of section 51 of the Criminal Law Amendment Act

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

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

528 See also Steytler 97.

529 "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 NO and others** 1984 (3) SA 148 (T) 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).

530 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).

531 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).

105 of 1997 (the Criminal Law Amendment Act).⁵³² 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 1996 Constitution provides for the vertical application of the Bill of Rights.⁵³³ Any offence or investigative procedure provided for in national legislation would thus be subject to constitutional review.⁵³⁴ 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.⁵³⁵ 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.⁵³⁶ The rights referred to are thus not absolute and could be limited in certain circumstances.

532 Sec 51 of the Criminal Law Amendment 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). 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; and fn 70 above.

533 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".

534 Cf also Steytler 15.

535 Du Toit et al 3-1, 3-2, 3-2A; Steytler 76, 97 and 115; Schwikkard 1995 **SACJ** 92; Clark in **Polisiëring en Menseregte** 260; cf also **Sapat and others v Director: Directorate for Organised Crime and Public Safety and others** 2000 (2) BCLR 200 (C) at 204. 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).

536 See also par 5.5.2 above.

7.11.2 Section 14 of the 1996 Constitution states that everyone has the *right to privacy*.⁵³⁷ This right derives from the right to dignity⁵³⁸ and is also closely intertwined with the right to bodily and psychological integrity.⁵³⁹ Compulsory subjection to a medical examination constitutes an interference with privacy rights.⁵⁴⁰ 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.⁵⁴¹ It has been submitted that, in the context of criminal justice, an intrusion on privacy (eg the 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.⁵⁴² International case law indeed recognises that "modern community living requires modern scientific methods of crime detection lest the public go unprotected".⁵⁴³ 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 the protection of the rights of others) is proved and if the least restrictive means to

-
- 537 See also **Jansen van Vuuren and another NNO 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 and another** 1971 (2) SA 294 (T).
- 538 Sec 10 of the 1996 Constitution provides that everyone has the right to dignity and the right to have their dignity respected and protected.
- 539 Sec 12(2) of the 1996 Constitution provides that everyone has the right to bodily and psychological integrity. See also **Jansen van Vuuren and another NNO v Kruger** 1993 (4) SA 842 (A) at 849E-F; **S v A and another** 1991 (2) SA 294 (T). Refer also to the discussion in Chapter 5 above (par 5.2-5.2.2).
- 540 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. See also par 5.2-5.5 above.
- 541 See the discussion on the limitation of privacy rights in Chapter 5 above (par 5.5-5.5.2 and 5.10-5.10.2).
- 542 Cf Steytler 86-87; 97.
- 543 See eg the United States Supreme Court decision in **Breithaupt v Abram** 352 US 432, 1 L ed 2d 448, 77S Ct 408.

achieve the purpose were used.⁵⁴⁴ Thus, if information regarding HIV status is in general necessary for the effective prosecution of crime in the current climate of lawlessness, and if the effective prosecution of a specific crime in particular (eg attempted murder) was practically impossible without utilising the powers under section 37,⁵⁴⁵ 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.⁵⁴⁶

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.⁵⁴⁷ Where a person submits him or herself to the control of police officials on the reasonable ground that there is no other choice - be it for a breathalysers test or a blood test - a deprivation of freedom within the meaning of section 12(1) would occur.⁵⁴⁸ Internationally, the right embodied in section 12(1) is absolute, non-derogable and unqualified.⁵⁴⁹ 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.⁵⁵⁰ The question of justification therefore does not arise.⁵⁵¹ 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

-
- 544 Clark in **Polisiëring en Menseregte** 265-266; Scwikkard 1995 **SACJ** 92. Cf also **S v Huma and another (2)** 1995 (2) SACR 411 at 416j-417a.
- 545 Cf Steytler 23 where he refers to **Scagell and others v Attorney-General, Western Cape and others** 1996 (11) BCLR 1446 (CC) par 9.
- 546 Cf also Clark in **Polisiëring en Menseregte** 265-266; Scwikkard 1995 **SACJ** 92; and **S v Huma and another (2)** 1995 (2) SACR 411 at 316j-317a.
- 547 The 1996 Constitution sec 12(1)(e). Cf the remarks of Hiemstra quoted in fn 529 above.
- 548 Cf Steytler 49.
- 549 Ibid 42-45, 50; Clark in **Human Rights for the Police** 256.
- 550 See **Bernstein and others v Bester NO and another** 1996 (4) BCLR 449 (CC) par 144-151;
- 551 Steytler 42-45, 50, 76; See also **Bernstein and others v Bester NO and another** 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).

gathering (an essential component of the investigation of crime and in many respects a prerequisite for the effective administration of any criminal justice system, including the proper adjudication of a criminal trial⁵⁵²), there would probably be no violation of section 12(1).⁵⁵³

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*.⁵⁵⁴ 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).⁵⁵⁵ 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."⁵⁵⁶ It has subsequently been held that the common-law distinction has not been affected by constitutional provisions.⁵⁵⁷ Real evidence in the form of a blood sample obtained in terms of section 37 thus falls outside the ambit of protection of the constitutional right not to be compelled to give self-incriminating evidence.

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

553 Cf Steytler 76.

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

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

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

557 **S v Huma and another (2)** 1995 (2) SACR 411 (W) and **S v Maphumulo** 1996 (2) SACR 84 (N) were decided in terms of the 1993 interim Constitution (sec 25); while **Ferreira v Levin NO and others and Vryenhoek and others v Powell NO and others** 1996 (1) BCLR 1 (CC) was decided in terms of the 1996 Constitution (sec 35). Cf also Scwikkard 1996 **SACJ** 113.

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 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.⁵⁵⁸
- 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 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 (i.e. imposition of life imprisonment if a person has been convicted of rape knowing that he or she has AIDS or HIV),⁵⁵⁹ a procedure taking recourse to the provisions of section 37 would have to be resorted to.⁵⁶⁰

Conclusion

- 7.15 The current position is that section 37 of the Criminal Procedure Act does not authorise the taking of a blood sample from a person arrested for having committed a sexual offence for purposes of disclosing the test result to the victim of such offence.

558 Cf also Du Toit et al 3-15.

559 See par 7.10 above.

560 See also par 12.20, 12.27 and 12.82 below where comments on this issue are discussed.

8 The need for statutory provision for compulsory HIV testing of arrested persons and for disclosure of the test results to victims

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 accordance with this, the compulsory medical examinations (which would include HIV testing) currently provided for in the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (the 1987 Regulations)⁵⁶¹ 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

561 See par 6.9 above.

health authorities.⁵⁶²

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 51 of 1977 (the Criminal Procedure Act)⁵⁶³ 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.⁵⁶⁴ 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.⁵⁶⁵ 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 law.⁵⁶⁶ 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.⁵⁶⁷ 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

562 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 5.10.1 and 6.14 above. At the time of compilation of this Report, the proposed amendment has not been enacted (see fn 467 above.)

563 See par 7.2 et seq above.

564 Du Toit et al 3-1; Clark in **Polisiëring en Menseregte** 271-272. See also the discussion on sec 37 in Chapter 7 above, and the discussion of privacy in Chapter 5 above.

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

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

567 See par 7.10.

offence case would thus possibly be illegal if it is not relevant to the trial per se.⁵⁶⁸ 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;⁵⁶⁹ and in argument relevant to the imposition of life imprisonment for rape in terms of section 51 of the Criminal Law Amendment Act 105 of 1997 (the Criminal Law Amendment Act).⁵⁷⁰ 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.⁵⁷¹

The need for legislative intervention

- 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.⁵⁷² 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

568 The presence of HIV would not be relevant for a prosecution under any of the *sexual* offences referred to in par 2.24.3 above.

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

570 See par 7.10 and 7.14 above. See also par 12.20, 12.27 and 12.82 below for comments on this issue.

571 See par 7.6 above.

572 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 2.4 et seq above.

might consider abortion were there is a possibility of her having been exposed to HIV).⁵⁷³ Such decisions would not be possible for her were she to wait at least the average six to 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.⁵⁷⁴

- 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.⁵⁷⁵ This issue 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 stigma attached to HIV/AIDS.⁵⁷⁶ 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.⁵⁷⁷
- 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. For purposes of this debate the Commission has not considered the possibility of compulsory HIV testing of persons *convicted* of a sexual offence to be a viable option and has thus not

573 Cf **AIDS Alert August** 1994 (Internet) 111.

574 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.

575 Jackson in **AIDS Agenda** 240-242; Buchanan in **African Network on Ethics, Law and HIV** 94-95; see also par 8.27 below.

576 See par 2.4 et seq for information on the public outcry for government action on the issue of rape and HIV. Attorney General Frank 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).

577 See Chapter 5 above and par 8.26 et seq below on privacy rights.

further explored it below.⁵⁷⁸ In most cases the utility of testing would have disappeared by the time of a conviction.⁵⁷⁹ Unless victims themselves underwent testing shortly after the attack, sero-positivity 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 sero-positivity is likely to show up on tests by the time of conviction.⁵⁸⁰

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.⁵⁸¹ 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;⁵⁸² 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;⁵⁸³ and when a convicted sex offender is released, the probability of that

578 See also par 12.13 et seq below on this issue.

579 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 South African Police Service (SAPS) resulted in convictions (**Mail and Guardian** 21-27 May 1999). See also par 8.17 et seq below where the utility of HIV testing in the criminal process is discussed.

580 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 (Field 1990 **AMJLM** 102; Andrias 1993 **Fordham Urban Law Journal** 507).

581 See par 2.7 et seq above.

582 See par 2.4 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.

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

offender committing another similar offence is high.⁵⁸⁴

- 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,⁵⁸⁵ 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.⁵⁸⁶ Studies in many countries show that male-to-female transmission of HIV appears to be two to four times more efficient than female-to male transmission.⁵⁸⁷ 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.⁵⁸⁸ Women are also more vulnerable to HIV because they are more likely to have untreated sexually transmitted diseases, 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.⁵⁸⁹
- 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 is diminished by the relatively small probability of HIV transmission in the case of sexual offences.⁵⁹⁰ They argue that scientific sources indicate that the possibility of contracting HIV through sexual assault

584 Ibid. See also the comments of Prof PWW Coetzer in this regard (par 12.18).

585 See par 2.24.3 and 3.16 et seq above.

586 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). See par 3.16.1 above for information on women's biological vulnerability to HIV.

587 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]).

588 Hankins **Canadian HIV/AIDS Policy & Law Newsletter** July 1996 (Internet).

589 Ibid. See par 3.16.1 above for information on the influence of sexually transmitted diseases on HIV transmission.

590 Cf par 3.16 above.

is very small indeed - even for female victims.⁵⁹¹ 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 and is simply not justified in the exceptionally limited circumstances where it would in all likelihood be relevant.⁵⁹²

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.⁵⁹³

8.9.1 Proponents for compulsory 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,⁵⁹⁴ to join a medical aid and insurance

591 It is indicated in par 3.16-3.17 above that on average the *theoretical* risk of becoming infected with HIV from a single unprotected sexual exposure may be similar to that from a single occupational percutaneous exposure to HIV - which is regarded as small. However, it is also indicated that the *actual* risk is highly variable due to factors which may be present during rape or sexual assault and which will increase the risk (eg the type of sexual exposure; the duration of the act; the presence of physical violence during the attack; the presence of sexually transmitted diseases in the victim or the assailant; the kind of body fluid and how much of it the victim was exposed to; and the serological and clinical status of the assailant).

592 See the discussion on privacy in Chapter 5 above and par 8.26-8.29 below. See also the comments in par 12.7 below.

593 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** 18-45 for the limits of HIV testing. This was also one of the main arguments raised in comments opposing the Commission's proposals (see par 12.7 below).

594 See eg the High Court decision in **Hoffmann v South African Airways** 2000 (2) SA 628 (W) where an application to set aside the decision of the respondent not to employ the applicant (an otherwise healthy person with HIV) was refused by the High Court on the basis that a policy of complete non-discrimination cannot be applied uniformly irrespective of job description and operational requirements. (This decision was however set aside by the Constitutional Court [**Hoffmann v South African Airways** 2000 (11) BCLR 1211 (CC)]. It is expected that the Employment Equity Act 55 of 1998 and the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 will also bring relief to persons with HIV in the work place.)

fund,⁵⁹⁵ and to relate with family, friends and sexual partners.⁵⁹⁶ 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.⁵⁹⁷ In addition to this, persons with HIV face a degree of social stigmatisation and discrimination.⁵⁹⁸ The long-term effectiveness and safety of new combination drug treatments (which may substantially postpone death for persons with HIV) are still unproven. These drugs carry the possibility of serious side effects,⁵⁹⁹ they are 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.⁶⁰⁰ 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.⁶⁰¹ 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.⁶⁰² Because HIV is transmitted through sexual contact, a victim of rape (or any sexual offence involving transmission of an HIV carrying bodily fluid)⁶⁰³ logically fears infection and thus

-
- 595 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 more 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 (**Sunday Independent** 25 October 1998). 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)).
- 596 Cf the leading German case on deliberate HIV infection (**BGH v O** 4.11.1988 - StR 262/88) referred to in **SALC Discussion Paper 80** fn 353 where it is indicated that the court ruled that an infected victim would be faced with, amongst others, the stress of knowing for the rest of his or her life that he or she now risks infecting someone else with HIV.
- 597 **Venter v Nel** 1997 (4) SA 1014 (D); Robling 1995 **Cleveland State Law Review** 678-681; Leary and Schreindorfer in **HIV & Social Interaction** 12-25.
- 598 Ibid. See also Sadler 1992 **Washington Law Review** 208-209.
- 599 See par 3.52 above.
- 600 Cohn 1997 **BMJ** 487-491; **BMJ** (SA Ed) August 1997 487. Cf also Groopman **The New Republic** 12 August 1996; Gyldmark and Tolley in **The Economic and Social Impact of AIDS in Europe** 30-37. In Chapter 3 above it is indicated that a basic retroviral course of a minimum of two drugs, and possibly three, may cost between R1 500,00 and R4 000,00 (par 3.52).
- 601 Sowadsky "A Few Questions From a Student" **The Body** (Internet).
- 602 See par 3.49-3.52 above.
- 603 See par 2.24.3.

desires information on the HIV status of his or her assailant.⁶⁰⁴

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 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 (WB) HIV tests utilised for this purpose are scientifically regarded as "highly reliable"⁶⁰⁵ 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.⁶⁰⁶ Although false positive and false negative test results may occur,⁶⁰⁷ 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.⁶⁰⁸ (It was indicated in paragraph 2.10 above that South Africa currently has a high prevalence rate of HIV infection.)

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

605 See par 3.32 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.

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

607 Cf par 3.28 above.

608 Cf **WHO Weekly Epidemiological Record** 21 March 1997. See also par 3.28 and fn 193 above.

8.11 Opponents to compulsory testing however submit that the medical limitations of HIV testing may make testing of the arrested person meaningless. Although the Centers for Disease Control (CDC)⁶⁰⁹ considers currently available HIV tests highly reliable,⁶¹⁰ opponents argue that the tests are subject to error for a variety of reasons.⁶¹¹ These include the fallibility of HIV tests (which may result in false positive or false negative results),⁶¹² technical errors,⁶¹³ unskilled staff,⁶¹⁴ and biological ambiguity.⁶¹⁵ Most importantly however are the scientific limitations of the tests in detecting antibodies to HIV during the window period. As indicated in Chapter 3 above, most individuals undergo sero-conversion and produce detectable levels of HIV antibodies within six to 12 weeks of infection. However, many may have an extended window period before sero-conversion and a few infected individuals may never test positive for the virus.⁶¹⁶ If an arrested person is in the window period, his or her HIV test will be negative and it will cause the false impression that the victim has not been exposed to HIV.⁶¹⁷ It follows that

609 See fn 349 above.

610 See also par 3.32 above.

611 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).

612 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 (WB) 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 WB 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 10% of the population - is high), 30-80% of repeatedly positive ELISA results are determined to have been false by WB (Burriss 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).

613 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).

614 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).

615 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).

616 See par 3.4.

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

the arrested person will have to be tested again to ensure that he or she was not infected. By this time the information regarding the arrested person's HIV status would no longer be useful for the administration of post exposure prophylaxis (PEP) (which has to be initiated promptly - not later than 24-36 hours to be effective).⁶¹⁸

618 Cf par 3.64 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 benefit victims' physical as well as mental health.
- 8.13 As regards victims' ***physical health***, proponents maintain that knowledge of their assailants' HIV status will allow victims to take early steps to protect their own and others' health.⁶¹⁹ First, such knowledge will assist a victim to make an informed decision as regards the initiation of treatment for the prevention of HIV infection (PEP⁶²⁰). As indicated above, one of the primary factors in initiating PEP is establishing the HIV status of the source person.⁶²¹ 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 assessing 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.)⁶²² 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.⁶²³ As indicated in par 8.3 above, such victim might consider abortion where there is a possibility of having been exposed to HIV.⁶²⁴ A decision in this regard would not be possible were the victim to wait the minimum six to 12-week period (or even longer) to see if she develops her own antibodies - even though

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

620 See par 3.62 et seq for details on this treatment.

621 Par 3.66.1 above.

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

623 Cf **AIDS Alert** August 1994 (Internet) 111; Jackson in **AIDS Agenda** 256; Gostin et al 1994 **JAMA** 1438.

624 Ibid.

the assailant's test results may not give her the definitive answer she sought.⁶²⁵

- 8.14 Proponents moreover believe that 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.⁶²⁶ Some argue that this is the strongest justification for compulsory HIV testing of arrested persons.⁶²⁷

8.14.1 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 post traumatic stress disorder.⁶²⁸ The trauma may also include anxiety about becoming pregnant and acquiring a sexually transmitted disease such as HIV.⁶²⁹ 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.⁶³⁰ 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.⁶³¹ 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

625 Ibid. See par 3.4 for information on the "window period".

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

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

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

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

630 Ibid.

631 Ibid.

assault because of the window period.⁶³² 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 HIV 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.⁶³³ 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.⁶³⁴ Knowledge of exposure might even allow victims to begin psychological preparation for the results of their own testing.⁶³⁵ Moreover, knowing their assailants' HIV status would assist victims in making decisions regarding the initiation of PEP to prevent HIV transmission.⁶³⁶ Initiating PEP might in turn help survivors gain a sense of control after the attack, and decrease their anxiety.⁶³⁷ In those cases where the assailant is apprehended relatively soon after the rape or sexual assault, compulsory testing could thus mitigate one of the primary ongoing harms of the attack - the victim's fear and uncertainty about the risk of contracting HIV.⁶³⁸

8.15 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 victims' (or others') physical or mental health.⁶³⁹

8.15.1 As far as a victim's *physical health* is concerned, they emphasise that a positive HIV test result in respect of the arrested person does not mean that the victim

632 Cf par 3.4 above on the window period.

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

634 Gostin et al 1994 *JAMA* 1442.

635 Ibid.

636 Cf par 3.66 et seq above for guidelines on the assessment of risk before initiating PEP.

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

638 Gostin et al 1994 *JAMA* 1442.

639 Report of the Working Group of the Interdepartmental Committee on Human Rights and AIDS referred to in Jürgens 168.

has been infected with HIV.⁶⁴⁰ First, there is the possibility of a false positive resulting from the flaws of the testing procedure.⁶⁴¹ 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).⁶⁴²

8.15.2 Likewise knowledge of a negative test result of an arrested person may not contribute to the victim's physical health.⁶⁴³ 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.⁶⁴⁴ In this case, victims may decline to be regularly tested, thereby putting their own health in jeopardy because if they are infected it 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.⁶⁴⁵

8.15.3 Opponents stress that the reality is that AIDS is currently still incurable.⁶⁴⁶ 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 the success of PEP after sexual exposure.⁶⁴⁷ PEP can be administered to a victim irrespective of the arrested person's HIV status.⁶⁴⁸ Opponents point out that a decision to take PEP is not only influenced

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

641 See par 8.11 above.

642 See par 3.16 et seq above. See also Sadler 1992 **Washington Law Review** 210-211.

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

644 Sadler 1992 **Washington Law Review** 211; Jürgens 174.

645 Ibid. See also the comments in par 12.7 below.

646 Cf par 3.49-3.52 above.

647 Cf par 3.71 above.

648 See the comments in par 12.7 below.

by the arrested person's HIV status, but by a variety of factors, both personal and medical.⁶⁴⁹ 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 result of their assailant.⁶⁵⁰

8.15.4 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.⁶⁵¹ 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).⁶⁵² 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.⁶⁵³

8.16 Opponents further submit that HIV testing of arrested persons will not aid victims' *mental*

649 Cf par 3.66 above.

650 Jackson in **AIDS Agenda** 256. Cf also the instances referred to in par 2.5 et seq above where rape victims have initiated PEP without knowing the HIV status of the assailant.

651 Sadler 1992 **Washington Law Review** 212-213; Jackson in **AIDS Agenda** 255. See also the comments in par 12.7 below.

652 Sadler 1992 **Washington Law Review** 212-213.

653 Sadler 1992 **Washington Law Review** 212-213; Andres 1994 **UMKC Law Review** 460; Jackson in **AIDS Agenda** 255-256; Report of the Working Group of the Interdepartmental Committee on Human Rights and AIDS referred to in Jürgens 168. 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 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 indication whether the victim is truly infected or not (**ACLU Freedom Network** [Internet]). See also the comments in par 12.7 below.

health.

8.16.1 They believe that knowledge of arrested persons' HIV status will not necessarily assist victims of crime and may even add to rape trauma syndrome.⁶⁵⁴ Some argue that if the arrested person for instance tests negative for HIV antibodies, the victim's psychological trauma will continue unabated.⁶⁵⁵ The test result could be falsely negative because of either the failure rate of the tests or the window period between infection and sero-conversion. 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.⁶⁵⁶ As indicated above, a positive result of the assailant is inconclusive as to the victim's HIV status⁶⁵⁷ and can serve only to exacerbate 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 sero-positive will undoubtedly suffer tremendous psychological trauma while awaiting the onset of a disease that may never occur.⁶⁵⁸ Moreover, if it could be established with 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

654 Andres 1994 **UMKC Law Review** 455-474 at 460. McKay and Wannenburg (Unpublished) 17.

655 Sadler 1992 **Washington Law Review** 210; cf also Jackson in **AIDS Agenda** 255.

656 Ibid.

657 See par 8.14.1 above.

658 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 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).

partner and family member reactions towards the victim.⁶⁵⁹

8.16.2 As regards their belief that victims should have themselves tested as an alternative to compulsory testing,⁶⁶⁰ opponents however point out that the question of self-testing for victims is an extremely complex one involving profound personal and psychological issues. They 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' fears.⁶⁶¹

Utility and limitations of HIV testing in the criminal process

8.17 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).⁶⁶² In many instances assailants will not have been apprehended within this short space of time.⁶⁶³ Similarly, many victims of rape and other sexual offences will not come forward to timeously receive PEP. Also in the latter instances opponents submit that it would serve no meaningful purpose to test the arrested person for HIV. Some opponents however concede that testing the arrested person could provide useful information for the purpose of *ending* PEP: if the arrested person tests negative, the victim could discontinue PEP and avoid the potential side

659 Mc Kay and Wannenburg (Unpublished) 11, 17; cf also Robling 1995 *Cleveland State Law Review* 679.

660 See par 8.15.4 above.

661 See also the comments in par 12.7 below.

662 Jürgens 174; see also par 3.64 above.

663 Cf Jürgens 175. See also the comments in par 12.7 below.

effects of continued prophylactic treatment.⁶⁶⁴

- 8.18 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 arrested persons tested will only tell whether they had detectable levels of HIV in their blood at the time of the tests, such tests will not indicate whether victims have 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 arrested persons will thus be a waste of resources if victims will in any event have themselves tested to establish whether HIV was in fact transmitted.⁶⁶⁵
- 8.19 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 South African Police Service (SAPS) apprehends such offenders. If assailants are apprehended soon after the commission of sexual crimes, testing could be carried out. According to information, most 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.⁶⁶⁶

Utility and limitations of HIV testing in the context of PEP (treatment for the prevention of HIV infection after sexual exposure)

- 8.20 It is indicated in Chapter 3 above that fairly recent scientific evidence shows that

664 Jürgens 175. See par 3.64 above for the possible side effects of PEP.

665 Cf Field 1990 **AMJLM** 105.

666 According to information from Rape Crisis, Cape Town, 90% of their clients who indeed reported the alleged rape to the SAPS indicated that they reported the alleged crime immediately after its commission, 9% waited a few days before reporting and a further 1% waited a couple of weeks before reporting (information supplied by Ms Kathleen Day, Counselling Coordinator, Rape Crisis Cape Town on 21 September 1998).

administering certain antiviral drugs shortly after HIV is communicated occupationally, has substantial beneficial effects with regard to the prevention of transmission of HIV.⁶⁶⁷ Some experts submit that the same treatment would be successful after 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).⁶⁶⁸ The latter has become the basis for arguments that victims of rape and other sexual offences should be allowed to require that arrested persons be tested for HIV so that if they are HIV positive, preventive treatment could be administered to victims.⁶⁶⁹

8.20.1 Scientific guidelines for the initiation and administration of PEP in the occupational setting suggest that it should not be administered on a routine basis.⁶⁷⁰ 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.⁶⁷¹

8.21 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.

8.21.1 As indicated in the discussion on PEP in Chapter 3 above, this treatment can be highly toxic and it has several adverse side effects.⁶⁷² 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

667 See par 3.58 et seq above for a full discussion on PEP after occupational and sexual exposure.

668 Ibid.

669 Cf Jackson in **AIDS Agenda** 256; Field 1990 **AMJLM** 102-103; Gostin et al 1994 **JAMA** 1438; Sadler 1992 **Washington Law Review** 212.

670 See the United States' CDC and South African Department of Health guidelines referred to in par 3.66-3.67 above.

671 Ibid.

672 See par 3.64 above. See also Sadler 1992 **Washington Law Review** 212-213.

treatment to a victim when it is in fact uncertain whether he or she may develop HIV infection. This view is supported in a recent report by the United States' CDC on management of possible sexual or other non-occupational exposures to HIV.⁶⁷³ 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).⁶⁷⁴

8.21.2 The studies that are used to support the theory that certain combination drugs may prevent transmission of HIV, are not applicable to victims of rape and sexual assault.⁶⁷⁵ The studies were conducted on health care workers in the health care setting - where it was possible to assess the risk of exposure, and to administer treatment immediately following exposure.⁶⁷⁶ The extremely short time interval between exposure and treatment appears to be a critical aspect of the therapy.⁶⁷⁷ Apart from the fact that there is thus no conclusive information regarding the efficacy of the treatment to prevent HIV infection in persons with non-occupational HIV exposure (including sexual exposure), this dramatically reduced time frame is impossible in the sexual offence context because of the realities of criminal process.⁶⁷⁸

8.21.3 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.⁶⁷⁹ 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

673 See par 3.67 above.

674 Ibid.

675 See par 3.71 above.

676 Sadler 1992 *Washington Law Review* 212; *CDC Morbidity and Mortality Weekly Reports* 25 September 1998 (Internet).

677 See par 3.64 above.

678 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.

679 See the comments in par 12.7 below.

at private establishments for victims who can afford the treatment.⁶⁸⁰ Because of the cost involved PEP would thus not be available to most victims of sexual offences in our country.⁶⁸¹ 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.⁶⁸²

Women's international and constitutional rights, including rights as victims of crime

8.22 Violence against women and children has reached epidemic levels in South Africa and takes many forms - including rape, incest, indecent assault and child abuse.⁶⁸³ These crimes are perpetrated against women and girls by strangers, intimate partners, relatives or acquaintances. 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 prevent women from exercising their rights to equality.⁶⁸⁴ 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

680 In single instances PEP is made available to rape victims free of charge by state hospitals. For instance, at Groote Schuur Hospital, Cape Town it is provided as part of a pilot project aimed at research on prophylaxis after rape (see fn 384 above).

681 It is indicated in par 3.64 and 3.66.1 above that the cost of a starter pack and 28 days' supply of a two drug regimen would amount to R1 493,00 if the drugs are obtained directly from a pharmaceutical wholesaler.

682 **Beeld** 22 May 1999. At the time of compilation of this Report no details of such research has been made available by the government.

683 Wolhuter 1998 **THRHR** 443 et seq; Meintjies-Van der Walt 1998 **SACJ** 157-158; see also comment by the Tshwaranang Legal Advocacy Centre on **SALC Discussion Paper 80** 2-3.

684 Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW) Recommendation 19 (see par 9.8-9.9 below). See also comment by the Tshwaranang Legal Advocacy Centre on **SALC Discussion Paper 80** 2-3; Wolhuter 1998 **THRHR** 443-444; Albertyn (Unpublished [Internet]); and par 9.2-9.11 below where international human rights instruments relevant to the current enquiry are discussed.

reality.⁶⁸⁵

- 8.23 As indicated in Chapter 9 below, during the last decade gender-based violence⁶⁸⁶ has received increasing attention in international human rights law, with concomitant emphasis 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),⁶⁸⁷ the United Nations Convention on the Rights of the Child 1989,⁶⁸⁸ and the Southern African Development Countries (SADC) Declaration on Gender and Development 1997.⁶⁸⁹ These instruments emphasise the principles of equality between women and men;⁶⁹⁰ of protection of women and children from all forms of physical violence, including sexual violence,⁶⁹¹ and of ensuring justice and fairness to both the victim and the arrested person in cases of sexual violence.⁶⁹²
- 8.24 International law may also be important in the interpretation of the fundamental rights entrenched in the 1996 Constitution.⁶⁹³

8.24.1 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 and another**.⁶⁹⁴

... 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

685 See par 2.4 et seq above.

686 "Gender-based violence" has been defined as "any act ... that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (Hirschowitz et al 5).

687 See par 9.8-9.9 below.

688 See par 9.10 below.

689 See par 9.11 below.

690 See par 9.8 below.

691 See par 9.9 and 9.10 below.

692 See par 9.11 below.

693 Cf sec 39(1)(b) of the 1996 Constitution; **SALC Research Paper on Domestic Violence** 17-18.

694 1997 (6) BCLR 759 (CC) par 26.

rule of law and the fundamental premises of the constitutional state ...
Moreover, section 9(3) provides that -

(T)he state may not unfairly discriminate 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.⁶⁹⁵ 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 (referring specifically to women and girls) should receive precedence over arrested persons' right to privacy.⁶⁹⁶ 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.⁶⁹⁷

8.24.2 Section 12(1)(c) of the 1996 Constitution provides that "(E)veryone 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.⁶⁹⁸ In this respect international human

695 Cf **SALC Research Paper on Domestic Violence** 17.

696 See par 5.2 et seq above and par 8.25 et seq below on privacy rights.

697 See the United States Supreme Court decision in **People v Adams** 579 NE 2d 574, 583 (Ill 1992). Cf also par 5.2.3 above where the Constitutional Court's approach of confining claims to privacy to aspects in regard to which a "legitimate expectation" of privacy can be harboured, is reflected.

698 Cf **SALC Research Paper on Domestic Violence** 18.

rights jurisprudence holds that states have certain positive duties to establish and maintain the necessary legal and extra-legal institutions and remedies through which human rights can be guaranteed.⁶⁹⁹ 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.⁷⁰⁰ 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,⁷⁰¹ and since the right to equality is the foundation of the right to freedom from violence,⁷⁰² 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.⁷⁰³ 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.⁷⁰⁴ Proponents hold that legislative intervention for the compulsory HIV testing of arrested persons would serve this purpose.

8.25 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.⁷⁰⁵

8.25.1 Victims' rights would inter alia include the constitutional rights of equality before

699 **Velasquez Rodriguez** Case Judgement of 27 July 1988, Inter-American Court of Human Rights, Ser C, Vol 4 paragraph 166.

700 "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).

701 Cf the 1996 Constitution sec 9(2).

702 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".

703 Cf Albertyn and Goldblatt 1998 **SAJHR** 464 et seq. Cf also **SALC Research Paper on Domestic Violence** 18 et seq.

704 Ibid. Cf also Albertyn (Unpublished [Internet]).

705 See comment by the Tshwaranang Legal Advocacy Centre on **SALC Discussion Paper 802-3**. See also the comments in par 12.6 below.

the law and the right to equal protection by the law;⁷⁰⁶ the right to life;⁷⁰⁷ and the right to bodily integrity.⁷⁰⁸ 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,⁷⁰⁹ current victim-support strategies in our country are inadequate.⁷¹⁰ 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.⁷¹¹

8.25.2 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.⁷¹² This is a fallacious and dangerous belief.⁷¹³ 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 and for recognition of the fact that crime does harm to victims.⁷¹⁴ Proponents maintain that legislative intervention aimed at compulsory HIV testing of arrested persons would constitute a much needed recognition of

706 The 1996 Constitution sec 8(1).

707 Ibid sec 11.

708 Ibid sec 12(2).

709 See par 9.5 below.

710 Meintjies-Van der Walt 1998 **SACJ** 158; **SALC Issue Paper 7** par 4.2; see also par 9.5-9.6 below.

711 See par 9.5 below for more detail on the Declaration.

712 Meintjies-van der Walt 1998 **SACJ** 158-159.

713 Cf Cameron 1997 **SALJ** 504 et seq.

714 See par 2.17 above. See also Meintjies-van der Walt 1998 **SACJ** 158-159.

victims' rights in the area of sexual violence without substantial inroads into arrested persons' rights.⁷¹⁵

The arrested person's constitutional rights, especially the right to privacy

- 8.26 As indicated in Chapter 5 above, the right to privacy is protected by both the common law and the 1996 Constitution.⁷¹⁶ 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*).⁷¹⁷ It is clear from the information supplied in Chapter 5 that compulsory subjection to a medical examination would constitute an interference with privacy rights. So would disclosure of AIDS-related information without the consent of the person concerned.⁷¹⁸ Compulsory HIV testing of arrested persons and the disclosure thereafter of the test results to victims of sexual offences would thus represent a considerable intrusion into the privacy rights of such persons.⁷¹⁹ Privacy rights are however not absolute and other interests may justify or necessitate its limitation.⁷²⁰
- 8.27 Opponents of compulsory testing submit that tests for HIV are different from other medical tests.⁷²¹ They maintain that such tests are considerably more disturbing because of the implications of a positive test result in respect of nearly every aspect of a person's life: it can for instance affect the ability to be employed and insured, it can

715 See par 8.26-8.29.1 below on the arrested person's constitutional rights.

716 Par 5.2-5.10.2 above.

717 Par 5.2 and 5.6 above.

718 Par 5.4 and 5.9 above. See also Strauss 3-13; Clark in **Polisiëring en Menseregte** 265; **SALC Second Interim Report on Aspects of the Law relating to AIDS** par 5.11 et seq.

719 See also Jürgens 175.

720 See the discussion on the limitation of privacy rights in par 5.5-5.5.2 and 5.10-5.10.2 above.

721 Sadler 1992 **Washington Law Review** 207 et seq; Jackson in **AIDS Agenda** 245; Robling 1995 **Cleveland State Law Review** 674-686.

disrupt personal relationships and lead to immeasurable psychological distress.⁷²² Compelling arrested persons to undergo HIV tests may impose upon them, prematurely and inopportunistly, invasive decisions and knowledge regarding their bodily integrity which they do not want to know at all.⁷²³ Moreover, the social ramifications of disclosure of HIV status to third parties may be devastating as AIDS carries with it a tremendous degree of social stigmatisation and can lead to intense discrimination against persons with HIV.⁷²⁴ Opponents argue that these interests should be weighed against the health concerns and psychological needs of rape and sexual offence victims. They concede that to provide victims with worthwhile information about whether they may have been exposed to HIV is a logical and human course of action. But they submit that, for various scientific and practical reasons (which have been discussed in detail in paragraphs 8.9 to 8.21.3 above), HIV testing of arrested persons lacks utility and therefore does not serve the interests of victims of sexual offences.⁷²⁵

8.27.1 Proponents however maintain that limitation of the arrested person's privacy rights through compelled HIV testing is justified because of the particular characteristics of rape and sexual assault which distinguish it from other situations involving possible exposure to HIV.⁷²⁶ They argue that victims of sexual offences in no sense consented to the behaviour that caused their potential exposure to HIV. Rape or sexual assault represents a violation and a harm to victims which assailants have a duty to limit. Moreover, rape and other forms of sexual assault cause *ongoing* harm to victims, (including the fear of HIV infection). Proponents emphasise that victims bear the sole burden of limiting

722 Ibid; Leary and Schreindorfer in **HIV & Social Interaction** 21-25. See also par 5.7 and 8.9.1 above.

723 See par 5.7 above. Cf also **UNAIDS Policy on HIV Testing and Counselling 1997** par 5. 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 and others v Bester NO and others** 1996 (4) SA BCLR 449 (CC). See also par 5.7 and 8.9.1 above.

724 Sadler 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.

725 Sadler 1992 **Washington Law Review** 209-211.

726 Other situations involving possible exposure to HIV include consensual sexual intercourse; or occupational exposure in the course of voluntary employment in the health care setting (Gostin et al 1994 **JAMA** 1439; Jürgens 171).

future harm to themselves, sexual partners and family members⁷²⁷ which can postpone or limit recovery from rape or other forms of sexual assault.⁷²⁸ They firmly believe that fairness dictates that the risks and burdens of limiting future harm should not rest solely with victims of sexual offences and submit that it would be in the public interest to test arrested persons for HIV without their consent in order to ease the burden of unfairness.⁷²⁹

8.28 Opponents also hold the view that overuse and abuse of any statutory intervention for compulsory HIV testing pose a potential invasion of arrested persons' privacy. They argue that victims' requests for information regarding an arrested person's HIV status could create an opportunity for individuals to claim that they were sexually assaulted as a way of discovering the HIV status of a sexual partner or other person.⁷³⁰ This could result in overuse and abuse of any statutory process created, which 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.⁷³¹

8.28.1 Proponents on the other hand submit 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. They believe that 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 possible overuse or abuse of a process of compulsory HIV testing.⁷³²

727 Eg where victims are pregnant or are breast-feeding.

728 See also par 8.14 et seq above.

729 Gostin et al 1994 **JAMA** 1439; Jürgens 171.

730 Field 1990 **AMJLM** 102-103; **Los Angeles Times** Washington Edition 1 October 1994 (Internet).

731 Ibid.

732 Gostin et al 1994 **JAMA** 1441-1443.

8.29 Opponents also suggest that statutory intervention for compulsory HIV testing fails to meet the criteria for limitation of constitutional rights⁷³³ particularly in that they believe that there are less intrusive measures to provide support and assistance to victims of sexual offences in protecting their own and others' health.⁷³⁴ These would include victims abstaining from sexual intercourse, using condoms or resorting to safer sex practices to protect sexual partners; victims delaying pregnancy and avoiding breast-feeding to protect offspring; and the government offering free HIV testing and counselling to victims of sexual offences.⁷³⁵

8.29.1 Proponents however reject these measures. They submit that the suggested alternatives are more burdensome for victims in that they would entail substantial behaviour changes, some risk for others⁷³⁶ and costs (both personal and financial) including alteration of life plans.⁷³⁷ They believe that the alternatives proposed by opponents would do nothing to ease the unfairness inherent in requiring the victim to bear the burden of prolonged uncertainty and possible alternations in life plans because of the possibility of having been exposed to HIV.⁷³⁸ As regards the provision of support services in the form of free HIV testing and counselling of victims, proponents moreover maintain that such services should in any event be supplied to victims and should, in addition to compulsory testing, be sought to protect victims more effectively as part of a comprehensive and holistic victim support program.⁷³⁹ They also point out that immediate post assault testing of victims will be of limited usefulness for

733 The criteria for limitation of constitutional rights are set out in par 5.5, 5.5.2 and 5.10.2 above.

734 Gostin et al 1994 **JAMA** 1441; Jürgens 175-179.

735 Ibid.

736 Eg the possibility of HIV transmission and of pregnancy resulting from improper use of condoms; and the unknown long-term effects of prenatal zidovudine treatment of infants if victims have been pregnant before the attack or become pregnant as a result of the attack (Gostin 1994 **JAMA** 1441; Jürgens 175-176).

737 Such as delaying parenthood, marriage, or sexual relationships (cf the arguments referred to by Jürgens 175-176).

738 Jürgens 172, 175-176.

739 See par 12.10 below.

medical or psychological purposes primarily because it will not indicate whether the victim has been exposed to HIV during the rape or sexual assault or whether he or she is likely to become infected.⁷⁴⁰

740 Gostin et al 1994 **JAMA** 1438. (A victim will have to wait the minimum six to twelve-week period for conclusive results on a personal HIV test [if conventional testing is used] to ascertain whether he or she has contracted HIV during rape or sexual assault. Although certain sophisticated tests could reduce the window period, they are either not normally used for determining HIV status, or they are considerably more expensive than conventional tests [par 3.4 et seq above]. See also par 8.12 et seq for information on the utility of HIV testing of arrested persons for victims' physical and mental health.)

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, Namibia and Botswana) are also set out below.

Relevant 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 they 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;⁷⁴¹ the United Nations Convention on the Elimination of all Forms of Discrimination Against Women 1979 [CEDAW];⁷⁴² and the United Nations Convention on the Rights of the Child 1989⁷⁴³) as well as persuasive guidelines (eg in the case of the United Nations International Guidelines on HIV/AIDS and Human Rights 1996;⁷⁴⁴ and the Southern African Development Countries [SADC] Declaration on Gender and Development 1997).⁷⁴⁵

741 See par 9.5 below.

742 See par 9.8 below.

743 See par 9.10 below.

744 See par 9.3 below.

745 See par 9.11 below.

International instruments on HIV/AIDS

- 9.3 The United Nations in 1997 adopted **International Guidelines on HIV/AIDS and Human Rights**⁷⁴⁶ 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.⁷⁴⁷ The essential conclusion underlying the Guidelines is that public health interests need not conflict with human rights of those at risk of infection.⁷⁴⁸ 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.⁷⁴⁹
- 9.3.1 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.⁷⁵⁰ Exceptions to voluntary testing would need specific judicial authorisation, granted only after due evaluation of the important considerations involved in terms of privacy and liberty.⁷⁵¹

746 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.

747 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 1996** 1-4, 60-61).

748 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 5.

749 Ibid 39-40, 58-61.

750 Ibid 12-13.

751 Ibid 12.

9.3.2 However, the Guidelines also provide that although certain rights are non-derogable and cannot be restricted under any circumstances,⁷⁵² international human rights law, under narrowly defined circumstances, allows States to impose restrictions on some rights if such restrictions are necessary to achieve overriding goods, such as public health, the rights of others, morality, public order, the general welfare in a democratic society and national security. For such restrictions to be legitimate, a state must establish⁷⁵³

- ! that 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);
- ! that they are based on a legitimate interest, as defined in the provisions guaranteeing the rights;
- ! that they are proportional to such legitimate interest; and
- ! that they constitute the least intrusive and least restrictive measures available and actually achieve such legitimate interest in a democratic society (i.e. they should be established in a decision-making process consistent with the rule of law).

9.3.3 Governments are specifically urged to promote a supportive and enabling environment for women and children by addressing underlying prejudices and inequalities.⁷⁵⁴ Positive measures, including support services should be established in relation to violence against women and sexual abuse.⁷⁵⁵ The Guidelines further point out that international human rights obligations essential to effective state responses to HIV/AIDS would inter

752 In this regard the Guidelines list the right to life; to freedom from torture; to freedom from enslavement or servitude; to protection from imprisonment for debt; to freedom from retroactive penal laws; to recognition as a person before the law; and to freedom of thought, conscience and religion (**United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 42-43).

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

754 **United Nations International Guidelines on HIV/AIDS and Human Rights 1996** 22-24 (Guideline 8).

755 Ibid 23.

alia include the elimination of all forms of discrimination against women, and the right to share in scientific advancement and its benefits.⁷⁵⁶ 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,⁷⁵⁷ 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.⁷⁵⁸ 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.⁷⁵⁹

9.3.4 The Guidelines are the product of the Second International Consultation on HIV/AIDS and Human Rights initiated by the United Nations Office of the High Commission for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS),⁷⁶⁰ 1996 in which South Africa was a participant.⁷⁶¹ They were issued in response to a call for guidelines that outline clearly how human rights standards apply in the area of HIV/AIDS. It was envisaged that one of the principal users of the Guidelines would be legislators and government policy makers.⁷⁶²

9.4 The **International Partnership against AIDS in Africa** was forged in July 1999 between 20 African countries (including South Africa) and certain UNAIDS cosponsors to intensify the response to AIDS in Africa. The vision of the Partnership is that within the next decade African nations will be implementing larger-scale, sustained and more effective national responses to HIV and AIDS. Through collaborative efforts and promotion and protection of human rights, countries will substantially reduce new HIV infections, provide a continuum of care for those infected and affected by HIV/AIDS, and mobilise

756 Ibid 41-42.

757 Ibid 44-45.

758 Ibid 49.

759 Ibid.

760 See fn 25 for information on UNAIDS.

761 Ibid v, 62.

762 Ibid v-vi.

communities, non-governmental organisations, the private sector, and individuals to counteract the negative effects of the epidemic in Africa.⁷⁶³ Amongst others the Partnership in particular calls for the strengthening of the status of women through legal and other means to reduce their vulnerability to HIV/AIDS.⁷⁶⁴

International instruments relating to victims' rights

9.5 South Africa is a signatory to the **United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power 1985**. The Declaration inter alia refers to four levels at which victims⁷⁶⁵ 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.⁷⁶⁶
- ! 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.⁷⁶⁷
- ! Offenders should, where appropriate make fair restitution to victims. Such restitution should include the provision of services and the restoration of rights.⁷⁶⁸
- ! 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

763 **International Partnership Against AIDS in Africa 1999.**

764 Policy Area 10 as referred to in Albertyn (Unpublished [Internet] 38).

765 The Declaration 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 1985** par A1).

766 **United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power 1985** par A4.

767 Ibid par A6(b).

768 Ibid par A8.

a result of serious crimes.⁷⁶⁹

- ! Victims should receive the necessary material, medical, psychological and social assistance through government, voluntary, community-based and indigenous means.⁷⁷⁰
- ! Victims should be informed of the availability of health and social services and other relevant assistance and be readily afforded access to them.⁷⁷¹
- ! Police, justice, health, social service and other personnel concerned should receive training to sensitise them to the needs of victims and be provided with guidelines to ensure proper and prompt aid.⁷⁷²
- ! 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.⁷⁷³

9.6 The South African Law Commission pointed out in its 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 victims of crime is inadequate and only limited services are at present being provided to victims.⁷⁷⁴ 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.⁷⁷⁵

769 Ibid par A12(a).

770 Ibid par A14.

771 Ibid par A15.

772 Ibid par A16.

773 Ibid par A17.

774 **SALC Issue Paper 7** par 3.14. See also the subsequent **SALC Discussion Paper 91** which further addresses these issues.

775 **SALC Issue Paper 7** par 4.2.

International instruments relating to violence against women and children

- 9.7 During the last decade "gender-based violence"⁷⁷⁶ has received increasing attention in international human rights law, with concomitant emphasis on the determination of state obligations to address such 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 entrenched in the 1996 Constitution.⁷⁷⁷
- 9.8 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 CEDAW undertake to condemn all forms of discrimination against women.⁷⁷⁸ 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.⁷⁷⁹ 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.⁷⁸⁰ Women and men must have equal access to health care.⁷⁸¹ Finally, the law must treat women and men equally.⁷⁸²

776 See fn 783 below.

777 Cf **SALC Research Paper on Domestic Violence** 10-11.

778 **CEDAW** art 2.

779 *Ibid* art 3.

780 *Ibid* art 5.

781 *Ibid* art 12.

782 *Ibid* art 15.

- 9.9 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 1.⁷⁸³
- 9.10 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;⁷⁸⁴ and further, to protect the child from all forms of sexual abuse.⁷⁸⁵
- 9.11 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;⁷⁸⁶ and providing easily accessible information on services available to women and children victims or survivors of violence.⁷⁸⁷

Experience in other legal systems

United States

-
- 783 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 in **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" (**CEDAW** art 1).
- 784 **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).
- 785 **United Nations Convention on the Rights of the Child 1989** article 34.
- 786 **SADC Declaration on Gender and Development 1997** par 12.
- 787 Ibid par 21.

9.12 In the United States there is currently no federal law requiring *alleged* sexual offenders to be tested for HIV. Federal law however 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.⁷⁸⁸ Five elements are to be met in such legislation.⁷⁸⁹

- ! 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 need not be met if the state statute allows any avoidance of the testing process.
- ! The state statute must provide for an agency of the state to authorise the HIV test although the actual physical testing may be delegated to another, such as a physician, laboratory etc. Typically, the state statute would provide 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 act⁷⁹⁰ 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; 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.

9.13 In an attempt to alter the current federal position as regards testing of *alleged* sexual

788 42 USC sec 3756(f); see also Gostin et al 1994 **JAMA** 1439; and Jürgens 173.

789 Ibid; see also **US Department of Justice Information** (Internet).

790 "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 sec 3756(f)(3) read with 18USC sec 2246(2)).

offenders, two Bills were recently proposed in the House of Representatives. Neither has however been enacted yet.

- 9.13.1 The HIV Prevention Bill was proposed in March 1997.⁷⁹¹ The Bill required that states should enact legislation for the compulsory HIV testing of *criminal defendants*⁷⁹² in cases of sexual activity where force or threats of force were involved.⁷⁹³ The Bill in particular provided that states require that a criminal defendant 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.⁷⁹⁴ Further, that the defendant should undergo the test not later than 48 hours⁷⁹⁵ 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 defendant (or his or her legal guardian if he or 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.⁷⁹⁶ 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 any follow-up tests be disclosed to the victim.⁷⁹⁷ 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.⁷⁹⁸ Representative Tom Coburn who introduced the Bill indicated that the main motivation for the provisions referred to above is the availability of treatment therapies to avert sero-conversion.⁷⁹⁹ The Bill (which also covered other aspects such as national partner notification and HIV testing of patients) was not

791 HIV Prevention Bill (105th Congress 1997 HR 1062). (The Bill is also known as the "Coburn HIV Prevention Bill" having been introduced by Representative Tom Coburn.)

792 "Criminal defendant" presumably refers to persons *charged* (as opposed to persons *convicted*).

793 HIV Prevention Bill clauses 3(a)(3)(A), (B), and (D).

794 Ibid.

795 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.

796 HIV Prevention Bill clause 3(a)(3)(B).

797 Ibid clause 3(a)(3)(C).

798 Ibid clause 3(a)(3)(D). This is allowed on condition that the defendant continues to be the defendant in the judicial proceedings involved, or is convicted in the proceedings.

799 Burr **POZ** July 1997 (Internet).

enacted⁸⁰⁰ because of vigorous opposition.⁸⁰¹

9.13.2 In October 1999 the Victims of Rape Health Protection Bill was introduced.⁸⁰² The Bill contains provisions regarding compulsory HIV testing of defendants in sexual offence cases which do not differ significantly from those of the HIV Prevention Bill of 1997.⁸⁰³ The Bill was approved by the House of Representatives on 2 October 2000. (At the time of compilation of this Report the Bill has not been passed by the United States Senate.)

9.14 As of 1994, 32 states explicitly authorised compulsory HIV testing in the criminal context.⁸⁰⁴

9.14.1 However, the provisions of these state statutes vary widely in form and detail on the following aspects: the stage of the criminal process when the person can be tested (i.e. pre- or post conviction); 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.⁸⁰⁵ In some states only the victim and the person tested receive the test results while in others the victim as well as spouse(s) of the person tested receive the results.⁸⁰⁶

800 Information supplied to the researcher by Ms Sarah Lightbown (AIDS Action New York) and Mr Roland Foster (Legislative Director of Rep Tom Coburn) on 10 August 2000.

801 See eg **ACLU News** 1 August 1996 (Internet); **AIDS Action Analysis** 21 April 1997 (Internet); **ACLU News** 29 September 1998 (Internet); **ACTUP Report** 23 March 2000 (Internet).

802 Victims of Rape Health Protection Bill (106th Congress 1999 HR 3088).

803 Ibid, section 2. (The Bill does not directly mandate compulsory HIV testing of defendants in sexual offence cases, but provides incentives for states to enact such legislation: The Byrne Grant Programme provides financial assistance to states for crime fighting activities. The Victims of Rape Health Protection Bill provides that a state would lose 10% of their Byrne grant if they do not adopt legislation as suggested in the Bill.)

804 **HIV Insite** "State Restrictions on Persons" (Internet); Jürgens 173.

805 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 or alleged sexual offenders, the test result may be disclosed to the victim. Four states also provided funding for testing or counselling of victims (Gostin et al 1994 **JAMA** 1439-1440; **AIDS Practice Manual** 13 par 10; Edgar and Sandomire 1990 **AMJLM** 194-196; Jürgens 173).

806 **US Department of Justice Information** (Internet); **AIDS Practice Manual** 13 par 9.

9.14.2 Moreover, the courts' interpretations of these statutes vary from state to state:⁸⁰⁷ Despite complaints that compulsory testing violates the privacy rights of criminal defendants (i.e. accused persons), many courts have upheld such testing as constitutional.⁸⁰⁸ 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.⁸⁰⁹ It has also been held that fairness dictated compulsory HIV testing to help mitigate the plaintiff's emotional suffering.⁸¹⁰ Several courts however, have limited states' ability to test criminal defendants.⁸¹¹ 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.⁸¹²

9.14.3 Existing American literature on HIV testing after sexual assault is divided as to whether or not compelled testing of the criminal defendant is justified.⁸¹³ Many of the above

807 Jürgens 173; **HIV Insite** "State Restrictions on Persons" (Internet).

808 See eg **People v Wealer** 642 NE 2d 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 **HIV Insite** "State Restrictions on Persons" (Internet).

809 **HIV Insite** "State Restrictions on Persons" (Internet).

810 **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's right to privacy (**HIV Insite** "State Restrictions on Persons"[Internet]).

811 See eg **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 **HIV Insite** "State Restrictions on Persons" [Internet]).

812 **In re Michael WW** 616 NYS 2d 480 (NY 1994). See also **HIV Insite** "State Restrictions on Persons" (Internet).

813 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

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.⁸¹⁴ In addition, statutes authorising testing of persons who have merely been *accused* of a crime met with strong opposition.⁸¹⁵ On the other hand the usefulness of knowing the accused's sero-status in mitigating the ongoing harm to the survivor (or victim) and others (particularly the psychological benefit and the potential protection of the survivor's partner and future children) has been emphasised.⁸¹⁶

9.15 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,⁸¹⁷ no official guidelines regarding the provision of these drugs to victims of sexual assault exist in the United States.

9.15.1 The Centers for Disease Control (CDC)⁸¹⁸ in September 1998 published a Report on

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 (par 9) - 13 (par 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 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).

814 **AIDS Practice Manual** 3 (par 9), 13 (par 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).

815 **AIDS Practice Manual** 3 (par 9).

816 Gostin et al 1994 **JAMA** 1443.

817 Cf par 3.73 above.

818 See fn 349 above.

management of possible sexual or other non-occupational exposure to HIV to address concerns in this regard.⁸¹⁹ The Report emphasised that as no data exist regarding the efficacy of drug therapies to prevent HIV infection in persons with non-occupational 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 (PEP) for sexual exposure.⁸²⁰ 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 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.⁸²¹ 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.⁸²² It was firmly stated that PEP should never be administered routinely or solely at the request of a patient - it is a complicated medical therapy, not a form of primary HIV prevention.⁸²³

United Kingdom

9.16 The United Kingdom has currently no legislative provisions aimed at the compulsory HIV testing of sexual offenders.

9.17 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.⁸²⁴ The Commission proposed legislation

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

820 Ibid.

821 Ibid.

822 Ibid.

823 Ibid. For more detail on the CDC Report see par 3.72 above.

824 **Law Commission Report No 218** 1993 par 15.17. See also **SALC Discussion Paper 80** par 6.13 and the sources quoted there.

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.⁸²⁵ HIV testing of offenders was not provided for in this proposed restatement of the law.

- 9.18 Enquiries regarding government policy on the provision of prophylaxis for victims of sexual assault showed that there is no formal protocol in this regard in the United Kingdom.⁸²⁶ This was confirmed in recent official guidelines on the administration of PEP after occupational exposure to HIV in the health care setting: Due to lack of any evidence of efficacy, the Department of Health was not prepared to recommend the use of PEP outside the occupational exposure context.⁸²⁷ It was suggested that in the case of possible exposure during rape, expert advice should be sought urgently from a physician experienced in the treatment of HIV and the use of PEP, and that a risk assessment should be made based on the circumstances of the individual case. Attention was specifically drawn to the fact that in coercive circumstances such as rape, scant (if any) detail may be available about the source person. This lack of information would make it difficult to tailor a specific PEP regimen to the exposed victim, increasing the risk of infection with a drug resistant strain of HIV in the event of PEP failure - especially where adherence to the drug regimen is sub-optimal.⁸²⁸ The United Kingdom Department of Health advised that the initiation of PEP after non-occupational exposure could be more beneficial in situations where the risk of HIV transmission is considered high, the exposure is considered unlikely to be repeated, PEP can be started promptly, and good adherence to the prescribed drug regimen is considered likely.⁸²⁹

Australia

825 See **SALC Discussion Paper 80** par 6.13 and the accompanying footnotes for more information.

826 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.

827 **PEP: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS** July 2000 19.

828 Ibid.

829 Ibid 20.

9.19 In Australia the federal government's HIV/AIDS Strategy (or White Paper) in 1989 recommended compulsory HIV testing inter alia in the following circumstances:⁸³⁰

- ! Where a person is charged with having committed a sexual offence and the alleged victim requests testing.
- ! Where HIV testing of a person is necessary to decide on the urgent medical treatment of another person.
- ! 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 this a way.

According to the White Paper compulsory testing under the above circumstances should only occur as a last resort and be ordered by a court sitting in camera using the following criteria:⁸³¹

- ! HIV 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.
- ! In the case of rape, a court should also take into account the availability of a proven prophylactic treatment, such as zidovudine (AZT).

The White Paper noted that in the case of rape blood may have already been taken for other purposes⁸³² and that the court could then order testing of the existing blood sample. It was further recommended that if a person refused to obey a court order for compulsory testing he or she would be in contempt of court.⁸³³

9.20 In 1991 the issue of compulsory HIV testing was reviewed by the Legal Working Party of the Intergovernmental Committee on AIDS. The review revealed that only in New South Wales and South Australia provision has been made in public health laws for court-ordered compulsory HIV testing in instances of persistent HIV-related behaviour placing others at risk of infection. The Working Party concluded that there was a need for clear and structured criteria to be contained in public health legislation country-wide, together

830 **Australia Discussion Paper Public Health 27.**

831 Ibid.

832 Presumably evidentiary purposes.

833 **Australia Discussion Paper Public Health 27.**

with procedural safeguards such as notice, reasons for decision, opportunity to be heard, and notification of review rights.⁸³⁴ 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.⁸³⁵

- 9.21 HIV testing in a criminal context is currently addressed by legislation in only one Australian state - Tasmania. The HIV/AIDS Preventive Measures Act 25 of 1993 inter alia provides for compulsory HIV testing of persons charged with having committed crimes of a sexual nature - including rape and sexual assault.⁸³⁶ In terms of the Act the Secretary of the Department of Health may require a person charged under the Criminal Code 1995 with a crime of a sexual nature to undergo an HIV test.⁸³⁷ Where such person refuses to be tested, the Secretary may apply to a magistrate for an order requiring the person to oblige to testing.⁸³⁸ In determining whether to make 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.⁸³⁹ A magistrate may however not order HIV testing unless satisfied on the balance of probabilities that it is in the interests of public health.⁸⁴⁰ The person tested is to be informed of the test result.⁸⁴¹ A positive test result must also be relayed to the Secretary of the Department of Health.⁸⁴² Information regarding the test result may not be further disclosed without the written consent of the person tested except in specific circumstances listed in the Act. The latter includes disclosure to a court where the information is directly relevant to the proceedings before the court.⁸⁴³ A court may, in any proceedings, disclose information relating to the HIV status of a person if disclosure is

834 Ibid 28.

835 **Australia Final Report on AIDS** 4. See also par 9.19.

836 Cf Jürgens 173.

837 Sec 10(1).

838 Sec 11(1).

839 Sec 11(3).

840 Sec 11(4).

841 Sec 15(1).

842 Ibid.

843 Sec 19(1)(a) and (i).

necessary.⁸⁴⁴ The Act does not provide for disclosure of HIV-related information directly to victims of crime.

- 9.22 Our research revealed no official guidelines or policies regarding the provision of prophylaxis to victims of sexual offences in Australia.⁸⁴⁵ Although the New South Wales Health Department currently runs a trial PEP protocol for sexual exposure to HIV, the participants in this trial have acquired HIV mostly during consensual sexual intercourse.⁸⁴⁶ It needs to be remembered that in Australia 80-85% of cases of HIV are homosexually acquired.⁸⁴⁷ HIV transmissions through non-consensual intercourse in Australia are so few that this has not emerged as a public policy issue.⁸⁴⁸

Canada

- 9.23 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: There is no specific legislation authorising compulsory HIV testing of offenders or alleged offenders. Neither does existing general criminal legislation provide authority for such testing.⁸⁴⁹ Recent research and discussion

844 Sec 42. (The court may order that only specified persons may be present during such proceedings because of the social and economic consequences of disclosure to the person with HIV - sec 42(b)).

845 Information supplied by Adv David Buchanan SC, member of the AIDS Council of New South Wales on 9 April 1999. See also Correl et al **NSW Public Health Bulletin** July 2000 113 et seq.

846 Correl et al **NSW Public Health Bulletin** July 2000 113 et seq. (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 [information supplied and views expressed by Ms Cabassi on 13 April 1999]. Queensland Health has recently also introduced guidelines for the management of non-occupational exposure to HIV. The guidelines are based on the New South Wales protocol and do not expressly address the issue of PEP after exposure to HIV through rape or sexual assault (**Guidelines for the Management of Non-Occupational Exposure to HIV and HBV** June 2000).

847 Information supplied by Adv David Buchanan SC, member of the AIDS Council of New South Wales on 9 April 1999.

848 Ibid.

849 Jürgens 164-169; Canadian HIV/AIDS Legal Network **HIV Testing** Info Sheet 15.

on the issue also clearly rejected proposals for creating measures to provide for compulsory testing of sexual offenders.⁸⁵⁰

9.23.1 The issue of compulsory HIV testing of persons accused or convicted of sexual assault has been the subject of a significant amount of media attention, community discussion and political debate in Canada. In 1987 the National Advisory Committee on AIDS discussed, but rejected a proposal that persons accused or convicted of sexual assault likely to transmit HIV infection be tested on a compulsory basis for the presence of HIV.⁸⁵¹ The Committee instead recommended voluntary HIV testing under these circumstances.⁸⁵² In the 1990s the issue received renewed interest after wide media coverage of court cases dealing with it.⁸⁵³ The federal government came under considerable pressure to respond to victims' concerns that they may have become infected with HIV as a result of sexual assault, and a working group of the Interdepartmental Committee on Human Rights and AIDS was formed to investigate the issue.⁸⁵⁴ The Working Group in its 1994 Report concluded that compulsory testing of persons accused or convicted of sexual assault is misguided because -

- ! it does not provide reliable information about the risks of contracting HIV;
- ! it is an unrealistic approach to address a sexual assault survivor's needs;
- ! it perpetuates the misperception that information about an assailant's HIV status is critical to survivors' health;
- ! it does not facilitate a survivor's psychological recovery; and
- ! it sets a dangerous precedent for extending mandatory testing to others.⁸⁵⁵

850 Ibid.

851 Jürgens 164-165.

852 Ibid. See also Canadian HIV/AIDS Legal Network **Policy & Law Newsletter** 1997 (Internet).

853 See eg **R v Beaulieu** (Roberge J CQ Bedford [Cowansville] 455-01-000963-920, 1992-11-03 Decision No 92-1769 [Court of Québec]) where a request for HIV testing of the accused was refused; **R v JPB** ([1992] NWTJ No 207 [North West Territories Youth Court]) where a court granted an order for testing under specific provisions of the Young Offenders Act which provides that a court may impose on the young offender "such other reasonable and ancillary conditions as it deems advisable and in the best interest of the young person and the public"; and the more recent decision in **DC v Paul Bernardo et al** (Court File No 93-CQ46124 unreported decision of 23 September 1996) where the court ordered HIV testing of the convicted accused upon the order not being opposed by the accused. For a discussion of these cases see Jürgens 165 et seq.

854 Jürgens 168; Canadian HIV/AIDS Legal Network **Policy & Law Newsletter** 1997 (Internet).

855 Ibid.

It was instead recommended that the focus should be on providing the appropriate counselling and assistance to those who may have been exposed to HIV, and ensuring that persons who commit violent sexual crimes are brought to justice for the offences defined in the Criminal Code 1985.⁸⁵⁶ The Working Group in particular recommended that a best practices model of the kinds of counselling, short and long term care, treatment and other services that should be made available to sexual assault survivors be developed.⁸⁵⁷ The Canadian government accepted these recommendations and in 1998 produced a guide for counsellors working with women who are survivors of sexual violence.⁸⁵⁸

9.23.2 In examining the question whether this position should be changed, the Canadian AIDS Legal Network and AIDS Society in a 1998 Final Report on the issue again concluded that compulsory testing of persons *convicted* of sexual assault cannot provide the survivor with useful and reliable information and is therefore not justified.⁸⁵⁹ Further that, 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.⁸⁶⁰ This Report suggested that what is required 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 inter 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;⁸⁶¹ and access to PEP.⁸⁶² These views have been confirmed in a recent Information Sheet on HIV testing published by the Canadian HIV/AIDS Legal Network.⁸⁶³

856 Ibid.

857 Ibid.

858 HIV and Sexual Violence Against Women: A Guide for Counsellors Working with Women Who Are Survivors of Sexual Violence: Health Canada, March 1998 as referred to in Jürgens 169.

859 Jürgens 179.

860 Ibid.

861 See par 3.35 et seq above for information on PCR testing.

862 Jürgens 179.

863 Canadian HIV/AIDS Legal Network **Testing** Info Sheet 15.

- 9.24 As far as PEP is concerned, Health Canada recently noted that non-occupational PEP (without referring specifically to PEP after sexual assault) remains controversial for many reasons, including the considerable expenses of the medications and associated treatment.⁸⁶⁴ Other concerns include adverse effects on quality of life from medication toxicity, the potential for transmission of antiretroviral-resistant viruses, and potential unintended increases in risky behaviours among PEP users.⁸⁶⁵
- 9.25 Although no official protocols on PEP after sexual assault exist, PEP has become available for survivors of sexual assault in a few areas of the country (eg at the British Columbia Women's Hospital).⁸⁶⁶

Zimbabwe

- 9.26 In Zimbabwe the issue of testing of sexual offenders was recently addressed in draft legislation (the Sexual Offences Bill 1999) providing for the criminalisation of deliberate transmission of or exposure to HIV, and for specific sentences where the person convicted was infected with HIV.⁸⁶⁷ The proposed testing provision will apparently only operate for evidentiary purposes and more specifically for gathering evidence for

864 Elliot and Jürgens 33.

865 Ibid.

866 Jürgens 169. See also fn 380 above.

867 The Sexual Offences Bill 1999 is the amended version of the Criminal Law Amendment Bill 1996 (which was published for public comment in 1996). The Criminal Law Amendment Bill contained more or less similar provisions regarding the creation of an HIV-specific offence, HIV testing of the accused, and specific sentences where the convicted person was infected with HIV. At the time the Zimbabwean Minister of Justice expressed the hope that the legislation will be passed by Parliament and several women's organisations in Zimbabwe welcomed the proposals saying it was long overdue (**The Herald** 20 May 1997). Representatives from eight Zimbabwean non-governmental organisations concerned with human and women's rights, although opposed in comments on the Bill to the criminalisation of HIV transmission, 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 (comment on the Criminal Law Amendment Bill 1996 supplied to the researcher by Ms Lynde Francis of The Centre, Zimbabwe on 14 March 1998).

sentencing purposes.⁸⁶⁸ No provision is made for the result of an HIV test to be relayed to the victim of the sexual offence concerned.

9.26.1 The Bill makes it a criminal offence for any person, having actual knowledge that he or she has HIV, intentionally to do anything or permit the doing of anything which he or she knows or ought reasonably to know will infect another person with HIV; or is likely to lead to another person becoming infected with HIV.⁸⁶⁹ The Bill further provides that where a court *convicts* a person of a "sexual offence",⁸⁷⁰ it may direct that an appropriate sample (blood, urine or other tissue or substance) be taken from such person to ascertain whether he or she is infected with HIV.⁸⁷¹ In the event of a direction for testing being given, a medical practitioner or designated person⁸⁷² must take an appropriate sample if so requested in writing by a senior police officer.⁸⁷³ If necessary reasonable force may be used to take the sample, but a medical practitioner or designated person may also decline to take the sample if he or she considers taking it would be prejudicial to the health, proper care or treatment of the sexual offender.⁸⁷⁴ Any person who unreasonably hinders or obstructs the taking of the sample shall be guilty of an offence and liable to a fine not exceeding ten thousand dollars or imprisonment not exceeding two years or to

868 The provision authorising HIV testing only allows testing in respect of *convicted* persons. Clause 15 of the Sexual Offences Bill provides that a court shall sentence a person convicted of rape and certain other sexual offences to imprisonment for a period not exceeding twenty years whether or not the convicted person was aware of his or her HIV infection at the time of commission of the offence. For purposes of this provision it shall be presumed, unless the contrary is shown, that the convicted person was infected with HIV when the offence was committed if it is proved that the accused was infected with HIV within thirty days after committing the offence (clause 17(2)). It is further provided that the presence in a person's body of HIV antibodies detected through an appropriate test, shall be prima facie proof that the person concerned is infected with HIV (clause 17(1)).

869 Clause 14.

870 A "sexual offence" for purposes of this provision is defined as rape; sodomy; incest; indecent assault; extra-marital sexual intercourse or the commission of an immoral or indecent act with a young person or a severely intellectually handicapped person; non-consensual penetration of any part of another person's body with the male organ; non-consensual fellatio with another person; non-consensual cunnilingus with another person; the deliberate transmission of or exposure of another person to HIV; or an attempt to commit any of the above offences (clause 16(1)). Cf the Commission's use of the term "sexual offence" for purposes of this Report in par 2.24.3 above.

871 Clauses 16(2) and (4)(a).

872 Referring to a member of a class of persons designated for the purposes of this clause by the Minister of Health (clause 16(1)).

873 Clause 16(3).

874 Ibid.

both.⁸⁷⁵

9.26.2 At the time of compilation of this Report the Sexual Offences Bill 1999 has not yet been approved by the Zimbabwe government.⁸⁷⁶

9.27 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.

Namibia

9.28 There is no legislative provision for the compulsory HIV testing of persons accused or convicted of sexual offences in Namibia. Legislation passed recently to deal comprehensively with sexual offences also does not address this issue.

9.28.1 Following on a 1997 Report⁸⁷⁷ by the Law Reform and Development Commission, the Combatting of Rape Act 8 of 2000 was passed by the Namibian Parliament and came into operation on 5 June 2000.⁸⁷⁸ The Act 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 trauma for rape victims.⁸⁷⁹

9.28.2 The Act inter alia provides for a minimum sentence (fifteen years' imprisonment in the case of a first conviction and 45 years for a subsequent conviction) for any person who

875 Clause 16 (6).

876 Information provided by Mr A McMillan, Deputy Chairperson Law Development Commission, Zimbabwe on 7 June 2000.

877 **Namibia Report on the Law Pertaining to Rape.**

878 Government Notice 114 of 2000 in **Government Gazette** of the Republic of Namibia 2326 of 10 May 2000. Information on the date of commencement supplied by Mr AF Bampton, Law Reform and Development Commission, Namibia on 3 August 2000.

879 **Namibia Report on the Law Pertaining to Rape** 2-9; The Combatting of Rape Act 8 of 2000.

is convicted of rape⁸⁸⁰ and who knew that he or she was infected with "any serious sexually-transmitted disease" at the time of the commission of the rape.⁸⁸¹ It however contains no provision for HIV testing of persons accused or convicted of sexual offences or for the disclosure of such persons' HIV status to victims of sexual crimes.

- 9.29 Our research did not reveal the existence of any official protocols or guidelines on the provision of PEP to victims after sexual assault or rape.

Botswana

- 9.30 The Botswana Penal Code (Amendment) Act 1998 provides for the compulsory HIV testing of persons *convicted* of rape or the defilement of a person under the age of 16 years where HIV infection in the perpetrator was involved.⁸⁸² It is clear that these provisions are aimed at gathering evidence for sentencing purposes. No provision is made for disclosure of the HIV test results obtained to the victims of these crimes.

- 9.30.1 The Act provides that any person convicted of rape shall be required to undergo an HIV test before he or she is sentenced by the court.⁸⁸³ Any such person who tests positive for HIV shall be sentenced to a minimum of 15 years' imprisonment and a maximum of life imprisonment with corporal punishment where it is *proved* that he or she was *unaware* of being infected with HIV. If it is *proved that on a balance of probabilities* the perpetrator was *aware* of his or her infection, the prescribed minimum sentence rises to 20 years.⁸⁸⁴ In the case of a conviction for defilement of a person under the age of 16 years the Act likewise prescribes that the perpetrator shall be required to undergo an HIV

880 "Rape" refers to a sexual act committed intentionally under coercive circumstances by the perpetrator, or which the perpetrator causes another person to commit with him or herself or with a third person. The Act indicates what "coercive circumstances" might include without exhaustively defining such circumstances (section 2).

881 "Serious sexually-transmitted disease" is not defined by the Act.

882 Sec 3 and 8.

883 Sec 3(3).

884 Sec 3(4).

test before sentencing.⁸⁸⁵ The prescribed minimum and maximum sentences for defilement differ from that in respect of rape only in so far as the maximum penalty (whether the perpetrator was unaware or aware of his or her HIV positive status) may also be imposed *without* corporal punishment.⁸⁸⁶

- 9.31 As far as could be ascertained no official protocols or guidelines regarding the provision of prophylaxis to victims of rape or other sexual offences operate in Botswana.

885 Sec 8(2).

886 Sec 8(3).

10 Preliminary recommendations in Discussion Paper 84

Background

- 10.1 As indicated in Chapter 2⁸⁸⁷ above, the Commission on 8 September 1999 published a discussion document (Discussion Paper 84) containing preliminary recommendations and draft legislation dealing with compulsory HIV testing of persons arrested in sexual offence cases for public comment.
- 10.2 The preliminary recommendations in Discussion Paper 84 are set out in the following paragraphs. The draft legislation included in the Discussion Paper for public comment is attached as ANNEXURE A. Information regarding the response to the Paper and a summary and evaluation of the comments received, appear in Chapters 11 and 12 below.⁸⁸⁸

Discussion Paper 84

- 10.3 The Commission in Discussion Paper 84 arrived at the preliminary conclusion that legislation should be adopted to provide for the compulsory HIV testing of persons arrested in sexual offence cases.⁸⁸⁹

887 Par 2.21 et seq provides a brief overview of the research and consultation undertaken for this investigation.

888 See par 11.3 et seq for the general response to the Paper and the need for further consultation; and Chapter 12 throughout, for a summary and evaluation of the comments.

889 Par 10.2 of Discussion Paper 84.

- 10.4 In motivating this conclusion the Commission stated that 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 disclosure of such information. Furthermore, neither currently available public health law⁸⁹⁰ nor criminal procedure⁸⁹¹ makes provision for compulsory HIV testing of persons arrested for having committed sexual offences with a view to disclosing their HIV status to victims. The Commission expressed the view that statutory 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. It was submitted that 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 or her accuser to know whether he or she has HIV or any other life-threatening sexually transmitted diseases. Further, that 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. The Commission conceded that the arrested person's rights will be infringed, but indicated that this must be acknowledged and reflected in safeguards built into the process created.⁸⁹²
- 10.5 The Commission suggested that the proposed change to the law should be based on the following principles:⁸⁹³

890 The compulsory medical examinations (which would include HIV testing) currently provided for in the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions (Government Notice R 2438 in **Government Gazette** 11014 of 30 October 1987) and draft Regulations intended to replace these (Government Notice 703 in **Government Gazette** 15011 of 30 July 1993) conceivably provide for HIV testing but not for disclosure of the test results to third parties other than the health authorities (see Chapter 6 above).

891 Although sec 37 of the Criminal Procedure Act 51 of 1977 (the Criminal Procedure Act) 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 (see Chapter 7 above).

892 Par 10.1-10.2 and 10.4 of Discussion Paper 84. See also Chapter 8 above for an analysis of the arguments relevant to this debate.

893 Par 10.5 of Discussion Paper 84. See also par 10.7 below for the explanatory notes on the proposed legislation which further clarify these principles.

- ! Compulsory HIV testing of an arrested person should in principle be victim-initiated. This would 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" should include initiation of the testing process by both the victim or a person acting on his or her behalf.
- ! In order to protect the victim from a potentially further traumatising confrontation, the arrested person should not be allowed to take part or give evidence in the application by the victim, except to the extent of challenging whether information on oath has been placed before the magistrate in compliance with the prescribed provisions.
- ! A specified standard of proof should be required on which to base an order for compulsory testing. At the time the Commission was of the opinion that this should consist of the prosecution showing on a prima facie basis 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 should have been transferred from the assailant to the victim, or that the victim experienced traumatic injury with exposure to semen or blood). A deliberately false complaint would amount to perjury and a malicious activation of the procedure would be actionable.
- ! 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 compulsory testing; the existence of a deposition on oath; and prima facie evidence of a sexual offence in which exposure to the body fluids of the arrested person may have occurred.
- ! The procedure to be created should ensure confidentiality of the test results so as to ensure that the information is only provided 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 the process of compulsory testing should not be admissible as evidence in a criminal trial.
- ! The procedure need not necessarily be HIV specific. In the light of the existence of other life-threatening sexually transmitted diseases which could potentially be transmitted through rape and other sexual offences, the proposed amendment had 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 Commission indicated that it had at that stage not done specific research on other life-threatening sexually transmitted diseases and comment was specifically invited on whether compulsory testing should be extended to include such diseases.⁸⁹⁴

10.6 The Commission indicated that it reached the above conclusion after having considered other legal and policy interventions. These (which were rejected by the Commission) included the following:⁸⁹⁵

! ***Retaining the status quo***

The Commission pointed out that 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 submitted that the Department of Health indicated on 21 May 1999 that it would be initiating controlled research into post exposure prophylaxis (PEP).⁸⁹⁶ Should this research show that providing PEP to victims of sexual crimes will reduce the possibility of HIV infection, a national policy decision might be taken to provide PEP to all sexual offence victims. This would mean that legislative intervention for compulsory testing is no longer needed. The Commission however rejected this approach as it did not deal with the key issues at stake, namely providing victims with peace of mind regarding

894 Par 11.16 of Discussion Paper 84.

895 Par 10.3 of Discussion Paper 84.

896 See par 3.75.2 above and **Beeld** 21 May 1999.

their possible exposure to HIV. Scientific evidence also shows that PEP should not be administered as a matter of course.⁸⁹⁷ The Commission added that, considering the public outcry in the wake of prominent incidents of rape and gang rape in the 18 months preceding publication of its Discussion Paper, and the alarming increase of HIV infection in the population (which led to continuous pressure being placed on the government to amongst others provide HIV testing and PEP to rape victims at state cost), it appeared necessary to deal with this issue directly. More critically, there was no indication at the time that the government would indeed be in a position to provide PEP on a routine basis to all sexual offence victims.⁸⁹⁸

! *Developing and establishing a policy process aimed at the voluntary HIV testing of arrested persons and the voluntary disclosure of their HIV status to victims of sexual offences*

The Commission stressed that 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.⁸⁹⁹ If it is assumed that HIV testing of arrested persons indeed benefit victims, then voluntary testing of arrested persons could hold the same benefits - provided they consent to testing and the disclosure of the test results. The Commission however concluded that the disadvantage of voluntary testing is that arrested persons will control the process of testing and disclosure. They may also have little motivation to participate in a process to assist victims of crime. In addition, they may view their voluntary participation in any HIV testing process as an indirect admission of guilt.

897 Par 3.60 of Discussion Paper 84.

898 At the time of publication of Discussion Paper 84 the government had already rejected the possibility of providing zidovudine (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). At the time of compilation of this Report, the government has not yet introduced antiretrovirals to prevent mother to child transmission (Press Briefing by the Minister of Health, 13 August 2000).

899 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 Professions Council of S A Guidelines on HIV/AIDS** 1994 5). See also **S A Medical Association HIV/AIDS Ethical Guidelines** 1998 par 3.

- ! *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***⁹⁰⁰

The Commission indicated that such a response could include ensuring access to -

- P 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;
- P 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 side-effects;
- P governmental assistance in providing HIV/AIDS-related training of staff at sexual assault crisis centres and of other professionals who have contact with survivors of sexual offences.⁹⁰¹

The Commission at the time expressed the view that practice and policy guidelines would 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. It was also pointed out that the Commission (under its investigation into Sexual Offences) is currently doing research which may lead to in principle recommendations in this regard.⁹⁰²

- 10.7 The following explanatory notes, which further clarified the suggested intervention, accompanied the proposed Bill to facilitate comments (reference to clauses refers to clauses in the Bill in ANNEXURE A).⁹⁰³

- ! *Purpose of the proposed intervention***

900 This approach is favoured by Pithey et al (Unpublished) 154-155.

901 Cf Jürgens 179.

902 See **SALC Discussion Paper 85**. This Discussion Paper was distributed for comment during 1999. A draft Report is currently being compiled.

903 Par 11.1-11.16 of Discussion Paper 84.

The Commission indicated that the primary purpose of the proposed 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 to HIV during the attack. It was also the Commission's intent to protect the health of victims of crime and others by providing victims with information which may be important -

- P in deciding whether or not to take precautions to avoid spreading the virus to his or her sex partners;
- P to assist with decisions about what medical testing and treatment should be pursued to prevent possible infection with HIV; and
- P in the case of a pregnant woman who has been the victim of rape, to assist in making 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).

! *Placement of the proposed intervention in the Criminal Procedure Act 55 of 1977 (the Criminal Procedure Act)*

The Commission indicated that it seemed 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. It was envisaged that the proposed amendment would form an extension of this provision by providing for taking the arrested person's blood for non-evidentiary purposes in certain limited circumstances.

! *Reasons for limiting the proposed procedure to "arrested" persons (cf subclause (1) of clause 37A)*

The Commission indicated that for purposes of the debate in Discussion Paper 84 it had not considered the possibility of compulsory HIV testing of persons *convicted* of sexual offences to be a viable option.⁹⁰⁴ It was explained that in most cases the utility of testing would have disappeared by the time of a

904 See also par 8.5 above and 12.9 and 12.13.2 below on this issue.

conviction.⁹⁰⁵

! ***Reasons for limiting the proposed procedure to testing in cases of sexual offences*** (cf subclause (1) of clause 37A)

The Commission pointed out that its proposed provision was limited to cases where a person had been the victim of an alleged *sexual offence*. (A sexual offence may include rape, statutory rape, indecent assault, and incest.⁹⁰⁶) Further that, although the Commission recognises that in the criminal context HIV may be transmitted in ways other than through sexual acts,⁹⁰⁷ in view of the violent epidemic of rape and other sexual offences in South Africa the primary purpose of the proposed intervention was to provide peace of mind for victims of sexual violence. The Commission expressed the opinion that in cases of the alleged injection of HIV infected body fluid (of which there had been press reports)⁹⁰⁸ it could moreover not be certain whether the arrested person was 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.

! ***Reasons for requiring testing to be initiated by victims*** (cf subclauses (1) and (2) of clause 37A)

In order to limit the invasion into arrested persons' privacy, the proposed amendment was drafted in such a way that HIV testing could be authorised only if initiated by either the victim or a person acting on his or her behalf. The Commission stated that this was in line with the purpose of the proposed amendment which was aimed at compulsory testing of the accused primarily for the *victim's* peace of mind and future health. It was also emphasised that the proposed intervention did 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 was recommended in order to protect the victim from a potentially further traumatising confrontation with his or her alleged

905 Par 8.5 and 11.5 of Discussion Paper 84.

906 Par 2.18.2.3 of Discussion Paper 84.

907 For example through biting and fighting (refer to par 3.18-3.24 of Discussion Paper 84 for information on other ways of HIV transmission).

908 See par 3.24 of Discussion Paper 84.

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 administration of treatment to prevent possible HIV infection in the victim.

! ***Jurisdiction*** (cf subclause (3) of clause 37A)

The Commission indicated that subclause (3) of the proposed amendment was intended to facilitate easy and speedy access to the HIV testing procedure. The magistrate of the district in which the offence was alleged to have occurred or in which the victim resided, was provided with jurisdiction to grant the order for compulsory testing. This would allow victims to approach their closest court. Provision was also made that an application for testing should be considered "as soon as is reasonably practicable". The Commission envisaged that magistrates should be readily available to hear applications for compulsory testing on a similar basis as is the case with bail applications.

! ***Reasons for requiring judicial authorisation for testing*** (cf subclause (4) of clause 37A)

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 were provided for. In terms of subclause (4) of the proposed amendment the court was 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.

! ***Providing for confidentiality and limited disclosure*** (cf subclauses (6) and (7) of clause 37A)

The Commission emphasised that strict confidentiality provisions had been created within the proposed draft amendment so as to ensure that arrested persons' right to privacy was protected as far as possible. Subclause (6) provided 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. Moreover, it was proposed that an order for compulsory testing may not be carried out more than four months after the date upon which it was alleged that the offence in question took place.

This was in accordance with the primary purpose of the statutory intervention. After four months the utility of testing would have disappeared: The time within which PEP 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 sero-positivity was likely to show up on tests after a period of four months.

! ***Practical implementation of the court order*** (cf subclauses (4) and (8) of clause 37A)

Subclause (4) of the proposed amendment provided that the testing and disclosure will be undertaken by the local health authority and the court respectively. The Commission was 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 were provided with the power to promulgate policy to deal with these issues.

! ***The proposed intervention need not be HIV-specific*** (cf subclause (1) of clause 37A)

The Commission observed that HIV is a life-threatening sexually transmitted 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 was drafted so as to allow the victim to apply for the testing of the blood sample taken from the arrested person also for such diseases. It was indicated that the latter would include a disease such as viral hepatitis B.⁹⁰⁹ Finally, it was stressed that in this sense the proposed amendment had been broadly drafted so as to avoid the criticism of "AIDS exceptionalism".⁹¹⁰

909 Hepatitis 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* Hepatitis 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 **Survival News** May 1999 (Internet); Robson et al 1994 **SAMJ** 530-535).

910 "AIDS exceptionalism" refers to the phenomenon of singling out HIV/AIDS for special treatment which, it is argued, may draw undue attention to the issue and in turn promote more subtle discriminatory practices against persons with HIV and AIDS (cf **SALC Second Interim Report on Aspects of the Law**

11 Public consultation: Response to Discussion Paper 84 and subsequent input

- 11.1 This Chapter sets out the response to Discussion Paper 84,⁹¹¹ the need for further consultation and how this was attained.
- 11.2 Comments received on the preliminary recommendations in Discussion Paper 84 and during subsequent consultations with experts are summarised and evaluated in Chapter 12 below. Comments which relate to scientific (legal or medical) background are integrated in the relevant background information in the preceding Chapters.

Response to Discussion Paper 84

- 11.3 Discussion Paper 84 was distributed to more than 400 identified parties during September 1999. These included the prosecuting and adjudicating authorities (judges, regional court presidents, magistrates, directors of public prosecutions and various divisions of the South African Police Service [SAPS]); criminal law and criminal procedure experts; medical experts (including medical officers involved in forensic practice); non-governmental organisations concerned with human rights and HIV/AIDS issues; non-governmental organisations concerned with women's and children's rights, and violence against women and children (including Rape Crisis centres throughout the country); non-governmental organisations concerned with prisoners' rights; organisations involved in women's issues in general; the national and provincial Departments of Health; the Commissioner of Correctional Services; AIDS Training, Information and Counselling

911 See Chapter 10 above for more information on Discussion Paper 84.

Centres (ATICCs) throughout the country; the organised legal profession; and persons and bodies who responded to the Commission's previous discussion papers on HIV/AIDS issues, especially Discussion Paper 80 (The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour).

- 11.4 The release of Discussion Paper 84 was advertised in the **Government Gazette**⁹¹² and by way of a media statement.⁹¹³ As a result of this, copies of the Paper were also distributed to members of the general public.
- 11.5 The initial closing date for comments (15 October 1999) was extended to 30 October 1999 at public request. Comments received after the closing date and subsequent to the consultative meeting referred to below, are included in the analysis of comments in the next Chapter.
- 11.6 Sixty-two written submissions were received. They reflected a range of relevant interests as is evident from the list of respondents attached as ANNEXURE B. Some of the comments represented the views of interest groups of considerable extent while others were the views of private individuals, researchers, or small organisations. Amongst the responses were valuable comments from criminal procedure experts; the prosecuting and adjudicating authorities; prominent non-governmental organisations concerned with human rights and HIV/AIDS, and with women's rights respectively. The comments included written responses from six members of the public reacting to a talk show hosted by Radio 702 on 27 July 1999 where the principle of compulsory HIV testing was discussed (without the Commission's knowledge and prior to the release of the Discussion Paper); and comment in the printed media.⁹¹⁴ Comment was also provided by the Commission's Sexual Offences Project Committee at a joint meeting with the HIV/AIDS Project Committee on 18 October 1999.⁹¹⁵

912 Government Notice 1982 in **Government Gazette** 20410 of 3 September 1999.

913 The Discussion Paper was officially released by the Minister of Justice at a press conference on 8 September 1999.

914 Mr Lucky Mazibuko interviewed Mr Justice Edwin Cameron, project leader, prior to the release of Discussion Paper 84 and the **Sowetan** of 3 August 1999 carried the journalist's views on the principle of compulsory HIV testing of alleged sexual offenders.

915 Comment by Ms Bronwyn Pithey, member of the Commission's Sexual Offences Project Committee.

- 11.7 The Commission's preliminary proposal of enacting legislation to provide for the compulsory HIV testing of persons arrested in sexual offence cases received overwhelming support from respondents. The Project Committee interpreted this as clear confirmation for the need for such intervention, and decided to proceed with its intention as suggested in Discussion Paper 84. (Motivation for this decision appears in Chapter 12 below.⁹¹⁶)
- 11.8 Many respondents however raised concerns about in principle issues dealt with in the proposed legislation, and about issues related to the implementation and cost of the proposed procedure. In general these concerns either involved issues which were addressed in the proposed draft legislation and which commentators submitted should be revisited, or which were not addressed and which they argued should be provided for.

Consultative meeting with experts

- 11.9 The comments on Discussion Paper 84 indeed identified a need to further develop and improve the Commission's proposed draft Bill.⁹¹⁷ Because of the range of concerns raised in the comments (and especially the practical nature of some of these), the Project Committee decided to submit an amended draft Bill to experts from the relevant interest groups for further discussion and debate.
- 11.10 The draft Bill included in Discussion Paper 84 was redrafted, and draft Regulations were added to deal with certain practical issues raised by commentators. These, together with a list of issues identified for further deliberation, were submitted to 29 experts who attended a consultative meeting with the Project Committee on 4 February 2000. The issues identified for deliberation included:
- ! Issues of principle (eg whether HIV testing should be limited to exposure during

916 See par 12.5-12.6, and 12.11-12.13.4.

917 See ANNEXURE A for the proposed draft Bill included in Discussion Paper 84. Motivation for the Commission's preliminary proposals and explanatory notes on the draft Bill are reflected in Chapter 10 above.

a *sexual offence* only; whether the arrested person should be allowed to be present at and give evidence in an application for testing; and how the draft legislation will impact on the debate about state provision of post exposure prophylaxis (PEP) to victims of sexual offences).

- ! Practical issues (eg whether a victim should be able to apply for compulsory HIV testing outside court hours; whether legislation should prescribe a testing protocol dealing with the type of tests that should be used and how many tests should be performed).
- ! Issues related to the cost of the proposed procedure (including whether legislation should specify who should carry the cost of the proposed procedure).

11.11 Persons who attended the meeting (which was chaired by the project leader Mr Justice Edwin Cameron) included experts in the fields of criminal procedure, the law of evidence, constitutional law, human rights and HIV/AIDS, prisoners' rights and correctional health practice, victims' rights, victim support and counselling services, children's rights, forensic practice and responsibility, police practice, prosecuting and judicial practice, and medical aspects relating to HIV/AIDS. Members of the Commission's Sexual Offences Project Committee were especially included in the deliberations because of their expertise and the relevance of the issue under discussion for that Committee's current work regarding the codification of the substantive law relating to sexual offences.⁹¹⁸ A list of persons who attended the meeting is attached as ANNEXURE C.⁹¹⁹

11.12 The amended draft legislation and the list of issues submitted to experts for debate are included in ANNEXURE D.

11.13 The Project Committee on 6 May 2000 considered the input received from experts attending the consultative meeting. Considerable changes were made to the proposed draft legislation then and thereafter in the process of developing it into final recommendations as included in Chapter 13 of this Report.

11.14 As indicated above, the input received from experts at the consultative meeting is

918 See also par 2.24.3 above.

919 35 Experts from relevant disciplines were identified and invited to attend the meeting. Of these 29 (excluding members of the HIV/AIDS Project Committee) accepted the invitation and attended the meeting.

incorporated in the summary and evaluation of comments in Chapter 12 below.

Submission by Prof PWW Coetzer, Department of Community Health, MEDUNSA

- 11.15 At the consultative meeting with experts referred to in the previous paragraphs, Prof PWW Coetzer (Head of the Department of Community Health, MEDUNSA) expressed the opinion that the Project Committee's proposed testing procedure is too cumbersome and that it might therefore not be successful in practice. He favoured a more streamlined, less complicated and more accessible *administrative procedure* instead of the Project Committee's proposed *judicial authorisation* as a basis for compulsory HIV testing. The Project Committee decided to explore these suggestions in the process of developing final recommendations for inclusion in this Report.
- 11.16 Prof Coetzer's draft proposals (in the form of draft legislation which enunciated his beliefs) were discussed with him and commented on by representatives of the Project Committee and the researcher on 7 and 14 April 2000.⁹²⁰ The full Project Committee considered his final proposals and the motivation for these proposals on 6 May 2000. The proposals proved to deal with more than procedural matters and entailed a considerable extension of the Project Committee's mandate. They were in principle rejected. However, the Project Committee aimed at incorporating some of Prof Coetzer's practical suggestions in its amended draft legislation.
- 11.17 Particulars of Prof Coetzer's proposals and the reasons for their rejection are set out in the evaluation of comments in Chapter 12.⁹²¹

920 Prof C Van Wyk and Ms Ann Strode (members of the Project Committee), Ms W Louw (Directorate: Subordinate Legislation, Department of Justice - who assisted the Project Committee with drafting its proposed legislation) and Ms A-M Havenga (researcher) consulted with Prof Coetzer on 7 and 14 April 2000.

921 See par 12.14 et seq below.

12 Summary of comments, evaluation and recommendations

- 12.1 This Chapter contains a summary of the comments received through public consultation (i.e. on Discussion Paper 84, at the consultative meeting with experts held on 4 February 2000, and from Prof PWW Coetzer in a submission for the extension of the Commission's mandate).⁹²² It also contains an evaluation of the comments in that all significant concerns as expressed by commentators are addressed either by discussion or by adapting and supplementing the Commission's proposed legislation. Some adaptations speak for themselves and are not discussed. The evaluation below is limited to the main concerns expressed and to additions or limitations which may need explanation. Finally, the Commission's conclusions or recommendations are provided with reference to the draft legislation contained in Chapter 13.
- 12.2 The Commission's premise in evaluating the comments was to prioritise victims' interests. This was thought to be particularly important in view of the high prevalence of rape and other sexual crimes; the high prevalence of HIV and the possibility of becoming infected through a sexual offence; and the current lack of institutional support and other victim support measures.

The need for enacting legislation providing for the compulsory HIV testing of persons arrested in

⁹²² See Chapter 10 for more information on Discussion Paper 84. See Chapter 11 for background information on the consultative meeting with experts and a submission received from Prof PWW Coetzer. Prof Coetzer's submission is also discussed in detail in par 12.14-12.23 below.

sexual offence cases

- 12.3 As indicated in Chapter 10 above, Discussion Paper 84 recommended the adoption of legislation (in the form of a specific amendment of section 37 of the Criminal Procedure Act 51 of 1977 [the Criminal Procedure Act]) with the primary purpose of providing a speedy and uncomplicated mechanism whereby the victims of sexual offences can apply to have arrested persons tested for HIV or any other life-threatening sexually transmitted disease; and to have information regarding the test result disclosed to victims in order to provide them with peace of mind regarding whether or not they have been exposed to HIV or any other life-threatening sexually transmitted disease during the attack and to enable them to take prophylactic measures.
- 12.4 An overwhelming majority of persons and bodies commenting on Discussion Paper 84 supported the principle proposed. A minority of respondents were against the proposed intervention. Their motivation for support or opposition is summarised below.

Support for the proposal

- 12.5 Commentators supporting compulsory HIV testing of persons arrested in sexual offence cases included members of the general public as well as stakeholders and experts. Many of them unconditionally supported the principle. Others, while maintaining that the proposed intervention would have limitations in practice, nevertheless supported it. Most respondents in this category offered suggestions for amendment or supplementation of the proposed legislation.
- 12.6 Support for the proposal was based mainly on the view that such legislation would enhance and protect victims' rights; and that it would create a balance between victims' and suspects' rights. However, a variety of other arguments were also put forward:

! ***The intervention is necessary as it will enhance and protect victims' rights***
 It seems that most of the respondents who supported the principle of compulsory

HIV testing argued that it was necessary in order to enhance and protect the rights of victims.⁹²³ Several of these complimented the Commission on its positive recommendations.⁹²⁴ The National Institute for Public Interest Law and Research specifically emphasised that the right to information of victims would be enhanced by the proposed intervention in that enabling them to obtain information on the arrested person's HIV status would assist them in adjusting their lives by seeking the necessary support in the form of counselling and treatment. Others voiced the firm opinion that rights of perpetrators must yield in every possible way to those of victims. They submitted that this would be the morally correct attitude to adopt. The law must, therefore, make provision for what is morally right and paramount to the health of the victim, as opposed to the perpetrator's right to privacy - whether constitutional or otherwise.⁹²⁵ Women's organisations in general felt very strongly that compulsory testing ought to be part of stricter measures taken by the authorities when dealing with alleged sexual offenders.⁹²⁶ Finally, although some supporters of the proposed draft Bill stated that there may be limited value in obtaining information on the alleged offender's HIV status, they submitted that victims should nevertheless have the right to decide whether they wish to apply for this information or not.⁹²⁷

! *The intervention is justified as it will create a balance between victims' and suspects' rights*

Some respondents considered the proposed intervention to be justified since they saw it as an attempt to provide women with greater control over their own lives

923 See eg the comments of the Director of Public Prosecutions Witwatersrand Local Division; the Magistrate Pretoria; the South African Dental Association; Tshwaranang Legal Advocacy Centre (however also drawing attention to the limitations of the proposed intervention); Prof CR Snyman; the Professional and Ethical Standards Committee, Faculty of Health Sciences University of the Witwatersrand; and members of the public responding to a talk show on Radio 702 on 27 July 1999.

924 See eg the comments of Prof Andrew Skeen, and that of the Department of Health.

925 Cf the comments of Judge President EKW Lichtenberg; the South African Dental Association; Prof CR Snyman; the Cape Town Child Welfare Society; the Afrikaanse Christelike Vrouevereniging; the Mpumalanga Provincial Government Department of Agriculture, Conservation and the Environment; and the Democratic Nursing Organisation of South Africa. Several members of the public responding to a talk show on Radio 702 on 27 July 1999 shared this view.

926 Comments of the Federation of Women's Institutes, KwaZulu-Natal. The Afrikaanse Christelike Vrouevereniging saw compulsory testing as a "basic premise" of support to victims of sexual crimes.

927 See eg the comments of the South African Dental Association.

in the context of rape being the ultimate degradation of an individual's rights.⁹²⁸ Others supported the proposals because of the strictly limited way in which the arrested person's rights were infringed in the proposals.⁹²⁹ Yet others saw justification in the fact that the proposals are broad enough to encompass male-on-male rape and other sexual offences.⁹³⁰ One respondent, although not satisfied that compulsory testing would sufficiently address the plight of women, saw it as an important measure "that would summon sexual offenders to a 'double penalty'" and believed that revealing the HIV status of the alleged offender would be fair to the victim, the community and government.⁹³¹

! *Compulsory testing will hold special benefits for child victims*

Certain women's and children's organisations pointed out that apart from supplying victims with peace of mind, the knowledge of a suspect's HIV status will, in the case of child victims, supply care givers with vital information regarding the care and counselling needs of sexually abused children (assuming that the test results would be disclosed to these persons).⁹³²

! *Compulsory testing will create awareness of potential sex offenders*

One commentator suggested that records be kept of the arrested person's HIV status, and on this premise stated that the procedure proposed would not only raise awareness of potential offenders, but will also enable the subsequent verification of a victim's exposure to HIV.⁹³³

! *The alternative of routinely administering post exposure prophylaxis (PEP) to all victims is not viable*

The Durban Children's Society stressed that although the alternative to

928 Comments of the AIDS Consortium.

929 Comments of Judge President E King.

930 Comments of the AIDS Consortium.

931 Comments of the National Institute for Public Interest Law and Research.

932 See eg the comments of the Afrikaanse Christelike Vrouevereniging; and the Durban Children's Society.

933 Comments of the National Institute of Public Interest Law and Research. See also the proposals by Prof PWW Coetzer discussed in par 12.14 et seq below.

compulsory testing (i.e. treating every victim of sexual assault as if the assailant were HIV positive) would circumvent infringement of individual rights, it would expose victims (particularly children) to the unnecessary side effects of such treatment and would in all likelihood not be affordable in the long term.

! *Compulsory testing holds specific benefits for victims, the arrested person and the health services*

In spite of perceived shortcomings,⁹³⁴ some respondents nevertheless supported the proposed procedure in emphasising the possible benefits it would have not only for victims but also for assailants and for the health services. According to this view victims would benefit by getting certainty about the assailant's HIV status; getting access to medical treatment; and being able to stop taking PEP should the assailant be confirmed as HIV negative. Assailants would benefit in getting access to treatment for sexually transmitted diseases without prejudicing their case. The health services would benefit in that a new, and possibly improved, role would develop for them in helping victims; and in that the proposed procedure will enable these services to supply clients with early treatment which

934 According to the comments of Dr Jim Te Water Naude the most important limitation of the proposed compulsory testing procedure would be that knowledge of the assailant's HIV status would in most instances come too late for an intervention to stop sero-conversion in the victim. Other limitations would include the following:

- * The right to request testing would only be conveyed to the victim if emergency personnel were properly trained.
- * The victim might not feel enabled to make a sworn statement under oath at an early stage after the sexual assault.
- * The police are often too busy to attend to alleged sexual assaults and rape which do not involve aggravated assault.
- * The arrest rate is very low; the relevant health services (i.e. medical officers involved in forensic practice or public health facilities like clinics) would in all likelihood be prejudiced to the assailant with confidentiality regarding the process likely to be breached. and
- * Prejudice will decrease the quality of post test counselling of the assailant - especially if the assailant is entitled to treatment that the victim is not.

The Director of Public Prosecutions Witwatersrand Local Division, in supporting the proposed intervention, added the following to the above:

- * The difficulties in enforcing the proposed legislation due to limited monetary, structural and physical resources.
- * The lack of collaboration among all concerned role players (i.e. the South African Police Service [SAPS]), the Department of Health, and relevant non-governmental organisations).

Tshwaranang Legal Advocacy Centre's comments referred to the following limitations:

- * The poor implementation of legislation.
- * The risk of increasing victim trauma.
- * The need to use limited resources strategically.

would prevent complications from sexually transmitted diseases in these clients. It was envisaged that the proposed new law would have the potential of becoming more effective as the quality of policing and health services increase, and if accessible and affordable treatment for HIV becomes a reality.⁹³⁵

! *The choice of having the arrested person tested for HIV should be available to victims*

Finally, certain respondents submitted that even with the inherent limitations in the criminal process which may render compulsory testing of less value,⁹³⁶ the decision whether compulsory testing will assist or worsen the trauma for the victim is a matter that should be left entirely to the victim and his or her family. These respondents argued that the levels of violence against women and children (which they submitted have reached epidemic levels in South Africa), justify that the proposed mechanism should exist in the event the victim chooses to initiate it. They stressed that regardless of whether victims would use the information for treatment decisions, it should be the victim's right to have the possibility of obtaining the arrested person's HIV status available to him or her.⁹³⁷

Opposition to the proposal and suggested alternatives

12.7 A minority of respondents commenting on Discussion Paper 84 were opposed to creating legislation to enforce HIV testing of persons arrested in sexual offence cases. Strong arguments were however submitted by these respondents, and two respondents even requested the Commission to withdraw its proposals.⁹³⁸ Respondents in this category were drawn from members of the legal profession, the prosecuting and adjudicating authorities and non-governmental organisations concerned with the rights of persons with HIV/AIDS, and the rights of prisoners. The major arguments raised

935 Comments of Dr Jim Te Water Naude.

936 Cf fn 908 above for the perceived practical limitations. See also par 8.17-8.19 for limitations relating to the criminal process.

937 Comments of the South African Dental Association.

938 Mr Ronald Louw and the AIDS Legal Network.

against the proposed intervention related to the interests of the arrested person: They emphasised the lack of utility of testing the arrested person for HIV, and the infringement of the arrested person's rights. Specific reasons for not supporting the proposed intervention were the following:

! *The lack of utility of compulsory HIV testing, particularly because of the window period*

Several of those who were opposed to the proposed intervention submitted that testing alleged offenders for HIV could not assist victims in determining whether or not they have been infected with HIV: a positive test result in the arrested person will not conclusively show whether the victim has been *infected* as such results can only be indicative of *exposure* to HIV. They argued that in reality the only way for a person to know if he or she has been infected with HIV is to have him or herself tested regularly; and that the only safe way open to a victim would be to take prophylactic treatment as soon as possible after the rape or sexual assault.⁹³⁹ Another reason relating to lack of utility was that the alleged offender may test negative because of the window period⁹⁴⁰ which may cause the victim to accept the negative test result with a false sense of security. It was argued that this may lead to victims declining to be tested themselves or to take prophylactic treatment, thereby putting their own health in jeopardy. Victims may under the possible false impression that the arrested person is HIV negative also act recklessly, increasing their chance of spreading the virus by donating blood, through breast feeding or engaging in unprotected sexual activity which may place other parties at risk of infection.⁹⁴¹

! *The time constraints required for the successful administration of PEP*

Most of those citing lack of utility as motivation for opposing the proposed intervention also pointed out that offenders would seldom be apprehended for

939 Respondents with this view included the Acting Director of Public Prosecutions Venda High Court; the Society of Advocates of Natal; Mr Ronald Louw; Pretoria AIDS Training, Counselling and Information Centre (ATICC); Northern Province ATICC; the South African Prisoners' Organisation for Human Rights (SAPOHR); representatives of the South African Law Commission's Sexual Offences Project Committee; and the AIDS Legal Network.

940 See par 3.4 above for information on the window period.

941 Comments of respondents referred to in fn 939.

PEP to be successfully initiated timeously. In this context they pointed out that treatment can in any case be administered to the victim without the information of the alleged offender's HIV status.⁹⁴²

! *The infringement of suspects' rights: the right to a fair trial and the right to privacy*

Commentators opposing the proposed intervention invariably believed that the considerable infringement of rights implied by compulsory testing is not justified. They were particularly concerned about the suspect's right to a fair trial and his or her right to privacy. As regards the right to a fair trial, they submitted that to test an alleged offender *before* conviction would amount to a violation of the right to be presumed innocent until proven guilty. It was stressed that this would be particularly so where at the end of the trial the accused is found not guilty.⁹⁴³ SAPOHR in particular submitted that testing the assailant is not the only way to determine whether the victim contracted HIV since victims can have themselves tested. Judges of the Durban High Court suggested that a balancing of rights might be achieved by testing the accused only *after* conviction and providing for the testing of victims at state expense immediately after an allegation of rape.⁹⁴⁴ It was also submitted that compulsory testing would infringe the assailant's right to a fair trial in that it may influence sentencing: It is believed that a presiding officer may presume that the accused raped with the intention to infect the victim with HIV even though this may not be the case, especially as many people with HIV are not aware of their infection.⁹⁴⁵ Some respondents firmly believed that the assailant's right to privacy would be infringed by compulsory testing even if knowledge of the test results is confined to a magistrate and the victim concerned. They questioned why any magistrate should be made aware of any person's HIV status.⁹⁴⁶

942 Ibid.

943 Comments of Judges of the Durban High Court; Mr Lucky Mazibuko; the AIDS Consortium; the Pretoria ATICC; and SAPOHR.

944 See also par 12.8 below where alternatives to the Commission's proposals are discussed.

945 Comments of SAPOHR.

946 Ibid.

! ***Compulsory testing will discredit the law***

One commentator argued that the proposed intervention would be counterproductive in that victims would attempt to use the testing process but find that it does not solve their problems. They would be frustrated by the procedures that will have to be followed and the delays in obtaining the HIV test results of the alleged offender. Such a procedure would not help victims who are not educated or informed. In all he argued that in the light of these failings, the law will be discredited in the eyes of victims.⁹⁴⁷

! ***Concern about the implications of compulsory testing for victims' safety***

A single organisation expressed particular concern regarding the possible implications of a subsequent acquittal of the arrested person in the case where the victim concerned applied for compulsory testing. The respondent submitted that victims may, in the case of an acquittal, face civil charges and even violence for attempting to obtain information about the arrested person's HIV status.⁹⁴⁸

! ***Possible misuse and abuse of the proposed procedure***

Several respondents in the category opposing compulsory HIV testing expressed concern about the possibility of misuse and abuse of the proposed measures by persons claiming to have been victims of rape and sexual assault.⁹⁴⁹ SAPOHR was especially concerned about cases of consensual sex, where medical evidence would probably show that intercourse did occur but where there would be nothing to prevent the "victim" from lying to establish another person's HIV status.

! ***Compulsory HIV testing of arrested persons is an emotive response***

Finally, Mr Ronald Louw criticised the Commission for making a proposal motivated more out of what he believed to be an emotive response than a

947 Comments of Mr Ronald Louw. The AIDS Legal Network's comments supported this view.

948 Comments of the Northern Province ATICC.

949 Comments of the Law Society of the Cape of Good Hope; SAPOHR; Dr JP Driver-Jowitt; and Mr Lucky Mazibuko.

reasoned one.⁹⁵⁰ In this context other opposing respondents also questioned whether the public outcry for testing is based on a true understanding of HIV test results and in particular of the implications that a negative test result in an assailant may have on a victim.⁹⁵¹

12.8 In its Discussion Paper 84 the Commission posed three alternatives to the proposed legislative intervention, these being -

- ! retaining the status quo;⁹⁵²
- ! establishing policy aimed at the voluntary HIV testing of suspects in sexual offence cases,⁹⁵³ and/or
- ! developing and establishing comprehensive support services for victims of such offences.⁹⁵⁴

These alternatives (which were discussed in par 10.3 of Discussion Paper 84), were rejected by the Commission.⁹⁵⁵ Two commentators responded to these alternatives. The Co-operative for Research and Education (CORE), expressing the opinion that the alternatives posed were rightly rejected as they are unacceptable and reflect a weak political will, remarked as follows:

The present crisis calls for unambiguous, decisive reaction and speedy implementation of the law. The whole nation needs to reflect a determined attitude. The social, psychological and even economic consequences of being infected have far reaching implications for the individual concerned, the family and society at large. Not to do anything therefore would be shirking our responsibility.

The Durban Children's Society observed that the alternative to compulsory testing would

950 Cf however the comments of Dr JP Driver-Jowitt who believed that the "foolishness of the current proposed legislation is an expression of political timidity on the part of the Law Commission, taken with a view which does not outwardly seem to have received useful socio-medical wisdom." This respondent proposed creating a summary right for any person to have another tested for HIV which is not linked to any criminal act (see par 12.9 below).

951 Comments of representatives of the South African Law Commission Sexual Offences Project Committee and of the Northern Province ATICC. See par 12.7 above for the implications which opposing respondents believed a negative test result in the arrested person may have on the victim.

952 See par 10.6 above for detail.

953 Ibid.

954 Ibid.

955 See par 10.6 above for the Commission's motivation for rejecting these alternatives.

be to treat every victim of sexual assault "as if" the assailant were HIV positive. They argued however that while this would take care of arguments regarding infringement of individual rights, it would expose victims (often children) to unnecessary side effects of PEP and would in all likelihood be unfordable in the long term.

12.9 Respondents opposing the proposed legislation suggested the following alternatives:

! *The provision of comprehensive health and social services to all rape and sexual offence victims instead of compulsory HIV testing - in particular providing victims with access to PEP*

Commentators not agreeing with the Commission's proposal for compulsory HIV testing strongly suggested the establishment of a comprehensive range of health and social services to all victims of rape and sexual offences as alternative to the proposed Bill.⁹⁵⁶ They supported a practical holistic approach which addressed victims' need for appropriate medical advice, short and long term medical treatment, counselling, and especially access to PEP. According to these respondents services related to victim support that should be included in a holistic approach are the following:

- P Counselling, information on PEP, access to HIV testing and immediate access to PEP. It was submitted that these services would be of more value to victims than the proposed intervention.⁹⁵⁷ Mr Ronald Louw in particular observed that if the Commission is concerned with the victim's peace of mind and ability to make urgent life decisions, it should recommend immediate and free PEP for such persons. Some suggested that treatment should include long term care.⁹⁵⁸
- P Streamlining the current justice system in order to reduce secondary and tertiary traumatisation of the victim. The Pretoria ATICC pointed out that victims are currently humiliated and traumatised by sending them from pillar to post to be attended to. The ATICC suggested that central service

956 See eg the comments of the Society of Advocates of Natal; the Acting Director of Public Prosecutions Venda High Court; the Pretoria ATICC; Mr Lucky Mazibuko; Mr Ronald Louw; and the AIDS Legal Network.

957 Comments of the Pretoria ATICC; the Society of Advocates of Natal; the AIDS Legal Network; and Mr Ronald Louw.

958 Comments of the Society of Advocates of Natal.

points should be established or identified where victims could receive a one-stop medical, legal and counselling service.

- P Considering and employing strategies to ensure that rapists are indeed tried and convicted.⁹⁵⁹
- P The imposition of stiff sentences to satisfy the natural desire for revenge.⁹⁶⁰
- P Educating men on sexuality. One commentator suggested that in addition to comprehensive health and support services to victims, "men, who are largely responsible for perpetrating the grossly inhumane act of rape, should be adequately educated in matters of sexuality so that they know it is not only barbaric but also unnatural for a man to forcefully and violently enter a woman".⁹⁶¹

! *Testing suspects for HIV only after conviction*

Judges of the Durban High Court suggested that in view of the severe encroachment of suspects' rights which the proposed Bill would bring (particularly as regards the right to be regarded as innocent until proven guilty), it would be preferable to test suspects for HIV *after* conviction. (SAPOHR however indicated that even post conviction testing would be unacceptable as every person has the right not to be subjected to HIV testing without his or her consent.) Judges of the Durban High Court suggested that a balance of rights could be achieved by providing for victims to be tested immediately after an allegation of rape with follow-up testing and treatment at state expense in addition to testing suspects after conviction.

! *Testing victims for HIV*

Dr K Müller at the consultative meeting of 4 February 2000 expressed the opinion that because the testing procedure envisaged is limited to victims who report sexual offences, the Commission's proposals will not assist the majority of

959 Comments of Mr Lucky Mazibuko.

960 Comments of the Acting Director of Public Prosecutions Venda High Court.

961 Comments of Mr Lucky Mazibuko.

victims.⁹⁶² State funds should therefore rather be used to test *victims* of sexual offences for HIV.

! *Establishing a summary right to initiate HIV testing not linked to any criminal act*

Dr JP Driver-Jowitt suggested that any person, male or female, should have a summary right to initiate testing of any other person, if there are reasonable grounds to believe that HIV infection might have been transmitted. The respondent believed that this approach will balance a current bias towards female strength in the testing issue and reduce spurious calls of rape.

12.10 Experts attending the consultative meeting of 4 February 2000 were unanimous in their views that in addition to the legislation proposed, comprehensive victim support services are in any event necessary.⁹⁶³

Evaluation and recommendation

12.11 The fact that the overwhelming majority of commentators strongly supported the principle of enacting legislation to provide for the compulsory testing of persons arrested in sexual offence cases, affirmed the Commission in proceeding with its in principle proposals. In view of this the need for legislation was not discussed with experts at the consultative meeting. This discussion was limited to issues of principle, practice and cost to be included in the proposed HIV testing procedure.

12.12 As indicated in the previous paragraphs, only a small minority of commentators were in principle opposed to the proposed legislation. Their primary concerns were based on the lack of utility of testing the offender for HIV; and the infringement of the accused's rights especially as alternatives could be made available to all victims of sexual offences thus negating the need to infringe such rights. The Commission's response to their concerns

962 Cf also Tshwaranang Legal Advocacy Centre's comments in this regard (par 12.29).

963 See also par 12.104 et seq below.

is as follows:

! ***Lack of utility - particularly because of the window period***

The Commission believes that utility and value do indeed derive from obtaining information about the arrested person's HIV status. In coming to this conclusion the Commission accepted scientific evidence that the current forms of HIV testing used in the public sector are 99% accurate if performed according to accepted medical standards,⁹⁶⁴ and that although the theoretical possibility of the arrested person being in the window period exists, the probabilities of such person testing negative because of this factor are small and may be minimised in future by more sophisticated forms of testing.⁹⁶⁵ This possibility was therefore not sufficient to deny *all* victims the opportunity of obtaining accurate information on the arrested person's HIV status. The Commission also accepted that in view of the well-known fact that one of the primary concerns of victims of sexual offences is the possibility of becoming infected with HIV, information on the arrested person's HIV status would directly assist them in dealing with the psychological trauma of the sexual offence. Information on their alleged assailant's HIV status in particular may give victims a sense of control after the attack, decrease their anxiety about possible HIV infection, and enable them to take steps to protect their physical as well as mental health and those of their sexual partners and immediate family.⁹⁶⁶

! ***The time constraints required for the successful administration of PEP***

The Commission accepted that it would not be advisable for victims to wait for the arrested person's HIV test results before initiating treatment against possible infection (where treatment was affordable and available).⁹⁶⁷ Information on the arrested person's HIV status could however assist victims in deciding whether to discontinue treatment or to make other decisions (such as regarding the termination of pregnancy, or discontinuing breastfeeding) when it becomes available. Thus the argument that the majority of alleged sexual offenders would

964 See par 8.10 above.

965 Ibid.

966 Cf the discussion in par 8.12 et seq above.

967 See par 3.64 on information relevant to time constraints and the initiation of PEP.

not be arrested in time for victims to initiate treatment against HIV infection within the prescribed time period was also considered insufficient to thwart the innovation.⁹⁶⁸

! *Infringement of the arrested person's rights*

As indicated above, commentators submitted that the proposed procedure will infringe the arrested person's right to a fair trial and his or her right to privacy, and that this is not justified. The Commission believes that the proposed legislation does not infringe the arrested person's *right to a fair trial* as the proposed procedure does not fall within the sphere of activity protected by the relevant provision of the 1996 Constitution. Constitutional analysis under the Bill of Rights takes place in two stages: First, it must be shown that the ability to exercise the fundamental right in question has been infringed i e that the activity for which constitutional protection is sought falls within the sphere of activity protected by a particular constitutional right.⁹⁶⁹ Only after this is established the question whether the proposed legislation actually impedes the exercise of the particular right comes into play.⁹⁷⁰ Section 35(3) of the 1996 Constitution deals with the right to a fair trial. The section refers to this right in the context of criminal proceedings consisting of or aimed at a prosecution, a hearing, an outcome and the imposition of punishment.⁹⁷¹ Steytler states in this regard:

The right of every accused person to a fair trial lies at the heart of the criminal justice system. It seeks to provide procedural fairness before the state intrudes upon core rights of a person, namely, dignity (the public denouncement as guilty in a status degrading ceremony), liberty (detention or imprisonment) and property (the imposition of a fine or

968 See also the arguments in par 8.10 above.

969 **S v Zuma and others** 1995 (2) SA 642 (CC); Chaskalson et al 12-3. See also par 5.5.2, fn 423 above.

970 Ibid.

971 Section 35(3) refers to the right to a fair trial as including aspects such as the right to be informed of the charge with sufficient detail to answer it; to be presumed innocent; not to be convicted of an act or omission that was not an offence under the national or international law at the time it was committed or omitted; not to be tried for an offence in respect of an act or omission for which the person in question has previously been either acquitted or convicted; to the benefit of the least severe of the prescribed punishments under certain circumstances; and to apply for appeal or review (cf paragraphs (a), (l), (m), (n) and (o) of that section).

forfeiture).⁹⁷²

The procedure proposed by the Commission is however not aimed at, and does not form part of, any criminal or pre-trial proceedings against the arrested person. It does not consist of prosecuting the arrested person for any offence. Nor is it in any way connected to an establishment of guilt, to a conviction for a specific act or omission, or to the imposition of punishment. Moreover, the proposed legislation expressly excludes the HIV test result obtained from being used as evidence in any criminal or civil trial.⁹⁷³

As regards infringement of the arrested person's *right to privacy*, the importance of this right and the fact that it should not be infringed lightly was stressed in Chapter 5 above.⁹⁷⁴ It is however clear from section 36 of the 1996 Constitution that no right is absolute and that rights may be limited to the extent that the limitation is reasonable and justifiable in an open and democratic society.⁹⁷⁵ As indicated in Chapter 5, the level of justification required depends on the extent of the limitation: the more invasive the infringement, the more powerful the justification must be.⁹⁷⁶ If the limitation is "overbroad" or if there are less restrictive means to achieve the purpose (of providing support and assistance to victims of sexual offences as regards their possible exposure to HIV) the limitation will not be justifiable.⁹⁷⁷ The proposed compulsory HIV testing procedure will have the effect that arrested persons are tested for HIV and the

972 Steytler 208. See also **Ferreira v Levin NO and others and Vryenhoek and others v Powell NO and others** 1996 (1) BCLR 1 (CC) at 26B where Ackermann J held that "the section 25(3) rights [under the Interim Constitution] accrue, textually, only to 'every accused person'. They are rights which accrue, in the subjective sense, when a person becomes an 'accused person' in a criminal prosecution". See also **Nel v Le Roux** 1996 (4) BCLR 592 (CC) at par 11 and **S v Baloyi and others** 2000 (1) SACR 81 (CC) at 93D-E.

973 Clause 16 the Bill in Chapter 13.

974 Par 5.6. See also par 5.2-5.4 and 5.6-5.9.

975 See the text of sec 36 in par 5.5.2 above.

976 **S v Manamela and another** 2000 (5) BCLR 491 (CC). See also par 5.5.2 above.

977 See the text of section 36 of the 1996 Constitution in par 5.5.2 above. See also **Coetzee v Government of the Republic of South Africa and others** 1995 (10) BCLR 1382 (CC); **Director of Public Prosecutions: Cape of Good Hope v Bathgate** 2000 (2) BCLR 151 (C).

test results disclosed without their consent.⁹⁷⁸ The Commission is aware that its proposal trenches upon the arrested person's right to privacy and bodily integrity but believes that it is justified in the light of women's undoubted vulnerability in South Africa to widespread sexual violence amidst the increasing prevalence of HIV and in the absence of adequate institutional or other victim support measures.⁹⁷⁹ In these circumstances there is a compelling argument for curtailing arrested persons' rights to a limited extent to enable their victims speedily to know whether they may have been exposed to HIV.⁹⁸⁰ The Commission moreover considers that the proposed procedure will not be extensively used or result in frequently inappropriate invasions of the arrested person's rights.⁹⁸¹ Use of the procedure is in the first place formally limited to victims who have laid a charge;⁹⁸² to those who are able to bring an application for compulsory testing within a prescribed, limited time period,⁹⁸³ and to those who have a genuine need for the information.⁹⁸⁴ It is believed that use of the procedure will be further limited to those victims who will have the necessary means of support, resources and energy to pursue compulsory testing.⁹⁸⁵ The

978 See the draft Bill and draft Regulations in Chapter 13.

979 The public outcry for the proposed measure based on the concern about the high incidence of rape and other sexual offences, the growing prevalence of HIV in South Africa, women's physiological vulnerability to HIV and victims' concerns about whether they may have been exposed to HIV during a sexual offence have been recorded in par 2.4-2.17, 3.16 et seq, 8.3, and 8.6-8.7 above. The absence of formal victim support measures as required by the United Nations is pointed out in par 9.9 above and constitutional obligations towards women and children in this regard amidst the current epidemic levels of violence are pointed out in par 9.9 and 8.22-8.25.2. Finally, the urgent need for practical measures to support and assist victims of sexual offences is evident from the comments on Discussion Paper 84 by both proponents and opponents of compulsory HIV testing (see par 12.9 and 12.104-12.108).

980 Extensive arguments on the utility of HIV testing of arrested persons as regards victims' physical as well as mental health and the practical need for the proposed procedure are set out in par 8.3, 8.9.1, 8.10, 8.12-8.13, and 8.19-8.20 above.

981 Cf **Director of Public Prosecutions: Cape of Good Hope v Bathgate** referred to in fn 947 at 160H.

982 Clause 2(2) of the draft Bill and par 12.30 et seq below.

983 Clauses 7(1)(a)(iii) and 13. See also par 12.52-12.56 below. If a suspect is not apprehended within the prescribed period of time in which an order for compulsory HIV testing has to be carried out (60 calendar days from the date on which it is alleged that the offence in question took place) testing is not authorised under the draft Bill. This period coincides with the length of the period during which a victim's own HIV test would not clearly indicate whether he or she had been infected with HIV (the "window period"). See par 12.52-12.56 below. See also par 3.4 for information on the "window period".

984 A penalty clause aimed at any malicious activation of the procedure is included in the draft Bill (clause 19). See also par 12.85-12.88 below.

985 See also par 12.30 below on the necessity for a victim-initiated process.

Commission acknowledges that the arrested person's rights are infringed and has reflected this concern in safeguards which have been built into the process created to ensure that the infringement is limited as far as is possible. These include the following: (Footnotes refer to the draft Bill in Chapter 13 below.)

- P A victim-initiated process⁹⁸⁶ based on information on oath, which requires the victim to have laid a criminal charge against his or her alleged assailant.⁹⁸⁷ This will ensure that only a person with a material interest in the arrested person's HIV status may apply for compulsory HIV testing.
- P A specified standard of proof (in the form of prima facie evidence that a sexual offence was committed against the victim during which exposure to the body fluids of the arrested person may have occurred).⁹⁸⁸
- P Authorisation of compulsory HIV testing by a court. This consists of a discretionary power resting with the presiding magistrate hearing the application.⁹⁸⁹
- P A right to apply to the High Court for review should the order for compulsory testing not be "properly" granted i e in the event that an order is not granted in accordance with the prescribed provisions.⁹⁹⁰
- P Supplying the arrested person with prescribed information on the entire process⁹⁹¹ before he or she undergoes HIV testing if an order for compulsory testing has been granted.⁹⁹²
- P Strict confidentiality measures in that the outcome of an application for a compulsory testing order may not be communicated to third parties bar

986 The proposed legislation also makes provision for a person to act on the victim's behalf if the victim is a minor or is incapacitated and cannot act on his or her own (clause 3 of the draft Bill). See also par 12.29-12.30 below.

987 Clause 2(1)-(2) of the draft Bill, and reg 3 and Form 2 of the draft Regulations. See also par 12.29-12.30 below.

988 Clauses 2(3) and 7(1)(a) of the draft Bill, and reg 3 and Form 2 of the draft Regulations. See also par 12.39-12.41 below.

989 Clause 7(1)(a), (b) and (c) of the draft Bill.

990 Clause 9 of the draft Bill. See also par 12.66-12.71 below.

991 Including information on the possibility of HIV transmission during a sexual offence, the basis on which the order has been granted, why victims have a need for information on the HIV status of their alleged assailants, and why the arrested person is not allowed to be present at the hearing of the application (Form 4 of the draft Regulations).

992 Clause 10(b), reg 6 and Form 4 of the draft Bill. See also par 12.89-12.91 below.

the victim, the arrested person, the investigating officer, and persons required to execute the order (i.e. the medical practitioner or nurse requested to take body specimens from the arrested person, and the person required to perform the HIV test);⁹⁹³ and the result of the arrested person's HIV test may not be disclosed to any person other than the victim (or a person acting on his or her behalf) and the arrested person.⁹⁹⁴ It is moreover stressed in prescribed information to be supplied to victims together with their assailants' test results that the result may not be further disclosed except to those who need to know (eg a sexual partner).⁹⁹⁵

- P Supplying arrested persons with prescribed information when providing them with their HIV test results.⁹⁹⁶ The information includes guidelines on how to deal with the result, stresses the importance of obtaining expert assistance in the form of post test counselling and indicate where such counselling is available.⁹⁹⁷
- P A specified, limited time period within which applications for compulsory testing must be brought and carried out.⁹⁹⁸ The total period corresponds with the period of time during which testing of arrested persons would have utility for victims of sexual offences.⁹⁹⁹
- P Inadmissibility as evidence, in any criminal and civil trial, of the result of the HIV test performed.¹⁰⁰⁰
- P A penalty clause aimed at the malicious use of the proposed procedure or the malicious disclosure of the HIV test results obtained.¹⁰⁰¹

993 Clause 11 of the draft Bill.

994 Clause 15 of the draft Bill. See also clause 12(1)(d)(iii) providing for the test results to be sealed. Refer also to par 12.73-12.84 below.

995 Reg 8 and Form 6 of the draft Regulations. For more detail see par 12.73-12.77 below.

996 Clause 12(1)(e)(ii) of the draft Bill, and reg 8 and Form 6 of the draft Regulations. See also par 12.89-12.91 below.

997 Reg 8 and Form 6 of the draft Regulations. See also par 12.89-12.91 below.

998 Clauses 7(1)(a)(iii) and 13 of the draft Bill. See also par 12.52-12.56 below.

999 See par 3.4 below on the length of the window period.

1000 Clause 16 of the draft Bill. See also par 12.78-12.84 below.

1001 Clause 19 of the draft Bill. See also par 12.85-12.88 below.

In coming to a conclusion the Commission has considered less restrictive means of obtaining support and assistance for victims as regards their possible exposure to HIV during rape and other sexual offences. As indicated in par 10.6 and 12.8 above, these include retaining the status quo; establishing policy aimed at the *voluntary* HIV testing of suspects in sexual offence cases; the provision of comprehensive health and social services to victims (including HIV testing, and counselling aimed at behaviour changes to prevent HIV transmission to sexual partners and others); and testing arrested persons *after* conviction. The purpose of the proposed intervention is to provide a speedy and uncomplicated mechanism whereby victims of sexual offences can apply to have arrested persons tested for HIV and to have information regarding the test results disclosed to them in order to provide them with peace of mind regarding whether or not they have been exposed to HIV during the attack. It is also the intent to protect the health of victims and others by providing victims with information which may be important in deciding whether or not to take precautions to avoid spreading HIV to their sexual 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). The alternatives mentioned have been rejected by the Commission because they will not serve these purposes and will in some cases be undertaken at considerable cost for victims.¹⁰⁰² The reasons for their rejection are fully discussed in par 12.13 below.¹⁰⁰³

In the light of the above the Commission is convinced that it has, in accordance with constitutional requirements regarding the limitation of rights, closely tailored the proposed procedure to meet victims' needs with due regard to infringing the arrested person's rights to the minimum.

1002 See **S v Manamela and another** 2000 (5) BCLR 491 (CC) referred to in par 5.5.2 above on giving appropriate effect to the factor of "less restrictive measures" in applying section 36 of the 1996 Constitution.

1003 See also par 10.6 above where possible alternatives posed in Discussion Paper 84 are discussed.

! ***Compulsory testing will discredit the law***

One commentator noted that the procedures proposed will result in frustrating delays, particularly for those who are not educated or informed. In the light of this, he argued that such victims will lose their faith in the legal process which will in turn lead to the law being discredited. The Commission is however of the view that the proposed procedure will create a balance between a speedy and accessible process whilst still being sufficiently formal so as to protect the arrested person's rights. Furthermore, the Commission believes that the proposed procedure is simply a first part of the development of a holistic system of victim support - it is not offered as a final solution to all the problems facing victims of sexual offences. The possible value of the proposed procedure in view of its several perceived limitations, was expressly discussed with experts attending the consultative meeting on 4 February 2000. They were unanimous in their view that, despite many practical limitations¹⁰⁰⁴ the proposal will nevertheless have definite value.

! ***Concerns about victims' safety***

In response to one commentator's fear that the proposed procedure may make victims the target of violence by arrested persons (particularly as the testing will take place before the trial), the Commission considers that although this is a possibility, it exists in respect of the reporting of any offence. This objection is therefore not sufficient reason for not proceeding with compulsory HIV testing of arrested persons.

! ***Possible misuse and abuse of the procedure***

The Commission's preliminary proposals in Discussion Paper 84 did not contain express sanction for misuse and abuse of the procedure although the Commission indicated that malicious activation of the procedure would be actionable. In response to comment for the need of express sanction to ensure that the proposed procedure is not misused or abused the Commission has included an offence and penalty provision in its final recommendations: Any person who with malicious intent uses the proposed procedure or discloses the

1004 See fn 934 above for the perceived limitations.

HIV test result obtained shall be guilty of an offence and on conviction be liable to a fine or to imprisonment for a period not exceeding six months or both.¹⁰⁰⁵

! *Creation of the proposed procedure is an emotive response*

A single commentator accused the Commission of making an emotive rather than a reasoned response in creating the proposed procedure. It is true that high emotions attend this issue. But that does not taint all sensible and balanced proposals in response to it. The Commission is convinced that its proposals have been developed through a sufficiently rational and consultative process, that they have the support of most people who participated in this process, and that they will indeed provide victims with a significant benefit while infringing the arrested person's rights in only a limited way. The balanced outcome of its proposals appears to be a rational and useful innovation rather than an emotive response.

12.13 The four alternatives to the proposed procedure suggested by respondents opposing compulsory testing (providing holistic social support and PEP to all victims of sexual offences; testing arrested persons after conviction; providing HIV testing services to victims of sexual offences; and creating a summary right to have any person tested for HIV),¹⁰⁰⁶ were rejected by the Commission.

12.13.1 First the Commission is of the opinion that practice and policy guidelines would not supply sexual offence victims with the psychological benefit of peace of mind that knowing their alleged attacker's HIV status may do. Moreover, guidelines as mentioned may in any case be developed alongside statutory provision for compulsory HIV testing.¹⁰⁰⁷

12.13.2 Second, the Commission is of the view that testing arrested persons *after* conviction will not provide victims with peace of mind as the victim will usually receive such information long after the commission of the crime.

1005 Clause 19 of the draft Bill.

1006 See par 12.9 above for the proposed alternatives.

1007 See also par 12.104 et seq below.

At this point the information will have little utility and the victim could have had herself or himself tested for HIV.¹⁰⁰⁸ It was explained in Discussion Paper 84 that in most cases the utility of testing would have disappeared by the time of a conviction.¹⁰⁰⁹ The Commission emphasised that the purpose of the proposed intervention was to allow HIV testing of an arrested person, and providing the information regarding the test results to the victim so as to enable him or her to use the information in making decisions regarding their, and others' future health. The Commission expressed the opinion that unless victims themselves underwent testing shortly after the attack, sero-positivity 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 sero-positivity is likely to show up on tests by the time of conviction.¹⁰¹⁰ It was furthermore stated that 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.¹⁰¹¹

12.13.3 Third, the alternative of offering testing to victims of sexual offences will not on its own provide them with a ready answer as to whether they have been infected with HIV through the sexual offence. Waiting for three to six months to confirm their HIV status through a personal test will prolong the victim's trauma and distress. The Commission however believes that in

1008 See also par 8.5 and 10.7 above.

1009 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. The Commission pointed out that it had been reported in the press that only 8% of rapes reported to the SAPS resulted in convictions (**Mail and Guardian** 21-27 May 1999). See also **SALC Discussion Paper 84** par 8.5 and 11.5.

1010 The Commission indicated that 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). See also **SALC Discussion Paper 84** par 8.5.

1011 Cf the discussion of sec 37 of the Criminal Procedure Act in Chapter 7 above.

time testing services for victims should form part of a holistic approach in dealing with sexual offences.¹⁰¹²

- 12.13.4 Fourth, creating a summary right to have any person tested for HIV without any legal basis will entail unacceptable inroads into fundamental rights and is therefore rejected.

The need to extend the Commission's mandate and enact legislation providing for a general procedure for compulsory HIV testing; and for the establishment of a national register recording HIV test results

12.14 As indicated in Chapter 11 above, the Project Committee considered proposals by Prof PWW Coetzer, Head of the Department of Community Health, MEDUNSA for the improvement of its proposed HIV testing procedure. Particulars of his proposals are set out below.¹⁰¹³

12.15 Prof Coetzer's main objections to the Project Committee's proposed procedure were

-

- ! that it entailed a mini-trial for obtaining a court order to take blood from the assailant and make the HIV test results available to the complainant, which he believed was neither fair to the complainant nor logistically feasible; and
- ! that it contained no provision for the HIV test results obtained to be available for purposes other than victims' peace of mind (eg for sentencing purposes and

1012 See also par 12.104 et seq below.

1013 Prof Coetzer's proposals were fully set out in a Memorandum "Compulsory Testing for HIV Infection" Draft 3, 25 April 2000 which included draft legislation. The information in the paragraphs below refers to the contents of this memorandum.

medical treatment of prisoners with HIV).

12.16 To overcome these perceived limitations Prof Coetzer proposed the enactment of legislation providing for the following:

- ! The creation of a more general procedure for compulsory HIV testing in the criminal context which would authorise testing of -
 - P persons *arrested* for having committed certain sexual offences (rape, attempted rape, and indecent assault);
 - P persons *arrested* for assault (where a transfer of body fluids to the complainant could have been possible);
 - P persons *convicted* of certain sexual offences (rape, attempted rape, and indecent assault) - if they have not been tested immediately after arrest;
 - P persons *convicted* of certain violent crimes (assault, assault with the intent to inflict grievous bodily harm, murder, attempted murder and armed robbery).¹⁰¹⁴
- ! The establishment of a national register for recording the HIV status of all arrested and convicted persons who have undergone HIV testing under the proposed procedure; and the disclosure of the results to -
 - P any complainant in respect of whom it has been certified that there exists a possibility that body fluids may have been transferred from the alleged assailant to the complainant;
 - P the courts - for sentencing purposes;
 - P medical practitioners and nurses - for the legitimate diagnosis or treatment of prisoners; and
 - P medical practitioners, dentists and nurses - with the written consent of the person with HIV.¹⁰¹⁵

12.17 Unrelated to the Commission's proposals and in addition to the above, Prof Coetzer suggested that any envisaged legislation dealing with compulsory HIV testing should also

1014 Clauses 2 and 3 of the proposed legislation contained in the Memorandum. See also the comments of Ms N Honono who suggested that the proposed legislation should also provide for prisoners to be tested compulsorily or voluntary, and that the results obtained should also be made available to the prisoner's wife or closest relative.

1015 Clause 4 of the proposed legislation contained in the Memorandum.

cover testing of persons whose body fluids have been implicated in sharps injuries,¹⁰¹⁶ and of deceased persons.¹⁰¹⁷ He believed that HIV test results obtained in these instances should be disclosed to health care workers in the case of their involvement in sharps injuries or exposure to the body fluids of a deceased person.¹⁰¹⁸

12.18 Prof Coetzer motivated his proposals as follows:

! He submitted that judicially it makes no sense to force a victim to convey the intimate details of his or her sexual assault to the court twice (as the Commission's preliminary proposals would entail). He maintained that the main issue for granting a court order for compulsory testing would be to establish the possibility of the transfer of body fluids between the assailant and the victim. The right person to ascertain this possibility is the medical practitioner who examines a victim after an alleged rape or sexual assault and not a magistrate. This could be brought about by using existing measures of criminal procedure¹⁰¹⁹ while new legislation needed to authorise disclosure of the HIV test results only. He submitted that in large centres the complainant can lay a charge, be medically examined, submit his or her application for disclosure of the HIV status of the assailant and secure the results under one roof. He believed that it would put an extraordinary burden on already overworked magistrates if they have to hear

1016 Prof Coetzer suggested that where a person whose body fluids have been implicated in a sharps injury is unable to undergo HIV testing, or refuses to undergo testing, the health care worker involved in the sharps accident should be able to apply to a court to order HIV testing of such a person. According to his proposal a medical practitioner would have to certify that the sharps injury could have resulted in the transfer of body fluids to the health care worker concerned (clause 6 of the draft legislation contained in the Memorandum). The need for adequate provision for compulsory HIV testing in all situations involving sharps injuries was also highlighted by Prof AN Smith of the Department of Virology, University of Natal Durban in his comments of 17 February 2000 to the Department of Health on the draft National Policy on Testing for HIV 1999 (Government Notice R 1479 in **Government Gazette** 20710 of 10 December 1999) (Prof Smith's comments were made available to the researcher by Ms Ann Strode, consultant to the Department of Health).

1017 Prof Coetzer suggested that a medical practitioner or nurse should be able to remove blood from a deceased person for HIV testing (after consultation with the deceased's next of kin) if he or she has been exposed to the body fluids of the deceased person; or if he or she is of the opinion that body fluids could have been transferred from the deceased person to another person (clause 7 of the proposed legislation contained in the Memorandum).

1018 Memorandum 4-5.

1019 Prof Coetzer suggested that when a victim is medically examined by a medical practitioner after rape or sexual assault, that medical practitioner could in the course of his or her duties certify whether there has been a possibility of transfer of bodily fluids.

applications for compulsory HIV testing at all hours of the day.¹⁰²⁰

- ! Prof Coetzer suggested that HIV testing of persons sentenced to imprisonment for violent crimes not related to sex, should be included in the proposed process. He stated that in South Africa a significant proportion of rapists have also been found guilty of other violent crimes and in any local prison between 30% and 40% of violent criminals are also HIV positive. For purely medical reasons HIV testing is also indicated for a large proportion of this population. Many of them undergo multiple HIV testing. Prof Coetzer argued that if a victim has been raped by a person who has been identified but not yet apprehended, there remains a significant chance that the assailant could have been convicted previously for a violent non-sexual crime. If a central national register as proposed existed, this assailant's HIV status may already have been recorded and be available for disclosure.¹⁰²¹
- ! Prof Coetzer submitted that to take blood from all sexual offenders¹⁰²² and persons sentenced to a compulsory term of imprisonment for a violent crime and store it on a central data base (i.e. a national register) is the only way to control HIV testing rigidly; avoid multiple testing of the same individual; enable victims to access the HIV status of offenders when they are away from the magisterial district concerned; enable courts to access without problems the HIV status of offenders for purposes of sentencing; and allow health care workers to access the HIV status of their patients without repeat testing. Prof Coetzer submitted that privacy and confidentiality could be maintained in the manner through which data is entered or withdrawn from the national register and by tying unauthorised disclosure of HIV status to a penalty clause.¹⁰²³
- ! Prof Coetzer stated that compulsory HIV testing after a sharps injury has become an urgent necessity where the source patient is unable or unwilling to give permission for such testing. The same applies to testing of the blood of a deceased person where body fluids have contaminated a health care worker and

1020 Memorandum 3.

1021 Ibid 2.

1022 According to Prof Coetzer's proposals "sexual offenders" will include all persons *arrested* for rape, attempted rape, and indecent assault; and all persons *convicted* of rape, attempted rape and indecent assault.

1023 Memorandum 2.

the next of kin refuses to give permission for blood to be taken from the deceased. He submitted that because of time constraints it is not feasible to employ a court order for these purposes.¹⁰²⁴ He conceded that HIV testing under these circumstances is health related (as opposed to the Project Committee's proposals which are criminally related), but emphasised that it is unlikely that these matters will be adequately addressed in health legislation in the near future.¹⁰²⁵ He appealed to the Project Committee that its proposals should therefore deal with compulsory HIV testing in its entirety and not be confined to sexual offences because the latter have assumed political importance.¹⁰²⁶

Evaluation and recommendation

12.19 Prof Coetzer's proposals differed radically from those of the Project Committee:¹⁰²⁷

- ! They aimed to create a general process for the compulsory HIV testing of a range of persons in order to disclose the test results for multiple purposes; while the Project Committee's proposals were confined to testing of suspects in sexual offence cases and disclosure of the test results was limited to victims of sexual offences with the single purpose of supplying them with peace of mind about the possibility of having been exposed to HIV during a sexual offence.¹⁰²⁸
- ! The testing process proposed by Prof Coetzer was not victim-initiated but a compulsory "automatic" process. (Blood samples for HIV testing would be automatically taken immediately after arrest or conviction - unless prior enquiry revealed that the HIV status of the person concerned was already indicated as positive in the proposed national register. A designated laboratory would perform

1024 See fn 1016 and 1017 - Prof Coetzer's proposals provide for such testing to take place "automatically" if certain conditions are met.

1025 Prof Coetzer pointed out that the new Health Act has not yet been promulgated and that the Department of Health is at present reconsidering their proposed amendment to the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (see Chapter 6 above for information on these Regulations and proposed amendments).

1026 Memorandum 4-5.

1027 Clauses 1-8 of the draft legislation contained in the Memorandum.

1028 Both the Project Committee's and Prof Coetzer's proposals provided for the disclosure of the test results to the person tested.

the tests and record the results in a prescribed manner for purposes of its inclusion into the national register by a person delegated to perform this task.)

- ! Under Prof Coetzer's proposals no person or body had any discretion to authorise or refuse the performance of HIV testing - if the provisions of his proposed legislation were met, testing would be automatic and compulsory. In contrast to this, HIV testing under the Project Committee's proposals would require a deposition on oath by the applicant, a specified standard of proof, judicial scrutiny and judicial authorisation as basis.
- ! An essential element of Prof Coetzer's proposals was that disclosure of HIV test results took place by way of access to a national register.¹⁰²⁹ His proposed procedure did not provide for an application for HIV testing as such. Testing in fact occurs "automatically" while the procedure prescribed concentrates on authorising disclosure of the test results through access to a national register. (In the case of victims of sexual offences, an application for disclosure would be directed to a designated medical officer or nurse who had access to the national register. The application had to contain certification by a medical officer of the possibility that body fluids could have been transferred from the alleged assailant or convicted person to the complainant.¹⁰³⁰ A designated medical officer or nurse - who would have access to the national register - would be obliged to provide the results in writing if the prescribed requirements were met.) According to the Project Committee's proposals, disclosure of HIV test results was dependent on a successful application for HIV testing with built-in safeguards to protect arrested persons' rights.

1029 The establishment of a national register was central to Prof Coetzer's proposals. He in fact indicated to the Project Committee that if his proposal regarding the creation of a central register is rejected, the entire process proposed by him falls through as it provides for no other means of disclosure of HIV test results.

1030 Prof Coetzer envisaged that the medical practitioner examining the complainant after an alleged sexual offence would supply such certification.

12.20 In considering Prof Coetzer's proposals related to HIV testing of arrested and convicted persons, the Project Committee acknowledged that the following differing though important objectives are at issue:

- ! The need for improvement of the current system of HIV testing of offenders in terms of section 37 of the Criminal Procedure Act for purposes of sentencing.
- ! The inefficiencies of a system in which offenders and alleged offenders must be tested on multiple occasions at state cost which the establishment of a national register may eliminate.
- ! The need to provide victims of sexual offences who may have been exposed to HIV with some limited assistance determining life choices immediately after violation.

The committee also acknowledged the unavoidably limited scope of the intervention it proposed. It had grave reservations however about the utility and practicality of extending its proposals at present. The committee believed that section 37 of the Criminal Procedure Act already provides sufficient authorisation for HIV testing for evidentiary purposes (which would include evidence for sentencing purposes), and that it is for the South African Police Service (SAPS) to establish a satisfactory and comprehensive administrative system of HIV testing for evidentiary purposes under section 37.¹⁰³¹

12.21 The Project Committee also concluded that it could not practicably extend its current focus to include testing related to sharps injuries and deceased persons. It considered that these further categories of compulsory testing (related to HIV infection or exposure which may have been acquired in other, mainly medical, circumstances in the course of employment) should be addressed separately in any appropriate legislation on HIV testing because of inherent differences of principle.

1031 See the discussion of sec 37 in Chapter 7 above.

- 12.22 As far as the establishment of a national register was concerned, the committee believed that the institutional and financial load of undertaking such a task will be enormous and will involve impracticable burdens at a time of severely stretched resources and capacities. In addition, privacy issues are immense.¹⁰³²
- 12.23 Finally, the committee recommitted itself to its immediate and urgent mandate of providing a means for HIV testing of sexual offenders in view of women's vulnerability to sexual violence amidst the increasing spread of HIV in the absence of other victim support measures. In this context and at the level of procedure, it also carefully considered Prof Coetzer's proposal for authentication by a medical practitioner of the victim's possible exposure to the body fluids of the arrested person. It was however decided against including such a requirement in its final proposals since many sexual offences (including rape) do not necessarily leave signs either of the application of trauma or of exposure to body fluids. It therefore seemed unlikely that medical authentication will add substantially to an averment on oath by the alleged victim.

Concerns and suggestions for the amendment and refinement of the Commission's proposed legislation

- 12.24 Most respondents, both for and against compulsory testing, made suggestions for amendments to the draft Bill proposed in Discussion Paper 84. Several of these were incorporated in the revised Bill included in Chapter 13. Suggestions not incorporated are addressed in the evaluation below. The most significant change to the proposed legislation - in response to a need reflected in the comments and after deliberation with the Department of Justice and Constitutional Development¹⁰³³ - consists in adding

1032 Prior to submitting his proposals to the Commission, Prof Coetzer briefly raised his suggestion for the creation of a national register for recording HIV test results at the consultative meeting with experts on 4 February 2000. Those experts who responded to this suggestion were of the view that a record of such information, especially where the arrested person's name is used, would constitute a major infringement of his or her privacy rights (comments of Dr Tertius Geldenhuys). Cf also Chapter 5 and par 12.12 on infringement of the right to privacy.

1033 Discussions with Ms I Wolmarans, Director: Subordinate Legislation, Department of Justice and Constitutional Development on 29 October 1999.

regulations addressing the practical implementation of the Bill in order to present the Commission's proposals as a complete, practical, and workable process.

Issues of principle

General issues

Where the proposed legislation should be placed

12.25 Some respondents to Discussion Paper 84 and experts attending the consultative meeting on 4 February 2000 expressed the opinion that it is not appropriate to enact the proposed intervention as an amendment to the Criminal Procedure Act.¹⁰³⁴ The reasons advanced for this were:

- ! The Criminal Procedure Act is of its very nature a *general* Act which does not focus on any specific offences or circumstances while the Commission's proposals deal exclusively with HIV testing in respect of sexual offences where there was the possibility of exposure to bodily fluid.¹⁰³⁵
- ! The only aspect the proposed provisions have in common with section 37 is the establishment of bodily features. However, the purposes of the proposed provisions and that of section 37 are completely different - section 37 is aimed at obtaining evidence in a criminal trial, while the proposed intervention is for non-evidentiary purposes (i.e. reducing trauma to victims).¹⁰³⁶ Inclusion of the proposed legislation in the Criminal Procedure Act will cause confusion between the current section 37 and the Commission's proposed amendment of that section.¹⁰³⁷
- ! The proposed procedure is not "criminal process-related" as it is not part of a

1034 Comments of the Director of Public Prosecutions KwaZulu-Natal; Director of Public Prosecutions Pretoria; and Tshwaranang Legal Advocacy Centre.

1035 Comments of Ms Wilma Louw.

1036 Comments of the Director of Public Prosecutions KwaZulu-Natal; and Ms Wilma Louw.

1037 View expressed by Adv Retha Meintjes at the consultative meeting on 4 February 2000.

criminal trial or aimed at bringing about any outcome in the criminal process - it deals more with restorative justice and victim empowerment.¹⁰³⁸ It is significant that the only other provision in the Criminal Procedure Act which can be regarded as victim-related in a sense is section 300 ("Court may award compensation where offence causes damage to or loss of property"). However, this provision is a *general* provision not focussing on a specific offence, or on specific circumstances relating to a specific offence.¹⁰³⁹

- ! The standard of proof required for granting an order for compulsory testing is not proof beyond reasonable doubt as in a criminal trial, but the establishment of a prima facie case.¹⁰⁴⁰
- ! The result obtained from an HIV test authorised in terms of the proposed intervention may be made known only to the victim and the arrested person, and is not admissible as evidence at the subsequent criminal trial.¹⁰⁴¹

12.26 The following alternative options were suggested:

- ! The proposed legislation should be included in the new Sexual Offences Act envisaged by the Law Commission since the proposed measures are limited to HIV testing in respect of sexual offences; and they are intended to provide peace of mind for victims of sexual offences only.¹⁰⁴²
- ! The proposed measures should be included in a specific separate Act dealing only with HIV testing.¹⁰⁴³ Such an Act could include measures aimed at HIV testing for sentencing purposes. Some experts however indicated that provision for HIV testing for sentencing purposes is already covered by section 37 of the Criminal Procedure Act.¹⁰⁴⁴
- ! Criminal procedure should not be utilised for the proposed intervention. A civil

1038 Comments of Ms Wilma Louw. See also the comments of Tshwaranang Legal Advocacy Centre.

1039 Comments of Ms Wilma Louw.

1040 Ibid.

1041 Ibid.

1042 Comments of the Director of Public Prosecutions Pretoria.

1043 Comments of the Director of Public Prosecutions KwaZulu-Natal.

1044 Views expressed by Adv Retha Meintjes and Prof PWW Coetzer.

remedy in the form of a mandatory interdict should rather be developed.¹⁰⁴⁵

Evaluation and recommendation

- 12.27 In view of the above comments the Commission reconsidered its preliminary intention to recommend enacting its proposals as an amendment to section 37 of the Criminal Procedure Act. In doing so it acknowledged first, that the proposed intervention in essence deals with victim empowerment; and second, that bearing in mind the strong arguments for not including it in the Criminal Procedure Act, the only advantage of retaining it as an amendment to section 37 would be the prominence the proposals would have.
- 12.28 The Commission concluded that the proposals would more fittingly be placed within legislation dealing with victim empowerment, or alternatively within envisaged legislation dealing with sexual offences as its aim is to provide assistance to victims of such offences. As legislation currently deals with neither victim empowerment in general, nor sexual offences¹⁰⁴⁶ the Commission's recommends that its proposals in the interim be placed within an individual separate Act with the long term vision of incorporating it in either of the two mentioned alternatives.¹⁰⁴⁷

-
- 1045 Comments of Tshwaranang Legal Advocacy Centre. Tshwaranang in particular submitted that a civil remedy would be more suitable in view of the fact that the majority of victims do not report sexual offences committed against them, and do not lay a criminal charge against their assailant. The advantages of a civil remedy would be that it will be truly victim-orientated in that the victim will be party to the proceedings; it will ensure that all rape victims including those who opt not to lay a charge, can obtain an order for compulsory testing; and it will circumvent any bureaucracy on the part of the Department of Health on the provision of PEP to victims (see par 12.102-12.103 on the last point).
- 1046 The Commission is currently engaged in an investigation which aims to codify both the substantial law and procedural matters relating to sexual offences.
- 1047 See the proposed draft Bill included in Chapter 13.

Whether a system of victim or state-initiated testing should be pursued

12.29 Some respondents commenting on Discussion Paper 84 as well as certain experts attending the consultative meeting on 4 February 2000 suggested that HIV testing of arrested persons should not be initiated by victims. They believed that it should be an "automatic" part of the procedure in respect of every person charged with having committed a sexual offence which should be initiated by the state.¹⁰⁴⁸ The following different arguments motivated this proposal:

- ! First, it was submitted that such an approach would relieve the victim of the burden of making an application for testing to the magistrate. The victim would be requested only to decide whether the HIV test results should be disclosed to him or her.¹⁰⁴⁹ Support for this argument may be found in the observation that one of the perceived limitations of the proposed procedure was that traumatised victims might not feel enabled to make the required sworn statement (on which an application for compulsory testing would be based) at an early stage after a sexual assault or after the medical examination.¹⁰⁵⁰
- ! Second, it was submitted that the information obtained by compulsory testing should be admissible in a criminal trial, and that under these circumstances HIV testing should be initiated by the prosecuting authority with the state being obliged to inform the victim of the test result.¹⁰⁵¹
- ! Third, it was stressed that the proposed testing procedure should not be available only to victims who are prepared or willing to lay a charge or report a sexual offence: It should also be available to those who allege that an offence has been

1048 Comments of the Acting Director of Public Prosecutions Venda High Court; and Regional Court Magistrate M Moloto. Views expressed at the consultative meeting by Adv Retha Meintjes; Prof PWW Coetzer; Ms Lebo Malepe; Ms Ros Halkett; and Prof S Gutto.

1049 Comments of the Acting Director of Public Prosecutions Venda High Court. This proposal was based on the premise that the proposed Bill will contain sufficient safeguards to prevent the flagrant violation of the rights of potentially innocent arrested persons by requiring a certain standard of proof on which a court will grant an authorisation for testing.

1050 Cf the comments of Dr Jim Te Water Naude.

1051 Comments of Regional Court Magistrate M Moloto. See also the submission of Prof PWW Coetzer discussed in par 12.14 et seq above.

committed against them but who choose *not* to lay a charge.¹⁰⁵² In this regard Tshwaranang Legal Advocacy Centre questioned whether the proposed procedure can at all be regarded as victim-centred or victim-initiated in view of the fact that victims' rights with respect to the application are not evident from the draft Bill. Tshwaranang presumed that this points to the prosecution playing a dominant role in the application for testing. They suggested that in order to grant victims control over the application, to achieve real representation of victims' interests, and to avoid secondary victimisation, victims need to be formally recognised as a party to any proceedings to have arrested persons tested for HIV.

Evaluation and recommendation

12.30 The Commission remains convinced that the proposed procedure should be victim-initiated as one of the fundamental safeguards built into the procedure to protect the arrested person's right to privacy. Clause 2 of the draft Bill reflects this. In response to the arguments above, the Commission concluded as follows:

- ! It is unnecessary to rely on state-initiated testing for reasons related to victim trauma as the draft Bill has been amended to make specific provision for traumatised victims who do not feel enabled to apply for compulsory testing themselves. Clause 3 provides that any person who has a material interest in the well-being of the victim (including a spouse, family member, caregiver, friend, counsellor, health service provider, police official, social worker or teacher) may bring the application - provided that the victim has given his or her written consent. Provision has also been made for the notice containing information on the testing procedure to be handed to a person acting on the victim's behalf.¹⁰⁵³
- ! To limit inroads into the arrested person's rights, the Commission rejected the proposal that information on the arrested person's HIV status should be available

1052 Views expressed by Prof PWW Coetzer, Ms Lebo Malepe, Ms Ros Halkett and Prof S Gutto at the consultative meeting of 4 February 2000. See also the comments of Tshwaranang Legal Advocacy Centre and the Federation of Women's Institutes KwaZulu-Natal on Discussion Paper 84.

1053 Clause 1 of the draft Bill and Form 1 of the draft Regulations.

for evidentiary purposes.¹⁰⁵⁴ This obviated the argument that the prosecution should initiate compulsory testing since it may utilise the information gained through such testing. Moreover, to relegate the victim's role from initiating the testing procedure to receiving information does not recognise the need for victims to regain control after rape or sexual assault.¹⁰⁵⁵

- ! The Commission concedes that its proposed procedure would not be available to all victims of sexual offences. As indicated above, the Commission is well aware of the limited nature of its proposals and does not submit them in the belief that they will solve all problems encountered by victims of rape and sexual assault.¹⁰⁵⁶ The Commission believes that the procedure proposed will not even be utilised by all victims who are willing to lay a charge, but by a limited group of victims who have the necessary means of support, resources and energy to pursue the procedure proposed. Comments and views gathered throughout the consultation process confirmed that the proposed procedure, despite its limitations, should nevertheless be proceeded with as it would benefit victims of sexual offences in that it would constitute a first step in establishing a holistic system of support for such victims.¹⁰⁵⁷ As indicated by Tshwaranang Legal Advocacy Centre, a fundamental principle of victim support is that victims should be enabled to take control over their situation.¹⁰⁵⁸ The Commission believes that its proposed system of victim-initiated testing would indeed provide this form of support in making it possible for victims not only to decide whether they wish to access information about the HIV status of the arrested person, but by instituting such process themselves. The Commission never envisaged that the prosecution would play any role in the proceedings and neither the draft legislation submitted for public comment nor the final draft contained in this Report provides for any role for the prosecution.
- ! A system of state-initiated routine testing would by its very nature have to be linked to a recording system or data base reflecting the information gained. Prof

1054 See clause 16 of the draft Bill. See also par 12.81-12.84 below.

1055 Cf the comments of Tshwaranang Legal Advocacy Centre in par 12.29.

1056 See par 12.12, 12.20 and 12.109.

1057 Ibid.

1058 See also the comments of Tshwaranang Legal Advocacy Centre referred to in par 12.29.

Coetzer's proposals for an "automatic" testing procedure and his concession that the entire procedure is based on disclosure through a national register bears evidence to this.¹⁰⁵⁹ This would entail a substantial infringement of the arrested person's rights, particularly as the proposed testing is to be carried out before conviction. Moreover, the Commission has rejected establishment of a national record of HIV test results in view of the institutional and financial load of undertaking such a task at a time of severely stretched resources and capacities.¹⁰⁶⁰

- ! An automatic system of state initiated routine HIV testing of all persons arrested in sexual offence cases (with the victim deciding on whether she wishes the results to be disclosed to her) would amount to a waste of valuable resources if neither the majority of victims nor the authorities have any use for this information. If the assailant is not apprehended soon after the alleged offence, the utility of testing will dissipate and sero-positivity in the arrested person at a late stage would not be indicative of whether the victim has been exposed to HIV.¹⁰⁶¹ As regards the authorities, even if utilising information gained through compulsory testing is allowed for evidentiary purposes, such evidence would not be relevant in all sexual offence cases and would thus not be used in all such cases.
- ! Finally, it is believed that victim-initiated testing provides a balance between the rights of victims and arrested persons as it places a responsibility on the victim to invoke the procedure; and requires the victim to base the application on information on oath that a sexual offence, in which exposure to the body fluids of the arrested person may have occurred, has been committed against him or her.¹⁰⁶²

1059 See par 12.19 and fn 1029.

1060 See par 12.232 above in response to Prof PWW Coetzer's proposal for a national register recording HIV test results of arrested and convicted persons.

1061 Criticism of this nature against the Commission's current proposals have been dealt with by providing for cut-off periods of 50 and 60 days within which an order for HIV testing must be granted and executed respectively. See Par 12.52 et seq.

1062 Clauses 2(1) and 7(1)(a)(i)-(iii) of the draft Bill.

Who may act on behalf of a victim in bringing an application for compulsory HIV testing

12.31 According to the draft Bill proposed in Discussion Paper 84, a victim or "a person acting on his or her behalf" may initiate compulsory testing. Some respondents requested the Commission to clarify this phrase. They specifically enquired as to whether the person acting on behalf of a victim has to be a relative; and whether it would also include a "health professional", or in the case of sexually abused children, the "primary caregiver".¹⁰⁶³

Evaluation and recommendation

12.32 In response to the above comments the Commission has amended the draft Bill to indicate clearly that "any person who has a material interest in the well-being of the victim" may bring an application for compulsory testing on behalf of such victim.¹⁰⁶⁴

12.33 A non-exhaustive list of persons who may possibly have such interest is provided and includes a spouse, family member, caregiver, friend counsellor, health service provider, police official, social worker or teacher.¹⁰⁶⁵

12.34 It is envisaged that two broad categories of victims could not or may not be able to bring applications themselves: those who are too traumatised by the rape or sexual assault and those who do not have the legal capacity to act on their own (eg where the victim is under the age of 14; mentally ill; unconscious; or a person in respect of whom a curator has been appointed in terms of an order of court).¹⁰⁶⁶

12.35 A victim's written consent is necessary for another person to bring the application on his or her behalf except in those specified cases where the victim cannot legally act on his

1063 Comment of the South African Dental Association and the Durban Children's Society respectively.

1064 Clause 3.

1065 Ibid.

1066 Ibid.

or her own.¹⁰⁶⁷

The relevance of the victim's HIV status before the alleged sexual offence

- 12.36 Some respondents to Discussion Paper 84 who opposed the proposed intervention raised the possibility that the victim may have become infected with HIV before the alleged rape or sexual assault. They suggested that the victim's previously acquired HIV infection should influence an application for compulsory testing of an arrested person.¹⁰⁶⁸
- 12.37 This proposal met with opposing views from experts attending the consultative meeting of 4 February 2000: Some expressed the view that where the victim is known to be HIV positive, the arrested person should not be tested for HIV as there would be no purpose in pursuing knowledge of the arrested person's HIV status in these circumstances.¹⁰⁶⁹ However others pointed out that a second infection or re-infection of the victim by the arrested person might cause acceleration of the disease in the victim.¹⁰⁷⁰ They submitted that the HIV status of the arrested person is therefore still of importance to the victim and that the victim's HIV status should be of no relevance in deciding whether the arrested person should be tested.¹⁰⁷¹

Evaluation and recommendation

- 12.38 The Commission considers the victim's HIV status to be irrelevant for purposes of an application for compulsory testing. Apart from scientific evidence that a second infection

1067 Ibid.

1068 Comments of Mr Lucky Mazibuko; SAPOHR; and the Northern Province ATICC. The Director of Public Prosecutions Witwatersrand Local Division, although supporting the proposal for compulsory testing, also raised this issue.

1069 View expressed by Prof S Gutto.

1070 This statement of Dr Jim Te Water Naude seemed to be debatable and was questioned by the project leader Mr Justice Edwin Cameron. See also fn 1072 below.

1071 Views expressed by Dr Jim Te Water Naude.

or re-infection may be detrimental to a person already infected with HIV,¹⁰⁷² the Commission submits that all victims of rape and other sexual offences are entitled to know the HIV status of their alleged assailants because of the violation involved in such offences. The draft Bill thus contains no reference to the victim's HIV status.

Whether testing should be limited to testing in cases of exposure during a sexual offence only

12.39 Certain commentators on Discussion Paper 84 were of the view that the Commission's proposals were flawed in that compulsory testing was reserved for instances of sexual contact only. They suggested that the proposals should take cognisance of risks of transmission of HIV as a result of other criminal means of contact such as physical assault (i.e. extending the proposal to include exposure to the body fluids of the accused irrespective of whether exposure occurred during a sexual offence or not).¹⁰⁷³ Some experts attending the consultative meeting shared this view and submitted that it is not logical to limit the procedure to exposure during a sexual offence as an "exchange of body fluids" rather than a "sexual act" places one at risk of HIV infection.¹⁰⁷⁴ One commentator suggested that availability of the proposed procedure should be even further extended to include exposure not only to the body fluids of the arrested person, but to "any substance" in order to enable the victim to know at the earliest possible moment exactly what he or she has been exposed to, and whether it was a dangerous substance.¹⁰⁷⁵

1072 Scientific evidence on the dangers of re-infection is at this stage not conclusive. It is not clear first, whether it is possible to be re-infected with HIV; and second, whether re-infection will lead to faster disease progression - either through the transmission or creation of a naturally more virulent virus or through the transmission of drug resistant virus (Howard 1999 **San Francisco Bar Area Reporter** [Internet]; Salyer **Survival News** June 1999 [Internet]).

1073 Comments of Judge President EKW Lichtenberg; Mr Rashid Patel; Dr A Hiemstra; and the Democratic Nursing Organisation of South Africa.

1074 Views of Dr Tertius Geldenhuys; Prof PWW Coetzer; and Dr K Müller. Dr Müller specifically referred to cases of fluid being injected into victims where the risk of HIV transmission could be very high (if the fluid was body fluid).

1075 Comments of Judge President EKW Lichtenberg.

Evaluation and recommendation

- 12.40 The Commission resolved to retain its preliminary proposal to limit applications for compulsory HIV testing to cases where a person has been the victim of an alleged sexual offence.
- 12.41 Although the Commission recognises in this Report that HIV may be transmitted in the criminal context in ways other than through sexual acts, scientific evidence shows that transmission in those instances (i e through fighting, biting, spitting and injecting HIV infected blood) is extremely rare.¹⁰⁷⁶ Moreover, in the case of the alleged injection of HIV infected bodily fluid it will not be certain whether the arrested person is in fact the source of the fluid to which the victim has been exposed and therefore testing the arrested person may serve no purpose. The Commission reiterates its view that the primary purpose of the proposed intervention is to provide peace of mind for victims of sexual violence against the background of the violent epidemic of rape and other sexual offences in South Africa.

Whether sexual offence should be defined in the draft Bill

- 12.42 Prof Sunette Lötter of the Department of Criminal and Procedural Law, UNISA observed that "sexual offence" is not defined in the proposed Bill. She submitted that in terms of the Sexual Offences Act 23 of 1957 "prostitution" is an offence, which would mean that the proposed Bill would be applicable to prostitution. She argued that it would be untenable if this would be the position as first, prostitution is regarded as a victimless offence and that it would be unacceptable if the client of a prostitute could rely on the same protection as a victim in a rape case; and second, that the situation may arise that a prostitute (who runs a much higher risk of becoming infected with HIV and who could to a certain extent also be regarded as a "victim"), may be treated in the same way as a rapist. Prof Lötter expressed concern that every one of the clients of a prostitute could insist that she undergoes testing and observed that this could certainly not have been the purpose of the proposed intervention.

1076 See par 3.18 et seq above.

Evaluation and recommendation

- 12.43 The Commission resolved not to include a definition of "sexual offence" in its final draft Bill.
- 12.44 The Commission indicated at the outset of the present Report that for purposes of its discussion 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.¹⁰⁷⁷ This may include the offences of rape, statutory rape, indecent assault, and incest. It should however be noted that the Commission is also engaged in an investigation into sexual offences which, inter alia, aims to codify the current range of sexual offences. At the time of compilation of the present Report the envisaged legislation on sexual offences (which will include a definition of "sexual offence") has not been finalised. The present Report's wide interpretation of "sexual offence", the express omission of a definition of "sexual offence" in the draft Bill, and the qualification in the draft Bill that the offence should be such that it was an offence in the course of which "the victim may have been exposed to the body fluids of the arrested person"¹⁰⁷⁸ are aimed at making the proposals compatible with any new statutory definition of "sexual offence".
- 12.45 In response to Prof Lötters concerns, the Commission is of the view that the client of a prostitute would not be able to utilise the proposed procedure as it is unlikely that a court would regard such client a "victim". "Victim" in the proposed Bill implies that the person has been unwittingly subjected to a sexual act, as opposed to a "client" who wittingly engages and pays for a sexual act.¹⁰⁷⁹ Moreover it is submitted that "prostitution" in itself is not a sexual offence in terms of the Sexual Offences Act 23 of 1957.¹⁰⁸⁰ In the light of this the Commission did not believe it was necessary to define the term "sexual offence"

1077 See par 2.24.3.

1078 See clause 2(1) and 7 (1)(a)(ii).

1079 Cf also par 2.24.4 where it was indicated that the term "victim" in this Report refers to any person (male or female, child or adult) who is the direct subject of an alleged sexual offence.

1080 According to sec 20 of the Act "any person who knowingly lives wholly or in part on the earnings of prostitution" commits an offence. I.e participating in the sexual act in itself is not an offence, whilst the proposed procedure requires the victim to be the subject of a sexual act involving the exchange of bodily fluid.

so as to ensure that clients of prostitutes would not be able to utilise the proposed procedure.

Whether compulsory testing should be limited to testing for HIV only

12.46 The Commission's proposed Bill in Discussion Paper 84 provided for compulsory HIV testing in respect of "HIV or any other life-threatening sexually transmitted disease". There was no consensus among respondents to Discussion Paper 84 on this issue. The same divergence of opinion was reflected in the views of experts attending the consultative meeting on 4 February 2000 when this issue was specifically submitted to them for discussion. Commentators and experts held the following views:

! *Providing for compulsory testing in respect of "HIV or other life-threatening sexually transmitted diseases"*

Some commentators supported the Commission's preliminary suggestion that compulsory testing should be provided for in respect of HIV or other life-threatening sexually transmitted diseases (i.e. *all* or *any* other life-threatening sexually transmitted diseases).¹⁰⁸¹ Experts attending the consultative meeting who supported this argued that there is logically no distinction between HIV and other sexually transmitted diseases which are also life-threatening conditions.¹⁰⁸² It was however submitted that referring to "other life-threatening sexually transmitted diseases" was confusing (as *many* of these diseases, if untreated, carry a threat to life), and that the proposed provision not making it clear for which sexually transmitted disease arrested persons would be tested, would in practice result in delays while courts argued the point.¹⁰⁸³ It was thus suggested that a list of specific sexually transmitted diseases should be compiled with the assistance of medical experts and be included in the envisaged policy to be

1081 Comments of Judge President E King; the Department of Welfare; and the Afrikaanse Christelike Vrouevereniging.

1082 Comments of Dr Jim Te Water Naude.

1083 Dr Te Water Naude by way of example referred to the human papilloma virus (which may cause cancer); gonorrhoea and chlamydia (which may cause infertility); and syphilis (which may cause still-births and miscarriages).

promulgated in terms of the proposed legislation. (The proposed sec 37(8) of the draft Bill included in Discussion Paper 84 provided that the Ministers of Health, and Justice and Constitutional Development promulgate policy on the testing methods and procedures to be used for compulsory testing.)

! *Providing for compulsory testing in respect of "any sexually transmitted disease"*

Other respondents to Discussion Paper 84 were of the opinion that compulsory testing should not be restricted to HIV or other life-threatening sexually transmitted diseases but extended to testing for "*any sexually transmitted disease*".¹⁰⁸⁴ Motivation for this was based on different arguments:

- P First, it was submitted that although not all sexually transmitted diseases are life-threatening, they all are potentially very harmful with long term consequences and the opportunity for compulsory testing for these diseases should thus be available to victims.¹⁰⁸⁵ (In this regard it was pointed out that tests would in some instances have to go beyond blood tests and require physical examination.¹⁰⁸⁶)
- P Second, it was argued that the explicit mention of HIV does nothing to advance the rights of the victim while it simultaneously exacerbates the broader societal stigmatisation of the HIV disease.¹⁰⁸⁷ In this regard it was stressed that HIV is a peculiar disease in that mention of it is often accompanied by moral indignation - which has not helped in managing the disease and which caused it to be a hidden and denied disease. Further, that the explicit reference to HIV in the Bill unnecessarily associated the disease with rapists and other sexual offenders while referring generally to sexually transmitted diseases (and omitting reference to HIV) would be in the greater good of society, and would in no

1084 Comments of Mr Rashid Patel; Mr Seth Abrahams; the Federation of Women's Institutes KwaZulu-Natal; NCEDO Care Centre; and Dr Walter Loening.

1085 Comments of Dr Walter Loening.

1086 Ibid. See also the comments of the Federation of Women's Institutes KwaZulu-Natal.

1087 Comments of Mr Ronald Louw (not supporting the proposed intervention, but nevertheless commenting on the terms of the Bill).

way detract from the rights of victims.¹⁰⁸⁸

! ***Providing for compulsory testing in respect of "HIV or any transmitted disease"***

One commentator suggested that compulsory testing should be available in respect of "HIV or any transmitted disease". He believed that a victim has the right to know whether his or her assailant suffered from any such transmitted disease at the time of the assault or attack - whether such attack or assault was sexual or otherwise.¹⁰⁸⁹

! ***Providing for compulsory testing in respect of "HIV and Hepatitis B"***

Certain experts attending the consultative meeting submitted that with the exception of Hepatitis B, all other sexually transmitted diseases are treatable. There is therefore no need to provide for compulsory testing in respect of them all. They suggested that testing be limited to testing for HIV and Hepatitis B.¹⁰⁹⁰

! ***Limiting compulsory testing to testing for "HIV only"***

Certain experts attending the consultative meeting on 4 February 2000¹⁰⁹¹ were of the strong opinion that the proposed procedure should be limited as far as possible -

P because of the cost implications of extended testing;¹⁰⁹²

P because it would be practically impossible and therefore not realistic to test for any number of sexually transmitted diseases in every perpetrator;¹⁰⁹³ and

P because of the fact that government does not have funds to make PEP available to victims, scarce funds should not be utilised for testing for any

1088 Ibid.

1089 Comments of Judge President EKW Lichtenberg.

1090 Views of Dr A Hiemstra; Dr N McKerrow; and Dr MJ Matjila.

1091 None of the respondents dealing with this issue in their comments on Discussion Paper 84 indicated that compulsory testing should be limited to testing for HIV only. (This could however be ascribed to the fact that this possibility was not posed in the draft Bill included for comment in Discussion Paper 84.)

1092 View of Prof S Gutto.

1093 View of Prof PWW Coetzer.

other diseases.¹⁰⁹⁴

On a practical level, Dr Graham Nielsen drew the Commission's attention to the fact that many sexually transmitted diseases are recurrent diseases which are only transmissible during a re-occurrence. Although a blood test in this instance may show that the arrested person has a certain sexually transmitted disease, this would not necessarily imply that the victim has been exposed to such disease.¹⁰⁹⁵

Evaluation and recommendation

12.47 Taking into account the diverse views of commentators and experts, the Commission, after consideration, concluded that the proposed procedure should be limited to testing for HIV only.

12.48 The Commission 's motivation for this is as follows:

- ! In the case of many sexually transmitted diseases, a positive test result in the arrested person may not necessarily imply that the victim has been exposed to such diseases.
- ! It is relatively easy to establish the presence of most other sexually transmitted diseases.
- ! Testing for other sexually transmitted diseases is cheaper than testing for HIV and is available at public health facilities (i e victims can have themselves tested through existing facilities).
- ! Except for Hepatitis B, all other sexually transmitted diseases can be medically treated.
- ! Such treatment is provided at state expense at primary health care facilities.

12.49 In response to the argument that testing must be extended because of the danger of other diseases to the health of the victim (as in the case of life-threatening sexually

1094 Ibid.

1095 Information supplied to the researcher by Dr Graham Nielsen of the Directorate: HIV/AIDS and STDs, Department of Health on 2 November 1999.

transmitted diseases such as Hepatitis B), the Commission submits that currently HIV is the only disease transmissible by sexual intercourse for which the state does not provide treatment. Furthermore, HIV is a life-threatening disease which will invariably result in death if the person does not receive treatment. HIV is also the only sexually transmitted disease which impacts severely not only on a person's health, his or her ability to procreate and to have sexual intercourse, but also on socio-economic aspects of a person's life.

- 12.50 The Commission is of the opinion that to extend compulsory testing to testing for "any (transmitted) disease" would be impractical and unaffordable: What diseases would be tested for, how many diseases would be tested for, and what tests would be used?
- 12.51 With regard to the criticism that the proposed procedure is a form of AIDS exceptionalism, the Commission acknowledges that the draft Bill indeed focuses on HIV.¹⁰⁹⁶ However it believes that this is necessary considering the concerns of victims of sexual offences regarding the possible transmission of HIV during a sexual offence. South African women and children face an epidemic of sexual violence amidst a growing HIV epidemic which justifies special measures to be taken.¹⁰⁹⁷

What cut-off period, if any, should be specified within which the application for HIV testing must be carried out

- 12.52 The proposed Bill included in Discussion Paper 84 provided that "(N)o 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".¹⁰⁹⁸ Several respondents to Discussion Paper 84 offered suggestions for amending this provision - with no unanimity on whether the proposed time limit should be scrapped, limited, or extended. In addition, the view was expressed that referring to the relevant period in days (eg "120 days"

1096 See fn 910 for information on "AIDS exceptionalism".

1097 Cf the discussion on the public outcry for measures aimed specifically at violence against women in the wake of the current HIV/AIDS epidemic in par 2.4 et seq above.

1098 See subclause (7) of the proposed Bill in ANNEXURE A.

instead of "four months") would have a more precise meaning.¹⁰⁹⁹ In view of the divergence of comments an amended provision was submitted to experts at the consultative meeting on 4 February 2000. The amended provision expressed the time limit in days and limited it to two months (i.e. "60 days"). The limited period was provided for to restrict the infringement on the arrested person's rights to the minimum in accordance with the comments of the Department of Health (see below). The following opinions were expressed by commentators and experts:

! *No restriction to be imposed*

A single commentator was of the opinion that the proposed limitation within which an application for compulsory testing should be carried out should be deleted in its entirety. He observed that although it is well-nigh unthinkable that the magistrate's order for compulsory testing has still not been put into effect after the lapse of four months of its having been issued, such time limit should not be stipulated.¹¹⁰⁰

! *Restriction to be extended in general*

Others, while not explicitly calling for deletion of the restriction, expressed concern about unnecessarily limiting the period.¹¹⁰¹ The reasons submitted for this were twofold:

P First, it was observed that the proposed limitation presupposed that the SAPS would be efficient in arresting the alleged offender prior to the stipulated cut-off time of four months. It was submitted that a victim who applies for a testing order before arrest is effected, may have to suffer the indignation of applying again if the suspect was not arrested within the four-month period. In the interim there could be intimidation of the victim who would then not reapply.¹¹⁰²

P Second, it was believed that post conviction testing (at the request of the

1099 View expressed by Prof Andrew Skeen.

1100 Comments of Judge President EKW Lichtenberg.

1101 Comments of the Dental Association of South Africa; and the Mpumalanga Provincial Government Department of Agriculture, Conservation and the Environment.

1102 Comments of the Dental Association of South Africa.

victim) should be available in addition to pre-conviction testing in view of the long incubation period of the disease. The cut-off period would thus have to be extended so as to leave sufficient time to also accommodate post conviction testing.¹¹⁰³

! *Restriction to be extended to a particular period of time*

Mr Seth Abrahams suggested that the proposed four month period (i.e. 120 days) should be extended to five months (i.e. 150 days) as according to his information the window period could in exceptional cases be as long as "four to five" months. Dr Neil McKerrow at the consultative meeting on 4 February 2000 suggested that the period be extended from 60 days to 90 days to make provision for the 2% of child victims of rape and sexual offences who would not present with HIV after 60 days.¹¹⁰⁴

! *Restriction to be further limited*

The Department of Health emphasised that the purpose of compulsory testing would be to provide victims with information on whether they have been *exposed* to HIV - not whether they have been *infected*, as the latter can only be established by testing the victim him or herself. In view thereof that the value of the information on the arrested person's HIV status therefore diminishes over time, the Department suggested that the period stipulated be reduced to three months (i.e. 90 days).¹¹⁰⁵

Evaluation and recommendation

1103 Comments of the National Institute for Public Interest Law and Research.

1104 Note that Dr McKerrow's submission was made at the consultative meeting i.e. subsequent to the Project Committee amending the proposed provision to provide for a 60 day cut-off period. Dr McKerrow stated that 98% of children exposed to HIV and who actually became infected, will test positive after 60 days of exposure. He recommended that the 60 day period be extended to 90 days to also provide for the remaining 2%.

1105 See also the discussion on the need for measures to ensure compliance with an authorisation to test in par 12.112-12.113 below where it is indicated that some commentators suggested that testing of arrested persons should be effectively carried out within 24 hours after authorisation by the court.

- 12.53 In its final recommendations the Commission elected to restrict the cut-off period for *execution* of the proposed testing procedure to a precise period of 60 calendar days in order to ensure that the procedure remain an urgent and speedy remedy for victims of sexual offences. The purpose of limiting the execution period of a compulsory HIV testing order was specifically created to limit the infringement of the arrested person's rights. The total cut off period of 60 days was calculated to coincide with the length of the period during which a victim's own HIV test would not clearly indicate whether he or she had been infected with HIV (the "window period"¹¹⁰⁶).
- 12.54 Originally the Commission suggested a cut-off period of four months (i e 120 days) in Discussion Paper 84. This period was reduced to a period of 60 days in the proposals submitted at the consultative meeting in response to the Department of Health's comment that the value of the information of the arrested person's HIV status diminishes in time.
- 12.55 The proposed alternatives of placing no restriction on when compulsory HIV testing should be executed or extending it to a period of 150 days, would entail an unjustifiable infringement of the arrested person's rights. To extend the period to 90 days as suggested at the consultative meeting in order to accommodate the interests of 2% of children who may only sero-convert after 60 days would be to make provision for exceptions.
- 12.56 It should be noted that the time restriction was originally created in respect of *executing* the order so as to include the entire period from application up to disclosure of the test results. This may however have the result in practice that if the assailant is arrested *after* the 60-day time limit, a testing order can still be obtained since no time restriction was placed on *granting* the order. To protect the rights of the arrested person and to prevent civil claims against the SAPS or the magistrate, an additional cut-off period of 50 days was inserted in the draft Bill as one of the requirements which a magistrate has to take into account before granting an order for testing: The final draft Bill provides that an order for compulsory testing may be *granted* by a magistrate only if no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took

1106 See the discussion of the "window period" in par 3.4 above.

place.¹¹⁰⁷

Whether previously established HIV test results of the arrested person should be released to the victim

12.57 NCEDO Care Centre in its comments suggested including in the testing procedure provision for the disclosure of the results of HIV tests *previously* performed on the arrested person. They suggested that the investigating officer should be obliged to enquire from the family of the arrested person about such previous test results, or to use any other means to establish whether the arrested person has recently been tested for HIV, and to make this information available to the victim.¹¹⁰⁸ NCDO submitted that this approach would be of value where a suspect flees.

Evaluation and recommendation

12.58 The Commission considered this to be an impractical proposal. Previous negative HIV test results may no longer be valid. Further, obtaining such information from the arrested person's medical doctor or health care worker would not only amount to an infringement of an arrested person's legal right to privacy but also to a breach of an ethical duty of confidentiality binding the medical doctor and health care worker. Finally, accessing such information would only be feasible in health systems with sophisticated patient record systems.

Whether a victim should have access to the body specimen taken from an arrested person for purposes of the proposed HIV testing procedure

12.59 Some experts at the consultative meeting suggested that victims should have access to the body specimen taken from an arrested person in order to have further tests

1107 Clause 7(1)(a)(iii) of the proposed draft Bill.

1108 See also the proposals of Prof PWW Coetzer referred to in par 12.14 et seq above.

performed on it at own cost if desired.¹¹⁰⁹ Those opposing this view posed the question whether the specimen should not be destroyed.¹¹¹⁰

Evaluation and recommendation

12.60 The Commission presumes that the motivation for the above proposal is to enable a victim of a sexual offence to have additional HIV tests (eg P24 antigen tests which are currently not available in the public sector and which reduce the window period)¹¹¹¹ or tests for other diseases (eg Hepatitis B) performed on the body specimen at his or her own cost. This proposal was rejected on the basis that it would constitute an enormous invasion into the arrested person's right to bodily integrity, dignity and privacy. Moreover it would require the setting up of special procedures to ensure that the specimen was transported and handled with the necessary regard to public health legislation.¹¹¹²

Whether an arrested person should be questioned on, or granted an opportunity to reveal, his or her HIV status as part of the proposed procedure

12.61 NCEDO Care Centre suggested that in order to save time, and to enable a victim to initiate PEP at the earliest possible opportunity, the proposed legislation should also provide for the arrested person to be questioned, at his or her first appearance in court, on whether he or she has any sexually transmitted disease including HIV. The Centre submitted that the information supplied should not be used for evidentiary purposes, and that the matter will inevitably have to be heard by another magistrate after disclosure of this information.

1109 View of Prof PWW Coetzer.

1110 Question posed by Adv ZJ Van Zyl.

1111 See par 3.39 and fn 226 above for information on P24 antigen tests.

1112 Cf the Regulations relating to Blood and Blood Products 1990 (Government Notice R 1935 in **Government Gazette** 12695 of 17 August 1990).

Evaluation and recommendation

12.62 The Commission did not consider this proposal to be viable or practical: Even if the arrested person offered the required information, there would be no way of medically verifying the information. The proposal was therefore rejected.

Whether there is a need for specific provisions relating to children

12.63 Personnel of the Red Cross War Memorial Children's Hospital expressed concern that the Commission's proposals are aimed mainly at adult victims of rape and sexual offences. They submitted that children's needs should also be assessed and that special programmes should be devised to deal with these needs. In response to a request by the Project Committee to experts attending the consultative meeting on 4 February 2000 to bring such special needs to its attention, Dr Neil McKerrow suggested that children's interests could be addressed by extending the cut-off period within which the application for testing must be carried out.¹¹¹³

Evaluation and recommendation

12.64 The Commission's proposed provisions do not contain any special arrangements for children.

12.65 Apart from Dr McKerrow's proposal (which has been dealt with in par 12.56 above), no imperative for special arrangements for children emerged from the consultative meeting. The Commission thus concluded that the basic procedure established by the proposed Bill (eg clause 3 allowing for a person to act on behalf of a child victim below the age of 14 years) provides an adequate framework within which children's needs could be met. It is recommended that policy and practice in implementing the proposed legislation (eg by offering special counselling for children who have been the victims of sexual offences

1113 See par 12.52.

and their care takers) further deal with any special needs which may arise.

Issues related to arrested persons' interests

Whether the arrested person should be allowed to be present at and give evidence in an application for testing

- 12.66 Adv L Roberts, Director of Public Prosecutions Eastern Cape drew attention to the fact that the proposed Bill does not indicate whether the arrested person is entitled to appear or be represented at the hearing of the application for compulsory testing. He was of the opinion that if appearance is not expressly excluded in the Bill, ordinary considerations might dictate that the arrested person be entitled to be heard. He suggested that, in order to avoid any confusion, the draft Bill should state expressly whether arrested persons are or are not entitled to be heard. Adv Roberts further noted that if a suspect does have the right of participation, the provision that the victim can bring an application for testing in the district where he or she resides,¹¹¹⁴ could cause severe logistical problems (eg if the rape occurred in Johannesburg and the victim resides in Cape Town). He suggested that if the suspect is to be entitled to be heard, an application for compulsory testing should be brought only in the district where the offence was committed.¹¹¹⁵
- 12.67 Concern in this regard was also expressed by Acting Judge HJ Erasmus of the High Court Cape Town. He in particular submitted that an arrested person should be afforded the opportunity to respond to an application for testing, whether by way of a statement on oath or oral evidence. However, he conceded that if this is allowed the proposed procedure would create a further, time consuming interlocutory phase in the criminal process.

1114 The draft Bill included in Discussion Paper 84 contained a provision to this effect - see clause 37A(3) of the draft Bill in ANNEXURE A.

1115 Cf also the comments of Acting Judge HJ Erasmus referred to in par 12.67.

12.68 Others commenting on this issue submitted that not affording the suspect an opportunity to be heard would have the effect that the suspect is denied the right to offer to undergo HIV testing; and further that such procedure infringes on the suspect's right to choose representation by a legal practitioner.¹¹¹⁶

Evaluation and recommendation

12.69 Although this was not expressly provided for in the proposed Bill included in Discussion Paper 84 and was only evident from the explanatory notes accompanying the Bill, the Project Committee's intention from the outset was that the arrested person should not take part or give evidence in a victim's application for compulsory HIV testing - except to the extent of being permitted to challenge whether information on oath has been placed before the magistrate in compliance with the prescribed provisions.¹¹¹⁷ Because of Adv Roberts' comment, an express provision to this effect was included in the amended draft which was submitted for discussion at the consultative meeting on 4 February 2000.¹¹¹⁸ No adverse comment on this explicit exclusion of the arrested person from the legal process was received from experts.

12.70 The Project Committee at its meeting on 6 May 2000 however again thoroughly and carefully considered the constitutionality of the proposed provision. It was agreed that the only alternatives to an explicit exclusion of the arrested person from the application process are -

- ! to reject the principle of victim-initiated testing and to provide for the "automatic" testing of all arrested persons in sexual offence cases;¹¹¹⁹ or
- ! to create an even more cumbersome procedure consisting of a mini hearing which would allow for the arrested person to be present and give evidence when the application is considered by the magistrate.

1116 Comments of the Evangelical Alliance of South Africa.

1117 Par 11.9 of Discussion Paper 84.

1118 See clause 37A(8) of the proposed draft Bill in ANNEXURE D providing that "the arrested person may not attend or defend the application for a compulsory HIV testing order ...".

1119 Cf Prof PWW Coetzer's proposals in this regard discussed in par 12.16-12.18 above.

Both these alternatives were rejected: Creating a procedure of "automatic" testing of all arrested persons would be even more invasive than the present proposals as it would be devoid of the safeguards of victim initiation, evidence on oath and a certain standard of proof, judicial scrutiny and authorisation, and a right to apply for review should the order not have been granted in accordance with the prescribed provisions.¹¹²⁰ As regards the second alternative it was acknowledged that it will be ideal for the arrested person to be able to scrutinise the applicant's allegations and to counter them.¹¹²¹ The Project Committee however believed that this situation will on balance not be practicable or desirable. It will not only thwart the aim of a speedy process whereby victims can obtain information on their attacker's HIV status without having to participate in lengthy proceedings which may delay the initiation of treatment to prevent possible HIV infection, but also carries the potential of a further traumatising confrontation with their alleged assailants for victims.¹¹²² The Project Committee was of the opinion that the constitutional challenges inherent in its proposed procedure can be met in the light of the victim's overriding interest in the HIV status of the arrested person being disclosed to him or her.¹¹²³ In any event, the threshold of evidence required for authorisation of compulsory testing is very low; and few applications could on this ground be successfully opposed.¹¹²⁴ Moreover, the confidentiality protections included in the proposed Bill balance the procedure to afford some protection to the arrested person.¹¹²⁵

-
- 1120 Cf also the Commission's rejection of similar proposals in this regard by Prof PWW Coetzer and others in par 12.19-12.20 and 12.29-12.30. See also par 12.12 above on the safeguards built into the proposed process to protect the arrested person's rights.
- 1121 According to clause 7(1)(a) of the draft Bill "(N)o order for compulsory HIV testing may be granted unless the magistrate is satisfied on information on oath that prima facie evidence exist that - (i) a sexual offence has been committed against the victim by the arrested person; (ii) in the course of such offence the victim may have been exposed to the body fluids of the arrested person; and (iii) no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took place". (Except for the requirement relating to the cut-off period, clause 37A(4) of the proposed draft Bill in Discussion Paper 84 contained a similar provision [see ANNEXURE A].)
- 1122 Cf the comments of Acting Judge HJ Erasmus in par 12.67 above.
- 1123 See the extensive arguments on the utility of HIV testing of arrested persons as regards victims' physical as well as mental health in par 8.3, 8.9.1, 8.10, 8.12-8.14.1 and 8.19-8.20 above. See also the discussion on justification of infringement of the arrested person's rights in accordance with constitutional principles in par 12.12 above.
- 1124 Clause 7(1)(a) of the proposed draft Bill requires prima facie evidence (see fn 1121 above).
- 1125 The proceedings must be held in camera (clause 5(a)); the fact that an order has been granted may not be communicated to any person other than the arrested person, the victim, the investigating officer and the person required to perform the HIV test (clause 11); the test result may not be communicated to any person other than the arrested person and the victim (clause 15); the result of the HIV test is not

12.71 To clarify the Project Committee's original intention and to protect the arrested person's rights as far as possible, the proposed Bill was finally formulated to expressly provide that the proceedings shall be held in the absence of the arrested person and his or her legal representative;¹¹²⁶ that the arrested person and his or her legal representative may not participate in or give evidence at the proceedings;¹¹²⁷ that an order for compulsory testing may only be granted if three specific elements are established from the evidence of the victim;¹¹²⁸ and that an order "*properly*" granted in terms of the prescribed provisions shall be final and no appeal or review shall lie from it (i.e. the arrested person would retain his or her right to apply to the High Court for review in the event that an order for compulsory testing is not granted in accordance with the prescribed provisions).¹¹²⁹ The Commission supports this conclusion of the Project Committee. In making this recommendation, the Commission wants to impress on magistrates their duty to scrutinise applications for compulsory testing properly to ensure that it complies with the prescribed requirements. In this balance the Commission considers the constitutionality of its proposed procedure has been reasonably established.

12.72 As far as the comments in paragraph 12.68 are concerned, the Commission indicated in paragraph 12.62 above that it does not consider the proposal of granting an arrested person an opportunity to offer information on his or her HIV status viable or practical: Even if the arrested person offered the required information, there would be no way of medically verifying the information. The Commission also does not agree with the comment that the proposed procedure will infringe the arrested person's right to choose and to consult with a legal practitioner.¹¹³⁰ According to Steytler the right to legal representation is of cardinal importance "where a person has been arrested for the

admissible as evidence in criminal or civil proceedings against the arrested person (clause 16); and malicious disclosure of the arrested person's HIV status is punishable (clause 19).

1126 Clause 5(b) of the draft Bill.

1127 Clause 6 of the draft Bill.

1128 Clause 7(1)(a) of the draft Bill. (See the text in fn 1121 above).

1129 Clause 9 of the draft Bill. The three elements which must be present in the victim's evidence before an order for compulsory testing may be granted are expressly listed in clause 7(1)(a) so as to make it quite clear that these are the requirements for an order "properly" granted. If the order is not granted in accordance with these requirements, the arrested person would have a right to apply to the High Court for review in terms of clause 9.

1130 Sec 35(2)(b) of the 1996 Constitution provides that "(E)veryone who is detained ... has the right to choose, and to consult with, a legal practitioner".

alleged commission of an offence, to ensure a fair trial".¹¹³¹ As indicated above, the proposed procedure is in no way aimed at or connected to a criminal trial.¹¹³²

Whether the arrested person's right to privacy should be protected by the enactment of more stringent measures, or whether the disclosure of information obtained through compulsory testing should be further extended

12.73 Respondents did not agree on the extent to which the arrested person's right to privacy should be protected. Some expressed concern that the draft Bill did not sufficiently protect this right while others submitted arguments for extending the disclosure of the information obtained through compulsory testing.

12.74 Those concerned with protection of the arrested person's right to privacy commented as follows:

- ! Even if it could be argued that a suspect's right to privacy should yield before a victim's right to bodily integrity, such infringement could not take place on the basis of prima facie evidence only.¹¹³³
- ! The proposed subsection (6) of the draft Bill¹¹³⁴ binds the magistrate, but does not appear to bind either the victim who applied for the testing order, the police officer/s who assisted with the carrying out of the order, or any other official becoming aware of the proceedings.¹¹³⁵ It was emphasised that once the court has informed the victim about the suspect's HIV status, it will have no control over the confidential handling of such information.¹¹³⁶ Dr Jim Te Water Naude

1131 Steytler 159.

1132 See the discussion on infringement of the arrested person's right to a fair trial in par 12.12 above.

1133 Comments of Acting Judge HJ Erasmus.

1134 Referring to the proposed section 37A(6) of the draft included in Discussion Paper 84 which provided that "... 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 ... ; and (b) the arrested person".

1135 Comments of the Director of Public Prosecutions Eastern Cape.

1136 Comments of the Pretoria ATICC; the AIDS Consortium; and Dr Jim Te Water Naude.

observed in this regard that the health services are unlikely to be able to maintain confidentiality and would probably be prejudiced to the suspect. Prejudice will decrease the quality of the post test counselling and care of the suspect, especially if he or she is entitled to therapy that the victim is not. Moreover, should the suspect be convicted and imprisoned, he or she will probably be made to endure physical or sexual attacks. The AIDS Consortium shared these concerns, referring especially to potential abuse by law and order institutions.

- ! To deal with these concerns some respondents suggested the enactment of specific provisions prohibiting victims from further disclosing the arrested person's HIV status to others - except to sexual partners and health care workers where necessary;¹¹³⁷ while others proposed that the draft Bill provides for the results of an HIV test to be destroyed if the arrested person is acquitted.¹¹³⁸

12.75 Other respondents however questioned the necessity of requiring prima facie evidence; and expressed the view that disclosure of the test results should not be limited to the suspect and the victim:

- ! The Director of Public Prosecutions Pretoria remarked that given the extreme confidentiality provided for, it is not deemed necessary to require prima facie proof as basis for authorisation for compulsory testing. He submitted that if HIV testing of the arrested person is to be performed as a matter of urgency, the required prima facie proof will in most instances be lacking. It might also lead to unnecessarily cumbersome proceedings.
- ! Those favouring a wider disclosure of the arrested person's HIV status commented as follows:
 - P The results should be recorded in the envisaged "*national register of sexual offenders*".¹¹³⁹

1137 Views expressed at the consultative meeting on 4 February 2000 by Ms C Mc Clain and Dr Tertius Geldenhuys.

1138 Comments of the Law Society of the Cape of Good Hope; and question posed by Adv ZJ Van Zyl at the consultative meeting.

1139 This view was held by Dr A Hiemstra. See also the proposals submitted by Prof PWW Coetzer discussed in par 12.14 et seq above. The Department of Welfare, in analogy to the present register for abused children established in terms of the Child Care Act 17 of 1983, has been considering the establishment of a "national register for sexual offenders" recently. The Commission's Sexual Offences Project Committee, in an envisaged Discussion Paper dealing with process and procedure relating to sexual offences, will also address this issue (information supplied by Mr G Hollamby, researcher SA Law

- P Government should inform the public about the HIV status of all sexual offenders.¹¹⁴⁰
- P The results should be disclosed to all relevant persons and authorities.¹¹⁴¹
- P It should be mandatory that the results be disclosed to sexual partners (without indicating whether this would include sexual partners of the arrested person as well as the victim) to curb the spread of HIV. And to protect, inform and educate sexual partners.¹¹⁴²
- P Health professionals responsible for the post test care and counselling (of presumably both the arrested person and the victim) should be confidentially informed of the test results.¹¹⁴³
- P Persons "who need to know" (eg care givers of abused children - as such information would assist them in counselling and caring for such children)¹¹⁴⁴ should have access to the test results.¹¹⁴⁵

Evaluation and recommendation

12.76 As indicated in respect of the arrested person's right to be present at and give evidence in an application for testing in the previous paragraphs, the Commission is aware that its proposals may be open to constitutional challenges. However, the premise upon which the Commission based its proposals is that in the light of the vulnerability of women and children to sexual violence and contracting HIV through rape and other sexual offences, extraordinary measures are needed to provide some relief to victims. Against this background limiting the arrested person's right to privacy can be justified and a balance created in providing victims with the necessary information while at the same time

Commission on 25 August 2000).

1140 Comments of the National Institute for Public Interest Law and Research.

1141 Comments of the Federation of Women's Institutes KwaZulu-Natal.

1142 Comments of the HIV/AIDS Prevention Workgroup. See also the comments of Ms N Honono who suggested that HIV test results should be made available "to a prisoner's wife or closest relative".

1143 Comments of Dr Jim Te Water Naude.

1144 Comments of the Afrikaanse Christelike Vrouevereniging.

1145 Comments of the Cape Town Child Welfare Society.

protecting the privacy interests of the arrested person through procedural safeguards.¹¹⁴⁶

Thus, while allowing infringement of the arrested person's right to privacy on the basis of prima facie evidence only for the benefit of victims, several provisions were also included in the draft Bill to protect this right. These include:

- ! Reducing the likelihood of testing persons wrongly accused of rape and sexual offences by requiring evidence on oath from victims as a basis for compulsory testing;¹¹⁴⁷ by requiring judicial authorisation by a court of an order for testing;¹¹⁴⁸ and by creating an offence for malicious use of the procedure.¹¹⁴⁹
- ! Limiting information with regard to the application and disclosure of the test results by providing for the application procedure to be held in camera;¹¹⁵⁰ by limiting information about the outcome of the application;¹¹⁵¹ by limiting disclosure of the test results;¹¹⁵² and by creating an offence for malicious disclosure of the test results.¹¹⁵³
- ! Preventing punitive use of the information regarding HIV status by expressly providing that the test results shall not be admissible in evidence in criminal or civil proceedings.¹¹⁵⁴

12.77 In the light of the Commission's decision to limit the arrested person's right to privacy, calls for express wider disclosure of his or her HIV test results were rejected. It has already been indicated above that the Commission is not in favour of a national register recording HIV test results because of the enormity of undertaking such a task which will involve impracticable burdens at a time of severely stretched resources and capacities. In addition, inroads into privacy would be immense.¹¹⁵⁵ The need for victims to disclose

1146 Cf the discussion in par 8.26 et seq above. See also par 12.12 above.

1147 Clause 7(1)(a).

1148 Clause 7(1)(b).

1149 Clause 19.

1150 Clause 5(a).

1151 Clause 11.

1152 Clause 15.

1153 Clause 19.

1154 Clause 16.

1155 See par 12.232above.

the results to persons who need to know (eg sexual partners and medical practitioners) has been dealt with by creating an offence aimed at "malicious" disclosure of the results.¹¹⁵⁶ Moreover, information on the misuse of the proposed procedure, and on the need to disclose the test results to third parties have been clearly spelt out in the prescribed notice about the procedure to be handed to the victim on reporting a sexual offence,¹¹⁵⁷ and in the notice to be handed to both the victim and the arrested person when disclosing the test results.¹¹⁵⁸

Whether it should be possible to utilise the HIV test results obtained for additional purposes

12.78 Discussion Paper 84 stated that it is the Commission's intention that the information gained through testing the arrested person for HIV should not be available for any other purposes than providing the victim with the test results.¹¹⁵⁹ However, the draft Bill did not include an express provision to this effect. Prof Andrew Skeen submitted that this principle should be expressly enunciated in the proposed Bill otherwise the question of the admissibility of improperly obtained evidence could arise if the result of the test fell into the hands of persons other than the victim, the arrested person and the magistrate. Prof Skeen suggested that such a provision should stipulate that in no circumstances can the result be used as evidence in the subsequent criminal case, the exact formulation of which may be modelled on section 79(7) of the Criminal Procedure Act.

1156 Clause 19.

1157 Form 1 of the draft Regulations contains a clear warning to alleged victims as well as persons acting on their behalf about misuse and abuse of the testing procedure (see p 2 of Form 1 of the draft Regulations in Chapter 13).

1158 Form 6 of the draft Regulations indicates that the implications of the penalty clause are that information about the arrested person's HIV status may only be disclosed to persons who need to know. Victims are advised to discuss the need for further disclosure in counselling before making any actual disclosures.

1159 See par 10.5 of Discussion Paper 84.

- 12.79 Several respondents were however of the opinion that HIV test results of suspects should be available for other purposes related to the criminal process and in particular for evidentiary purposes, for purposes of bail applications, and for sentencing purposes.¹¹⁶⁰ It was in particular submitted that in a country with limited resources the Commission's preliminary proposal should be seriously reconsidered.¹¹⁶¹
- 12.80 This issue was submitted for discussion at the consultative meeting with experts on 4 February 2000. Experts did not agree on a final recommendation. On the one hand there were strong views that whether a new, separate Act is introduced or whether the proposals are retained as an amendment to the Criminal Procedure Act,¹¹⁶² a link must be created between HIV testing aimed at disclosure of test results to victims and HIV testing for evidentiary purposes.¹¹⁶³ It was suggested that this could be a two-stage procedure where the test results should mainly be utilised for disclosure to victims, but with the possibility of an application to use it for evidentiary purposes (which may be criminal or civil).¹¹⁶⁴ However Prof Skeen pointed out that obtaining a body specimen from an arrested person for one purpose (disclosure of HIV status to victims) and utilising it for another purpose (evidence) will not be legally sound. This was countered by the view of Prof PWW Coetzer who submitted that it does not make sense that body specimens have to be taken from an arrested person on different occasions for purposes of evidence and disclosure to victims respectively. He stressed that the same specimen (and the same test result) should be able to be utilised for both purposes (i.e. if a medical officer takes a blood sample from the accused for evidentiary purposes, it must also be utilised for purposes of disclosure of HIV test results to victims¹¹⁶⁵).

1160 Comments of the National Institute for Public Interest Law and Research; the Acting Director of Public Prosecutions Venda High Court; the Director of Public Prosecutions Pretoria; and Regional Court Magistrate M Moloto.

1161 Comments of the Director of Public Prosecutions Pretoria. See also the proposals of Prof PWW Coetzer in this regard (par 12.14 et seq above).

1162 See the discussion of this issue in par 12.25 et seq above.

1163 Views of Prof PJ Schwikkard; Dr Tertius Geldenhuys.

1164 Ibid.

1165 Judge Edwin Cameron, project leader, however pointed out that a blood sample is only taken from the accused by a medical officer if it is *necessary* for evidentiary purposes - eg for DNA testing. A blood sample is not taken from *every* person arrested in a rape or sexual offence case. To have such sample taken from *every* accused, sec 37 of the Criminal Procedure Act would have to be amended. Prof Skeen questioned the wisdom of the latter, observing that it would not be a realistic and viable option.

Evaluation and recommendation

- 12.81 It seemed that the main reason why certain respondents and experts felt that the arrested person's HIV test results (obtained under the proposed procedure) should be admissible in a subsequent trial, was that it may be relevant for sentencing purposes.¹¹⁶⁶ They argued that to obtain a second body specimen from the same accused and have it tested a second time for HIV for sentencing purposes would be a waste of resources.
- 12.82 The Commission is however of the opinion that section 37 of the Criminal Procedure Act is sufficiently wide to cover HIV testing for sentencing purposes and that it is for the SAPS to establish a satisfactory and comprehensive administrative system under this provision.¹¹⁶⁷ To expressly extend the use of the test results obtained through the proposed procedure to include utilising them as evidence for sentencing purposes would, apart from the further considerable inroads into the arrested person's rights, be a duplication of already existing procedure. It should in any event be noted that clause 19 of the draft Bill (creating an offence for use of the testing procedure or disclosure of the test result with malicious intent) would not apply to disclosure of HIV test results for sentencing purposes.
- 12.83 Having said that, the Commission also holds the view that ultimately a well run, rationally connected system might well amalgamate the two procedures (i e HIV testing of arrested persons for non-evidentiary and evidentiary purposes respectively). The Commission's current proposals however do not create such a comprehensive system but only a first, limited step towards such a system.

1166 Sec 37 of the Criminal Procedure Act already provides for the ascertainment of bodily features (which would include establishing HIV status) for evidentiary purposes. See fn 68 above for provisions of the Criminal Law Amendment Act 105 of 1997 (the Criminal Law Amendment Act) with regard to the relevance of information on HIV status for sentencing purposes.

1167 See Chapter 7 above for a discussion on section 37 and especially par 7.10 as regards its application to HIV testing for sentencing purposes. Although the Criminal Law Amendment Act requires that the accused must have "known" about his or her HIV positive status for the provisions regarding minimum sentences to apply, testing the arrested person for HIV would be a useful first evidentiary step in proving such knowledge.

12.84 Finally, following Prof Skeen's advice, the Commission has expressly enunciated its intention that the test results should not be available for other purposes in including a provision to this effect in clause 16.

The draft Bill should contain clear and express sanction in respect of deliberately false complaints

12.85 Although the Commission stated in Discussion Paper 84 that the proposed intervention will inter alia be based on the principle that malicious activation of the testing procedure would be actionable, this principle was not enunciated in the draft Bill.¹¹⁶⁸

12.86 Some respondents submitted that it is not sufficient to articulate this principle - the draft Bill needs to contain an express clause clearly setting out a penalty for false accusations.¹¹⁶⁹ They believed that a malicious complaint should be dealt with quite severely as the attendant trauma and anxiety of a false accusation also have dire consequences for the family, relatives and friends of the arrested person. They suggested a sentence of a fixed period of at least two years' imprisonment as an appropriate penalty which would be severe enough to act as a deterrent to prevent such malicious conduct.¹¹⁷⁰

12.87 The need for express provision to prohibit victims from maliciously disclosing arrested persons' HIV status to others was supported by experts at the consultative meeting on 4 February 2000.¹¹⁷¹

Evaluation and recommendation

1168 See par 10.5 of Discussion Paper 84.

1169 Comments of CORE.

1170 Ibid.

1171 Views expressed by Ms C McClain and Dr Tertius Geldenhuys.

12.88 In response to the above comments and to further protect the rights of the arrested person, the Commission included in its final draft Bill express provision providing that any person who with malicious intent uses the proposed procedure or discloses the result of an HIV test so obtained, shall be guilty of an offence and on conviction be liable to a fine or to imprisonment for a period not exceeding six months or both. A relatively heavy penalty has been prescribed to protect the arrested person's rights.

How a more sympathetic process could be created to disclose HIV test results to the arrested person

12.89 In response to concerns about infringement of the arrested person's rights (especially by those respondents to Discussion Paper 84 who were opposed to the proposed intervention¹¹⁷²) and in view of its decision to proceed with its proposals, the Project Committee attempted in the amended draft legislation submitted for discussion at the consultative meeting on 4 February 2000 to create a more sympathetic process for disclosing the test results to the arrested person. The amended version provided for the investigating officer to hand a notice to the arrested person together with the written record of the test results.¹¹⁷³ The notice contained information on how the HIV test results will be disclosed, how the arrested person could deal with the results, and on the importance of obtaining counselling.¹¹⁷⁴ The need for the draft Bill to explicitly provide for pre- and post test counselling was also submitted for discussion.¹¹⁷⁵ Experts expressed the following views:

- ! Some believed that health care workers, and not members of the SAPS, should be responsible for the disclosure of HIV test results to arrested persons.¹¹⁷⁶ Others however stressed that SAPS members should not be underestimated as they are currently being trained as counsellors - they could thus be trained to

1172 See par 12.7 and 12.12 above.

1173 See draft reg 6(2)(c) and Form 5 of the draft legislation in ANNEXURE D.

1174 See Form 6 of the draft legislation in ANNEXURE D.

1175 See the list of issues for discussion (par II (vi)) included in ANNEXURE D.

1176 View of Ms H van Rooyen.

deliver HIV test results to arrested persons.¹¹⁷⁷

- ! As regards the need to provide pre- and post test counselling, some submitted that no pre-test counselling is necessary in the case of "compulsory" testing. They argued that pre-test counselling is given to obtain consent for HIV testing. Where the arrested person does not have the option to decline testing, counselling is not necessary.¹¹⁷⁸ Others were of the view that pre-test counselling is essential - even where consent for HIV testing is not necessary. They submitted that in such cases counselling can concentrate on the specific purpose of HIV testing of arrested persons, and on the possible consequences of testing.¹¹⁷⁹ Another opinion was that pre-test counselling should at least be *offered* and that it should be the arrested person's right to refuse it should he or she not wish to utilise it.¹¹⁸⁰ Experts generally believed that post test counselling was necessary. However, as with pre-test counselling, the view was generally held that counselling cannot be forced on the arrested person but should at least be offered.

Evaluation and recommendation

12.90 As indicated in the previous paragraph, the Commission in response to comments on Discussion Paper 84 attempted to create a more acceptable procedure of disclosing the HIV test results to the arrested person by explicitly providing that the investigating officer is responsible for making available the test result to the arrested person in the form of a written record of the test as executed by a designated laboratory, together with an informational notice. After considering the input received at the consultative meeting, the Commission concluded that there are no viable alternatives to this proposal. The practical difficulties of ensuring post test counselling in respect of a range of arrested persons who may either be out on bail or in custody, and the problem of who should be made responsible for such counselling and its costs, could not be satisfactorily

1177 View of Dr A Hiemstra.

1178 Views expressed by Prof PWW Coetzer; Dr G Nielsen.

1179 Views of Ms H van Rooyen; Dr J Te Water Naude.

1180 View of Ms J Van Niekerk.

addressed through legislation. Providing the arrested person with information on what counselling is, how important it is and where it can be obtained is the Commission's proposed solution to this problem.¹¹⁸¹ This approach also deals with the views expressed at the consultative meeting that counselling cannot be forced on the arrested person, but should be available. The Commission believes that making sufficient information available to arrested persons, and especially indicating where counselling is obtainable, serves this purpose.

- 12.91 In addition to the above, and in response to views expressed at the consultative meeting on the necessity of pre-test counselling of the arrested person, the Commission has subsequently also added provision in its proposed draft legislation for a notice to be handed to arrested persons *before* being tested. This notice supplies information on HIV and its transmission - and particularly the risk of transmission during a sexual offence; the reason for compulsory testing and the benefit that testing may hold for the victim; the grounds on which an application for testing has been granted; reasons why the arrested person has not been allowed to be present at and give evidence in the application; information on how the HIV testing will be executed and the test results relayed; confidentiality of the test results; the inadmissibility of the test result as evidence in subsequent criminal or civil proceedings; the arrested person's responsibility, if he or she is infected, towards other members of society; and information on the importance of counselling and where it could be obtained.¹¹⁸²

Whether arrested persons should have the right to decline to receive information about their HIV status

- 12.92 Experts attending the consultative meeting raised, but did not agree, about this issue. Some submitted that the arrested person should have the right to decline to receive

1181 For the Commission's final recommendations see clause 12(e) of the draft Bill, and reg 8 and Form 6 of the draft Regulations in Chapter 13.

1182 See Form 4 of the draft Regulations.

information about his or her HIV status.¹¹⁸³ Others observed that this information has far reaching implications for third parties (eg the arrested person's sexual partner) and that it is therefore essential that arrested persons should receive the information. They qualified this view by stressing that counselling should accompany all HIV testing and the disclosure of all HIV test results.¹¹⁸⁴

Evaluation and recommendation

12.93 Even though the proposed legislation is explicitly victim centred, an incidental effect of its implementation would be the ascertainment of the arrested person's HIV status. The Commission considered, after deliberating on the arguments in issue, that the interests and autonomy of the arrested person made it necessary for him or her to be given access to those test results. Moreover, the Commission believed that in view of the implications of the test results for third parties, the arrested person should receive the test results. In the latter regard the Commission included in the notice to be handed to the arrested person before HIV testing, information on his or her responsibility - should they be infected - towards third parties.¹¹⁸⁵

Issues related to victims' interests

The accessibility of the proposed procedure

12.94 Several respondents to Discussion Paper 84 raised concerns about the accessibility of

1183 View of Prof PWW Coetzer. (This view is probably based on the belief that in medicine a patient's right to know or be informed of the full nature of the seriousness of an illness needs to be balanced with the right or need to *not* know, when knowing might cause a traumatic state of disorganisation and collapse which may interfere with active problem solving behaviour necessary for survival [Rotenberg 1997 **Medicine and Law** 49]).

1184 View of Ms H van Rooyen.

1185 See par 12.91 above and Form 4 of the draft Regulations.

the proposed procedure.¹¹⁸⁶ Stressing the problems courts face today in terms of efficiency, they were not satisfied that a process of authorisation by the court would necessarily lend credence to the aim of providing a speedy and uncomplicated mechanism to have arrested persons tested for HIV.¹¹⁸⁷ They were in particular concerned about the position of rural and uneducated women who may be unaware of their rights as victims and suggested that measures be put in place to enable all victims to make use of the proposed procedure.¹¹⁸⁸ Suggestions for specific measures included the following:

- ! Either a magistrate or the investigating officer should be obliged to inform all victims of sexual offences and persons acting on their behalf immediately and fully of all the relevant provisions relating to compulsory testing.¹¹⁸⁹ The proposed legislation should expressly provide for this.¹¹⁹⁰
- ! Magistrates should be available on a 24-hour basis to consider applications for compulsory testing and to relay test results to victims.¹¹⁹¹
- ! Proper utilisation of the proposed procedure would depend on training staff attached to the various governmental and non-governmental systems currently providing services to victims of rape and sexual assault (eg the SAPS, the public health care services - especially emergency staff attending to victims of crime, and service organisations like Rape Crisis).¹¹⁹²

12.95 In response to these concerns the Project Committee, in the redrafted Bill submitted at the consultative meeting on 4 February 2000, provided for an informational notice to be handed to the victim or the person acting on his or her behalf by any police official when

1186 Comments of the South African Dental Association; the Democratic Nursing Association of South Africa; Judge President EKW Lichtenberg; Dr A Hiemstra; the Department of Correctional Services; the Mpumalanga Provincial Government Department of Agriculture, Conservation and the Environment; Dr Jim Te Water Naude; the Cape Town Child Welfare Society; and the Magistrate Pretoria.

1187 Comments of the South African Dental Association; and the Democratic Nursing Association of South Africa.

1188 See eg the comments of the Department of Correctional Services; and Dr Jim Te Water Naude.

1189 Comments of Judge President EKW Lichtenberg; and Dr A Hiemstra.

1190 Comments of Dr A Hiemstra.

1191 Comments of the Cape Town Child Welfare Society; and the Magistrate Pretoria.

1192 Comments of Dr Jim Te Water Naude.

any sexual offence is reported.¹¹⁹³ The contents of the notice were prescribed.¹¹⁹⁴ Experts agreed with this approach in principle but stressed that the notice (as well as other informational notices provided for¹¹⁹⁵) should be in plain language, as many victims will not be able understand or even read the notice. These victims will have to rely on SAPS members to read and explain the contents to them. Thus also for the benefit of SAPS members experts urged that the forms should be understandable.¹¹⁹⁶

Evaluation and recommendation

12.96 As indicated in the previous paragraph, the Commission responded to concerns raised on accessibility of the proposed procedure by providing for an obligatory informational notice to be supplied to all victims of sexual offences when an offence is reported at the SAPS. The notice contains information on HIV and its transmission - specifically the possibility of transmission during a sexual offence; victims' responsibility to sexual partners after possible exposure to HIV; the utility of establishing the HIV status of an arrested person; how and where the HIV status of the alleged assailant could be obtained through utilising the proposed procedure; who will pay for HIV testing of the arrested person; how the test results will be disclosed; the need for further disclosure of the results by the victim; the importance of counselling and where it can be obtained; misuse and abuse of the proposed procedure; and the circumstances under which an application may be brought on behalf of a victim. The Commission heeded advice regarding the use of plain language.

12.97 The Commission rejected the proposal that magistrates should be available on a 24-hour basis to consider applications as this would place further strain on the justice system.¹¹⁹⁷

1193 See clause 37A(1) of the redrafted Bill in ANNEXURE D.

1194 See Form 1 of the draft Regulations in ANNEXURE D.

1195 See Form 6 of the draft Regulations in ANNEXURE D.

1196 View of Ms Joan van Niekerk who stated that 45% of rape victims are illiterate and would not be able to read the notice.

1197 See par 12.111 below.

12.98 The Commission supports the proposal that all relevant service providers be trained.¹¹⁹⁸

1198 See par 12.123 below.

The need for a more supportive procedure for the disclosure of HIV test results to victims

- 12.99 Although the draft Bill included in Discussion Paper 84 did not expressly provide how HIV test results of arrested persons will be disclosed to victims, clause 37A(6) created the impression that this information would be conveyed by the magistrate.¹¹⁹⁹ The Department of Health in its comment on Discussion Paper 84 observed that receiving information on possible exposure to HIV would be a potentially traumatic experience for victims of rape and sexual crimes. With this in mind, it was submitted that magistrates do not have the experience or skill to convey HIV test results to victims. The Department proposed that the draft Bill be supplemented to provide for delegated health officials from local authorities to assist magistrates in conveying HIV test results.
- 12.100 Experts attending the consultative meeting on 4 February 2000 commented on the amended version of the proposed Bill which provided for the investigating officer to deliver the HIV test result to the complainant together with a notice containing information on the meaning of the HIV test results, indicating how to deal with the result, and stressing the importance of obtaining counselling.¹²⁰⁰ Experts did not unanimously support the Department of Health's view that conveying HIV test results to victims should be left to health care workers. Some were of the opinion that health care workers should be responsible for disclosure of HIV test results¹²⁰¹ while others observed that SAPS members should not be underestimated as they are currently being trained as counsellors and could thus also be trained to disclose HIV test results.¹²⁰²

1199 As indicated in par 11.8-11.9 above, the draft Bill included in Discussion Paper 84 did not deal with the practical implementation of the proposed procedure. The latter issue has been addressed by the Commission in the subsequent drafts submitted to experts at the consultative meeting on 4 February 2000 and also in the final recommendations in this Report in response to comments received on Discussion Paper 84.

1200 See reg 6 and Form 6 of the Draft Regulations in ANNEXURE D.

1201 Eg Ms H van Rooyen. See par 12.89 above.

1202 View of Dr A Hiemstra.

Evaluation and recommendation

12.101 As indicated above, the Commission responded to concerns about especially the need for counselling of the victim by providing for an informational notice to be supplied to him or her together with the written record of the arrested person's HIV test results. It was also provided that the information in the notice should be explained to victims, if necessary (eg if the victim cannot read). After consideration, the Commission abides by this procedure which is in line with the opinion of experts at the consultative meeting that counselling cannot be forced on either the arrested person or the victim but should be available.¹²⁰³ In doing so the Commission acknowledges that its proposed procedure is limited and that the relief it would provide to victims is modest.

Whether provision needs to be made in the draft Bill to protect victims from being prejudiced in their access to services if they either utilise or do not utilise the proposed HIV testing procedure

12.102 Some organisations concerned with women's interests in their comment on Discussion Paper 84 cautioned that women's rights should not be compromised in any way in the application of the proposed procedure. They stressed that a victim's access to health services, medical treatment, and recourse to legal and judicial process should in no way be linked to an obligation to ascertain his or her exposure to HIV.¹²⁰⁴ They were particularly concerned that medical treatment of victims would be determined by the results of suspects' HIV tests.¹²⁰⁵ Tshwaranang Legal Advocacy Centre in particular raised the concern that since the Department of Health has cited lack of resources as key factor for its reluctance to provide victims with PEP, the Department may (if PEP should eventually be offered to victims) in a bid to cut down on costs and to circumvent abuse of the availability of free PEP, require a victim to obtain an order for compulsory testing and to produce her assailant's HIV positive results in order to qualify for free PEP.

1203 See par 12.89 above.

1204 Comments of Tshwaranang Legal Advocacy Centre; and the Women's Health Project.

1205 Comments of FAMSA; Tshwaranang Legal Advocacy Centre; and the Professional and Ethical Standards Committee, Faculty of Health Sciences University of the Witwatersrand.

Similar concerns were raised by the Commission's Sexual Offences Project Committee which observed that the consequences of a negative test result in the arrested person may have negative consequences for the victim (including the possibility of a victim not being able to receive PEP) that would justify not supporting the proposed intervention.¹²⁰⁶

Evaluation and recommendation

12.103 The Commission doubted the necessity of a provision to protect victims from being prejudiced in their access to medical and judicial recourse if they utilise the proposed procedure. At the most the Commission believed that such provision should be limited to dealing only with any right to medical treatment that victims may have. A provision as suggested was therefore not included in the proposed draft legislation.

The need for comprehensive health and social services to all rape and sexual offence victims in addition to the proposed testing procedure

12.104 Although this issue was not dealt with in Discussion Paper 84 and comment was not elicited on it, virtually every person and body supporting the proposed intervention in their comments strongly emphasised the dire need for comprehensive health and social services (including access to PEP) to all rape and sexual offence victims.¹²⁰⁷ Respondents saw it as essential *in addition to* the proposed intervention for compulsory HIV testing of arrested persons.

12.105 Arguments advanced to support this point of view were the following:

1206 Comments of Ms Bronwyn Pithey at a joint meeting of the South African Law Commission HIV/AIDS and Sexual Offences Project Committees on 18 October 1999.

1207 See eg the comments of Prof S Lötter; Dr Jim Te Water Naude; the Dental Association of South Africa; Dr A Hiemstra; the Durban Children's Society; the Suid-Afrikaanse Vrouefederasie; the Mpumalanga Provincial Government Department of Agriculture, Conservation and the Environment; the AIDS Consortium; the Federation of Women's Institutes KwaZulu-Natal; the Township AIDS Project; the HIV and AIDS Prevention Work Group; Regional Court Magistrate M Moloto; the Evangelical Alliance; personnel of the Red Cross War Memorial Children's Hospital; Tshwaranang Legal Advocacy Centre; FAMSA; the Professional and Ethical Standards Committee, Faculty of Health Sciences University of the Witwatersrand; and the Director of Public Prosecutions Witwatersrand Local Division.

- ! The mere institution of compulsory testing would not control the spread of HIV: the necessity of a general health policy providing the required assistance and support from government's side to victims of sexual offences with a view to their possible HIV infection, cannot be emphasised strongly enough.¹²⁰⁸
- ! Bearing in mind the inherent limitations¹²⁰⁹ of the proposed procedure, other avenues (such as a range of victim support services including counselling and provision of PEP) should in addition be promoted to protect victims more effectively.¹²¹⁰ In this regard Tshwaranang Legal Advocacy Centre submitted that the proposed procedure is a "stand alone approach" which offers victims no support or assistance in addition to the availability of the testing procedure. They believed that this will serve to inevitably increase victim trauma and secondary victimisation.
- ! The proposed procedure should not overshadow or compromise the duty owed to victims of crime.¹²¹¹ This duty arises from a range of Constitutional provisions including a victim's right to human dignity and to freedom and security of the person¹²¹² and the state's fundamental duty to protect its citizens from crime.¹²¹³ The Commission is rightly concerned for the psychological well-being of the victim, but there is an even greater urgency to protect the victim's physical well-being. There is a strong public perception that the new constitutional democracy is leaning towards protection of criminals and neglecting the victims of crime. This wrong perception needs to be confronted through concrete measures such as by providing immediate PEP and counselling to victims of rape and other sexual offences as a matter of public duty.¹²¹⁴

1208 Comments of Prof S Lötter. See also the comments of the Director of Public Prosecutions Witwatersrand Local Division.

1209 For the perceived limitations, see fn 934 above.

1210 Comments of Dr Jim Te Water Naude.

1211 Comments of the Professional and Ethical Standards Committee, Faculty of Health Sciences University of the Witwatersrand.

1212 Cf secs 10 and 12 of the 1996 Constitution.

1213 Comments of the Professional and Ethical Standards Committee, Faculty of Health Sciences University of the Witwatersrand.

1214 Comments of the Professional and Ethical Standards Committee, Faculty of Health Sciences University of the Witwatersrand.

- ! The vision of compulsory testing is commendable but will be meaningless if the Department of Health is unable to provide victims with the necessary counselling, testing and PEP sufficiently in time to be of any effect.¹²¹⁵
- ! The proposal for compulsory testing would be justifiable only if strategies for the immediate treatment of *all* victims are in place, or the development of strategies are certain.¹²¹⁶ PEP is currently available only in private establishments for victims who can afford the treatment. As the majority of victims will only benefit from the current proposal if state facilities for the necessary support services are available, it is imperative that state funding be made available for this purpose.¹²¹⁷
- ! Compulsory testing may become a way for government to avoid its urgent responsibility which should be to focus its efforts on preventing both rape and new HIV infections.¹²¹⁸
- ! If the government can spend money on the medical treatment of prisoners with HIV at private hospital rates, then there should be money available for the treatment of victims of sexual offences. PEP should therefore be available at public health facilities dealing with victims of sexual crimes.¹²¹⁹

12.106 Some commentators listed a range of services which they believed should be included in appropriate victim support services. These covered HIV testing; pre-and post test counselling; the availability of PEP; the availability of emergency contraception; appropriate and necessary psychological and medical follow-up services for all infections (not only life-threatening infections); medical treatment of injuries sustained as a result of rape or a sexual offence; additional therapy on receipt of the test results of the arrested person if necessary; and victim empowerment services (such as providing access to

1215 Comments of the Dental Association of South Africa; and the Mpumalanga Provincial Government Department of Agriculture, Conservation and the Environment.

1216 Comments of the Dental Association of South Africa; and Dr A Hiemstra.

1217 Ibid.

1218 Comments of the AIDS Consortium who conditionally supported the intervention.

1219 Comments of the personnel of the Red Cross War Memorial Children's Hospital; and Tshwaranang Legal Advocacy Centre.

legal services¹²²⁰).¹²²¹ Some suggested the establishment of one-stop crisis counselling and treatment centres to supply the range of services suggested at state expense.¹²²² Many respondents however singled out counselling¹²²³ and the provision of PEP¹²²⁴ as the two services of exceptional importance.

12.107 As far as PEP was concerned, commentators were of the overwhelming opinion that all victims should have access to it at state expense.¹²²⁵ Some emphasised the current element of inconsistency and unfairness in the general treatment of victims in that the majority of victims are not in a position to afford PEP.¹²²⁶ (PEP is currently available only in private establishments for victims who can afford the treatment.) Others suggested that the proposed legislation should include express provision for more comprehensive health care services and indeed for PEP.¹²²⁷

1220 Comments of the Durban Children's Society.

1221 Comments of Dr Jim Te Water Naude. See also the comments of Tshwaranang Legal Advocacy Centre.

1222 Comments of the Durban Children's Society.

1223 All three government departments concerned (Health, Welfare, and Correctional Services) emphasised the importance of pre-and post test counselling accompanying all forms of HIV testing and disclosure of test results. The AIDS Consortium and the Evangelical Alliance supported this.

1224 See eg the comments of the Township AIDS Project; the HIV and AIDS Prevention Work Group; Regional Court Magistrate M Moloto; the Dental Association of South Africa; Dr A Hiemstra; the Durban Children's Society; the Federation of Women's Institutes KwaZulu-Natal; and personnel of the Red Cross War Memorial Children's Hospital.

1225 See eg the comments of the Dental Association of South Africa; Dr A Hiemstra; Dr Jim Te Water Naude; the Durban Children's Society; the Suid-Afrikaanse Vrouefederasie; the Mpumalanga Provincial Government Department of Agriculture, Conservation and the Environment; the Federation of Women's Institutes KwaZulu-Natal; the Township AIDS Project; the HIV and AIDS Prevention Work Group; Tshwaranang Legal Advocacy Centre; Regional Court Magistrate M Moloto; personnel of the Red Cross War Memorial Children's Hospital; and FAMSA.

Dr Jim Te Water Naude, the only medical expert commenting at length on PEP, referred to the Centres for Disease Control's (CDC) view that PEP should not be given as a matter of course following exposure to risk of HIV transmission (see par 3.72 above). He however emphasised that the prevalence of HIV infection in the United States is very low compared with South Africa (i e the likelihood of transmission of HIV as a result of a single high risk encounter in the United States is considerably lower than in South Africa). Dr Te Water Naude believed that "opt-in" PEP (i e access to PEP at government cost for all victims - with victims deciding, after counselling, whether they wish to initiate the treatment) is indicated for South Africa.

1226 Comments of the Dental Association of South Africa; and Dr A Hiemstra.

1227 Tshwaranang Legal Advocacy Centre suggested that legislation should make it standard practice for every state health care agency to provide victims of sexual offences at state expense with adequate health care and support such as that currently afforded victims by Groote Schuur Hospital in the Cape. See par 3.71 and fn 363 above for the services provided by Groote Schuur.

12.108 Many of the experts attending the consultative meeting on 4 February 2000 expressly supported the above views. They were unanimous in the view that all victims of alleged sexual offences must have access to the best possible care and treatment - even without an arrest having been effected or being a prerequisite.¹²²⁸ Some questioned whether the sense of urgency related to HIV testing of the arrested person (because of the time factor involved in administering PEP to a victim who may have been exposed to HIV) which the Commission wants to convey with its proposed legislation, will still be there if compulsory testing is not expressly linked to the provision of PEP in the proposed Bill.¹²²⁹

Evaluation and recommendation

12.109 The Commission acknowledges the overwhelming need for a comprehensive health and social support system for victims of sexual offences reflected in the comments received from respondents to Discussion Paper 84 and experts attending the consultative meeting on 4 February 2000. It also acknowledges the concerns expressed about the urgent need for making PEP available to victims of sexual offences at government cost. The Commission's mandate did not include investigating the provision of support services to victims of sexual offences and this is moreover a policy issue rather than an issue for law reform. However, the Commission is of the firm view that there are obvious social merits in a broader system under which all victims of sexual offences, in addition to changes to the law, also have access to HIV testing and PEP. The Commission's proposals offer an alternative and modest intervention focussing on creating a process which would on a psychological level benefit victims and create a sense of urgency with a view first, to enable the initiation of PEP to those who can currently afford it themselves and second, with a view to possible government assistance in this regard in future. The latter is a very important part of the proposed draft Bill and Regulations, and is built into

1228 Comments eg of Ms Ros Halkett.

1229 Comments of Dr Graham Nielsen. See also the comments of Tshwaranang Legal Advocacy Centre in this regard.

every part of the proposed process¹²³⁰ in spite of the fact that no direct recommendations regarding the provision of PEP are made.

Practical issues

Whether it should be possible to bring an application for compulsory HIV testing outside court hours

12.110 The draft Bill included in Discussion Paper 84 provided that applications for compulsory HIV testing should be considered by the magistrate "as soon as is reasonably practicable".¹²³¹ In this regard it was envisaged that magistrates should be readily available to hear applications on a similar basis as is the case with bail applications.¹²³² None of the respondents commenting on Discussion Paper 84 questioned this proposal. At the consultative meeting with experts on 4 February 2000, it was however observed that current problems with availability of magistrates in respect of bail applications after hours, seem to call for a procedure which does not make use of magistrates.¹²³³ Officials of the Department of Justice and Constitutional Development also pointed out that in practice the availability of magistrates and court personnel to deal with bail applications outside court hours (i e over weekends and after hours) is problematic and

1230 See the provisions that convey the sense of urgency with a view to the initiation of PEP (where it is accessible and affordable) providing for -

- * the procedure to commence as soon as is reasonably practicable (clause 1);
- * an application to be made at the earliest possible opportunity (clause 2(2));
- * an application to be submitted to a magistrate as soon as is reasonably practicable (clause 2(4));
- * a magistrate to consider the application as soon as is reasonably practicable (clause 4);
- * a cut-off period within which an order for compulsory testing may be granted (clause 7(1)(a)(iii));
- * the investigating officer to as soon as is reasonably practicable after the magistrate has considered the application to inform the arrested person and the victim of the outcome thereof (clause 10);
- * any person tasked with executing an order for compulsory testing to take the necessary steps as soon as is reasonably practicable (clause 12(2)); and
- * a time limit within which an application must be brought and executed (clause 13).

1231 Clause 37A(3) of the draft Bill in ANNEXURE A.

1232 See par 11.11 of Discussion Paper 84.

1233 View of Dr Tertius Geldenhuys on Prof PWW Coetzer's suggestion that a less cumbersome procedure, not involving judicial authorisation, should replace the Commission's proposal. Dr Geldenhuys suggested that "a member of the SAPS in charge of a police station" or "a commissioned officer" could issue the order for compulsory HIV testing. See par 12.14 et seq above for Prof Coetzer's proposals.

suggested that an additional similar burden should not be placed on the judicial system.¹²³⁴

Evaluation and recommendation

12.111 The Commission heeded concerns about placing additional burdens on the judicial system and did not include a provision in the draft Bill providing for bringing applications for compulsory HIV testing outside court hours. The sense of urgency built into the process with a view to the initiation of PEP (where accessible and affordable) was conveyed throughout the draft Bill in providing for the procedure to commence as soon as is reasonably practicable (clauses 1 and 2); granting the application within a specified time limit (clause 7); doing without formalities of appearance (clauses 5 and 6);¹²³⁵ and executing the testing order as soon as is reasonably practicable and within a specified time limit (clauses 12 and 13).

The need for measures to ensure execution of and compliance with an authorisation to test an arrested person for HIV¹²³⁶

12.112 Some respondents suggested that the proposed draft Bill should include measures to ensure the execution of and compliance with a court order for compulsory HIV testing of the arrested person. The following measures were suggested:

- ! The draft Bill should be amended to provide that police officers should be obliged to effectively carry out an order for compulsory testing within 24 hours after its authorisation.¹²³⁷ Respondents making this suggestion emphasised

1234 Comments of Ms Wilma Louw.

1235 An arrested person however retains his or her right to apply to the High Court for review in the event that an order for compulsory testing is not properly granted (see par 12.66 et seq and clauses 7 and 9 of the draft Bill).

1236 See also the discussion of the need for a cut-off period for executing the order of court in par 12.52 et seq above.

1237 Judges of the Durban High Court suggested that clause 37A(5) of the draft Bill included in Discussion Paper 84 (see ANNEXURE A) should be amended to this effect. The Afrikaanse Christelike Vrouevereniging agreed with this.

that time is of the essence in ensuring any benefit from PEP.¹²³⁸

- ! The draft Bill should place a legal duty on the arrested person to cooperate and not to resist where a police officer, medical practitioner or nurse execute their powers in terms of the proposed legislation.¹²³⁹ Non-compliance with such duty should be punishable.¹²⁴⁰ SAPS Legal Services Southern Cape in addition suggested that express provision should be made for reasonable force to be used to execute the powers granted. They expressed the opinion that if these aspects are not addressed, SAPS will be saddled with legislation which would be unenforceable since police officers will not have the confidence to execute their powers without clear guidelines.

Evaluation and recommendation

12.113 The Commission considered including a provision obliging SAPS members to execute compulsory HIV testing orders within 24 hours after its authorisation to be impractical. The sense of urgency conveyed through several provisions in the draft Bill,¹²⁴¹ some of which are indeed directly aimed at SAPS members,¹²⁴² was believed to be sufficient.

12.114 As regards ensuring the co-operation of the arrested person in executing HIV testing, the Commission considered its proposed clause 12(2), providing for any person tasked with executing an order for compulsory testing to "take the necessary steps as soon as reasonably practicable" to be sufficient.

1238 See eg the comments of the Federation of Women's Institutes KwaZulu-Natal; The Cape Town Child Welfare Society; and the Pretoria ATICC.

1239 Comments of SAPS Legal Services Southern Cape; and the Acting Director of Public Prosecutions Venda High Court.

1240 Ibid.

1241 See fn 1230 above for a list of these provisions.

1242 Clause 12(2) of the draft Bill provides that any person tasked with executing an order granted in terms of the proposed legislation, must take the necessary steps as soon as is reasonably practicable. Clause 12(1) provides for specific tasks to be executed by the investigating officer. Clause 13 further provides that no order for compulsory testing may be executed if more than 60 calendar days have lapsed from the date on which it is alleged that the offence in question took place.

Whether the practical implementation of the proposed procedure should be expressly provided for in draft legislation

12.115 As indicated earlier, the draft Bill included in Discussion Paper 84 did not expressly provide for the practical implementation of the proposed testing procedure.¹²⁴³ It was instead provided that the Ministers of Health, and Justice and Constitutional Development may promulgate policy on the testing methods and procedure to be used.¹²⁴⁴ Several respondents to Discussion Paper 84 raised concern about this:

- ! Certain members of the legal fraternity were especially concerned that the proposed provision may not sufficiently empower the Ministers to ensure successful implementation of the proposed procedure since it conferred the power to make "policy" only.¹²⁴⁵ It was suggested that the draft Bill should grant the Ministers the power to promulgate policy "by way of regulation".¹²⁴⁶
- ! From a practical point of view, the lack of provision for a testing protocol elicited comments from members of the medical fraternity. They were in particular concerned about the following:

P *The number of tests to be carried out to establish the HIV status of the arrested person*

Respondents submitted that neither subclauses (1), (4) or (7) of the proposed section 37A¹²⁴⁷ supplied any clarity on the number of permissible tests to be performed on a suspect. They pointed out that if the arrested person is in the window period at the time of testing, a false negative test result could be obtained which may necessitate further testing.¹²⁴⁸ It was suggested that the Bill provide for at least two tests -

1243 See Chapter 11 for background on the development of the current final proposals to also address practicalities.

1244 See clause 37A(8) of the draft Bill in ANNEXURE A.

1245 Judge President EKW Lichtenberg cautioned that it must at all costs be avoided that the non-compliance with one or other item of "policy" (as opposed to "regulation" which would have the force of subordinate legislation) would lead to possible arguments of ultra vires which would in all probability stultify and, in actual fact, destroy the entire object and purposed of the testing procedure. See also the comments of the Law Society of the Cape of Good Hope.

1246 Comments of the Law Society of the Cape of Good Hope.

1247 See the proposed draft Bill included in Discussion Paper 84 (ANNEXURE A).

1248 Comments of Dr A Hiemstra; and Dr Jim Te Water Naude.

the first to be carried out at the earliest opportunity after the arrested person have been charged, followed by a repeated test not earlier than three months and not later than four months after the offence has been committed.¹²⁴⁹

P *By whom HIV tests should be performed*

In accordance with the Commission's preliminary vision that existing facilities should be used to perform compulsory testing, clause 37A(4) of the draft Bill included in Discussion Paper 84 provided for HIV testing to be carried out by "designated local health authorities". Respondents commenting on this issue did not agree with this proposal. They suggested the following alternatives:

- > Dr A Hiemstra believed that the Commission's proposal is unrealistic and impractical and does not take into account the current position regarding medico-legal functions and primary health care. She brought to the Commission's attention that only a few "designated local health authorities" (eg district health authorities) are in place as yet and that there could be no expectation that Local Authorities (i.e. Municipalities), who also have duties pertaining to primary health care, could be assigned to perform medico-legal functions at this stage. She however stated that certain provinces may be in the process of training "Forensic Nurses" in order to perform essential medico-legal functions due to the shortage of District Medical Officers, and suggested that the proposed legislation may have to make provision for such Nurses to do the testing.
- > The Dental Association of South Africa was of the opinion that the Department of Justice and Constitutional Development should carry the responsibility to conduct all HIV tests of arrested persons.
- > The Department of Health submitted that an inter-sectoral approach is needed in implementing the proposed legislation. To this end the Department suggested that the draft Bill provide for

the establishment of "provincial inter-departmental sexual offence committees" which could be made up of representatives from the Departments of Health, Justice and Constitutional Development, Correctional Services and Safety and Security. The objectives of such committees would be to set standards for and to monitor the services being provided to victims of rape and other sexual offences. The Department stressed the need for victims to be provided with information, counselling, medical treatment and psycho-social support in order for the information on the arrested persons' HIV status to be of real practical benefit to them. The Department believed that an inter-sectoral approach would fulfill this need.

12.116 Whether the practicalities of the proposed testing procedure should be legislated for, and what such provisions should stipulate in respect of the scientific procedure related to HIV testing was one of the major issues discussed with experts at the consultative meeting on 4 February 2000.¹²⁵⁰ There was however little consensus on issues such as what test/s should be used;¹²⁵¹ how many tests should be performed to establish the arrested person's HIV status;¹²⁵² and where and by whom HIV testing should be performed.¹²⁵³ A strong view was also expressed that practical issues relating to the testing protocol should rather be provided for in policy documents of the government department/s who will be responsible for the implementation of the proposed legislation.¹²⁵⁴

-
- 1250 See the list of issues discussed with experts included in ANNEXURE D.
- 1251 Some experts believed that rapid tests are in general suitable (Dr Graham Nielsen). Others suggested that the standard ELISA and a confirmatory ELISA should be performed (Prof A Heyns). It was also suggested that two blood samples could be taken for the performance of a rapid test on the one sample and an ELISA on the other (Prof A Heyns). Yet others suggested that the use of specific tests should not be referred to in legislation as current medical practice would prescribe what tests should be done (Prof PWW Coetzer).
- 1252 Some experts suggested that two tests should be performed on two different blood samples (Prof A Heyns).
- 1253 Some strongly believed that available facilities (eg those used for ante-natal testing) should be utilised and that these must be designated by notice in the **Government Gazette** (Prof PWW Coetzer).
- 1254 Comments by Prof PWW Coetzer.

Evaluation and recommendation

12.117 As indicated in Chapter 11 above, the Commission in response to the criticism in the previous paragraph extended its draft Bill and also developed draft Regulations to deal with the implementation of its proposed procedure. These were submitted to experts at the consultative meeting for comment. After thorough consideration and discussion with experts it was resolved to limit the draft legislation to provide the broad framework of the testing process and to authorise specific persons or bodies to execute it. To this end the following was added to the draft Bill:

- ! Providing in detail for the form of the compulsory testing order to be granted by the magistrate.¹²⁵⁵
- ! Authorising the taking of bodily specimens from the arrested person.¹²⁵⁶
- ! Authorising the designation of facilities to perform HIV testing.¹²⁵⁷
- ! Authorising the performance of HIV testing.¹²⁵⁸
- ! Setting out the duties of the investigating officer and others involved in executing an order for compulsory testing.¹²⁵⁹

In addition, draft Regulations were developed prescribing -

- ! the manner in which information regarding the availability of the testing process is relayed to the victim;¹²⁶⁰
- ! the manner of application for a testing order;¹²⁶¹
- ! the manner in which an order for compulsory testing is issued;¹²⁶²
- ! the manner in which the arrested person is notified of the fact that he or she will be tested for HIV;¹²⁶³

1255 Clause 7(2).

1256 Clause 12(1)(a) and (b).

1257 Clause 14.

1258 Clause 12(1)(c) and (d).

1259 Clause 12(1) and (2).

1260 Draft reg 2 and Form 1.

1261 Draft reg 3 and Form 2.

1262 Draft reg 4 and Form 3.

1263 Draft reg 6 and Form 4.

- ! the manner in which the test results are recorded;¹²⁶⁴ and
 - ! the manner in which the HIV status of an arrested person is disclosed.¹²⁶⁵
- The draft Regulations contain six Forms to facilitate the above in practice.

12.118 Finally, after input at the consultative meeting and thereafter, it was resolved not to provide for a testing protocol (i e the scientific testing procedure to be utilised) in the draft Bill or Regulations, but to leave that to be determined by current medical practice.

How could the currently proposed legislation ensure that appropriate pre- and post test counselling would be provided to both the victim and the arrested person in accordance with the proposed Draft National Policy on HIV Testing¹²⁶⁶

12.119 Several commentators (including the Departments of Health, Welfare, and Correctional Services) emphasised the need for pre- and post test counselling to accompany HIV testing of both victims and arrested persons.¹²⁶⁷ The Department of Health in particular suggested that in order to ensure that the proposed testing of alleged sexual offenders indeed contribute to the public health goals of reducing the number of new HIV infections and assisting those living with HIV to live healthy, responsible lives, it is essential that pre- and post test counselling are provided to both victims and alleged offenders. The Department stated that although this could be provided for in terms of the envisaged

1264 Draft reg 7 and Form 5.

1265 Draft reg 8 and Form 6.

1266 The Draft National Policy on HIV Testing 1999 (Government Notice R 1479 in **Government Gazette** 20710 of 10 December 1999) provides as follows:

- "(4) Pre-test counselling should occur before an HIV test is undertaken. ...
- (5) ... (P)amphlets and other media may be used in making information on HIV/AIDS available, but cannot be regarded as a general substitute for pre-test counselling ...
- (7) A doctor, nurse or trained HIV counsellor should also ensure that post test counselling takes place as part of the process of informing an individual of an HIV test result.
- (8) Where a health facility lacks the capacity to provide a pre-test or post test counselling service, a referral to a counselling agency or another facility with the capacity to provide counselling should be arranged before an HIV test is performed, and when an HIV test result is given".

1267 See also the comments referred to in par12.89 and 12.99-12.100. (Discussion Paper 84 envisaged an implementation policy - see par 12.116 above.)

implementation policy, it believed that provision should be expressly made for such counselling within the proposed legislation itself.¹²⁶⁸

12.120 In response to the above comments the Project Committee included in its amended draft legislation, which was submitted at the consultative meeting on 4 February 2000, a more supportive procedure for the disclosure of HIV test results to both the victim and the arrested person. This included provision for supplying the arrested person and the victim with an informational notice together with the HIV test results. The notice *inter alia* carries information about the importance of counselling and where it can be obtained.¹²⁶⁹ As indicated above,¹²⁷⁰ experts attending the consultative meeting considered it essential that pre- and post test counselling should be available to victims and arrested persons alike. They however believed that it should be left to the arrested person and the victim to choose whether they wish to utilise it. It was agreed that the proposed draft legislation should ensure that counselling is at least offered to, or made available to, the arrested person and the victim.¹²⁷¹

Evaluation and recommendation

12.121 These issues are covered in the discussions relating to the creation of a more supportive procedure of disclosing HIV test results to both the victim and the arrested person in paragraphs 12.89 et seq and 12.99 et seq above.

The importance of training for the successful implementation of the proposed procedure

12.122 The importance of urgent training of relevant officials attached to health, police, prosecutorial and adjudicating services to ensure the successful implementation of the

1268 See also the comments of the AIDS Consortium.

1269 See Forms 5 and 6 of the Draft Regulations included in ANNEXURE D.

1270 See par 12.89 et seq and 12.99 et seq.

1271 *Ibid.*

Commission's proposed legislation was stressed by several commentators.¹²⁷² It was in particular suggested that forensic training be expanded and legalised to include other branches of the medical profession to give greater impetus to the examination of rape victims.¹²⁷³

Evaluation and recommendation

12.123 No provision on the need for training has been included in the draft legislation as this issue deals with ensuring successful implementation of the procedure rather than the procedure itself. However, the Commission acknowledges the concerns raised by commentators and recommends that the government departments who would be involved in executing the proposed legislation (Justice and Constitutional Development, Health, and Safety and Security), provide their staff with the necessary training so as to assist in achieving the aims of the proposed procedure.

Issues related to cost

Whether the cost of the proposed testing procedure should be expressly addressed in draft legislation

12.124 The Commission did not expressly address the cost implications of its proposals in the draft Bill in Discussion Paper 84. The draft Bill provided that the details of implementation of the principle of compulsory testing will be determined by the Departments of Justice and Constitutional Development, and Health by way of policy.¹²⁷⁴ The cost of the proposed procedure and the human resource implications for its successful

1272 See eg the comments of Dr Jim Te Water Naude; CORE; and the Federation of Women's Institutes KwaZulu-Natal.

1273 Comments of the Federation of Women's Institutes KwaZulu-Natal.

1274 The proposed subsection (8) of the Bill provided that "(T)he Ministers of Health and Justice may promulgate policy on the testing methods and procedures to be used for purposes of this section". See also par 12.115 above.

implementation however proved to be a major point of concern in particular to the Department of Health, the SAPS and some members of the medical fraternity. The following concerns were raised:

- ! Which state departments will be liable for the costs of the proposed procedure and at what stage in the proposed process will these liabilities arise? (Eg: Would the Department of Justice and Constitutional Development bear the burden of expenses in processing applications for testing up to the issue of the court order directing a local authority to conduct such testing; and would the Department of Health incur all expenses relative to procuring the HIV test?)¹²⁷⁵
- ! Who exactly is the "local health authority" (who, according to the draft Bill in Discussion Paper 84, would be designated to carry out HIV testing under the draft legislation) and do such authorities have the necessary infrastructure and financial resources to effectively deal with discharging the obligations created in the Bill?¹²⁷⁶
- ! Would it be possible to successfully implement the proposed procedure in view of the lack of clarity on the capacity of existing structures of the health and police services?¹²⁷⁷

12.125 This issue was submitted for discussion to experts attending the consultative meeting on 4 February 2000.¹²⁷⁸ Experts who had views on this were of the opinion that the state should carry the costs of the proposed procedure.¹²⁷⁹ The view was however firmly expressed that cost is an issue which should be dealt with by government policy - it should not be addressed in legislation.¹²⁸⁰

1275 Comments of SAPS Legal Component Detective Services.

1276 Ibid. See also the comments of Dr A Hiemstra in par 12.115 above. Clause 37A(4) of the draft Bill included in Discussion Paper 84 provided for a "designated local health authority" to perform the HIV tests.

1277 Comments of Dr A Hiemstra; and Dr Jim Te Water Naude.

1278 See the list of issues for discussion included in ANNEXURE D.

1279 View eg of Prof PWW Coetzer.

1280 Ibid.

Evaluation and recommendation

12.126 There was relative consensus among respondents and experts that the state should carry the costs of the proposed testing procedure. After consideration and consultation a broad provision to this effect was included in the draft Bill.¹²⁸¹ The Commission submits that details (such as which government department should carry the costs and whether the costs should be jointly carried by certain departments) are policy matters which the Commission is not in a position to advise on.

1281 See clause 17.

13 Draft legislation and explanatory notes

REPUBLIC OF SOUTH AFRICA

COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS BILL

(As introduced)

MINISTER FOR JUSTICE AND CONSTITUTIONAL DEVELOPMENT

BILL

To provide for a speedy procedure for a victim of an alleged sexual offence in which exposure to the body fluids of the arrested person may have occurred, to apply for the compulsory HIV testing of the arrested person and the disclosure of the test results to the victim.

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

Notice to victim

1. When any sexual offence is reported, or as soon thereafter as is reasonably practicable, the police official to whom the offence is reported shall hand a notice as prescribed containing information regarding compulsory HIV testing of a person arrested in an alleged sexual offence case to the victim, or any person acting on his or her behalf in terms of section 3, and must explain the contents of the notice.

Manner of application

2. (1) Any victim of an alleged sexual offence in which exposure to the body fluids of the arrested person may have occurred, or any person acting on his or her behalf in terms of section 3, may apply to a magistrate for an order that the person arrested on the charge or on suspicion of having committed the offence in question, be tested for HIV.
- (2) The application must be made at the earliest possible opportunity after a charge has been laid, and may be made before or after an arrest has been effected.
- (3) The application must be made in the prescribed manner and be handed to the investigating officer.
- (4) The investigating officer who receives an application contemplated in subsection (3) shall as soon as is reasonably practicable submit such application to a magistrate who has jurisdiction to consider the application in terms of section 4.

Application may be brought on behalf of victim

3. The application referred to in section 2 may be brought on behalf of the victim by any person who has a material interest in the well-being of such person, including a spouse, family member, care giver, friend, counsellor, health service provider, police official, social worker or teacher: Provided that the application shall be brought with the written consent of the victim, except where the victim is -

- (a) under the age of 14;¹²⁸²
- (b) mentally ill;
- (c) unconscious;
- (d) a person in respect of whom a curator has been appointed in terms of an order of court; or
- (e) a person whom the court is satisfied is unable to provide the required consent.

1282 Sec 39(3)(b) of the Child Care Act 74 of 1983 provides that any person over the age of 14 years shall be competent to consent, without the assistance of his or her parent or guardian to the performance of any medical treatment of him or herself or his or her child.

Jurisdiction

4. A magistrate of the magisterial district in which the sexual offence is alleged to have occurred has jurisdiction to grant the order contemplated in section 7, and shall as soon as is reasonably practicable consider the application contemplated in section 2.

Parties who may appear before magistrate

5. The proceedings contemplated in section 4 -
- (a) shall be held in camera;
 - (b) shall be held in the absence of the arrested person and his or her legal representative; and
 - (c) need not be attended by the victim or the person acting on his or her behalf in terms of section 3.

Arrested person may not give evidence

6. The arrested person and his or her legal representative may not participate in or give evidence at the proceedings contemplated in section 4.

Magistrate's order

7. (1)(a) No order for compulsory HIV testing may be granted unless the magistrate is satisfied from information on oath that prima facie evidence exist that -
- (i) a sexual offence has been committed against the victim by the arrested person;
 - (ii) in the course of such offence the victim may have been exposed to the body fluids of the arrested person; and
 - (iii) no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took place.
- (b) If satisfied as contemplated in paragraph (a), the magistrate shall order -
- (i) the collection on the same occasion from the arrested person of two body specimens;
 - (ii) the performance on the body specimens of one or more HIV tests as are reasonably necessary to determine the presence or absence of HIV infection; and
 - (iii) the disclosure of the HIV test result so obtained to the victim or any person acting on his or her behalf in terms of section 3, and the arrested person.
- (c) If not satisfied as contemplated in paragraph (a), the magistrate shall dismiss

the application.

- (2) The magistrate shall make the order contemplated in subsection (1)(b) or (c) in the prescribed manner and make such order available to the investigating officer.

Register of application

8. The investigating officer shall keep a register as prescribed of the application contemplated in section 2 and the magistrate's order contemplated in section 7.

Magistrate's order final

9. An order properly granted in terms of section 7 shall be final and no appeal or review shall lie from it.

Victim and arrested person to be notified of outcome of application

10. The investigating officer shall as soon as is reasonably practicable after the magistrate has considered an application contemplated in section 2 -

- (a) irrespective of whether an order has been granted or not as contemplated in section 7, inform the victim or the person acting on his or her behalf in terms of section 3 of the outcome of such application; and
- (b) if an order has been granted as contemplated in section 7, inform the arrested person thereof, hand him or her a notice containing the information as prescribed and if necessary explain the contents of the notice.

Confidentiality of outcome of application

11. The fact that an order for HIV testing of an arrested person has been granted as contemplated in section 7 shall not be communicated to any person other than -

- (a) the victim or any person acting on his or her behalf in terms of section 3;
- (b) the arrested person;
- (c) the investigating officer; and
- (d) the persons who are required to execute the order as contemplated in section 12.

Execution of order

12. (1) For purposes of executing an order granted in terms of section 7 -
 - (a) the investigating officer shall request a medical practitioner or nurse to on the same occasion take two body specimens from the arrested person and shall make the arrested person available or cause such person to be made available for this purpose;
 - (b) a medical practitioner or a nurse contemplated in paragraph (a) may take two body specimens from the arrested person;
 - (c) the investigating officer shall make the two body specimens contemplated in paragraph (b) available for HIV testing to a person attached to a facility designated in terms of section 14;
 - (d) a person contemplated in paragraph (c) and requested thereto by the investigating officer shall -
 - (i) perform one or more HIV tests on the body specimens of the arrested person as are reasonably necessary to determine the presence or absence of HIV infection in the arrested person;
 - (ii) record the result of the HIV test performed in duplicate in the prescribed manner; and
 - (iii) provide the investigating officer with duplicate sealed records of the test result for purposes of making them available to the victim and the arrested person;
 - (e) the investigating officer shall collect the two sealed records of the HIV test result from the person contemplated in paragraph (d) and make available to the victim or the person acting on his or her behalf in terms of section 3 of the Act, and to the arrested person -
 - (i) the sealed record of the test result referred to in paragraph (d)(ii); and
 - (ii) a notice containing information as prescribed, and if necessary explain the contents of the notice.
- (2) Any person tasked with executing an order granted in terms of section 7 as contemplated in subsection (1) must take the necessary steps as soon as is reasonably practicable.

Limitation of period to execute magistrate's order

13. No order granted under section 7 may be executed if more than 60 calendar days have lapsed from the date on which it is alleged that the offence in question took place.

Place where HIV testing may take place

14. The testing of body specimens to establish an arrested person's HIV status in terms of this Act may take place only at a facility designated for that purpose by the Minister in consultation with the Minister of Health by notice in the Gazette, subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act.

Confidentiality of HIV test result obtained

15. The result of the HIV test performed on the body specimens of an arrested person in terms of this Act shall be communicated only to -

- (a) the victim or any person acting on his or her behalf in terms of section 3; and
- (b) the arrested person.

Inadmissibility of HIV test result as evidence

16. The result of the HIV test performed on the body specimens of an arrested person in terms of this Act shall not be admissible in evidence in criminal or civil proceedings.

Costs

17. The state shall be responsible for all costs related to the application contemplated in section 2 and the execution of an order granted in terms of section 7 as contemplated in section 12.

Regulations

18. The Minister may make regulations regarding -

- (a) any form required to be prescribed in terms of this Act;
- (b) any matter required to be prescribed in terms of this Act; and
- (c) any other matter the Minister deems to be necessary or expedient to achieve the objects of this Act.

Offences and penalties

19. Any person who with malicious intent uses the procedure contemplated in section 2 or 3 or discloses the result of an HIV test so obtained shall be guilty of an offence and on conviction be liable to a fine or to imprisonment for a period not exceeding six months or both.

Definitions

20. For purposes of this Act -

'AIDS' means the acquired immuno-deficiency syndrome;

'body fluids' means any body substance which may contain HIV but does not include saliva, tears or perspiration;

'body specimen' means any body sample which can be tested to determine the presence or absence of HIV infection;

'HIV' means the human immuno-deficiency virus;

'HIV test' means any validated, medically recognised test for determining the presence or absence of HIV infection in a person and *'HIV testing'* has a corresponding meaning;

'investigating officer' means a member of the South African Police Service responsible for investigating the charge or any member acting under his or her command;

'medical practitioner' means a person registered as such in terms of the Health Professions Act, 1974 (Act No. 56 of 1974);

'Minister' means the Minister for Justice and Constitutional Development;

'nurse' means a person registered as such in terms of the Nursing Act, 1978 (Act No. 50 of 1978); and

'*prescribed*' means prescribed by regulation made under section 18.

'*victim*' means any person alleging that a sexual offence has been committed against him or her.

Short title and commencement

21. This Act shall be called the Compulsory HIV Testing of Alleged Sexual Offenders Act, 2001, and shall come into operation on a date fixed by the President by proclamation in the Gazette.

DEPARTMENT OF JUSTICE

NO R ... 2000

**REGULATIONS UNDER THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL
OFFENDERS ACT, 2001 (ACT NO ... OF 2001)**

The Minister for Justice and Constitutional Development has under section 18 of the Compulsory HIV Testing of Alleged Sexual Offenders Act, 2001 (Act No ... of 2001), made the regulations in the Schedule

SCHEDULE

Definitions

1. In these Regulations any word or expression to which a meaning has been assigned in the Act shall have that meaning and, unless the context otherwise indicates -

"the Act" means the Compulsory HIV Testing of Alleged Sexual Offenders Act, 2001 (Act No. ... of 2001).

Notice to victim

2. The notice contemplated in section 1 of the Act shall contain the information provided for in Form 1 of the Annexure.

Manner of application

3. A victim of an alleged sexual offence or a person acting on his or her or behalf in terms of section 3 of the Act applies for an order contemplated in section 2 of the Act in the form of Form 2 of the Annexure.

Magistrate's order

4. The order contemplated in section 7(1)(b) or (c) of the Act shall be made in the form of Form 3 of the Annexure.

Register of application

5. The register contemplated in section 8 of the Act shall contain the following information regarding an application contemplated in section 2 of the Act:
 - (a) The application number;
 - (b) the date of the application;
 - (c) the case number or South African Police Service reference number;
 - (d) the full names of the victim or the person acting on his or her behalf in terms of section 3 of the Act;
 - (e) the full names of the arrested person;
 - (f) whether the application was granted or dismissed as contemplated in section 7 of the Act; and
 - (g) the full names of the magistrate hearing the application.

Notice to arrested person of outcome of application

6. The notice contemplated in section 10(b) shall be in the form of Form 4 of the Annexure.

Recording of HIV test result

7. The person performing an HIV test on a body specimen of the arrested person contemplated in section 12(1)(d) of the Act shall record the result of the HIV test in the form of Form 5 of the Annexure.

Notice to victim and arrested person following compulsory HIV testing

8. The notice contemplated in section 12(1)(e)(ii) of the Act shall contain the information provided for in Form 6 of the Annexure.

Short Title

9. These regulations shall be called the Regulations for Compulsory HIV Testing of Alleged Sexual Offenders.

ANNEXURE

FORM 1

[Regulation 2]

NOTICE OF AVAILABILITY OF PROCESS FOR THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS AS CONTEMPLATED IN SECTION 1 OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT No. ... OF 2001)

(To be handed to a victim of an alleged sexual offence or any person acting on his or her behalf)

This information sheet will provide you with information, and give you details on how the South African Police Service (SAPS) will assist with obtaining information on the HIV status of the person who allegedly committed the offence against you.

What is HIV?

HIV refers to infection with the human immuno-deficiency virus. HIV destroys important cells which control and support the immune system. As a result the body's natural defence mechanisms cannot offer any resistance against illnesses. Most people infected with HIV ultimately develop AIDS and die as their bodies can no longer offer any resistance to illnesses such as TB, pneumonia and meningitis. Infection with HIV therefore has serious consequences for you as an individual.

How is HIV transmitted?

HIV is transmitted in three ways: via sexual intercourse; when HIV infected blood is passed directly into the body; and from mother to child during pregnancy, childbirth or whilst breast feeding.

Can I be exposed to HIV during a sexual offence?

Yes you can if you have had any contact with the alleged offender's blood, semen or vaginal fluid. For example, if you have been raped vaginally or anally and the alleged offender's semen entered your body you may have been exposed to HIV.

Can I put other people at risk of HIV infection because of my possible exposure to HIV?

You cannot transmit HIV through daily contact with other people. HIV is not transmitted through hugging, shaking hands, and sharing food, water or utensils. However, because HIV is transmitted through sexual intercourse, you may have become infected through the alleged sexual offence and may in turn infect your sexual partner. You should practice safe sex until you have established with certainty that you have not been infected. If you are pregnant, there is a possibility that you could transmit HIV to your unborn child. If you are breast feeding there is also a possibility that your child may be at risk of contracting HIV infection. You must obtain expert advice to deal with the implications of the risk of infection for yourself, your sexual partner and others.

How could I deal with my possible exposure to HIV during the alleged sexual offence?

You can -

- # consult a health care worker for more information on the risk of HIV transmission, and the possibility of taking medication to prevent transmission of HIV;
- # consult a counsellor at one of the service organisations listed below for counselling and support;
- # apply to have the alleged offender tested for HIV, and the results disclosed to you.

Why should I apply to have the alleged offender tested for HIV?

Knowing the HIV status of the alleged offender may -

- # give you peace of mind as you will be in a better position to determine whether you were exposed to HIV during the alleged offence;
- # enable you to make decisions on whether to take medication to prevent HIV transmission; and
- # empower you to make decisions regarding the protection of your sexual partner and others against HIV infection.

How can I apply for compulsory HIV testing of the person who allegedly committed a sexual offence against me?

- # Lay a charge at the police station nearest to where the offence took place.
- # Inform the Investigating Officer that you wish to apply for compulsory HIV testing of the alleged offender.
- # Complete an application for an order for compulsory HIV testing with the assistance of the Investigating Officer.
- # Hand the completed and signed application to the Investigating Officer.

Who will consider my application?

The Investigating Officer will submit your completed application to a Magistrate who will consider the application during court hours. The Investigating Officer will inform you of the outcome of your application.

What will happen once the Magistrate has ordered that the arrested person must be tested for HIV?

The Investigating Officer will ensure that two body specimens are on the same occasion taken from the arrested person and tested for HIV.

Who will pay for the HIV testing?

The state.

How will I be informed about the HIV test result?

The Investigating Officer will as soon as possible ensure that you receive a sealed envelope containing the HIV test result, and information on where you can get help with understanding the implications of the result.

May I disclose the arrested person's HIV test result to other people?

You may not disclose this information **except** to those who need to know. This will include such persons as your sexual partner, your medical doctor, or those persons who provide emotional support to you. You should discuss the disclosure of the test results with the service organisation providing you with counselling and support before making any disclosures. If you maliciously disclose the arrested person's HIV status, you may be convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also face a civil claim for damages.

Cut-off period for bringing an application

A limited period of time is allowed for compulsory HIV testing of an arrested person. You must apply for such testing before 50 calendar days have lapsed from the date on which the alleged offence took place. The arrested person must be tested for HIV and the results must be disclosed to you before 60 calendar days have lapsed from the date on which the alleged offence took place. It is therefore advised that if you decide to apply for having the arrested person tested for HIV, you do it as soon as possible after the alleged offence.

Service organisations which can provide counselling and support

Expert assistance in dealing with the implications of HIV test results is available at a number of different private and public facilities. These include:

- # Private medical and social facilities (eg a general medical practitioner or psychologist).
- # Public medical and social facilities, including -
 - Ž Life Line
 - Ž Child Line
 - Ž The National Council for Child Welfare
 - Ž Local State Hospitals and Clinics
 - Ž Local AIDS Service Organisations
 - Ž Rape Crisis
 - Ž FAMSA
 - Ž Regional Departments of Social Welfare
 - Ž Local ATTICS

Contact details of the above public facilities are available in the telephone directory, or from the Investigating Officer.

Misuse and abuse of this procedure

The procedure to establish an arrested person's HIV status without obtaining his or her consent for HIV testing has been created strictly for the purpose of assisting victims of sexual offences. If you have not been the victim of a sexual offence, or act on behalf of someone who has not been the victim of a sexual offence, and abuse this procedure to establish another person's HIV status with malicious intent, you may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also face a civil claim for damages.

CIRCUMSTANCES UNDER WHICH AN APPLICATION FOR COMPULSORY HIV TESTING MAY BE BROUGHT ON BEHALF OF A VICTIM

Any person who has a material interest in the well-being of a victim of an alleged sexual offence (eg a spouse or other family member, friend, counsellor, health service provider, police official, social worker or teacher) may apply for compulsory testing on his or her behalf, provided that the victim has given written consent.

Written consent is not necessary if the victim is -

- # under the age of 14;
- # mentally ill;
- # unconscious;
- # a person in respect of whom a curator has been appointed by an order of court; or
- # a person whom the court is satisfied is unable to provide consent.

FORM 2

[REGULATION 3]

**APPLICATION TO A MAGISTRATE IN TERMS OF SECTION 2 OF THE
COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001
(ACT No. ... OF 2001)**

PART A: VICTIM'S DECLARATION

- (1) **PARTICULARS OF VICTIM** *(To be completed by the victim or the person acting on his or her behalf; or by the Investigating Officer)*

Name:

ID No/Date of birth/Passport No:

Home/Temporary Address:

Telephone No:

- (2) **PARTICULARS OF PERSON ACTING ON BEHALF OF VICTIM (IF APPLICABLE)** *(To be completed by the person acting on behalf of the victim; or by the Investigating Officer)*

Name:

ID No/Date of birth/Passport No:

Home/Temporary Address:

Telephone No:

Nature of relationship with victim (eg parent):

Reason why application is made on behalf of victim:

Written consent of victim has been obtained and is attached: **YES/NO**

Written consent is not necessary since the victim is: *(Delete if not applicable)*

! Under the age of 14 years

! Mentally ill

! Unconscious

! A person in respect of whom a curator has been appointed by the court
! Unable to provide consent because:

(3) PARTICULARS OF ALLEGED SEXUAL OFFENCE AND POSSIBLE EXPOSURE TO ASSAILANT'S BODY FLUIDS (To be completed by the victim or the person acting on his or her behalf; or by the Investigating Officer)

Date and place of alleged offence:

Description of alleged offence (eg rape):

Was the victim exposed to the body fluids (blood, semen, vaginal fluid) of his/her assailant: YES/NO
(Delete if not applicable)

In what way was the victim exposed:

.....
.....

(4) SIGNED BY VICTIM OR PERSON ACTING ON HIS OR HER BEHALF

.....

Signed

Place

Date

5) AFFIDAVIT BY VICTIM OR PERSON ACTING ON HIS OR HER BEHALF

(To be completed by Commissioner of Oaths)

I hereby certify that before administering the *oath/taking the affirmation I asked the Deponent the following questions and noted *his/her answers in *his/her presence as indicated below :-

(a) Do you know and understand the contents of the above declaration?

Answer -

(b) Do you have any objection to taking the prescribed oath?

Answer -

(c) Do you consider the prescribed oath to be binding on your conscience?

Answer -

I hereby certify that the Deponent has acknowledged that *he/she knows and understands the contents of this declaration which was sworn to/affirmed before me, and the Deponent's *signature/thumb print/mark was placed thereafter in my presence.

Dated at..... this day of..... 20.....

.....
SIGNED: Justice of the Peace/Commissioner of Oaths

Full names:

Designation:

Area for which appointed:

Business address:

**Delete whichever is not applicable*

PART B: ARRESTED PERSON

1) PARTICULARS OF ARRESTED PERSON CHARGED WITH COMMITTING ALLEGED SEXUAL OFFENCE *(To be completed by the Investigating Officer)*

The person whose particulars appear below has been arrested on a charge or on suspicion of having committed the sexual offence mentioned below against the victim whose particulars appear in PART A.

Name:

ID No/Date of birth:

Home/Temporary Address:

Telephone No:

Case No (or SAPS reference no):

Offence charged with:

In custody/On bail:(Delete if not applicable)

! In custody. If so: Place:

! On bail

Date arrested:

(2) SIGNED BY INVESTIGATING OFFICER

.....

Signed

Place

Date

(3) AFFIDAVIT BY INVESTIGATING OFFICER

(To be completed by Commissioner of Oaths)

I hereby certify that before administering the *oath/taking the affirmation I asked the Deponent the following questions and noted *his/her answers in *his/her presence as indicated below :-

(a) Do you know and understand the contents of the above declaration?

Answer -

(b) Do you have any objection to taking the prescribed oath?

Answer -

(c) Do you consider the prescribed oath to be binding on your conscience?

Answer -

I hereby certify that the Deponent has acknowledged that *he/she knows and understands the contents of this declaration which was sworn to/affirmed before me, and the Deponent's *signature/thumb print/mark was placed thereafter in my presence.

Dated at..... this day of..... 20.....

.....

SIGNED: Justice of the Peace/Commissioner of Oaths

Full names:

Designation:

Area for which appointed:

Business address:

**Delete whichever is not applicable*

FORM 3

[REGULATION 4]

ORDER OF THE COURT IN TERMS OF SECTION 7(1)(b) OR (c) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001)

(To be completed by the magistrate considering the application)

IN THE MAGISTRATES COURT

FOR THE DISTRICT OF: HELD

AT:

APPLICATION NO:

PART A: VICTIM

(1) PARTICULARS OF VICTIM

Full names:

(2) PARTICULARS OF PERSON ACTING ON BEHALF OF VICTIM (IF APPLICABLE)

Full Names: PART B:

ARRESTED PERSON

(1) PARTICULARS OF ARRESTED PERSON CHARGED WITH COMMITTING SEXUAL OFFENCE

Full Names:

Case No (or SAPS reference no):

PART C: ORDER BY THE COURT

THE COURT ORDERS THAT:

*(*Delete if not applicable)*

- *The application is dismissed.
- *The application is granted for -
 - the collection on the same occasion from the arrested person of two body specimens;
 - the performance on the body specimens of one or more HIV tests as are reasonably necessary to determine the presence or absence of HIV infection; and
 - the disclosure of the test results to -
 - a) the victim or the person acting on his or her behalf; and
 - b) the arrested person.

.....

MAGISTRATE

.....

DATE

FORM 4

[Regulation 6]

NOTICE IN TERMS OF SECTION 10(b) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001) REGARDING AN ORDER OF COURT THAT THE HIV STATUS OF AN ALLEGED SEXUAL OFFENDER MUST BE ESTABLISHED

(To be handed to the arrested person)

The purpose of this notice is to provide you with information about an order of court which has been obtained to have you tested for HIV without your consent, and for your HIV status to be disclosed to your alleged victim.

What is HIV?

HIV refers to infection with the human immuno-deficiency virus. HIV destroys important cells which control and support the immune system. As a result the body's natural defence mechanisms cannot offer any resistance against illnesses. Most people infected with HIV ultimately develop AIDS and die as their bodies can no longer offer any resistance to illnesses such as TB, pneumonia and meningitis. Infection with HIV therefore has serious consequences for you as an individual.

How is HIV transmitted?

HIV is transmitted in three ways: via sexual intercourse; when HIV infected blood is passed directly into the body; and from mother to child during pregnancy, childbirth or whilst breast feeding.

Can HIV be transmitted during a sexual offence?

Yes. If there has been any exposure to HIV infected blood, semen or vaginal fluid during the alleged offence, HIV may have been transmitted.

Why should I be tested for HIV?

You may have exposed the victim to HIV during the alleged sexual offence with which you are charged. In the light of the serious consequences of HIV infection and victims' fear of becoming infected with HIV, they have been granted a right to apply for the HIV testing of their alleged offenders and for the disclosure of the test results.

How will knowledge about my HIV status help the alleged victim?

The information may help him or her -

- # to decide whether to submit him or herself to medical treatment which is costly and has serious side effects but could prevent him or her contracting the virus;
- # to take measures to prevent the virus from being further transmitted from him or herself to other people (eg to the victim's sexual partner, or to her baby if she is pregnant or breast-feeding).

to provide the victim with peace of mind regarding his or her possible exposure to HIV during the sexual offence.

Who has granted the order that I be tested for HIV?

A magistrate from the magistrate's office in the district in which you allegedly committed the sexual offence has granted the order.

On what basis has the court order been granted?

The magistrate has granted the order after considering evidence on oath by the person who applied to have you tested for HIV and by the investigating officer. The magistrate is satisfied on a prima facie basis -

- # that you committed a sexual offence against the victim who applied, or on whose behalf it was applied, to have you tested for HIV;
- # that in the course of such offence the victim may have been exposed to your body fluids (semen blood or vaginal fluid); and
- # that no more than 50 calendar days have lapsed from the date on which it is alleged that the offence in question took place.

You must note that the existence of prima facie evidence against you does not mean that if the criminal case against you went to trial you would be convicted of the crime. The state will still have to prove beyond reasonable doubt that you committed the offence you were charged with. Prima facie evidence is being used only for the application to have you tested for HIV without your consent.

Why was I not given an opportunity to be present and to give evidence in the application to have me tested for HIV?

The legislation providing the victim or a person acting on his or her behalf with the right to apply to have you tested for HIV does not give you the right to respond to the application. The reason for this is that a victim of a sexual offence needs to establish the HIV status of the alleged sexual offender as soon as possible if he or she wants to use this information to make important decisions regarding their own health. Allowing you to be present or to give evidence and participate in the proceedings will delay the process. Furthermore, it has been decided by Parliament that the limitation of your right to bodily integrity and privacy in this instance is both reasonable and justifiable in the light of the grave danger of HIV infection to which you have allegedly exposed your victim.

What if the charge against me is a false charge?

Any person who misuses or abuses the procedure to obtain information about your HIV status may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also bring a civil claim for damages against such person.

How will I be tested for HIV?

The investigating officer will take you to a registered medical practitioner or nurse who will on the same occasion take two body specimens from you. The investigating officer will take the properly identified specimens to a

designated facility where they will be tested for HIV.

Who will pay for the HIV test?

The state.

Will I be informed about the result of the HIV test?

Yes. The investigating officer will ensure that you receive the HIV test result and information on where you can get help with understanding the implications of the result.

Will the test result be disclosed to other people?

The test result will be disclosed only to you and the victim or a person acting on his or her behalf. Your HIV status is confidential medical information which is not for public information. Any person who has obtained information about your HIV status through this process and who maliciously discloses it to others may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also bring a civil claim for damages against such person.

Will the test result be used in the trial against me?

No. The HIV test result obtained through this procedure may not be used as evidence in any criminal or civil trial. The investigating officer may however, under the provisions of the Criminal Procedure Act, 1977 have you tested for HIV for evidentiary purposes (which would include evidence for sentencing) if necessary.

How does my HIV status affect others?

Your HIV status does not only have serious implications for your alleged victim, but also for your own health and the health of others (eg your sexual partner). Every person has a responsibility to ensure that they don't put others at risk of HIV infection. It is important that you get expert advice, assistance and information on how to protect yourself and others against infection with HIV.

Service organisations which can provide counselling and support

Expert assistance in dealing with the implications of HIV test results is available at a number of different private and public facilities. These include:

Private medical and social facilities (eg a general medical practitioner or psychologist).

Public medical and social facilities, including -

<input checked="" type="checkbox"/>	Life Line	<input checked="" type="checkbox"/>	Rape Crisis
<input checked="" type="checkbox"/>	Child Line	<input checked="" type="checkbox"/>	FAMSA
<input checked="" type="checkbox"/>	The National Council for Child Welfare	<input checked="" type="checkbox"/>	Regional Departments of Social Welfare
<input checked="" type="checkbox"/>	Local State Hospitals and Clinics	<input checked="" type="checkbox"/>	Local ATTICS
<input checked="" type="checkbox"/>	Local AIDS Service Organisations		

Contact details of the above public facilities are available in the telephone directory, from the Investigating Officer, and from the Prison authorities.

FORM 5

[REGULATION 7]

RECORD OF HIV TEST RESULT OBTAINED IN TERMS OF AN ORDER GRANTED UNDER SECTION 7(1)(b) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001)

(To be completed by an authorised person attached to a facility designated to carry out compulsory HIV testing under Government Notice No R ... of ... 2001)

PART A: PARTICULARS OF ARRESTED PERSON

Case No (or SAPS reference no):

Full names:

ID No:

PART B: PARTICULARS OF HIV TEST/S PERFORMED

Type of HIV test/s performed:

.....
.....
.....

PART C: RESULT OF HIV TEST

Positive 9

Negative 9 *(Mark relevant block with a cross)*

Indeterminate 9

PART D: PARTICULARS OF DESIGNATED FACILITY PERFORMING HIV TEST/S:

Name of facility:

Address:

Telephone No:

FORM 6

[REGULATION 8]

NOTICE REGARDING HIV TEST RESULT OBTAINED FOLLOWING COMPULSORY HIV TESTING OF AN ARRESTED PERSON IN TERMS OF SECTION 7(1)(b) OF THE COMPULSORY HIV TESTING OF ALLEGED SEXUAL OFFENDERS ACT, 2001 (ACT NO. ... OF 2001)

(To be handed to: a) The victim or the person acting on his or her behalf who applied to have the arrested person tested

for HIV; and

b) The arrested person who has been tested for HIV)

The purpose of this information sheet is to provide a victim or a person acting on his or her behalf, and the arrested person with information on how to deal with receiving information about the outcome of a compulsory HIV test.

How will I be told about the HIV Test Results?

The results will be made available to you in a sealed envelope.

What will be contained within the sealed envelope?

The sealed envelope will contain a document completed by a person attached to the facility who performed the HIV testing on the body specimens of the arrested person. The form will state whether the HIV test result was:

positive;

negative; or

indeterminate (i.e. the test is not clear either way).

If I am the victim, may I disclose the arrested person's HIV status to other people?

You may not disclose the arrested person's HIV status **except** to those who need to know. This will include such persons as your sexual partner, your medical doctor, or those persons who provide emotional support to you. You should discuss the disclosure of the test results with the service organisation providing you with counselling and support before making any disclosures. If you maliciously disclose the arrested person's HIV status, you may be prosecuted and convicted of an offence and sentenced to a fine or to imprisonment for a period not exceeding six months or both. You may also face a civil claim for damages. The same applies to a person acting on behalf of the victim.

If I am the arrested person, may I refuse to receive the HIV test result?

No.

What should I do with the HIV test result?

Every person receiving an HIV test result should get expert assistance in understanding and dealing with it regardless of whether the test result was positive, negative or indeterminate. Expert assistance will help you to -

- # understand the test result;
- # deal with immediate emotional reactions and concerns;
- # understand how the result will affect your future health and the health of others (eg your sexual partner);
- # identify the need for social and medical care; and
- # discuss the need to disclose the test result to others.

Service organisations which can provide counselling and support

Expert assistance in dealing with the implications of HIV test results is available at a number of different private and public facilities. These include:

- # Private medical and social facilities (eg a general medical practitioner or psychologist).
- # Public medical and social facilities, including -

Ž	Life Line	Ž	Rape Crisis
Ž	Child Line	Ž	FAMSA
Ž	The National Council for Child Welfare	Ž	Regional Departments of Social Welfare
Ž	Local State Hospitals and Clinics	Ž	Local ATTICS
Ž	Local AIDS Service Organisations		

Contact details of the above public facilities are available in the telephone directory, or from the Investigating Officer.

If, after reading this notice, there is anything you do not understand ask the Investigating Officer or the Department of Correctional Services' Social Worker for assistance.

Explanatory notes

- 13.1 Explanatory notes to amplify the provisions of the proposed draft Bill and Regulations are provided below. The information contained in Chapter 12 in most instances also serves as detailed background to the proposed provisions and are referred to below where relevant. (As indicated in paragraph 12.24 above, draft regulations addressing the practical implementation of the Bill were developed by the Commission alongside the draft Bill in response to a need reflected in the comments on Discussion Paper 84 and after deliberations with the Department of Justice.)

Purpose of statutory intervention

- 13.2 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 to HIV during the attack. 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.¹²⁸³

Clause 1, Draft Regulation 2, Form 1

Notice to victim

- 13.3 The purpose of this provision is to make the procedure created as accessible as possible by providing victims of sexual offences (or persons acting on their behalf),

¹²⁸³ See par 12.11-12.12.

with information to enable them to initiate an application for compulsory testing.¹²⁸⁴

The contents of the informational notice to be supplied and explained to victims are prescribed in Form 1 of the draft Regulations and aim to be sufficient to enable victims to make an informed decision on whether to pursue the available process. The notice further sets out the steps to be followed in making an application for compulsory testing and addresses issues that victims may be concerned about (including who will consider the application, who will pay for the HIV test, how will the test result be disclosed, and whether the result may be disclosed to others). Significantly, the notice also contains a warning against misuse and abuse of the procedure, as well as information on the importance of obtaining counselling on dealing with the implications of an HIV test result.

- 13.4 The sense of urgency - aimed at enabling the initiation of post exposure prophylaxis (PEP)¹²⁸⁵ where it is accessible and affordable - that is conveyed throughout the proposed legislation, is enunciated in this very first provision. It is also conveyed in clauses 2(2); 2(4); 4; 7(1)(a)(iii); 10; 12(2); and 13.

Clause 2, Draft Regulation 3, Form 2

Manner of application

- 13.5 Clause 2 (read with draft regulation 3 and Form 2) gives effect to the Commission's recommendations that compulsory testing must be victim-initiated and based on evidence on oath by the victim or a person acting on his or her behalf.¹²⁸⁶
- 13.6 It is evident from this clause that the availability of the procedure is limited to possible exposure to body fluids of arrested persons during alleged *sexual offences*;¹²⁸⁷ that application can be made for testing arrested persons for *HIV only*;¹²⁸⁸ and that the

1284 See par 12.94-12.98.

1285 See par 3.62 et seq for information on PEP after sexual exposure.

1286 See par 12.29-12.30.

1287 See par 12.39-12.41.

1288 See par 12.46-12.51.

procedure is aimed at HIV testing *before* conviction. It should be noted that "sexual offence" has specifically not been defined in the Bill for the reasons set out in paragraph 12.42 et seq.

- 13.7 An application for compulsory HIV testing must be in the prescribed form (Form 2 of the draft Regulations) which provides for recording information under oath supplied by the victim or a person acting on his or her behalf. To make the procedure as simple and accessible as possible Form 2 requires that the specific information that a magistrate would need in exercising his discretion on whether to grant an order for compulsory testing or not, be set out. Form 2 also requires investigating officers to assist in completing applications for compulsory testing (eg by providing particulars of the arrested person).

Clause 3

Application may be brought on behalf of victim

- 13.8 The main purpose of this provision is to provide for situations where victims are psychologically too traumatised to bring applications for HIV testing of arrested persons themselves.¹²⁸⁹ In such circumstances a victim may give written consent for another person to apply for compulsory testing on her or his behalf. At the same time provision was made for applications to be brought on behalf of persons who lack legal capacity to act on their own.¹²⁹⁰

Clause 4

Jurisdiction

- 13.9 This provision embodies the Commission's recommendation that an order for

1289 See par 8.14.

1290 See par 12.31-12.35.

compulsory testing should take place on authorisation by a court only.¹²⁹¹ The sense of urgency conveyed throughout the procedure is again evident in this provision. It is however not expected that magistrates should attend to applications for compulsory testing outside court hours.¹²⁹²

Clauses 5 and 6

Parties who may appear before the magistrate and who may give evidence

13.10 Clauses 5 and 6 give effect the Commission's recommendation that in order to ensure an uncomplicated and speedy process and to protect the victim from unnecessary contact with the justice system and from contact with his or her assailant (which could lead to further traumatisation) the victim is not obliged to attend the proceedings; and the arrested person (or his or her legal representative) is not allowed to be present or give evidence at the proceedings.¹²⁹³ The arrested person retains his or her right to apply to the High Court for review in the event that an order for compulsory testing is not properly granted in accordance with the prescribed requirements.¹²⁹⁴

Clause 7, Draft Regulation 4, Form 3

Magistrate's order

13.11 This provision gives effect to the Commission's recommendations that an order for compulsory testing must be based on a specified standard of proof - this being prima facie evidence that a sexual offence in which exposure to the body fluids of the arrested person may have occurred, was committed against the victim;¹²⁹⁵ and

1291 See par 12.11-12.12.

1292 See par 12.110 et seq.

1293 See the motivation for this in par 12.69-12.72.

1294 Ibid. Refer also to clauses 7 and 9.

1295 See par 12.11-12.12.

further, that such order should be granted by a court.¹²⁹⁶

- 13.12 It also embodies the recommendation that compulsory testing should be available for a limited time period corresponding with the period during which a victim's own HIV test would not clearly indicate whether he or she had been infected with HIV (the "window period").¹²⁹⁷ Clause 7(1)(a)(iii) allows a maximum of 50 calendar days to grant an order for compulsory HIV testing - which leaves 10 calendar days to execute the order (cf clause 13 which provides that no order may be executed if more than 60 calendar days have lapsed from the date on which it is alleged that the offence in question took place). The longer period of 50 days for granting an order is prescribed to allow sufficient time for the arrest of an assailant. It may of course be possible, if the assailant is arrested soon after the alleged sexual offence has been committed, that an application will be granted and executed in a much shorter period of time.
- 13.13 "Body specimen" referred to in clause 7(1)(b)(i) has been broadly defined in clause 20 as any body sample which can be tested to determine the presence or absence of HIV infection. Currently HIV tests are being performed on blood, saliva and urine.¹²⁹⁸ No reference is made to these specific substances in the draft Bill as the purpose is to create a dynamic procedure which could still be relevant as scientific technology changes (eg if HIV tests on hair samples become available and are cost effective, this should not be precluded). For the same reason a specific testing protocol (indicating what type of tests and how many tests should be carried out) has not been included in clause 7(1)(b)(ii).¹²⁹⁹ Moreover, HIV testing technology is well established in practice. The reason why it is necessary to provide for *two* body specimens to be taken on the same occasion from the arrested person is discussed in paragraph 3.75.1 and footnote 387 above.

1296 Ibid.

1297 See par 12.52-12.56, and 3.4.

1298 See par 3.25 et seq.

1299 See par 12.115 et seq.

Clause 8, Draft Regulation 5

Register of proceedings

13.14 To establish some measure of control over the submission of applications to magistrates and the execution thereof by the SAPS, clause 8 provides for a register containing basic information on all applications received and their outcome (i.e. whether an order for HIV testing was granted or not). Regulation 5 prescribes what information should be contained in the register. It is clear that HIV test results are not to be recorded.

Clause 9

Magistrate's order final

13.15 See paragraphs 13.10 and 13.11 above.¹³⁰⁰

Clause 10, Draft Regulation 6, Form 4

Victim and arrested person to be notified of outcome of application

13.16 The proposed procedure creates tremendous inroads into the arrested person's right to privacy and bodily integrity.¹³⁰¹ To limit this invasion as far as possible, clause 10(b) provides for the arrested person to be supplied with prescribed information (in the form of Form 4) after an order for compulsory testing has been granted and before it is executed. Form 4 contains information on the rationale for compulsory testing and on the testing and disclosure process. It also addresses concerns which the arrested person may have about confidentiality of the test result, the possibility of the order for testing being based on a false charge, and utilisation of the test result as evidence in a criminal or civil trial. Information is finally provided on the importance of post test counselling and where to obtain it. Providing the arrested person with this information

1300 See also par 12.66-12.72 above.

1301 See par 12.11-12.12 et seq.

should ensure that HIV testing is undertaken with his or her full knowledge.¹³⁰²

Clause 11

Confidentiality of outcome of application

13.17 Clause 11 is self-explanatory and again embodies the Commissions aim to limit the infringement of the arrested person's right to privacy as far as possible.¹³⁰³

Clause 12, Draft Regulations 7 and 8, Form 6

Execution of order

13.18 The purpose of these provisions is to set out the practical steps to be taken to execute an order for compulsory testing. In particular clause 12 embodies the sense of urgency referred to in paragraph 13.4 above, and clarifies the role of the investigating officer as the central figure in executing the order.¹³⁰⁴

13.19 According to clause 12(1)(a) a nurse may also take body specimens for HIV testing from an arrested person. This provision aims to cater for situations where a medical practitioner may not be available to take the specimens (eg in rural areas). This provision is in line with current medical practice, and will ensure that the process remains speedy and accessible.

13.20 The reason why authorisation is given for taking *two* body specimens on the same occasion from the arrested person for HIV testing is discussed in paragraph 13.13 above.

13.21 Clause 12(1)(e)(ii) enunciates the importance of post test counselling in requiring that an informational notice (in the form of Form 6) be handed to both the arrested person

1302 See par 12.89-12.91.

1303 See par 12.73-12.77.

1304 See par 12.112-12.114.

and the victim on disclosing the arrested person's HIV test results.¹³⁰⁵ The notice contains prescribed information on the process of disclosure and whether the arrested person may refuse receiving the result. It also underscores the necessity for counselling and indicates where this could be obtained.

Clause 13

Limitation of period to execute magistrate's order

13.22 See paragraph 13.12 above.

Clause 14

Place where HIV testing may take place

13.23 The purpose of this provision is to ensure that existing government facilities are used for carrying out HIV tests on body specimens of arrested persons and that properly qualified people do the tests. This should ensure quality control over testing and integrate the latest available technology into the proposed procedure.¹³⁰⁶

Clause 15

Confidentiality of HIV test result obtained

13.24 This provision embodies the Commission's recommendation that the procedure should ensure confidentiality of the arrested person's HIV test result.¹³⁰⁷ Further disclosure of the test result would be covered by common law principles pertaining to confidentiality of medical information.¹³⁰⁸ This is made clear to victims in the informational notice provided to introduce the procedure to them (Form 1 discussed

1305 See par 12.89-12.91 and 12.99-12.101.

1306 See par 12.115-12.118.

1307 See par 12.73-12.76.

1308 See Chapter 5 for a discussion of these principles.

in par 13.3 above). Malicious disclosure of the arrested person's HIV status to others is punishable (see clause 19 below).

Clause 16

Inadmissibility of HIV test result as evidence

13.25 Clause 16 reflects the Commission's recommendation that the use of information relating to the HIV status of an arrested person obtained under the procedure created should be clearly limited: test results should not be admissible as evidence in criminal or civil proceedings.¹³⁰⁹

Clause 17

Costs

13.26 This provision gives effect to the Commission's recommendation that the state should be responsible for all costs related to applications for compulsory HIV testing of arrested persons and the execution of orders for such testing.¹³¹⁰

Clause 18

Regulations

13.27 Clause 18 is self-explanatory - it serves as authorisation for the draft regulations accompanying the proposed draft Bill.

1309 See par 12.78-12.84.

1310 See par 12.124-12.126.

Clause 19**Offences and penalties**

13.28 Clause 19 embodies the Commission's recommendation that malicious activation of the procedure or the malicious disclosure of the test results should be punishable.¹³¹¹

Clause 20**Definitions**

13.29 "Body fluids" refer to "any body substance which may contain HIV but does not include saliva, tears or perspiration". Although saliva, tears and perspiration may contain HIV, they have been expressly excluded from this definition since it is highly improbable that the amount of HIV in these substances will be enough to cause HIV transmission. 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.¹³¹²

13.30 The definition of "body specimen" is discussed in par 13.13 above.

1311 See par 12.85-12.88.

1312 See par 3.11.

ANNEXURE A

Draft Bill included in Discussion Paper 84, September 1999

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*.

ANNEXURE B

Respondents to Discussion Paper 84 in order of receipt of submissions

Respondents to Discussion Paper 84 in order of receipt of submissions

1-6 Members of the public responding to a talk show on Radio 702 on 27 July 1999 where the principle of compulsory HIV testing was discussed and a response was invited

Written comments received from Mrs H Nichols; DM Geldenhuys; Mrs RV Shuttle; Ms Meliny Fok; Ms Beverley Stevens; and Mrs BR Merry

7 Mr Lucky Mazibuko

Comment published in the *Sowetan* 3 August 1999

8 Mr Rashid Patel

9 Mr Seth Abrahams

10 Dr Walter Loening

11 Prof Andrew Skeen, Dean: Faculty of Law University of the Witwatersrand

12 Co-operative for Research and Education (CORE)

Comment by Piroshaw Camay

13 South African Police Service: Legal Services Southern Cape (Referred to as SAPS Legal Services Southern Cape)

Comment by Adv AC Potgieter, Legal Officer. The comments included a legal opinion by Mr MR Du Preez, Legal Officer South African Police Service: Legal Services Western Cape on the taking of blood samples in terms of sec 37 of the Criminal Procedure Act, 1977

14 Judge President EKW Lichtenberg, High Court Bloemfontein

Commenting in his personal capacity

15 Prof Sunette Lötter, Law Faculty University of South Africa

16 South African Dental Association

Comment by P Govan, Legal Adviser

17 Federation of Women's Institutes KwaZulu-Natal

Comment by Ms Heather May, Interaction Council Chairman

18 Director of Public Prosecutions Eastern Cape

Comment by Adv LJ Roberts

19 Prof CR Snyman, Law Faculty University of South Africa

20 Judges of the High Court Durban

Comment by Acting Judge President VEM Tshbalala

21 Cape Town Child Welfare Society

Comment by L Doran

22 **Acting Director of Public Prosecutions Venda High Court**

Comment by EG Mhlanga

23 **Society of Advocates of Natal**

Comment by Adv JE Hewitt SC

- 24 **Judge President E King, High Court Cape Town**
Comment by Judge FDJ Brand
- 25 **National Department of Welfare**
- 26 **Regional Court President Pretoria**
Comment by Regional Court Magistrate ME Moloto
- 27 **Women's Health Project**
Comment by Ms Marion Stevens, Policy Analyst
- 28 **Pretoria AIDS Training, Information and Counselling Centre (ATICC)**
Comment by Ms Marlene Fourie
- 29 **Afrikaanse Christelike Vrouevereniging Hoofbestuur**
Comment by Mrs M Koornhof, Director
- 30 **Durban Children's Society**
Comment by Ms Sharda Rampersad, Senior Manager Community Services and Ms Dorothy Neilson, AIDS Project Coordinator
- 31 **Amatikulu Primary Health Training Centre**
- 32 **NCEDO Care Centre**
Comment by Adv N Van Wyngaardt
- 33 **Western Cape AIDS Training, Information and Counselling Centre (ATICC)**
Comment by Ms Carroll Jacobs, Acting ATICC Manager for The Director: Health Services and Medical Officer of Health, City of Cape Town
- 34 **Department of Correctional Services**
Comment by Ms TM Magoro, Director Health and Physical Care
- 35 **Suid-Afrikaanse Vrouefederasie Hoofbestuur**
Comment by Mrs GC Viljoen-Toet, Manager Social Services
- 36 **Director of Public Prosecutions KwaZulu-Natal**
Comment by Adv Rita Blumrick
- 37 **Mpumalanga Provincial Government Department of Agriculture, Conservation and the Environment**
Comment by Ms MS Kgaphola, Assistant Director Agricultural Home Economics
- 38 **AIDS Consortium**
Comment by Ms Morna Cornell, Director
- 39 **The Evangelical Alliance of South Africa**
Comment by Mr V Mdlankomo
- 40 **Magistrate Pretoria**
Comment by Ms S Snyman, Commissioner of Child Welfare
- 41 **Township AIDS Project**
Comment by Ms Enea Motaung, Director
- 42 **HIV & AIDS Prevention Workgroup**
Comment by Ms Cecile Manhaeve

- 43 **Family and Marriage Society of South Africa (FAMSA)**
 Comment by Dr A Janse van Rensburg, National Director and Mr NE Mashigo, Advocacy and Development Manager
- 44 **Medical Officer of Health Bloemfontein**
 Comment by Dr A Hiemstra
- 45 **Democratic Nursing Association of South Africa**
 Comment by Ms Nelouise Geyer, Deputy Director Professional Matters for Ms TT Gwagwa, Executive Director. The comment included written comment by Mrs CJ Rinquist of the Red Cross War Memorial Children's Hospital
- 46 **National Department of Health**
 Comment by Dr N Simelela
- 47 **Mr Ronald Louw, School of Law University of Natal**
- 48 **South African Police Service: Legal Component Detective Service (Referred to as SAPS Legal Component Detective Service)**
 Comment by NF Van Graan, Deputy Manager: Legal Component Detective Service. The comment was supported by the Office for Serious and Violent Crimes; and the Child Protection Unit within the Detective Service
- 49 **Law Society of the Cape of Good Hope**
 Comment by the Criminal Law and Procedure Committee
- 50 **Northern Province AIDS Training, Information and Counselling Centre (ATICC)**
 Comment by Mr Herbert Smith, Clinical Psychologist
- 51 **The South African Prisoners' Organisation for Human Rights (SAPOHR)**
 Comment by Mr Percy Ngonyama
- 52 **National Institute for Public Interest Law and Research**
 Comment by Ms Alidia Seabi, Research Coordinator
- 53 **Dr Jim Te Water Naude, Western Cape Health Department**
 Commenting in his personal capacity
- 54 **Acting Judge HJ Erasmus, High Court Cape Town**
- 55 **AIDS Legal Network**
 Comment by Ms Mary Caesar, National Coordinator
- 56 **Tshwaranang Legal Advocacy Centre to End Violence Against Women**
 Comment by Ms Lebo Malepe
- 57 **Director of Public Prosecutions Witwatersrand Local Division**
 Comment by Adv AP De Vries, Director of Public Prosecutions
- 58 **Professional and Ethical Standards Committee, Faculty of Health Sciences University of the Witwatersrand**
 Comment by Prof K Huddle, Dr G McLean, Prof S Gutto, and Prof Trefor Jenkins
- 59 **The South African Medical Association**

Comment by Mr A Volschenk, Head: Human Rights, Law And Ethics. The comment included written comment by Dr PT Comfort

60 **Dr JP Driver-Jowitt**

61 **Director of Public Prosecutions Transvaal**

Comment by Adv TG Marx. The Project Committee was also supplied with a memorandum by Adv JA v S d'Oliveira SC on a proposed amendment to the Criminal Procedure Act, 1977 relating to DNA profiling and a DNA database

62 **Ms N Honono, Magistrate Pretoria**

ANNEXURE C

List of experts who attended a consultative meeting on 4 February 2000

List of experts who attended a consultative meeting on 4 February 2000

Criminal procedure and constitutional law

- 1 Prof PJ Schwikkard, Rhodes University
- 2 Prof Andrew Skeen, University of the Witwatersrand
- 3 Prof Shadrack Gutto, University of the Witwatersrand

Victims' rights and victim support

- 4 Ms Lebo Malepe, Tshwaranang Legal Advocacy Centre to End Violence Against Women
- 5 Ms Lisa Vetten, Centre for the Study of Violence and Reconciliation
- 6 Ms Heidi van Rooyen, Department of Psychology University of Natal

Prisoners' rights

- 7 Mr Brian Thusi, South African Prisoners' Organisation for Human Rights (SAPOHR)
- 8 Ms KM Mabena, Department of Correctional Services

Forensic practice and responsibilities

- 9 Dr Katrin Müller, District Medical Officer's Office Pretoria
- 10 Dr Jim Te Water Naude, University of Cape Town
- 11 Dr Ann Hiemstra, Office of the Medical Officer of Health Bloemfontein

Rights of persons with HIV/AIDS

- 12 Mr Herbert Smith, Pietersburg AIDS Training Information and Counselling Centre (ATICC)

Medical information

- 13 Prof Anthon Heyns, South African Blood Transfusion Service
- 14 Dr Graham Nielsen, Directorate: HIV/AIDS and STDs Department of Health
- 15 Prof PWW Coetzer, Department of Community Health MEDUNSA

Legal process

- 16 Mr PB Monareng, Regional Court Mmabatho

- 17 Ms NN Honono, Magistrate Pretoria
- 18 Adv Z J Van Zyl, Deputy Director of Public Prosecutions Johannesburg
- 19 Adv Retha Meintjes, Deputy Director of Public Prosecutions Pretoria
- 20 Dr Tertius Geldenhuys, Head: Legal Services South African Police Service
- 21 Mr Gerry Prins, Detective Services South African Police Service

Children's issues

- 22 Dr Neil McKerrow, Department of Paediatrics: Grey's Hospital Pietermaritzburg
- 23 Ms Ros Halkett, S A National Council for Child Welfare

Department of Justice and Constitutional Development

- 24 Ms Wilma Louw, Directorate: Subordinate Legislation, Department of Justice and Constitutional Development

Members of the South African Law Commission Sexual Offences Project Committee

- 25 Ms Joan van Niekerk, Child Line
- 26 Ms Charlotte McClain, South African Human Rights Commission
- 27 Ms Edmara Mtombeni, Department Correctional Services
- 28 Adv Gordon Hollamby, Researcher South African Law Commission
- 29 Adv Puleng Matshelo-Busakwe, Researcher South African Law Commission

Members of the South African Law Commission HIV/AIDS Project Committee

- 30 Mr Justice Edwin Cameron, Judge of the Constitutional Court of South Africa (at the time) (Chairperson)
- 31 Dr Maila John Matjila, Department of Community Health MEDUNSA
- 32 Prof Christa Van Wyk, Department of Jurisprudence University of South Africa
- 33 Prof Thandabantu Nhlapo, full-time member of the South African Law Commission (at the time)
- 34 Ms Ann Strobe, AIDS Law Project
- 35 Adv A-M Havenga Researcher, South African Law Commission

ANNEXURE D

**Draft Bill, draft Regulations and issues identified for discussion
submitted for debate to experts who attended a consultative meeting
on 4 February 2000**

REPUBLIC OF SOUTH AFRICA

CRIMINAL PROCEDURE AMENDMENT BILL

(As introduced)

MINISTER FOR JUSTICE AND CONSTITUTIONAL DEVELOPMENT

BILL

To amend the Criminal Procedure Act, 1977, so as to provide for the compulsory HIV testing of arrested persons in order to inform victims of any sexual offence in which an exchange of body fluids with the arrested person may have occurred, of 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 after section 37 of the following section:

"Compulsory HIV testing of arrested persons for non-evidentiary purposes

37A(1) When any sexual offence is reported, or as soon thereafter as is reasonably possible, any police official shall -

(a) hand a notice containing information as prescribed, to the person who

- alleges that he or she has been the victim of such offence in the official language of the complainant's choice;
- (b) enquire whether the complainant understands the contents of the notice; and
 - (c) explain the contents to the complainant if necessary.
- (2) Any complainant 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, in the prescribed manner, for an order that the person arrested on the charge or on suspicion of having committed the offence in question, be tested for HIV.
- (3) The application referred to in subsection (2) may be brought on behalf of the complainant by any other person, including a spouse, family member, friend, counsellor, health service provider, police official, social worker or teacher, who has a material interest in the well-being of the complainant: Provided that the application shall be brought with the written consent of the complainant, except where the complainant is -
- (a) under the age of 14;¹³¹³
 - (b) mentally retarded;
 - (c) unconscious;
 - (d) a person in respect of whom a curator has been appointed in terms of an order of court; or
 - (e) a person whom the court is satisfied is unable to provide the required consent.
- (4) The application contemplated in subsection (2) may be brought outside ordinary court hours or on any day.
- (5) The magistrate of the district in which the offence is alleged to have occurred or in which the complainant resides has jurisdiction to grant the order, and shall as soon as is reasonably practicable consider the application.
- (6) The magistrate -

1 Sec 39(3)(b) of the Child Care Act, 74 of 1983 provides that any person over the age of 14 years shall be competent to consent, without the assistance of his or her parent or guardian, to the performance of any medical treatment of him or herself or his or her child.

- (a) if satisfied from information on oath that prima facie evidence exists that an offence as described in subsection (2) has been committed, shall order the removal from the arrested person of a single sample of blood, urine or saliva for the performance upon it of one or more HIV tests; or
 - (b) if not satisfied as contemplated in paragraph (a), shall dismiss the application.
- (7) No order may be granted under this section if more than 60 days have lapsed from the date upon which it is alleged that the offence in question took place.
- (8) The arrested person may not attend or defend the application for a compulsory HIV testing order described in subsection (2).
- (9) The fact that an order for HIV testing of an arrested person has been granted shall not be communicated to any person other than -
- (a) the complainant;
 - (b) the arrested person; or
 - (c) any person required to carry out the order contemplated in subsection (6)(a).
- (10) The proceedings shall be held in camera and the magistrate shall keep a record of the application and its outcome.
- (11) The investigating officer shall -
- (a) assist in procuring the compulsory HIV testing of the arrested person; and
 - (b) deliver the confidential HIV test results, together with a notice as prescribed, to -
 - (i) the complainant; and
 - (ii) the arrested person.
- (12) Any police official may take such steps as may be reasonably necessary to carry out the order.
- (13) The result of the HIV test or tests performed on an arrested person in terms of this section, shall not be communicated to any person other than -
- (a) the complainant; and
 - (b) the arrested person.
- (14) Any person using the procedure in subsection (2) or (3) with malicious intent shall be guilty of an offence and may be sentenced to a fine or to 6 months' imprisonment or

both.

(15) Nothing in this section shall be construed as affecting any right of the complainant to medical or judicial recourse.

(16) The Minister may -

(a) make regulations regarding -

- (i) the manner in which information regarding the availability of the compulsory HIV testing procedure is relayed to any victim;
- (ii) the manner of application for an order for compulsory HIV testing;
- (iii) the manner in which an application for compulsory HIV testing is processed;
- (iv) the manner in which an order for compulsory HIV testing is issued;
- (v) the place where and the manner in which samples of an arrested person's or persons' body fluid are to be procured and in which HIV testing of arrested persons are to be performed;
- (vi) the manner in which the HIV test results of an arrested person are disclosed;
- (vii) any other matter the Minister deems to be necessary for the implementation of the Act; and

(b) after consultation with the Minister of Health, make regulations regarding the types and methods of compulsory HIV testing.

(17) For purposes of this section -

"AIDS" means the acquired immune deficiency syndrome;

"body fluids" mean any body fluids other than tears, saliva or perspiration;

"complainant" means a victim who laid a charge at the South African Police Service; or a person acting on his or her behalf in terms of subsection (3).

"day" means any day of the week including Saturday, Sunday or a public holiday;

"HIV" means the human immuno-deficiency virus;

"HIV test" means any medically recognised test for determining the presence of HIV in blood, urine or saliva and *"HIV testing"* has a corresponding meaning;

"investigating officer" means the police official responsible for investigating the charge or any police official acting under his or her command; and

"victim" means a person who alleges that a sexual offence was committed against him or her.

DEPARTMENT OF JUSTICE

NO R ... 2000

REGULATIONS UNDER THE CRIMINAL PROCEDURE ACT, 1977 (ACT NO 51 OF 1977)

The Minister of Justice has under section 37A(16) of the Criminal Procedure Act, 1977 (Act No. 51 of 1977), made the regulations in the Schedule

SCHEDULE

--

Definitions

1. In these Regulations any word or expression to which a meaning has been assigned in the Act shall have that meaning and, unless the context otherwise indicates - "the Act" means the Criminal Procedure Act, 1977 (Act No. 51 of 1977).

Notice containing information

2. The notice contemplated in section 37A(1) of the Act shall contain the information provided for in Form 1 of the Annexure.

Manner of application for order for compulsory HIV testing

3. (1) A complainant applies for an order that the arrested person be tested for HIV in the form of Form 2 of the Annexure.
(2) The investigating officer who receives an application contemplated in subregulation (1), shall as soon as is reasonably practicable submit such application to the nearest magistrate.

Issuing of order for compulsory HIV testing

4. The magistrate shall make an order in terms of section 37A(6) of the Act in the form of Form 3 of the Annexure.

Establishing HIV status of arrested person

5. (1) The investigating officer -
 - (a) shall inform the arrested person if an order is granted in terms of section 37A(6) of the Act;
 - (b) shall make the arrested person available or cause such person to be made available for HIV testing; and
 - (c) shall take all necessary steps to carry out the order granted in terms of section 37A(6).
- (2) Any medical officer of any correctional facility or any district surgeon or, if requested thereto by any police official, any registered medical practitioner or registered nurse shall take a blood, urine or saliva sample from the arrested person for purposes of the order contemplated in section 37A(6) of the Act.

Disclosure of HIV status of arrested person

6. (1) The person authorised to perform an HIV test on a body sample of the arrested person in terms of an order granted under section 37A(6) of the Act shall -
 - (a) record the result of the HIV test in the form of Form 4 of the Annexure; and
 - (b) provide the investigating officer with the sealed original record of the result of the HIV test performed on the arrested person, and a sealed copy of such record.
- (2) The investigating officer shall -
 - (a) collect the recorded results of the HIV test from the person contemplated in subregulation (1);
 - (b) forthwith inform the complainant and the arrested person that the HIV test result is available;
 - (c) hand the original record of the HIV test result to the arrested person, together with a notice containing the information provided for in Form 5; and
 - (d) hand the copy of the record of the HIV test result to the complainant together with a notice containing the information provided for in Form 6.

Short Title

7. These regulations shall be called the Regulations relating to Compulsory HIV Testing of Arrested Persons, 2000.

ANNEXURE

FORM 1

Regulation 2

**NOTICE TO COMPLAINANT OF AVAILABILITY OF
COMPULSORY HIV TESTING OF A PERSON ARRESTED
FOR AN ALLEGED SEXUAL OFFENCE**

If you have been the victim of a sexual offence *you may be afraid that you have been exposed to HIV*. This information sheet will provide you with information on this issue, explain to you what your rights are, give you details on how the South African Police Service will assist you and give you contact details of organisations in your area who can provide further assistance.

If, after reading this notice, there is anything you do not understand, ask the investigating officer for assistance. If he or she is unable to help, you may contact any of the listed organisations in this area for further information.

Can I be exposed to HIV during a sexual offence?

HIV is transmitted in three ways: via sexual intercourse; when HIV infected blood is passed directly into the body; and from mother to child during pregnancy, childbirth or whilst breast feeding. This means that you may be exposed to HIV during a sexual offence if you have any contact with the offender's blood, semen or vaginal fluid. For example, if you have been raped vaginally or anally and the offender's semen entered your body you may have been exposed to HIV, if the offender was HIV positive.

What can I do if I am afraid that I might have been exposed to HIV during the sexual offence?

It is recommend that you -

- # consult a health care worker for more information on the risk of HIV transmission in your individual situation and the possibility of taking medication to prevent you from becoming infected (prophylaxis);
- # consult a counsellor at a Rape Crisis or Lifeline centre for counselling and support;
- # apply to have the offender(s) tested for HIV and the results disclosed to you.

How do I apply for compulsory HIV testing of the person(s) charged with committing a sexual offence against me?

- # Lay a charge at the police station nearest to where the offence took place.
- # Inform the investigating officer that you wish to apply for compulsory HIV testing of the offender(s).

- # Tell the investigating officer to contact you or a person nominated by you as soon as the offender(s) are arrested.
- # After you have been informed that the suspect(s) have been arrested, complete FORM 2 (the application for an order for their compulsory HIV testing).
- # Hand the completed and signed form to your investigating officer.

Who can apply for compulsory HIV testing?

- # Any person (male or female) who has been the victim of a sexual offence.
- # Provided that -
 - # you have laid a charge;
 - # you have completed Form 2 (the application for the compulsory testing) which includes an oath stating you were the victim of a sexual offence during which you may have been exposed to the offender's body fluids;
 - # the offender has been arrested within 60 days of the date of the offence.

Where can I apply for a compulsory HIV testing order?

You can apply at any police station -

- # in the area where the offence took place; or
- # in the area where you live.

Can I apply for a compulsory testing order at any time?

Yes. You can apply on any day of the week - including Saturday, Sunday and public holidays; and outside ordinary court hours.

How long after the alleged sexual offence can I apply for a compulsory testing order?

You can only apply for a compulsory testing order if the offender(s) are arrested within 60 days following the alleged crime. This limit has been created as after this period you will probably be able to determine whether you have been infected with HIV by having yourself tested.

What if I am unable to apply for a compulsory testing order myself?

Any person who has a material interest in your well-being (eg a spouse or other family member, friend, counsellor, health service provider, police official, social worker or teacher) may apply on your behalf provided that you have given your written consent to that person to make the application. Written consent is not necessary if the complainant is -

- # under the age of 14;
- # mentally retarded;

- # unconscious;
- # a person in respect of whom a curator has been appointed by an order of court; or
- # a person whom the court is satisfied is unable to provide consent.

Who orders the compulsory HIV testing of the arrested person(s)?

The investigating officer will submit the completed Form 2 to the nearest magistrates court, where a magistrate will consider the application. If the magistrate is satisfied that prima facie evidence exists that a sexual offence has been committed in which exposure to the body fluids of the arrested person may have occurred, he or she will order the compulsory HIV testing of the arrested person. If not so satisfied, the magistrate will dismiss the application.

What will happen once the Magistrate has ordered that the arrested person(s) must be tested for HIV?

A sample of the arrested person(s) blood, urine or saliva will be taken and an HIV test(s) will be carried out.

Who will pay for the HIV test?

(To be discussed).

How will I be told about the HIV test results?

The result will be handed to you in a sealed envelope by the investigating officer. It is very important that you obtain HIV counselling to assist you to deal with the results whether HIV positive or negative. Please contact one of the organisations listed below for further assistance.

Contact Organisations who can provide further assistance

.....

FORM 2**(Regulation 3)**

**APPLICATION FOR AN ORDER FOR COMPULSORY
HIV TESTING OF A PERSON ARRESTED FOR A
SEXUAL OFFENCE**

PART A: APPLICATION

1. PARTICULARS OF THE COMPLAINANT (Victim of the sexual offence)**(To be completed by the Complainant or a person acting on his or her behalf)**

Surname:	
Full names:	
Id number or Date of birth or Passport number:	
Home or temporary address:	
Contact telephone number:	
Name the person whom you nominate to receive the HIV test results on your behalf (it may be yourself):	

2. PARTICULARS OF THE PERSON MAKING THE APPLICATION ON BEHALF OF THE COMPLAINANT**(To be completed by the person applying on behalf of the Complainant if applicable)**

Surname:	
Full names:	
Id number or Date of birth or Passport number:	

Home or temporary address:	
Contact telephone number:	
Nature of the relationship with the Complainant (eg cousin):	
State the reason(s) why the application is made on behalf of the Complainant:	
Indicate whether written consent of the Complainant has been obtained: (Delete whichever is not applicable)	Written consent * has been obtained and is attached/is not necessary since the Complainant is : # under the age of 14 years # mentally retarded # unconscious # a person in respect of whom a curator has been appointed by the court # unable to provide consent because

3. PARTICULARS OF THE ARRESTED PERSON(S) WHO ARE CHARGED WITH COMMITTING THE SEXUAL OFFENCE

(To be completed so far as possible by the investigating officer)

If more than 3 persons have been arrested with regard to this case, the additional details should be added as Appendix A to this application

3.1 ARRESTED PERSON NO 1 :

Surname:	
Full names:	
Id number or date of birth:	
Case number:	
Home or temporary address:	

Contact telephone number:	
Offence charged with:	
In custody/on bail: (Delete whichever is not applicable)	# *In custody. If so: Place # *On bail
Date of arrest:	

3.2 ARRESTED PERSON NO 2 :

Surname:	
Full names:	
Id number or date of birth:	
Case number:	
Home or temporary address:	
Contact telephone number:	
Offence charged with:	
In custody/on bail: (Delete whichever is not applicable)	# *In custody. If so: Place # *On bail
Date of arrest:	

3.3 ARRESTED PERSON NO 3 :

Surname:	
Full names:	
Id number or date of birth:	
Case number:	

Home or temporary address:	
Contact telephone number:	
Offence charged with:	
In custody/on bail: (Delete whichever is not applicable)	# *In custody. If so: Place # *On bail
Date of arrest:	

4. INFORMATION REGARDING THE POSSIBLE TRANSMISSION OF HIV DURING THE ALLEGED SEXUAL OFFENCE

Describe the events surrounding the sexual offence (giving full details). Use the headings below for assistance.

(To be completed by the person laying the charge or the person acting on his or her behalf)

4. (a) DETAILS OF THE ALLEGED SEXUAL OFFENCE

Date of the alleged offence:	
Describe in detail the alleged offence committed against you:	
Where did the offence take place?	

4. (b) DETAILS OF THE POSSIBLE EXPOSURE TO THE ARRESTED PERSON(S) BODY FLUIDS DURING THE OFFENCE

Were you exposed to the arrested person(s) body fluids (blood, semen, vaginal fluid); and if so, in what way:	
--	--

DEPONENT

(Person who applies for the order)

DATE

PART B : AFFIDAVIT (For official use)

I hereby certify that before administering the*oath/taking the affirmation I asked the Deponent the following questions and noted *his/her answers in *his/her presence as indicated below :-

(a) Do you know and understand the contents of the above declaration?

Answer -----

(b) Do you have any objection to taking the prescribed oath?

Answer -----

(c) Do you consider the prescribed oath to be binding on your conscience?

Answer -----

I hereby certify that the Deponent has acknowledged that *she/he knows and understands the contents of this declaration which was sworn to/affirmed before me, and the Deponent's *signature/thumb print/mark was placed thereafter in my presence.

Dated at ----- this ----- day of ----- *20 -----

Justice of the Peace/Commissioner of Oaths

Full names : -----

Designation : -----

Area for which appointed : -----

Business address : -----

*Delete whichever is not applicable

FORM 3**Regulation 4**

**ORDER FOR COMPULSORY
HIV TESTING OF A PERSON(S) ARRESTED FOR
A SEXUAL OFFENCE**

SECTION 37A(6) OF THE CRIMINAL PROCEDURE ACT 1977, (ACT NO. 51 OF 1977)

IN THE MAGISTRATE'S COURT FOR THE DISTRICT OF -----

HELD AT ----- APPLICATION NO. -----

In the application by:

APPLICANT : -----

(* Id no./Date of birth : -----)

In the matter of:

ARRESTED PERSON(S):

1. PARTICULARS OF THE ARRESTED PERSON(S)

ARRESTED PERSON NO 1:

Surname:	
Full names:	
Id number or date of birth:	
Case number:	
Home or temporary address:	
Contact telephone number:	
In custody/on bail: (Delete whichever is not applicable)	# *In custody. If so: Place # *On bail
Date of arrest:	

ARRESTED PERSON NO 2 :

Surname:	
Full names:	
Id number or date of birth:	
Case number:	
Home or temporary address:	
Contact telephone number:	
In custody/on bail: (Delete whichever is not applicable)	# *In custody. If so: Place # *On bail
Date of arrest:	

3.3 ARRESTED PERSON NO 3 :

Surname:	
Full names:	
Id number or date of birth:	
Case number:	
Home or temporary address:	
Contact telephone number:	
In custody/on bail: (Delete whichever is not applicable)	# *In custody. If so: Place # *On bail
Date of arrest:	

2. ORDER BY THE COURT AND PARTICULARS OF THE ORDER

3.1 The court orders that :

- 3.1 (a) *The application is dismissed;
- (b) *The application is granted in terms of section 37A(6) of the Act for the extraction from the arrested person(s) of a single sample of blood, urine or saliva, for the performance upon it of one or more HIV tests.
- (c) The testing must be carried out on or before the ----- day of -----20*

- (d) The test results will be made available to -
 - (i) the applicant:; or
a person nominated by the applicant:; and
 - (ii) the arrested person(s):
.....
.....
.....
.....
.....
- (e) The cost of the testing will be carried by -
(to be discussed)

MAGISTRATE

DATE

*Delete whichever is not applicable

FORM 4

Regulation 6(1)

**RECORD OF HIV TEST RESULTS
OF A PERSON(S) ARRESTED FOR
A SEXUAL OFFENCE**

(To be completed by the person authorised to establish the HIV status of an arrested person(s) in terms of an order granted under section 37A(6) of the Criminal Procedure Act 1977, (Act No. 51 of 1977)

1. CASE NUMBER:

2. PARTICULARS OF ARRESTED PERSON(S); TYPE OF HIV TEST PERFORMED AND RESULT OF TEST:

ARRESTED PERSON NO 1:

Surname:	
Full names:	
Type of HIV test performed:	
The result of the HIV test(s) performed on the body sample of the above arrested person is as follows: (Tick appropriate block)	<input type="checkbox"/> * Positive <input type="checkbox"/> *Negative <input type="checkbox"/> *No result obtained

ARRESTED PERSON NO 2:

Surname:	
Full names:	
Type of HIV test performed:	

<p>The result of the HIV test(s) performed on the body sample of the above arrested person is as follows: (Tick appropriate block)</p>	<p># * Positive # *Negative # *No result obtained</p>
---	---

ARRESTED PERSON NO 3:

<p>Surname:</p>	
<p>Full names:</p>	
<p>Type of HIV test performed:</p>	
<p>The result of the HIV test(s) performed on the body sample of the above arrested person is as follows: (Tick appropriate block)</p>	<p># * Positive # *Negative # *No result obtained</p>

SIGNED ATON THIS DAY OF

.....
FULL NAMES

.....

OCCUPATION AND WORK ADDRESS

FORM 5

Regulation 6(2)(c)

**NOTICE REGARDING THE HIV TEST RESULTS OBTAINED FOLLOWING
COMPULSORY HIV TESTING OF AN
ARRESTED PERSON IN TERMS OF SECTION 37A(6)
OF THE CRIMINAL PROCEDURE ACT, 1977**

(To be handed to the arrested person who has been tested for HIV)

This information sheet will be handed to you with a sealed envelope containing your HIV test results if you have undergone compulsory HIV testing in terms of section 37A(6) of the Criminal Procedure Act, 1977.

The aim of this sheet is to provide you with information on this issue, to give you details on the social support you can receive and to give you the contact details of organisations in your area who can provide further assistance, support and counselling.

If, after reading this notice there is anything you do not understand, ask the assistance of the investigating officer or if you are in custody the social worker at your correctional facility.

How will I be told about the HIV test results?

The results will be handed to you in a sealed envelope by the investigating officer, or if you are in custody by the social worker at your correctional facility.

What will be contained within the sealed envelope?

The sealed envelope you received from the investigating officer or the social worker will contain Form 4 which is a document completed by the person who performed the HIV testing. The form will state whether your HIV test result was -

- # positive;
- # negative; or
- # indeterminate (there was no clear result).

What should I do with the HIV test results?

Opening the sealed envelope will be a difficult and traumatic experience. It is also difficult to interpret the implications of the test results whether they are negative, positive or indeterminate. It is therefore recommended that you ask either one of the organisations listed below, or if you are in custody the social worker at your correctional facility, to provide you with support and assistance. They will be able to answer your questions, as for instance what the position is if you were in the window period.

Should I go for counselling?

It is very important that you obtain HIV counselling to assist you deal with the results whether HIV positive or negative. Please contact one of the organisations listed below, or if you are in custody the social worker at your correctional facility, for further assistance.

Contact Organisations who can provide further assistance

.....

FORM 6

Regulation 6(2)(d)

**NOTICE REGARDING THE HIV TEST RESULTS OBTAINED FOLLOWING
COMPULSORY HIV TESTING OF AN
ARRESTED PERSON IN TERMS OF SECTION 37A(6)
OF THE CRIMINAL PROCEDURE ACT, 1977**

(To be handed to the complainant or the person acting on his or her behalf)

This information sheet will be handed to you together with a sealed envelope containing the HIV test result(s) of the arrested person(s) who has undergone compulsory HIV testing in terms of s 37A(6) of the Criminal Procedure Act, 1977.

The aim of this sheet is to provide you with information on this issue, give you details on how you can get social support and to give you the contact details of organisations in your area who can provide further assistance, support and counselling.

If, after reading this notice, there is anything you do not understand, ask the investigating officer for assistance. If he or she is unable to help, you may contact any of the listed organisations for further information.

How will I be told about the HIV test results?

The results will be handed to you, or a person nominated by you, in a sealed envelope by the investigating officer.

What will be contained within the sealed envelope?

The sealed envelope you received from the investigating officer will contain Form 4 which is a document completed by the person who performed the HIV testing. The Form will indicate whether the HIV test result(s) was -

- # positive;
- # negative; or
- # indeterminate (there was no clear result).

What should I do with the HIV test results?

It is very important that you obtain support to assist you deal with the results whether HIV positive or negative. It is therefore recommended that you take the HIV test results to -

- # a health care worker;
- # a trained HIV/AIDS counsellor;
- # a social worker; or
- # a Rape Crisis or Lifeline Counsellor.

Please contact one of the organisations listed below for further assistance. These organisations will be able to assist you understand, deal with and use the information you have received on the arrested person's HIV status.

Should I go for counselling?

It is very important that you obtain HIV counselling to assist you deal with the results whether HIV positive or negative. Please contact one of the organisations listed below for further assistance.

Contact Organisations who can provide further assistance

LIST OF ISSUES SUBMITTED TO EXPERTS FOR DELIBERATION

Background documentation submitted to experts invited to the 4 February 2000 consultative meeting listed the following issues for discussion and debate:¹³¹⁴

I Issues of principle (to be) addressed in the Draft Bill (References in brackets refer to the preceding Draft Bill and Draft Regulations.)

General issues:

- i) Whether testing should be limited to exposure during a "sexual offence" only. **(Clause 37A(2))**
- ii) Whether testing should be limited to testing for HIV only, or extended to life-threatening sexually transmitted diseases; or to sexually transmitted diseases in general. **(Clause 37A(2))**
- iii) What cut-off period, if any, should be specified within which the application must be brought. **(Clause 37A(7))**
- iv) Whether there is a need for specific provisions relating to children.

Issues related to infringement of the arrested person's rights:

- v) Whether prima facie evidence is sufficient to justify the infringement of the arrested person's rights necessitated by compulsory testing. **(Clause 37A(6))**
- vi) Whether the arrested person should be entitled to appear at, or to defend, an application for testing. **(Clause 37A(8))**
- vii) Whether HIV test results should be disclosed to additional parties (i.e. to persons other than the victim and the arrested person). **(Clause 37A(11)(b) and reg 6(2))**
- viii) Whether it should be possible to utilise the HIV test results for additional purposes.

Issues related to victim protection:

- ix) Whether a more supportive procedure should be created for the disclosure of the test

1314 Extract from South African Law Commission Documentation "Background Information" Aspects of the Law relating to AIDS Project 85 (Compulsory HIV Testing of Persons Arrested in Sexual Offence Cases) Consultative Meeting Friday 4 February 2000 4-7.

- results to victims and if so, what should this be. **(Reg 6(2)(b) and (d))**
- x) Whether provision needs to be made in the draft Bill to protect victims from being prejudiced in their access to services if they either utilise or do not utilise the proposed procedure. **(Clause 37A(15))**
- xi) How the draft Bill will impact on the debate about state provision of post exposure prophylaxis (PEP) to victims.

II Practical issues (to be) addressed in the Draft Regulations

- i) Whether a standard form with information on the testing procedure is a suitable way in which to ensure that victims of sexual offences come to know about the testing procedure. **(Clause 37A(1); reg 2; Form 1)**
- ii) Whether a standard form should be used for the application for testing. **(Clause 37A(2); reg 3; Form 2)**
- iii) Whether the complainant should be able to apply for compulsory HIV testing outside court hours in view of problems currently encountered with "night courts". **(Clause 37A(4) and definition of "day" in clause 37A(17))**
- iv) Whether a standard form should be used for authorisation of testing by a magistrate. **(Clause 37A(6); reg 4; Form 4)**
- v) Whether the following practical issues related to compulsory HIV testing should be expressly provided for in the Regulations:
- * What tests should be used?
 - * Who should do the testing i e carry out the order of the magistrate?
 - * How many tests should be done?
 - * Where should testing be done?
 - * Should the body sample be destroyed after it has been tested?
- vi) How could the legislature ensure that appropriate pre- and post test counselling is provided to both the victim and the arrested person in accordance with the proposed Draft National Policy on HIV Testing (cf GN 1479 of 10 December 1999 in **GG 20710** of the same date)¹³¹⁵? And how would practical problems in this regard be dealt with

1 GN 1479 in **GG 2071** of 10 December 1999 provides as follows:

"(4) Pre-test counseling should occur before an HIV test is undertaken. ...

(5) ... (P)amphlets and other media may be used in making information on HIV/AIDS available, but cannot be regarded as a general substitute for pre-test counseling ...

(7) A doctor, nurse or trained HIV counsellor should also ensure that post test counselling takes

(eg who should do the counselling, where should it be done, and who should carry the costs)? **(Reg 6(2); Forms 5 and 6)**

- vii) What procedure should be created for the arrested person to be informed of the result of his/her HIV test? **(Reg 6(2))**

III Issues related to cost of the proposed procedure

- i) Whether the cost and human resource implications of the proposed testing procedure should be expressly addressed in the draft Bill and/or the draft Regulations? I e:
- * Which government department should be responsible for implementing the proposed procedure?
 - * Who should carry the cost of compulsory HIV *testing* of arrested persons? And if this is to be provided for, should the order by the magistrate stipulate who should carry the cost of testing?
 - * Who should carry the cost of pre- and post test *counselling* of the victim and the arrested person?

-
- (8) place as part of the process of informing an individual of an HIV test result.
Where a health facility lacks the capacity to provide a pre-test or post test counselling service, a referral to a counselling agency or another facility with the capacity to provide counselling should be arranged before an HIV test is performed, and when an HIV test result is given".